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CORE ELEMENTS OF GENDER-TRANSFORMATIVE FATHERHOOD PROGRAMS TO PROMOTE CARE EQUALITY AND PREVENT VIOLENCE

Results From a Comparative Study of Program P Adaptations in Diverse Settings Around the World

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1. Introduction

Parenting programs have been identified as a promising strategy to strengthen parenting skills; increase men's participation in caregiving; improve the quality of family relationships, health, and well-being; and prevent violence against children.[1-5] While most parenting programs primarily reach mothers and female caregivers, evidence demonstrates that fathers and male caregivers have a significant impact on children's early development.[6] Nurturing interactions with fathers can improve children's emotional and cognitive development,[7-8] while harsh discipline by fathers can be associated with later behavioral problems.[9] Furthermore, strengthening couple relationships and reducing violence between the parents can reduce children's exposure to intimate partner violence (IPV); numerous studies have shown witnessing IPV increases children's future risk of perpetrating or being victims of violence in adolescence and adulthood.[10-11] Additionally, children who grow up in families where parents share household chores and care for their siblings are more likely to repeat these behaviors in adulthood,[12] thus helping reduce the gap between women's time spent in care work and men's. Men themselves report benefits from having closer relationships with children and others, including improved mental health.[13] This virtuous cycle contributes to a reduction in stress levels and the use of violence at home, and thus, can help prevent the intergenerational transmission of violence.[14-15]

Program P **("P" for the words for father in Portuguese, *pai*, and Spanish, *padre*) was developed specifically to promote men's positive involvement as fathers in maternal, newborn, and child health (MNCH) and in caring for their children.**[16] It provides concrete strategies to engage men in active fatherhood, starting from their partner's pregnancy through childbirth and into children's early years. The focus on men comes from recognizing the specific gendered experiences and risks and the importance of reaching men when they are developing their attitudes and beliefs about gender norms and power dynamics in relationships. Becoming a father is a unique phase in a man's life, a time when he is particularly interested in and receptive to learning about how to build close and caring relationships with his children or how to support them in their development and life journey. Program P was developed in 2011 as part of the MenCare campaign by Equimundo: Center for Masculinities and Social Justice (formerly Promundo-US), along with CulturaSalud/EME (Chile), Red de Masculinidad por la Igualdad de Género (REDMAS, Nicaragua), and Instituto Promundo (Brazil).

Program P has been adapted in close to 30 countries by a wide array of partner organizations, ranging from small community-based organizations to large multilateral development organizations and governments, often in partnership with Equimundo. This wide array of adaptations in diverse settings has generated a rich body of both evaluation research and practice-based knowledge from partners and the Equimundo staff technically supporting the design, implementation, and evaluation of its varying models across contexts. Different types of quantitative and qualitative evaluations have produced evidence about how the program has affected areas such as promoting gender-equitable relationships between female and male caregivers, balancing decision-making and power in couple relationships, improving the quality of couple and parent-child relationships, and reducing risk factors associated with IPV and the use of violence against children.

Partners originally developed Program P: A Manual for Engaging Men in Fatherhood, Caregiving, and Maternal and Child Health concurrently in English, Portuguese, and Spanish. Linguistic and cultural adaptations have since been developed with partners in multiple languages, including Arabic, Russian, and Spanish (Bolivia).

This review seeks to consolidate learning from existing evaluations of Program P adaptations and the wealth of practice-based knowledge from program adapters and implementers. It seeks to identify the core components or essential elements that guide effective, high-quality Program P adaptation and implementation. In a few countries, Program P is being taken to scale, evolving and being adapted to respond to the needs and realities of different groups of parents in very different settings. This makes it imperative to take stock, learn from the evidence and experience so far, and identify the core components that we believe are linked to the program's impact in order to provide guidance that can support future adaptations.

2. What Is Program P?

The Program P manual was designed for use by health workers, social activists, nonprofit organizations, early childhood educators, parenting support professionals and other individuals and institutions aiming to engage men in caregiving and maternal, newborn and child health (MNCH), as well as to improve family well-being and support gender equality. The manual includes three components:

1. A guide for health professionals on engaging fathers and male caregivers through the health sector

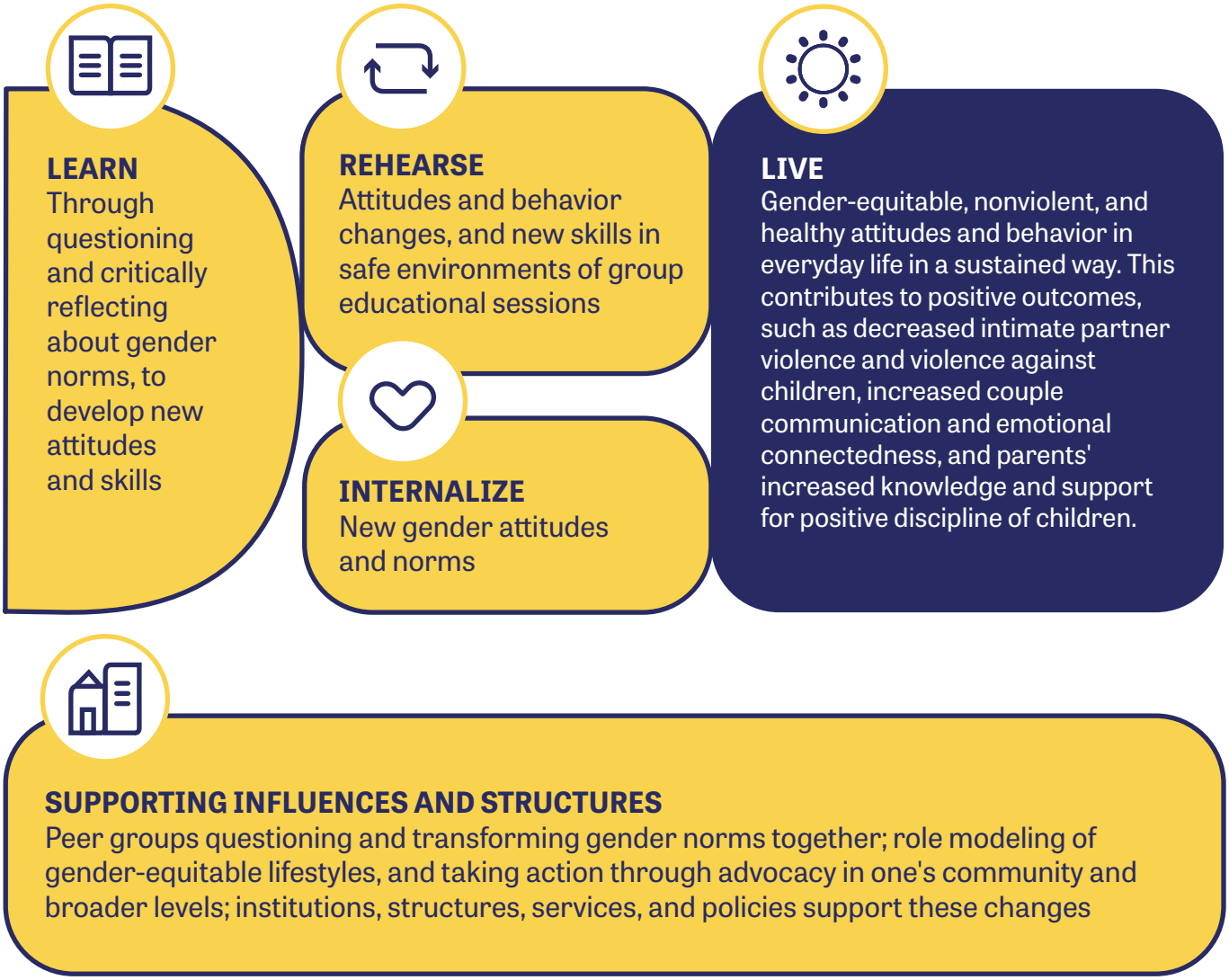
2. A group education curriculum for engaging fathers and their partners

3. A guide for developing community mobilization strategies and campaigns to promote engaged fatherhood

All three components can be implemented separately or in tandem, by a single organization or through partnerships between nongovernmental organizations (NGOs) and the public sector.

This brief focuses specifically on the gender-transformative group education component for men and their partners, as this is the central component of the program model and the most frequently adapted, implemented, and evaluated one in different settings. The goal of the group education component is for men (and their partners) to (1) learn about gender norms through activity-based questioning and critical reflection; (2) rehearse equitable, caring, and nonviolent attitudes and behaviors in a safe space; and (3) internalize these new gender attitudes and norms, applying them in their own relationships and lives and in the process increasing men's nurturing, caring, and hands-on care activities. (See the following figure for Program P's theory of change.) Accompanying this group education process, supporting institutions and structures give the parents and organizations involved the tools to become agents of change for gender justice and care equity. By questioning gender stereotypes, particularly those related to care and caregiving, men and women who already act as "voices of resistance" against rigid gender norms become further engaged and serve as role models for others.

Program P Theory of Change



The program's group education curriculum uses small-group sessions composed of participatory activities and group discussions to encourage male caregivers and their partners to challenge restrictive gender norms, learn new skills around childrearing and couple communication, and adopt more equitable couple and parenting behaviors (such as balanced decision-making, caregiving, and domestic responsibilities). Hands-on activities and role-playing exercises with fathers and couples aim to create a safe environment for discussing and challenging traditional gender norms and practicing new, positive social behaviors related to men's caregiving and equitable partner relations, including supporting women's decision-making and full economic participation. In particular, the program helps participants unpack harmful social beliefs and norms around gender and power, particularly notions of male authority and female subordination, which are strongly linked with higher levels of familial violence. By improving gender relations in the home and supporting parents to raise children equally, the curriculum also aims to transmit the values of gender equity and nonviolence to the next generation. Sessions are often implemented weekly over three to five months.

3. Objectives and Scope of This Review

This learning brief represents a systematic, broad-based effort to identify the common elements of success among Program P adaptations, as well as common challenges and constraints, to support practitioners interested in adapting, implementing, and evaluating gender-transformative parenting programs (such as Program P) in other settings. We draw on different sources of evidence (both quantitative and qualitative research as well as practice-based knowledge) to identify lessons learned and emerging recommendations on how to strengthen future program design, implementation, and evaluation efforts. Throughout this study, we triangulate information from both evaluation research and practice-based knowledge to answer the following questions:

DOMAIN	RESEARCH QUESTION
Core components of success	What were the core elements of success or essential ingredients contributing to the positive results of the program?
Adaptation	What was the process (methods, duration, ownership by partners) of adapting the program strategy and content to respond to the sociocultural context in which it was implemented?
Central themes and balance	Which themes were prioritized in different adaptations of Program P in line with the theory of change, and how was the balance between depth and breadth of topics achieved? *(Program P has multiple goals: promoting care equity, more equitable household, and couple relations, nurturing and nonviolent child-rearing, and reducing gender-based violence (most often a focus on intimate partner violence). Not all of these themes are given equal weight in all interventions.)*
Training and technical accompaniment of facilitators	What approaches did Equimundo and/or partners use to train facilitators and provide them with ongoing technical accompaniment and support to develop their skills?
Strategies for men's engagement	What approaches were followed and found to be effective to achieve men's uptake, sustained participation, and engagement during the program?

3a. Methodology

The first stage of this study involved mapping the known Program P adaptations globally to take stock of the breadth of settings in which the program had been adapted, implemented, and evaluated. This process identified 26 adaptations in 23 countries in Africa, Latin America, the Middle East, Europe, and South Asia. Then, we used desk research and inquiries to partners and Equimundo staff to create a consolidated descriptive overview of each program's main characteristics.

In the second stage, we selected eight Program P adaptation case studies (implemented in 12 countries) for a deeper dive based on the following criteria:

- The program was centered on the delivery of a curriculum-based set of group education sessions aimed at engaging fathers or male caregivers of young children, on their own or with their female partners.

- The program objectives included, at minimum, promoting gender-equitable relationships, improving couple/parent-child relationship quality, reducing IPV and/or violence against children, and promoting shared caregiving.

- A robust evaluation was completed and publicly available, Equimundo was sufficiently involved in the adaptation process to provide insights about it, and/or partners directly involved in it were reachable and available to share their learning with the research team.

This study relies on two sources of information:

1. **Evaluation evidence from eight case studies:** This report presents a synthesis of existing evidence from quantitative and qualitative evaluations of select Program P case studies (see Annex C). In addition, we reviewed qualitative and quantitative evaluations beyond the eight case studies, from adaptations of Program P in various settings around the world, to complement or provide additional perspectives from diverse settings.

2. **Practice-based knowledge:** The study also draws on interviews with 15 practitioners closely involved in the design, implementation and/or evaluation of the case studies. We sought to include a range of stakeholders and, therefore, spoke with long-term partners (NGOs), former Equimundo staff, men's engagement and gender technical advisors involved in the adaptation, and partners who led the adaptation with limited involvement of Equimundo. A list of people interviewed can be found in Annex A.

For the eight selected case studies, we triangulated the synthesized information from evaluations and interviews and identified common themes, core components, challenges, and pitfalls that could be avoided in future adaptations, as well as successful recruitment, training, social mobilization, and government involvement strategies. We compared the processes of adaptation, the programmatic strategies followed in different settings, and the results achieved, to respond to recurrent questions voiced by partners interested in promoting men's engagement in parenting programs. The learning brief draft was then shared with all those who participated for feedback and validation to ensure we captured key learning and emerging recommendations to inform future adaptation.

3b. Limitations of This Review

One key limitation of this review is that it covers eight case studies out of the 30 known adaptations. Information and documentation for these adaptations (e.g., on their implementation or evaluations) were not always available or complete, including for the eight case studies discussed here. The evaluation design and outcomes of interest for each adaptation also varied considerably, including in their quality, making it difficult to compare across countries. Finally, many of the studies included in this review collected self-reported health and behavioral data, although a few evaluations did interview men's female partners to report on changes in men's behavior.

4. Case Studies Included in the Review

The eight Program P adaptations highlighted in this review share several common features related to the main goal of engaging male caregivers as equitable, caring, and nonviolent fathers and partners through an experiential methodology that encourages participants to challenge harmful gender norms. However, the programs varied in their goals, approaches, and population groups reached. The following table presents an overview of the case studies' characteristics, with additional information available in the table of evaluative evidence in Annex B. There were different partnership approaches, or level of involvement, between Equimundo and the partner organizations through the design and implementation of these programs.

Program P Adaptation Case Studies Included in the Review

PROGRAM	PARTNER ORGANIZATIONS	COUNTRIES	POPULATION TARGETED	THEMATIC FOCUS	SESSIONS (#)
PARENT (Promotion, Awareness Raising and Engagement of men in Nurture Transformations) pilot[18]	In Austria, Association for Men's and Gender Issues in Styria; in Italy, Cerchio degli Uomini; in Lithuania, Center for Equality Advancement; in Portugal, Centre for Social Studies of the University of Coimbra and Nursing School of Coimbra	Austria, Italy, Lithuania, Portugal	Fathers/fathers-to-be and their partners, health professionals, health students, social workers	Equitable caregiving; engaged fatherhood; MNCH; preventing violence against women and children	Parents: 1–8 Profes-sionals: 4–11
MenCare Bangladesh: **Prio Baba** ("Dear Father")/ Engaging Fathers for Family Well-Being and Gender Transformation	Centre for Men & Masculinities Studies (CMMS) with technical support from Equimundo	Bangladesh	Fathers, with female partners in approximately half the groups; healthcare providers/gatekeepers (i.e., family planning workers from the public health system, nurses, midwives, pharmacists, and local-level medical practitioners) engaged in gender sensitization workshops	Preventing violence against women and children	6
Strengthening Health Outcomes for Women and Children (**SHOW**) Project[19]	Plan International Canada Ghana: Ministry of Health and Ministry of Gender, Children, and Social Protection; Nigeria: National Ministry of Health and Ministry of Women Affairs and Social Development and the Sokoto State Government, Ministry of Health, Ministry of Women Affairs, and Primary Health Care Development Agency with technical support from Equimundo	Bangladesh, Ghana, Haiti, Nigeria, Senegal (This brief focuses on Ghana and Nigeria.)	Adult men and their female partners of reproductive age	Positive masculinities, MNCH, sexual and reproductive health (SRH), continuum of care	20
Program P Bolivia[20]	Inter-American Development Bank, Consejo de Salud Rural Andino	Bolivia	Cohabiting mothers and fathers of children aged 0 to 3	Preventing violence in the family (IPV and violence against children), equitable caregiving and domestic work, positive parenting	10
MenCare+ Brazil/**+Pai** ("Father")	Instituto Promundo, Instituto Papai, Instituto Noos, Rio de Janeiro's Municipal Health Secretariat; Brazilian Ministry of Health	Brazil	Young men and women, fathers and fathers-to-be (and couples), men who have perpetrated domestic violence, health providers, health and legal sector staff	SRH, maternal and child health, violence prevention	10
Program P-ECD Lebanon (ECD=Early Childhood Development) and Program P or Abb (in Arabic)	ABAAD, in partnership with Equimundo	Lebanon	Syrian and Lebanese fathers/ male caregivers and their female partners (all participants were married and had at least one child aged 0 to 5)	Fatherhood, caregiving, violence prevention	13
Program P Nicaragua	Puntos de Encuentro, Red de Masculinidad por la Igualdad de Género (REDMAS), Ministry of Health; Ministry of Education; with technical support from Equimundo	Nicaragua	Health providers and volunteer health educators (main targets, although group educations sessions also reached young fathers and their partners)	Sexual and reproductive health and rights (SRHR), violence prevention	12
Program P: **Bandebereho** ("Role Model")/ MenCare+ Rwanda: Bandebereho[21]	Rwanda Men's Resource Centre (RWAMREC), in partnership with Equimundo	Rwanda	Couples recruited via male partner (men aged 21 to 35, expecting or current parent of child under age 5, cohabiting with a partner)	MNCH, SRHR, violence prevention, caregiving	15

Program delivery across the eight programs used the following approaches:

- **Implementing group education methodologies** designed to generate critical reflection and question restrictive gender norms through experiential activities (such as role-plays, open-ended case studies, and interactive dialogues), as well as to raise awareness about how restrictive gender norms influence the formation of identity, personal relationships, opportunities, and well-being.

- **Focusing on young to middle-aged fathers, fathers-to-be, and/or male caregivers with female partners of reproductive age.** Most programs engaged participants who were cohabitating with or married to their partner and included sessions with both members of the couple. Additionally, most programs were restricted to parents with at least one child under age 5, while a few programs targeted parents of younger children (ages 0 to 3). Several programs sought to reach migrants or refugees, Indigenous couples, members of religious and ethnic minorities, and those predominantly living in low-income settings; some focused on reaching families in rural areas, while others focused on urban populations, and several programs reached both urban and rural areas.

- **Being delivered by trained male and/or female facilitators** who included (depending on the setting) health providers and volunteer or paid community health promoters, program staff, community leaders, and/or community members.

- **Including a core curriculum delivered to small groups of approximately eight to 20 participants.** In some cases, these group sessions were combined with ad-hoc individual meetings or visits to participants' homes, public spaces, or workplaces. Group sessions took place in a range of settings, such as health facilities, daycare centers, community centers, religious facilities, refugee camps, and online.

- **Including a series of group sessions with average durations ranging from one to three hours; adaptations ranged from six to 17 sessions.**

Additionally, most adaptations included women/female partners as program participants, with variations in the number of group education sessions and approach. Four programs (**Prio Baba, +Pai, Program P Nicaragua,** and **PARENT Portugal**) offered couple groups for men and women to participate together throughout the sessions; this was the case in about half of the groups in Prio Baba, while the other half were for men only. Several programs included both mixed- and single-sex sessions. In **Bandebereho** in Rwanda, female partners were invited to join men in eight of the 15 sessions, while female partners in **Program P-ECD Lebanon** joined their male partners for five of 13 sessions. In a few settings, men and women participated only (or mostly) in separate-sex sessions. In **Program P Bolivia**, for example, men and women partners received essentially the same core content, but mostly in separate, same-sex groups; men received one additional session on gender-based violence that women did not, and women had one session on the different uses of power that men did not. As another example, once the **SHOW Ghana** men's groups started, women's interest and requests led the program to offer a complementary women's curriculum. In two of four **PARENT** countries (Austria and Italy) and in **SHOW Nigeria**, programs reached only men with curriculum content.

Alongside group education for fathers and – to varying degrees – mothers, the eight adaptations discussed in this brief also engaged key institutions, mostly public or NGO service providers. These included health facilities, hospitals, and clinics; schools, childcare, or educational institutions; governments (local to national health, child protection, social development, gender and family, and education ministries or institutions); community and religious institutions and leaders**;** NGO networks; and national or sub-national professional association networks (early childhood and child protection networks). Some of the organizations also carried out national- or local-level advocacy with policymakers building on the global MenCare campaign approach.

4a. Similarities and Differences Among the Case Studies

All eight Program P case studies had gender-transformative curriculum-based group education sessions for fathers as the main program component. They used methodologies designed to generate critical reflection and question restrictive gender norms through experiential activities (such as role-plays, open-ended case studies, and interactive dialogues), as well as to raise awareness about how restrictive gender norms influence the formation of identity, personal relationships, opportunities, and well-being. Curriculum content varied depending on the focus of each adaptation, but all eight included foundational content aimed at understanding gender and power relations, promoting men's active engagement in domestic and caregiving work, promoting shared decision-making with female partners, and preventing gender-based violence. Most programs included all or some of the following topics: positive parenting skills, including nonviolent discipline strategies; couple communication; understanding and promoting early childhood development; supporting reproductive, maternal, and newborn health; and anger management or problem-solving.

The programs sought to promote changes in the following outcomes (although not all of these had all these outcome objectives):

- Increase gender-equitable attitudes and norms
- Increase women's participation in joint and autonomous decision-making on household, couple, and family issues (e.g., related to household finances, reproductive and sexual decisions, women's work outside the home)
- Improve the quality of couple communication
- Increase male partner support during pregnancy and birth
- Increase modern contraception use
- Decrease parental use of physical punishment against children
- Decrease IPV
- Create more equitable distribution in women's and men's time spent on unpaid care work

The content, including its depth, also varied depending on the specific program objectives, organizational expertise, and/or donor focus. All programs included content related to nonviolence, children's and women's rights, and conflict resolution within families, although how this content was presented varied across the adaptations. In some cases, such as **Program P Bolivia**, the adaptation focused specifically on preventing IPV and violence against children. In other cases (**SHOW Nigeria**), the father club curriculum covered healthy relationships without explicitly discussing IPV. Half of the programs (**Prio Baba, Program P Bolivia, Program P-ECD Lebanon**, and **Bandebereho**) emphasized positive parenting techniques and concrete parenting skills as alternatives to corporal punishment of children. All but two programs (**Program P-ECD Lebanon** and **Program P Bolivia**) emphasized men's engagement in SRHR and MNCH. Some programs (**SHOW** and **+Pai**) paid special attention to adolescents' improved reproductive health knowledge and/or outcomes. Three programs (**Program P-ECD Lebanon, Bandebereho**, and **PARENT**) emphasized early childhood development in the curriculum content, and alcohol/drug use and women's economic empowerment were included in only one adaptation each (**Bandebereho** and **Program P Bolivia,** respectively).

5. What Does the Evidence Say About Impact?

This section synthesizes the main findings based on the available evidence from the respective program documentation. Details about the evaluation methods used and major results can be found in Annex B. The programs featured in this report used a wide range of evaluation methodologies. Two programs conducted randomized controlled trials (RCTs) (**Bandebereho** in Rwanda and **Program P Bolivia**) in addition to qualitative research. Three other programs used both quantitative methods (e.g., pre-post surveys with no control group) and qualitative methods (e.g., in-depth interviews and focus group discussions). Only pre-post survey data were available for one program (**Prio Baba**), and only qualitative data were available for two other programs (**Program P Nicaragua** and **+Pai**). All quantitative findings reported are statistically significant ($p<0.05$) unless otherwise stated.

5a. Gender Attitudes & Norms

All eight programs saw positive shifts in men's (and sometimes women's) gender attitudes and norms. Some of the most common related to believing that fathers should be more involved in caregiving and MNCH, that women are not solely responsible for childcare and domestic tasks, and that "being a man" should include respecting women and children. Other common changes had to do with men becoming more aware of the domestic burden on women and no longer feeling they needed to use violence to gain respect. In several programs, both quantitative and qualitative findings affirmed that gender attitudes and norms around masculinity had shifted for male and female participants. For example:

- In **Program P-ECD Lebanon**, the proportion of women who believed that men should use violence if necessary to get respect decreased from 45 percent at baseline to 10 percent post-intervention.[22] This finding was complemented by qualitative findings in which men and women reported that their perceptions of masculinity had changed: Men no longer felt that "being a man" required physical strength or violence, and women felt that "being a man" included sharing power, respecting women, and helping with childrearing and household tasks.

- In **Bandebereho** in Rwanda, the RCT found significant changes in men's gender attitudes, including those related to caregiving and decision-making roles (but not in women's attitudes (women participated in roughly half the sessions). It also found shifts in both men's and women's attitudes related to the acceptability of violence against women and against children.

- In **Program P Bolivia**, although the RCT found no significant changes in gender attitudes among participants relative to the control group,[23] the qualitative evaluation reflected some important positive shifts in male participants' awareness of gender

inequity in caregiving and the benefits of men's involvement, and of equitable decision-making among couples for better decisions on finances and children's well-being.[24]

- In **Program P Bolivia** and **SHOW Ghana and Nigeria,** qualitative findings suggested that while gender attitudes around caregiving and men's engagement in domestic work shifted positively as a result of the intervention, restrictive ideas around gender roles and power distribution between men and women sometimes remained.[25-28] This indicates that transforming ingrained gender beliefs might require more time and more structural-level change.

5b. Intimate Partner Violence and Couple Relations

Not all adaptations explicitly sought to reduce IPV or measured these outcomes, and those that did varied in the depth of content addressing violence – but all four programs for which findings are available on women's experiences of IPV found some reduction in at least one form of violence. Taken together, the findings from these four programs – **Bandebereho, Program P Bolivia, Program P-ECD Lebanon,** and **SHOW** – suggest that Program P adaptations have significant potential to help reduce women's experiences of IPV from their male partners. However, they also highlight that the specific contextual drivers of violence, program population, and program characteristics (e.g., dosage, thematic focus on violence prevention, and implementation quality) play a role in determining the magnitude of the intervention's impact and the type of IPV that is reduced.

The two programs rigorously evaluated with RCTs found statistically significant differences between women in the intervention group and those in the control group for at least one form of IPV. At 21 months post-baseline, an RCT of **Bandebereho** in Rwanda found that compared to a control group, female participants reported statistically significant lower rates of past-year physical (OR 0.37, $p<0.001$), sexual (OR 0.34, $p<0.001$), emotional (OR 0.38, $p<0.001$), and economic (OR 0.36, $p<0.001$) violence from their husband or partner.[29-30] A recent follow-up study found these reductions were sustained six years later.[31] Further analysis shows the greatest proportion of Bandebereho's impact on physical and sexual IPV occurred via several mechanisms or changes brought about by the intervention: more positive couple dynamics (emotional closeness and communication frequency), men's gender-equitable attitudes, and men's alcohol use.[30] The **Program P Bolivia** RCT noted a 15 percent reduction in psychological IPV experienced by women in the intervention group compared to those in the control group during the six months before the survey, but not in other forms of IPV.[23] Both adaptations had two or more sessions specifically devoted to discussing IPV.

Two other adaptations (Program P-ECD Lebanon and SHOW) offer more limited evidence for Program P's impact on women's experiences of IPV, but nevertheless provide valuable information about program participants' experiences related to violence. In **Program P-ECD Lebanon**, women's reports of experiencing any form of IPV (physical, emotional, or economic) over the previous month decreased somewhat from baseline to endline,[j] although the changes were not statistically significant.[22] While IPV prevalence was not measured as part of the SHOW project, qualitative findings from **SHOW Ghana and Nigeria** found that women and adolescent girls and boys all described a reduction in arguments between parents, and fathers themselves said they had improved their emotional regulation and argued in a less contentious manner.[26-28]

The three programs that measured and reported changes in attitudes around IPV found mixed results. The **Bandebereho** RCT in Rwanda found statistically significant reductions in men's acceptance of wife-beating (across several scenarios) compared to the control group,[30] and results from **Program P-ECD Lebanon** also showed that female and male participants' agreement with statements justifying IPV decreased significantly.[22] On the other hand, the RCT of **Program P Bolivia** found no statistically significant changes in men's or women's attitudes toward violence compared to the control group.[23]

The findings also point to encouraging changes in attitudes and practices related to equitable household decision-making. Only two programs (**Bandebereho** and **Program P Bolivia**), which were rigorously evaluated through RCTs, presented statistically significant quantitative evidence of increased joint couple decision-making.[29,23] For example, **Bandebereho** found that women were more involved in household decisions, with only half of women in the intervention group saying their partner had the final say about the use of weekly and monthly income and expenses compared to roughly three-quarters of the control group.[29] However, three additional programs (**Program P-ECD Lebanon,** and **SHOW Ghana and Nigeria**) found qualitative evidence of positive changes in decision-making.[22,26-28] Additionally, four programs (**Program P-ECD Lebanon, Bandebereho,** and **SHOW Ghana and Nigeria**) led to improved couple communication and emotional support[k] outcomes.[22,26-28,30]

5c. Positive Parenting Practices and Violence Against Children

Across settings, Program P showed promising evidence on improving support for and use of parenting practices to reduce harsh punishment. Of the four programs that measured parents' understanding and use of positive parenting practices, three (**Prio Baba, Program P-ECD Lebanon,** and **Bandebereho**) had statistically significant positive results. Fathers in the **Prio Baba** program in Bangladesh reported increased use of several positive parenting techniques, such as redirecting their child's attention when they misbehaved (16 percent at baseline versus 33 percent at endline).[l] Men's survey results in **Program P-ECD Lebanon** showed they held more supportive attitudes regarding positive discipline (e.g., using encouragement as a reward) at endline than at baseline; women's results did not show a similar shift, which may be because women's baseline attitudes were already strongly supportive of nonviolent parenting approaches.[22] The **Bandebereho** RCT results in Rwanda found that mothers, but more especially fathers, who participated in the intervention were more likely to use positive parenting practices (such as explaining why the child's behavior was wrong) compared to the control group.[m] The fourth program – **Program P Bolivia** – did not see statistically significant improvements for the entire sample of participants, although the RCT results did find that women with higher levels of education reported a modest increase (4 percent) in the likelihood of using positive discipline methods after participating in the program compared to mothers with lower levels of education.[23] Qualitative findings indicated some moderate changes occurred among participants, such as participants reporting the value of more constructive communication skills to discipline children rather than resorting to harsh punishment, although they still found positive approaches difficult to implement at times.[24]

Three of the four programs that measured and reported the prevalence of physical violence against children found reductions (Prio Baba, Program P-ECD Lebanon, and Bandebereho), although other forms of harsh discipline may have persisted. For example, the **Bandebereho** RCT found that the intervention group reported lower rates of physical punishment of children compared to the control group – for both men

(58 percent versus 67 percent) and women (68 percent versus 79 percent) – despite having only one session on violence against children and positive parenting.[29] Similarly, in **Program P-ECD Lebanon**, the reported use of physical discipline with children declined significantly for both men (from 65 percent to 45 percent) and particularly women (from 82 percent to 26 percent).[22] Endline evaluation results from **Prio Baba** found that the proportion of fathers who reported they had spanked, hit, or slapped their child on the bottom with a bare hand in the past month dropped from 51 percent at baseline to 28 percent at endline; however, there were mixed results regarding emotional violence, as fathers reported a decrease in calling their children names like stupid or lazy but an increase in shouting or yelling at their children.[n]

The fourth program (Program P Bolivia) also reported some positive changes, albeit not statistically significant ones, with qualitative evidence again providing a more nuanced picture. The RCT for this program found that female participants who worked outside the home at baseline reported a 13-percentage-point decrease in the probability of using physical punishment, while those who didn't work outside the home at baseline reported no change.[23] The qualitative evaluation found that several participants reported learning about the consequences of harsh physical discipline through the program, and this awareness changed how they felt about the educational merits of violent discipline.[24] Moreover, many reported the value of learning nonviolent discipline techniques and self-regulation skills to prevent anger from escalating. However, participants said it was challenging to not use harsh discipline to reassert their authority as parents; for example, some parents no longer used whips (*chicotes*) but continued to threaten their children with physical violence. Additionally, some parents found positive discipline difficult to implement regularly. Facilitators said parents' use of religion to justify physical discipline against children made it difficult to challenge this social norm.

Program evaluations also revealed qualitative evidence of improved parent-child relationships because of the interventions. Qualitative findings from the evaluation of **SHOW Ghana** showed that, across genders and ages of children, participants reduced the traditional emotional distance between fathers and children.[26] Women said their children were happier due to seeing improved peaceful relations between their parents, and respondents across all categories described fathers as more dedicated to their children and more approachable. In **SHOW Nigeria**, women offered consistent positive feedback on improved spousal and family relationships, stemming from changed behaviors of male heads of households that open space for communication, involvement, and closeness.[27] Separately, qualitative data from **Bandebereho** also found that the program contributed to improved relationships and communication between men and their children, including reducing children's fear of their fathers (as reported by both mothers and fathers).[o]

Overall, the findings indicate that Program P adaptations have considerable potential to reduce violence against children, support parents in using positive parenting practices, and improve relationships between parents and children. To date, many adaptations have had only minimal content on positive parenting, particularly regarding skill-building, due in part to Program P's initial focus on the prenatal period. This suggests there is substantial room for strengthening the curriculum's focus on addressing violence against children to have a greater impact.

5d. Men's Participation in Caregiving and Domestic Work

Six of the seven programs that measured and reported on men's participation in housework and/or caregiving found positive changes in this area, although gendered domestic roles and attitudes often persisted despite increases in men's participation. Notably, one program (**Program P Bolivia**) found no significant impact on gendered distributions of household activities.[23-24] Examples of positive changes include:

- In **Program P-ECD Lebanon,** men and women reported significant increases in men's participation in both housework and caregiving. At baseline, 29 percent of men reported participating equally or taking on the bulk of at least one of three household tasks typically considered "women's work" – washing clothes, cooking, and cleaning – while a smaller proportion of women (17 percent) reported the same about their partners. At endline, around two-thirds of both men (63 percent) and women (67 percent) reported that men were participating in these tasks.[22]

- In **Prio Baba,** men reported they were sharing parenting tasks more with their partners after the intervention, such as talking to their children about personal matters in their lives (29 percent at baseline vs. 44 percent at endline) and helping the child with homework (28 percent at baseline vs. 53 percent at endline).[p]

- In **SHOW Ghana and Nigeria,** fathers, mothers, and adolescent boys and girls in qualitative evaluations said that fathers had started to take on household work and childcare because of participation in the intervention. However, in both Ghana and Nigeria, endline results showed that men's engagement in household and childcare work was still broadly understood as "help," "assistance," or "support" for what was still fundamentally seen as women's responsibility.[26-28]

- **PARENT Portugal** measured and found positive shifts in men's intent to participate in housework and caregiving tasks rather than their actual participation.[31]

- In **Bandebereho,** the RCT found that both women and men in the intervention were more likely to report sharing childcare and household work equally between partners at endline compared to the control group. Men in the intervention group also reported spending 52 more minutes per day on such work compared to men in the control group.[29]

- **Program P Nicaragua** participants reported that they learned how to participate and share household duties and the workshops helped them to dedicate more time to their children and wives.[32]

Bandebereho provides a salient example of how evaluation findings (in this case, related to sharing childcare and household work) can lead to changes in future iterations of the program. While the RCT found positive changes in men's participation in childcare and household work, it did not find that this reduced the overall amount of time women spent on these tasks, with no statistically significant difference found between women in the control and intervention groups. Qualitative research with program participants identified several reasons: Women said they often felt they had to redo men's work, and men's time spent on household tasks freed up women's time – but only to address previously ignored household tasks. Efforts to strengthen the curriculum's focus on care work – including promoting greater couple communication around expectations for care work and highlighting how men sharing care work can support women's paid employment – have been integrated into a revised Bandebereho curriculum that is currently being taken to scale via the health system in Rwanda.

A mixed methods evaluation of the adapted curriculum indicates that it has contributed to greater changes in the gendered division of labor, including reducing women's time spent on household tasks.[q]

5e. Sexual and Reproductive Health & Maternal, Newborn, and Child Health

The four programs that measured attitudes about men's participation in MNCH and family planning found positive results (Prio Baba, PARENT, SHOW, and Bandebereho). **Prio Baba** found the proportion of fathers who agreed that "a man should not accompany his wife to an antenatal care" visit dropped from 83 percent at baseline to 33 percent at the endline, and the proportion of fathers who agreed that "men should not take care of women during pregnancy" fell from 38 percent to 18 percent.[r] Similarly, in **PARENT** Portugal, slightly over half of the men disagreed at the pre-test with the statement "men are not well received in prenatal service"; at post-test, 94 percent disagreed.[31] The **Bandebereho** RCT found positive changes in men's attitudes toward their participation in MNCH, including greater agreement with the benefits of men's accompaniment to antenatal care or childbirth.[s]

Two programs measured and found significant positive shifts in women's and men's behaviors regarding MNCH and family planning (Bandebereho and SHOW). The **Bandebereho** RCT found that women reported attending more antenatal care visits and being accompanied by their male partners to antenatal care more often compared to the control group. It also found greater levels of men's support (e.g., material, economic, emotional, spiritual) for their partner during pregnancy compared to the control group, as well as greater use of modern contraceptives by men (75 percent for intervention vs. 65 percent for control) and women (70 percent vs. 60 percent) at endline.[29] At the time of this analysis, midterm quantitative findings from the five **SHOW** countries also found increased percentages of pregnant women attending antenatal care visits, with all five countries reporting a greater proportion of births attended by a skilled birth attendant and of women attending postnatal visits within 48 hours of birth; in four of the five countries, postpartum use of contraception increased.[t] Fathers, their families, and community leaders in both Ghana and Nigeria were more aware and supportive of male engagement in maternity and family health, and focus groups reported men's greater participation in MNCH.[26-28] These findings show how men's positive engagement as partners and fathers can also result in favorable reproductive outcomes for their female partners and their children's health.

5f. Research and Evaluation Gaps

Several key gaps in the evidence emerged from this review, which present opportunities for future Program P adaptations and other gender-transformative programming to build on prior programs' lessons and challenges. These gaps also present promising avenues for future research.

- **Most Program P adaptations used non-experimental evaluation approaches, with neither randomized selection of participants nor control groups.** Most case studies included in this report were pilot programs seeking to learn about the feasibility of implementing the program in a specific setting rather than using an RCT to rigorously examine causal relationships between the interventions and outcomes of interest. Further, while the number of male and female participants

included in pre/post surveys ranged tremendously across the eight case studies (from 17 to 1,137), the sample sizes were mostly small. Small sample sizes limited the ability to statistically analyze how outcomes changed from baseline to endline, leading to inconclusive results. In addition, multiple studies faced challenges related to retaining study participants at endline, which some key informants connected to respondent fatigue. In addition, only a few programs had multiple implementation cycles. There is a clear need for more long-term implementation and evaluation processes to gauge program effectiveness. Importantly, although most case studies collected responses from women as well as men, women's responses were reported in only a few cases, and it was often unclear whether evaluations asked men and women the same questions.

- **Most programs lacked longitudinal data to assess whether participants sustained attitude and behavior changes beyond the end of program implementation.** Available evidence suggests that some changes, particularly those related to violence against children and power in intimate partnerships, may require more follow-up time to understand whether participants can practice and eventually integrate program ideas into their daily lives, as well as whether early changes are sustained long term. Future evaluations could be strengthened by adding longer follow-up times to the research plan. A notable exception among the case studies is the **Bandebereho** RCT evaluation, which examined long-term outcomes six years after implementation and showed sustained impacts across multiple outcomes.[31]

- **The mechanisms of change need to be explored in greater depth, particularly around the more fundamental shifts achieved by these (and future) programs.** Further quantitative and qualitative research would help to identify the specific program aspects and pathways through which changes in key outcomes (e.g., improved relationships, more equitable distribution of care work, violence reductions, men's engagement in MNCH) occur. Few programs explicitly explored these mechanisms. A key exception is **Bandebereho,** which used structural equation modeling to identify the specific mechanisms through which the intervention reduced physical and sexual IPV. That analysis showed that several mechanisms (not just one) were responsible for the largest proportion of the effects on IPV – more positive couple dynamics, including emotional closeness and communication frequency; men's gender-equitable attitudes; and men's alcohol use.[30] This suggests the holistic nature of the intervention (i.e., its impact on multiple components rather than any specific one) may be integral to its positive impact. Additional exploration is also needed on the role that fatherhood and parenting, which are central to these programs, have in encouraging and sustaining change.

- **There is an opportunity to (better) capture the impact of programs' advocacy efforts to create an enabling environment for men's engagement.** Many of the case studies included efforts to work with government and stakeholders at the national or local levels to create policy or institutional change (e.g., within health facilities), but few specifically sought to measure or document these changes. It would be valuable to explore novel approaches to measure results from policy influence and advocacy efforts (e.g., the passage of relevant legislation, changes in institutional policies) to better capture such change and link them to programmatic efforts that work with individual men and their partners.

6. Adapting Program P

This section presents experiences and findings related to adapting Program P across the eight case studies. It is divided into three subsections: adapting the content (6a); balancing the depth and breadth of content (6b); and engaging government and promoting an enabling environment (6c). It draws upon practice-based insights from interviews with 15 practitioners, as well as qualitative and quantitative evidence beyond the formal evaluations of the eight case studies. Programmatic examples are used to illustrate the key findings throughout this section and those that follow – however, this does not mean that the program mentioned was the only example of a particular practice or experience.

HOW WE DEFINE IT

"Adaptation" refers to the process of ensuring the program strategy, methodologies, and content respond to the sociocultural context in which the program will be implemented. The adaptation process usually starts with formative research to understand the socioeconomic and cultural context, priorities, gender norms and practices, and delivery modality preferences of participating individuals and communities, as well as to gather insights from practitioners and thematic experts working where the program will be implemented. Research informs the specific curriculum content development (as well as any relevant changes to the original content), after which some key activities or all sessions are tested through piloting. Then comes revision, adjustment, and final validation by representatives from concerned stakeholders. Adaptation is necessary to ensure the program content and its delivery are relevant, useful, and effective to the men and women, service providers, and communities they intend to serve.

6a. Adapting the Content

The eight case studies highlighted different approaches and processes for adapting Program P to the local context. Despite these differences, several common themes or key factors for success were highlighted by the practitioners involved.

A prerequisite for effective program adaptation was formative research to identify key issues concerning gender and family relations, fatherhood, and caregiving (and, thus, to guide program development). Focus group discussions and individual in-depth interviews were the most common formative research methods used across the eight programs. Depending on the program's focus and scope, focus group discussions involved men, women, adolescents, health and/or social service providers (including early childhood development professionals and social workers), local experts on masculinity, community leaders and local authorities, and/or government officials. Qualitative formative research provided valuable insights on gender relations and parenting practices in all case studies. For instance, formative research with health

providers helped **Program P Bolivia** and **+Pai's** implementing partners understand their challenges, daily practices, and prior understanding of information on engaged fatherhood. When partners collaborated to interpret and act on the results of formative research, the program benefited from the diverse experiences and expertise among partners and, thus, became more culturally relevant and evidence-driven than if only one partner organization had been responsible for analysis.

Those involved in adaptation stressed the importance of consulting women in the formative research. They highlighted multiple reasons to conduct formative research with women, such as to assess whether women want their male partners to participate in a parenting or relationship-strengthening program; to identify any concerns they may have (and, thus, be able to address them); and to identify key topics to include in the curriculum content so that it resonates with the gender dynamics in their lives and their desires regarding men's engagement. One good practice appeared to be complementing programming for men's increased caregiving with content supporting women's ability to exercise agency. Informants also emphasized the importance of engaging women in critical reflection exercises on gender norms, power, and decision-making in relationships and parenting within the program. Formative research was a critical method to assess the best ways to engage women alongside their partners, on which topics, and key barriers to working with couples.

Partners usually followed an iterative process to develop the program or select relevant curriculum content, informed by the theory of change and once key goals were determined. In several cases (**Program P Bolivia, Bandebereho,** and **Program P-ECD Lebanon**), workshops were held among program design and implementation partners, including facilitators and other program staff. The decisions and feedback from these workshops were used to draft or finalize the curricula in these different settings. For example, **Bandebereho** held a weeklong workshop with all staff involved in the project, about 25 people. These workshops were a fun and iterative process of trying out activities by facilitating them among staff members, discussing what worked and what didn't, ranking the activities, and documenting feedback.

Partners invested considerable time in adaptation, with most adaptation processes lasting six to 18 months. For instance, **Program P Bolivia** took six months, **Program P Nicaragua** and **Bandebereho** took eight months, and **Program P-ECD Lebanon** took 18 months. Successful programs evolved over longer-term engagements with communities and government institutions, and in these cases, the intervention priorities and content delivery methods were collaboratively defined. These more balanced and collaborative processes usually took about one year, or longer, to develop a locally grounded and validated curriculum or program. Among the case study programs, **Bandebereho** and **Program P-ECD Lebanon** were considered optimal in length within their contexts because the partners involved had time to go through the different phases of adaptation together.

Programs needed to involve people from the community in co-creation and adaptation to be able to promote social change that communities saw as valuable. Their insights and feedback were critical to determining whether the program content, strategies, and messages would resonate and realistically reflect issues they wished to address within the context, as well as whether the operational and delivery aspects worked for them (e.g., when and where sessions would take place). Where community members were not meaningfully engaged in shaping the program, the program's influence was more likely to be limited. For instance, while **SHOW** prompted some fundamental shifts in gender-related attitudes and behaviors, the program's ability to transform ingrained gendered power dynamics could have been partly inhibited by not developing a stronger involvement of participating communities during adaptation. As gender advisors closely involved in the program design acknowledged, one limitation of international development programs is that organizations come to communities

with "pre-baked" sessions (i.e., sessions that were designed outside of the intended implementation context and have not been validated or adapted to suit the unique needs and capacities of a certain population, location, or cultural context), as well as definitions of "gender," "equality," and "progress" that may not take into account how the intended participants might interpret these concepts.

Successful programs involved many stakeholders working closely together from the start of the adaptation process, with a spirit of mutual learning and exchange. Stakeholders included Equimundo, partner organizations leading the implementation, participating communities, government representatives, and thematic experts. Such partnerships enabled mutual learning and were more likely to create a program that resonated locally, could be effectively implemented, and could make a difference in participants' lives and communities. Collaborative partnership between organizations that shared common principles and goals was a key determinant of effective design and implementation in several case study programs. In programs such as **Program P-ECD Lebanon** and **Bandebereho**, Equimundo and the respective local partner organization (ABAAD and RWAMREC) had relationships with balanced decision-making roles based on mutually defined terms of collaboration, as well as a longer-term vision, with prior collaborations and/or ongoing commitments to pursue common medium- to longer-term goals beyond the Program P adaptation process. In partnerships between a global organization (such as Equimundo) and partner organizations in Global South countries, the global organization offered practice-based knowledge from other settings, a deep understanding of the program and its logic, and help maintaining the core components and methodology. Local partners ensured the program was contextually relevant, engaging, and responsive to their communities' needs and lived experiences, and they proved invaluable in co-creating content and modalities to deliver the program in innovative and creative ways.

By sharing a mission to advance gender justice, partner organizations could co-develop culturally responsive curriculum content and methodologies, participant engagement strategies, and facilitator training approaches. For instance, the **SHOW** implementing partner, Plan Canada, had a clear gender strategy informing its programming in all areas, a dedicated gender team, and a relatively high level of gender sensitivity among country-level program staff. Informants noted that much of SHOW's success could be credited to Plan Canada and Equimundo's shared commitment to gender equality as a foundational objective. When the partners working together to adapt a program share core principles and goals, these inform and support gender-transformative program design and implementation and enable mutual learning. This also facilitates the process of engaging participant communities to question gender inequalities, roles, and norms.

Several programs established technical review committees or partnered with organizations that had technical expertise in a new or specific area. For instance, at various points during curriculum development and validation, **Program P-ECD Lebanon** consulted with child development experts in the US and Lebanon via its technical review committee as new content was added on positive parenting to promote early childhood development. In Portugal and Italy, **PARENT** partnered with an organization specializing in early childhood development (the International Step by Step Association) to create new content in this area. For **+Pai** in Brazil, Instituto Promundo partnered with an organization that specialized in working with men who had perpetrated violence against women, and in **Program P Nicaragua**, grassroots organizations working on community health, youth development, and women's rights were central to creating a relevant Program P curriculum. For **Prio Baba**, the Centre for Men & Masculinities Studies worked with Engage Men and Boys Network members in Bangladesh to discuss the project and shortlist ten network organizations that were present and highly respected in communities. These project partners were crucial to helping the center understand community priorities, taboos, language specificities,

and cultural references they needed to consider for the implementation sites. These local partners also helped recruit facilitators and the participants for fathers groups, which contributed to participants' acceptance of the program. **SHOW Nigeria** engaged religious leaders who were respected by the general public and government in co-creating and reviewing the curriculum. These leaders also advocated for the program's key messages in mosques and encouraged people to talk about those topics.

Piloting the initial curriculum with a small group of community members before larger-scale implementation, or the case study program itself serving as a pilot for future scale-up, was also critical to successful adaptation. These pilots created an opportunity to test the sessions to see if the activities, language, and messages resonated with members of the participating communities. **Bandebereho** and **Program P-ECD Lebanon** both used a five-day pilot, in which couples went through the entire curriculum and gave feedback on every session. These sessions allowed program staff and facilitators to test the curriculum in context and allowed participants to share their feedback and influence the final curriculum before implementation.

Another common theme among effective adaptations was continuous monitoring of implementation to further refine the program. PARENT had to significantly adjust its program delivery in the face of the COVID-19 pandemic, with PARENT Portugal adapting its curriculum for fathers, health professionals, and education professionals to be implemented virtually. Male participants in **Program P Bolivia** found it challenging to attend all sessions due to busy work and caregiving schedules, migration, lack of free time, and difficult living conditions. Facilitators offered one-on-one sessions at their homes or workplaces after they had participated in at least five group sessions. This adjustment allowed facilitators to cover topics that participants felt more comfortable discussing in intimate conversations or smaller groups. However, it may have also been a disincentive for men to continue attending group sessions, undermining a key aspect of what makes the methodology effective. **SHOW Nigeria** found that religious leaders and participants with high literacy levels dominated some group discussions, so facilitators responded to the literacy gap by removing the need to write things down in group discussions. **Bandebereho** increased the number of couples' sessions over time – from six to eight and later ten – based on continuous feedback from participating men and their partners requesting additional sessions for couples.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TYPES OF PROGRAM ADAPTATIONS

Looking across all eight case studies, we found five main types of adaptations made by partners:[33]

1. **Cultural adaptations** involved systematically modifying program content to ensure the program's language, illustrations, and cultural references were relevant, engaging, and compatible with the program participants' cultural context. For example, the multi-country **SHOW** program faced the challenge of developing a manual with images that were culturally appropriate across multiple country contexts. **Program P Bolivia** designed special illustrations depicting Indigenous women and men in their everyday clothes to accompany the manual's participatory activities, and **Prio Baba** had traditional musicians compose lyrics affirming gender equality. For **Prio Baba** and **SHOW,** staff recognized from formative research the importance of showing that Islam does not forbid women's empowerment and men's participation in household chores, and they included relevant passages from the Quran in program content to make gender equality messages more salient for participants.

2. **Issue integration** meant including new, contextually relevant topics as a primary focus. For instance, many programs (**Program P-ECD Lebanon, Program P Bolivia, PARENT,** and **+Pai**) added skill development activities on positive parenting and positive discipline to their curricula. **Bandebereho** added women's economic empowerment content in the scale-up of the program and enhanced the content on violence in both adaptations, while **SHOW** added a session on child, early, and forced marriage.

3. **Implementation innovations** consisted of implementing the group education curriculum alongside complementary interventions rather than as a standalone methodology to create a synergetic effect across the program (e.g., in **SHOW** and **+Pai**). A few programs added a dedicated set of women-only sessions (**SHOW Nigeria** and **Program P Bolivia**), expanded the number of take-home activities, and added behavioral incentives to practice skills in between sessions as part of the manual (**Program P Bolivia**) or to promote reflection on gender relations, power, violence, and women's empowerment. **SHOW Ghana** identified low literacy as a barrier to participants' attendance and developed a low-literacy version of the manual (i.e., more visual, simpler language, more games, and activities), based on community members' suggestions. It also engaged traditional and religious leaders, elder women (i.e., queen mothers), and health workers alongside men and women to create a broader supportive environment through synchronized messaging.

4. **Identifying activities for use in certain sub-communities or age groups** (such as refugee or migrant populations, Indigenous populations, low-literacy individuals, or conflict-affected populations) also occurred. **Program P-ECD Lebanon**, for example, had to adapt some activities for Syrian refugee populations living in tents in camps, as some parenting approaches were not feasible – such as separating two bickering children into different rooms.

5. **Aligning program content** to specific national health policies and including information about national laws against gender-based violence also took place for several programs (**Bandebereho** and **PARENT**).

ACCOUNTABILITY TO WOMEN AND TO CHILDREN'S WELL-BEING THROUGHOUT THE ADAPTATION PROCESS

Organizations focused on engaging men and boys can make valuable contributions to the field of gender equality, including related to greater participation in hands-on caregiving. But these organizations must understand how this work can support – or compromise – the overarching goal of advancing the rights of women and girls, and of all children. Organizations that engage men and boys are responsible for ensuring their involvement in the gender equality field does not unintentionally reinforce unequal power dynamics and is synchronized with work on women's and girls' empowerment.[34]

When planning new initiatives or adaptations, organizations that engage men (for example) in promoting reproductive, maternal, or child health should consult with and be accountable to women's rights organizations and activists. Accountability to women's rights organizations should be a central component of the adaptation process, beginning from the planning stage and continuing throughout implementation, evaluation, and the use of findings in advocacy and other efforts. Concrete steps include consulting and seeking feedback from organizations working to advance women's rights in the communities where the program is being adapted from the outset (e.g., key issues constraining women's agency within the family and community, concerns about potential backlash if the program encourages challenging restrictive gender roles). In doing so, it's important to understand that women's groups may often have limited interest in working on male engagement in caregiving, as well as scarce resources to adequately enable a fruitful collaboration.

While the eight case study programs included in this brief took some essential steps toward ensuring accountability to women (e.g., engaging them in formative research and programming, ensuring that referrals to gender-based violence services were available to participants if needed), there is room for improvement in terms of long-term partnerships and power-sharing. However, we must note that assessing the case studies' efforts to ensure full accountability to women and children's rights groups was not within the scope of this study.

6b. Balancing Depth and Breadth of Content

While the eight case studies shared many common themes, they also varied in terms of program content and how deeply they addressed particular themes or content. Selecting the range of topics for an adaptation often depends on the outcomes of interest for the partners, funders, and other stakeholders (such as government institutions), as well as contextual factors such as a community's level of awareness on a topic.

Key informants highlighted the tension between trying to keep curriculum content relevant to the program's core interest and managing stakeholders' desire to add additional themes. Having too many topics is detrimental because participants cannot explore all the themes in sufficient depth. Many case study programs limited themselves to three or four central themes and organized their manuals into sections, with two or three sessions focused on each theme. Certain themes were threaded throughout the entire curriculum so they became self-reinforcing and participants could see links across topics. **Program P-ECD Lebanon, Bandebereho,** and **Program P Bolivia** all had sessions specifically focused on gender, masculinity, and power, but those topics were also integrated throughout all the other sessions as well.

For instance, sessions talking about corporal punishment and positive parenting contained discussions of gender, masculinity, and power, which reinforced the centrality of those themes in different areas of the participants' lives.

A few programs limited the total number of sessions to address retention challenges or removed sessions with themes that were considered taboo in their implementing context. Key informants felt the limited dosage may have contributed to a lack of depth, particularly regarding power dynamics in relationships and opportunities to practice couple communication and positive discipline. Some informants felt strongly that reducing the dosage too much would hamstring the comprehensive theory of change, but others felt that reducing the number of sessions could be ideal if the program was more focused on a smaller number of themes and privileged quality over quantity. In any discussion of shortening a program, though, it is important to focus on the program's theory of change and consider how the sessions link together logically.

It is also important to be humble and realistic about how much change is possible for participants to experience over the course of the program. Informants stressed that programs should have more modest expectations in terms of what shifts are possible within a context of centuries-old traditions that are deeply rooted in childhood and social conditioning. Although gender-transformative parenting programs like Program P often constitute a huge step to start engaging men in advocating for women's rights and gender equality, these programs alone are insufficient to sustain change. Ideally, programs should provide opportunities for continued individual and community reflection and refreshers on newly learned and/or adopted skills, behaviors, and norms, and they should be complemented by broader structural initiatives to transform norms and institutions.

Programs sometimes faced challenges in reaching and retaining men but had to adapt because of difficulties in sustaining men's participation during sufficient program dosage. Several programs found alternative methods to engage busy participants: for example, by meeting individual men at their homes or workplaces (**Program P Bolivia)** or groups of men in other spaces where they already convene. **Prio Baba** organized discussions in tea stalls, for example, and **Program P Nicaragua** organized football meets and facilitated dialogues with men afterward. Poverty and food insecurity, complex emergencies (such as civil unrest), environmental disasters, and disease outbreaks normally prevent participation in parenting programming, and these emergencies can also hinder organizations' ability to implement effectively. Challenges reaching the desired target population (typically, men) or implementing the program with a sufficient dosage (e.g., donor requirements to reduce the number of sessions) might also mean it is best to reevaluate before moving forward with implementation.

A common request from donors and government partners (and, sometimes, participants themselves) was to shorten programs. However, learning from these case studies and other violence prevention programs suggests that cutting content makes programs less effective. If a program cannot be delivered with sufficient fidelity to its core principles and methodology, implementers should consider alternative methods to engage busy participants through complementary spaces where they already convene.

6c. Engaging Government and Promoting an Enabling Environment

Many of the case studies included some level of government engagement– at the national and/or local levels – whether involving them directly in adapting or implementing the program, training service providers to create an enabling environment, or advocating for key law or policy changes.

Working closely with government and the public health sector during adaptation, and engaging them early in the process, was critical to gaining support and buy-in for implementation across several programs. SHOW Nigeria had to be validated by the Ministries of Health, Women's Affairs, and Local Government and the Sultanate Council (the lead religious group). Government representatives, the Sultanate Council, and all implementing partners provided input and validated the curriculum in a full-day workshop. In particular, the Sultanate Council's involvement was pivotal for adopting the health curriculum at the national level; the council was involved in organizing health provider training at the state and then local levels and could ensure that gender-responsive service delivery and the importance of engaging men were infused into the technical training of health providers. Indeed, of the five SHOW countries, Nigeria was the only one to actively adopt that curriculum for the nation's health providers due to the close partnership with key government bodies.

In Rwanda, the Ministry of Health had to approve the **Bandebereho** curriculum, and the Rwanda Biomedical Centre (implementing arm of the Ministry of Health) participated in adapting the curriculum, observed the curriculum piloting, and validated the final version after several revisions. This close collaboration, from the beginning of program adaptation, was critical to the success of its early implementation and to Bandebereho's ongoing scale-up through the country's health system. The program also worked closely with leaders at the district and local levels, collaborating on both the technical and operational sides to enable implementation. This crucial to gaining the buy-in needed for the current scale-up of the program.

One of the core strengths of the **+Pai** adaptation in Brazil was building on Instituto Promundo's longstanding relationships, such as with the Ministry of Health at the national and state levels, leading to changes in health sector policies. They included early childhood development partners, members of the breastfeeding movement, and health ministry partners at two key moments of adaptation: during needs assessment and during validation of the final manual. Based on this experience, the **PARENT Portugal** program deliberately engaged with the Portuguese Ministry of Health from the very beginning of the project. Moreover, generating compelling data analysis on the benefits of engaging fathers and evidence of program effectiveness (e.g., *State of the World's Fathers*,[13] **Bandebereho** impact evaluation) and sharing this evidence with policymakers strengthened the relationships between case study programs and institutional partners.

Many programs sought to create an environment that welcomed men's participation in MNCH, specifically by engaging health providers to change institutional practices that typically exclude fathers. Several programs (**+Pai, Program P Nicaragua, PARENT, Bandebereho**, and **Program P Bolivia**) conducted formative research with health providers and institutions to identify obstacles and opportunities to bring men into health facilities to support MNCH. The strategic entry points that were identified later proved important to garner support for program implementation. **Prio Baba, +Pai** in Brazil, **Program P Nicaragua**, **Bandebereho**, and **Program P Bolivia** sensitized health providers in the primary health facilities where Program P was being implemented or in their catchment areas. Specifically, programs

encouraged health workers to welcome the men accompanying women to facilities, ensured these workers were aware of how they could support equitable decision-making and fathers' positive participation while always prioritizing women's needs, and ensured they did not undermine women's agency.

Across the case studies, health professionals helped make institutional practices more welcoming to fathers by organizing groups focused only on fathers or signaling dedicated friendly spaces specifically for men's use. Several programs (**+Pai** and **PARENT**) conducted participatory group education sessions with health professionals, which helped them adopt less restrictive individual attitudes and daily practices and, thus, avoid reproducing harmful behaviors and support men's increased positive engagement in MNCH. **Bandebereho** gave health providers a one-week gender-transformative training on promoting men's engagement in MNCH and providing youth-friendly SRH services.

The program also invited a number of these trained professionals to co-facilitate two group education sessions for couples (on pregnancy and family planning) alongside the Bandebereho facilitators. During these sessions, participants could ask questions they might not normally feel comfortable asking during a health visit, and they established relationships with health providers. This safe space forged links between the health providers and participants (particularly men), which helped to remove barriers – such as fear, anxiety, or lack of familiarity – to men's (and women's) participation in MNCH and family planning services.

Developing alliances, across and within broader networks or communities of practice, and mobilizing stakeholders around fatherhood and caregiving were critical to achieving policy change for several programs. A common insight shared by those involved in engaging stakeholders for policy change was that rallying forces around fatherhood and caregiving was a strategic entry point to advancing dialogue to promote gender equality in settings where gender or gender-based violence prevention were threatening concepts.

The **+Pai** program found the MenCare campaign's fatherhood and caregiving aspects increased the visibility of and receptivity to those topics. In Brazil, fatherhood was used as an entry point to advocate for other issues related to gender inequality and violence that were otherwise challenging to place on the public agenda.[36] Instituto Promundo joined efforts with the Rede Nacional Primeira Infância (National Early Childhood Network), which brought together more than 200 research, public, and non-governmental institutions in Brazil, to create a Men for Early Childhood working group to influence the policy dialogue around engaging men in caregiving, strengthening the national campaign "*Pai não é visita*" ("The father is not a visitor"), increasing the days of parental leave for fathers within national parental leave legislation,[u] and strengthening health providers' capacity to engage men. Collaboration within and across national networks was a strategy for ensuring sustainability,[35] and these networks have flourished in the years since the working group's inception and led to men's caregiving having increased visibility, as well as a plethora of new civil society initiatives (e.g., via vlogs, YouTube, and Instagram).

Program P in Nicaragua identified the Ministry of Health's new humanized birth policy as a strategic public policy that required engaging men as supportive fathers during delivery.[v] The program allied with national civil society partners and worked with the Ministry of Health to support the dissemination and implementation of the policy.[36] Partners in Nicaragua jointly developed national campaigns to support engaged fatherhood, as well as research to understand barriers preventing men from participating in their children's delivery. Across the country, the program also trained community health workers, NGOs, and teachers sent by the Ministry of Education to implement Program P sessions. After this, the Ministry of Family responsible for child

protection and family support services requested that Program P be offered to men who faced legal consequences for not paying court-ordered child support.

Another key component of success was fostering an enabling environment to support men in taking on previously stigmatized roles (those traditionally seen as feminine), as well as to support women in practicing agency on issues considered "men's entitlement." Informants from all case study programs emphasized the importance of working to promote this supportive environment among participants' reference groups and relevant institutions, with the goal of these groups contributing to and gradually "owning" the process of promoting men's engagement for gender equality and against violence in their families. Several programs used a multi-component strategy – working at the individual, family, community, institutional, or policy levels – to bolster practices and norms that were supportive of gender equality as promoted by the interventions.

For instance, men who actively engaged as fathers in the **SHOW** program said they gained respect in their neighborhoods, the combined result of the normative shift initiatives involving community and religious leaders, spouses, adolescent children, and healthcare workers. Changing perceptions among these key groups positively influenced community expectations and practices related to fatherhood. Media campaigns were a component of many programs (such as **Prio Baba, +Pai, SHOW,** and **Bandebereho**). Programs used messages shared via video, radio, and print media (e.g., posters, pamphlets) to foster dialogue about fatherhood and contribute to a supportive, enabling environment.

7. Facilitating Program P Implementation

Despite being diverse in many ways, all eight case studies emphasized the importance of getting the right facilitators as a key element of success. They also highlighted lessons on how to train and support facilitators so that they can help participants develop critical consciousness around harmful gender norms, build and practice skills such as communication and conflict resolution, and develop within the group a sense of solidarity and belief in their ability to enact positive changes.[37] This section outlines the learning captured in this regard, it is organized into two sections: selecting facilitators (7a) and training and technical accompaniment of facilitators (7b).

7a. Selecting Facilitators

Depending on the program's needs, facilitators were typically selected from among partner organization staff, health providers or health educators,[w] civil society organization staff, or peers. There are benefits and challenges associated with each type of facilitator. For instance, Equimundo and/or partner organization staff are typically fluent in gender equality topics and experienced in participatory facilitation, but they may struggle to communicate with and be accepted by members of the local community. Health providers can bring expertise and authority on a range of health topics and may be trusted members of the community, but they may have intense time constraints and require additional training to facilitate participatory conversations rather than didactic education sessions.

A NOTE ON "ROLE MODELS"

While it is beneficial for skilled facilitators to demonstrate their alignment with the gender-equitable attitudes and behaviors that the program seeks to develop in its participants, there is always a risk that community facilitators may be put on a pedestal as infallible "role models." **But facilitators are human and can make mistakes. For this reason, former program staff encouraged partners to step away from calling facilitators "role models" or "role model couples."** These terms set unrealistic expectations for those individuals: If facilitators make mistakes, such as having arguments with their partners, it may make participants and community members doubt the benefits of the gender equality program.

Examples from the case studies demonstrate that selecting certain types of facilitators can be a strategic choice to make the program more relevant and valuable to participants. For instance, as part of **SHOW Nigeria**'s approach, some sessions were facilitated by local religious leaders with prior engagement in MNCH projects. Some programs had both male and female facilitators, some had only male facilitators, and one had only female facilitators – all three approaches were successful depending on the context. Programs chose to work with facilitators of certain genders based on insights from prior experience and formative research about what would be best received in their implementation context, as well as based on the existing gender breakdown of trained program staff.

Several programs found success working with peer facilitators or local civil society staff already living and working in the community. Facilitators who were respected community members and understood the local context might have been more easily trusted and, therefore, better able to recruit participants; they might have also found it easier to implement the sessions due to their proximity and knowledge of existing resources. For instance, facilitators in **Program P Bolivia** lived in El Alto and knew the realities, multiple adversities, and social norms in which the participants were embedded. **Bandebereho** selected local fathers from the couples who participated in the initial curriculum pilot to be facilitators.

In both countries, local facilitators felt motivated to carry the program forward in their communities and were able to build trusting relationships with participants. They were also able to speak directly to how they had benefited from the program. This led to increased participant attendance and engagement, as well as sustainability. For instance, in some cases, facilitators continued discussing program content with the community or with grassroots parenting groups even after the official end of implementation.

The case study programs show it is vital to recruit facilitators with personal qualities and skills that enable participatory, experiential, and power-balanced group dialogue and interaction. Many facilitators were parents themselves and had personal characteristics such as being a respectful listener; the ability to make others feel safe, included, and comfortable discussing sensitive topics; empathy; the ability to respond constructively to challenges; open-mindedness; and being friendly, engaging, and nonjudgmental. Men need to trust that their voices will be heard and valued, which is why facilitators must be able to manage power imbalances resulting from different literacy levels, socioeconomic positioning, or levels of community influence.

Key informants emphasized skills such as the ability to facilitate participatory conversations and respond to difficult questions, and these skills could be developed or strengthened with training. While facilitators ideally had some experience facilitating or working on gender equity, programs also found success in training and supporting peer facilitators or health providers without such experience. When program facilitators across the eight case studies possessed relevant skills and received quality training and support, they were more likely to foster shifts in attitudes and behaviors among program participants. Facilitators often received specific training on how to encourage open dialogue and challenge gender-inequitable ideas. For instance, facilitators of **Program P-ECD Lebanon** were supported until they felt confident in guiding conversations on challenging topics and ensuring a "do no harm" approach was followed to protect women participants.

7b. Training and Technical Accompaniment of Facilitators

It was important to engage future facilitators in critical reflection and provide opportunities for them to practice facilitating participatory group discussions prior to starting the program. This included ensuring facilitators' understanding of curriculum content and gender, power, and masculinities. Facilitator training needed to provide guidance and ample opportunities to practice group discussion facilitation techniques, such as getting to know the participants in the session, understanding the realities of participants' lives that may create challenges or risks as they try to change attitudes and behaviors, and encouraging participants to work through challenging emotions. Additionally, training emphasized the importance of fostering inclusion and ensuring that all participants have the opportunity to speak.

Particularly for facilitators who are health providers, as in **Program P Nicaragua**, it was important that training enabled them to share scientific information about the benefits of men's engagement in reproductive, maternal, and child health and early childhood development, grounded in an understanding of gender and power relations. Facilitators were most successful at applying Program P's participatory group discussion methodology when they had been trained on how to motivate participants to engage and learn from each other, critically examine harmful norms around masculinity, question their own prejudices, and reflect on the implications for their lives and those of people they love. When training future facilitators on these topics, the eight case study programs typically used training approaches such as participatory and reflective group activities, observation of skilled facilitators, and facilitating mock sessions with feedback from peers and trainers.

Sufficient time had to be allocated for the initial training and for ongoing mentorship, supervision, and technical accompaniment of facilitators. The number of days allocated for initial facilitator training varied across the eight case studies, from two full days (**Prio Baba**) to ten days (**Program P Nicaragua** and **Bandebereho**), with most training averaging five to seven days. After the completion of initial training, facilitators needed ongoing support to thrive in their roles. Training in these Program P adaptations often involved shifting facilitators' attitudes, and consistent, sustainable, and structured support to understand and practice nuanced gender-transformative concepts. As implementation proceeds, program staff must be able to dedicate the necessary time and resources to regularly assess the extent to which facilitators

HOW WE DEFINE IT

This section explores how Equimundo and/or partners provided **training and technical accompaniment to facilitators** and supported them in developing skills. The facilitator's role is to promote critical reflection and learning, present information about the themes covered in a neutral and nonjudgmental manner, and create a safe space where balanced power and a horizontal learning experience encourage participants to learn from each other and from their active participation in the activities.

A key aspect of effective training is guiding future facilitators to examine their own views, assumptions, and prejudices and to be aware of these to avoid bringing them to the group discussions. Learning how to facilitate gender-transformative, curriculum-based discussions requires training facilitators more than once. Ideally, after five- or 10-day initial training, facilitators receive refresher training: regular opportunities to debrief about their experiences, share challenges and how they are addressing them with their groups, and receive advice and supportive supervision.

are following activity guidelines, the level and quality of participant engagement, any potential increases in gender-based violence or signs that women's safety or access to services may be compromised, and signs that facilitators may be experiencing vicarious trauma[x] or emotional distress caused by exposure to participants' testimonies.[38]

In addition, program staff should have the skills and bandwidth to give guidance to individual facilitators and respond to widespread issues that require comprehensive solutions (e.g., the need for a low-literacy manual for facilitators in **SHOW Ghana**). Although ongoing support for facilitators is essential to the program's success and the confidence, safety, and well-being of facilitators, most programs underestimate the degree of support that will be needed or are unable to secure sufficient funding to enable this degree of support.

Several key informants recommended facilitators be trained directly by program originators/adapters rather than through a cascade training model. Where Equimundo was involved in the adaptation, partner organizations highlighted the benefits of close collaboration in conducting the facilitator training, with support from staff with a diverse range of expertise and experience. In one case (**SHOW**), Equimundo and partner organization staff conducted an initial "training of trainers" session; these trainers then had to rapidly, and sometimes in addition to their full-time responsibilities, train a group of additional facilitators through a "cascade training" sequence rather than direct training.

The cascade training model can enable many facilitators to be trained over a larger geographical spread, but it risks losing nuance and quality if not enough time and preparation are devoted to training at each level. For example, SHOW program staff realized during monitoring that many facilitators who had not experienced direct training were not truly adhering to the curriculum. The program required refresher training to support the facilitators who had not experienced direct training by program developers (Equimundo and Plan staff). Further, it was difficult to trace where in the cascade discrepancies arose. For these reasons, cascade models of training are not recommended; instead, facilitators should be trained directly whenever possible.[y]

Several programs provide valuable examples of supporting facilitators with special accommodations (e.g., language, literacy) and giving them the tools to make sessions inclusive of people with disabilities and other community members who might otherwise have difficulty participating. In **SHOW Ghana**, the facilitators' literacy levels varied. Therefore, the program developed a low-literacy manual with illustrations to support them and address this challenge. Moreover, the program produced a Braille version of the facilitator manual to accommodate a visually impaired facilitator, and the facilitator received feedback via audio recordings of facilitator sessions. Facilitators must also be prepared to ensure the inclusion of all participants. For example, the **Bandebereho** manual currently being used in scale-up includes concrete suggestions for making sessions inclusive of participants with different types of disabilities, although there is still much to do to make the sessions fully inclusive.

Several programs noted that maintaining facilitator morale was a challenge. For instance, facilitators in **Program P Bolivia** were sometimes overwhelmed by the pressure to meet program objectives, the difficulties of encouraging participants to attend sessions, and the stress of witnessing the extreme deprivation many participants faced (e.g., food insecurity, violence, a lack of resources to support children with disabilities). For facilitators' well-being as well as their ability to successfully deliver the program, it is important to provide facilitators with links to mental health providers, in addition to other resources, such as transport, childcare, or community spaces for sharing and healing together.

The case studies highlight the importance of training facilitators on how to respond to and support participants (especially women) who may be experiencing violence from their partners in the home or problems in other areas, such as mental health, substance abuse, or a child's disability. Facilitators needed guidance on how to respond and rely on a list of available resources for participants should they need specialized, survivor-centered mental health or other services. Facilitators should also receive training to familiarize them with local laws on violence against women and violence against children and with survivor-centered principles. Several case study programs gave training and manual guidance on how to support women who are experiencing violence. For example, **Program P Bolivia** trained facilitators on how to respond to participants who were experiencing IPV or mental health issues, including how to do a "warm referral"[z] to survivor-centered or mental health providers;[39] the manual also included guidance on survivor-centered response. **Program P Nicaragua** provided facilitators with a two-day training on "In Her Shoes,"[40] in alliance with a feminist organization (Pathfinder), to build understanding about gender-based violence and survivor-centered response; the program also developed a directory of gender-based violence services for them to connect survivors to services.

It is important to keep in mind that facilitators themselves may be experiencing gender-based violence in their homes. For example, local staff implementing the scale-up of **Bandebereho** recognized that many of the community health workers who were being trained to facilitate the sessions were experiencing violence at home. The program secured additional funding to conduct Bandebereho sessions with all the community health workers involved in scale-up and their partners. This component is continuing under the next phase of scaling.

COMMON TYPES OF ONGOING TECHNICAL SUPPORT AND ACCOMPANIMENT

- **Field visits/supportive supervision:** This involves accompanying facilitators to the field as technical support to assess facilitator strength or as emotional support to boost facilitators' confidence. For instance, some of **Program P-ECD Lebanon's** female facilitators were hesitant to – and a little fearful of – going to speak with fathers in rural areas of Lebanon. Program staff accompanied the facilitators to the first few sessions to make sure they felt supported, could rely on more seasoned trainers to intervene should they need it, and gained confidence in managing difficult conversations. In **SHOW**, program staff made an effort to attend four or five sessions to monitor facilitators' fidelity to curriculum content (using a diagnostic tool) and support the facilitators. For **Bandebereho,** session observations were critical during both the pilot and the current scale-up of the curriculum in terms of assessing program quality and fidelity and identifying facilitators who required additional support.

- **Regular meetings:** These are scheduled sessions convened by supervisors that give facilitators the space to share experiences and address issues. In **Program P Bolivia**, two supervisors met monthly with the team to check progress and help facilitators navigate difficult circumstances, such as the conditions of poverty in which many families were living and problems with participant retention. **Program P Nicaragua** also held monthly meetings with facilitators in each of the three cities of implementation to exchange experiences, challenges, and potential solutions. In its current model, **Bandebereho** holds monthly meetings, using community health worker supervisors as an intermediary between RWAMREC staff and community health worker facilitators. This staff structure enables more frequent support for smaller groups of facilitators. Moreover, some programs organized ad-hoc coaching sessions in which program staff and facilitators had one-on-one or group discussions about their experiences, challenges, and successes working with participants, as well as brainstormed ways to perform better.

- **Peer support and referral to specialized services:** Peer support allows facilitators to discuss experiences, challenges, and solutions together, either in person or virtually via platforms such as WhatsApp. The **SHOW** program had a system for facilitators at the father club level to have a collective quarterly or monthly dialogue, with partner staff present to help with problem-solving. Peer support was important not just for problem-solving but also for self-care and building community. As program managers explained, for facilitators, delving into issues of violence in relationships can bring up past traumas and issues in their lives, or they may experience vicarious trauma from listening to participants' own experiences. It is paramount to have spaces where facilitators can come together to talk about what's happening to them as well, both to promote self-care and to be linked with specialized external services as needed.

- **Refresher training:** Additional sessions can give facilitators more opportunities to practice and recall manual content. **SHOW Ghana** provided refresher training to introduce facilitators to a new low-literacy version of the manual with less text and more imagery, as well as to boost the confidence of facilitators who had limited comfort with reading. Regular three-day refresher trainings were helpful for **Bandebereho** facilitators in both the pilot and the current scale-up via the health system, and program staff in **Prio Baba** believed that a mid-point refresher training would have made their program more effective.

8. Strategies for Male Engagement

The eight case studies demonstrated different strategies for reaching and retaining men and their partners, as well as what worked to create supportive environments in which men felt supported to critically reflect, learn, and practice new skills. This section presents those findings in three parts: reaching and retaining men and their partners (8a); fostering critical reflection and learning (8b); and areas for further learning (8c).

8a. Reaching and Retaining Men and Their Partners

One key strategy for recruiting men was identifying what brought men together: the places where men gathered, the moment in life they shared (e.g., first-time fathers), or activities that drew them together. Facilitators went into the community to meet with men and open informal, participatory conversations about fatherhood and the general topics of the program. For example, program implementers in **+Pai** and **Program P Nicaragua** used football matches and recreational activities (in addition to mobilizing men via health units); facilitators in **Program P-ECD Lebanon** met men in cafes and restaurants; and **Bandebereho** facilitators led community meetings introducing men to the topic and informing them about the program's existence.

When possible, case study programs built on existing spaces where men gathered to discuss parenting topics, such as father's clubs and couples groups. SHOW Ghana built its programming around Daddies Clubs, which have existed in Ghana since 1996 in the form of workplace clubs for family planning. Similarly, **PARENT Portugal** achieved uptake and engagement by delivering program content to existing couples groups

HOW WE DEFINE IT

This section, on **strategies for male engagement**, explores strategies for achieving **uptake, sustained participation**, and engagement of program participants, particularly considering the barriers that often hinder men's engagement. *Uptake* refers to potential participants taking up, making use of, or agreeing to participate in the program. *Sustained participation* involves attending program sessions regularly and completing program activities. *Engagement* involves a deeper level of personal investment. While the findings in this section focus primarily on strategies that worked well to engage with male participants, all programs engaged female as well as male participants to different degrees; further, many of the following strategies may be relevant for participants of any gender.

and maternity groups within health facilities. These approaches facilitated men's engagement because the clubs and couples/maternity groups were seen as legitimate, established practices, and men's receptivity to participating was already high.

Programs also used novel approaches to connect with men. Facilitators of **Program P Bolivia** conducted home visits with potential participants to encourage them and let them sample the activities before they committed to the program. This gave men a taste of the program and helped them agree to participate. **SHOW** produced documentaries with testimonies from male community members who had participated in the program and initially felt stigmatized, but who then started seeing benefits and feeling more respected. A film crew followed these men in their daily lives to gather footage, and then these documentaries were projected to the rest of the community and motivated others to join. In the same spirit, **Program P Nicaragua** produced a publication with men's experiences of learning to be caring and invested fathers, and the protagonists shared their stories in neighborhoods, which motivated other men in their communities.

Highlighting the program's benefits for men, their partners, and their children proved particularly effective, with particular attention to the positive aspects of men's caring role. For instance, men who participated in **Program P Bolivia** appreciated the program's positive framing and benefits-based approach, which were strong motivators for engagement because they had not thought being close to their children's emotional lives was as important as providing for them financially. **SHOW** and **Program P-ECD Lebanon** emphasized that the program could lead to benefits relevant to men at their current stage of life (e.g., balancing work and family life, newborn health, improving couple communication to become better parents). Framing the program around these positive topics, rather than calling out men to "step up" to correct gender inequality or power imbalance or stop using violence, invites men to participate with an open mind rather than become defensive.

It is important to be mindful of potential challenges if men are being recruited through their wives. Some programs (**Program P-ECD Lebanon** and **+Pai**) found it effective to reach men through their wives, who had been involved in other programs. When women are already participating in a program that wants to engage their partners, it is important to first consult these women to ensure they agree and feel safe with their partner's participation. However, some men may be less motivated to attend if their wives were recruited first. Some men recruited through their wives could perceive the program as being focused on "women's issues" and less relevant to their own lives. One facilitator in **Program P Bolivia** suggested that recruiting fathers directly rather than through their female partners would make men more motivated to participate. This is the process taken by many of the adaptations in this review**.** In this situation, formative research with women to understand their needs and desires for men's participation – particularly if the program will engage them together – is important and should assess any concerns or risks associated with engaging men in the local context to inform recruitment and program design.

It is also important to ensure session venues are accommodating and to schedule sessions around participants' work hours and other time constraints that vary by setting. Program P-ECD Lebanon found that scheduling sessions on nights and weekends, keeping sessions short (45 to 60 minutes), and limiting the number of sessions are helpful approaches. **SHOW** scheduled programming at places and times that worked for the participants rather than Plan International staff, which is another reason why it's essential to have local facilitators running the program. **Bandebereho** used an initial meeting of prospective participants as an opportunity not only to confirm men's commitment to participating but also to determine where and when to meet. Bandebereho's minimum session length is two hours, with longer sessions reaching three hours (which is generally acceptable in that context); if sessions happened to exceed this, participants would trickle out one by one before the end of the session.

Providing incentives and compensation can help men (and women) overcome constraints to participation. Men's engagement can also be enhanced by linking the parenting program to economic or in-kind support. For instance, **Prio Baba** and **Program P Bolivia** program implementers saw it as their responsibility to provide snacks at their sessions, as the arriving participants were tired after working long hours. Some earlier cycles of **Bandebereho** provided refreshments and transport fees to enable participants to attend sessions; these were removed during scale-up, but learning suggests that some form of one-time material incentive may also be useful to retain couples when implemented at scale. **Program P Bolivia** offered a basket of household goods to those that completed the program, and some facilitators responded to the challenges of engagement by offering ad hoc incentives, such as a knitted hat or toys for children. The program also found that women had difficulty attending all sessions (although less difficulty than men) due to work and/or family commitments. When mothers did attend, many of them had to bring babies or young children. In qualitative research, some women participants suggested the program should incorporate livelihood skills or provide financial incentives to encourage more active participation, as well as provide childcare onsite. **Program P-ECD Lebanon** provided boxes of aid (e.g., bags of rice, olive oil, cooking oil, diapers, and formula) to male participants who completed three-quarters of the sessions. Men thus saw tangible benefits that compensated for the opportunity cost of attending sessions instead of working for pay. This might have also made them feel like they were fulfilling their role as economic providers by attending the session.

8b. Fostering Critical Reflection and Learning

Trust-building was an important foundation for men's and women's participation and engagement. All informants acknowledged the importance of facilitators' ability to achieve trust, and the facilitator qualities discussed in the prior section can all help create an atmosphere of trust, in which participants feel respected and heard. Additionally, a participatory approach allowing men to speak freely among peers helps these men to bond by sharing personal issues they cannot discuss in other spaces, develop trust in the group, and want to continue attending. Building trust begins from the recruitment stage.

An ABAAD program officer working with **Program P-ECD Lebanon** explained that when facilitators are opening dialogue with men about fatherhood, it is essential to let men feel that you're a person like them. In **Program P Bolivia**, the key drivers motivating men to continue attending sessions were having a space to share with others and an appreciation for the facilitators, both of which created an atmosphere of trust. In **+Pai**, facilitators prioritized sustaining a space where men felt they could talk and know they were being listened to. **Program P Nicaragua** fostered a relaxed atmosphere and trust-building through participatory, playful, exploratory, and hands-on activities, and the **Bandebereho** team acknowledged men's desire to be respected and ensured each participant felt respected, heard, and valued through horizontal relationships and participatory approaches.

Inviting female partners to some or most of the sessions not only helps keep both partners accountable and motivated but also provides an opportunity for partners to develop mutual trust, reflect on how gender roles and power influence their couple and family relationship, and build positive relationship and communication skills. It also provides a safe space to develop a common vision for the family, acknowledge the value of care and domestic work, and renegotiate how to balance it.

Most programs included sessions with men and women together, and several included curriculum content specifically designed for women. **Program P-ECD Lebanon** was among the few offerings in that context that engaged men and their female partners together, as most other programs targeted single-sex groups. Working as couples helped break the stereotype that women and men cannot speak about their problems, helping strengthen the participants' communication and relationship skills. However, the program always held sessions discussing the violence that men have experienced and perpetrated, as well as this violence's consequences and commitments to nonviolent relationships, with men only.

While engaging men and women together can be an invaluable program characteristic, **Bandebereho** found that having an initial session with just men to set ground rules and establish men's commitment was also very helpful when scaling up the program. RWAMREC's field coordinator noted that when men are alone, they are free to talk and criticize and to disclose personal issues happening at the household level, which they would not share in front of women.

Designing experiential group-based approaches that included fun and appealing elements helped engage participants and contributed to their positive changes. In most case studies, the program's participatory methodology, grounded in participants' experiences using structured facilitation guides, created a space for men to share their perspectives with each other; learn, offer support, and receive support among peers; and be accountable on gender equality in their homes. In **Program P Nicaragua**, men helped define program content and messages for graphic and media campaigns, and they shared their experiences in community events with other men like them. **Program P Bolivia** provided detailed guidance and questions for facilitators to motivate critical reflection, as many facilitators lacked experience facilitating community discussions on gender norms and needed detailed instructions and suggestions on how to manage sensitive conversations. The activities focused on participants' lived experiences, and therefore, resonated with their lives and did not feel imposed or culturally inadequate.

In **SHOW**, the participatory and reflective sessions created a sense of collective ownership among the participants, which was something they cherished. In addition to interactive methodologies, male and female participants across the case studies also felt drawn in by flexible scheduling to accommodate their work schedules and program content that was clearly relevant to their lives. For instance, **Bandebereho** ended each session with a hint of what was coming to pique men's interest in the next session. **Prio Baba** integrated dramas, games, and musicians from local communities to make sessions enjoyable, and **+Pai** included activities that men were interested in, such as football championships, plays, and prizes in the health units. For **SHOW,** it was important to ensure the encounters were enjoyable and fun, not dry and tedious informational sessions.

Fostering an enabling environment in men's homes and communities is essential to sustain men's engagement throughout the intervention and maintain their positive attitude and behavior changes. It is crucial to reinforce the program's messages at the family, community, institutional, and policy levels (where feasible) so that participants hear these messages in more than one place. For example, programs with a focus on MNCH partnered with health providers to ensure that professionals were aware of the importance of men's engagement in antenatal care, birth, and postnatal care.

In many cases, training health providers on Program P content made them interested in shifting institutional policies to make health facilities more inviting to men. An informant from **Prio Baba** explained that if the program had only worked with fathers, then men might accompany their female partners to the health facility in accordance with the program, but healthcare providers would neglect them or turn them away. Gender sensitization workshops with health providers created an

environment in which men and women would hear messages about the importance of men's engagement from family planning workers in the public health system, nurses, midwives, pharmacists, and local-level medical practitioners.

8c. Areas for Further Learning

Programs often didn't explore alternative methodologies or strategies that could have been more contextually relevant due to constraints (such as insufficient funding and short time frames) or overconfidence in the original model. Future programs could significantly expand their reach, or reach specific underrepresented groups, by being more open to creativity in content design and alternative delivery modalities. For example, how could programs be prepared to further adapt to the specific constraints of post-conflict or low-resource settings? How could the content and methodologies be adapted to respond to different types of families, particularly LGBTQIA+ or nonbinary couples? How could programs leverage digital technologies and social media to engage fathers beyond the in-person group formats?

It is unclear whether there is a most effective time in the curriculum sequence to introduce the topics of gender, power, and identity (i.e., during the first session, within the first few sessions, or later in the curriculum). There are both opportunities and challenges involved in talking about gender equality early on or later in the curriculum. In **Bandebereho**, the first session in the pilot was directly designed to unpack the concept of gender and societal expectations for women and men – and it was very successful with participants. However, depending on the cultural context, it sometimes may be more effective to delve into critical reflections around gender and power relations after covering less sensitive topics, such as participants' aspirations for their children or their experiences with their own fathers, and after trust is built within the group. In addition, future research should consider the most opportune times to engage female partners in curriculum content and how this can be done safely and with sensitivity to local contexts.

All case study programs primarily relied on text-based materials, and the evaluations identified the need to incorporate more innovative, engaging, fun, and inclusive approaches both during and after interventions. For instance, programs often find that in-person sessions frequently do not appeal to all fathers, particularly at the start of the program, and that they could increase engagement by exploring complementary digital or remotely delivered content and materials, particularly images and video. There is also a need to explore novel approaches to better engage urban parents.

More broadly, programs should consider how they can be scaled to have a larger impact. Scaling up fatherhood interventions to expand program coverage (reaching a larger population or geographic area) while maintaining quality requires that they become integrated into the program delivery of existing institutions (public or nonprofit) and systems that are providing support for parents and families (e.g., social protection, family support, and/or structural poverty alleviation programs).[41] This involves designing the program content and delivery modality with scale-up in mind from the outset (i.e., considering the human and financial resources, organizational capacity, institutional and policy frameworks, and priorities of the setting where the intervention will be implemented). It also requires sufficient long-term resources and time to build the solid relationships among partners that could support a collaborative process of development, identifying the most effective, feasible, and sustainable pathways to scale through piloting, testing, and adaptive learning.

9. What We Learned: Core Components to Guide Practitioners

Findings from this analysis suggest that Program P – when contextually adapted and well-implemented – can contribute to positive attitude and behavior changes. Findings from multiple adaptations show that it has contributed to positive shifts in men's and women's gender-related attitudes and behaviors, particularly on caregiving, MNCH, joint couple decision-making, shared domestic responsibilities, and violence perpetrated by men. In addition to achieving individual-level attitude and behavior change, implementing partners of some Program P adaptations made strides at the policy or institutional level: for instance, by shifting norms within health institutions to support men's participation in MNCH or advocating for national policies to encourage men's use of parental leave. These structural-level changes, as well as stronger positive impacts at the individual level, tended to be possible only when programs were able to enact, to a significant degree, all or most of the core components of success outlined in this brief.

Programs tended to achieve greater impact, be more methodologically sound, and have broader influence across the socio-ecological model when they had more of these core components or carried out these components to a greater degree. Practitioners who wish to adapt, implement, and evaluate gender-transformative parenting programs that engage fathers in different settings globally can find the following emerging recommendations valuable to consider.

HOW WE DEFINE IT

"Core components of success" refers to the program characteristics that appear to have been essential ingredients for a program to achieve its outcomes. Although the eight case studies varied somewhat in the specific themes they prioritized and outcomes of interest, some shared definitions of success include gender-transformative program design and implementation; sustained participant engagement; relevance of the adaptation to the cultural context; sustainable changes within influencing structures and institutions; and an intentional focus on shifting attitudes, behaviors, policies, or laws around enhancing equitable and less violent couple and parent-child relationships, increasing men's participation in caregiving and domestic work, and/or reproductive and maternal health outcomes.

CORE COMPONENT #1:

Develop balanced and long-term partnerships with organizations that share common principles.

In several case study programs, a key determinant of effective design and implementation was collaborative partnership between organizations that shared common principles and goals. Sharing a mission to advance gender justice allowed those developing Program P adaptations to co-develop culturally responsive curriculum content and methodologies, participant engagement strategies, and facilitator training approaches.

- **Invest in developing balanced relationships, in which implementing partner organizations all have equal decision-making roles based on mutually defined terms of collaboration.** Balanced power within partnerships enables programs to benefit from partners exchanging expertise, while working in consultation with the communities they serve, to define what changes they would like to see and what success looks like, thus outlining together the theory of change behind their program. "Top-down" organizational approaches, in which one organization dominates decision-making, should be avoided; these often occur due to the funding of predetermined project logframes to be completed in short time frames and insufficient funding for more balanced co-creation of program content. Such partnership structures typically make programs overly formulaic, less contextually relevant, and less innovative.

- **Seek to build and sustain long-term partnerships.** Programs benefit when the implementing organizational partners share prior collaborations and/or ongoing commitments to pursuing common medium- to longer-term goals beyond the time bounds of the program adaptation process. Long-term partnerships build trust and strengthen program implementation structures and practices.

- **Engage men for gender equality through an intentional approach, centered on a contextual understanding of the gendered drivers of attitudes and behaviors around parenting, caregiving, the use of violence, and harsh discipline.** Ensure alignment between partners, especially those leading implementation, on their organizational commitment to gender equality from a feminist-informed approach. This requires that implementing partners prioritize supporting processes and interventions that question harmful gender norms and seek to redress power imbalances, as well as follow "do no harm" approaches while centering women's needs and priorities.

CORE COMPONENT #2:

Foster strong alliances with government, health, and other sectors to catalyze collective efforts and achieve policy-level changes.

Building strong alliances with government, health, education, child protection, and other sectors was an essential ingredient to programmatic success across multiple programs. Government commitment and strong relationships with the program team helped create support for the program, linking it to relevant policy discussions, which in turn, generated further interest and opportunities that sustained the success of the program.

- **Develop collaborative partnerships** among implementing institutions; professional networks supporting early childhood development, family strengthening, violence prevention, or healthy masculinities; public sectors (such as health and social services), community members; and women's rights organizations and activists from the very beginning of the adaptation process to create an ecosystem of support that can enable individual-, community-, and policy-level changes.

- **Ensure that organizations interested in men's engagement for gender equality assume responsibility for aligning their efforts with, and supporting the efforts of, feminist organizations.** They should create structures of partnership and accountability that are not extractive or burdensome to feminist organizations.

CORE COMPONENT #3:

Commit to a contextualized, engaging, and experiential methodology that is based on social learning and centered on equitable couple relations and men's caregiving.

- **Conduct formative research to identify the key issues that will guide program development and ground the curriculum content in a clear theory of change, being humble and realistic about how much change is possible in the program time frame.** Each adaptation should develop a curriculum and other program strategies that will contribute to specific goals (e.g., changed behaviors and attitudes) by addressing the key normative drivers and providing opportunities to strengthen participants' skills. Prioritize a few central themes that address the adaptation's main objectives and areas of focus (e.g., preventing family violence, MNCH) as articulated in the theory of change, and thread them throughout the curriculum content and learning objectives. To the greatest degree possible, maintain fidelity to the core components of the program being adapted, maintaining the goal of engaging men as equitable, caring, and nonviolent fathers and partners and always prioritizing doing no harm to their female partners.

- **Affirm the program's benefits for men, their partners, and their children, with particular attention to the positive aspects of men's caring role.** It's important that men feel that the language, images, and messages used during recruitment, as well as the framing of the program goals, address their concerns in the context of their lived realities and that this is not a "parenting" program but one that is designed to support fathers like them. Mobilize male participants by identifying what brings them together and going to places where men gather. Identifying commonalities among men (e.g., being first-time expectant fathers or fathers of young children attending the same childcare center, attending the same church, or living in the same refugee camp) is critical to spark their initial interest and foster a sense of belonging based on affinity.

- **Design, test, and refine the program content and approach so that they resonate with participants and are grounded in their specific social and cultural context.** To this end, conduct an operational validation or pilot with a subgroup of participants. Monitor and assess the adapted curriculum throughout implementation, remain flexible, and be prepared to make adjustments as needed based on feedback from participants and facilitators. Activities may need to be modified if participants are not comfortable with certain experiential or role-playing activities or if the case studies or personas used in exercises don't resonate with them, and illustrations may need to be designed to more faithfully reflect how participating men and women see themselves and their environment.

- **Consider starting with several sessions for men and women separately to build trust among the group and then continuing with mixed men-and-women or couples sessions**. A gender-synchronous approach is more effective to shift attitudes and behaviors, build relationship skills, and practice more gender-equal parenting and relationship dynamics.

- **Ensure the program curriculum includes sufficient sessions for learning, reflection, and skill-building to achieve impact while being respectful of participants' time constraints.** This balance can be achieved in approximately 12 sessions that are each one to three hours long, although some adaptations may choose to include fewer sessions or find that more sessions are feasible.

- **Consider offering incentives and compensation to help men and women overcome constraints to participating regularly in sessions.** These can be a one-time material incentive at the start or end of the program (e.g., a transportation stipend or a basket of household goods), benefits available at each program session (e.g., refreshments or onsite childcare), or benefits linked to economic support and skill-building (e.g., boxes of in-kind aid).

- **Make plans to ensure the inclusion and safety of facilitators and participants in the program design and budget.** This includes provisions such as resources to ensure safe transport to and from the venues where activities occur and where participants live, developing "warm referral" pathways with survivor-centered and mental health providers, and ensuring the content is accessible and intelligible for participants to engage fully considering barriers due to language, literacy skills, mobility, and hearing or visual impairment.

CORE COMPONENT #4:

Plan adequate time and resources to recruit, train, and support local facilitators.

Selecting facilitators with the specific qualities and skills to facilitate critical reflection and learning sessions – and investing adequate time and resources to recruit, train, and support them – is paramount to quality program implementation and affects their capacity to encourage processes of critical reflection and behavior change in participants. Several programs found success by having facilitators who lived or worked in the local community rather than relying on external staff who were less familiar with the context.

- **Recruit facilitators who possess certain key qualities,** particularly being able to create an atmosphere of trust, being nonjudgmental, and being able to establish horizontal relationships in a group setting.

- **Ensure the facilitators' training provides them with opportunities to engage in critical reflection and practice facilitating participatory group dialogue.** An initial training is best delivered in person over seven to ten days. Consider including refresher training to address challenges and provide additional space to practice managing difficult conversations and situations, including when to refer to specialized services.

- **Allocate sufficient time for the initial training; plan regular check-in meetings with the team, field visits, and supportive supervision during implementation; and provide ongoing mentorship and technical accompaniment of facilitators.**

CORE COMPONENT #5:

Create an enabling environment to support and sustain change through engaging service providers, institutions, local researcher and practitioner networks, and community structures.

Many programs sought to create an enabling environment that welcomed men's participation in MNCH, specifically by engaging health providers to change institutional practices that typically exclude fathers. They often developed alliances across and within broader networks or communities of practice to advocate for policy change, using fatherhood as an entry point to advance gender justice.

- **Identify influential community leaders, policymakers, and key institutions (such as health centers and religious institutions) that have a key role in defining, reproducing, and supporting the adoption of gender norms.**

- **Consider strategies to help transform the societal patriarchal norms, institutions, and structures that shape participants' lives as part of the program adaptation approach, even though gender-transformative parenting programs such as Program P often focus on the individual, family, and community levels.**

CORE COMPONENT #6:

Secure funding from flexible donors that will support long-term and quality partnerships.

Developing impactful, sustainable, and scalable gender-transformative parenting programs requires long-term and flexible funding that provides the time and resources required to build solid partnerships among stakeholders working to address complex problems, such as gender-inequitable relations or preventing family violence.

- **Advocate with donors on the importance of engaged fatherhood and the potential to create positive impact through gender-transformative parenting programs**, including on gender relationships through an equitable distribution of care and children's gender socialization, family health and well-being, childhood development, and violence prevention. These shifts in gender norms and changes in institutional practices and behaviors are usually slow, messy, uncertain, complex, and hard to control. Thus, they require a flexible and adaptive approach to develop and implement interventions to facilitate them.

ENDNOTES

a REDMAS developed the content for the group education sessions with fathers based on formative research, iterative testing, and validation in partnership with community civil society organizations across Nicaragua. In turn, Instituto Promundo in Brazil developed the manual's community mobilization section based on its strong trajectory of social and community activism and advocacy, and CulturaSalud in Chile leveraged its experience working with the health sector and designed a guide for health professionals to raise their awareness on how gender inequality and restrictive masculinities affect reproductive, maternal, and child health and strengthen their skills to engage men in support of reproductive, maternal, and child health. All partner teams as well as child development experts reviewed all sections.

b The Prevention Collaborative defines practice-based knowledge as "the cumulative knowledge and learning acquired by practitioners through years of innovation, reflection, and refinement. It includes insights gained from observations, conversations, direct experience, and programme monitoring. Practice-based knowledge is an important source of learning, but it is not always captured, used, or valued by the field."[17]

c "Care equity" is understood as the equitable distribution of unpaid care work (which includes care for dependent people, including children, older adults, and people living with disabilities) between men and women and caregivers of all gender identities, families, and the private and public sectors.

d Equimundo was involved in the inception process and formative research, and affiliated Equimundo specialists, a team of regional gender specialists, and the local partner organization adapted the curriculum and then implemented and evaluated the program.

e Program Abb adapted the original Program P manual to the local context through a close collaboration between Equimundo and ABAAD, with the latter leading implementation in Lebanon. Close partnership characterized this program from inception, starting with the formative research, curriculum content co-creation and design, and testing and validation; this continued to piloting, full implementation, and monitoring, evaluation, and learning.

f MenCare partners in Nicaragua (REDMAS), Chile (CulturaSalud), and Brazil (Equimundo) designed the first Program P manual based on each organization's experience.

g Program P was adapted to the local context through a close collaboration between Equimundo and RWAMREC, with the latter leading implementation in Rwanda. Close partnership characterized this program from inception, starting with the formative research, curriculum content co-creation and design, and testing and validation; this continued to piloting, full implementation, and monitoring, evaluation, and learning.

h This curriculum was subsequently tailored for other SHOW countries (including Bangladesh, Nigeria, and Senegal) and was applied in the various women's support groups.

i Findings on attitudes presented in internal program reports, but not publicly available.

j It is worth noting that the proportion of missing values for these questions was particularly high (ranging from 10 percent to 12 percent). ABAAD also reported significant difficulties administering these questions. This mirrors previous difficulties Equimundo encountered in trying to measure the prevalence of IPV in Lebanon for the IMAGES MENA (Middle East and North Africa) study in 2017, as well as highlights the importance of finding other innovative approaches to reliably collect this sensitive data.

k Quality of couple relationship was measured in different ways: for instance, asking both men and women about the quality of communication (Program P-ECD Lebanon, Program P Bolivia, and Bandebereho), mutual respect and expressions of affection (SHOW), and emotional connectedness (Program P-ECD Lebanon).

l Findings presented in internal program reports, but not publicly available.

m Internal analysis not publicly available (forthcoming).

n Findings presented in internal program reports, but not publicly available.

o Findings presented in internal program reports, but not publicly available.

p Findings presented in internal program reports, but not publicly available.

q Findings presented in internal program reports, but not publicly available.

r Findings presented in internal program reports, but not publicly available.

s Internal analysis not publicly available (forthcoming).

t Findings presented in internal program reports, but not publicly available.

u In March 2016, President Dilma Rousseff signed into law the "Legal Framework for Early Childhood." The law provides for an integrated national policy on early childhood, including the expansion of paternity leave from five to 20 days for employees of companies that participate in the government's Corporate Citizen (Empresa Cidadã) program. The National Early Childhood Network helped draft the text of the law.

v Humanized Institutionalized Childbirth Regulation, which promoted a woman's right to make informed decisions about the way she wanted to deliver her baby.

w Local health providers were sometimes invited to facilitate the full curriculum or to support other facilitators to lead specific sessions related to MNCH or reproductive health.

x Vicarious trauma, also called "compassion fatigue," is the emotional consequence that facilitators or counselors "have from working with participants as they are hearing their trauma stories and become witnesses to the pain and fear that trauma and violence survivors have endured" as defined by the American Counseling Association.[38]

y When the program's scale makes it impossible to directly train facilitators, cascade approaches to training can be considered that include master trainers along with the facilitator trainers to ensure adherence to the content and methodology. In addition, all facilitators need to receive periodic refreshers given their wide array of experience and expertise.

z A "warm referral" is a referral made by a worker by directly contacting the competent service on the survivor's behalf and with appropriate permissions. Warm referrals can be made by email or by phone and involve the referring worker providing appropriate verbal and written information, where relevant, about the survivor.[39]

aa Multiple Indicator Cluster Surveys can be accessed at http://mics.unicef.org/surveys.

bb This tool was created by the CMMS for Bangladesh. Examples of areas covered include attitudes about violence against children and men's roles in SRH and maternal health, as well as self-reported use of positive parenting techniques.

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ANNEX A.

List of People Interviewed

Rudy Broers (Director of Monitoring, Evaluation, and Research, Plan International Canada)

Milena do Carmo (Sociologist and Researcher, Centre for Social Studies of the University of Coimbra, Portugal)

Saifullah Chaudhry (Senior Advisor – Gender Equality, Plan International Canada)

Irma Condori (Program P Coordinator, Consejo de Salud Rural Andino)

Kate Doyle (Fellow, Equimundo)

Saadya Hamdani (Director of Gender Equality, Plan International Canada)

Hassan Joumaa (Projects Coordinator, ABAAD)

Emmanuel Karamage (Scale-Up Coordinator, Bandebereho, RWAMREC)

Jane Kato-Wallace (Fellow, Equimundo)

Michelle MacInnes-Rae (Senior Program Manager, Plan International Canada)

Douglas Mendoza (Gender Consultant – Masculinities, MenEngage Latin America)

Tatiana Moura (Researcher, Co-Coordinator of the Observatory on Masculinities, Centre for Social Studies of the University of Coimbra, Portugal)

Theodora Quaye (Project Manager for SHOW Ghana, Plan International Ghana)

Tahia Rahman (Acting Director, Centre for Men & Masculinities Studies, Bangladesh)

Zakaria Abdul Rashid (Media & Communications Manager, Norsaac)

ANNEX B.

Characteristics and Key Findings of Program P Adaptations Included in This Review

Intervention Name, Countries, Years & Partners	Setting, Population & Reach	Components	Intervention Description	Evaluation Type & Methods	Key Findings (qualitative findings italicized) *p<0.01 **p<0.05 ***p<0.001
Austria, Italy, Lithuania, Portugal **PARENT** (Promotion, Awareness Raising and Engagement of men in Nurture Transformations) pilot **Years:** 2019–2021 **Partners:** In Austria, Association for Men's and Gender Issues in Styria; in Italy, Cerchio degli Uomini; in Lithuania, Center for Equality Advancement; in Portugal, Centre for Social Studies of the University of Coimbra and Nursing School of Coimbra	**Setting**: Styria, Austria; Sicily and Reggio Emilia, Italy; various regions of Lithuania; Coimbra and Lisbon, Portugal **Population**: Fathers/ fathers-to-be and their partners; health professionals; health students; social workers **Reach**: In Austria, 72 fathers/fathers-to-be; in Italy, 130 health professionals and 20 fathers/fathers-to-be; in Lithuania, 125 social workers and two fathers groups (total of 49 fathers); in Portugal, 100 health professionals and 30 parents	1. Engagement with healthcare and/or social work professionals (all countries) 2. Group education for fathers and their partners (all countries) 3. Community- and institution-based campaigns (all countries) 4. Embedding fatherhood within nursing school curriculum (Portugal only)	**Dose**: **Healthcare and social work professionals:** Italy: four eight-hour modules for health professionals; Lithuania: 11 sessions for social workers (16 hours in-person, eight hours independent); Portugal: ten two-hour in-person sessions and ten asynchronous hours for health professionals. **Fathers/couples in group education:** Austria: six four-hour sessions (12 modules), later adapted to a single session of up to two hours; Italy: eight two-hour sessions for fathers; Lithuania: eight hours for fathers; Portugal: four sessions for parents/couples (4.5 hours in-person, eight hours online). **Thematic focus:** Caregiving, engaged fatherhood, MNCH, preventing violence against women and children **Aims**: Engaging men in co-responsible parenting and caregiving and their participation in an equal share of unpaid care work; helping prevent domestic and family gender-based violence	**Evaluation type:** Pre-post surveys conducted immediately before/after workshops (in Austria: post survey only) **Sample size:** In Austria, 72 fathers at endline; in Italy, 129 health professionals at baseline, 105 at endline; in Lithuania, 125 social workers (baseline and endline); in Portugal, 23 fathers at baseline, 17 at endline **Indicators:** Attitudinal items from the Gender Equitable Men (GEM) Scale,[42] behavioral items (e.g., intention to take parental leave, perform childcare, and perform household tasks) (Ignacio, 2021)	**Healthcare and social work professionals:** Italy: health professionals self-reported an increase in behaviors related to providing information on antenatal care/postnatal care (ANC/PNC), parental leave, and encouraging men's continued/future participation in MNCH at post-test. Improvements in professionals' attitudes about health facilities providing a changing table in the men's room, and the importance of men's presence during labor and delivery were also found (statistically significant, but details not provided in the report). Lithuania: social work practitioners held more gender-equitable attitudes and practices on men's involvement in MNCH at endline than at baseline; male participants in Portugal father/couple groups showed positive shifts in their engagement as fathers in health services. **Fathers/couples in group education:** **Caregiving:** Male participants in Portugal father/couple groups reported increased intention to participate in activities such as washing clothes, changing diapers, preparing food for children and other adults, and taking parental leave at the birth of a child. Sample size too small to assess statistical significance. **IPV/violence against children:** Men in Portugal showed reductions in their endorsement of using violence against women and children. **Gender attitudes:** Endline GEM scores related to masculinity (e.g., what it means to be a "real man" and how "real men" should behave) shifted in an undesired direction (supporting inequitable views) from baseline to endline among participants in Portugal father/couple groups, although the sample size was limited.
Bangladesh **Prio Baba** ("Dear Father")/ Engaging Fathers for Family Well-Being and Gender Transformation **Years:** 2015–2017 **Partners:** Centre for Men & Masculinities Studies (CMMS); Equimundo	**Setting:** Rangpur, Sirajganj, Pabna, Natore, Cox's Bazar **Population:** Fathers and (in approximately half the groups) their female partners; healthcare providers/ gatekeepers (i.e., family planning workers from the public health system, nurses, midwives, pharmacists, and local medical practitioners) were engaged in gender sensitization workshops **Reach:** 1,200 fathers; 380 mothers (who participated in sessions); 796 health providers	1. Community-based group education sessions for fathers and their partners 2. Gender-synchronized workshops for healthcare providers and gatekeepers 3. Community-based campaign and dialogues	**Dose:** Six group sessions with fathers (and their female partners when present) **Thematic focus:** Preventing violence against women and children **Aims:** Raising awareness on the harms of corporal punishment and the benefits of gender-equal, nonviolent parenting; increasing men's involvement in and support of women's SRHR and MNCH; reducing fathers' use of physical punishment of children and increasing the use of positive parenting techniques	**Evaluation type:** Pre-post survey conducted directly before/after implementation **Sample size:** 600 men at baseline, 339 at endline; 420 female partners at baseline, 339 at endline **Indicators:** Attitudinal and behavior change measures from the GEM Scale and the International Men and Gender Equality Survey (IMAGES)[43]; specific measures from the Multiple Indicator Cluster Survey[44]; Men and Masculinities tool[bb] (Internal report, 2017)	**Violence against children:** At endline, men showed decreased endorsement of physically punishing children and increased agreement on the negative impacts of physical punishment.*** There were also decreased self-reports of using physical violence and name-calling against children, but increased reports of shouting/yelling at children.*** **SRHR/MNCH:** At endline, fewer fathers agreed that men should not participate in ANC visits or pregnancy care for women,*** and a greater proportion agreed that women should be able to get help from skilled birth attendants if they need it.*** **Positive parenting:** Fathers reported increased use of positive parenting techniques (taking away privileges, explaining why their child's behavior was wrong, and giving their child something else to do).*** **Caregiving:** At endline, a greater proportion of fathers reported that they shared parenting tasks with their partners, talked to their children about personal matters in their lives with their partners, and helped children with homework.***
Bangladesh, Ghana, Haiti, Nigeria, Senegal[§] **SHOW** (Strengthening Health Outcomes for Women and Children) Program **Years: 2016–2020** **Partners:** Plan International Canada; Equimundo; in Ghana, the Ministry of Health and Ministry of Gender, Children, and Social Protection; in Nigeria, the national Ministry of Health and Ministry of Women Affairs and Social Development and the Sokoto State Government, Ministry of Health, Ministry of Women Affairs, and Primary Health Care Development Agency [§]*This report focuses on Ghana and Nigeria.*	**Setting:** Remote, underserved, and marginalized regions with high poverty; in Ghana, this included eight districts with high poverty in the Volta, Eastern, and Northern regions (only Adaklu Have, Leklebi Kame, and Adaklu Ahunda-Kpodzi in the Volta Region were included in the qualitative study); in Nigeria, this included five rural locations in Sokoto state (Mabera, Mabera Mujaya, Bado Kasarawa, Kalmalo, and Dagawa) **Population:** Adult men and their women partners of reproductive age **Reach:** 6,465 fathers in Ghana; 4,148 fathers in Nigeria	1. Community-based group education sessions for fathers 2. Social and behavior change communication interventions 3. Interventions to increase women and girls' gender equality knowledge, leadership capacities and networks, and economic capacities and decision-making 4. Health system strengthening and building the capacity of community and facility-based health providers 5. Complementary interventions engaging community traditional and religious leaders, community women elders to create a supportive environment for male engagement	**Dose:** 20 one-hour group education sessions for fathers **Thematic focus:** Positive masculinities, MNCH/SRH continuum of care **Aims:** Supporting groups of husbands and male partners ("Fathers Clubs") to transform attitudes and behaviors that harm women and children; promoting gender-equitable relationships within couples	**Evaluation type:** Cross-sectional surveys (household survey, adolescent survey, and health facility assessment); in-depth interviews with men and community leaders; focus group discussions with women and adolescent girls/boys **Sample size:** Ghana household survey sample included 1,458 women and men at baseline and 1,137 at endline; Nigeria household survey sample included 1,759 women and men at baseline and 1,200 at endline; Ghana and Nigeria qualitative samples included 128 and 150 participants, respectively[cc] **Indicators:** Indicators related to access to and utilization of health services; attitude/ behavior items adapted from IMAGES and "Helping Dads Care"[44] survey items (e.g., on attitudes about men's engagement in household work, caregiving, and MNCH/SRH; perceptions about men's behavior and attitude change) (Plan International Canada, 2020a-c; internal report, 2022)	**Household work and childcare:** *Fathers in Ghana and Nigeria reported increased participation in household chores; women, adolescents, and community leaders validated these changes. The notion that the father's role is to "help" or "assist" mothers persisted across all age and gender groups in both settings.* **MNCH:** In both Ghana and Nigeria, the percentage of female respondents who received ANC from a skilled professional at least four times during pregnancy, had their births attended by a skilled health professional, and/or received PNC within two days of childbirth increased significantly from baseline to endline.*** More women reported ever or currently using modern family planning methods,*** and women and men showed increased knowledge of key gender equality messages related to MNCH.*** In Nigeria, both women and men showed increased knowledge of MNCH danger signs and strategies,*** while in Ghana, men showed a substantial increase*** and the low proportion of women remained unchanged at endline. *In both Ghana and Nigeria, fathers, their families, and community leaders showed increased awareness and endorsement of male engagement in maternity and family health. Focus groups reported increased men's participation in MNCH.* **Gender-based violence:** *In Ghana, women and adolescent girls and boys all confirmed a reduction in men's violence (especially arguments). Fathers reported improved moods and emotional control and reduced argumentativeness. Groups in Nigeria did not directly talk about gender-based violence, although many groups noted less quarreling among couples.* **Decision-making**: In both Ghana and Nigeria, there were substantial increases among women and men in overall support for women's decision-making in most domains, as well as increases in women's sole decision-making power on the use of family planning methods. *Several men in Ghana and Nigeria talked about increases in shared decision-making and cooperation among spouses. Women in Ghana validated this change. Not many women's groups in Nigeria discussed an increase in shared decisions, although some noted changes in men discussing matters with their wives.* **Spousal relationships and father-child relationships:** *Respondents of all ages and genders in both settings said spousal and family relationships improved (e.g., improved communication, mutual respect, and love).*
Bolivia **Program P Bolivia** **Years:** 2016–2017 **Partners:** Inter-American Development Bank; Consejo de Salud Rural Andino; Equimundo	**Setting:** District 8 in El Alto, La Paz; Indigenous urban communities **Population:** Cohabitating mothers and fathers of children aged 0 to 3 **Reach:** 747 women and men partners were randomized to receive the intervention	1. Community-based group education sessions, with separate content for fathers and for mothers	**Dose:** Ten sessions for fathers; nine sessions for mothers **Thematic focus:** Prevention of violence in the family (IPV and violence against children), equitable caregiving and domestic work, and positive parenting **Aims:** Promoting an equitable division of caregiving and domestic work, positive parenting, the prevention of corporal punishment, gender-equitable socialization of children, and the prevention of IPV	**Evaluation type:** RCT with five-month post-implementation follow-up; in-depth interviews and focus group discussions **Sample size:** 697 women and men partners in the intervention group, 713 in the control group; in-depth interviews were conducted with 14 women and men partners, nine facilitators, and one program coordinator; six focus group discussions were conducted with male and female participants and couples of the RCT's control arm **Indicators:** Items from scales related to the distribution of household activities; household decision-making; quality of couples' communication; depression; parenting attitudes and practices; discipline methods; parent-child conflict tactics; and physical, sexual, and psychological IPV (ever and last six months) (Alemann et al., forthcoming, Stern et al, 2023)	**IPV:** Women participants' reports of experiencing psychological violence from an intimate partner in the last six months decreased, while women's reports in the control group did not ($p<0.1$). **Violent discipline:** Among mothers who were working for pay at baseline, there was a decreased probability of physically punishing children, while this was not the case for female participants who were not working.** Among mothers with at least secondary education, there was an increase in the probability of using positive discipline after program participation relative to treatment mothers with lower levels of education.** **Shared decision-making:** Improvements were noted among mothers and fathers in reporting joint decision-making relative to their respective control groups.** **Other outcomes identified through qualitative evaluation:** *The program seems to have had a stronger influence in improving positive parenting awareness and practices than in improving couple relationships. Some findings reported by participants included improved parenting skills; increased men's participation in domestic and childcare responsibilities; improved interpersonal communication; and raised awareness on gender inequality and its impact on family health and the quality of relationships.*

Intervention Name, Countries, Years & Partners	Setting, Population & Reach	Components	Intervention Description	Evaluation Type & Methods	Key Findings (qualitative findings italicized) *p<0.01 **p<0.05 ***p<0.001
Brazil +**Pai** ("Father")/MenCare+ Brazil **Years:** 2013–2015 **Partners:** Instituto Promundo; Instituto Papai; Instituto Noos; Rio de Janeiro's Municipal Health Secretariat; Brazilian Ministry of Health	**Setting:** Rio de Janeiro (urban), Recife **Population:** Young men (and women), fathers and fathers-to-be (and couples), men who had perpetrated domestic violence, health providers, health and legal sector staff **Reach:** 147 men and women in couple groups; 845 young men and women in youth groups; 1,339 health workers trained on young men's SRH needs; 1,580 health workers trained on engaging fathers in maternal health visits; 214 counselors trained on domestic violence counseling; 574 partner organization staff trained and sensitized on advocating for young men's/caregivers' access to SRHR, MNCH, and domestic violence services	1. Healthcare unit-based group education sessions for pregnant couples (Program P) 2. Community campaign on fatherhood ("You Are My Father" campaign)	**Dose:** Ten group education sessions with men/couples **Thematic focus:** SRH, MNCH, violence prevention **Aims**: Preventing violence; promoting SRH/MNCH; increasing young men's/couples' access to contraceptives, including male and female condoms, to promote good health	**Evaluation type:** Post-intervention evaluation questionnaires; qualitative assessment conducted at the end of the three-year program **Sample size:** 147 people in the men/couple groups participated in qualitative and/or quantitative evaluation **Indicators:** e.g., number of men and women with changed views on contraceptive use (Internal report, 2016)	**SRHR/MNCH:** There was a positive trend toward changes in men's participation in family planning and changed views on contraceptive use. At the pre-test, 72% of couples said they always talked about family planning, and at post-test this rose to 78% (not statistically significant). There was also a reduction in the number of couples who said they 'never' spoke about family planning, from 11% to 8%. The sample of men whose partners were pregnant was too small to be able to measure a change in men's participant in antenatal care. *Qualitative research indicated that in the safe spaces created by the reflection groups, mothers and fathers were able to reflect on and question the traditional gender norms related to newborn and childcare. Participants reported that the meetings increased their perception of the significant role and contribution of male partners during the prenatal and postpartum period, which can impact the health of mothers, children and fathers themselves. Many of the participants stressed the need to advocate with employers for men to be able to take time off work to attend prenatal consultations with their partners without fear of being fired.* **Father-child relationships:** *Participants reported that the intervention enabled men to challenge notions that men cannot show affection and participate in the daily care of their children. Raising children without violence was another important theme that many men remarked about, because they learned new ways of mediating conflicts, and were able to reassess their practices, particularly through the experiences of other participants.*
Lebanon **Program P ECD** (Early Childhood Development)/ Program Abb **Year: 2018** **Partners:** ABAAD; Equimundo	**Setting:** 13 cycles at 11 sites across various areas of Lebanon (North, South, Beirut, Bekaa, and Mount Lebanon) **Population**: Syrian and Lebanese fathers/male caregivers and their female partners; all participants were married and had at least one child aged 0 to 5 **Reach:** 316 male and female participants	1. Group education sessions with fathers/male caregivers and their female partners	**Dose:** 13 one- to two-hour sessions for male caregivers; their women partners joined for five sessions **Thematic focus:** Fatherhood, caregiving, violence prevention **Aims:** Increasing men's involvement in early childhood development for children aged 0 to 3; promoting positive parenting skills; preventing violence in the family (IPV and violence against children)	**Evaluation type:** Pre-post survey, in-depth interviews, and focus group discussions conducted directly before/after the intervention **Sample size:** 121 men and 76 women from eight sites for baseline survey, and 121 men and 71 women for endline survey; three focus group discussions with men and three with women; 12 in-depth interviews with men and 12 with women **Indicators:** GEM Scale, IMAGES items (e.g., on attitudes and behavioral outcomes regarding parenting roles, caregiving and domestic work distribution, use of positive and violent forms of discipline, and IPV) (Promundo-US and ABAAD, 2019)	**Positive discipline:** The use of harsh physical punishment declined for men** and for women*** from baseline to endline. **IPV:** Justification of physical IPV decreased among male participants.** Women participants' reports of experiencing any form of IPV over the previous month decreased somewhat from baseline to endline, though this decrease was not statistically significant. **Couple communication and joint household decision-making:** Women reported increases in how often they talked with their male partners about their own worries and feelings*** and their partner's worries and feelings.*** Men also reported an increase in how often they talked with their partner about their own worries and feelings*** and their partner's worries and feelings (although the latter was not statistically significant). *In focus group discussions, male and female respondents noted an increase in joint household decision-making at the end of the intervention.* **Unpaid care work:** Both men and women reported significant increases in men's participation in housework (equal or primary responsibility for washing clothes, cooking, and/or cleaning),*** and caregiving (equal or primary responsibility for routine care, feeding, and/or bathing).*** **Perceptions of masculinity and gender roles:** Both male and female participants (but particularly the latter) endorsed less rigid and violent versions of masculinity at endline, such as the notion that men should use violence to get respect.** Men and women held less supportive attitudes toward gender inequality, such as the notion that a woman's most important role is to take care of the home and family.*** *In the focus group discussions and in-depth interviews, men and women reported changed perceptions of masculinity: Men no longer felt they needed to be physically strong or violent to "be a man," and women felt that "being a man" included helping raise the children, helping with household tasks, sharing power, and respecting women.* **Men's emotional connectedness and anger:** Men*** and women** were more likely to report that men engaged in at least one of three emotionally supportive or help-seeking behaviors at endline than at baseline.
Nicaragua **Program P Nicaragua** **Years:** 2012–2013 **Partners:** Puntos de Encuentro; Red de Masculinidad por la Igualdad de Género (REDMAS); Ministry of Health; Ministry of Education; Equimundo; MenCare	**Setting:** Granada, Somoto, Managua, Ciudad Sandino **Population:** Health providers and volunteer health educators were the main targets, although group education sessions also reached young fathers and their partners **Reach:** 70 health professionals; 300 men and women	1. Community-based workshops for parents 2. Education seminars (Program P) with health professionals 3. Establishing "Fathers Schools" in different communities 4. Community-driven educational media campaign	**Dose:** 12 group education sessions with fathers and their partners **Thematic focus:** SRHR, violence prevention **Aims:** Sensitizing and training fathers, especially community leaders, about the importance of participating in care work and MCH	**Evaluation types:** Focus group discussions and in-depth interviews **Sample size:** 41 fathers (13 in Granada, 14 in Somoto, 14 in Managua) **Indicators:** None available (ECPAT et al., 2015; internal draft report, 2014)	**Unpaid care, spousal relationships, and parent-child relationships:** *Program participants said as a result of the workshops, they learned how to share household duties, dedicate more time to their children and wives, and teach their children values of respect and equality.*
Rwanda **Bandebereho** ("Role Model")/ MenCare+ Rwanda: **Years:** 2013–2015 (pilot), 2019–present (scale-up) **Partners:** Rwanda Men's Resource Centre (RWAMREC); Equimundo; MenCare+; Rutgers WPF	**Setting:** For the pilot, sessions were conducted in 48 sites across four Rwandan districts (Karongi, Musanze, Nyaruguru, and Rwamagana); for scale-up, Musanze district **Population:** Couples were recruited via the male partner (men ages 21 to 35 who were expecting a child or had a child under age 5 and also were cohabiting with a partner) **Reach:** 575 couples were randomized to receive the intervention in the evaluated third cycle	1. Community-based educational sessions for fathers/couples 2. Health sector training of healthcare professionals on men's engagement in MNCH, SRHR, and working with young people	**Dose:** 15 sessions (up to three hours each) for men; partners invited to eight sessions **Thematic focus:** MNCH, SRHR, violence prevention, caregiving **Aims:** Improving fathers' involvement in MNCH, family planning, caregiving, and violence prevention	**Evaluation type:** RCT with findings from 21-month follow-up (men interviewed at baseline, nine months post-baseline, and 21 months post-baseline; women interviewed at both follow-ups, but not at baseline) **Sample size:** 575 couples in the intervention group; 624 couples in the control group **Indicators:** Women's reports of their experiences of physical and sexual IPV (adapted from World Health Organization multi-country study[45]) and their reproductive and maternal health behaviors (adapted from DHS[46]); men's and women's reports of physically punishing children (items from the Multiple Indicator Cluster Survey child discipline module); gendered division of childcare and household tasks and men's dominance in household decision-making (items from IMAGES), GEM Scale (equitable gender attitudes), and depression scores (CESD-10[47]). (Doyle et al., 2018; Levtov et al 2022); unpublished analyses)	**IPV:** Compared to women in the control group, female participants in the intervention group reported lower rates of experiencing past-year physical,*** sexual***, economic***, and emotional*** IPV. **Violence against children:** Women*** and men** in the intervention group reported lower rates of physically punishing children compared to the control group; these women and men were also less likely to espouse attitudes supportive of corporal punishment, and they were more likely to use positive discipline techniques, such as explaining why the child's behavior was wrong. **SRHR/MNCH:** Compared to women in the control group, women in the intervention group reported attending more ANC visits*** and receiving more support from their partner during pregnancy.*** Women and men in the intervention group reported higher levels of men accompanying women to ANC visits.*** A higher proportion of men*** and women** in the intervention group reported using modern contraception, and a lower proportion said men had the final say in decisions on having children or the spacing of children.*** **Men's increased caregiving**: Men in the intervention group reported spending more hours on child caregiving and domestic work compared to men in the control group.*** Men and women in the intervention group reported greater sharing of these tasks between partners compared to the control group,*** and both partners were also more likely than those in the control group to report participation in stimulating interactions with their children.*** **Communication and shared decision-making:** Compared to women in the control group, women who received the intervention reported lower levels of male dominance in household financial decision-making.*** Women in the intervention also reported increased communication frequency*** and satisfaction*** compared to women in the control group. **Couple relations:** Both men and women in the intervention group reported better relationship quality and emotional closeness than those in the control group.*** **Men's gender attitudes:** Men in the intervention group reported more equitable gender attitudes*** and lower acceptance of wife-beating*** compared to men in the control group. **Men's alcohol consumption:** Both men and women in the intervention group reported lower rates of men's alcohol consumption compared to the control group.*** **Maternal depression:** Women in the intervention group reported lower rates of depressive symptoms than women in the control group.***


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