ADAPTING AN EVIDENCE-BASED MALE ENGAGEMENT INTERVENTION TO THE ETHIOPIAN CONTEXT

USAID TRANSFORM: PRIMARY HEALTH CARE

November 2021

This publication was produced for review by the United States Agency for International Development (USAID). It was prepared by EnCompass LLC for the USAID Transform: Primary Health Care Project (Award No. AID-663-A-17-00002). The views expressed in this publication do not necessarily reflect the views of USAID or the United States Government.

CONTENTS

LIST OF EXHIBITS

ACRONYMS AND ABBREVIATIONS

A&B	Attitudes and behavior
ANC	Antenatal care
DAIS	Data Analysis and Interpretation Session
FGD	Focus group discussion
FMoH	Federal Ministry of Health
FP	Family planning
GEM	Gender-equitable men
GBV	Gender-based violence
HSP	Health service provider
KII	Key informant interview
MCH	Maternal and child health
ME	Male engagement
ML	Male leader
RWAMREC	Rwanda Men's Resource Center
SNNPR	Southern Nations, Nationalities, and Peoples' Region
ToT	Training of trainers
USAID	United States Agency for International Development

MALE ENGAGEMENT FORMATIVE RESEARCH AND IMPLEMENTATION TEAM

CORE TEAM MEMBERS

Heran Tadesse, Senior Gender Advisor
Diana Santillán, Senior Gender & Social Inclusion Advisor
Elizabeth Stones, Gender & Health Specialist II
Patrick Welsh, Male Engagement Consultant
Adinew Husein, Local Male Engagement Consultant, Translator
Dustin Smith, Gender & Evaluation Specialist
Abigail Spangler, Gender Integration Specialist
Shailee Ghelani, Gender Integration Specialist
Katie Cheney, Gender Integration Specialist II
Natalie Petrulla, Gender Integration Associate
Pragati Godbole, Monitoring & Evaluation Specialist II
Simon Hiltebietel, Monitoring & Evaluation Specialist II
Hirut Demissie, Finance and Operations Manager

OROMIA TEAM MEMBERS

Meseret Bejiga Biftu, Regional Gender Officer & Team Lead
Haji Aman Deybasso, Regional Male Engagement Coordinator
Zubeida Abdulkadir, Regional Male Engagement Coordinator, Data Collector
Abebe Lemessa, Data Collector
Ayantu Habtamu, Data Collector
Solomon Eree, Data Collector
Yehualashet Muluneh, Translator

SNNPR TEAM MEMBERS

Yidnekachew Legesse, Regional Gender Officer & Team Lead
Benchialem Nega Angore, Regional Male Engagement Coordinator
Abereham Alemu, Data Collector
Miruk Alemu, Data Collector
Tesfahun Mulatu, Data Collector
Mekdes Berhanu, Data Collector

EXECUTIVE SUMMARY

INTRODUCTION

In the past two decades, Ethiopia has experienced significant improvements in its health system and the health status of its population. Despite such advancements, however, the population still has limited access to quality reproductive, maternal, and child health services through the primary healthcare system. Further, as evidenced by a body of existing research, the social determinants of health affect women, men, girls, and boys in different ways. In 2017–18, the Transform: Primary Health Care Activity carried out a comprehensive gender analysis that identified the need for improving and enhancing male engagement (ME) in family planning and maternal healthcare to address barriers to care.[1] The report revealed the following main findings related to engaging men and boys in reproductive health and/or maternal and child health services:

a) Many men oppose their partners' use of family planning methods.
b) A lack of men's participation exists in antenatal care (ANC).
c) Men influence women's decisions/autonomy on their healthcare in a variety of ways, even when collaboration occurs on seeking health services for themselves or for their children.
d) Many (young) men perceive that healthcare services are unfriendly and fail to address their needs.

The Activity responded to these findings by conducting formative research to guide the adaptation of Program P, an evidence-based male engagement intervention based on community dialogue sessions. The research and implementation teams adapted the Program P curriculum to the Ethiopian context based on the formative research findings, completed community mobilization activities, and trained community facilitators in March 2020 in preparation of the launch of the intervention. Due to the outbreak of COVID-19, however, the Transform: Primary Health Care Activity postponed and, in October 2020, eventually canceled the dialogue sessions. This report summarizes the research methodology and results, and the collaborative adaptation of the ME intervention based on the completed formative research.

METHODOLOGY

SELECTION OF INTERVENTION

To begin the process of identifying and adapting an evidence-based ME intervention, the team conducted a desk review of relevant documentation on ME interventions and background research within Ethiopia and in other parts of the world, particularly in other African countries, to select an intervention model with proven efficacy for adaptation. Program P emerged as a front runner, given its focus on engaging fathers and couples for the purpose of increasing the use of ANC and family planning services.[2] Promundo, in partnership with Puntos de Encuentro in Nicaragua, CulturaSalud in Chile, and the Brazilian Ministry of Health, initially developed the intervention, and it has since been adapted for

[1] Transform: Primary Health Care Activity. 2018. *Gender Analysis: Final Report.* Rockville, MD: EnCompass, LLC.
[2] See: *Program P* | Promundo

implementation in at least 15 countries, including the Bandebereho program in Rwanda, which demonstrated many positive results through a randomized-controlled trial.

FORMATIVE RESEARCH

In October 2019, the Transform: Primary Health Care Activity carried out formative research to inform and guide the **adaptation of Program P**. Teams of data collectors in the two targeted regions, Oromia and Southern Nations, Nationalities, and People's Region (SNNPR), collected both quantitative and qualitative data at health facilities and among community members. Data collectors conducted attitudes and behaviors (A&B) surveys and focus group discussions (FGDs) with the 96 couples targeted for the intervention. The team also completed health facility service delivery surveys at the health centers in the two selected *woredas* in each region as well as key informant interviews (KIIs) with two healthcare providers from each health center (eight) and an influential male leader/community facilitator from each of the eight targeted *kebeles*. The research team coded, analyzed, and triangulated the data to draft findings and conclusions during a collaborative and participatory data analysis and interpretation session (DAIS) in December 2019.

FINDINGS

Based on the analysis and triangulation of emerging themes from the FGDs, KIIs, health facility service delivery surveys, and A&B surveys, the team grouped findings into three categories: women and men's engagement in ante-natal care and family planning (FP), factors that enable and inhibit men's engagement with ANC and FP, and factors associated with maximizing men's and women's participation in the dialogue groups.

WOMEN AND MEN'S ENGAGEMENT IN ANC AND FP

FINDING 1: Although women in Oromia tend to access ANC services earlier in the facilities sampled, the same facilities showed lower ANC utilization rates than the two facilities sampled in SNNPR.

FINDING 2: Men's attendance at health facilities for FP and ANC varies, but respondents reported men attend more visits when their wife or child is sick, when their wife or healthcare provider requests it, or when their partner is delivering.

FINDING 3: While the majority of respondents reported that couples make FP decisions together and sometimes women make final decisions about FP (including secretly), most respondents agree that men make the final decision on the number of children to have.

FINDING 4: Respondents reported that some men support their pregnant partners by sharing household chores, looking after children, and accompaniment to vaccination appointments, but women remain responsible for most household activities most of the time.

FACTORS THAT ENABLE AND INHIBIT MEN'S ENGAGEMENT WITH ANC AND FP

FINDING 5: Respondents believe low male engagement is due to lack of education and awareness, and many reported that education, especially among younger men, has led to more positive attitudes and practice of male engagement.

FINDING 6: Respondents cited formal education (mostly younger couples) and continuous, community awareness raising as important drivers of ANC and FP and for changing behavior to increase male engagement in ANC and FP.

FINDING 7: Respondents mentioned several ways to enhance male engagement in ANC and FP, including involving other local professionals, providing space for community members to share experiences, and using model households.

FINDING 8: Traditional gender roles and norms, often influenced by religion, cause negative attitudes toward male engagement, which is considered a taboo. Men are often criticized by community members for accompanying women to ANC or FP visits.

FINDING 9: Respondents reported higher male engagement in urban areas, and a higher prevalence of negative attitudes in rural areas.

FINDING 10: Respondents reported that women spend a majority of time on household and caregiving tasks, while men spend time on income-generating activities, limiting men's time for engagement in ANC and FP.

FACTORS ASSOCIATED WITH MAXIMIZING MEN'S AND WOMEN'S PARTICIPATION IN THE DIALOGUE GROUPS

FINDING 11: Well-facilitated sessions led by trusted community members will increase participation in dialogue groups.

FINDING 12: Participants can participate together in these sessions; however, there is concern about who will take care of household duties or if women will be comfortable discussing sensitive topics if participating together.

FINDING 13: To increase participation, it is important for facilitators and coordinators to take into account local schedules and take advantage of community and social gatherings.

FINDING 14: FGD participants emphasized gender roles and family dynamics as the most important topics, whereas male leaders and healthcare providers emphasized family planning and pregnancy as the most important topics.

FINDING 15: Male leaders and health service providers (HSPs) are willing and happy to participate in this program.

FINDING 16: External motivation and incentives such as financial incentives and refreshments will increase participation in dialogue groups.

CONCLUSIONS

At the end of the DAIS, the research team collaboratively developed conclusions grounded in the findings listed above. They concluded that rigid gender roles affect both men's and women's capacity to fully participate in ANC, FP, and MCH, with some exceptions, in both Oromia and SNNPR. Dialogue sessions in the adapted Program P should, therefore, include critical reflection on gender roles and dynamics, in order to transform them. Education and raising awareness around FP, gender, GBV, pregnancy, and gender roles are also considered important for increasing ME in ANC and FP. Because there were little to no significant differences in findings between the regions, the adaptation of Program P need not be region specific. Furthermore, gendered division of labor will impact women's ability to engage in scheduled dialogue sessions. Male leaders and Activity staff should be flexible in scheduling sessions and location to account for the local context.

RECOMMENDATIONS

Based on the findings and conclusions detailed above, the research team recommended addressing the following key areas of interest in the process of introducing adaptations into the Bandebereho Program P manual:

1. Dialogue sessions should address GBV, gender norms, and household division of labor to match gender-equitable men (GEM) scale data and FGD participant preferences.
2. The adapted Program P curriculum and manual should integrate a strong gender-transformational approach, underlying all dialogue sessions.
3. The adapted Program P curriculum should include relevant information about family planning and pregnancy to help male partners be better informed about their partners' and children's needs
4. The curriculum should address contextual factors, given that traditional gender roles and cultural norms reinforce negative attitudes about male engagement.

ADAPTATION OF PROGRAM P TO THE ETHIOPIAN CONTEXT

An ME consultant with over 30 years researching, developing, and implementing curricula related to gender, masculinities, violence, sexuality, and reproductive health completed an initial review of the Bandebereho Program P training manual and made suggestions for a session outline for the Ethiopian adaptation based on the recommendations above. EnCompass staff in the United States and Ethiopia reviewed the outline and provided feedback before the ME consultant drafted an adapted Program P curriculum.

The study team then shared the draft adapted curriculum with representatives from the Federal Ministry of Health (FMoH), Activity technical specialists, and other key stakeholders operating in the field of gender equality and ME in health during an adaptation workshop in January 2021. During the workshop, participants reviewed findings and conclusions from the formative research and completed a close review of sessions in small groups to provide feedback for specific session revisions as well as the intervention overall.

In February 2020, the implementation team trained the selected male and female facilitators from the targeted communities who would lead the dialogue sessions to prepare them to implement the intervention. This training provided another opportunity for final revisions to ensure the language used was easy to understand and relevant for community participants. The final version of the Engaging Men in Family Planning and ANC dialogue session curriculum can be found here. Because the Transform: Primary Health Care Activity was unable to implement the dialogue sessions because of COVID-19, the Activity has shared the final curriculum, including guidelines for mobilization and implementation, with the FMoH's Women, Youth, and Children's Directorate for use in follow-on or other future programming.

INTRODUCTION

This report summarizes formative research findings on male engagement for reproductive, maternal, newborn, and child health in Ethiopia and describes the process for adapting an evidence-based intervention (Program P) to increase male engagement for improved maternal and child health.[3]

The research and implementation teams completed the formative research, adaptation of Program P to the Ethiopian context, community mobilization activities, and training for community facilitators by March 2020. Because of the COVID-19 outbreak, however, the Transform: Primary Health Care Activity postponed and, in October 2020 for the safety of its staff and participants, eventually canceled the dialogue sessions. This report presents the formative research design, methods, and results and how the findings guided the collaborative adaptation of the Program P curriculum for Ethiopia.

BACKGROUND

In the past two decades, Ethiopia has experienced significant improvements in its health system and the health status of its population. Despite such advancements, however, the population still has limited access to quality reproductive, maternal, and child health services through the primary health care system. Only 41% of women in Ethiopia use a family planning method,[4] and one in five married women still have an unmet need for family planning services.[5] Only 43% of women completed the recommended four ANC visits during pregnancy,[6] and the pregnancy-related mortality ration remains high – almost twice the global average at 412 deaths per 100,000 pregnancies.[7]Further, as evidenced by a body of existing research,[8] the social determinants of health affect women, men, girls, and boys in different ways.

In response, the 5-year Transform: Primary Health Care Activity, funded by the United States Agency for International Development (USAID), provides technical assistance to the Government of Ethiopia to support its implementation of the Health Sector Transformation Plan, with the ultimate goal of preventing child and maternal deaths.

The Activity focuses primarily on reproductive, maternal, newborn, child, and adolescent health and nutrition in five regions: Amhara, Oromia, Southern Nations, Nationalities, and Peoples' Region

---

[3] See: *Program P* | Promundo
[4] Ethiopian Public Health Institute (EPHI) [Ethiopia] and ICF. 2021. Ethiopia Mini Demographic and Health Survey 2019: Final Report. Rockville, Maryland, USA: EPHI and ICF.
[5] Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. Ethiopia Demographic and Health Survey 2016: Key Indicators Report. CSA and ICF: Addis Ababa, Ethiopia, and Rockville, MD, USA.;
[6] Ethiopian Public Health Institute (EPHI) [Ethiopia] and ICF. 2021. Ethiopia Mini Demographic and Health Survey 2019: Final Report. Rockville, Maryland, USA: EPHI and ICF.
[7] Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. Ethiopia Demographic and Health Survey 2016: Key Indicators Report. CSA and ICF: Addis Ababa, Ethiopia, and Rockville, MD, USA.;
[8] Carmela Alcántara, Sarah Valentina Diaz, Luciana Giorgio Cosenzo, Eric B. Loucks, Frank J. Penedo & Natasha J. Williams (2020) Social determinants as moderators of the effectiveness of health behavior change interventions: scientific gaps and opportunities, Health Psychology Review, 14:1, 132-144, DOI: 10.1080/17437199.2020.1718527

(SNNPR), Sidama,[9] and Tigray and takes a holistic approach to health systems strengthening by addressing four result areas:

1. Improved management and performance of health systems
2. Increased sustainable quality of service delivery across the continuum of care
3. Improved household and community health practices and health-seeking behaviors
4. Enhanced program learning to impact policy and programming related to preventing child and maternal deaths

Alongside Pathfinder International and JSI Research & Training Institute, Inc., EnCompass LLC serves as a key partner on this Activity.

MALE ENGAGEMENT IN REPRODUCTIVE HEALTH AND MATERNAL AND CHILD HEALTH SERVICES

Existing evidence links male engagement (ME) with improvements in ante-natal care (ANC) attendance, skilled birth attendance, births taking place in facilities, postpartum care, birth and complications preparedness, and maternal nutrition.[10] Similarly, myriad interventions in Ethiopia and other global contexts have shown that engaging men can lead to gender-transformative behavior change and increased uptake of family planning services.[11]

The Government of Ethiopia recognizes the important role of men in improving health outcomes at the national level. The National Guideline for Family Planning Services (2011) aims to bolster men's role as users, promoters, and decision makers with regard to family planning. Similarly, the guidelines suggest the need to ensure that family planning services are friendly toward men and promote male accompaniment when women access family planning services.[12]

In 2017–18, the Transform: Primary Health Care Activity carried out a comprehensive gender analysis that identified the need for improving and enhancing male engagement in family planning and maternal healthcare to address barriers to care.[13] The report revealed the following main findings related to engaging men and boys in reproductive health and/or maternal and child health services:

- Many men oppose their partners' use of family planning methods.
- A lack of men's participation exists in ANC.
- Men influence women's decisions/autonomy on their healthcare in a variety of ways, even when collaboration occurs on seeking health services for themselves or for their children.

---

[9] In June 2019, Sidama split from SNNPR to become an independent region, increasing the number of target regions for the Transform: Primary Health Care project from four to five.
[10] Tokhi, M., L. Comrie-Thomson, J. Davis, A. Portela, M. Chersich, and S. Luchters. 2018. *Involving men to improve maternal and newborn health: A systematic review of the effectiveness of interventions.* PLoS ONE 13(1): e0191620.
[11] In Ethiopia, see Tilahun, Coene, Temmerman and Degomme (2015) and Terefe and Larson (1993). Globally, see Daniele et al. (2018) in Burkina Faso; Al-Sabir, Alam, Hossain, Rob, and Khan (2004) in Bangladesh; and Wilder, J., R. Masilamani, and E. Daniel. 2005. *Promoting Change in the Reproductive Behavior of Youth: Pathfinder International's PRACHAR Project.* Bihar, India: Pathfinder International in India.
[12] Government of Ethiopia. 2011. *National Guideline for Family Planning Services*.
[13] Transform: Primary Health Care Activity. 2018. *Gender Analysis: Final Report.* Rockville, MD: EnCompass, LLC.

- Many (young) men perceive that healthcare services are unfriendly and fail to address their needs.

Similarly, the gender analysis found that men's behaviors around accessing healthcare services in Ethiopia are likely influenced by:

- Sociocultural taboos
- Expectations and norms preventing men's engagement
- Lack of knowledge of or familiarity with ways to engage in familial health
- Lack of social and peer support
- Poor couple communication

Consequently, in its conclusions, the gender analysis report recommended that the Activity should work with the government and partners to:

- "engage men and boys at community and facility levels to increase acceptance and use of RMNCAH-N [reproductive, maternal, newborn, child, and adolescent health and nutrition] services for themselves and their families" (Recommendation 16)
- "improve the quality of client and couples counseling on family planning to address myths and misconceptions that deter use of family planning" (Recommendation 18).

In response to those recommendations, the Activity decided to develop an **evidence-based male engagement intervention** to be implemented between September 2019 and July 2020.

REVIEW OF MALE ENGAGEMENT INTERVENTIONS

Having taken the decision to develop an evidence-based male engagement intervention, EnCompass proceeded to carry out a formative research study that included the following actions:

- A desk review of relevant documentation on male engagement interventions and background research within Ethiopia and in other parts of the world, particularly in other African countries
- The selection of an intervention model with proven efficacy for adaptation (Program P)
- The elaboration of a provisional outline of the male engagement intervention based on the Program P model

DESK REVIEW OF RELEVANT DOCUMENTATION

As a first step in the development of the evidence-based male engagement intervention, EnCompass carried out a review of relevant documentation related to engaging men for improving access to ANC and family planning services. This included the analysis of 25 research studies and 20 programmatic interventions carried out in Ethiopia, and 31 experiences from other parts of the world (see Annex A).

The evidence reviewed highlighted the following key findings:

1. There are important links between the engagement of men and boys and the achievement of the following outcomes:

    a) Increased uptake of family planning services
    b) Improvements in ANC attendance
    c) Skilled birth attendance
    d) Births taking place in facilities
    e) Postpartum care
    f) Birth and complications preparedness
    g) Maternal nutrition

2. The engagement of men and boys for gender equality can lead to gender-transformative behavior change.

3. Engaging men simultaneously **as partners,** in which they are central to supporting women's health, and as **agents of positive change,**[14] in which they are involved in actively promoting gender equity, can enable important contributions to improvements in both men's and women's health.

[14] In reference to Male Engagement Framework cited in Greene M.E., Mehta M, Pulerwitz J, Wulf D, Bankole A, & Singh S. 2006. Involving men in reproductive health: contributions to development. Washington, D.C., USA: Millennium Project.

THE SELECTION OF PROGRAM P

In assessing which interventions and approaches would best coincide with the needs of Transform: Primary Health Care and its proposed outcomes, Program P emerged as a front runner, given its focus on engaging fathers and couples for the purpose of increasing the use of ANC and family planning services.[15]

Program P was developed initially by Promundo in partnership with Puntos de Encuentro in Nicaragua, CulturaSalud in Chile, and the Brazilian Ministry of Health, and has since been adapted for implementation in at least 15 countries. It focuses on the following thematic content and approaches:

- Responsible fatherhood ("P" for "*padre*" and "*pai*" in Spanish and Portuguese respectively, means "father")
- Couples' engagement to build respectful, healthy relationships
- Men's roles in family planning, during pregnancy, labor and delivery, and postpartum
- Positive parenting and healthy, non-violent relationships with children
- Prevention of GBV
- Gender identities and roles, and gender equality
- The use of experiential learning and participatory methodologies (gender transformative) to enable reflection, critical analysis, and the articulation of changes in attitudes and behaviors

The promising results achieved in a 2014/15 adaptation of Program P in Rwanda, the Bandebereho/Role Models: Fathers and Couples program,[16] promoted by Promundo and Rutgers University and implemented by the Rwanda Men's Resource Center (RWAMREC) also influenced the final decision to select Program P.

The findings of a randomized controlled trial conducted as part of the Bandebereho program and published in 2018 highlighted the following promising results:[17]

- Increased overall ANC attendance
- ANC visits accompanied by men
- Women's perceived support during pregnancy
- Sharing of childcare and household tasks
- Reductions in intimate partner violence, in the use of physical punishment against children, and in men's dominance in household decision-making

---

[15] See: *Program P* | Promundo

[16] *Bandebereho Program P manual*: RWAMREC, Promundo-US, MenCare+, Rutgers. 2013. *Facilitator's Manual - Engaging men as fathers in gender equality, maternal and child health, caregiving and violence prevention*. Rwanda.

[17] Doyle, K., R.G. Levtov, G. Barker, G.G. Bastian, J.B. Bingenheimer, S. Kazimbaya, 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. https://doi.org/10.1371/journal.pone.0192756.

PROVISIONAL OUTLINE OF THE MALE ENGAGEMENT INTERVENTION

Based on the Bandebereho adaptation of the Program P model and the projected outcomes of the male engagement intervention envisaged by Transform: Primary Health Care, the following provisional outline of the intervention summarizes elements that were included in the Male Engagement Implementation Research Inception Report.

Exhibit 1: Provisional outline of the ME intervention

Purpose of the intervention:	"To change men's attitudes about family planning and ANC and norms around masculinity by demonstrating positive models of fatherhood, to increase positive involvement in their partners' use of relevant healthcare services."
Target populations:	• Men aged 15 to 35 years and their partners (married or cohabiting) • Living in eight *kebeles* in Oromia and SNNPR[18] • Must be expectant and/or current parents with one or more children under 5 • Living within accessible distance of a health post or health center
Group dialogue sessions	• Eleven 2- to 3-hour long, small group dialogue sessions for critical reflection and analysis • Men will participate in all 11 sessions and their wives/partners with them in six sessions
Learning approach:	• Gender transformative approach to promote changes in existing inequitable attitudes, beliefs, and behaviors
Training curriculum thematic content:	• Gender and power; intimate partner violence • Fatherhood • Inter-couple communication and decision-making • Caregiving; child development • Family planning and male engagement in reproductive and maternal health (including accompaniment of their wife/partner to ANC services) • Accompaniment of their wife/partner to delivery; joint discussion on where to deliver • Danger signs in each phase during pregnancy, delivery, and postpartum • Birth preparedness and complication readiness (BPCR) actions
Facilitators' profile	• Influential community members selected in consultation with local administration, health extension workers, and Activity staff • Literate, have good community rapport and community acceptance • Optional: Be a father—not obligatory, as younger community members could be influential, but not have children • Same facilitator to each group of participants for the 11 sessions

[18] A *kebele* is the smallest administrative unit of Ethiopia, similar to a ward, a neighborhood, or a localized and delimited group of people.

	• Local healthcare providers and health extension workers will co-facilitate the sessions related to pregnancy and family planning (prior prep given by the Transform: Primary Health Care Activity)
Training of facilitators	• A 2-week training of trainers (ToT) delivered by the Transform: Primary Health Care Activity prior to the intervention • Material support and refresher training sessions during the intervention • Per diem will be provided to facilitators, healthcare providers, and health extension workers for the duration of their training/orientation
Organization/ logistics	• Multiple sessions may be conducted on each day the groups are brought together to minimize the logistical challenges and cost of the intervention • Convenient and accessible locations in the intervention communities (*kebeles*) for the group dialogue sessions will be decided on by the participants • Intervention of up to three months • Refreshments will be provided to men/couples and facilitators for each session attended

Drawing from the Bandebereho/Role Models: Fathers and Couples manual, the provisional 11 sessions for group dialogues, their names, proposed sequencing, and respective objectives and participants are demonstrated below in Exhibit 2. The final intervention design, including number, names, and content of the sessions, and their length, would be determined by the findings of the pre-intervention formative research.

Exhibit 2: Program P adaptation for Ethiopia: Proposed sessions, objectives, and participants

SESSION	OBJECTIVES	PARTICIPANTS
1. Expectations	• Receive feedback on the needs, expectations, and motivations of participants • Use the expressed needs and interests of men to encourage their participation and answer their most pressing questions • Get input from the participants on planning or adapting future sessions to address the particular needs of the group	Couples
2. Father's Impact/ Legacy	• Reflect on the influence fathers or other male authority figures have had on the participants while they were growing up • Discuss how participants can take the positive aspects of their fathers' influence, and address the negative impacts so as not to repeat harmful patterns	Men
3. Pregnancy	• Normalize men's involvement in maternal health and the prenatal period • Address many of the concerns that men have about the experience of pregnancy, such as couples' conflict and stress, loss of sexual desire, and more	Couples

SESSION	OBJECTIVES	PARTICIPANTS
4. Birth	• Share ideas and experiences about the role of a father during birth and prepare the father for his role as a companion for the mother • Address concerns men have about childbirth • Highlight the importance of physically and emotionally bonding with their sons and daughters	Couples
5. Family Planning	• Reflect on the benefits of family planning and the value of couples' communication in this process; talk about the use of condoms and other methods of birth control • Remind the couple that, even if their first child was not planned with the use of birth control methods, they can decide when to have other children or they can make the decision not to have any more children • Invite a reproductive health professional to speak at the session to increase the participants' knowledge of available birth control methods	Couples
6. Caregiving	• Learn about a baby's care needs and reflect on men's capacity to satisfy these needs • Question the stereotype that women are naturally better equipped to provide care and upbringing for children than men	Men
7. Gender	• Reflect on norms of gender socialization, i.e., the different ways we treat and educate our children based on gender • Reflect on the communication and affection between parents and their sons and daughters	TBD
8. Non-Violence	• Reflect on the violence that occurs in families, among couples (mostly of men against women), and against children. (It is recommended that men undertake this activity without the women so that men may express themselves more freely and honestly.)	Men
9. Children's Needs and Rights	• Make connections between the long-term goals fathers and mothers have for their children (ages 0–4) and how harsh discipline affects those goals	Couples
10. Division of Caregiving	• Reflect on the time men dedicate to caring for and attending to their children and compare it to the time women spend; reflect on male involvement in these activities and discuss the sexual division of labor • Analyze the relationship and communication fathers have with the mothers of their children to identify weaknesses and strengths • Discuss the devaluation of daily housework in society	Couples

SESSION	OBJECTIVES	PARTICIPANTS
	• Make 1–2 commitments to participate more equally in domestic work	
11. Final Reflections	• Reflect on the experiences that participants have had in this cycle of sessions • Make a commitment to be a more involved father • Encourage the participants to continue to meet after the session ends	Men

IMPLEMENTATION RESEARCH STUDY

PURPOSE OF THE STUDY

Having selected the Bandebereho/Role Models: Fathers and Couples adaptation of Program P in Rwanda, the Transform: Primary Health Care Activity then embarked on a process of "implementation research."

Broadly understood as "the study of methods to promote the uptake of research findings into routine practice,"[19] the implementation research study carried out by the Transform: Primary Health Care Activity sought to build on the effectiveness of the Bandebereho experience in Rwanda by identifying cultural and contextual factors specific to the two regions in Ethiopia (Oromia and SNNPR) where the intervention would be implemented. This, in turn, would enable all necessary adaptations to be introduced into the Bandebereho Program P model and enhance the pertinence and efficacy of its implementation in Oromia and SNNP regions.

The data generated by the implementation research would contribute to maximizing gender transformative approaches within the adapted Bandebereho Program P manual for engaging men as partners and agents of positive change, considered pivotal in supporting their role in improving health outcomes and in contributing to the ultimate goal of mitigating preventable child and maternal deaths.

STUDY DESIGN AND OBJECTIVES

In the **design phase** of the implementation research study, the Transform: Primary Health Care Activity identified that the study's aim would be to generate quantitative and qualitative data that would:

- Assist in assessing the **adaptability** of Program P to the Ethiopian context and the **feasibility** of its implementation
- Facilitate the evaluation of the **effectiveness** of the completed ME intervention and its **scalability**, with a view to its future roll out on a larger basis through the Transform: Primary Healthcare Activity regions

This implementation research study was planned to be conducted in three phases:

1. Pre-intervention phase:
   - Formative research to understand local context and inform adaptations
   - Baseline data collection to assess the effectiveness of the intervention
2. Mid-intervention phase:
   - Follow-up visits to monitor implementation of the ME intervention (dialogue sessions) and recommend adjustments

[19] Bhattacharyya O, Reeves S, Zwarenstein M. What Is Implementation Research?: Rationale, Concepts, and Practices. Research on Social Work Practice. 2009;19(5):491-502. doi:10.1177/1049731509335528

3. Post-intervention phase:
    - Assessment to examine adaptability, feasibility, effectiveness, and scalability of the ME intervention

Dialogue sessions had been scheduled to begin in March 2020. Because of the COVID-19 outbreak, however, the Transform: Primary Health Care Activity postponed and, in October 2020, canceled the dialogue sessions, as the full intervention and implementation research study could not be completed before the end the Activity's last year of implementation. The study and implementation teams were able to complete the pre-intervention formative research, adaptation of Program P for use in rural Ethiopia, and training of community facilitators.

This report presents the methods and results of the pre-intervention phase (formative research), completed for adaptation of the Program P curriculum to the Ethiopian context.

METHODS

In October 2019, the Transform: Primary Health Care Activity carried out formative research to inform and guide the **adaptation** of Program P. To do so, the data collection team, consisting of the Activity's Regional Gender Officers in Oromia and SNNPR, the two Male Engagement Coordinators, and eight external data collectors, conducted appreciative, participatory methods for collecting and analyzing qualitative and quantitative data.

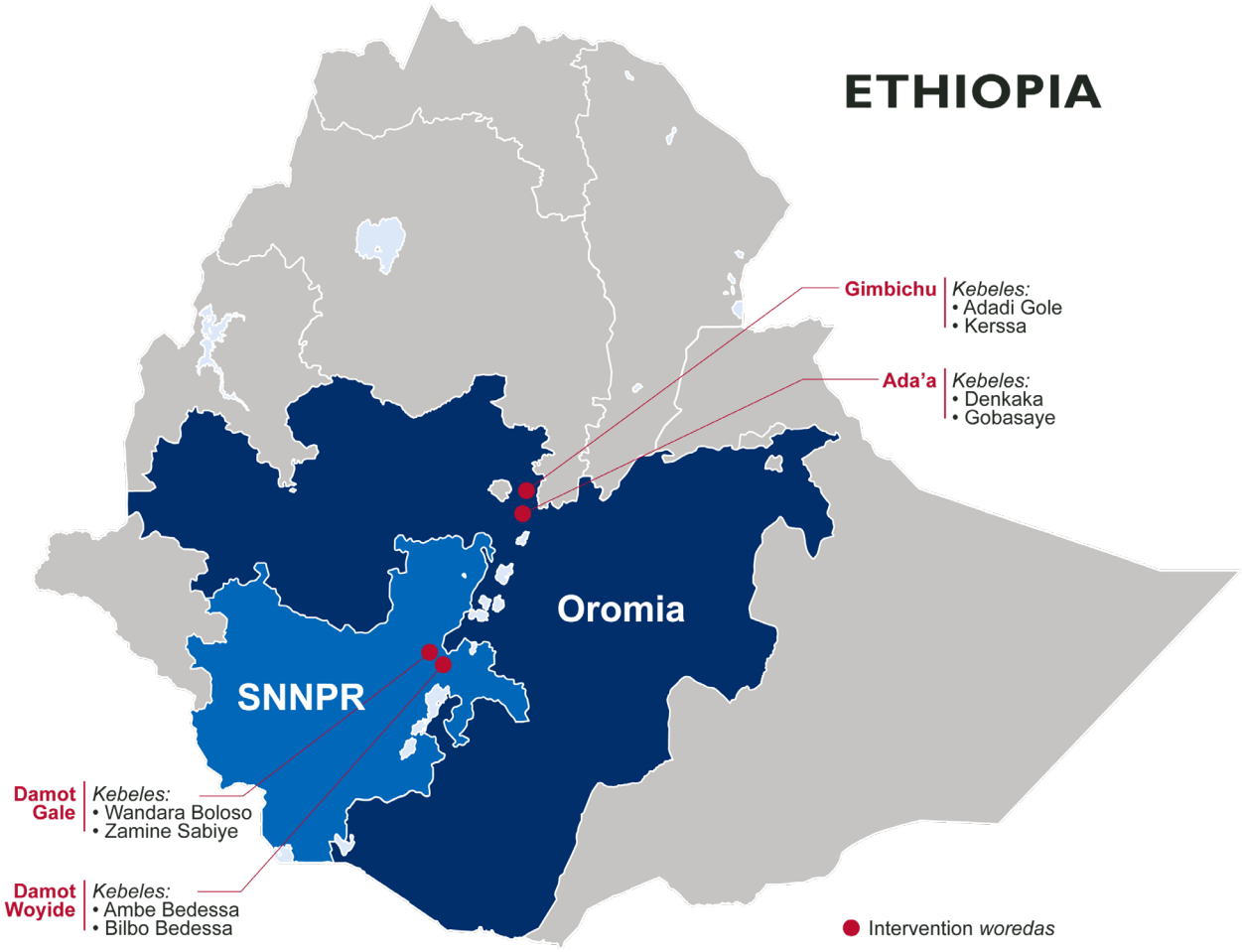
SAMPLING

The study took place in Oromia and SNNPR, the two regions selected for participation in the intervention due to the large number of intervention *woredas* and the relative stability in relation to political reforms taking place at the time. Data collection events occurred in eight *kebeles,* two from each of the two selected learning *woredas* from each region. Refer to Exhibit 5 below for a summary of data collection events. The selection of the eight *kebeles* to take part in the implementation research study was based on the following criteria:

1. Ongoing participation in the Transform: Primary Health Care Activity
2. Rural and urban representation in the sample
3. Feasible access considering the start of the rainy season and to facilitate close follow-up by the implementation team

The study sought to recruit one male leader and 12 qualifying couples from each *kebele* for a total of eight male leaders/community facilitators and 96 participating couples. The study team also planned to interview two health service providers (HSPs) and complete one health facility survey at the health center in each of the four *woredas*.

Exhibit 3 Data collection event locations



QUALITATIVE PRIMARY DATA COLLECTION

The data collection team gathered primary data using both key informant interviews (KIIs) and focus group discussions (FGDs). KIIs took place with eight HSPs, two from the health center in each of the intervention *woredas,* and the eight selected male leaders from the community who would have served as the facilitators for the dialogue sessions. Data collectors then conducted FGDs with the 12 men and 12 women selected in each *kebele* to participate in the ME intervention dialogue sessions, separated into groups by sex and age group (18–24 years of age and 25–35 years of age).

The KIIs and FGDs served to help the Activity better understand the potential challenges and opportunities for conducting an intervention based on Program P in the target communities; inform appropriate adaptations to Program P in the Ethiopian context and the context of the regions where the Transform: Primary Health Care Activity operates; and identify region-specific and culturally appropriate messages for, barriers to, and determinants of access to ANC and family planning. The original tools are in English, and local translators translated the tools into Amharic and Afan Oromo for data collection. Copies of the questions included in each of the qualitative data collection tools can be found in Annex C.

QUANTITATIVE PRIMARY DATA COLLECTION

Quantitative data for the study consisted of attitudes and behavior (A&B) surveys with the dialogue session participants and a service delivery survey at the health center in each *woreda*. Men and women selected for the dialogue sessions responded to an interviewer-led, paper personal survey that used the gender-equitable men (GEM Scale[20]) and additional demographic and behavioral questions to assess changes in gender attitudes and in health-seeking behaviors related to ANC and family planning.

The A&B surveys served to establish a baseline set of data on male and female participants' attitudes toward gender norms, the use of modern family planning methods, access to the healthcare system, gendered division of childcare and household tasks, and men's dominance in decision-making about birth spacing and how many children to have.

Health facility surveys conducted in each health center gathered ANC, delivery, and family planning service delivery data in target communities to establish a baseline on the use of relevant healthcare services in the target communities. Copies of the health facility survey and A&B surveys for male and female participants can be found in Annex C.

DATA COLLECTION TEAMS

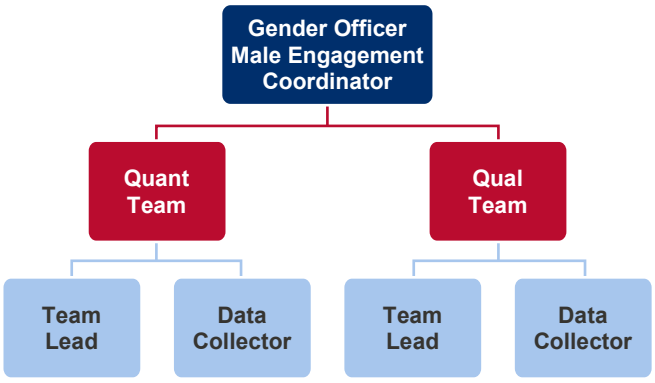
As shown in Exhibit 4 below, two data collection teams were formed in each of the two study regions (Oromia and SNNPR): a **qualitative data** collection team and a **quantitative data** collection team. Each team consisted of a man and a woman and was comprised of a **team lead** and a **data collector** who together were responsible for collecting data from male and female participants as indicated by the research team.

Within each region, the Regional Gender Officers provided technical oversight and quality control in addition to supporting facilitation of FGDs, and the Regional Male Engagement Coordinators supported the management of data collection schedules and logistics in addition to facilitating FGDs. The functions of all involved in data collection are detailed in Annex B.

In each of the qualitative data collection activities (KIs and FGDs), one team member facilitated the interview or discussion while the other took notes. Gender Officers and Male Engagement Coordinators supported, so that each FGD was facilitated by two people of the same gender.

With participants' permission, recordings were made for back-up purposes, to fill in any necessary gaps in notetaking. Final

Exhibit 4: Structure of Regional Data Collection Teams



[20] The GEM scale, developed by Population Council/Horizons and Promundo, includes 24 statements designed to gather and assess information about community norms related to gender norms, violence, sexuality, masculinities, and reproductive health.

transcriptions of the activities were produced in English.

To conduct the A&B surveys, quantitative data collectors interviewed participants of the same gender, and together collected quantitative data from heath facilities data for submission to the Regional Gender Officers.

DATA COLLECTOR TRAINING

Prior to data collection, in September 2019, the Regional Gender Officers, Male Engagement Coordinators, and data collectors participated in a 3-day training on (1) male engagement concepts, terms, and sensitivities; (2) the implementation research study's purpose, design, and evaluation questions; (3) the data collection tools; (4) best practices and ethical considerations for data collection (e.g., respectful treatment of respondents, maintaining respondents' privacy, and following all informed consent and data management processes); and (5) interviewing and note-taking skills by piloting the tools.

The training focused specifically on protecting human research subjects over the span of the data collection process. Data collectors also received a field guide during the training that outlined their commitments to and responsibilities for the treatment of respondents, protection of their identities and information, and safeguarding the data collected. A field guide data protocol was developed and was fundamental in articulating and managing consistent data collection and storage.

PARTICIPANT RECRUITMENT

In collaboration with the *Woreda* Health Office staff, the Regional Gender Officers recruited participants in each of the eight targeted *kebeles* in the implementation research study, using previously prepared recruitment scripts and templates. (See Annex D)

The selection of potential HSPs and influential male leaders as key informants and facilitators of the envisaged dialogue sessions was conducted through informal communication drawing on existing relationships between Transform: Primary Health Care Activity staff. All male leaders had previous knowledge of family planning and ANC services and facilitation of workshop processes.

In each region, Regional Gender Officers worked with health extension workers in each *kebele* to compile a list of prospective couples based on their knowledge of the communities and the selection criteria. They then used a simple random sampling process to select the final set of participants for the study and dialogue sessions. Staff proceeded to carry out home visits to formally invite the couples to take part in the implementation research study and future dialogue sessions.

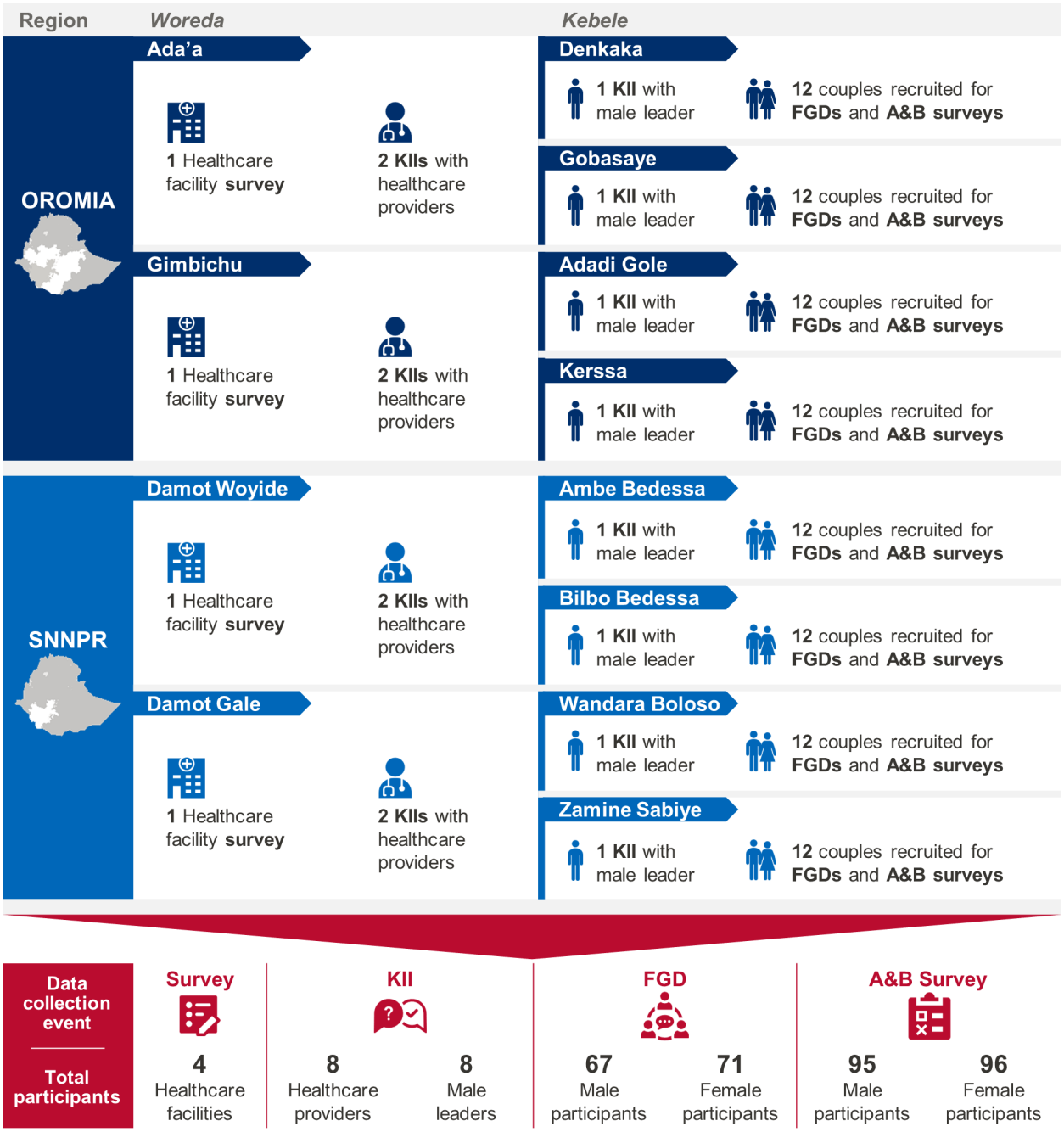
A simple random sampling process was also used to choose which of the 96 couples selected to take part in the ME intervention would be invited to participate in the 16 FGDs that would take place with men (four in Oromia and four in SNNPR) and women (four in Oromia and four in SNNPR).

If a couple were to drop out of the program or the data collection, they would be replaced with another couple in the program, also selected using a simple random sampling process.

All data collection occurred in October 2019.

Exhibit 5 below summarizes all data collection events and the actual numbers of participants that were successfully recruited for each of the data collection activities in each region during the pre-intervention phase.

Exhibit 5: Data collection events and participants reached



CONSENT

In alignment with international standards on human subject research, and with approval from the EnCompass Institutional Review Board and the Regional Health Bureau, the research team developed

informed consent forms for KIIs, FGDs, and A&B surveys. The interviewer read the consent form and all participants provided oral consent for the activity before proceeding with the interview. The information contained in the consent forms is summarized below.

- The purpose of the study and its duration (approximately 12 months)
- Methods of data collection being used
- Reasons for their participation (facilitators and participants in the proposed ME intervention dialogue sessions)
- Voluntary participation and right to withdraw at any time without fear of reprisals
- Periodicity of data collection (pre-, mid- and post intervention phase) and the purpose of data collection during each phase
- Measures taken to maximize confidentiality and the safety of participants in the study
- Benefit criteria: no direct personal benefits or incentives; travel costs would be reimbursed
- All information provided will be combined with information from other interview respondents and presented in a final report that will be shared with the Ethiopian Ministry of Health, USAID, Transform: Primary Health Care Activity staff, participating health facilities, and other key stakeholders
- EnCompass LLC's role: focusing primarily on collecting data to help strengthen and improve the curriculum to be used in the ME intervention that will be directly implemented by local leaders
- Permission to record or take notes during the interview, explaining measures to guarantee the anonymity of information provided
- Details on whom to contact and how for more information about the ethics review or any future questions about the research study

Full copies of the consent forms can be found in Annex E.

CONSOLIDATION OF DATA SETS

On conclusion of all data collection events, as detailed in Exhibit 5 above, two sets of data were available for analysis.

Qualitative data set

1. Results of 8 KIIs with HSPs
   - ✓ 4 KIIs in Oromia
   - ✓ 4 KIIs in SNNPR
2. Results of 8 KIIs with male leaders
   - ✓ 4 KIIs in Oromia
   - ✓ 4 KIIs in SNNPR
3. Results of 16 FGDs with prospective dialogue sessions' participants.
   - ✓ 4 FGDs with men in Oromia
   - ✓ 4 FGDs with women in Oromia
   - ✓ 4 FGDs with men in SNNPR

- ✓ 4 FGDs with women in SNNPR

Quantitative data set

4. Results of A&B surveys with 191 prospective dialogue sessions' participants
   - ✓ 47 A&B surveys in Oromia with men
   - ✓ 48 A&B surveys in Oromia with women
   - ✓ 48 A&B surveys in SNNPR with men
   - ✓ 48 A&B surveys in SNNPR with women
5. Results of data collected from 4 healthcare facilities
   - ✓ 2 healthcare facilities in Oromia
   - ✓ 2 healthcare facilities in SNNPR.

DATA ANALYSIS

The data analysis team coded and analyzed all qualitative and quantitative data in October and November 2019.

QUALITATIVE DATA ANALYSIS

The analysis team coded and analyzed qualitative data using Dedoose 7.0.23, a web-based application for managing, analyzing, and presenting qualitative and mixed-methods research data. The team developed a comprehensive data coding structure based on the review of KII and FGD transcripts to guide thematic coding. To analyze the data, members of the research team developed and grouped emerging themes in a "Qualitative Data Analysis Summary," in relation to the following key questions of analysis:

1. To what extent are men engaged in ANC and family planning?
2. What supports access to ANC and family planning services?
3. What hinders access to ANC and family planning services?
4. What would support participation in the dialogue groups?
5. What would hinder participation in the dialogue groups?

With regard to each of the above questions of analysis, reviewers also recorded the source(s) of the information and representative quotes from specific sources in their qualitative data analysis summaries.

QUANTITATIVE ANALYSIS

The research team compiled, cleaned, and analyzed quantitative data from the A&B surveys and health facility surveys guided by a comprehensive data analysis plan. Team members entered and cleaned all data from the A&B surveys and health facility data in Excel before uploading and analyzing them in STATA 15.

For the A&B survey data, the research team used the following research sub-questions to guide their analysis:

1. Are there significant differences between men and women's responses in the overall GEM Scale; in the four sub-scales?

2. Are there significant differences in men's GEM Scale scores by the age of participants?
3. Are there significant differences in women's GEM Scale scores by the age of participants?
4. Are there significant differences in men's GEM Scale scores by region?
5. Are there significant differences in women's GEM Scale scores by region?
6. Does education play a role in participants' responses?

To answer these questions, the research team analyzed each question on an item-by-item basis, separately by sex. For the GEM Scale questions in the A&B survey, the team also disaggregated by age, education, and region to determine statistically significant differences. Additionally, the team used unique "family IDs" in addition to individual IDs to analyze responses by couples to determine any statistically significant differences or trends among couples. Variables related to the GEM Scale have been treated as scaled items in previous studies,[21] and the research team employed the same approach, calculating a total and subscale scores rather than analyzing each question separately for frequencies and percentages. Other questions in the A&B surveys were categorical and, as such, were analyzed for descriptives.

For the health facility surveys, the research team entered and analyzed data from the four health facilities surveyed in Excel in order to answer the following research sub-questions:

1. For the topics assessed, are there any differences between regions?
2. For the topics assessed, are there any differences within regions?

The research team calculated frequencies and percentages for each item in the health facility survey to compare between and within regions.

DATA ANALYSIS AND INTERPRETATION (DAIS)

In order to analyze, triangulate, and interpret the data summaries and articulate findings and conclusions, members of the research team and the ME consultant hired to draft the adapted version of Program P took part in a face-to-face Data Analysis and Interpretation Session (DAIS) in December 2019. During this session, team members presented emerging themes and discussed the significance and interrelationships among themes, guided by the evaluation questions to triangulate across data sources. Team members then drafted findings and conclusions grounded in the data.

[21] Diamond-Smith, N., Treleaven, E.,Murthy, N., & Sudhinaraset, M. (2017). Women's empowerment and experiences of mistreatment during childbirth in facilities in Lucknow, India: results from a cross-sectional study; BMC Pregnancy and Childbirth, 17(2); doi: 10.1186/s12884-017-1501-7; Scott, J., Averbach, S., Modest, A.M., Hacker, M.R., Cornish, S., Spencer, D., Murphy, M., & Parmar, P. (2013). An assessment of gender inequitable norms and gender-based violence in South Sudan: a community-based participatory research approach, Conflict and Health, 7(4), doi: 10.1186/1752-1505-7-4

FINDINGS

During the DAIS session, the triangulation and analysis of the responses, opinions, and beliefs of diverse stakeholders and of other quantitative data collected, using a variety of methods, led to the articulation of a series of pre-intervention findings that would inform the subsequent adaptation of the Bandebereho Program P manual for the Ethiopian context.

These findings are organized below under the following themes:

1. Women's and men's engagement in ANC and family planning
2. Factors that enable and inhibit men's engagement with ANC and family planning
3. Factors associated with maximizing men's and women's participation in the dialogue groups

WOMEN'S AND MEN'S ENGAGEMENT IN ANC AND FAMILY PLANNING

FINDING 1: Although women in Oromia tend to access ANC services earlier in the facilities sampled, the same facilities showed lower ANC utilization rates than the two facilities sampled in SNNPR.

Health facility service indicators from a 6-month period preceding data collection revealed that the percentage of women that received ANC at least once and received ANC four or more times during their current pregnancy was high in SNNPR (near or above 100 percent in both *woredas*). Percentages were lower in Oromia, particularly for the health center in *woreda* 2, which were between 32 percent and 45 percent.

Exhibit 6: Percentage of women who received ANC at least once during their current pregnancy

*Percentage of Women who Received ANC at Least Once During the Current Pregnancy**

FACILITY	REGION	WOREDA	MONTH 1	MONTH 2	MONTH 3	MONTH 4	MONTH 5	MONTH 6
Health Center 1^	SNNPR	Woreda 1	114%	134%	116%	95%	93%	105%
Health Center 2^	SNNPR	Woreda 2	102%	100%	98%	100%	94%	88%
Health Center 1^	Oromia	Woreda 1	87%	78%	76%	112%	83%	80%
Health Center 2**	Oromia	Woreda 2	37%	36%	36%	32%	45%	40%

**Number of pregnant women that received antenatal care at least once / Total number of expected pregnancies.*
^Data recorded for March–August 2019
***Data recorded for April–September 2019*

Women in Oromia, however, attended their first ANC visit earlier than their counterparts in SNNPR. With regards to family planning use, there were more new users of family planning in SNNPR than Oromia, but there were higher numbers of repeat family planning users in Oromia than SNNPR.

FINDING 2: Men's attendance at health facilities for FP and ANC varies, but respondents reported men attend more visits when their wife or child is sick, when their wife or healthcare provider requests it, or when their partner is delivering.

Although many men and women reported that men attend health facility appointments for FP and ANC with their partners, attendance is inconsistent and depends on the type and severity of the visits. Participants reported that men typically attend appointments when their partner is delivering, when their partner or child is sick, or when an HSP or their partner requested them to attend, but men often do not accompany their partners for ANC, family planning, and vaccination visits.

These reports correspond with the data gathered in the A&B surveys from these same participants, indicating that among female and male participants currently expecting a child who had attended at least one ANC visit (n=15 and n=13),[22] all reported that men did not accompany their partners to ANC visits.

> *It is because husbands already made the discussion and decision on family planning with their wives to the point that they feel there is no need for them to be involved further. After the decision is made, he goes somewhere else to attend another business. He would not be able to go with her.* – Female participant, SNNPR

> *The community of this area is aware of male support towards mothers and child health, because they know the problems from the past. But still there is a strong gap on coming together of husbands to this health post with their wives.* – HSP, Oromia

FINDING 3: While the majority of respondents reported that couples make FP decisions together and sometimes women make final decisions about FP (including secretly), most respondents agree that men make the final decision on the number of children to have.

Close to 90 percent of men and 80 percent of women affirmed that they often or sometimes have discussions with their partner on the number of children to have or on the spacing of children.

> *My wife is asking me for second child, but I declined her proposal because I don't feel comfortable with our current economic condition that I want to prolong when to have our second child.* – Male participant, Oromia

> *On child spacing couples decide together. The two couples should cooperate with each other on child spacing. Otherwise, conflict will arise if they do not cooperate with each other. If I want to have children rather than child spacing, and if she wants to have child spacing, there should be cooperation between the couples. We have to educate both couples on child spacing. We have to convince the couples. Now is better than before. The community is spacing with education given by health workers. Child spacing is well going within the Kebele. Other health related affairs are going well.* – Male leader, SNNP

[22] All participants surveyed were coupled. Fifteen female participants reported that they were expecting a child, while only 13 male participants reported the same. The study team is unsure of the reason for this discrepancy, but it is possible two of the male participants were not yet aware of their partner's pregnancy or other extenuating circumstances.

Only 30 percent of women, however, said that their partners "often" considered their opinions seriously, compared to 61 percent of men who said they do so. Similarly, slightly less than half of women (49 percent) reported that both partners in the relationship have the same say in making the final decision about how many children to have or the spacing of children, compared to 61 percent of men. Similar numbers of women and men (36 percent and 35 percent, respectively) said that it is the man who makes the final decision on how many children to have or on the spacing of children.

> *We couldn't say that all couples are deciding and discussing together the number of children they planned to have; there are circumstances when a husband decide alone to do so. Even if she discusses and expresses her will on the number of children she wants to have and the time gap, the final decision belongs to husband. Because it is he…who provides money and fulfills necessities for the children and family as a head of household.* – Woman participant, Oromia

> *I think it is largely the husband who makes decision. In context of our community, when you get married it is at disposal of the husband that the woman relocates to the man's home. This may give male to hold upper hand. This however does not mean all men act in the same way…. In general, though it is difficult to clearly put it, in most of the cases I can say it is men who make decision. There is a saying that goes: Dubartiin abbaa warraa jala hindubbattu to mean "women have to comply with what the husband says" which is handed down and inherited by older men.* – Male leader, Oromia

> *I try to explain to him(husband) the kinds of problems that will surface when the economic status of the family does not match / fail to sustain the size of the family. I attempt to make him understand. However, it is the father who makes the final decision regarding the number of children that the family will have… Even if it is preferable to have agreement between father and the mother, it is the father who makes the decision (predominantly).* – Health service provider, SNNP

A small number of respondents (4 percent of men and 7 percent of women) acknowledged that there are cases where women make the final decision on how many children to have or on the spacing of children. Many health service providers and a few male leaders and male participants noted that women often make such decisions by using family planning in secret.

> *After giving birth to three or four children, if I say to myself, "I am the one who suffers from the consequences of multiple childbearing." I can decide on my own how many children I must have.* – Woman participant, SNNP

> *For economically poor families, men are mainly engaged in farming and do not have information about child spacing, hence women are the decision makers for child spacing. …. Most of the time women alone come to the health center to get health services. So, it is the women who gets health education. Because of this, women from poor families decide alone to use family planning and decide on child spacing too. In most cases women decide to use family planning alone secretly without the knowledge of the husband, since having more children affects her severely.* – Health service provider, SNNP

> *In most cases, it is wives who use family planning secretly because of the high number of family size. Wives usually secretly visit health facilities to get family planning services.* – Male leader, SNNP

Injectable family planning methods were reported by both men and women as the most commonly used. to avoid or delay pregnancy (63 percent of men and 53 percent of women receptively).

FINDING 4: Respondents reported that some men support their pregnant partners by sharing household chores, looking after children, and accompaniment to vaccination appointments, but women remain responsible for most household activities most of the time.

According to two-thirds of women and three out of four men, it is women who always or usually provide daily care for their child/ren. On disaggregated tasks, however, both women and men reported similar and even higher degrees of women's responsibility in relation to holding newborn children, feeding, bathing, and taking children to the health post/health center for vaccination.

Exhibit 7: A&B survey results regarding women's household responsibilities

THE WOMAN IS USUALLY OR ALWAYS RESPONSIBLE FOR:	WOMEN'S RESPONSES	MEN'S RESPONSES
• holding their child/ren when he or she was a newborn (only asked if they had a child under 1 years old)	80% (*n=25*)	83% (*n=30*)
• feeding their children.	71%	79%
• bathing their child/ren.	81%	71%
• taking their child/ren to the health post/health center for vaccination	84%	74%

While women reported holding, feeding, and bathing their children on a daily basis, men's participation in those tasks was much less frequent. Sixty-three percent of men reported holding their newborn child three days or less a week. Similarly, 40 percent and 53 percent of men, respectively, said that they had not fed or bathed their child/ren on any day in the past week.

Participants in both regions indicated ways men support their partners during pregnancy. In contrast to the results of the A&B surveys, many participants, female and male from both regions, shared instances of male partners sharing household chores, especially to help pregnant partners avoid strenuous activity. A few others indicated looking after children to allow their partners to attend health appointments.

> *If it were not for accepted norms, it would not be necessary to have gender-based division of labor. What does it matter if a man bakes injera and a woman takes up ploughing? It is a skill. I support my wife with such household chores as taking grain to flourmill, fetching water among others. But such men can be ridiculed at or could be subject of mockery.* – Male participant, Oromia

> *Whenever I have ANC follow-up visit at the HC, my husband stays at home and performs some household chores. After delivery, we take our child to the health facility for immunization together with my husband. He works on the farm as I do housework and look after the children. I even help him with digging our farmland whenever necessary. After we return home from the farm, I roast coffee while he helps me with crushing coffee and serving already prepared food. In short, we support one another in life. We communicate well, he listens to me and is supportive of me.* – Female participant, SNNP

FACTORS THAT ENABLE AND INHIBIT MEN'S ENGAGEMENT WITH ANC AND FP

ENABLING FACTORS

FINDING 5: Respondents believe low male engagement is due to lack of education and awareness, and many reported that education, especially among younger men, has led to more positive attitudes and practice of male engagement.

Men's exposure to health education in the community improves the historically low or non-existent levels of male awareness and engagement.

> *Compared to the past, now is better in male engagement since we deliver education about it. Currently even communication between couples is better. When I discuss with some families, husbands talk freely about family planning. I think now is relatively better than the past.* – Health service provider, SNNP

> *What is behind the positive attitude is pretty clear. It is education. These days, health extension workers have done remarkable jobs in teaching our community in rural kebeles. In the past, there was no exposure to media, no education, nor training as we witness today.* – Male participant, Oromia

> *Until the first four children are born, I did not have the awareness to accompany my wife. Then after I learnt from health center and accompanied my wife for the youngest two children. This is because I got education from health center as vaccination improves the health of the child. Because of such education, I closely followed up and accompanied my wife for vaccination.* – Male participant, Oromia

Respondents reported that education has resulted in young men having more positive attitudes toward male engagement and practicing more male engagement, compared to older men.

> *There are good individuals in the community that respond positively for male's support to his wife. This positive view is developed from education and young male partners in the community perceive it as the result of modernization.* – Woman participant, Oromia

> *Most of the time, urban youth couples visit the health center together. It is less likely elder couples visit the health center together. However, elder men who married young girls visit the health center together so as to get counseling, health medication, and family planning.* – Health service provider, SNNP

> *Young generations tend to settle the decision though discussion. Older men may tend to make decision authoritatively while young couples tend to make joint decisions.* – Male leader, Oromia

FINDING 6: Respondents cited formal education (mostly younger couples) and continuous community awareness raising as important drivers of ANC and FP and for changing behavior to increase male engagement in ANC and FP.

Formal education and awareness raising processes in the community by health workers for both men and women enhance family planning use, enable discussions among couples about family planning and birth spacing decisions, and are important in changing behaviors and increasing male engagement in ANC and FP.

Nowadays, we live in the world of technology and widespread modern education. In such a context no one can force anyone. So, we have equal say and make joint decisions. – Male participant, Oromia

There has been extensive awareness creation underway at community level since recent time. So, there is increased involvement of women in family planning. They may go to health post or health center to talk to healthcare providers. – Male participant, Oromia

When husbands are aware their wives are using family planning, then the husband threatens her. Then the wife will inform health extension workers. So that the health extension worker goes to the house of such families and advises the husband. The health extension workers advise the husband about the side effect of having more children. There are husbands who nag their wife when the wife uses family planning. There are husbands who challenge their wives for using family planning. – Male participant, Oromia

FINDING 7: Respondents mentioned several ways to enhance male engagement in ANC and FP, including involving other local professionals, providing space for community members to share experiences, and using model households.

Engaging professionals from diverse public and private sector bodies (such as local administration and health extension workers, justice and police officials, and lawyers) who understand local context and the norms and values of the community is one possible way recommended by respondents in Oromia to increase male engagement in ANC and FP.

Local leaders and health practitioners of this area should be initiated to open a discussion with the community on gender equality and the importance of male engagement in women and child health services. – Male participant, Oromia

Similarly, having role models or model households would also be beneficial for communities to support male engagement in ANC and FP.

I think experience sharing is also important whereby lessons are drawn from model households. For me, learning from your neighbor is important since it costs nothing. – Male participant, Oromia

Now, we have taken some lessons. We will be role models and encourage those at home to take after us. – Female participant, Oromia

Using of role models on awareness creation program is the best way for improving such negative views. The program should be facilitated once a week and work on its continuity. – Male leader, Oromia

Respondents in Oromia also considered the exchange of knowledge, information, and sharing of experiences as another way to raise levels of education and awareness in the community on ANC and FP.

There are individual differences based on the commitment men show in supporting women. Some are more engaged than others. So, sharing experience helps a lot in this regard. People emulate exemplary individuals. – Female participant, Oromia

At different kebele meetings, it is a man who participates, attends various community meetings. So, he has to share what he has learned from the meeting to his wife, or equal participation of females and males in different meetings can bring change. – Female participant, Oromia

INHIBITING FACTORS

FINDING 8: Traditional gender roles and norms, often influenced by religion, cause negative attitudes toward male engagement, which is considered a taboo. Men are often criticized by community members for accompanying women to ANC or FP visits.

Some respondents considered religion and son preference, linked to entrenched social norms and gender inequalities, as barriers to the use of family planning.

> *In our community, there are people who consider children as a gift of Waaqa (God) hence no need of planning.* – Male participant, Oromia

> *It is the husband who decides on the number of children we want to have. For instance, if the newborn sex is female, he forces me to have the second male child. If there is a property, he (husband) also forces to have an additional baby. But female/women suffer a lot during this, but the husband suffers nothing.* – Female participant, SNNP

Similarly, several respondents, particularly women, highlighted social taboos and fears of ridicule and criticism as factors that inhibit men from accompanying their wives to the health center and from engaging in FP activities.

> *If a man goes together with his wife, people will say, "What a show off! Did he just get his wife today!? They are going together!" These kinds of remarks frighten husbands. Otherwise, it is not because they(husbands) have an evil intention. It is just that we do not have the custom of women and their children going with men. It has never happened before. We are not used to practicing this. It is not due to ill intent.* – Female participant, SNNP

> *It is not to be rude that my husband refrain from participation, as mentioned by all the participants. Rather, it is because tradition does not dictate it; people would talk and criticize the act. Otherwise, my husband and I do not have any problem/conflict amid ourselves at home that hinders us from going together. But when couples go in public, it is considered as something silly. Thus, husbands do not escort their wives.* – Female participant, Oromia

> *My husband used to escort me to the HC for ANC visits at the beginning of my pregnancy. Because people's view on what he was doing was so negative, he stopped coming with me to the HC altogether due to the pressure.* – Female participant, SNNP

> *The old perception still exists that if a husband supports his wife he is considered as an ordinary man not accepted in the society, locally called as "nadheen" or taken as a woman not a man.* – Male leader, Oromia

FINDING 9: Respondents reported higher male engagement in urban areas, and a higher prevalence of negative attitudes in rural areas.

Men's greater engagement in ANC and FP in urban areas compared to rural ones, and a higher prevalence of negative perceptions of male engagement in the latter, reflects the wider persistence of traditional gender roles in rural areas.

The urban based families or families of this town are coming to this heath post together with their wives but from the rural community, husbands do not come with their wives unless it is a critical time like delivery. – Health service provider, Oromia

Some husbands are not comfortable to come with their wives to health facilities. In the past, when couples go together, the husband should be in the front and his wife should be following him at the back. Such trend in rural area exists now too. – Health service provider, SNNP

…rural husbands are not like the town ones in supporting their wives he may not even take her to the health post/center for vaccination because of societal culture and beliefs. It is only during critical sickness that the husbands support their wives. – Female participant, Oromia

FINDING 10: Respondents reported that women spend a majority of time on household and caregiving tasks, while men spend time on income generating activities, limiting men's time for engagement in ANC and FP.

As reported in Finding 4 above, respondents reported that women are mainly responsible for childcare (holding, feeding, and bathing their children) and spend more time each day than men doing so. Similarly, respondents also considered that men's time and physical presence is mostly dedicated to income generating activities. As a result, the persistence of strict, traditional gender roles reinforces men's role as breadwinners and is a factor that inhibits their participation in and support for ANC and FP activities.

There were strict norms of gender-based roles. Activities in the house and around homestead belong to women whereas men's role is outside home activities, mainly agriculture. So, it wouldn't come as a surprise if men develop negative attitudes toward male engagement in maternal and child health services. – Male participant, Oromia

Had it not been for nature of agricultural activities we have at hand; men would love to accompany their women to the health facility. For instance, when there is no one to mind the cattle, it is difficult to accompany women unless it is a serious issue like delivery or when she falls sick. – Male participant, Oromia

Just because a husband does not escort a mother to the health facility, it does not mean that all husbands are against it. They might come after having discussed it with their husband at home. She comes alone, because she has relatively more time to come and attend services. Most people here are agrarian/ farmers, they have a huge workload. – Health service provider, SNNP

The social value placed on productive and reproductive work also contributes to men often limiting their engagement in ANC and FP activities to serious health problems that may occur during pregnancy and delivery.

The main reasons are workload. If there is no outstanding health concerns or diseases, husbands say to their wives; "You do not need me to take family planning, you can do this on your own. I have a lot of work." If a mother must go to the health center for a (serious issue) like delivery, her husband will escort her. They(husbands) give less weight to family planning issues compared to delivery. They all come when she encounters a problem during pregnancy or at the time of delivery. Not a single person refrains from coming in such situations/times. However, in terms of family planning services, he encourages it but he does

not come along. So, I think it is because they do not give the issue much weight and due to their work burden. – Health service provider, SNNP

FACTORS ASSOCIATED WITH MAXIMIZING MEN'S AND WOMEN'S PARTICIPATION IN THE DIALOGUE GROUPS

FINDING 11: Well-facilitated sessions led by trusted community members will increase participation in dialogue groups.

HSPs and male leaders thought that participants in the dialogue sessions will be more engaged if they are well facilitated by experienced and trusted leaders from the community.

> *Playing a good facilitation role is quite important based on our past experience and knowledge. Because we couldn't say that the community is not aware of the issue, they might ask unexpected questions, so the facilitator should be well prepared on the lessons. For the lessons/topics that are not referring to me, I feel nothing if I'm not engaged in it; provided that those who facilitate the other sessions deliver it by internalizing the lesson properly. Yes, the community may prefer me than others, because of our long-term intimacy in the community's health related issues.* – Health service provider, Oromia

Similarly, HSPs and male leaders also thought that participants' engagement will be enhanced if the topics addressed are relevant to them and respond to their reality.

> *I am not saying the topic is not important, but the question is, is it relevant in the community, given the reality on the ground? It is going to be too strange. For people not to perceive it as something too refined, irrelevant, it is recommendable to introduce it slowly. If the idea is too strange, they might be puzzled /intrigued and end up being distracted from addressing/discussing the other topics. They might say, 'what a strange topic they have brought up today? It should not sound as if women are deliberately raising issues to gain unfair advantage over men. If we counsel them siding for women a lot, they may ask their wives; 'did you tell them to raise this issue? 'My fear is for their focus and discussion point not confined to this topic and become distracted by it, due to its strangeness/refinement /advancement / irrelevance.* – Health service provider, SNNP

FINDING 12: Participants can participate together in these sessions; however, there is concern about who will take care of household duties or if women will be comfortable discussing sensitive topics if participating together.

Many respondents, primarily female participants, agreed that couples participating together in the dialogue sessions would not be a problem, while also acknowledging that some women participants and facilitators in mixed dialogue sessions could experience discomfort discussing sensitive topics.

> *Participating with male partners in the sessions is a great opportunity, and it will not pose any problem. It is preferable to give trainings and educate husbands and wives together to improve husbands' engagement.* – Female participant, SNNP

> *As to me there is no problem with regard to couples participating together. However, I cannot say that there are women who are afraid of their husbands to participate and speak frankly. So, we will see the sessions*

where couples are participating together and observe carefully with providing possible solutions for such cases at the spot. – Health service provider, SNNP

Other concerns on mixed dialogue sessions, expressed particularly by men, were related to who would care for the home (see Findings 4 and 10 above) and the possible loss of income associated with their participation.

One of the main challenges will be there is no one who covers household chores and other activities when we come together for training. No one cares for our younger children. Incentive in the form of money is also needed as we sacrifice our time for income generating activities. Incentive that would compensate our income that we sacrificed for the education. – Male participant, SNNP

FINDING 13: To increase participation, it is important for facilitators and coordinators to take into account local schedules and take advantage of community and social gatherings.

Recognizing participants' multiple home and work-related commitments and to maximize participation, respondents highlighted the need to program the dialogue groups (including their length and frequency) to take into consideration agricultural cycles, (planting, weeding, and harvest seasons), market days, community and social events, and working days.

Health extension workers need to be involved in scheduling the sessions because they are the one who know when the community are busy with agricultural activities (harvest, weeding, plowing etc.). – Health service provider, Oromia

I agree with him [R013]. It is better if we discuss with the facilitators on how to reschedule the sessions with less weeks and longer hours. It needs working closely with facilitators in such a way that it doesn't affect our working days. For instance, there are holy days in a month. So, we can adjust the schedules on such holy days. – Male participant, Oromia

While me and my wife participate here for education, no one will care for our younger children and cattle at home. It will be challenging if I come with my wife here for training. My wife is expected to prepare food for the family. So, it is better if the session for the training is an hour session. – Male participant, SNNP

One male leader from Oromia noted that security may affect the implementation of the dialogue sessions.

Some NGOs initiate some programs and disappear before fully putting it into practice. We hear it started but fail to see when it is completed. The other factor is problem related to security. Security issue is a very determinant factor in the implementation of the curriculum. For instance, if there is any security threat at Bishoftu, there is no way to get connected with someone in charge of the curriculum. – Male leader, Oromia

Respondents generally reported that when scheduling dialogue sessions, taking customary community and/or social gatherings and the facilities used for them into consideration is a good way to provide educational trainings and could increase male engagement and participation.

Educating the community and men in each village is ideal so as to easily access them. Since the health post is located far from some of the villages, educating the community and men at each village is better. Training

on male engagement should be given repetitively for men so as to rehearse them. Educating the community in community meetings is also vital. – Male leader, SNNP

We can take advantage of such social gatherings as Edir and Iqub to teach them. This is because people tend to prefer to be taught in group than learning individually or at household level. – Health service provider, Oromia

If that approach is not feasible, one can also use the community gathering's/platforms in every kebele, extension health worker's site, like the HV initiatives that have used such platforms to promote awareness creation on relevant issues. We could be successful if we do the same. – Health service provider, SNNP

FINDING 14: FGD participants emphasized gender roles and family dynamics as the most important topics, whereas male leaders and HSPs emphasized family planning and pregnancy as the most important topics.

Across all respondents, caregiving was commonly cited as an important subject matter in the proposed curriculum, with women from both Oromia and SNNP regions highlighting the significance of their husbands learning about providing care to children.[23]

The lessons you are mentioning here is very important, but if our husbands learn more about childcare giving in detail it will bring more changes, because they consider this task as easy work and considering it as our own (women) responsibility. – Female participant, Oromia

In my opinion, all topics are important and relevant. But, of all topics, I think caregiving and birth are the most important issues for our community. – Male participant, Oromia

Emphasis should be given on gender equality and childcare than other session of the curriculum. Because as to my observation in the community there is a big gap on gendered equality and childcare provision by men. – Male leader, Oromia

While in principle, some HSPs agreed on the importance of promoting men's responsible engagement in childcare, they were dubious about men's receptivity to doing so, (perhaps reflecting their own gender bias), and were concerned about the practical implications and possible resistance in the context of traditional gender roles.

The two topics that I want to take a close look at are, the one about fathers dedicating time to caring for and attending to their children and make a commitment to participate more equally in domestic work. I think you mentioned at the end that fathers will make a commitment to be a more involved father. This might make them laugh because almost all women in this Kebele do not have a job. Thus, her primary responsibility is to stay at home and take care of children do household chores. He might be encouraged to give more value for this daily housework. Raising the topic that addresses the devaluation of daily housework in society is a wonderful idea. – Health service provider, SNNP

The idea that a man must give time to care for children is unrealistic, because the husband, here, leaves home early at 6am to work on his farm. After working in the farm, he might have to go to the market and take care of other duties. By the time he returns home he will be too tired and won't have the energy to take

[23] In the SNNP region, no suggestions from men on important topics in the curriculum were recorded.

care of children. And if you raise such a topic, they might say, what is going to be the wife's contribution if the husband does all these things, how can they raise this topic? Her job is just to take care of children, cook, and feed her husband. It would make sense to equally share household chores if both husband and wife had work outside of home. I am not saying that it is not an important concept per se, but considering the reality on the ground, I do not think the community will accept this idea. The other topics are relatively easy to digest, but this one is difficult to convince people. – Health service provider, SNNP

Alongside childcare, respondents, in general, also underscored the importance of addressing gender equality in the curriculum, reflecting the results of the GEM Scale survey baseline that detected overall moderate equitable gender attitudes, in which women scored lower than men.[24]

All topics are important. Husbands become joyful when a baby boy is born. They have a preference for boys than girls. However, children are equal. So, they need to be taught around that to change their perspective. – Female participant, SNNP

Emphasis should be given on gender equality and childcare more than other sessions of the curriculum. Because as to my observation in the community there is a big gap on gendered equality and childcare provision by men. – Male leader, Oromia

In my opinion, all curriculum topics are equally important, though the topics are not new. What lacked is taking it seriously or deep commitments to exhaustively take on the assignments. From the topics, I think child-care and gender issues need more emphasis than the rest. This is because it is here where men consider it as the responsibility of women alone. – Health service provider, Oromia

The inclusion of childbirth/delivery in the curriculum was also considered by female participants from both Oromia and SNNP regions as an important and relevant topic.

All 11 topics are good, and we approve all of them. However, what we find most important is the discussion on how our husbands/partners can provide assistance and be with us during delivery (and as we attain all other health care services) because we will naturally be overburdened and need most support from our husbands. The topic that you talked about to address this issue is quite appealing to us. – Female participant, SNNP

Many health service providers viewed family planning as a priority topic for the curriculum and also considered pregnancy as important subject matter.

Most importantly fathers must learn concretely the importance of usage of family planning in a timely manner. That women hide their pregnancy especially for the first months of pregnancy. For women who are reluctant to use contraceptives, they may get pregnant and try to hide it. During this time, they can have bleeding that can be life threatening. – Health service provider, SNNP

All the topics listed are important and essential. However, the two topics i.e., gender and family planning are more important to focus on than others for the community. These two topics incorporate the rest of the topics. While family planning includes male engagement in pregnancy, ANC, and delivery care. On the other

[24] Data from administration of the classic GEM Scale Survey showed that female respondents had an overall mean score of 37.32 and male participants an average mean score of 47.8. Scores of 1–23 are generally considered to portray attitudes that indicate low gender equity, scores of 24–47 indicate moderate gender equity and scores of 48–72 indicate high gender equity.

hand, the gender education incorporates the problems of male engagement within the community. – Health service provider, SNNP

Respondents in general, but particularly women participants in Oromia, considered non-violence as an important topic in the curriculum, with some emphasis placed on its significance by male participants and leaders.

The topic of non-violence should be emphasized very well between husband and wife to live in harmony and in peace. Because, if there is no peace it is very difficult to do other things. – Female participant, Oromia

The proposed curriculum topics appear very nice. What particularly interests me is non-violence. Otherwise, education is good, it makes a difference. – Male participant, Oromia

The session indicates about violence occurs in the family in which men violates against women and child and the session of pregnancy should be stressed more. – Male leader, Oromia

One HSP in SNNP also suggested addressing the issue of female genital mutilation as an important topic in the context of non-violence and preventing violence against women.

I recommend for you to teach the community about female genital mutilation. Because the females are still being affected/hurt by the practice. There are still some people who would still practice female genital mutilation and girls are being harmed, the practice is carried out. It is there. … The impact should be described to mothers. In our community, people say how can a female live without being circumcised and we tried to teach them, scare them off by punishment legally buy they're even do it hiding. We taught the community the consequence of genital mutilation that a woman becomes more at-risk during delivery having the analogy of the burnt plastic, how painful it could make it for women to give birth but the community has not totally changed/instilled in people's health. The awareness is not yet created. – Health service provider, SNNP

FINDING 15: Male leaders and HSPs are willing and happy to participate in this program.

Male leaders from both regions expressed their readiness to participate in this program as facilitators of the dialogue sessions and their disposition to co-facilitate health-related sessions with local health service providers who also expressed their willingness to collaborate.

I am highly committed and willing to give up myself for this activity. Within the Kebele I am the one assigned for such type of work. I want to sacrifice myself for this work. I will sacrifice my time and myself for this work. – Male leader, SNNP

Frankly speaking, I'm very happy to play my part on my professional concerns. Here also I'm working on teaching the community on health-related issues. I feel comfortable for joining the session that meets my knowledge and experiences in health. The participants may prefer healthcare providers on health-related issues, because most of the time we are teaching and meeting them on health-related lessons for the community. – Health service provider, Oromia

FINDING 16: External motivation and incentives, such as financial incentives and refreshments, will increase participation in dialogue groups.

Respondents thought that in-kind and financial incentives would help maximize participants' retention rates in the dialogue sessions and that there may, in fact, be an expectation linked to taking time away from work to be able to take part in the dialogue sessions.

> *Participants may expect a number of incentives. Participants may expect financial incentive and also since the training time is longer, refreshment like tea-coffee is needed. I think there has to be incentive of some sort. The communities we are working with have tired of such training and gatherings.* – Health service provider, SNNP

CONCLUSIONS

The final exercise of the DAIS session entailed an in-depth analysis of the findings with the aim of developing the conclusions of the formative research study. The following questions were used to guide that process of analysis and collective construction of the conclusions:

1. What do the findings mean for adapting Program P in Ethiopia?
2. What is their significance for curriculum implementation?
3. What do they mean in the context of evaluating the curriculum?
4. How engrained are patriarchal norms and when should men and women be together or separate?

The conclusions that follow highlight the cultural and contextual factors specific to the Oromia and SNNP regions in Ethiopia that should be addressed to adapt the Bandebereho Program P model to the Ethiopian context. By doing so, its proven effectiveness for engaging men as partners and as agents of positive change will be enhanced.

CONCLUSION 1: In both Oromia and SNNP, rigid gender roles affect both men's and women's capacity to fully participate in ANC, FP, and MCH, with some exceptions.

Traditional gender norms and division of labor that view ANC, FP, and maternal and child health as culturally taboo for men have a negative effect on men's attitudes and practical engagement in ANC, FP, and MCH. The considerable power men enjoy within their relationships and homes because of the aforementioned strict gender norms and roles influences men and women's decision-making and time-use, preventing men from engaging directly and regularly in ANC and FP visits and childcare.

CONCLUSION 2: Gendered division of labor will impact women's ability to engage in the envisaged Bandebereho Program P adapted for the Ethiopian context.

Division of labor and gender norms will impact women's ability to engage in the dialogue sessions, because their participation in the program will limit their time to complete household and childcare tasks. It is harder for women to participate in the sessions because of the expectation that they are solely responsible for the home.

CONCLUSION 3: Education and raising awareness around FP, gender, GBV, pregnancy, and gender roles are considered important for increasing male engagement in ANC and FP.

Participants in the FGDs value education and awareness-raising as important methods for increasing male engagement in ANC and in the use of FP. The latter can be augmented by increasing educational opportunities on FP, gender, GBV, pregnancy, and gender roles.

CONCLUSION 4: End-line GEM scale and health facility source indicators may not reflect progress made due to data limitations.

Men's overall mean score on the GEM Scale, which is higher than women's, sparked some debate in the research team on the possible influence of observation bias and political correctness (male respondents giving the answers they expect were being solicited) that could lead to depressed GEM Scale scores for men in the post-curriculum implementation. Consequently, follow-up (end-line) GEM Scale surveys for

men may not genuinely reflect progress toward improved gender equity. The latter may also be affected by data limitations related to the accuracy of ANC utilization rates in both regions.

CONCLUSION 5: Male leaders and ME coordinators should be flexible in scheduling sessions and location to account for the local context.

To successfully implement the dialogue sessions and maximize men's and women's participation in them, male leaders and ME coordinators in each region need to be in tune with community needs and schedules and offer flexible solutions for participants to engage most effectively. This would entail planning the timing and location of the dialogue sessions based on local context (including farming seasons and conflict) and making any necessary adaptations.

Similarly, involving trusted community leaders as facilitators in the implementation of the dialogue sessions and as role models will increase participation and buy-in.

CONCLUSION 6: Dialogue sessions in the adapted Program P should include critical reflection on gender roles and dynamics in order to transform them.

While HSPs and male leaders placed emphasis on the importance of addressing topics of a more clinical nature, the responses of participants in the FGDs and via the GEM Scale surveys underscored the importance of addressing social norms. Indeed, the persistence of patriarchal gender norms, corroborated by the results of the FGDs and GEM Scale surveys, underlines the importance for both men and women participants to be able to unpack cultural stereotypes related to gender identities, roles, and relationships.

Consequently, in modifying Program P, the following adaptations should be applied: a) the dialogue sessions should address GBV, gender norms, and household division of labor to match GEM Scale data and FGD participant preferences; b) a strong gender-transformational approach should be integrated, underlying all dialogue sessions; and c) the curriculum should address contextual factors, given that traditional gender roles and cultural norms reinforce negative attitudes about male engagement.

CONCLUSION 7: The adaptation of Program P need not be region specific.

Comparative analysis of GEM Scale surveys and FGDs showed little regional difference on gender norms, suggesting that the same adapted Program P curriculum can be implemented in both Oromia and SNNP, with adult women and men, independently of their age. Minor discrepancies related to ANC service utilization in each region do not have a major bearing on the Program P curriculum and its adaptation.

RECOMMENDATIONS

Based on the findings and conclusions detailed above, the research team, including members in the United States and Ethiopia, recommended addressing the following key areas of interest in the process of introducing adaptations into the Bandebereho Program P manual:

1. Dialogue sessions should address GBV, gender norms, and household division of labor to match GEM Scale data and FGD participant preferences.
2. The adapted Program P curriculum/manual should integrate a strong gender-transformational approach, underlying all dialogue sessions.
3. The adapted Program P curriculum should include relevant information about family planning and pregnancy to help male partners be better informed about their partners' and children's needs.
4. The curriculum should address contextual factors, given that traditional gender roles and cultural norms reinforce negative attitudes about male engagement.

Similarly, Conclusion 7 of the formative research study also indicated that the adaptation of the Bandebereho Program P curriculum and manual would not need to vary in relation to the ages of participants and the geographical regions in which they reside. The same manual could be used with all couples in both Oromia and SNNP regions.

ADAPTING PROGRAM P TO THE ETHIOPIAN CONTEXT

EnCompass hired a ME consultant to draft an adapted version of the Program P curriculum for use in Ethiopia based on the findings, conclusion, and recommendations from the formative research outlined above. The consultant has over 30 years of experience researching, developing, and implementing curricula and training programs, training manuals and educational materials, and institutional strengthening and organizational development related to gender, masculinities, violence, sexuality, and reproductive health. The consultant reviewed and prepared an initial draft of the adapted Program P curriculum between November and December 2019.

INITIAL REVIEW OF THE BANDEBEREHO PROGRAM P MANUAL

In the initial review of the Bandebereho Program P manual, carried out in the light of the findings, conclusions, and recommendations of the formative research study, a series of proposals for adaptations emerged and are described below.

GENDER-TRANSFORMATIONAL APPROACH

- Strengthen a gender-transformational approach by enhancing the use of participatory methodologies that prioritize reflection and collective analysis of life experiences and shifting the emphasis of some activities from a teacher/student model to a facilitator/active participant one.
- Transformational shifts in attitudes and behaviors are more likely to occur when participants are able to interiorize learning and recognize the value for themselves, their relationships, and their families.
- Strengthening a gender-transformational approach across the dialogue sessions also entails identifying opportunities for adaptations to activities to foster the "horizontal" sharing of positive and negative experiences between participants, through which they learn from each other and can identify inequities/contradictions linked to their relationships with their wives/partners and children.

GENDER

- Widen the focus and content of the initial session on gender equality to strengthen the critical review by participants of their values, beliefs, and practices and understanding of the sociocultural character of gender inequalities.
- Redesign the initial session on gender equality as a required couples' session, bearing in mind that the GEM Scale results showed high levels of inequitable attitudes among the women surveyed. This highlights the need for women to also have the opportunity to critically appraise how gender and social norms determine unequal opportunities, rights, and resources for men and women and the consequences for themselves, and also be able to propose and realize changes to address inequalities in their own relationships and families.

- The inclusion of women in the first session also reinforces the message that the dialogue sessions are couple oriented and not just a process for men to which women are only invited for specific thematic sessions.
- Address processes of gender socialization and the influence of family, school, religion, media, culture on pressures to conform to be accepted as a boy/man or girl/woman, despite negative consequences for boys/men and girls/women.
- Adapt the content on gender roles and division of work to integrate the articulation of concrete commitments (particularly by men) to a gender equitable share of domestic work and to valuing and appreciating the work carried out by women.

FATHERHOOD

- Include a more in-depth focus on the characteristics and qualities of responsible fatherhood, with less emphasis on expectant fathers.
- The Bandebereho Program P curriculum/manual was designed mainly for expectant fathers and couples at the time of their participation in Program P. In accordance with data from the formative research study, the majority of couples who would participate in the dialogue sessions were not currently expecting a child and the average number of children under the age of five per household was between 2.62 and 2.72.
- Maintain the current thematic content on pregnancy, childbirth, and caregiving, anticipating that couples may have more children in the future, while enhancing the experiential learning approach to these topics. The session on pregnancy for example, could enable participants to focus on previous pregnancies as an anchor for reflection and identifying things they can do differently if/when they decide to have another child, while identifying gaps in knowledge and information that the health worker as a resource person could then address.
- Amplify the focus on parents' impact to include the role and influence of mothers and women in general in reinforcing patriarchal masculinities and the perpetuation of the gender stereotypes that lead to unequal opportunities, abuse of power, privileges, etc.

MEN'S ENGAGEMENT IN ANC AND FP

- Integrate reflection on and analysis of the cultural aspects of patriarchal masculinities that inhibit men from engaging in ANC and FP, not only on the reasons why they should engage. This can also focus on the courage it takes to be different, and how men can be positive bystanders to stick up for other men who do accompany their partners in ANC and FP activities.
- Directly address joint decision-making by couples in relation to FP in the context of interpersonal communication.

GENDER-BASED VIOLENCE

- Adjust the sequencing and focus of activities on violence and GBV to:
  - Strengthen analysis of power (sources and types)
  - Start with an interactive approach to male participants' own experiences of power and violence, linked to their boyhood experiences of socialization

- Integrate activities into the couples' session on the causes and consequences of GBV (for women, men, families, communities), how to avoid/prevent violence, and how to speak up and support those who experience violence

RESOLVING CONFLICT

- Balance the content on "self-control" and "anger management" skills with a focus on how to identify and manage "triggers" of violence within the framework of unequal power dynamics as the root cause of GBV.

ARTICULATING PROPOSALS FOR CHANGE

- Strengthen the focus on commitments to personal changes to ensure proposals made are practical and achievable.

The initial review of the Bandebereho Program P manual also took into consideration the need to reduce the curriculum from 15 to 11 sessions, in accordance with the contextual requirements of the Transform: Primary Health Care Activity. To that end, the following proposals were made:

- Merge the two sessions on pregnancy and childbirth into a single session, followed by a session on men's roles in antenatal care, birth, and caring for newborn babies; to include discussions on how patriarchal masculinities exclude men from caregiving and practical exercises to develop caregiving skills.
- Merge the sessions on my parents' impact and becoming a father into a single session on responsible fatherhood.
- Remove the session on alcohol and drug abuse and address alcohol abuse in the context of the (secondary) causes of GBV and/or when analyzing the socialization of masculinities.
- Remove the content on household finances and helping couples develop a household budget.

In line with the above proposals, the following general outline was developed for the implementation of an adapted version of Program P, integrating 11 sessions as demonstrated in Exhibit 8 below.

Exhibit 8: Program P adaptation for Ethiopia: proposed sessions, objectives, and participants

SESSION	OBJECTIVES	PARTICIPANTS
1. **Gender equality**	To create a space of trust and confidentiality and to discuss the differences between sex and gender and reflect on how gender norms influence the ideas and expectations of men and women as parents.	Couples
2. **Involved, responsible fatherhood**	To encourage men to reflect on how their parents have influenced their lives, their own roles as fathers, and the future they envision for their children; including how to use the positive influences and how to avoid the negative aspects so they do not repeat them.	Men
3. **Family planning and pregnancy**	To inform expectant fathers and mothers about the biological process of pregnancy, including what men can do to ensure the health of the mother and fetus during and after birth, and to address many of their concerns.	Couples *(requires health worker)*

SESSION	OBJECTIVES	PARTICIPANTS
4. Our role as involved husbands and fathers	To enable men and their partners to understand the importance of men: a) accompanying their pregnant partners to antenatal care visits b) being present at the birth c) being involved in caring for the newborn baby	Couples *(requires health worker)*
5. Identifying types of violence	To identify the different types of violence that exist and to understand how, when growing up as boys, we learn to use violence to control and dominate other people, especially women.	Men
6. Violence in our own lives	To reflect on the violence we have used against others, that has been used against us, and that we have witnessed, and analyze the causes and consequences of the abuse of power and violence for men, for women, and for relationships.	Men
7. Gender-based violence	To deepen understanding of gender-based violence, its effects on women's and men's lives and relationships, and to reflect on the ways that men can break the culture of silence surrounding GBV, particularly in families and in couple relationships.	Couples
8. Resolving conflict	To identify non-violent ways to resolve conflict and to reflect on the importance of strong relationships and social networks when we face difficult moments as fathers and husbands.	Men
9. Raising children	To make connections between the long-term goals fathers and mothers have for their children (ages 0–5) and how harsh discipline affects those goals.	Couples
10. Sharing responsibilities at home	To reflect on how gender roles influence the distribution of care work within the household, and to encourage a more equitable distribution of childcare and housework between men and women.	Couples
11. Consolidating commitments	To reflect on the experiences that participants have had in the group sessions and to make concrete commitments to be more involved and responsible fathers and husbands.	Men

DEVELOPMENT OF THE ADAPTED PROGRAM P MANUAL (FIRST DRAFT)

Adhering to the agreed 11-session outline and applying the consolidated proposed adaptations that were identified in the initial review of the Bandebereho Program P manual, the ME consultant elaborated on the first draft of the adapted Program P manual for the Ethiopian context.

In drafting the adapted Program P manual, several methodological considerations were taken into account:

REVIEW OF RELEVANT DOCUMENTATION

A review of relevant documentation (see Annex F), throughout the adaptation process to source new activities (and/or adaptations of existing ones) for the adapted Program P manual included:

- Training manuals developed for engaging men and boys for gender equality in several African and Latin American countries
- Evaluations of processes of training carried out with men and boys, including the randomized controlled trial of the Bandebereho Program P implementation in Rwanda

FIDELITY TO THE BANDEBEREHO PROGRAM P MANUAL

Given the positive results of the randomized controlled trial of the Bandebereho Program P implementation in Rwanda, efforts were made to retain of as many of the original activities in the Bandebereho Program P manual as possible.

Relevant adaptations to the content and methodology of some activities were made and supplementary activities introduced to address the recommendations of the formative research study and address the needs of the Ethiopian context.

STRENGTHENING OF THE DIALOGUE SESSION CHECK-IN/CLOSING MODALITY

The check-in/closing modality used in the Bandebereho Program P manual endeavored to ensure that learning from the dialogue sessions translated into concrete actions that the participants could put into practice between sessions.

This modality was strengthened by standardizing the methodology for dialogue session check-in activities and providing facilitators with precise procedures to follow for each of the check-in and check-out activities.

ENRICHMENT OF THE GENDER TRANSFORMATIVE APPROACH

Building on the gender transformative approach used in the Bandebereho Program P manual, the strengthening of the participatory approach to facilitating personal and collective critical reflection and analysis focused on the inclusion and/or reinforcement of methods such as role plays, case studies, and group work. This also involved weaving both thematic content and participatory methodologies, as much as possible, into energizers and icebreakers, including into the initial activities in Session 1, to set the tone of the participant-centered approach that would be used throughout the process.

Strengthening the gender transformative approach also entailed a revision of the trainers' role in delivering the dialogue sessions. Some activities were adjusted to place greater emphasis on the facilitation of dialogue between participants, while simultaneously reducing dependence on the vertical transmission of knowledge or information by the trainers to the participants. This involved acknowledging the empirical and scientific knowledge that participants already possessed, underlining their capacity to learn from each other and through reflecting on and analyzing past life experiences.

Furthermore, the curriculum utilizes a gender synchronized approach, defined as interventions that intentionally engage both men and boys and women and girls in programs to promote gender equality. In this program, men-only sessions provide space for men to reflect upon their own experiences, critically examine power dynamics, and assess their own behavior. Couples' sessions then build upon those discussions by sharing experiences and building mutual understanding between men and women participants. Gender synchronized approaches allow participants to reflect upon harmful gender norms

that are reinforced by all in a community, recognize the role each plays in upholding or transforming restrictive norms, and build empathy and understanding of others' experiences and challenges, which several interventions across Latin America and sub-Saharan Africa have shown have the potential to bring about more meaningful and lasting change.[25]

INCLUSION OF "KEY MESSAGES"

In addition to strengthening the gender transformative approach, pivotal for shifting inequitable attitudes and behaviors, a series of "key messages" was included at the beginning of each dialogue session. These included the main points of information, knowledge, and concepts that facilitators could make use of to carry out summaries of the thematic content that had been addressed during the sessions and reinforce the principal areas of knowledge-based learning.

THEMATIC SEQUENCING AND BLOCKS

In reducing the number of sessions from 15 to 11, minor adjustments were made to the sequencing of the sessions to ensure a training process in which each new session builds on the previous one(s) in terms of thematic content, critical analysis of attitudes and beliefs, and knowledge acquisition.

The dialogue sessions were grouped into five thematic blocks, as shown below in Exhibit 9.

Exhibit 9: Dialogue sessions' thematic blocks

THEMATIC CONTENT	SESSION NUMBER AND NAME
Gender, gender socialization, gender roles, gender identities, gender equality	1. Gender equality 2. Involved, responsible fatherhood.
ANC, FP, and childcare	3. Family planning and pregnancy 4. Our role as involved husbands and fathers
Power, violence, and conflict resolution	5. Identifying types of violence 6. Violence in our own lives 7. Gender-based violence 8. Resolving conflict
Family dynamics/living together	9. Raising children 10. Sharing responsibilities at home
Personal changes	11. Consolidating commitments

The sequencing of the thematic blocks was influenced by a series of factors that are detailed below.

[25] Greene, M.E. and Levack, A. (2010). Synchronizing Gender Strategies: A cooperative model for improving reproductive health and transforming gender relations. Interagency Gender Working Group: Washington, DC.

- Ensuring that participants, at the beginning of the process, understand the terms "sex" and "gender," the relation between them, and the sociocultural characteristics of gender inequalities sets the foundations for addressing the subsequent topics and for analyzing how, specifically, they are influenced by patriarchal masculinities.
- Grouping together the "practical" health-related topics that focus mainly on knowledge/information acquisition by the participants and that require the presence of HSPs, while also making sure these are addressed from the perspective of gender inequalities.
- Addressing together the more demanding and emotionally challenging themes (power, violence, and conflict resolution) in the middle of the process anticipates that in the previous sessions, bonds of trust and an atmosphere conducive to more in-depth analysis and sharing will have been created between the participants and with the facilitator.
- Toward the end of the process, centering on practical skills-related topics (caring for children, domestic work, etc.) in the context of the previous sessions' focus and content and that have enabled participants to review attitudes and behaviors and acquire critical consciousness of how power is constructed, used, and abused.
- Ending the process with a session that facilitates opportunities for the participants to look back on the significance of the dialogue sessions for themselves, their relationships, and their families, and to make concrete commitments that will contribute to equitable relationships within their households.

ADAPTATION WORKSHOP

In January 2020, to enhance the relevance of the first draft of the Program P manual to the Ethiopian context, EnCompass organized an in-country (curriculum) adaptation workshop with Transform: Primary Health Care Activity staff, including regional Gender Officers and ME coordinators, FMoH representatives, and other local stakeholders operating in the field of gender equality and male engagement.

With particular emphasis on cultural sensitivity and the applicability of the curriculum, the adaptation workshop aimed to review the overall structure, content, and methodology of the first draft of the adapted Program P manual and of the educational activities proposed in each of the 11 dialogue sessions.

In reviewing the dialogue sessions, small groups of participants concentrated on two or three sessions each and were asked to consider the following questions:

1. What resonates with you in these sessions?
2. What needs to be emphasized more?
3. What is currently missing from these sessions?
4. What else would help make this session more successful?

The thematic content, methodology, and sequencing of sessions, in general, resonated well with the participants in the adaptation workshop, who affirmed the transformative gender approach and use of experiential learning techniques as appropriate for the contexts of the envisaged participants and for contributing to the desired outcomes of the program.

Plenary sessions and discissions during the adaptation workshop led to a series of recommendations for further adaptations to the first draft of the adapted Program P manual. These were consolidated after

the workshop and used as a guide to develop the **second draft** of the Program P manual (see next section).

The in-country (curriculum) adaptation workshop also made the following recommendations in relation to the implementation of the adapted program manual:

- The need for a comprehensive ToT to ensure that the community facilitators who will use the manual have the knowledge and skills they require, in relation to:
  - ✓ The thematic content covered in the manual and its internalization
  - ✓ The use of experiential learning and participatory methodologies with adults from rural areas and with limited formal education
  - ✓ Strong facilitation skills to moderate discussions, navigate possible conflict between participants, and manage couple dynamics
- The need for an appropriate "jargon-free" intervention name in local languages that doesn't use technical terms like "male engagement"

DEVELOPMENT OF THE SECOND DRAFT OF THE ADAPTED PROGRAM P MANUAL

In accordance with the consolidated recommendations of the in-country (curriculum) adaptation workshop, the elaboration of the **second draft** of the Program P manual, completed in January 2020, entailed the integration of a series of modifications related to several areas of interest that are summarized below.

CHARACTERISTICS OF PARTICIPANTS

Content that required participants to read or write (on flipcharts, for example) was amended/minimized and replaced with the use of groups discussions, role plays, etc.

This was to maximize the inclusion and active participation of men and women with limited literacy skills and in settings where material conditions are challenging and resources like flipcharts not easily available or functional.

Data from the A&B surveys, however, indicted that many of the participants had basic literacy skills.

TIME ALLOCATION

The allotted time for each dialogue session was increased from 2 hours to 2.5–3 hours, taking into consideration that both the thematic content and the participatory, transformative approach need more time to be successfully implemented.

This was also considered a feasible length for the dialogue sessions in relation to the time that participants would be able to dedicate, taking into consideration their multiple family, work, and community commitments.

SESSION AND ACTIVITY STRUCTURE AND FORMATS

The internal format of the dialogue sessions and their respective activities was standardized to enable users to more clearly understand and differentiate between the information/knowledge they need to deliver the sessions and the steps they should follow, which were not always apparent in some of the draft sessions that were taken/adapted from other sources.

Exhibit 10 below shows the standardized table that was included at the beginning of each session and that contains a summary of relevant information about the session, including the methodology/methods to be used (previously missing).

Exhibit 10: Standardized session information, included at the beginning of each dialogue session

SESSION ELEMENT	DESCRIPTION
Facilitator	• Male facilitator for men only sessions • Male and female facilitators for couples' sessions • Health Extension Worker for ANC and FP sessions (Sessions 3 and 4)
Participants	• Men only (Sessions 2,5,6,8 and 11) • Couples (Sessions 1,3,4,7, 9 and10)
Session time	• The estimated time the session should take and is generally between 2.5 and 3 hours. This is based on the time participants can dedicate on a given day, in relation to their multiple work, family, and other commitments.
Learning objectives	• Description of what participants will have learned by the end of the session
Materials	• These are the materials and resources facilitators need to carry out each session. • Some may need preparation before the session begins.
Methods	• A brief description of the training methods that will be employed by the facilitator(s) during the session
Overview	• An outline of the training activities that will make up each session • These include a "check-in" and a "checking out" activity

Similarly, as can be seen in Exhibit 11 below, the training activities included in each of the dialogue sessions were edited to ensure the following standardized format was adopted throughout the manual.

Exhibit 11: Standardized activity format

SESSION ELEMENT	DESCRIPTION
Purpose	• Description of what the activity endeavors to achieve
Materials and preparation	• The materials and resources facilitators need to carry out the activity • Some may need preparation before the activity begins.
Facilitator's notes	• These notes refer to aspects of the training process, methodology, and methods and are "tips" to help facilitators prepare and implement the activity fluidly and be aware of things to look out for. • Facilitators should read these notes VERY carefully before carrying out the activities.
Instructions	• These are the individual steps that make up the activity and that facilitators should follow carefully and methodically in order to implement the activity

well. The steps are numbered and should be executed in the order in which they are presented.
- Facilitators should review and practice the steps before implementing the activity to make sure they understand how they link together and to avoid skipping any of the steps.

SESSION OPENING AND CLOSING ACTIVITIES

The **check-in/closing** modality used in the Bandebereho Program P was strengthening by standardizing the methodology for both dialogue session check-in and checking-out activities and providing facilitators with precise procedures to follow for each of the check-in and checking-out activities.

In doing so, the **checking-out** activity closes each session highlighting the **key messages** of the session (included here and not in the session overview as in the first draft of the manual) and enabling the participants to articulate commitments and changes they will put into practice in their homes and/or communities before the next session.

Similarly, the **check-in** activity welcomes the participants to the session and serves the double function of a) bridging the new session with the previous one(s) by inviting participants to share experiences of actions taken, enabling them to learn from their own and others' successes and obstacles faced, and b) linking the thematic content of the sessions to build a consistent cycle of reflection-learning-action throughout the process of the 11 dialogue sessions.

HEATH-RELATED CONTENT

The health-related content of the curriculum, particularly Session 3, was reviewed by the Transform: Primary Health Care Activity reproductive and maternal health technical specialists to ensure that men, as a result of their participation in the dialogue sessions, would acquire the information and knowledge they need on ANC and FP (and that is vital to increasing equitable practices related to ANC and FP), and which they do not receive from other sources in the community in the ways that that women do.

In doing so, in-country technical specialists considered the following aspects:

- Inclusion of the precise knowledge/information facilitators would need to implement the session, such as nutrition, other antenatal care issues, postpartum care, birth planning, and exclusive breastfeeding.
- Clear separation of FP activities and ANC/pregnancy activities with distinct and clear objectives.
- FP information aligned to national guidelines.
- Acknowledgement of how participants are influenced by local and national policies and discussions on FP.
- How to deal with possible spousal conflict/disagreements about FP during the session.
- Increased time allocation to three hours to allow the content of the session to be addressed adequately.

SESSION -SPECIFIC MODIFICATIONS

As well as the above general adaptations, the in-country (curriculum) adaptation workshop made recommendations in relation to each of the 11 dialogue sessions, leading to specific modifications, where needed, in one or more of the following areas:

- Simplification/clarification of language used in, for example, session purpose and activity objectives; step-by-step instructions for facilitators; questions used to promote reflections and analysis with/among participants; in line with terminology used locally.
- Greater use and contextualization of interactive activities, pictures/images, role plays, stories, etc. to make them culturally appropriate and more real for participants, and maximize participants' readiness to take part.
- Further anchoring of concepts, definitions, and proposals for change (commitments) in the everyday life experiences of participants.
- Avoidance of the use of language that could be interpreted as blaming of men and therefore possibly alienating them; highlighting analysis of the prevalence of social and gender norms and proposals on individual and shared responsibility for achieving gender justice and changes that are beneficial to all involved.

In accordance with the specific recommendations made for each of the 11 dialogue sessions, the ME consultant redrafted each of the sessions which, in turn, were reviewed by EnCompass staff in the United States and Ethiopia before being integrated into the second draft of the adapted Program P manual.

COMMUNITY FACILITATOR TRAINING AND FINALIZATION OF THE ADAPTED PROGRAM P MANUAL

In February 2020, EnCompass staff conducted ToT workshops using the second draft of the adapted Program P manual in two stages:

- A 4-day encounter with EnCompass Gender Officers and ME coordinators from Oromia and SNNPR, co-facilitated by the ME consultant, EnCompass Gender and Health Specialist, and Transform: Primary Health Care Activity Senior Gender Advisor in Ethiopia
- An 8-day ToT workshop with male and female community facilitators from Oromia and SNNPR, facilitated by the EnCompass Gender Officers and ME coordinators, with support from the ME consultant, EnCompass Gender and Health Specialist, and Transform: Primary Health Care Activity Senior Gender Advisor in Ethiopia, who were present for the duration of the ToT workshop.

Both training events used activities from the second draft of the adapted Program P manual to deepen participants' understanding of gender, power, and GBV, while simultaneously enabling them to experience the methodology firsthand and understand the experiential learning approach that is used in the manual.

The ToT workshop with male and female community facilitators from Oromia and SNNPR also contained "teach-back" sessions in which pairs/groups of participants had to prepare selected activities

and implement them with the other participants, following the sequencing of the sessions and their activities in the manual to simulate a training process as it would be carried out at the community level.

In observing this process, the ME consultant, EnCompass Gender and Health Specialist, and Transform: Primary Health Care Activity Senior Gender Advisor in Ethiopia were able to identify several areas where some further tweaking could enhance the effectiveness of the manual and contribute to its user friendliness:

- To support community facilitators' planning and implementation of the dialogue sessions, an introductory session to the manual was included that contains:
    - ✓ The purpose of the manual
    - ✓ An outline of the sessions and their thematic content
    - ✓ A description of the structure of the sessions and the format in which the activities are designed
    - ✓ An index of the sessions with their respective activities

- Similarly, a section was included on methodology and facilitation that contains:
    - ✓ A brief description of the experiential learning approach
    - ✓ Tips for the planning, preparation, and implementation of the sessions
    - ✓ The role of the facilitator
    - ✓ Evaluation and feedback suggestions

- In many of the sessions, facilitators' notes were improved, added to, or, where they were absent, included.
- In a few activities, materials and advanced preparation needs were updated to reflect previous modifications to the activities.
- In some activities, implementation instructions (for example, discussion questions, plenary sessions, role play directions, check-in/checking out instructions) were edited and/or additional instructions or tips were included for greater flow, more focused plenary discussions and contextualization, and to make facilitators aware of possible reactions or resistance they might face from participants.
- In some sessions, additional content was added to "key messages" and tweaked appropriately.
- Some additional information on sexual relations and pregnancy was included in the session on ANC and FP.

The final version of the Engaging Men in Family Planning and ANC dialogue session curriculum can be found here. Because Transform: Primary Health Care was unable to implement the dialogue sessions due to COVID-19, the Activity has shared the final curriculum, including guidelines for mobilization and implementation, with the FMoH's Women, Youth, and Children's Directorate for use in follow-on or other future programming.

ANNEXES

ANNEX A: DOCUMENTS REVIEWED RELATED TO ENGAGING MEN FOR IMPROVING ACCESS TO ANC AND FAMILY PLANNING SERVICES

1: ETHIOPIA RESEARCH STUDIES

Abraham W., et al. 2010. The Involvement of Men in Family Planning an Application of Transtheoretical Model in Wolaita Soddo Town South Ethiopia. *Asian Journal of Medical Sciences 2(2): 44-50, 2010 ISSN: 2040-8773*

Abusha N. 2014. Assessment of Male Partners' Involvement in Promoting Skilled Delivery Attendance of Spouses and Associated Factors in Lemo Woreda, Hadiya Zone, Southern Nation Nationality People Region, Ethiopia, 2014. *Addis Ababa University, College of Health Sciences. School of Allied Health Sciences. Department of Nursing and Midwifery*

Addis Adera, Tilahun Belete, Asefa Gebru, Alganesh Hagos, Woldegebriel Gebregziabher. Assessment of the Role of Men in Family. 2015. Planning Utilization at Edaga-Hamuse Town, Tigray, North Ethiopia. *American Journal of Nursing Science*. Vol. 4, No. 4, 2015, pp. 174-181.

Amsalu E., et al. Level of Male Partner Involvement and Associated Factors in Prevention of Mother to Child Transmission of HIV/AIDS services in Debremarkos town, Northwest Ethiopia. *African Journal of AIDS and HIV Research Vol. 1 (2), pp. 016-025, November, 2013.* Available online at www.internationalscholarsjournals.org © International Scholars Journals

Bayray A. 2012. Assessment of Male involvement in family planning among men in south eastern zone of Tigray, Ethiopia. *Scholarly Journal of Medicine, Vol. 2(2) pp. 1-10 January, 2012*. Available online at http://www.scholarly-journals.com/SJM ISSN 2276-7134

Beekle A. T. and McCabe C. 2006. Awareness and determinants of family planning practice in Jimma, Ethiopia. *International Nursing Review 53, 269–276*

Belema D. 2017. Male Partner's Involvement and its Associated Factors in Promoting Skilled Delivery Attendance Among Father Who Have Children Less than one year of Age in Ambo Town, Ethiopia, 2017. *College of Health Sciences, School of Allied Health Science , Department of Nursing And Midwifery, Addis Ababa University*

Berhane A., et al. 2011. Men's Knowledge and Spousal Communication about Modern Family Planning Methods in Ethiopia. *African Journal of Reproductive Health December 2011; 15(4):*

Bogale B., et al. Married Women's Decision-Making Power on Modern Contraceptive Use in Urban and Rural Southern Ethiopia. *BMC Public Health 2011, 11:342* http://www.biomedcentral.com/1471-2458/11/342

Gurmu E. 2017. Differentials and Determinants of Men's Sexual Behavior in Ethiopia. *Ethiop. J. Health Dev.* 2017;31(1)

Haile A., Enqueselassie F. 2006. Influence of women's autonomy on couple's contraception use in Jimma town, Ethiopia. *Ethiop.J.Health Dev. 2006;20(3*)

Haile and Brhan. 2014. Male partner involvements in PMTCT: a cross sectional study, Mekelle, Northern Ethiopia. *BMC Pregnancy and Childbirth 2014 14:65*. doi:10.1186/1471-2393-14-65

Katiso NA , Adinew YM. 2015. Male Partners' Involvement in Institutional Delivery in Rural Ethiopia: Community Based Survey. *J Women's Health Care 4: 239. doi:10.4172/2167-0420.1000239*

Lingerh W., et al. 2014. Magnitude and factors that affect males' involvement in deciding partners' place of delivery in Tiyo District of Oromia Region, Ethiopia *Ethiop. J. Health Dev.* 2014; (Special Issue 1)

Mesfin G. 2002. The role of men in fertility and family planning program in Tigray Region. *Ethiopian Journal of Health Development 16(3).* DOI: 10.4314/ejhd.v16i3.9822

Mohammed et al. 2014. Determinants of modern contraceptive utilization among married women of reproductive age group in North Shoa Zone, Amhara Region, Ethiopia. *Reproductive Health 2014 11:13*. doi:10.1186/1742-4755-11-13

Mulatu K. and Mekonnen W. 2016. Men's Involvement in Long Acting and Permanent Contraceptive Use in Mizan-Aman District Southwestern Ethiopia: A Community Based Cross-Sectional Study. *Health Science Journal ISSN 1791-809X. Vol. 10 No. 2: 2*

Tamiso A. et al. 2016. Barriers to Male Involvement in Family Planning Services in Arba Minch Town, Southern Ethiopia: Qualitative Case Study. *International Journal of Public Health Science (IJPHS)* Vol.5, No.1, March 2016, pp. 46 ~ 50 ISSN: 2252-8806

Tilahun et al. 2015. Couple based family planning education: changes in male involvement and contraceptive use among married couples in Jimma Zone, Ethiopia. *BMC Public Health (2015) 15:682 DOI 10.1186/s12889-015-2057-y*

Tilahun T, Coene G, Luchters S, Kassahun W, Leye E, et al. 2013. Family Planning Knowledge, Attitude and Practice among Married Couples in Jimma Zone, Ethiopia*. PLoS ONE 8(4): e61335. doi:10.1371/journal.*

Tilahun T. 2014. Marital dynamics in family planning: the role of couple interaction in Jimma Zone, Southwest Ethiopia. *Faculty Of Medicine And Health Sciences Ghent University*

Tilahun T., et al. 2014. Spousal discordance on fertility preference and its effect on contraceptive practice among married couples in Jimma zone, Ethiopia. *Reproductive Health 2014 11:27.* doi:10.1186/1742-4755-11-27

Tsedeke Tuloro T., et al. 2006. The role of men in contraceptive use and fertility preference in Hossana Town, Southern Ethiopia. *Ethiop.J.Health Dev.* 2006;20(3)

Tsehay Birhanu. 2014. Knowledge, Attitude and Practices of Male Partners Involvement in Reducing Antenatal HIV Infection and PMTCT. *Addis Ababa University. College of Education and Behavioral Studies, School of Psychology*

Zerihun Tamirat, Tizta Tilahun, Misra Abdulahi. 2015. Male Involvement on Skilled Delivery Care Utilization in Mareka Woreda, Southern Ethiopia: A Community Based Cross Sectional Study. *Science Journal of Public Health*. Vol. 3, No. 5, 2015, pp. 699-706. doi: 10.11648/j.sjph.20150305.26

2. PROGRAMMATIC INTERVENTIONS CARRIED OUT IN ETHIOPIA

Comrie-Thomson, L., et al. 2015. Men Matter: Engaging Men in MNCH Outcomes. *Plan Canada, Toronto.*

EMERGE. 2015. Lessons in Good Practice from Work With Men and Boys for Gender Equality. *Institute of Development Studies (IDS), Promundo-US and Sonke Gender Justice as part of the Engendering Men: Evidence on Routes to Gender Equality (EMERGE) project.*

Erulkar A. and Tamrat T. 2014. Evaluation of a Reproductive Health Program to Support Married Adolescent Girls in Rural Ethiopia. *African Journal of Reproductive Health June 2014; 18(2)*:68

Evidence To Action Project. 2015. E2A Grantee in Ethiopia Mobilizes Faith-based Networks to Promote and Deliver Family Planning Services. *Pathfinder International in partnership with the African Population and Health Research Center, ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.*

Getachew E. Nd. Male Norms and HIV Risk Behaviors in Ethiopia (Literature Review)

Girma W., et al. 2012. Addis Birhan Wendoch ("New Light Boys"): Working With Boys and Young Men to Create Healthier Futures. *The Federal Democratic Republic of Ethiopia, Ministry of Women's, Children's and Youth Affairs, USAID and Population Council*

Hiwot .Nd. Growing in to Gender Equitable Norms - Working with Boys and Parents. *Hiwot, Ethiopia.*

Hiwot. 2010. Hiwot Profile 2010-2015. *Hiwot Addis Ababa, Ethiopia*

Hiwot. 2010. MAP (Men as Partners). *Newsletter Volume I Issue II Nov. 2010, Addis Ababa, Ethiopia*

Hiwot. 2011. Prevention of HIV and AIDS by Targeting Highly at Risk Urban Youth in Addis Ababa Through the Men As Partners Approach. *MARPs News Ethiopia October /2011 volume 2*

Hiwot. 2015. Program Brief: Men and Boys Do Care. *Yenigat Weg Radio Program, Addis Ababa, Ethiopia November 2015.*

Hiwot. 2015. Together for Change (T4C): Enhancing Paternal Involvement and Economic Resilience. *Addis Ababa, Ethiopia.*

Hiwot. 2017. Communication for Health Project (draft proposal to JSI). *Addis Ababa, Ethiopia*

Pulerwitz J., et al. 2010. Promoting Gender Equity for HIV and Violence Prevention: Results from the Male Norms Initiative Evaluation in Ethiopia. *Washington, DC: PATH; 2010.*

Pulerwitz J., et al. 2015. Changing Gender Norms and Reducing Intimate Partner Violence: Results from a Quasi-Experimental Intervention Study with Young Men in Ethiopia. *American Journal of Public Health, January 2015, Vol 105, No. 1*

Terefe A. and Larson C. 1993. Modern Contraceptive Use in Ethiopia: Does Involving Husbands Make a Difference? *American Journal of Public Health November 1993, Vol. 83, No. 11; 1567-1571*

Tilahun et al. 2015. Couple based family planning education: changes in male involvement and contraceptive use among married couples in Jimma Zone, Ethiopia. *BMC Public Health (2015) 15:682 DOI 10.1186/s12889-015-2057-y*

Tilahun T., et al. 2015. Couple based family planning education: changes in male involvement and contraceptive use among married couples in Jimma Zone, Ethiopia. *BMC Public Health (2015) 15:682 DOI 10.1186/s12889-015-2057-y*

Verani F. 2016. Gender-Transformative Cultural Ceremonies to Prevent Intimate Partner Violence and HIV in Ethiopia. *EngenderHealth-Presentation IPV Prevention in Ethiopia*

Zewale M. 2013. What can other *family members* do? Behaviors for fathers in Ethiopia. *Alive & Thrive, Ethiopia, FHI 360; Presentation Stunting Reduction Forum, October 2013 Addis Ababa.*

ANNEX B: FUNCTIONS OF TEAM LEADERS, DATA COLLECTORS AND REGIONAL COORDINATORS

QUALITATIVE TEAM		QUANTITATIVE TEAM		REGIONAL COORDINATORS
LEAD - FUNCTIONS	**DATA COLLECTOR - FUNCTIONS**	**LEAD - FUNCTIONS**	**DATA COLLECTOR - FUNCTIONS**	
Qualitative data collection team lead as well as data collector (interviewer, facilitator and note taker). Quality control and ensures agreed processes are followed. Conducts periodic "spot checks" of notes and recordings to ensure that desired levels of quality are maintained. Meets with the qualitative data collector for debriefing each day after returning to the hotel. Communicates any anomalies in data collection to the Senior Gender Advisor. Reviews and approves all final transcripts to ensure they are accurate, fully transcribed, and properly labeled.	Conducts interviews and takes notes when not leading a data collection session. Takes high quality (i.e., comprehensive and accurate) notes. Cleans their transcripts and ensures that their transcripts accurately represent what was heard during data collection, and that final transcripts are in English. Spells out all acronyms and abbreviations used. Ensures that all transcript data files are fully transcribed and properly labeled.	Quantitative data collection team lead as well as data collector (A&B enumerator, healthcare facility data collector). Quality control and ensures agreed processes are followed. Conducts periodic "spot checks" of completed quantitative data collection tools to ensure that desired levels of quality are maintained. Meets with the quantitative data collector for debriefing each day after returning to the hotel. Communicates any anomalies in data collection to the Senior Gender Advisor. Reviews and approves all completed A&B surveys and health facility service indicator data sheets to	Conducts A&B surveys, and assists with collecting health facility service data. Takes high quality (i.e., comprehensive and accurate) notes, where relevant. Spells out all acronyms and abbreviations used. Ensures that all A&B surveys and health facility service indicator data sheets are fully and clearly completed.	Oversee each round of data collection. Organize and facilitate focus group discussions and key informant interviews with participants. Supervise all data collection teams. Ensure all data is properly and securely stored and transmitted to study leader.

QUALITATIVE TEAM		QUANTITATIVE TEAM		REGIONAL COORDINATORS
LEAD - FUNCTIONS	**DATA COLLECTOR - FUNCTIONS**	**LEAD - FUNCTIONS**	**DATA COLLECTOR - FUNCTIONS**	
Ensures that all transcript data files are accounted for and final versions uploaded to Teams. Photocopies the KII and FGD notes, safely stores the backup copies, and couriers the original copies to the Senior Gender Advisor.		ensure they are fully and clearly completed. Ensures that all A&B surveys and health facility service indicator data sheets are accounted for and final versions uploaded to Teams. Photocopies the A&B surveys and health facility service indicator data sheets, safely stores the backup copies, and couriers the original copies to the Senior Gender Advisor.		

ANNEX C: DATA COLLECTION TOOLS

KII AND FGD GUIDES

KII GUIDE FOR ML IN THE COMMUNITY	KII GUIDE FOR HSPS	FGD GUIDE MEN	FGD GUIDE WOMEN
Introductory questions			
1. I would like to start by learning a bit about your role in the community. Can you tell me what role you play here? How did you achieve this role? How long have you been in it? Who do you interact with in this role? 2. Do you have any experience with family planning and/or maternal health care services at the health care facilities here? a. If yes, could you share your experience? b. If no, what is your understanding of family planning and/or maternal health care services at the local facilities? What do you know about these services?	1. I am going to give you a few minutes first to think about your experience providing family planning and/or maternal and child health services to couples. Would you feel comfortable sharing an experience?	1. I am going to give you a few minutes first to think about your experience participating in family planning and/or maternal and child health services. For example, have you gone to the doctor with your partner or wife before or after her pregnancy? Another example would be if you and your partner or wife visited the doctor together to talk about family planning. If you haven't participated in these types of services, I'd like you to think about the reasons why not. Is anyone comfortable sharing his experience?	1. I am going to give you a few minutes first to think about your experience participating in family planning and/or maternal and child health services. For example, have you gone to the doctor with your partner or husband before or after pregnancy? Another example would be if you and your partner or husband visited the doctor together to talk about family planning. Is anyone comfortable sharing her experience?
General Male Engagement			
3. In this community, who makes decisions about how many children a couple should have?	2. In this community, who makes decisions about how many children a couple should have?	2. In this community, who makes decisions about how many children a couple should have?	2. In this community, who makes decisions about how many children a couple should have?

KII GUIDE FOR ML IN THE COMMUNITY	KII GUIDE FOR HSPS	FGD GUIDE MEN	FGD GUIDE WOMEN
How are these decisions made? Who makes decisions about how much time in between having another baby? How are these decisions made?	How are these decisions made? Who makes decisions about how much time in between having another baby? How are these decisions made?	How are these decisions made? Who makes decisions about how much time in between having another baby? How are these decisions made?	How are these decisions made? Who makes decisions about how much time in between having another baby? How are these decisions made?
	3. In your experience providing direct services, do you feel that men are engaged in family planning and/or maternal and child health services? a. If yes, can you provide examples of when men have accompanied their female partners and/or children for services? b. If no, what do you think hinders their participation?		
4. What are the attitudes or thoughts this community has toward men being engaged in family planning and maternal and child health services? Examples of men being engaged in these areas would be a man going with his partner or wife to the doctor to discuss options for family planning, or a man accompanying his pregnant wife when she visits the doctor.	4. What are the attitudes or thoughts this community has toward men being engaged in family planning and maternal and child health services? a. Probe for concrete examples. 5. What drives these positive/negative views? For the negative views, what could be	3. What are the attitudes or thoughts you and your friends and family and this community have toward men being engaged in family planning and maternal and child health services? 4. Based on what we just discussed, what are the positive views? What are the negative views? What drives these views? For the negative views, what could be done to change these perceptions? 5. What could be done to increase male involvement in family	3. What are the attitudes or thoughts you and your friends and family and this community have toward men being engaged in family planning and maternal and child health services? 4. Based on what we just discussed, what are the positive views? What are the negative views? What drives these views? For the negative views, what could be done to change these perceptions? 5. What could be done to increase male involvement in family

KII GUIDE FOR ML IN THE COMMUNITY	KII GUIDE FOR HSPS	FGD GUIDE MEN	FGD GUIDE WOMEN
a. Probe for concrete examples 5. What drives these positive/negative views? For the negative views, what could be done to change these perceptions? a. Probe for concrete examples 6. What could be done to increase male involvement in family planning and maternal and child health services? Are there certain actions or activities that you think would help increase male involvement? a. Probe for concrete examples 7. Of all the ways of increasing male engagement in health care services that we have talked about today, what is the most important to you?	done to change these perceptions? a. Probe for concrete examples. 6. What could be done to increase male involvement in family planning and maternal and child health services? a. Probe for concrete examples. b. Probe for specific things healthcare providers and facilities could do to encourage male involvement. 7. Of all the ways of increasing male engagement in health care services that we have talked about today, what is the most important to you?	planning and maternal and child health services? 6. Of all the ways of increasing male engagement in health care services that we have talked about today, what is the most important to you?	planning and maternal and child health services? 6. Of all the ways of increasing male engagement in health care services that we have talked about today, what is the most important to you?
The Proposed thematic content of the curriculum [Have curriculum topics on a handout to share and review with the respondent.]			
8. What are your thoughts on the topics I have just described? Are there ones that seem more important or relevant than	8. What are your thoughts on the topics I have just described? Are there ones that seem more important or relevant than	7. What are your thoughts on the topics I have just described? Are there ones that seem more important or relevant than	7. What are your thoughts on the topics I have just described? Are there ones that seem more important or relevant than

KII GUIDE FOR ML IN THE COMMUNITY	KII GUIDE FOR HSPS	FGD GUIDE MEN	FGD GUIDE WOMEN
others? Are there any topics missing that you would like to see included in the curriculum?	others? Are there any topics missing that you would like to see included in the curriculum?	others? Are there any topics missing that you would like to see included in the curriculum?	others? Are there any topics missing that you would like to see included in the curriculum?
9. As a male community leader, the intention is to have you facilitate all the sessions and have a healthcare provider co-facilitate those sessions which are health-focused, such as those on pregnancy, birth, and family planning. What do you feel about having a co-facilitator? What about that co-facilitator participating in only some of the sessions? Would you suggest changing that plan? In what way?	9. As a healthcare provider, the intention is to have you co-facilitate the sessions which are health-focused, such as those on pregnancy, birth, and family planning. What do you feel about participating in only some of the sessions? Do you think participants may prefer that a healthcare provider co-facilitate more sessions? Would you suggest changing that plan?		
10. We have presented 11 topics with each topic held once a week, for an 11-week course. Each weekly meeting would be approximately 90 minutes long. Do you think this amount of time would be acceptable to participants? Would you suggest fewer weeks, but longer sessions each week? Is there another way you would structure the sessions?	10. We have presented 11 topics with each topic held once a week, for an 11-week course. Each weekly meeting would be approximately 90 minutes long. Do you think this amount of time would be acceptable to participants? Would you suggest fewer weeks, but longer sessions each week?	8. We have presented 11 topics with each topic held once a week, for an 11-week course. Each weekly meeting would be approximately 90 minutes long. Is this amount of time acceptable to you? Would you prefer to see the curriculum for less weeks, but longer sessions each week? What challenges do you foresee in participating in this kind of program as I have described? What could be done to overcome these challenges?	8. We have presented 11 topics with each topic held once a week, for an 11-week course. Each weekly meeting would be approximately 90 minutes long. Is this amount of time acceptable to you? Would you prefer to see the curriculum for less weeks, but longer sessions each week? What challenges do you foresee in participating in this kind of program as I have described? What could be done to overcome these challenges?
11. For some of these sessions, only men participate, but there are some sessions where female partners also participate. What	11. For some of these sessions, only men participate, but there are some sessions where female partners also participate. What do you think the main issues	9. For some of these sessions, only men participate, but there are some sessions where your female partners are also present. Do you foresee any challenges with having your partners participate in some of these	9. For some of these sessions, only men participate, but there are some sessions where you participate with your male partners. What do you think the main issues around your

KII GUIDE FOR ML IN THE COMMUNITY	KII GUIDE FOR HSPS	FGD GUIDE MEN	FGD GUIDE WOMEN
do you think the main issues around couples' participation? How could these be addressed? 12. Are there any other challenges you could foresee in the implementation of this curriculum as it has been described? What could be done to manage or prevent those challenges? 13. What other suggestions do you have?	around couples' participation? How could these be addressed? 12. What other suggestions do you have?	sessions? How could these be addressed? 10. What other suggestions do you have?	participation? How could these be addressed? 10. What other suggestions do you have?
Exit Questions			
14. Is there anything else you'd like to say about male engagement in health services? I want to take the last 5 minutes to review the main things I heard from our conversation today. Please correct me or add any details if you feel that I missed something. I want to be sure to accurately represent all that you have shared today. [Share summary]. Is this an adequate summary? Thank you for your time.	13. Is there anything else you'd like to say about male engagement in health services? I want to take the last 5 minutes to review the main things I heard from our conversation today. Please correct me or add any details if you feel that I missed something. I want to be sure to accurately represent all that you have shared today. [Share summary]. Is this an adequate summary? Thank you for your time.	11. Is there anything else you'd like to say about male engagement in health services? I want to take the last 5 minutes to review the main things I heard from our discussion today. Please correct me or add any details if you feel that I missed something. I want to be sure to accurately represent all that you have shared today. [Share summary]. Is this an adequate summary? Thank you for your time.	11. Is there anything else you'd like to say about male engagement in health services? I want to take the last 5 minutes to review the main things I heard from our discussion today. Please correct me or add any details if you feel that I missed something. I want to be sure to accurately represent all that you have shared today. [Share summary]. Is this an adequate summary? Thank you for your time.

HEALTH FACILITY SERVICE DELIVERY SURVEY

Transform: Primary Health Care male engagement implementation research

HEALTH FACILITY INDICATORS

Facility Information

Health facility Name: _____

Health Facility Type (circle one): Health Post Health Center

Woreda: _____

Kebele: _____

City/Town: _____

Date of data collection (Day/Month/Year): _____

1. Percentage of women that received ANC at least once during the current pregnancy

Instructions: Collect the monthly totals for this HMIS indicator from the ANC register for the health facility or service delivery tally for the health post. The denominator for this indicator is an estimate of the number of pregnancies expected for the facility. Collect the most recent 6 months of data.

Sources: ANC register, Service delivery tally (for HP)

	Mo. 1	**Mo. 2**	**Mo. 3**	**Mo. 4**	**Mo. 5**	**Mo. 6**
Month-Year						
Numerator: *Number of pregnant women that received antenatal care at least once*						
Denominator: *Total number of expected pregnancies*						

2. Percentage of women that received ANC four or more times during the current pregnancy

Instructions: Collect the monthly totals for this HMIS indicator from the ANC register for the health facility or service delivery tally for the health post. The denominator for this indicator is an estimate of the number of pregnancies expected for the facility. Collect the most recent 6 months of data.

Sources: ANC register, Service delivery tally (for HP)

	Mo. 1	Mo. 2	Mo. 3	Mo. 4	Mo. 5	Mo. 6
Month-Year						
Numerator: *The number of pregnant women that received antenatal care at least four visits*						
Denominator: *Total number of expected pregnancies*						

3. Average number of ANC visits completed by women delivering at the facility by month

Instructions: Select a random sample of 30 deliveries of women residing in the intervention kebeles each month, for the past six months. Collect this information from the ANC register for the health facility or service delivery tally for the health post. The denominator for each month should be 30, since this is the total number of deliveries sampled each month. For the numerator, record and add up the total number of ANC visits attended by the sample of women delivering that month.

Sources: ANC register, Service delivery tally (for HP)

	Mo. 1	Mo. 2	Mo. 3	Mo. 4	Mo. 5	Mo. 6
Month-Year						
Numerator: *Total number of ANC visits attended by the sample of women delivering that month.*						
Denominator: *Random sample of 30 deliveries of women residing in the intervention kebeles.*	30	30	30	30	30	30

4. Average estimated gestational age at ANC 1

Instructions: This is not an HMIS indicator. Review a sample of the most recent 30 ANC visits to this facility. Record the estimated gestational age for each of those 30 visits below.

Sources: ANC register, Service delivery tally (for HP)

	1	2	3	4	5	6	7	8	9
Estimated gestational age									
Date of ANC visit									

	10	11	12	13	14	15	16	17	18
Estimated gestational age									
Date of ANC visit									

	19	20	21	22	23	24	25	26	27
Estimated gestational age									
Date of ANC visit									

	28	29	30
Estimated gestational age			
Date of ANC visit			

5. Proportion of women of reproductive age (15-49 years) who are not pregnant and are accepting a modern contraceptive method (new and repeat acceptors)

Instructions: Collect the monthly totals for this indicator from the family planning register for the health facility or service delivery tally for the health post. Collect the most recent 6 months of data.

Each acceptor is counted only once, the first time s/he receives contraceptive services in the fiscal year.

"New acceptors" refers to the number of acceptors who receive family planning services from a recognized program for the first time irrespective of the method used. This is not the number of

consultations. Each acceptor is enumerated once in the year, at the first consultation for contraception in the calendar year.

"Repeat acceptors" refers to the number of acceptors who receive family planning services from a family planning program previously irrespective of the method used. Long acting FP method users will also be counted as repeat every year including routine checkup for ongoing use of a long-term method such as Norplant, IUD, etc.

New and repeat contraceptive acceptors are reported as two separate counts, so it is possible to calculate each rate separately as needed. Acceptor data reported from NGOs and other community-based non MOH sources can also be included in this calculation.

Sources: Family planning register; Service delivery tally (for HP), RH register (for primary private clinics), Pre-ART, ART registers

	Mo. 1	**Mo. 2**	**Mo. 3**	**Mo. 4**	**Mo. 5**	**Mo. 6**
Month-Year						
Numerator 1: *Number of new acceptors*						
Numerator 2: *Number of repeat acceptors*						
Numerator 3: *Number of new and repeat acceptors (N1+N2)*						
Denominator: *Total number of women of reproductive age (15-49) who are not pregnant*						

6. Proportion of births attended by skilled health personnel

Instructions: Collect the monthly totals for this indicator from the delivery register for the health facility. The denominator for this indicator is an estimate of the number of deliveries expected for the facility. Collect the most recent 6 months of data. ***Note: This data is not to be collected at the health post level.***

Sources: Delivery Register

	Mo. 1	**Mo. 2**	**Mo. 3**	**Mo. 4**	**Mo. 5**	**Mo. 6**
Month-Year						
Numerator: *The number of births attended by skilled health personnel*						

	Mo. 1	Mo. 2	Mo. 3	Mo. 4	Mo. 5	Mo. 6
Month-Year						
Denominator: *Total number of expected Deliveries*						

ATTITUDES AND BEHAVIORS SURVEY – FEMALE PARTICIPANTS

Participant ID # _____

Date of Interview: _____

Region: _____

Kebele: _____

Interviewer: _____

Start Time: _____

End Time: _____

Introduction

My name is [insert name] and I work for EnCompass LLC, a partner on the Transform: Primary Health Care Project. Today I will be asking you a series of questions about you and your family, health care during pregnancy, family planning, household decision making, household division of labor, and men's and women's roles regarding these topics.

Ensure that the informed consent is obtained before proceeding with this survey.

I have obtained consent/assent from the respondent prior to beginning this survey: Yes / No

NUMBER	QUESTION	ANSWER
A1	How old are you?	# 998 Don't know 999 Refused to answer
A2	What is the highest level of school you have attained? (For reference, Primary School includes Grades 1-8. Secondary school includes Grades 8-10)	0 No Education 1 Some primary 2 Completed primary 3 Some secondary 4 Completed secondary

NUMBER	QUESTION	ANSWER
		5 More than secondary 6 Other 999 Refused to answer
A3	What is your main source of employment?	1 Employed/earning a wage 2 Self-employed 3 Daily Laborer 4 Unemployed, seeking work 5 Unemployed, not seeking work 6 Unable to work/disabled 999 Refused to answer
A4	How many adult men (18 years of age and above) live in your household?	# 998 Don't know 999 Refused to answer
A5	How many adult women (18 years of age and above), including yourself, live in your household?	# 998 Don't know 999 Refused to answer
A6	How many male children (under 18) live in your household?	# 998 Don't know 999 Refused to answer
A7	How many female children (under 18) live in your household? [If the female respondent is under 18 years of age, include her in this count]	# 998 Don't know 999 Refused to answer
A8	How many biological children do you have?	# 998 Don't know

NUMBER	QUESTION	ANSWER
		999 Refused to answer
A9	What is the age and sex of each of your biological children? • Child 1: Age ___ Sex___ • Child 2: Age ___ Sex___ • Child 3: Age ___ Sex___ • Child 4: Age ___ Sex___ • Child 5: Age ___ Sex___ • Child 6: Age ___ Sex___ • Child 7: Age ___ Sex___ • Child 8: Age ___ Sex___ • Child 9: Age ___ Sex___ • Child 10: Age ___ Sex___	# 998 Don't know 999 Refused to answer
B1	Are you currently expecting a child? If No, continue to B6 If Yes, continue to B2	0 No 1 Yes 999 Refused to answer
B2	If Yes to B1) How many months until the child will be born?	# 998 Don't know 999 Refused to answer
B3	If Yes to B1) How many antenatal care (ANC) visits have you attended so far in your current pregnancy?	# 998 Don't know 999 Refused to answer
B4	If Yes to B1)	# 998 Don't know

NUMBER	QUESTION	ANSWER
	How many times has your husband/male partner accompanied you to attend antenatal care visits during your current pregnancy?	999 Refused to answer
B5	If Yes to B1) During the last ANC visit your partner attended for your current pregnancy, did he: 1) Accompany you all the way from home to the health facility up to the entrance or wait outside for you? 2) Wait in the health facility, but did not participate in ANC? 3) Join you for at least part of the ANC visit?	1 2 3 998 Don't know 999 Refused to answer
B6	I would now like to ask about the pregnancy and birth of your youngest living child. When you were pregnant with your youngest child, how many ANC visits did you attend?	# 998 Don't know 999 Refused to answer
B7	When you were pregnant with your youngest child, how many ANC visits did your husband/male partner accompany you to attend?	# 998 Don't know 999 Refused to answer
B8	During the last ANC visit your partner attended when you were pregnant with your youngest child, did he: 1) Drop you off at the entrance or wait outside for you? 2) Wait in the health facility, but did not participate in ANC? 3) Join you for at least part of the ANC visit?	1 2 3 998 Don't know 999 Refused to answer
B9	After the birth of your youngest child, did you or your partner ever take the child for vaccination, or did you take the child together?	0 No, we did not take the child for vaccination 1 Yes, I took the child 2 Yes, my partner took the child

NUMBER	QUESTION	ANSWER
		3 We both took the child, either separately or together 998 Don't know 999 Refused to answer
B10	During your most recent pregnancy, did you and your partner discuss your health care during pregnancy?	1 Often 2 Sometimes 3 Rarely 4 Never 998 Don't know 999 Refused to answer
B11	During your most recent pregnancy, did you and your partner discuss your concerns about having children?	1 Often 2 Sometimes 3 Rarely 4 Never 998 Don't know 999 Refused to answer
B12	During your most recent pregnancy, did your partner do some of the household tasks that you would normally do?	0 No 1 Yes 997 Not applicable N/A explanation: _____ 998 Don't know 999 Refused to answer
B13	If applicable: During your most recent pregnancy, did your partner take care of your other children? By care, we mean ensuring that your other children are fed, put to bed and	0 No 1 Yes

NUMBER	QUESTION	ANSWER
	awoken as needed, and generally looked after throughout the course of the day.	997 Not applicable N/A explanation: _____ 998 Don't know 999 Refused to answer
B14	If applicable: Do you or your partner currently use any method to avoid or delay pregnancy?	0 No 1 Pill 2 Male condom 3 Female condom 4 Injection 5 IUD 6 Vasectomy 7 Tubal ligation or hysterectomy 8 Implant 9 Traditional methods (periodic abstinence, withdrawal, cycle beads, etc.) 10 Other 997 Currently pregnant (not applicable) 998 Don't know 999 Refused to answer
C1	How often do you discuss your household's weekly or monthly income and expenses with your partner?	1 Often 2 Sometimes 3 Rarely 4 Never

NUMBER	QUESTION	ANSWER
		998 Don't know 999 Refused to answer
C2	When you discuss your household's weekly or monthly income and expenses, do you feel that your partner takes your opinions seriously?	1 Often 2 Sometimes 3 Rarely 4 Never 998 Don't know 999 Refused to answer
C3	Who makes the final decision about your household's weekly or monthly income and expenses?	1 You 2 Your partner 3 Both have the same say 4 Someone else 998 Don't know 999 Refused to answer
C4	How often do you discuss spending money on large investments, such as buying a cow, with your partner?	1 Often 2 Sometimes 3 Rarely 4 Never 998 Don't know 999 Refused to answer
C5	When you discuss spending money on large investments, such as buying a cow, do you feel that your partner takes your opinions seriously?	1 Often 2 Sometimes 3 Rarely 4 Never

NUMBER	QUESTION	ANSWER
		998 Don't know 999 Refused to answer
C6	Who makes the final decision about spending money on large investments, such as buying a cow?	1 You 2 Your partner 3 Both have the same say 4 Someone else 998 Don't know 999 Refused to answer
C7	How often do you discuss with your partner how many children to have or the spacing of children?	1 Often 2 Sometimes 3 Rarely 4 Never 998 Don't know 999 Refused to answer
C8	When you discuss how many children to have or the spacing of children, do you feel that your partner takes your opinions seriously?	1 Often 2 Sometimes 3 Rarely 4 Never 998 Don't know 999 Refused to answer
C9	Who makes the final decision about how many children to have or the spacing of children?	1 You 2 Your partner 3 Both have the same say 4 Someone else

NUMBER	QUESTION	ANSWER
		998 Don't know 999 Refused to answer
D1	If you disregard the help you receive from others, such as grandparents or other adult members of your household, how do you and your partner divide the task of providing daily care for your child/ren?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D2	During the last 7 days, on how many days did you provide daily care for your child/ren?	# 998 Don't Know/Don't Remember
D3	On a typical day, when you think of providing daily care for your child/ren, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D4	*If the mother has a child under 1 year old in the household ask this question. If not, skip to D7.* If you disregard the help you receive from others, how did you and your partner divide the task of holding your child/ren when he or she was a newborn?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D5	During the last 7 days, on how many days did you hold your child/ren who are less than one year old?	# 998 Don't Know/Don't Remember

NUMBER	QUESTION	ANSWER
D6	On a typical day, when you think of holding your child/ren who are less than one year old, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D7	If you disregard the help you receive from others, how do you and your partner divide the task of feeding your children?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D8	During the last 7 days, on how many days did you feed your children?	# 998 Don't Know/Don't Remember
D9	On a typical day, when you think of feeding your children, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D10	If you disregard the help you receive from others, how do you and your partner divide the task of bathing your child/ren?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____

NUMBER	QUESTION	ANSWER
D11	During the last 7 days, on how many days did you bathe your child/ren?	# 998 Don't Know/Don't Remember
D12	On a typical day, when you think of bathing your child/ren, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D13	If you disregard the help you receive from others, how do you and your partner divide the task of soothing your child/ren if he or she is crying or upset?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D14	During the last 7 days, on how many days did you soothe your child/ren if he or she is crying or upset?	# 998 Don't Know/Don't Remember
D15	On a typical day, when you think of soothing your child/ren if he or she is crying or upset, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D16	If you disregard the help you receive from others, how do you and your partner divide the task of taking your child/ren to the health post/health center if they are sick?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation:

NUMBER	QUESTION	ANSWER
		_____
D17	During the last month, on how many days did you take your child/ren to the health post/health center if they are sick?	# 998 Don't Know/Don't Remember
D18	On a typical day, when you think of taking your child/ren to the health post/health center if they are sick, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D19	If you disregard the help you receive from others, how do you and your partner divide the task of taking your child/ren to the health post/health center for vaccination?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D20	During the last year, on how many days did you do take your child/ren to the health post/health center for vaccination?	# 998 Don't Know/Don't Remember
D21	On a typical day, when you think of taking your child/ren to the health post/health center for vaccination, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D22	If you disregard the help you receive from others, how do you and your partner divide the task of telling your child/ren stories, signing them songs, or playing with your child/ren?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner

NUMBER	QUESTION	ANSWER
		997 Not applicable N/A explanation: _____
D23	During the last 7 days, on how many days did you tell your child/ren stories, sign them songs, or play with your child/ren?	# 998 Don't Know/Don't Remember
D24	On a typical day, when you think of telling your child/ren stories, signing them songs, or playing with your child/ren, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D25	If you disregard the help you receive from others, how do you and your partner divide the task of teaching your child/ren something? This can include teaching your child/ren practical skills, life skills, about religion or history, about a craft, or other things that you or your partner would want to teach your children.	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D26	During the last 7 days, on how many days did you teach your child/ren something?	# 998 Don't Know/Don't Remember
D27	On a typical day, when you think of teaching your child/ren something, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D28	If you disregard the help you receive from others, how do you and your partner divide the task of disciplining your child/ren? By disciplining your children, we mean teaching them to obey rules and acceptable behaviors and/or enforcing punishments, if punishments are used.	1 Always you 2 Usually you 3 Shared equally or done together

NUMBER	QUESTION	ANSWER
		4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D29	During the last 7 days, on how many days did you discipline your child/ren?	# 998 Don't Know/Don't Remember
D30	On a typical day, when you think of disciplining your child/ren, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D31	If you disregard the help you receive from others, how do you and your partner divide the task of fetching water for the household?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D32	During the last 7 days, on how many days did you fetch water for the household?	# 998 Don't Know/Don't Remember
D33	On a typical day, when you think of fetching water for the household, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D34	If you disregard the help you receive from others, how do you and your partner divide the task of washing clothes/doing laundry?	1 Always you 2 Usually you

NUMBER	QUESTION	ANSWER
		3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D35	During the last 7 days, on how many days did you wash clothes/doing laundry?	# 998 Don't Know/Don't Remember
D36	On a typical day, when you think of washing clothes/doing laundry, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D37	If you disregard the help you receive from others, how do you and your partner divide the task of going to the market for shopping, such as to buy food, coffee, oil, gas or other goods? This does not include times when you go to the market primarily for the purposes of selling goods or engaging in social activities.	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D38	During the last 7 days, on how many days did you go to the market for shopping, such as to buy food, coffee, oil, gas or other goods? This does not include times when you went to the market primarily for the purposes of selling goods or engaging in social activities	# 998 Don't Know/Don't Remember
D39	On a typical day, when you think of going to the market for shopping, such as to buy food, coffee, oil, gas or other goods, how many hours do you spend doing it? This does not include times when you go to the market primarily for the purposes of selling goods or engaging in social activities.	# 998 Don't Know/Don't Remember

NUMBER	QUESTION	ANSWER
	(round to 15 minute intervals)	
D40	If you disregard the help you receive from others, how do you and your partner divide the task of cleaning the household?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D41	During the last 7 days, on how many days did you clean the household?	# 998 Don't Know/Don't Remember
D42	On a typical day, when you think of cleaning the household, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D43	If you disregard the help you receive from others, how do you and your partner divide the task of repairing the house?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D44	During the last one month, on how many days did you repair the house?	# 998 Don't Know/Don't Remember

NUMBER	QUESTION	ANSWER
D45	On a typical day, when you think of repairing the house, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D46	If you disregard the help you receive from others, how do you and your partner divide the task of agricultural activities (farming/livestock/forestry/other agricultural activities, including farming, plowing, weeding) whether for pay, in-kind, or for no pay?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D47	During the last 7 days, on how many days did you do agricultural activities?	# 998 Don't Know/Don't Remember
D48	On a typical day, when you think of agricultural activities, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D49	If you disregard the help you receive from others, how do you and your partner divide the task of doing non-agricultural work outside the household whether for pay, in-kind, or not for pay? By non-agricultural work, we are referring to work that does not involve growing plants or raising livestock.	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____

NUMBER	QUESTION	ANSWER
D50	During the last 7 days, on how many days did you do non-agricultural work outside the household?	# 998 Don't Know/Don't Remember
D51	On a typical day, when you think of non-agricultural work outside the household, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
For the following questions, indicate whether you 1) agree, 2) partially agree, or 3) do not agree		
E1	There are times when a woman deserves to be beaten	1 Agree 2 Partially agree 3 Do not agree
E2	A woman should tolerate violence to keep her family together	1 Agree 2 Partially agree 3 Do not agree
E3	It is alright for a man to beat his wife if she is unfaithful	1 Agree 2 Partially agree 3 Do not agree
E4	A man can hit his wife if she won't have sex with him	1 Agree 2 Partially agree 3 Do not agree
E5	If someone insults a man, he should defend his reputation with force if he has to.	1 Agree 2 Partially agree 3 Do not agree
E6	A man using violence against his wife is a private matter that shouldn't be discussed outside the couple.	1 Agree 2 Partially agree

NUMBER	QUESTION	ANSWER
		3 Do not agree
E7	It is the man who decides what type of sex to have.	1 Agree 2 Partially agree 3 Do not agree
E8	Men are always ready to have sex.	1 Agree 2 Partially agree 3 Do not agree
E9	Men need sex more than women do.	1 Agree 2 Partially agree 3 Do not agree
E10	A man needs other women even if things with his wife are fine.	1 Agree 2 Partially agree 3 Do not agree
E11	You don't talk about sex, you just do it.	1 Agree 2 Partially agree 3 Do not agree
E12	It disgusts me when I see a man acting like a woman.	1 Agree 2 Partially agree 3 Do not agree
E13	A woman should not initiate sex.	1 Agree 2 Partially agree 3 Do not agree
E14	A woman who has sex before she marries does not deserve respect.	1 Agree

NUMBER	QUESTION	ANSWER
		2 Partially agree 3 Do not agree
E15	Women who carry condoms on them are easy.	1 Agree 2 Partially agree 3 Do not agree
E16	Men should be outraged if their wives ask them to use a condom.	1 Agree 2 Partially agree 3 Do not agree
E17	It is a woman's responsibility to avoid getting pregnant.	1 Agree 2 Partially agree 3 Do not agree
E18	Only when a woman has a child is she a real woman.	1 Agree 2 Partially agree 3 Do not agree
E19	A real man produces a male child.	1 Agree 2 Partially agree 3 Do not agree
E20	Changing diapers (including the use of washable/re-usable cloth diapers), giving a bath, and feeding kids is the mother's responsibility.	1 Agree 2 Partially agree 3 Do not agree
E21	A woman's role is taking care of her home and family.	1 Agree 2 Partially agree 3 Do not agree

NUMBER	QUESTION	ANSWER
E22	The husband should decide to buy the major household items.	1 Agree 2 Partially agree 3 Do not agree
E23	A man should have the final word about decisions in his home.	1 Agree 2 Partially agree 3 Do not agree
E24	A woman should obey her husband in all things.	1 Agree 2 Partially agree 3 Do not agree

ATTITUDES AND BEHAVIORS SURVEY – MALE PARTICIPANTS

Participant ID # _____

Date of Interview: _____

Region: _____

Kebele: _____

Interviewer: _____

Start Time: _____

End Time: _____

Introduction

My name is [insert name] and I work for EnCompass LLC, a partner on the Transform: Primary Health Care Project. Today I will be asking you a series of questions about you and your family, health care during pregnancy, family planning, household decision making, household division of labor, and men's and women's roles regarding these topics.

Ensure that the informed consent is obtained before proceeding with this survey.

I have obtained consent/assent from the respondent prior to beginning this survey: Yes / No

NUMBER	QUESTION	ANSWER
A1	How old are you?	# 998 Don't know 999 Refused to answer
A2	What is the highest level of school you have attained? (For reference, Primary School includes Grades 1-8. Secondary school includes Grades 8-10)	0 No Education 1 Some primary 2 Completed primary 3 Some secondary 4 Completed secondary 5 More than secondary

NUMBER	QUESTION	ANSWER
		6 Other 999 Refused to answer
A3	What is your main source of employment?	1 Employed/earning a wage 2 Self-employed 3 Daily Laborer 4 Unemployed, seeking work 5 Unemployed, not seeking work 6 Unable to work/disabled 999 Refused to answer
A4	How many adult men (18 years of age and above), including yourself, live in your household?	# 998 Don't know 999 Refused to answer
A5	How many adult women (18 years of age and above) live in your household?	# 998 Don't know 999 Refused to answer
A6	How many male children (under 18) live in your household?	# 998 Don't know 999 Refused to answer
A7	How many female children (under 18) live in your household?	# 998 Don't know 999 Refused to answer
A8	How many biological children do you have?	# 998 Don't know

NUMBER	QUESTION	ANSWER
		999 Refused to answer
A9	What is the age and sex of each of your biological children? • Child 1: Age ___ Sex___ • Child 2: Age ___ Sex___ • Child 3: Age ___ Sex___ • Child 4: Age ___ Sex___ • Child 5: Age ___ Sex___ • Child 6: Age ___ Sex___ • Child 7: Age ___ Sex___ • Child 8: Age ___ Sex___ • Child 9: Age ___ Sex___ • Child 10: Age ___ Sex___	# 998 Don't know 999 Refused to answer
B1	Are you currently expecting a child with your current partner? If No, continue to B6 If Yes, continue to B2	0 No 1 Yes 999 Refused to answer
B2	If Yes to B1) How many months until the child will be born?	# 998 Don't know 999 Refused to answer
B3	If Yes to B1) How many antenatal care (ANC) visits has your partner attended so far in her current pregnancy?	# 998 Don't know 999 Refused to answer
B4	If Yes to B1) How many times have you accompanied your partner to attend antenatal care visits during her current pregnancy?	# 998 Don't know

NUMBER	QUESTION	ANSWER
		999 Refused to answer
B5	If Yes to B1) During the last ANC visit you attended for your partner's current pregnancy, did you: 4) Did you accompany her all the way from home to the health facility up to the entrance or wait outside for her? 5) Wait in the health facility, but not participate in ANC? 6) Join her for at least part of the ANC visit?	1 2 3 998 Don't know 999 Refused to answer
B6	I would now like to ask about the pregnancy and birth of your youngest living child. When your partner was pregnant with your youngest child, how many ANC visits did she attend?	# 998 Don't know 999 Refused to answer
B7	When your partner was pregnant with your youngest child, how many ANC visits did you accompany her to attend?	# 998 Don't know 999 Refused to answer
B8	During the last ANC visit you attended when your partner was pregnant with your youngest child, did you: 1) Drop her off at the entrance or wait outside for her? 2) Wait in the health facility, but not participate in ANC? 3) Join her for at least part of the ANC visit?	1 2 3 998 Don't know 999 Refused to answer
B9	After the birth of your youngest child, did you or your partner ever take the child for vaccination, or did you take the child together?	0 No, we did not take the child for vaccination 1 Yes, I took the child 2 Yes, my partner took the child 3 We both took the child, either separately or together

NUMBER	QUESTION	ANSWER
		998 Don't know 999 Refused to answer
B10	During your most recent pregnancy, did you and your partner discuss health care during pregnancy?	1 Often 2 Sometimes 3 Rarely 4 Never 998 Don't know 999 Refused to answer
B11	During your most recent pregnancy, did you and your partner discuss her concerns about having children?	1 Often 2 Sometimes 3 Rarely 4 Never 998 Don't know 999 Refused to answer
B12	During your most recent pregnancy, did you do some of the household tasks that your partner would normally do?	0 No 1 Yes 997 Not applicable N/A explanation: _____ 998 Don't know 999 Refused to answer
B13	If applicable: During your most recent pregnancy, did you take care of your other children? By care, we mean ensuring that your other children are fed, put to bed and awoken as needed, and generally looked after throughout the course of the day.	0 No 1 Yes 997 Not applicable

NUMBER	QUESTION	ANSWER
		N/A explanation: _____ 998 Don't know 999 Refused to answer
B14	If applicable: Do you or your partner currently use any method to avoid or delay pregnancy?	0 No 1 Pill 2 Male condom 3 Female condom 4 Injection 5 IUD 6 Vasectomy 7 Tubal ligation or hysterectomy 8 Implant 9 Traditional methods (periodic abstinence, withdrawal, cycle beads, etc.) 10 Other 997 Currently pregnant (not applicable) 998 Don't know 999 Refused to answer
C1	How often do you discuss your household's weekly or monthly income and expenses with your partner?	1 Often 2 Sometimes 3 Rarely 4 Never 998 Don't know

NUMBER	QUESTION	ANSWER
		999 Refused to answer
C2	When you discuss your household's weekly or monthly income and expenses, do you feel that you take your partner's opinions seriously?	1 Often 2 Sometimes 3 Rarely 4 Never 998 Don't know 999 Refused to answer
C3	Who makes the final decision about your household's weekly or monthly income and expenses?	1 You 2 Your partner 3 Both have the same say 4 Someone else 998 Don't know 999 Refused to answer
C4	How often do you discuss spending money on large investments, such as buying a cow, with your partner?	1 Often 2 Sometimes 3 Rarely 4 Never 998 Don't know 999 Refused to answer
C5	When you discuss spending money on large investments, such as buying a cow, do you feel that you take your partner's opinions seriously?	1 Often 2 Sometimes 3 Rarely 4 Never 998 Don't know

NUMBER	QUESTION	ANSWER
		999 Refused to answer
C6	Who makes the final decision about spending money on large investments, such as buying a cow?	1 You 2 Your partner 3 Both have the same say 4 Someone else 998 Don't know 999 Refused to answer
C7	How often do you discuss with your partner how many children to have or the spacing of children?	1 Often 2 Sometimes 3 Rarely 4 Never 998 Don't know 999 Refused to answer
C8	When you discuss how many children to have or the spacing of children, do you feel that you take your partner's opinions seriously?	1 Often 2 Sometimes 3 Rarely 4 Never 998 Don't know 999 Refused to answer
C9	Who makes the final decision about how many children to have or the spacing of children?	1 You 2 Your partner 3 Both have the same say 4 Someone else 998 Don't know

NUMBER	QUESTION	ANSWER
		999 Refused to answer
D1	If you disregard the help you receive from others, such as grandparents or other adult members of your household, how do you and your partner divide the task of providing daily care for your child/ren?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable
D2	During the last 7 days, on how many days did you provide daily care for your child/ren?	# 998 Don't Know/Don't Remember
D3	On a typical day, when you think of providing daily care for your child/ren, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D4	*If the father has a child under 1 year old in the household ask this question. If not, skip to D7.* If you disregard the help you receive from others, how do you and your partner divide the task of holding your child/ren when he or she was a newborn?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D5	During the last 7 days, on how many days did you hold your child/ren who are less than one year old?	# 998 Don't Know/Don't Remember
D6	On a typical day, when you think of holding your child/ren who are less than one year old, how many hours do you spend doing it?	# 998 Don't Know/Don't Remember

NUMBER	QUESTION	ANSWER
	(Round to 15 minute intervals)	
D7	If you disregard the help you receive from others, how do you and your partner divide the task of feeding your children?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D8	During the last 7 days, on how many days did you feed your children?	# 998 Don't Know/Don't Remember
D9	On a typical day, when you think of feeding your children, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D10	If you disregard the help you receive from others, how do you and your partner divide the task of bathing your child/ren?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D11	During the last 7 days, on how many days did you bathe your child/ren?	# 998 Don't Know/Don't Remember

NUMBER	QUESTION	ANSWER
D12	On a typical day, when you think of bathing your child/ren, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D13	If you disregard the help you receive from others, how do you and your partner divide the task of soothing your child/ren if he or she is crying or upset?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D14	During the last 7 days, on how many days did you soothe your child/ren if he or she is crying or upset?	# 998 Don't Know/Don't Remember
D15	On a typical day, when you think of soothing your child/ren if he or she is crying or upset, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D16	If you disregard the help you receive from others, how do you and your partner divide the task of taking your child/ren to the health post/health center if they are sick or for vaccination?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____

NUMBER	QUESTION	ANSWER
D17	During the last month, on how many days did you take your child/ren to the health post/health center if they are sick?	# 998 Don't Know/Don't Remember
D18	On a typical day, when you think of taking your child/ren to the health post/health center if they are sick, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D19	If you disregard the help you receive from others, how do you and your partner divide the task of taking your child/ren to the health post/health center for vaccination?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D20	During the last year, on how many days did you do take your child/ren to the health post/health center for vaccination?	# 998 Don't Know/Don't Remember
D21	On a typical day, when you think of taking your child/ren to the health post/health center for vaccination, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D22	If you disregard the help you receive from others, how do you and your partner divide the task of telling your child/ren stories, signing them songs, or playing with your child/ren?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable

NUMBER	QUESTION	ANSWER
		N/A explanation: _____
D23	During the last 7 days, on how many days did you tell your child/ren stories, sign them songs, or play with your child/ren?	# 998 Don't Know/Don't Remember
D24	On a typical day, when you think of telling your child/ren stories, signing them songs, or playing with your child/ren, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D25	If you disregard the help you receive from others, how do you and your partner divide the task of teaching your child/ren something? This can include teaching your child/ren practical skills, life skills, about religion or history, about a craft, or other things that you or your partner would want to teach your children.	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D26	During the last 7 days, on how many days did you teach your child/ren something?	# 998 Don't Know/Don't Remember
D27	On a typical day, when you think of teaching your child/ren something, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D28	If you disregard the help you receive from others, how do you and your partner divide the task of disciplining your child/ren? By disciplining your children, we mean teaching them to obey rules and acceptable behaviors and/or enforcing punishments, if punishments are used.	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner

NUMBER	QUESTION	ANSWER
		5 Always partner 997 Not applicable N/A explanation: _____
D29	During the last 7 days, on how many days did you discipline your child/ren?	# 998 Don't Know/Don't Remember
D30	On a typical day, when you think of disciplining your child/ren, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D31	If you disregard the help you receive from others, how do you and your partner divide the task of fetching water for the household?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D32	During the last 7 days, on how many days did you fetch water for the household?	# 998 Don't Know/Don't Remember
D33	On a typical day, when you think of fetching water for the household, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D34	If you disregard the help you receive from others, how do you and your partner divide the task of washing clothes/doing laundry?	1 Always you 2 Usually you 3 Shared equally or done together

NUMBER	QUESTION	ANSWER
		4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D35	During the last 7 days, on how many days did you wash clothes/doing laundry?	# 998 Don't Know/Don't Remember
D36	On a typical day, when you think of washing clothes/doing laundry, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D37	If you disregard the help you receive from others, how do you and your partner divide the task of going to the market for shopping, such as to buy food, coffee, oil, gas or other goods? This does not include times when you go to the market primarily for the purposes of selling goods or engaging in social activities.	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D38	During the last 7 days, on how many days did you go to the market for shopping, such as to buy food, coffee, oil, gas or other goods? This does not include times when you went to the market primarily for the purposes of selling goods or engaging in social activities	# 998 Don't Know/Don't Remember
D39	On a typical day, when you think of going to the market for shopping, such as to buy food, coffee, oil, gas or other goods, how many hours do you spend doing it? This does not include times when you go to the market primarily for the purposes of selling goods or engaging in social activities. (round to 15 minute intervals)	# 998 Don't Know/Don't Remember

NUMBER	QUESTION	ANSWER
D40	If you disregard the help you receive from others, how do you and your partner divide the task of cleaning the household?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D41	During the last 7 days, on how many days did you clean the household?	# 998 Don't Know/Don't Remember
D42	On a typical day, when you think of cleaning the household, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D43	If you disregard the help you receive from others, how do you and your partner divide the task of repairing the house?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D44	During the last one month, on how many days did you repair the house?	# 998 Don't Know/Don't Remember
D45	On a typical day, when you think of repairing the house, how many hours do you spend doing it?	# 998 Don't Know/Don't Remember

NUMBER	QUESTION	ANSWER
	(round to 15 minute intervals)	
D46	If you disregard the help you receive from others, how do you and your partner divide the task of agricultural activities (farming/livestock/forestry/other agricultural activities, including farming, plowing, weeding) whether for pay, in-kind, or for no pay?	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D47	During the last 7 days, on how many days did you do agricultural activities?	# 998 Don't Know/Don't Remember
D48	On a typical day, when you think of agricultural activities, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
D49	If you disregard the help you receive from others, how do you and your partner divide the task of doing non-agricultural work outside the household whether for pay, in-kind, or not for pay? By non-agricultural work, we are referring to work that does not involve growing plants or raising livestock.	1 Always you 2 Usually you 3 Shared equally or done together 4 Usually partner 5 Always partner 997 Not applicable N/A explanation: _____
D50	During the last 7 days, on how many days did you do non-agricultural work outside the household?	# 998 Don't Know/Don't Remember

NUMBER	QUESTION	ANSWER
D51	On a typical day, when you think of non-agricultural work outside the household, how many hours do you spend doing it? (round to 15 minute intervals)	# 998 Don't Know/Don't Remember
For the following questions, indicate whether you 1) agree, 2) partially agree, or 3) do not agree		
E1	There are times when a woman deserves to be beaten	1 Agree 2 Partially agree 3 Do not agree
E2	A woman should tolerate violence to keep her family together	1 Agree 2 Partially agree 3 Do not agree
E3	It is alright for a man to beat his wife if she is unfaithful	1 Agree 2 Partially agree 3 Do not agree
E4	A man can hit his wife if she won't have sex with him	1 Agree 2 Partially agree 3 Do not agree
E5	If someone insults a man, he should defend his reputation with force if he has to.	1 Agree 2 Partially agree 3 Do not agree
E6	A man using violence against his wife is a private matter that shouldn't be discussed outside the couple.	1 Agree 2 Partially agree 3 Do not agree
E7	It is the man who decides what type of sex to have.	1 Agree

NUMBER	QUESTION	ANSWER
		2 Partially agree 3 Do not agree
E8	Men are always ready to have sex.	1 Agree 2 Partially agree 3 Do not agree
E9	Men need sex more than women do.	1 Agree 2 Partially agree 3 Do not agree
E10	A man needs other women even if things with his wife are fine.	1 Agree 2 Partially agree 3 Do not agree
E11	You don't talk about sex, you just do it.	1 Agree 2 Partially agree 3 Do not agree
E12	It disgusts me when I see a man acting like a woman.	1 Agree 2 Partially agree 3 Do not agree
E13	A woman should not initiate sex.	1 Agree 2 Partially agree 3 Do not agree
E14	A woman who has sex before she marries does not deserve respect.	1 Agree 2 Partially agree 3 Do not agree

NUMBER	QUESTION	ANSWER
E15	Women who carry condoms on them are easy.	1 Agree 2 Partially agree 3 Do not agree
E16	Men should be outraged if their wives ask them to use a condom.	1 Agree 2 Partially agree 3 Do not agree
E17	It is a woman's responsibility to avoid getting pregnant.	1 Agree 2 Partially agree 3 Do not agree
E18	Only when a woman has a child is she a real woman.	1 Agree 2 Partially agree 3 Do not agree
E19	A real man produces a male child.	1 Agree 2 Partially agree 3 Do not agree
E20	Changing diapers (including the use of washable/re-usable cloth diapers), giving a bath, and feeding kids is the mother's responsibility.	1 Agree 2 Partially agree 3 Do not agree
E21	A woman's role is taking care of her home and family.	1 Agree 2 Partially agree 3 Do not agree
E22	The husband should decide to buy the major household items.	1 Agree 2 Partially agree 3 Do not agree

NUMBER	QUESTION	ANSWER
E23	A man should have the final word about decisions in his home.	1 Agree 2 Partially agree 3 Do not agree
E24	A woman should obey her husband in all things.	1 Agree 2 Partially agree 3 Do not agree

ANNEX D: RECRUITMENT SCRIPTS AND TEMPLATES

RECRUITMENT SCRIPTS

KEY INFORMANT INTERVIEW: RECRUITMENT SCRIPT FOR MALE LEADERS

[Salutation]

My name is [insert name], and I am working for EnCompass, LLC, a partner on the Transform: Primary Health Care Activity. The Transform: Primary Health Activity is a USAID-funded program that is working to end preventable maternal and child deaths in Ethiopia. We are conducting a study to examine how to modify a curriculum to increase male engagement in health care services. I am inviting you to participate in an in-person interview to discuss your perceptions and experiences regarding how men in your community participate in their partners' healthcare, especially with regard to family planning and antenatal care. The interview will take no longer than 60 minutes. Participation is completely voluntary and your answers will be kept confidential. I will follow up with a phone call to set the date and time of the interview, if you are interested. If you have any questions, please do not hesitate to contact me.

Provide the prospective participant with your phone number and email address. If they indicate their interest to participate, also ask for their preferred contact information.

Thank you for your time.

KEY INFORMANT INTERVIEW: RECRUITMENT SCRIPT FOR HEALTHCARE PROVIDERS

[Salutation]

My name is [insert name], and I am working for EnCompass, LLC, a partner on the Transform: Primary Health Care Activity. The Transform: Primary Health Activity is a USAID-funded program that is working to end preventable maternal and child deaths in Ethiopia. We are conducting a study to examine how to modify a curriculum to increase male engagement in health care services. I am inviting you to participate in an in-person interview to discuss your perceptions and experiences regarding how men in the community you serve participate in their partners' healthcare, especially with regard to family planning and antenatal care. The interview will take no longer than 60 minutes. Participation is completely voluntary and your answers will be kept confidential. I will follow up with a phone call to set the date and time of the interview, if you are interested. If you have any questions, please do not hesitate to contact me.

Provide the prospective participant with your phone number and email address. If they indicate their interest to participate, also ask for their preferred contact information.

Thank you for your time.

FOCUS GROUP DISCUSSIONS: RECRUITMENT SCRIPT FOR FEMALE/MALE COMMUNITY MEMBERS

[Salutation]

My name is [insert name], and I am working for EnCompass, LLC, a partner on the Transform: Primary Health Care Activity. The Transform: Primary Health Activity is a USAID-funded program that is working to end preventable maternal and child deaths in Ethiopia. We are conducting a study to examine how to modify a curriculum to increase male engagement in health care services. I am inviting you to participate in a group discussion where participants will share their perceptions and experiences regarding how men in your community participate in their partners' healthcare, especially with regard to family planning and antenatal care. The group discussion will take no longer than 60 minutes.

We would also like to invite you to participate in a survey about men's attitudes in your community. This survey would also take no longer than 60 minutes. The information from this survey will also help us to better understand how to modify the proposed curriculum to increase male engagement in healthcare services.

Participation in both of these activities is completely voluntary and your answers will be kept confidential. I will follow up with a phone call to set the date and time of these activities, if you are interested.

If the respondent indicates that they are interested in participating in the focus group discussion, proceed to obtain consent/assent to participate:

Thank you for interest to participate in the focus group discussion. If you have time now, it would be great if we could have your consent to participate in the upcoming discussion.

[If participate indicates that they have time, proceed using the appropriate Consent/Assent Form. If they indicate that they do not have time, make sure to request Consent/Assent prior to their participation in the FGD.]

Whether or not the participant chooses to participate, continue with:

If you have any questions, please do not hesitate to contact me.

Thank you for your time.

Provide the prospective participant with your phone number and email address. If they indicated their interest to participate, also ask for their preferred contact information.

RECRUITMENT TEMPLATES

Male Engagement in ANC and FP Implementation Research

Intervention Participants List

Region: _____

Zone: _____

Woreda: _____

List prepared by: _____

Date:_____

Reminder: Criteria for selection of Participant: Expecting or child less than one year and age 15-35, married, co-habiting
: Once you get the list fulfilling the criteria from health extension worker you choose participants randomly
: Criteria for selection of Male leader/Facilitator: Literate, good community rapport, be a father (optional) or positive attitude about fatherhood, open-minded (Please refer Participants Recruitment Script)

	Husband Name	Age	Wife Name	Age	Address/ Name of the Kebele and phone number	Average distance from the nearest health post or health center in (KM)

	Husband Name	Age	Wife Name	Age	Address/ Name of the Kebele and phone number	Average distance from the nearest health post or health center in (KM)

Male Engagement in ANC and FP Implementation Research

Male Leader/Facilitator Profile and address

Region: _____

Zone: _____

Woreda: _____

List prepared by: _____

Date:_____

	Name of male leader	Age	Contact address / Woreda/ Kebele	Phone number

ANNEX E: CONSENT FORMS

FGD INFORMED CONSENT FORM – INTERVENTION PARTICIPANTS

Principle Investigators: Diana Santillan, Heran Tadesse

Organization: EnCompass LLC

Sponsor: United States Agency for International Development (USAID)

This Informed Consent Form has two parts: (1) information sheet and (2) provision of oral assent.

You will be given a copy of the full Informed Consent Form.

PART I: INFORMATION SHEET

My name is [insert name] and I work for EnCompass LLC, a partner on the Transform: Primary Health Care Project. We are conducting a study to examine how to modify a curriculum to increase male engagement in health care services and assess its effectiveness.

Before you decide to participate, you can talk with anyone you feel comfortable with. As I go through this information with you, there may be words or ideas you are not familiar with. Please interrupt me at any time and ask questions. If you have questions later or in the future, you can ask them of me or another person involved in this study. Contact information where we can be reached is included in this information sheet.

Purpose of the Study

The findings from this research will enable the Transform: Primary Health Care Project to effectively adapt and implement, and evaluate a male engagement curriculum within Ethiopia, with the ultimate aim to reduce preventable child and maternal deaths.

Method of Data Collection

This study will involve interviewing healthcare providers and male community leaders, conducting group discussions with male and female session participants, and collecting data from health facilities. This group discussion will take no more than 60 minutes.

Participant Selection

You have been chosen to participate in this group because you will be participating in the intervention along with your partner.

Before we continue, I just wanted to confirm your age. What is your age? (Participant's age: _____)

If the participant's age is 18 years or above, continue with this form. If participant's age is under 18 years, please continue using the Assent Form.

Voluntary Participation and Right to Withdraw

Your participation in this study is entirely voluntary. It is your choice whether to participate or not. If you choose not to participate, we will destroy the contact information we have for you. If you decide to participate, you may change your mind and withdraw from the study at any time and we will destroy your contact information and any other information you have provided up to that time. If you choose not to participate in this study, you will not be automatically excluded from participating in the intervention that I will describe.

Duration

This study will take place over approximately 12 months.

Procedures

We will be conducting these group discussions three times during the 12 months. The first time, before we start the intervention, will be to examine the potential barriers or challenges to male engagement and inform any modifications to the curriculum to make it more acceptable to the Ethiopian context. At the second discussion, which will be held half-way through the intervention, we will explore the successes and challenges in implementing the intervention and identify opportunities for improvement. Finally, at the end of the intervention, our discussion will reflect on the successes and challenges with the intervention and inform future versions of the intervention. I will give you an opportunity at the end of the interview to review your remarks, and you can ask to modify or remove portions if you do not agree with my notes or if I did not understand you correctly.

Risks

The most significant risk from participating in this study is a breach of privacy protections and loss of confidentiality. We cannot guarantee your confidentiality as this is a group discussion, but we ask that you agree to not share the details of our discussion outside of this room. You may feel uncomfortable or experience other emotions when sharing your perspectives on male engagement. Understand that you do not have to participate if you do not want to. We will hold these discussions at a private location where you feel comfortable. If you do choose to participate, the study team will keep all your answers and personal information in a secure location and will not share this information with anyone not involved in the study. Your responses will not be shared with health facility staff or the community. Your personal information, including your name, will not be included in the final report or any presentation of findings.

Benefits

You may receive no direct benefits from participating in this study, but your participation is likely to help inform future male engagement activities in Ethiopia.

Reimbursements

You will be reimbursed for travel associated with participating in the discussions, if travel is required. You will receive no incentives for your participation.

Confidentiality

We will not share the information you provide to us with anyone who is not part of the study team. We will store information electronically, such as transcripts, notes and databases, on password-protected computers and web-based data storage and analysis platforms. We will destroy all of the information you provide 3 years after the publication of the final report.

Sharing Summary Results

The information you provide will be combined with information from other interview respondents and presented in a final report which will be shared with the Ethiopian Ministry of Health, USAID, Transform: Primary Health Care project staff, participating health facilities, and other key stakeholders.

Transparency

It is also important to note that EnCompass LLC will not be using the male engagement curriculum to directly lead events in your community. When events using this curriculum are held in your community, these will be led by local leaders. EnCompass LLC will be focusing primarily on collecting data (interviews with healthcare providers and male community leaders, group discussions with male and female session participants, and collecting data from health facilities), to help strengthen and improve this curriculum. Our role will help us to think objectively about how to do this.

Permission to Record

I would like to take notes and audio-record our upcoming discussions so we can have an accurate record. We will delete these recordings and destroy written notes 3 years after the publication of the final report. In the meantime, no one outside of the study team will have access to this information.

Whom to Contact

This study has been reviewed and approved by the EnCompass LLC Institutional Review Board [insert reference number] and the Regional Health Bureau, which are tasked with making sure participants are protected from harm. If you wish to find out more about the ethics review, contact Dr Sarah Lunsford at ssmith@encompassworld.com or [insert contact for someone at the Regional Health Bureau].

If you have any questions about this research study in the future, please contact me using the following contact information:

Name and Phone # of Data Collector: _____

If you have complaints about our team or the study, please contact:

Heran Abebe Tadesse, Senior Gender Advisor, Transform: Primary Health Care
e-mail: htadesse@encompassworld.com Direct: +251 11 320 3501

PART II: PROVISION OF ORAL CONSENT

Say to the participant: You can ask me any questions about any part of this research or the consent information sheet, if you wish. Do you have any questions?

[After answering any questions, continue with the following:]

Say to the participant: I just wanted to confirm that you have been asked to participate in a study on male engagement. You have read the relevant information or I have read it to you. You have also had the opportunity to ask questions about it and I have answered, to your satisfaction, any questions that you have asked. Do you voluntarily consent to participate in this study?

The participant provides oral consent: Yes / No

Thank you for your consent to participate in this study. I will now provide you with a copy of the information sheet that we reviewed.

Signature of Data Collector: _____

Date: _____

INTERVIEW INFORMED CONSENT FORM – HEALTHCARE PROVIDERS

Principle Investigators: Diana Santillan, Heran Tadesse

Organization: EnCompass LLC

Sponsor: United States Agency for International Development (USAID)

This Informed Consent Form has two parts: (1) information sheet and (2) provision of oral assent.

You will be given a copy of the full Informed Consent Form.

PART I: INFORMATION SHEET

My name is [insert name] and I work for EnCompass LLC, a partner on the Transform: Primary Health Care Project. We are conducting a study to examine how to modify a curriculum to increase male engagement in health care services and assess its effectiveness.

Before you decide to participate, you can talk with anyone you feel comfortable with. As I go through this information with you, there may be words or ideas you are not familiar with. Please interrupt me at any time and ask questions. If you have questions later or in the future, you can ask them of me or another person involved in this study. Contact information where we can be reached is included in this information sheet.

Purpose of the Study

The findings from this research will enable the Transform: Primary Health Care Project to effectively adapt and implement, and evaluate a male engagement curriculum within Ethiopia, with the ultimate aim to reduce preventable child and maternal deaths.

Method of Data Collection

This study will involve interviewing healthcare providers and male community leaders, conducting group discussions with male and female session participants, and collecting data from health facilities. This interview will take no more than 60 minutes.

Participant Selection

You have been chosen to participate in this interview because you will be facilitating some of the sessions included in the male engagement intervention.

Voluntary Participation and Right to Withdraw

Your participation in this study is entirely voluntary. It is your choice whether to participate or not. If you choose not to participate, we will destroy the contact information we have for you. If you decide to participate, you may change your mind and withdraw from the study at any time and we will destroy

your contact information and any other information you have provided up to that time. Choosing not to participate in this study will not impact your work.

Duration

This study will take place over approximately 12 months.

Procedures

We will be speaking to you three times during the 12 months. The first time, before we start the intervention, will be to examine the potential barriers or challenges to male engagement and inform any modifications to the curriculum to make it more acceptable to the Ethiopian context. At the second interview, which will be held half-way through the intervention, we will interview you to understand the successes and challenges in implementing the intervention and identify opportunities for improvement. Finally, at the end of the intervention, our interview will reflect on the successes and challenges with the intervention and inform future versions of the intervention. I will give you an opportunity at the end of the interview to review your remarks, and you can ask to modify or remove portions if you do not agree with my notes or if I did not understand you correctly.

Risks

The most significant risk from participating in this study is a breach of privacy protections and loss of confidentiality. You may feel uncomfortable or experience other emotions when sharing your perspectives on male engagement. Understand that you do not have to participate if you do not want to. We will interview you at a private location where you feel comfortable. If you do choose to participate, the study team will keep all your answers and personal information in a secure location and will not share this information with anyone not involved in the study. Your responses will not be shared with colleagues or your supervisor or the community. Your personal information, including your name, will not be included in the final report or any presentation of findings.

Benefits

You may receive no direct benefits from participating in this study, but your participation is likely to help inform future male engagement activities in Ethiopia.

Reimbursements

You will be reimbursed for travel associated with participating in the interviews, if travel is required. You will receive no incentives for your participation.

Confidentiality

We will not share the information you provide to us with anyone who is not part of the study team. We will store information electronically, such as transcripts, notes and databases, on password-protected computers and web-based data storage and analysis platforms. We will destroy all of the information you provide 3 years after the publication of the final report.

Sharing Summary Results

The information you provide will be combined with information from other interview respondents and presented in a final report which will be shared with the Ethiopian Ministry of Health, USAID, Transform: Primary Health Care project staff, participating health facilities, and other key stakeholders.

Transparency

It is also important to note that EnCompass LLC will not be using the male engagement curriculum to directly lead events in your community. When events using this curriculum are held in your community, these will be led by local leaders. EnCompass LLC will be focusing primarily on collecting data (interviews with healthcare providers and male community leaders, group discussions with male and female session participants, and collecting data from health facilities), to help strengthen and improve this curriculum. Our role will help us to think objectively about how to do this.

Permission to Record

I would like to both take notes and audio-record our conversations. This is so we can have an accurate record of what you say. We will delete these recordings and destroy written notes 3 years after the publication of the final report. In the meantime, no one outside of the study team will have access to this information.

If respondent declines the use of audio recording equipment during your conversation:

I understand your decision not to have our conversation recorded using audio equipment. Would you be comfortable proceeding with this interview if I take written notes only, and do not use any audio recording equipment?

Proceed only if participant consents to the use of written notes during the interview.

Whom to Contact

This study has been reviewed and approved by the EnCompass LLC Institutional Review Board [insert reference number] and the Regional Health Bureau, which are tasked with making sure participants are protected from harm. If you wish to find out more about the ethics review, contact Dr Sarah Lunsford at ssmith@encompassworld.com or [insert contact for someone at the Regional Health Bureau].

If you have any questions about this research study in the future, please contact me using the following contact information:

Name and Phone # of Data Collector: _____

If you have complaints about our team or the study, please contact:

Heran Abebe Tadesse, Senior Gender Advisor, Transform: Primary Health Care
e-mail: htadesse@encompassworld.com Direct: +251 11 320 3501

PART II: PROVISION OF ORAL CONSENT

Say to the participant: You can ask me any questions about any part of this research or the consent information sheet, if you wish. Do you have any questions?

[After answering any questions, continue with the following:]

Say to the participant: I just wanted to confirm that you have been asked to participate in a study on male engagement. You have read the relevant information or I have read it to you. You have also had the opportunity to ask questions about it and I have answered, to your satisfaction, any questions that you have asked. Do you voluntarily consent to participate in this study?

The participant provides oral consent: Yes / No

Thank you for your consent to participate in this study. I will now provide you with a copy of the information sheet that we reviewed.

Signature of Data Collector: _____

Date: _____

INTERVIEW INFORMED CONSENT FORM – MALE LEADERS

Principle Investigators: Diana Santillan, Heran Tadesse

Organization: EnCompass LLC

Sponsor: United States Agency for International Development (USAID)

This Informed Consent Form has two parts: (1) information sheet and (2) provision of oral assent.

You will be given a copy of the full Informed Consent Form.

PART I: INFORMATION SHEET

My name is [insert name] and I work for EnCompass LLC, a partner on the Transform: Primary Health Care Project. We are conducting a study to examine how to modify a curriculum to increase male engagement in health care services and assess its effectiveness.

Before you decide to participate, you can talk with anyone you feel comfortable with. As I go through this information with you, there may be words or ideas you are not familiar with. Please interrupt me at any time and ask questions. If you have questions later or in the future, you can ask them of me or another person involved in this study. Contact information where we can be reached is included in this information sheet.

Purpose of the Study

The findings from this research will enable the Transform: Primary Health Care Project to effectively adapt and implement, and evaluate a male engagement curriculum within Ethiopia, with the ultimate aim to reduce preventable child and maternal deaths.

Method of Data Collection

This study will involve interviewing healthcare providers and male community leaders, conducting group discussions with male and female session participants, and collecting data from health facilities. This interview will take no more than 60 minutes.

Participant Selection

You have been chosen to participate in this interview because you will be facilitating the sessions included in the male engagement intervention.

Voluntary Participation and Right to Withdraw

Your participation in this study is entirely voluntary. It is your choice whether to participate or not. If you choose not to participate, we will destroy the contact information we have for you. If you decide to participate, you may change your mind and withdraw from the study at any time and we will destroy your contact information and any other information you have provided up to that time. If you choose

not to participate in this study, you will not be automatically excluded from participating in the intervention that I will describe.

Duration

This study will take place over approximately 12 months.

Procedures

We will be speaking to you three times during the 12 months. The first time, before we start the intervention, will be to examine the potential barriers or challenges to male engagement and inform any modifications to the curriculum to make it more acceptable to the Ethiopian context. At the second interview, which will be held half-way through the intervention, we will interview you to understand the successes and challenges in implementing the intervention and identify opportunities for improvement. Finally, at the end of the intervention, our interview will reflect on the successes and challenges with the intervention and inform future versions of the intervention. I will give you an opportunity at the end of the interview to review your remarks, and you can ask to modify or remove portions if you do not agree with my notes or if I did not understand you correctly.

Risks

The most significant risk from participating in this study is a breach of privacy protections and loss of confidentiality. You may feel uncomfortable or experience other emotions when sharing your perspectives on male engagement. Understand that you do not have to participate if you do not want to. We will interview you at a private location where you feel comfortable. If you do choose to participate, the study team will keep all your answers and personal information in a secure location and will not share this information with anyone not involved in the study. Your responses will not be shared with colleagues or your supervisor or the community. Your personal information, including your name, will not be included in the final report or any presentation of findings.

Benefits

You may receive no direct benefits from participating in this study, but your participation is likely to help inform future male engagement activities in Ethiopia.

Reimbursements

You will be reimbursed for travel associated with participating in the interviews, if travel is required. You will receive no incentives for your participation.

Confidentiality

We will not share the information you provide to us with anyone who is not part of the study team. We will store information electronically, such as transcripts, notes and databases, on password-protected computers and web-based data storage and analysis platforms. We will destroy all of the information you provide 3 years after the publication of the final report.

Sharing Summary Results

The information you provide will be combined with information from other interview respondents and presented in a final report which will be shared with the Ethiopian Ministry of Health, USAID, Transform: Primary Health Care project staff, participating health facilities, and other key stakeholders.

Transparency

It is also important to note that EnCompass LLC will not be using the male engagement curriculum to directly lead events in your community. When events using this curriculum are held in your community, these will be led by local leaders like yourself. EnCompass LLC will be focusing primarily on collecting data (interviews with healthcare providers and male community leaders, group discussions with male and female session participants, and collecting data from health facilities), to help strengthen and improve this curriculum. Our role will help us to think objectively about how to do this.

Permission to Record

I would like to both take notes and audio-record our conversations. This is so we can have an accurate record of what you say. We will delete these recordings and destroy written notes 3 years after the publication of the final report. In the meantime, no one outside of the study team will have access to this information.

If respondent declines the use of audio recording equipment during your conversation:

I understand your decision not to have our conversation recorded using audio equipment. Would you be comfortable proceeding with this interview if I take written notes only, and do not use any audio recording equipment?

Proceed only if participant consents to the use of written notes during the interview.

Whom to Contact

This study has been reviewed and approved by the EnCompass LLC Institutional Review Board [insert reference number] and the Regional Health Bureau, which are tasked with making sure participants are protected from harm. If you wish to find out more about the ethics review, contact Dr Sarah Lunsford at ssmith@encompassworld.com or [insert contact for someone at the Regional Health Bureau].

If you have any questions about this research study in the future, please contact me using the following contact information:

Name and Phone # of Data Collector: _____

If you have complaints about our team or the study, please contact:

Heran Abebe Tadesse, Senior Gender Advisor, Transform: Primary Health Care
e-mail: htadesse@encompassworld.com Direct: +251 11 320 3501

PART II: PROVISION OF ORAL CONSENT

Say to the participant: You can ask me any questions about any part of this research or the consent information sheet, if you wish. Do you have any questions?

[After answering any questions, continue with the following:]

Say to the participant: I just wanted to confirm that you have been asked to participate in a study on male engagement. You have read the relevant information or I have read it to you. You have also had the opportunity to ask questions about it and I have answered, to your satisfaction, any questions that you have asked. Do you voluntarily consent to participate in this study?

The participant provides oral consent: Yes / No

Thank you for your consent to participate in this study. I will now provide you with a copy of the information sheet that we reviewed.

Signature of Data Collector: _____

Date: _____

ANNEX F: RELEVANT MALE ENGAGEMENT TRAINING MANUALS REVIEWED

Training manuals developed for engaging men and boys for gender equality in several African, Latin American and Middle East countries

- Burden, A., Fordham, W., Hwang, T., Pinto, M. and Welsh, P. (2013). *Gender Equity and Diversity Module Five: Engaging Men and Boys for Gender Equality*. GED 501, CARE USA.
- CARE/ Rwanda Men's Resource Center, (RWAMREC). (2018). *Model Couples in Eliminating Gender-Based Violence*. CARE Rwanda
- Centro de Educación y Comunicación Popular. (1998). *El Significado de Ser Hombre: Propuesta metodológica para el trabajo de género entre hombres*. Managua. Nicaragua: CANTERA
- Centro de Educación y Comunicación Popular. (2001). *El Significado de Ser Hombre: Guía metodológica para el trabajo de género con hombres (masculinidad)*. Managua, Nicaragua: CANTERA
- CARE. (2018). *Indashyikirwa Couples Curriculum*. Rwanda with the Rwanda Men's Resource Centre (RWAMREC)
- IRC. (2014). *My Safety, My Wellbeing*. Lebanon
- IRC. (2018). *Girl Shine – Female Caregivers Curriculum*.
- Prabu Deepan. (2017*). Transforming Masculinities - A training manual for Gender Champions.* Tearfund, UK
- Promundo and USAID. (2008). *Engaging Boys and Men in Gender Transformation: The Group Education Manual*. Acquire Project. USA
- Promundo, CulturaSalud, and REDMAS (2013). *Program P – A Manual for Engaging Men in Fatherhood Caregiving, Maternal and Child Health. Promundo*. Rio de Janeiro, Brazil and Washington, D.C. USA.
- Promundo-US, MenCare+, Rutgers. (2013). *Bandebereho Program P - Facilitator's Manual Engaging men as fathers in gender equality, maternal and child health, caregiving and violence prevention*. RWAMREC, Rwanda
- Rachel Jewkes, Mzikazi Nduna and Nwabisa Jama. (2010). *A training manual for sexual and reproductive health communication and relationship skills.* Stepping Stones Edition III. adapted from the original Stepping Stones manual by Alice Welbourn.:
- Raising Voices (2020) *SASA! Together manuals: An activist approach for preventing violence against women*. Uganda.
- Sonke Gender Justice & IOM. (2009) *An Action Oriented Training Manual on Gender, Migration and HIV*, South Africa
- Sonke Gender Justice. (2015). *Tsima Booklet 2: Community Mobilization Workshop Manual*. South Africa
- Sonke Gender Justice. (2015). *Tsima Booklet 3: Community Mobilization Toolkit. South Africa*
- Sonke Gender Justice. (2016). *Sonke CHANGE Trial: A Community Mobilization Training Manual for Preventing men's use of violence against women. Workshop Manual*. Diepsloot, South Africa
- Sonke Gender Justice. (2008). *One Man Can (OMC), Manual - Working with Men and Boys to Reduce the Spread and Impact of HIV and AIDS*. South Africa

- Welsh P.. (2001). *Men aren't from Mars: Unlearning machismo in Nicaragua*. London: CIIR
- Welsh, Patricio y Muñoz, Xavier. (2004). *Hombres de verdad o la verdad sobre los hombres: guía de reflexión con grupos de hombres en temas de género y masculinidad*. Programa Regional de Masculinidad del CID-CIIR / Asociación de Hombres contra la Violencia AHCV. Managua: CIIR. 2004.

Evaluations of processes of training carried out with men and boys.

- Andrew Gibbs, Kristin Dunkle, Leane Ramsoomar, Samantha Willan, Nwabisa Jama Shai, Sangeeta Chatterji, Ruchira Naved & Rachel Jewkes. (2020). *New learnings on drivers of men's physical and/or sexual violence against their female partners, and women's experiences of this, and the implications for prevention interventions.* Global Health Action,
- Centro de Educación y Comunicación Popular. (1999). *Hacia una nueva masculinidad: impacto de los cursos metodológicos de masculinidad y educación popular 1994-1997*. Managua, Nicaragua: CANTERA
- Chatterji, S., Stern, E., Dunkle, K., & Heise, L. (2020). *Community activism as a strategy to reduce intimate partner violence (IPV) in rural Rwanda: Results of a community randomized trial. Draft manuscript* – What Works.
- Chirwa E; Sikweyiya Y.; Addo-Lartey A; Ogum Alangea D ; Coker-Appiah D; Adanu RMK ; Jewkes R ; (2018). *Prevalence and Risk Factors for Intimate Partner Violence against Women: Baseline findings from a Community Randomized Control Trial in the Central Region of Ghana*.
- Doyle K, Levtov RG, 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.
- EVIDENCE BRIEF (2019). *Impact of Indashyikirwa, An innovative programme to reduce partner violence in rural Rwanda*. What Works
- Gibbs A, Dunkle K, Mhlongo S, et al. (2020). *Which men change in intimate partner violence prevention interventions? A trajectory analysis in Rwanda and South Africa*. BMJ Global Health 2020;5:e002199. doi:10.1136/mjgh-2019-002199
- Kerr-Wilson, A.; Gibbs, A.; McAslan Fraser E.; Ramsoomar, L.; Parke, A.; Khuwaja, HMA.; and Rachel Jewkes. (2020). *A rigorous global evidence review of interventions to prevent violence against women and girls*. What Works to prevent violence among women and girls global Programme, Pretoria, South Africa
- Leane Ramsoomar, Andrew Gibbs, Mercilene Machisa, Esnat Chirwa, Jeremy Kane and Rachel Jewkes. (2019). *Associations between Alcohol, Poor Mental Health and Intimate Partner Violence* Evidence Review, What Works,
- Mastonshoeva, S., Shonasimova, S., Gulyamova P., Jewkes R., Shai, N., Chirwa, E.D., & Myrttinen, H. (2019). *Mixed methods evaluation of Zindagii Shoista (Living with dignity) intervention to prevent violence against women in Tajikistan.* What Works.
- Nicola J. Christofides1, Abigail M. Hatcher1, Dumisani Rebombo, Ruari-Santiago McBride, Shehnaz Munshi, Angelica Pino, Nada Abdelatif, Dean Peacock, Jonathan Levin and Rachel K. Jewkes. (2018). *Effectiveness of a multi-level intervention to reduce men's perpetration of intimate partner violence: a cluster randomized controlled trial.* Sonke CHANGE Programme, Souht Africa.

- Prevention Collaborative, (2019). *Evidence Review Parenting and Caregiver Support Programmes to Prevent and Respond to Violence in the Home*. USA
- Rachel Jewkes, Erin Stern, Leane Ramsoomar, (2019) *Preventing Violence Against Women and Girls: Community Activism Approaches to Shift Harmful Gender Attitudes, Roles and Social Norms Evidence Review*. What Works
- Raising Voices, LSHTM and CEDOVIP. (2015). *Is Violence Against Women Preventable? Findings from the SASA! Study summarized for general audiences*. Kampala, Uganda: Raising Voices.
- Stepping Stones and Creating Futures: *An evidence-based intervention to prevent violence against women and improve livelihoods.* What Works Briefing October 2018.
- The Prevention Collaborative (2019) Study Summary**:** *Bandebereho Couples' Intervention to Promote Male Engagement in Reproductive and Maternal Health and Violence Prevention in Rwanda*