Chapter III
Involving Men in Reproductive Health through Maternal and Child Health

KEY STEPS TO IMPLEMENTING PROJECTS that INVOLVE MEN in RH through MCH	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
Assess infrastructure of clinics and maternity wards in hospitals and their accessibility to men	Conduct a facility-based analysis to understand how clinic functions, services offered, patient flow, and time spent with each patient. Consider if privacy and confidentiality is assured (e.g., rooms with closed doors, curtains between beds). Conduct focus groups with providers to assess their attitudes about treating men and couples. Assess if clinics have waiting rooms and if so. are they gender neutral and male-friendly? Review guidelines and protocols, available equipment, drugs and commodities that provide quality MCH care.
Assess attitudes among women and men in the community	Conduct focus group discussions with women, or surveys to find out if they want to involve their partners in FP, MCH, HIV/AIDS prevention, and/or addressing issues of violence. Assure women that they decide as to whether or not to involve their partner. They must give consent for him to be involved. Conduct separate focus groups or surveys with men to find out if they want to be involved.
Advocate and buy in activities with decision-makers and local leaders	Host meetings with department of health officials at national, provincial, and regional level to inform, promote, and encourage buy-in to male involvement programs. Where appropriate, include traditional and local leaders or have separate meetings with them. Use these meetings to get feedback and agree on windows of opportunity for initiating male involvement programs.
Promote and advertise male involvement program	Advertise that clinics welcome men. Dispel the notion that clinics are for women only.

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IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
	Partner with community leaders, media organizations, churches, and community centers to let people know that men are welcome at clinics.
Develop plans of actions	Action plans should consider how involving men affects every aspect of service delivery (e.g., scheduling, time spent per client, patient flow, tracking and monitoring client visits, costs, décor and upkeep of waiting rooms and rest rooms). Action plans should include adjustments to infrastructure to assure privacy and confidentiality (e.g., rooms with doors, curtains between beds).
Adjust or develop monitoring tools and management information systems to track services provided to men and women	Establish systems that disaggregate data by gender and services provision (e.g., number of counseling sessions provided and issues addressed, number of men and women that visit the clinic and services they receive).
Training	Train all staff from doctor to maintenance staff about working with men; provide on-going technician training to nurses and counselors who will be working with men.
Develop and disseminate training materials for in-service training and IEC materials geared for couples	This may require setting up a technical working group to develop materials or outsourcing this activity to an experienced NGO or governmental department. Discuss and distribute IEC materials to women and men in couple counseling sessions. Encourage couples to tell their friends that clinics are not for women only but also welcome men.
Introduce couple counseling	Offer couple counseling as an alternative to individual counseling based on women's consent. Consider flexible hours for couple counseling taking into account men's work schedule.

KEY STEPS TO IMPLEMENTING PROJECTS that INVOLVE MEN in RH through MCH	
IMPLEMENTATION ACTIONS	IMPLEMENTATION ACTIVITIES
	Consider group counseling as an alternative to couple counseling to facilitate scheduling.
Evaluate project	Use monitoring tools, interviews, and focus group discussions with providers, clients, and community leaders.

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Maternal and child health (MCH) presents many opportunities for involving men in reproductive health, whether through pregnancy or through the health of the baby. Research findings and program experience concur that “pregnancy is a time when both parents have similar interests in the survival and health of their babies. However pregnancy presents a time of vulnerability for women and their babies with respect to sexually transmitted infections (STIs) including HIV” (Marindo et al., 2003). Furthermore, in patriarchal societies, where men hold the decision making power in matters including use of family income, access to health care, and reproductive and contraceptive choices, involvement of male partners in RH services may have a crucial impact on women’s and families’ reproductive health. Yet, public health services still tend to exclude men when counseling women about childbearing, contraception, and STI protective behaviors, even though many service providers feel the need to involve and educate men about reproductive health. Research in North India confirms that men want to know more about reproductive health and that couples are uncomfortable discussing family planning and STI related issues (Singh et al., 1998).

The seven projects presented herein illustrate opportunities to include men in maternal and child health programming. Many of the presentations are operations research projects that provide information on how to replicate and scale up similar types of programs. The ***Mira Newako* project: Involving men in pregnancy and ANC in Zimbabwe** described in depth below addresses themes covered by most maternal and child health programs that welcome men. Their IEC and couple counseling sessions inform about the male and female anatomy, how a healthy pregnancy should progress, what symptoms indicate an abnormal pregnancy, and the actions men can take to seek emergency medical care for their partners. These programs promote antenatal and postnatal care, or what is also commonly referred to as maternity care or safe motherhood; programs such as these reach out to men by focusing on ways to encourage positive male involvement in caring for their partners during pregnancy and postpartum. They integrate STI prevention, including HIV, family planning, and preventive health care.

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- **Involving Men in Antenatal and Postnatal Care: The Men in Maternity Project in South Africa.** Despite such obstacles as staff reluctance to include men in maternal health services and an infrastructure that was unwelcoming to men because of lack of privacy and inflexible clinic hours, this project found that men are interested and willing to be involved and women want such involvement.
- **Successfully Involving Men in Maternity Care: The Men in Maternity Project in India**. This project successfully overcame health care workers' discomfort in doing demonstrations of proper condom use by having male doctors initiate such demonstrations.
- **Involving Husbands in Safe Motherhood: The *Suami Siaga* ("Alert Husband") Campaign in Indonesia.** The project aims to involve men in MCH through a mass media campaign. Aspects of this project are highlighted in Chapter VII under Media Approaches.
- **Supporting Married Adolescent Girls: Encouraging Positive Partner Involvement (India).** This project sought to better understand the social context and health seeking behavior of young couples experiencing the first birth. The project assessed how a the first pregnancy affects a young woman's position and prospects within the household and with her husband. Based on their findings, project managers developed and tested interventions that increase young women's social support and designed services to first-time mothers in a manner attentive to the role of fathers. Thus, the project focused on the special opportunity that a first birth provides to establish health care behavior for future births.
- **Promotion of Male Involvement in Adolescent Married Women's Reproductive Health through Reproductive Health Education in Rural Area in Maharashtra, India.** This community-based intervention trained peer educators to impart knowledge about reproductive and sexual anatomy and physiology, menstruation, pregnancy and delivery, contraception, infertility, RTIs and STIs, HIV and AIDS.
- **Caring Men? Husbands' Involvement in Maternal Care among Young Couples in Rural India.** This operations research project inquired about what men with young wives know about maternal care. It also asked: "How does the socio-cultural context influence husbands' participation in maternal care among young couples? What other factors are associated with husbands' participation in maternal care for young wives?"

Involving Men in Antenatal and Postnatal Care: The Men in Maternity Project in South Africa.

Based on a paper submitted by Busisiwe Kunene, Involving Men in Antenatal and Postnatal Care: The Men in Maturity Project in South Africa, September 2003.

Implementing Agencies: Reproductive Health Services Unit (RHSU)/Durban; Department of Obstetrics and Gynecology, University of Witwatersrand; and Population Council, FRONTIERS in Reproductive Health Program and Family Health International.

1. Background

KwaZulu-Natal (KZN) Province in South Africa has a population of 9.1 million people, with fifty-seven percent living in rural areas. Men are traditionally not expected to be involved in maternity related issues with some believing that a man will become weak if he is present at the birth of his baby. The HIV prevalence among antenatal clients in KZN was 33.5% in 2001, and maternal mortality increased from 188 in 1998 to 243 in 2001, with 23% of these deaths HIV related. Although HIV/AIDS is known due to national IEC campaigns, sexually transmitted infections (STIs) are another major public health problem and are less well known. Reproductive health information including STIs and condom use, if ever given, is primarily aimed at women who are not financially and culturally enabled to make decisions on many of these issues. In addition, women are not in a position to talk about sex or condom use with their partners while men, as partners and decision makers, have very little knowledge of reproductive health issues.

Sources: Department of Health, 1997; Editors Inc., 2001; National HIV Survey, 2001; Saving Mothers, 1999-2001

2. Project Goal

The goals and objectives were to:

- Develop an expanded, acceptable antenatal and postpartum care program which includes both men and women and aims to improve reproductive health and pregnancy outcomes;
- Assess the impact of involving men in two pre and one post-delivery counseling sessions conducted in couple groups.

Exposure to the intervention was expected to result in:

- Improved male involvement and intra-couple communication
- Improved family planning knowledge and use at six months postpartum
- Improved STI preventive behaviors
- Improved knowledge of dual protection offered by condom use
- Improved syphilis testing and management
- Improved infant health, feeding, and immunization
- Greater providers' satisfaction

3. Project Design

Duration: June 2000 – March 2003

Needs assessment: As this was an operations research assessment the study was not based on a needs assessment, though formative research (see below) was carried out to understand how the clinics functions.

Surveys were conducted prior to clinic interventions and at a six months post-due date in women's and men's homes in both control and intervention sites. At baseline a total of 2,082 women, (1,087 control and 995 interventions) were interviewed using a structured questionnaire. Males were only interviewed in intervention sites at baseline if the female participant agreed to have her partner involved. Ninety nine percent of women who qualified to participate in the study consented to have their partners involved. However,

only 59% of the 995 men eligible to participate in the study were interviewed, mainly due to difficulties in tracing them as most participants were not married and cohabitation was low among those who were not married. A follow-up rate of 66% (n=712) of the control women and 75% (n=745) of the intervention women was achieved and 604 control and 652 intervention male partners were also interviewed at six months postpartum. Towards the end of the project, focus group discussions were conducted with health care providers to evaluate their satisfaction.

Research design: Two clusters of 6 clinics each matched for a range of characteristics were randomly assigned to either treatment (intervention) or control. Six clinics implemented the intervention and another six control clinics continued to provide services following the current practices and guidelines of the Department of Health.Both rural and urban clinics were included. The size of the clinics varied considerably with some clinics seeing 185 first time antenatal care (ANC) clients and some as few as 20 clients per month. All study sites were in the catchment area of Prince Mshiyeni Memorial Hospital, a tertiary hospital with 22 clinics under its administration; almost all providing antenatal care services. It is located in Umlazi Township which, with a population of about two million, is the largest township in the Durban metropolitan area and the second largest township in South Africa.

Strategies: The intervention was clinic based and included two broad strategies:

- Improving antenatal care services by improving counseling and providing basic essential equipment, as well as strengthening service monitoring and supervision;
- Introducing couple counseling by providing training to health care providers and inviting partners of antenatal women to attend couple counseling twice during pregnancy and once post-delivery. Couple counseling was conducted in small groups. In addition to this, a booklet called Ukuba umzali (*Being a Parent*) was newly produced, provided to all women during their antenatal care; they, in turn, were encouraged to share these with their partners.

Various activities were implemented to achieve the goals and objectives. These included:

- **Advocacy and buy-in activities** - With existing cultural beliefs that discourage male involvement in maternity, there was a need for extensive and intensive buy-in activities among health care providers, clients, and relevant non-governmental organizations. Several meetings were held with different groups and individual representatives at all levels of the department of health (national, provincial, regional district) as well as in each clinic. Clinics' committee members, where available, were also approached to sell the idea to the community and get feedback from policy makers and the community. They also helped inform project designers with suggestions on where to start to assure cooperation and ownership of the program. (Most of this was done during the Syphilis case study involving primarily the policy makers.)

Formative research to inform the planned intervention as there was a need to understand how the clinics functioned. The research included a facility-based analysis, a case study on syphilis screening and management in antenatal clients, client flow analysis, and time spent by provider per client, focus group discussions and reviews of records.

Formative research findings revealed a lack of ANC guidelines and protocols, inadequate basic essential equipment, and shortage of drugs required for routine pregnancy care and STI management. The management information was inadequate and IEC materials focusing on pregnancy were lacking. Most clinics were not assessing, educating or counseling clients on STI and HIV/AIDS. In most clinics, congestion was compromising clients' privacy during consultations.

Tools development **-** Several technical working groups were established to develop IEC materials and a training package for in-service training, identify relevant trainers, and make recommendations for a couple-friendly environment. They also designed a supervisory tool to monitor the intervention, drafted and sent out invitation letters, and distributed attendance certificates that men who participated in couple counseling sessions during their working hours could show to their employers. The Department of Health made trainers and staff available to develop IEC and training modules.

Training - Two types of training were conducted. Initially, whole site overview training was given to all staff in intervention clinics including support staff such as general assistants and clerks to inform them of the study and its components. The second training was more intensive and involved all nurses working in the intervention clinics; training not only updated and expanded existing antenatal care curricula but also included counseling skills and information on how to address men and couples. Sixty-five professional nurses working in the intervention clinics attended the workshops between February and March 2001 at Prince Mshiyeni Hospital.

Implementation - Each clinic developed its own plan on how to conduct their couple counseling. Four clinics chose to utilize less busy afternoons, one clinic preferred two mornings per week and one that was already conducting antenatal care daily chose to introduce couple counseling during this period. The counseling sessions included the following topics: antenatal care procedures, physiological and emotional changes, pregnancy danger signs and care seeking, delivery plan, post delivery care for mother and baby, prevention and management of sexually transmitted infections and HIV/AIDS, and family planning and exclusive infant feeding.

Continuous support and mentoring was given by both the district trainer and staff of the reproductive health services unit to ensure that participants adapted to their new practices at their facilities until competency was gained and at least a minimum quality of service was achieved.

Monitoring activities included:
Supportive supervision - A supervisory tool was used to continuously monitor practice and record keeping and facilitate follow-up and supportive supervision. Intervention

clinics were visited monthly for the first six months, bimonthly for the second six months, and every three months thereafter through the completion of the study. Monitors observed clinic structures, service provision, and couple counseling sessions during their visits. Progress made and problems identified were discussed with the clinic staff. Supervisors from all the clinics participating in the study met regularly to share lessons learned and foster peer support.

Management information system – Newly developed and improved registers for antenatal care and counseling sessions recorded data on the number of clients counseled, topics discussed, and the job title or position of the person who conducted the counseling session.

Surveys (see **needs assessment** above)

Cost and client flow analysis and time motion studies – Family Health International, a FRONTIERS partner, provided technical assistance to calculate intervention costs, client flow analysis, and helped conduct time motion studies at two points in the study in the intervention clinics.

Stakeholders and their roles**:** The KZN Department of Health, Maternal and Child Health Unit provided support and guidance in developing the curriculum and IEC materials. The Regional Department of Health provided trainers and support to ensure that supplies such as drugs were always available in the clinics. The Provincial STI Advisory Committee and Provincial Maternal Task Team provided guidance on how to best run the intervention. Hospital management, especially the maternity and community health sections, provided the facilities, training venue and trainers, and supported and motivated the staff to implement the project. The Henry J. Kaiser Family Foundation and Department for International Development (DID UK) provided financial support for the production of the booklet on becoming a parent. The United States Agency for International Development (USAID), through FRONTIERS, provided funds for the project including essential equipment. FRONTIERS also provided technical assistance. The Reproductive Health Research Unit of the University of Witwatersrand, based in Durban, KwaZulu-Natal managed the program and conducted the research component.

Target population: All women who attended the antenatal care clinics for one of their early prenatal visits from June to September 2001 in the control clinics and from October 2001 to February 2002 in the intervention clinics were approached for permission to be enrolled. Eligibility criteria included: consent to be interviewed and to have their partner interviewed; 10 to 30 weeks of gestation; living with their partner or having regular visiting relationship for at least one year; and expecting the partner to be present during and after the pregnancy. These women had to have been resident in the area for at least one year prior to recruitment and who plan to stay in the study area for at least six months post delivery.

Obstacles and strategies used to overcome them: Involving men in maternity was a process that required several stages of implementation, and each one required health

professionals to take on different roles, as trainees, motivators, and counselors. Nurses needed continuous motivation and support while in turn motivating and encouraging the women. Women have traditionally experienced pregnancies and childbirth without their partners; thus, it was a challenge for these women to start involving partners in their maternity care.

Although men were interested in being involved in their partners' maternity care, participating was not always possible because public health clinic services in South Africa are only open during working hours. This poses a problem for men who may not be able to leave work to attend couple counseling.

Traditionally men have not been involved in any aspect of their partners' maternity care. This posed challenges for both the nursing staff and the ANC clients. Nurses had to become the primary motivators of the clients, to encourage them to bring their partners to participate in counseling and other maternity care visits. Both nurses and clients were initially unsure if men would be interested in being involved in an area that has traditionally been a woman's domain. Some clients felt they needed a letter from the clinic to get their partners to participate as this formalized the process and the man would see that it was not just the woman wanting them to participate. There was also some confusion with the parallel introduction in some clinics of a mother to child transmission (MTCT) program, leading some clients to think these projects were related.

Staff rotations, which ranged from one to three months in each clinic section, posed another challenge as changes in personnel assigned to the maternity ward did not consider the interests of health workers. This had implications on the trained and experienced staff that left their jobs and newly arriving staff that had no previous experience working in maternity care. Rotations also affected clients who became familiar and comfortable with certain staff members and had to reacquaint themselves with new personnel.

Although the referral hospital was not part of the project, hospital staff were concerned about the shortage of linen and lack of privacy in the labor ward. These were obstacles that would make it difficult for men wanting to accompany their partner during delivery. The hospital solved this challenge by allocating a waiting room next to the delivery room, which was furnished by the project. In addition, hospital management put curtains between beds to provide visual privacy.

Loss of staff due to emigration was an issue for some of the clinics. Supportive supervision was particularly affected, in that three supervisors left within the first two years of the project. Those who were left had no cars to visit the clinics due to problems with administrative logistics. The same situation prevails in the clinics with skilled and motivated staff becoming highly marketable in the private sector as well as overseas. A number of nurses left while the project was underway. This was an on-going challenge, though provisions were made to orientate new staff who joined the intervention clinics.

Clinics are commonly congested in the morning so no space was available for couple counseling at this time of the day. To overcome this obstacle and accommodate the new and time consuming couple counseling sessions, the sessions were scheduled later in the day when the clinic was not as busy.

4. Results

Is the intervention acceptable to clients and providers?

Men were willing to be involved and also admitted that they lacked knowledge in reproductive health. Women felt they would benefit by having nurses give health education messages directly to their partners: *"Men will learn how to treat us. They will treat us like ladies,"* said one woman. Most women were excited*: "Nurses will stop harassing us when men get involved in maternity care,"* said one woman. Not all of them were enthusiastic *"…he is going to say why now…I've had babies without him,"* said one participant.

The majority of women (84%) expressed a desire for men to be involved to provide them with comfort and support. About half of the men said they wanted to be involved in all aspects of maternity care. Seventy-seven percent of the interviewed men and eighty percent of the women would like their partners to be present at clinic visits and group discussions. The lowest level of interest in men's presence was for the actual delivery (females 66-72%, males 53%). Only two men did not want to be involved in any aspect of maternity care.

Opinions on male involvement differed among health providers. Some of them were concerned about involving men based on cultural beliefs. Others were convinced this was a good practice. Some were also concerned that men might not come for couple counseling.

Is the intervention feasible?

A total of 524 couples were counseled and all women attending antenatal care were given the same information that was given during couple counseling.

Clinic services were rearranged to accommodate couple counseling. Every clinic managed to make its own schedule for couple counseling at the time that suited the clinic best. When individual counseling became obviously impractical, intervention clinics were able to arrange group couple counseling sessions. These changes were accomplished without increasing clinic staffing. Ideally, low male attendance could be overcome by offering couple counseling at times when men are not involved in income producing activities. However, this may not be possible for providers and clinics due to restricted hours when the clinic is open.

Is the intervention effective?

All participants were followed up six months post-due date of delivery to assess if the intervention was effective.

Table 2 shows topics discussed with partners post delivery reported by control and intervention women and men.

Table 2: RH topics discussed with partner (end-line survey)

	Intervention %		Control %	
Topics discussed with partner	Women (n=589)	Men (n=589)	Women (n=526)	Men (n=526)
Sexual relations	86**	88	74	84
Baby feeding	83*	86	76	83
STI/HIV	81**	85*	67	76
Family planning	82**	84	74	81

*p=0.001; ** p=0.000

The differences in couple communication on RH topics between intervention and control groups were significant when comparing the women in the intervention and the control group, particularly in terms of women discussing STI/HIV and FP with their partners. When intervention women were compared with control women, changes remained significantly high (p=0.000). However, when intervention men were compared with control men only STI/HIV communication was significantly improved in the intervention group (p=0.001); the rest were not significant.

Table 3 shows differences in family planning and condom use comparing control and intervention women pre- and post-intervention. In addition it includes data on self-risk perception of contracting HIV.

Family planning and condom use (p=0.000) improved significantly in the intervention compared to the control groups even though condom use remains low. However, a high percentage at baseline in both groups said they had no chance or did not know whether they had a chance of contracting HIV. This did not change much with the intervention, although the tendency is in the right direction. These results should be viewed with caution since this preliminary analysis has not taken the cluster design into consideration. Analysis was based on individuals.

Table 3: Family planning, condom use and HIV risk-perception

	Intervention Women %		Control Women%	
	Pre (n=995)	Post (n=728)	Pre (n=1081)	Post (n=694)
FP use postpartum	-	59*	-	49
Condom use with current partner	34	55*	34	47
Condom use last sex	4	22*	6	14
Dual protection ever use	13	24*	16	17
Don't know/no chance of getting HIV	65	53	58	46

* p=0.000

The knowledge of women in the intervention group improved more than those in the control group. The pre-intervention figure is lower than the post figure for “do not know or chance of getting HIV” which is to be expected.

Table 4 indicates knowledge of danger signs before and after the intervention. Although the control women had better knowledge of obstetric danger signs before the intervention, intervention women had more knowledge than their control counterparts at endline Those who did not know any danger sign in the intervention dropped from 11% to 3%. The changes were significant (p=0.000)

Table 4: Women’s knowledge of danger signs (baseline and end-line surveys)

	Intervention Women %		Control women %	
Danger signs	Pre (n=994)	Post (n=729)	Pre (n=1081)	Post (n=694)
Bleeding	44	51*	59	50
High blood pressure	26	57*	33	38
Fever	27	35*	30	20
Swelling of hands and face	5	11*	6	15
Don’t know any	11	3*	8	5

* p=0.000

LESSONS LEARNED

The lessons learned pertain to adjusting institutional structures to welcome men and women and to outreach and dissemination strategies that target men.

- Public services have to adjust their institutional structures to accommodate working men and women and provide career opportunities to health care professionals interested in involving men in MCH. Structural adjustments should consider revisiting rotations, scheduling flexible hours for couple counseling, strengthening monitoring, and supportive supervision. Hospital management and staff should be involved at the outset of couple-service interventions to accommodate couples that wish to be together during delivery.
- Outreach to communities needs strengthening to inform larger numbers of men that they are welcome to participate in their partner’s maternity care, based on their partners consent, and to disseminate information targeted at sub-groups of men and women (e.g., adolescents, at risk, illiterate, employed, unemployed, urban, rural).
- Health care providers need additional training on how to serve couples and how to conduct couple counseling.
- New strategies need to be designed to address remaining challenges in HIV/VCT (Voluntary Counseling and Testing) and integration of other services into maternal services.

Chapter III
References

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