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## Engaging Males in Maternal Care

**“It took someone from the community to lead the change.”**

### Authors

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### Introduction

#### *Patient-centered care*

Family engagement is an important strategy for providing care that is dignified, human-centered and fosters a better interaction between patients and the healthcare system. The foundation of patient- and family-centered care is that patients and their families can transcend traditional doctor-patient power structures in order to actively partner with providers. This empowers patients in their healthcare decisions and increasing transparency and accountability in the care they receive (World Health Organization, 2014). The commitment of the World Health Organization (WHO) to family-centered care is codified in the [2014 Framework on Patient and Family Engagement](#) (Carman, et al., 2013).

This technical brief focuses on one aspect of family inclusion, which is partner engagement.<sup>1</sup> We specifically look at male engagement<sup>2</sup> in

<sup>1</sup> The authors acknowledge that this technical brief is heteronormative, considering only male-female couples due to the focus areas of the quality improvement (QI) projects that were undertaken by the midwives were interviewed for this brief.

<sup>2</sup> Male engagement and male involvement are used interchangeably throughout this technical brief.

maternal care during pregnancy as well as in the immediate postpartum period. In general, male partners may want to be engaged in maternal care, but traditional gender roles, doctor-patient power structures, and even physical structures in the health system act as significant obstacles to allow this engagement. Patient-centered care should always ensure that those included in healthcare decision-making are empowering the patient and not limiting autonomy. It is important not to reinforce patriarchal systems through the involvement of men, and to actively empower women to access care and benefit from their partner's assistance in pregnancy (Char, 2011).

“Companion of choice during labor” is a recommendation by the WHO describing an effective intervention of engaging any trusted individual, whether family or not, who is key to a patient's support system (WHO, 2016). These individuals are often instrumental in reducing maternal mortality and in the delivery and follow-up of healthcare.

The concept of family inclusion acknowledges that partners or men do not always have an active role in women's lives or women's healthcare decision-making. That role is instead

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**TECHNICAL BRIEF**

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played by someone who is part of a woman's supportive network. In the context of this brief, male engagement is utilized as an intervention to engage male partners as allies to improve the health of their partners during pregnancy and also to empower their partner's healthcare decision-making. The brief acknowledges that there are gender inequities in decision-making and power structures linked to traditional gender roles that might permeate male-female partner interactions.

*Male engagement in maternal health*

Male engagement is a broad concept that refers to the various ways in which men relate to reproductive health problems and programs, reproductive rights and reproductive behavior; (Promundo, UNFPA, and MenEngage, 2010). It is considered an important strategy for improving maternal health (Promundo, UNFPA, and MenEngage, 2013). There are many factors that affect male engagement.

Men can impact maternal health because they often hold decision-making power and also control the financial resources needed to access health services. This can influence women's care-seeking behavior for nutrition during pregnancy, antenatal care, and emergency obstetric care, all of which directly address

the major causes of maternal mortality globally (Beenhakker, 2005). It has been established that when men lack knowledge on maternal health issues, women's access to life-saving treatment can be limited (Promundo, UNFPA, & MenEngage, 2010). Maternal deaths are often the result of three types of delays: delays in the decision to seek care; delays in arrival to the health facility; and delays in provision of timely care. Given unequal gender roles, male engagement is critical to preventing each type of delay throughout pregnancy (Maine and Thaddeus, 1994).

Increased engagement of men in reproductive and maternal care is consistent with global agreements that promote human rights and gender equity. This includes the 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which emphasizes the responsibility of both men and women in raising children. This also includes the 1994 Program of Action at the International Conference on Population and Development which stated that a full partnership between men and women is required in both productive and reproductive life.

Building on the WHO's 2014 Framework on Patient and Family Engagement, USAID included constructively engaging men in

maternal care in its 2016 publication, Answering the Call, which is part of the Agency's comprehensive equity-based approach to ending preventable maternal and child death.

When engaging men in maternal care, it is imperative to examine the roles of power, socio-cultural values and reproductive health that are associated with each gender. The Interagency Gender Working Group (IGWG) has developed a Gender Equality Continuum Tool (Figure 1) to assess the degree to which policies or programs address gender-related norms. Gender-blind programs or policies ignore existing power dynamics and socio-political roles of gender in a given society, whereas gender-aware programming addresses factors that affect gender and fall along the spectrum from exploitative to accommodating or transformative. IGWG states that "...focusing on transformative interventions has a positive impact on gender equity and on reproductive health and HIV outcomes" (Interagency Gender Working Group, 2014).

A United Nations Fund for Population Activities (UNFPA) literature review of men's roles in gender equality described how gender transformative programs could be used to increase male engagement in reproductive, maternal, newborn and child health (RMNCH), including engaging men as partners in reproductive health and involving men in the prevention of mother-to-child transmission (PMTCT) of HIV (Kiarie, Kreiss, Richardson, and John-Stewart, 2003). Similarly, recent studies reinforce that establishing the consistent participation of male partners in PMTCT activities is a determinant for successful implementation of PMTCT (Greene, et al.).

**The LMG for Midwifery Managers Certificate Course**

The Leadership, Management and Governance (LMG) Project works on the premise that local groups who experience health challenges can identify tailored solutions to achieve sustainable results. By empowering and supporting local communities to initiate and lead change, the LMG Project facilitates the implementation of creative, localized solutions.

As part of this work, the LMG Project developed an innovative course to support midwives in low- and middle-income countries in improving the health of their communities. The course, created in 2013, was developed as a partnership between Management Sciences for Health

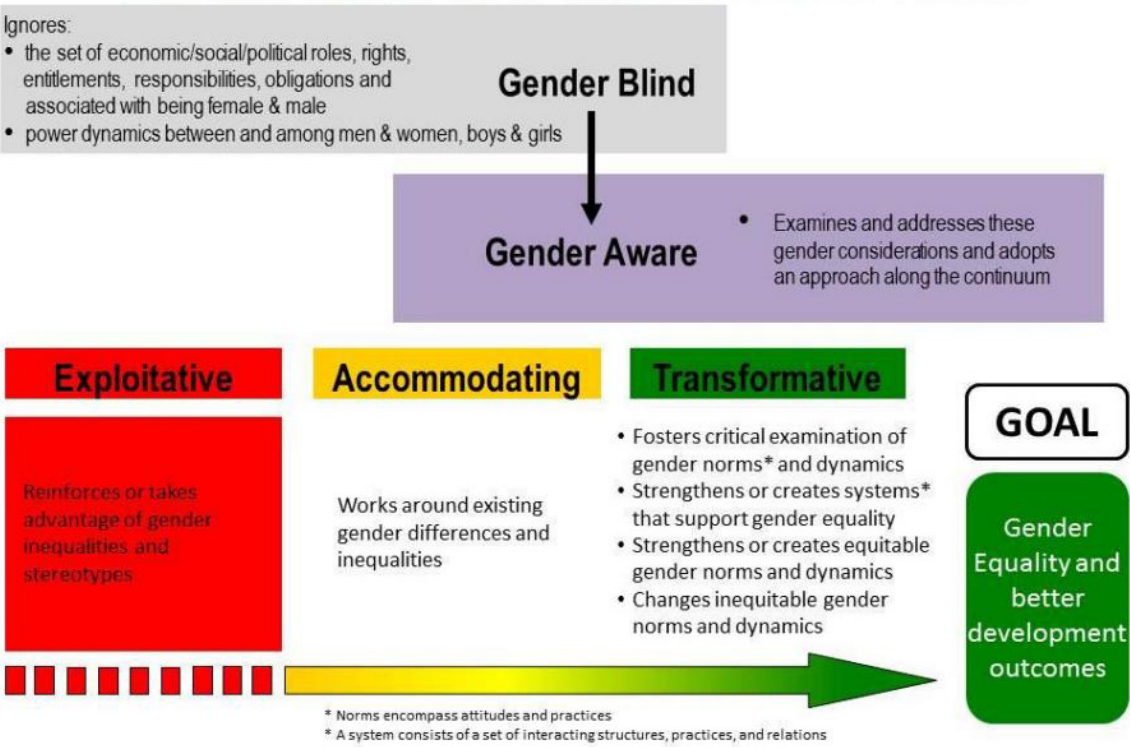
(MSH) and Amref Health Africa under the LMG Project. Content from MSH's flagship program, the Leadership Development Program, was adapted and incorporated into a course designed specifically for midwives. The LMG Project team also conducted interviews with 16 midwives from several Sub-Saharan African countries to inform and guide the development of the curriculum. The feedback from the midwives, along with feedback from stakeholder meetings across the region, helped refine content for the course, which was then piloted in Ethiopia, Kenya, Malawi, Tanzania and Uganda. The training became known as the LMG for Midwifery Managers Certificate Course and was implemented in 10 countries in Sub-Saharan Africa (including the five pilot countries) over two years.

**The purpose of this course was to provide midwives with the skills needed to identify problems in their workplaces, and to lead and manage teams to solve these problems.**

Midwives working in areas with poor MNCH indicators were nominated by their Ministries of Health (MoH) to attend the LMG Project training. Each participating MoH nominated two midwives to participate in a Training of Trainers (ToT) workshop held in Kenya. The trainers then returned to their countries and facilitated the LMG Project training for ten nominated midwife participants. The course consisted of a five-day workshop that taught midwives leadership, management, and governance practices that could help them identify and solve common workplace issues, leading to improved service delivery outcomes. After completing this course, the midwives were able to: scan their environments; identify challenges and solutions; plan and implement programs; mobilize stakeholders; and monitor and evaluate essential midwifery activities. During the course, midwives utilized the skills they learned to identify a workplace challenge and created an action plan to address it, which became the basis of a six-month quality improvement (QI) project.

After the initial five-day training, the midwives received continuous support from their local trainers and from other course participants during the six months of implementation of their QI projects. During this time, each midwife conducted a root cause analysis of the identified challenge, identified priority actions and developed an action plan to address this challenge. Utilizing the [Challenge Model](#) introduced during the workshop, midwives completed action plans that included a desired measurable result (DMR) and the key indicators necessary to measure

Figure 1: Gender Equality Continuum Tool







the success of their work. These action plans guided the midwives in the implementation of their QI projects. During the six-month period they achieved measurable health changes in their communities or facilities and gained experience using the leadership and management skills they learned in the course.

Under the LMG Project, the LMG for Midwifery Managers Certificate Course was delivered in two cohorts involving 99 midwives from ten sub-Saharan African countries with unique and complex RMNCH challenges. The selection process resulted in a diverse mix of male and female participants from both rural and urban areas, with one to 30 years of on-the-job experience. The 99 participants (working individually or in teams of two) used the skills they learned in the workshop to develop 87 action plans that aimed to improve RMNCH service delivery within their communities. In total, 44 plans (51%) from both cohorts met or exceeded their targets. **This technical brief explores qualitative data collected from the midwives who focused on improving male engagement in maternal care at their facility.**

### Data Collection Methodology

The authors identified seven midwives who completed the LMG for Midwifery Managers Certificate Course and also had action plans that concentrated on increasing male engagement in maternal care as their six-month QI project.

In-depth interviews were conducted via Skype with five of the seven midwives. The respondents spanned four countries, including Zimbabwe (cohort 2; n=2), Zambia (cohort 2; n=1), Tanzania (cohort 1; n=1), and South Sudan (cohort 1; n=1). Two additional midwives from South Sudan were not able to be interviewed because of political unrest.

A structured questionnaire (Appendix 2) was used to guide the in-depth interviews. The questionnaire focused on the communities and health facilities where the midwives worked; their action plans and QI projects; and socio-cultural factors that impacted engaging men in their communities. Four interviews were recorded and conducted in English and one interview was conducted with an Arabic translator in South Sudan.

The notes from the interviews were coded and organized by themes defined by the interviewer. Salient issues were identified by grouping quotes into thematic “buckets” that were then further explored depending on frequency

and geographic variability. Based on the emerging themes, a literature review was conducted to aid in the analysis and discussion. Grey literature was used to broaden the applicability of the interview data and to make connections with studies already conducted.

### Limitations

Limitations of this study include the small sample size and limited geographic variability of the qualitative responses, which restrict the generalizability of findings. In addition to the cancellation of two interviews in South Sudan, the one interview that was conducted with a third midwife in South Sudan had technical difficulties that affected the quality of the interview. Additionally, the analysis of qualitative data involved only one researcher, leading to unilateral coding and key theme generation that was not reviewed or reconciled with a larger team. Midwives were not questioned about whether protocols existed regarding family inclusion and male engagement within the facility, so it is not known if the protocols exist, and if these protocols do exist, it is not known if they are being implemented.



### Characteristics of Midwives Interviewed

Table 1 is a summary of the health facility, focus area and key strategies employed by each of the midwives interviewed. Three of the five midwives focused on increasing male engagement in antenatal care (ANC), one focused on engagement during maternity care, and one focused on engagement in PMTCT of HIV.

Four of the midwives interviewed achieved the targets they set for themselves in the six-month implementation period. To see monthly achievements alongside the midwives' baseline and target measurements, refer to Appendix 1, which includes the monthly data for the five interviewed midwives, as well as the two midwives who were unable to be interviewed.

There were five midwives interviewed, one male and four females. They worked mostly in rural areas, except for one midwife from Zimbabwe who worked in an urban facility. Those who worked in rural areas said their facilities had fewer than 10 beds and had limited staffing, with less than 20 healthcare workers in the facility. The midwife interviewed from Zambia worked in a larger facility with approximately 50 beds per ward. One midwife in Zimbabwe worked at Masvingo Hospital, which employs over 200 nurses and 75 midwives. Half of the midwives worked in reference hospitals and the other half worked in district health centers.

Table 1: Summary of Male Engagement Interventions<sup>3</sup>

Country	Health Facility	Focus Area	Desired Measurable Result (or indicator)	Key Strategies Developed
South Sudan	Nyokuron Primary Health Center Clinic	ANC	Increase the number of women who attend ANC visits with male partners	Community education, grassroots policy changes and health worker sensitization
Tanzania	Mikindani Health Clinic	ANC	Increase the number of women who attend their first ANC visit with male partners	Incentives for male participation, community education, health worker sensitization training and community partnerships
Zambia	Batoka Health Center	ANC	Increase the number of women who attend ANC visits with male partners	Grassroots policy changes, community education and community partnerships
Zimbabwe	Birriri Hospital	PMTCT	Increase number of males tested and counselled for PMTCT	Community education, incentives for male participation and health worker sensitization training
Zimbabwe	Masvingo Provincial Hospital	Maternity	Increase number of men engaged in perinatal services	Community education, community partnerships, mental health support for mothers and health worker sensitization

<sup>3</sup> Appendix 1 contains all six-month data for all seven projects that focus on male engagement



## Results

Three major key themes emerged from our interviews on male engagement in the LMG for Midwifery Managers Certificate Course. These themes were:

1. The complexities of decision-making authority around women's maternal health, highlighting the need for gender-transformative approaches to address the inability of women to make these decisions;
2. The lack of male-friendly spaces in maternal health facilities, including the need to educate providers and the community on the importance of male involvement; and
3. The essential role of developing, aligning and mobilizing partnerships, both within traditional healthcare institutions and in the community to improve maternal health.

For each of these themes, the interviews provided further information regarding:

1. Contextual barriers identified through the root cause analyses guided by the course;
2. Strategies and solutions undertaken by the midwives through their QI projects; and
3. Key programmatic considerations from the LMG for Midwifery Managers Certificate Course for the wider global health community.

### *1. The complexities of decision-making authority around maternal health*

#### *Contextual barriers*

In many cultures and contexts, childbearing and child-rearing are primarily seen as the responsibility of women. Yet, reproductive autonomy and decision-making around childbirth are often held by male partners (and occasionally by other familial authority figures) because they control financial resources (Dudgeon & Inhorn, 2004). In the interviews conducted, the midwives noted that in their communities, pregnancy was not recognized as a risky process that required attention by male partners. And, when medical complications emerged, women often lacked the necessary financial means, freedom of movement, and decision-making authority to seek necessary care.

**This underscores a general lack of recognition that pregnancy requires medical care or, as a female respondent from Zambia put it, “Men don’t**

**understand that every pregnancy is risky.”** As a result, men can take the decision to have additional children more lightly. The midwife interviews highlighted that, because of power dynamics, women are sometimes not empowered to make family planning decisions on their own. Thus, programs that encourage male involvement and commitment are necessary to educate and improve RMNCH outcomes.

The sentiment that “men are the decision-makers for all health and financial matters” (Male, Tanzania) was pervasive throughout the areas where the midwives lived and worked. The interviews highlighted that the men were unaware and unprepared to make many of these health decisions regarding the needs of women during pregnancy, which led to potential health problems for mothers and their children. According to a midwife in Zimbabwe, “pregnancy and children are the world of the woman, and involving men in that is seen as unnecessary and taboo.” She added that men are not taught to recognize danger signs during pregnancy and furthermore are not aware of the potential life-threatening complications of pregnancy.

According to the interviews, men were less likely to prioritize the health needs of pregnant women and new mothers, which includes, “rest, exercise, special nutrition, and check-ups” (Female, Zambia). Fulfilling dual responsibilities of work and family was described as a leading cause of pregnancy-related complications.

A female midwife from Zimbabwe described the consequences of this gender dynamic:

“One time, a pregnant woman from a hard-to-reach area refused to be tested for HIV because she wanted [her] husband to give permission. She walked 100 kilometers back home without being tested. Next time, she agreed to be tested, but refused to take drugs [after testing positive], waiting for her husband to give her permission to take the [antiretroviral drugs] ARVs...She got to the point of delivery. Her husband was not involved and neither was her mother-in-law. She was worried about answering all of the questions from us [nurses and midwives at the health center], so she delivered at home, but came in after a month. The exposed child did not get enough protection [through ARV medication] before and after birth, so the infant was born HIV positive.”

The lack of recognition of maternal emergencies leads to countless preventable deaths, as most preventable maternal and child deaths occur because of delays in seeking care and delays in reaching health care facilities (Beenhakker, 2005). The midwife interviewed from Tanzania discussed why he was inspired to focus on male involvement in maternal care:

“Once a pregnant woman was bleeding and extremely sick, but refused to go to the clinic without her husband’s permission...Eventually, the community intervened and brought her in, but she still refused the treatment that she needed from us and left. Shortly after, this woman died of maternal complications that could have been prevented. This inspired me to work for male involvement.”

#### *Midwives’ Solutions: Engaging men through storytelling and health education*

One of the most common and reportedly effective strategies utilized by all of the midwives interviewed was developing or strengthening health education programs for men on maternal and neonatal health. Each midwife used his/her own locally tailored educational strategies to inform men on what women need during and after pregnancy, including “nutrition, anemia [prevention], birth preparedness, tuberculosis, HIV, rest, exercise, danger signs, and mental health.” (Female, Zimbabwe).

The midwives reported that these sessions were effective in educating men and that they saw changes in behavior among male partners:

“Now, since we are teaching them, they come along with their wives. I make sure that once a woman is admitted, I send for her husband. I give health education for the husband: how this woman needs help, that she finds time to rest and exercise, and to help her as needed so we don’t lose this pregnancy....When mothers are admitted [to the hospital], and when the husband comes, we explain the severity of the problem. It is really working out really well.” (Female, Zambia)

A female midwife from Zimbabwe recounted:

“Three quarters of the men we talk to don’t even know the birthdate of their children. I tell them that if they plan for farming, how many bags of fertilizer they need to buy, and so on, that if the wife was really a friend, they need to sit down and discuss and plan not only about farming but about birth preparedness.

“Who will be there to help this wife of mine?” and “What mode of transport are we going to use to get to the facility?” We emphasize how men need to plan. This message [about farming] really was effective for the headmen, so they now push the men to come on their own. We went to the headmen and told them this story...and requested them to hold meetings with their people. In one outreach area, there are 10-20 village headmen. Now, we also have NGOs on board to support us on projects.”

During health education sessions, **the midwives reported urging men to allow women to make health-related decisions on their own.** Given the understanding of the severity of the health issues surrounding pregnancy and childbirth, midwives reported that men were likely to share decision-making responsibility with their female partners. It was also clear from the interviews that after receiving some education on maternal health, **a vast majority of men were self-reported to be appreciative and eager to change their behavior.** The fact that health information was given by a healthcare provider who was seen as an authority figure was powerful for mothers, empowering them to voice concerns, health needs, and to reach out for emotional support. In Tanzania, one male midwife reported that during the duration of his QI project, he saw fewer women coming late in pregnancy. “My project has also reduced the number of women who come very late in their pregnancy. They have all the information that woman can make a decision on their own, even if the husband is gone,” he explained. As a female midwife from Zimbabwe described, “They felt like they weren’t alone anymore and had the support of a partner.” Thus, health education with partners can represent a gender transformative intervention that results in empowered women. It is essential that interventions consider how best to transform gender norms, and not exploit or reinforce them. This sort of health education also served to prompt men and women to plan together. As explained by a female midwife in Zimbabwe, “We told the husbands that if you discuss and agree on a plan for labor and delivery ahead of time, it will help both the mother and the baby...there needs to be a plan. Especially for transmission of HIV. If drugs are given to the babies within one hour, it decreases risk substantially.”





#### Programmatic consideration

Peer-reviewed literature has echoed that engaging men in health education, particularly during the prenatal period, increases male knowledge of pregnancy and preparedness for it, and helps them understand the importance of seeking timely care (Mekonnen & Worku, 2011). The interviews underscored the detrimental effects of the lack of education among male partners, most notably, the lack of awareness of the severity and risks involved in pregnancy. Likewise, interviewees stated that men who received health education or were present during delivery were more likely to support the use of family planning. **Most importantly, programming was not just aimed to educate men on maternal care, but also to share decision-making authority.** The experiences of the midwives in the LMG for Midwifery Managers Certificate Course underscores the importance of using skilled healthcare workers (in or outside) of the facility to provide key educational messaging to men, specifically during the antenatal period.

Furthermore, the literature notes that programming should emphasize thoughtfully designed gender-transformative interventions. Shared education, for instance, allows both men and women to negotiate terms for shared decision-making on family planning, pregnancy, birth preparedness and much more. **The experiences highlighted in these interviews emphasize that creating gender-transformative interventions that target both men and women can foster or strengthen shared decision-making power in maternal care.** Educational interventions to address gendered power dynamics should broaden the scope beyond just health to also include information on gender roles and the importance of women's autonomy. Studies have shown that maternal health education interventions targeting both men and women have proven to increase: knowledge in both men and women; health-seeking behavior among pregnant women; awareness and use of family planning (FP) in the postpartum period; and awareness of dual protection for STIs (Mekonnen & Worku, 2011).

#### 2. The lack of male-friendly spaces in maternal health facilities

##### Contextual Barriers

Interviewees stated that men often did not feel that they were welcomed by health providers into the health center, which was traditionally regarded as a female space.

Midwives in Zimbabwe, Zambia, Tanzania and South Sudan all said that men had been excluded from this space, most often implicitly. The midwives discussed how health service providers were not trained to educate men on maternal issues and were not trained to welcome men into areas of the health center usually designated for maternal, neonatal and child health. Also, they noted clinics were often crowded and had little extra space and privacy. As the male midwife from Tanzania explained, "The space is not organized for a man to accompany [his] wife. The place is for children, vaccinations, [health services for] women, exams...there is no place for men." In Zimbabwe, a midwife said that male nurses would speak to male partners outside and not invite them inside.

Often, healthcare staff did not accommodate male partners in these circumstances. As a female midwife from Zimbabwe explained, "We focused just on health education for the woman who is walking in and [did] not think about her male partner." Additionally, the male Tanzanian midwife articulated that some health workers had negative attitudes about male involvement, feeling that men attending appointments with their female partners was "unnecessary."

All of the interviewees stated that men had conflicting priorities in choosing between accommodating doctor's appointments or going to work. Men did not have the time to accompany their female partners to attend appointments and receive health education, as they needed to spend time farming, selling products in markets, or otherwise generating income. This belief was reinforced by community perceptions, including the perceptions of the midwives and the health providers themselves. The midwives in Zambia and Tanzania explained how maternal health clinics were considered women's spaces, and a male partner's presence there could be interpreted as him being "weak." A midwife from Zimbabwe explained how the community could judge the man, as if he were reneging on his responsibilities as the family breadwinner by spending time at the health center.

The barrier of time to accompany a partner is embedded in the structure of the health system. While family-centered and patient-centered care is the gold standard, this is not always possible when the clinic's hours of operation conflict with working hours for the patient or her family. The physical structures of the clinics can also be seen as a barrier because they do not afford privacy for a patient and

there is often no space for a partner. The additive effect of infrastructure and physical space issues plus the societal ideology of health centers as "women's spaces" are a sufficient deterrent for male partners.

Another emerging theme seen in all countries was the stigma for men surrounding HIV/AIDS testing, which serves as a deterrent for male engagement. As a male midwife from Tanzania described a sentiment shared by several others, "One barrier [that prevented] men coming in was fear of HIV tests." It was discovered that many men were not only afraid of being tested, but would also avoid entering health facilities because they thought they would be tested against their will. As described by a midwife from Tanzania, men were afraid that if they tested positive, they would be required to take medications, change their behavior, possibly be denied sexual interactions and be otherwise stigmatized by the community. Men often felt that being HIV-positive would lead them to lose power in their communities and within their families. It is also important to note, however, that it was articulated by a male interviewee from Tanzania that this applied "not only [to] HIV testing but all STI [testing]."

Among some groups, the concept of privacy was threatened by male engagement. The midwives told stories of how important it was for "men to be in the labor ward, to see how difficult delivery is...to be aware of risks," (Female, Zambia) but that they most often did not feel comfortable there due to multiple women in labor in the same ward. A husband or male partner's presence during medical exams, treatments, or in the labor ward posed particular cultural challenges related to nudity and modesty for his wife and the other women in the same area. A midwife from Tanzania articulated that these beliefs were most common among religiously conservative groups. Similarly, many groups of men in the communities practiced polygamy or polyamory. These practices presented obstacles to male engagement for two reasons. First, men perceived social shame from publicly accompanying an unmarried or extramarital partner to a health clinic. Secondly, men committed to multiple wives or partners did not have the time or ability to support all of their health needs, whether through accompaniment or otherwise. According to a midwife from Zambia, the former case would happen most often in cases of teenage pregnancy and among migrants. Both factors deterred men from being with their partners during care.

Finally, at the clinic level, it also was clear that the lack of educational materials for men at the facilities affected the perception of the trustworthiness and reliability of the health center personnel. There were challenges in terms of the availability of informational material for male partners and other community partners. Midwives felt that giving out printed materials would boost their credibility and reach, but this was often a financial and logistical impossibility. Since not every health center had the same amount of materials or the same materials, this affected the ability to train staff to include men in a consistent way.


#### Midwives' Solutions: Supply-side improvements

A majority of the midwives implemented interventions involving the training of staff to encourage and educate male partners. Many midwives emphasized the collaborative nature of their projects, assembling teams to identify how they could improve together. Because the LMG for Midwifery Managers Certificate Course supported the development of a facility-level plan translated into a QI project, success often hinged on how well the midwives were able to engage their coworkers. As one female midwife from Zimbabwe put it:

There was a knowledge deficit among health workers. Before, nothing there [at the hospital] was there for men. But [the health workers] searched together with each department head and staff. Everyone felt involved... **Planning together was key.** Health workers were not empowered to invite men inside. **They would not feel like they could call the man inside. They did not have the skills.** Men would stay outside and talk to general workers and talk about other things.

It was emphasized in the interviews that, before the project, health workers did not feel it was their place to encourage men to participate in their female partner's care. They did not feel empowered to invite a husband or male partner into the room when giving treatment or care instructions. Cultural traditions in the community have held that men, when accompanying, would wait outside. This was generally not questioned until the midwives began their QI projects. As a female midwife from South Sudan echoed, "We did not know the importance [of male engagement] until [we took the] LMG [course]."

To counter men's perceptions that attending the clinic made them "weak" or was of less value than working, some



midwives used incentives to increase male attendance with their spouses. In Zimbabwe, a midwife did a needs assessment of why men were not coming, and found that they cited having no time to come. This was paralleled in many countries. To address this, midwives in Zimbabwe and Tanzania changed health facility practices to prioritize pregnant women who came with their male partners, allowing them into the clinic first. This allowed men to get back to their work more quickly. Additionally, in Tanzania, the clinic where the midwife worked extended its hours of operation to allow more time for women to come with their partners outside of traditional working hours.

In Zambia and Zimbabwe, attention was given to reading materials and entertainment for men in the waiting areas. This was to both welcome men to the space and also alleviate perceptions of time waste. A female midwife from Zimbabwe articulated, “Before, only HIV testing what was on their [male partners’] minds... but now, after they come, I ask them if they are happy they came, and they say ‘yes.’ They appreciate all the information and learned a lot of things.”

These interventions, coupled with other ways to encourage men’s involvement, were found to be successful. When women attended appointments without their partners, midwives communicated to male partners by sending wives home with flyers or personalized notes for the men, and by advertising new clinic practices that would appeal to men.

It is important to note that some men were already accompanying their female partners to clinical facilities. Although the analysis has focused on community factors that presented barriers to male engagement, there were some facilitating factors that encouraged male participation. As a midwife from Zimbabwe articulated, “Yes, some men go. The men who are well-educated come to the hospital with their wives; they read, watch TV, they have a bit of knowledge from new technologies. Those are some of the people that we see.” Similarly, some public policies had been developed, for example in Zimbabwe, which set national benchmarks for male engagement in maternal care. However, despite these policies, midwives communicated that male engagement was quite low in all countries where interviews took place.

### Programmatic Considerations

It is important to note that the practice of male engagement represented a dramatic change from traditional practices. “We faced opposition in the sense that everyone asks, ‘This has never been an issue before, why is this suddenly an important thing?’ We’ve had other children without needing this,” said a female midwife from Zambia. Because of this departure from the status quo, some groups such as community elders and religious groups felt that it threatened their traditional practices. It was seen that healthcare and masculinity do not mix; clinics were not seen as a place for men, services were not tailored to them, and there was no feeling of trust. The midwives reported that most men were interested in better supporting their wives and children, which is consistent with the literature on male involvement. “Most men were interested in being more involved in newborn care, but identified barriers to increased involvement, many of which related to gendered and generational divisions of labor and space.” (Dumbaugh, et al., 2014)

Fostering increased male engagement involves surmounting both structural and socio-cultural barriers. Midwife-led solutions and techniques addressed both of these barriers. Findings from these interviews suggest that developing creative ways to make clinics more male-friendly is key; programs should work to welcome men into the health care sphere, and engage them as willing and enthusiastic partners in RMNCH. The midwives undertook a variety of contextually-specific solutions that were reported to be effective during their projects. Common strategies included **extending clinic hours so men were able to work and attend the clinic, as well as revamping waiting areas with materials (educational and recreational) for men.** The physical structure of clinics, including lack of private spaces for counseling, delivery and postpartum care were mentioned as barriers affecting men’s comfort in the clinic. Despite being mentioned as barriers, structural changes were not undertaken by the midwives (likely due to financial constraints), but are important considerations for future programming aiming to engagement in maternal care.

### 3. The essential role of developing, aligning and mobilizing partnerships

#### Contextual Barriers

To focus on building partnerships to increase male engagement in maternal health, a paradigm shift to seeing “men as agents of positive change” needs to happen in the health system and community. When we talk of men as clients we see them in light of addressing their reproductive health needs only and when we talk of them as partners we see them as allies in improving women’s health. Seeing men as agents of positive change emphasizes the central role they play in supporting women’s health and transforming social roles, and implies that we must recruit men to this effort to help change gender norms. (Greene, et al., 2006). Midwives who identified partnership development as a solution to their challenge of low male engagement had a difficult time recognizing and determining the multiple actors that exist in the space. As a female midwife from Zimbabwe articulated, “Before we did not have the skills. [We] did not know that there were a lot of other advocates to use in the community. Before, we did not participate well in the community, we did not make use of other people in the community who could help us involve the men. We focused on the health education of the woman who is walking in.”

It is important to note that access to high-quality maternal care is especially threatened in conflict and post-conflict zones. In the case of South Sudan, midwives reported losing much of their gains during the last period of conflict. They reported having made significant strides in developing monitoring strategies to track pregnant mothers and initiate community outreach to involve them and their partners in health education. During their QI projects, South Sudanese midwives were able to develop partnerships with community leaders and larger public hospitals to broaden their reach. However, faced with another wave of violence, midwives reported the loss of this expanded network. To illustrate this, one female midwife from South Sudan told a story from her community:

“Before, we [and community leaders] recorded all the women who were pregnant and we went to them to tell them to come out [to community

education workshops]. But now, they don’t have the money to do that. They can’t provide them with water to drink for them to attend. [They] cannot travel safely.”

#### Midwives’ Solutions: Leveraging networks inside and outside the health center

All the midwives interviewed reported they were implementing activities that used the power of the community to achieve results. The midwives recognized their own limitations, whether related to geographic reach, community influence, resource availability or other factors. As part of the LMG for Midwifery Managers Certificate Course, they were guided through a process of identifying external stakeholders and potential partners. They thought creatively about how to develop and leverage partnerships and how to align diverse groups towards the same goal. In this case, they brought together a variety of partners to collaboratively work on male engagement in maternal care. Most often, the midwives reported relying on connections with community leaders, but in some cases they forged relationships with local NGOs, traditional birth attendants and health professionals from other centers.

For instance, in Tanzania, the midwife manager and a colleague hosted community meetings every month where the importance of male engagement was explained to local community leaders and medical staff/ managers from other health centers, who then directed their staff to prioritize male engagement activities.

**Several of the midwives echoed that the creation of partnerships was the most effective strategy employed during their projects.** They found that their ability to provide education during scheduled appointments was limited, so follow-up with expectant mothers via community health workers, traditional birth attendants or with their village communities was essential. Village health workers played a large role in following up with partners and continuing to reinforce that men should attend maternal health appointments. The midwives emphasized that this became a community-wide effort, with everyone, “looking at the advantages of male engagement together.” (Female, Zimbabwe).



**Midwives also cited relying on men as peer educators. Many used innovative strategies for reaching hard-to-reach groups of men.** For example, a midwife from Zimbabwe went to bars with her husband to conduct health education and encourage men to accompany their wives. Others used storytelling; they would recount a powerful male-involvement success story to husbands and even encourage them to talk with the husband from the story.

It was also interesting to note that the midwives intended to make their projects community-led, and actively sought to prevent undue outside influence. A midwife from Zambia explained that the community leaders had initially wanted to implement a campaign that required them to be notified directly if a father did not attend care with their female partners. Although this seemed like an intervention that may have been effective to bring men in immediately, it would have left the women without agency and disempowered the midwife. She described this process:

“First, it was promoted that if a woman comes to the clinic without her husband, we write a note to the headman. But we said ‘no.’ We didn’t want to involve

them first; it is a matter of the community first. The mother should involve the husband on her own. If not, he needs to go to the headmen to be excused if he cannot attend.”

This idea of grassroots community empowerment allowed the midwives to be the driving force behind the intervention, a concept that the literature has associated with sustainability of programming (Kululanga, Sundby, Malata, & Chirwa, 2011).

#### Programmatic Considerations

Grassroots community ownership of initiatives to engage males in maternity care should ensure that community-led solutions are gender-transformative. The midwives interviewed all mentioned that networking and partnership formation was the foundation from which they were able to address male engagement. The midwives leveraged existing support networks in their communities to educate others about the importance of male involvement and to hold husbands accountable. In some cases, this involved using existing networks, but other midwives tried non-traditional outreach methods or leveraged male champions from the community. Using

male peer educators to provide peer education is a strategy that has been used successfully in India, where a cadre of community male health activists was introduced to target men’s health needs and increase male engagement (Fotso, Higgins-Steele, & Mohanty, 2015).

#### Conclusions

The main focus of the Leadership, Management, and Governance for Midwifery Managers Certificate Course was to equip midwives with these skills to complement and amplify the clinical skills they already possessed.

The selected QI projects highlighted in this brief identified the common challenge of engaging spouses in the healthcare of expectant mothers. It was encouraging to learn from the interviewees that men in their communities often showed openness and willingness to move beyond traditional gender roles when given the opportunity. However, responses from the midwives interviewed generated even more questions regarding gender roles and health care in Sub-Saharan Africa: When do men access health care? When do men feel welcome? And, what can health programs do to support the needs of men? More research is needed to create a fuller picture of the intersectionality of masculine gender roles, maternal health and the healthcare system.

Further work is needed to determine the sustainability of these interventions and assess long-term outcomes and programmatic success. Also, information was self-reported; triangulating these findings with men and women in the community would provide an even richer understanding of promising practices undertaken by the midwives. The midwives (except for those in South Sudan) communicated many lasting gains from the QI project undertaken as part of the LMG for Midwifery Managers Certificate Course. During these interviews, when asked to describe their communities, midwives asked for clarity as to if the interviewer meant the communities before or after the LMG for Midwifery Managers Certificate Course. To them, health impacts, attitudinal shifts, and behavior changes at the community level were so stark they needed to clarify if the evaluation wanted to know about their communities as they were after the course, or their communities before they had begun the community change process.

The success of the midwives’ QI projects hinged on their leadership and ownership of their action plans, underscoring the added value of leadership and management competencies to improve service delivery challenges. The communities where the midwives lived and worked did not encourage men to participate in the maternal care of their partners. Lack of knowledge of pregnancy risks, complexities of decision-making authority, and the lack of male-friendly spaces in health facilities resulted in barriers to family involvement. The development, alignment and mobilization of partnerships, both in traditional health care institutions and in the community was found to be essential in increasing male involvement. Because the LMG for Midwifery Managers Certificate Course provided midwives with competencies and support to scan their own environments, discover the root causes of health problems in their communities and design context-specific solutions, they were invested in achieving results. Focusing on the development of midwives’ capacities to identify challenges, develop action plans to overcome those challenges, lead teams, monitor progress, and engage diverse community stakeholders reinforced their agency to make change and achieve positive health outcomes.



**Appendix I: Monthly tracking of midwives' six-month action plan data**

Country	Health Center	Desired Measurable Result	Numerator	Denominator	Baseline
Tanzania	Mikindani Health Center	Increase the number of males involved in first ANC visits from 2 to 8 per month by July 2015			2 male visits/month
South Sudan	Nyokuron PHCC	Increase the number of women attending ANC with male partners from 6 to 30 per month between May and October 2015	Number of men coming to the health facility with their wives for ANC care	Total number women ANC clients per month	6/700: 0.75%
South Sudan	Gurei Primary Health Center	Increase the proportion of women attending ANC with male involvement from 1% to 10% between May and October 2015	Number of men accompanying their wives for ANC for the first time	Total number of pregnant mothers attending ANC for the first time	0%
South Sudan	St. Kizito Health Center	Increase the number of males who accompany their wives to the first ANC visit by 10%	Number of women attending ANC with their husband	Total number of women who attend ANC for first time	50/397: 12.5%
Zimbabwe	Masvingo Provincial Hospital	Increase male involvement in perinatal services from 20% to 40% by November 2015	Number of male partners accompanying mothers seeking peri-natal services monthly	Number of mothers seeking peri-natal services every month	66/394: 16.7%
Zimbabwe	Birriri Rural Hospital	Increase male uptake in PMTCT by 50% by October 2015	Number of women accompanied for testing and counseling by their male partner	Total number of women tested and counseled	5/54: 9%
Zambia	Batoka RHC	Increase the percentage of male involvement in ANC from 29% to 50% by the end of October 2015	Number of male partners at first ANC visit	Number of first ANC attendees	26/59: 44%

Mo 1	Mo 2	Mo 3	Mo 4	Mo 5	Mo 6	Target	Target Met?
8/36: 22.2%	10/34: 29.4%	7/37: 18.9%	7/33: 21.2%	7/11: 63.6%	7/7: 100%	8 male visits/month	Yes
28/689: 4.1%	57/759: 7.5%	25/703: 3.6%	59/692: 8.5%	47/581: 8%	89/1188: 7%	30 per month	Yes
2/400: 1%	25/622: 4%	38/644: 5.9%	40/666: 6.2%	50/661: 8%	48/455: 10%	10%	Yes
36/66: 54.5%	15/64: 23.4%	29/79: 36.7%	28/88: 31.8%	20/55: 36.4%	14/46: 30.4%	10%	Yes
76/441: 18.4%	93/360: 25.8%	117/411: 29.1%	135/380: 35.5%	96/249: 38.5%	102/252: 40.5%	40%	Yes
8/24: 33%	9/31: 29%	11/37: 29.7%	18/37: 49%	14/28: 50%	11/35: 31%	59%	No
28/62: 45%	29/64: 45.3%	21/61: 34.4%	26/50: 52%	40/47: 85%	32/67: 48%	60%	Yes





Appendix 2: Semi structured interview guide

Male Involvement and Engagement in Maternal Health Care: Leadership, Management & Governance (LMG) for Midwifery Managers

Introduction:

My name is \_\_\_\_\_ and I work as a consultant on the Leadership, Management, and Governance (LMG) Project. Thank you for setting aside time to be interviewed as part of our ongoing efforts to better understand the work done by midwives who have taken part in the Leadership, Management & Governance (LMG) for Midwifery Managers Course. During this interview, I will be asking questions and taking notes. In order to accurately capture your opinions, I will also be recording this interview. Through this interview we want to get more information about your work. We are particularly interested in the action plan that you developed as part of the Leadership, Management & Governance for Midwifery Managers Course. We would like to hear more about how you involved men in your work on sexual and reproductive health issues, as well as hear about norms surrounding sexual health in your community. We are also interested in what worked well and what challenges you faced when working on this issue in your health facility.

Your participation is entirely voluntary and you have the right to refuse to participate in this study or stop participating at any time without any consequences. Giving consent means that you understand why we are interviewing you and that you agree to participate. We expect to use this information in communications and reports. If you are uncomfortable with sharing information, including your name, please let us know now. If you don't want your name used, we will keep all personal information confidential and will not associate your responses with you now or in the future.

Do we have your permission to use your name and your responses?

Note: interviewer checks off based on verbal consent. Interview must be recorded for the LMG Project's records.

- ☐ Yes
- ☐ No If no, please initial \_\_\_\_\_

If you have any questions during the interview, please do not hesitate to ask. Contact information will also be provided at the end of the interview so you can follow up with any additional questions. This interview will last approximately 1 hour and will be recorded.

Do you agree to participate in this interview?

Note: interviewer checks off based on verbal consent. Interview must be recorded for the LMG Project's records.

- ☐ Yes
- ☐ No If no, please initial \_\_\_\_\_

Do you have any questions before we begin this interview?

We appreciate your willingness to participate! Thank you!

Please obtain the following information about the clinic where they implemented the project	
Name	
Country	
Name of Health Facility	
Hospital Classification	<input type="checkbox"/> Reference <input type="checkbox"/> District (rural hospital)
Current # Maternity Beds	
Location of Facility?	<input type="checkbox"/> Rural <input type="checkbox"/> Peri-Urban <input type="checkbox"/> Urban
For the following questions, please estimate the number of staff that support MNCH services at your facility:	
# ObGyns	
#MNCH nurses	
#MNCH midwives	
#Community Health Workers	

I'd like to start by asking you a few questions about your facility.

1. Do you still work at the same clinic as when you implemented your project from the Leadership, Management & Governance for Midwifery Managers Course? Yes

Probe: If not, when did you leave this clinic?

For the next few questions, I would like you to tell me about your community:

2. What is the general opinion in your community about a family's role in pregnancy?

a. Who generally makes decisions around health care in a family?

i. Probe: What is the role of a husband, mother, or mother-in law?
3. What do you think people in your community think about men who participate in their wives' pregnancy-related healthcare? (Note: All midwives to be interviewed focused prenatal, labor and delivery, or postpartum care.)

a. What are the biggest challenges to getting men to accompany their wives to health services?

b. Are there any factors that encouraged men to being involved?

c. Before you started your project, had you noticed any changes in your community's attitudes toward male involvement? If so, what changes have you noticed?



4. What do your co-workers think about men who accompany their wives to pregnancy-related appointments?
  - a. Do providers think this is a good thing?
  - b. Do any of them think this is not appropriate? Are there any negative attitudes among providers?
  - c. Before you started your project, had you noticed any changes in your co-workers attitudes toward male involvement? If so, what changes have you noticed?

**Now, I'm going to ask you a few questions about your experience before you participated in the Leadership, Management and Governance for Midwifery Managers Course:**

5. What does male involvement mean to you?
6. Before starting your LMG action plan, what things, if any, did you or others at your health center do to encourage men to accompany their wives to pregnancy-related appointments?
  - a. Were these strategies successful?
  - b. What worked well and what needed to be improved?

**Now, I'm going to ask you a few questions about the project you worked on as part of the Leadership, Management and Governance for Midwifery Managers Course:**

7. Why did you choose to focus on encouraging men to accompany their wives to pregnancy-related services?
  - a. Was there a particular service that you focused on? And why did you pick this focus?
  - b. Was your project mainly focused within the health center or did you also work in the community? Note: (If there was no community outreach please skip question #10.)
8. What was your project's strategy to engage more men? *Probe: What activities did you undertake?*
  - a. What were the results of your project?
  - b. What worked well as you implemented your project?
  - c. Were there any challenges?
  - d. Where there any unintended or unexpected results?
9. What changes, if any, did you see as a result of your action plan in your health center?
  - a. In the health center, how did men clients (or spouses of clients) react to your project? What changes, if any, did you notice in the men's attitudes?
10. In the community, what changes, if any, did you see as a result of your project?
  - a. Were there positive reactions? What are some examples?
  - b. Were there negative reactions? What are some examples?

11. How do you think leaders in your community and managers in your health center contributed to the success or failure of engaging men in your health center?
  - a. Did you see any changes in the leadership and management practices of the leaders of your hospital/clinic during this project?
12. Since your project ended, have you continued to encourage men to accompany their wives to pregnancy-related appointments? If so, have you changed or adapted your strategy from what you did in your project?
13. Have you taken on any other challenges using the Challenge Model Approach? *Probe: Did you use any other LMG practices that you learned in the training?*
14. Do you have questions for us?

**Thank you so much for speaking with us! Your answers have been very helpful.**





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