

Couple-Based Approaches in Reproductive Health

The Evidence to Action (E2A) project has been drawing global attention to an important subset of youth—first-time parents (FTPs)—defined as young women under the age of 25 years who are pregnant with or have one child, and their male partners. Through implementing FTP programs in Nigeria, Tanzania, and Burkina Faso, we have learned that for many FTPs, their relationships with their partners may be transitional in nature, and the types of relationships that FTPs have vary from place to place.

Even so, and despite the variety of relationships, FTPs across contexts expressed an interest in addressing key issues like communication and conflict management to improve the nature of their relationships. Couple-focused interventions (CFIs) are a potentially valuable strategy to address some of these challenges and accelerate progress towards achieving reproductive health goals. CFIs in reproductive health are of compelling public health interest for three reasons: (i) most reproductive health, family planning, and childbearing decisions are made or may be made by both partners of a couple¹; (ii) the emergence of HIV and growing awareness of the social dynamics involved in its transmission has upended traditional theoretical models of behavior change focused on individual determinants; and (iii) literature on CFIs indicates that interventions that focus on couples are as effective, or more effective, in achieving desired reproductive health outcomes than interventions that focus on either individual alone². In beginning to think through the possibility of CFIs, however, we realized that little is known or has been written about the nature, needs, and concerns of adolescent and youth couple relationships and how the relationship influences reproductive health decisions and behaviors.

Couple-focused interventions conceptualize ‘the couple’ as the basic unit that the intervention targets and seek to change one or more elements of that relationship to achieve an explicit couple-focused or individual reproductive health outcome—whether that intervention is conducted wholly together as a couple, or using a synchronized approach



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Thus, given previous FTP programmatic experiences, including the relative powerlessness of first-time mothers (FTMs) in their relationships, and the relative invisibility of young couples in the reproductive health literature and policy arena, E2A was motivated to examine the gender-transformative potential of CFIs within the FTP framework—and beyond—to improve reproductive health outcomes. This brief is a summarized version of an [extensive technical report](#) comprising three components—a literature review, a global reproductive health policy analysis, and key informant interviews—that explores the extent to which programs and policies consider couple-based approaches (CBAs) as a means to improve reproductive health outcomes, the reasons such approaches do not feature more prominently, and recommendations for program designers/ implementers, policy makers, and researchers. The hope is that through dissemination of the encouraging findings of this report, E2A can lay the groundwork and point the way to future programming which recognizes the essential role both women and men play in reproductive and family health.

Couple-based approaches is an umbrella concept to describe any policy, research, or practice that conceptualizes ‘the couple’ as the basic unit of intervention to achieve a reproductive health outcome

1 Becker S. Couples and reproductive health: a review of couple studies. *Stud Fam Plann.* 1996; 27(6):291–306.

2 Burton, Jennifer; Darbes, Lynae A; Operario D. Couples-focused behavioral interventions for prevention of HIV: Systematic review of the state of evidence. *AIDS Behav.* 2010;14(1):1–10.

METHODS

The study investigator undertook a literature review and policy analysis and conducted semi-structured interviews with eight key informants to gain insight into the understanding and use of CFLs in programs and policies.

When conducting the literature review, the E2A study group searched electronic databases PubMed, Embase, and POPLINE to identify relevant studies. The search was limited to three primary areas of concern within reproductive health: family planning, maternal health, and HIV. This study was limited to English-language public health literature on clinical, community-based, and behavioral reproductive health interventions that target couples as the unit of intervention. This paper incorporated works focused on the diversity of couples who have been studied, including, for example, male-female dyads of reproductive age, same-sex couples, and adolescent couples. To analyze the results of the literature review, the E2A study group developed an article review matrix to enable analysis, extracting specific information from articles to complete the matrices. Once completed, the lead investigator reviewed the matrices to learn: 1) how couple-based interventions were utilized within each of the three subfields (i.e., family planning, maternal health, and HIV), 2) the differences among the fields, including frequency, types of interventions, barriers, etc., and 3) commonalities intrinsic to the couple-based approach, their effectiveness, and mechanisms of change.

In addition to the literature review, the lead investigator analyzed the following global reproductive health policies to learn how the selected policies enabled or inhibited couple-based approaches in research and practice: (i) *The Global Strategy for Women's, Children's and Adolescents' Health, 2016-2030*; (ii) "Chapter Three – Health," from the Framework of Actions for the Follow-Up to the Programme of Action of the International Conference on Population and Development Beyond 2014; and (iii) *WHO Global Health Sector Strategy on HIV, 2016–2021: Towards Ending AIDS*. The lead investigator conducted a content analysis of these policies as well as a thematic analysis of the policies, paying special attention to gender and couples, implementation guidance, and the conceptual frameworks that guided the development of the policy documents.

Lastly, semi-structured interviews were conducted with key informants who are prominent members of the global reproductive health professional community. Purposive sampling was used to select eight key informants who were geographically centered in North America (despite many attempts to recruit participants from Europe and Africa) and included four academics/researchers, one independent consultant, two representatives from international NGOs, and one representative from a bilateral donor. The study investigator took detailed notes, including verbatim passages of significance, from each of the eight recorded hour-long interviews and conducted a thematic analysis, identifying significant domains of thought or concepts and patterns of meaning.

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RESULTS

The majority of the studies explored in the literature review compared CFLs with interventions focused on individuals, and most showed that CFLs were found to be equally or more effective in achieving immediate and longer-term health outcomes (as defined by the studies) than interventions that target a single sex, across all reproductive health sub-fields explored. The use of CFLs remains relatively rare, though CFLs are used much more frequently in programs to prevent and mitigate HIV/AIDS compared to programs in the fields of maternal health and family planning.

THE NUMBER OF ARTICLES PER SUBFIELD

First, there was a relative paucity of articles that engage couples in reproductive health interventions, across the three RH sub-fields. Second, maternal health appears to be the field that least engages in studies focused on couples. With FP, we witness a significant increase in the number of articles over the maternal health subfield. Finally, it is clear that the field of HIV conducts a dramatically higher number of studies with couples—both heterosexual and homosexual couples—than either maternal health or FP. This large variation in the number of articles identified by reproductive health subfield can be seen in Figures 1, 2 and 3, using various search strategies.

Figure 1: Number of articles retrieved by subfield: PubMed search

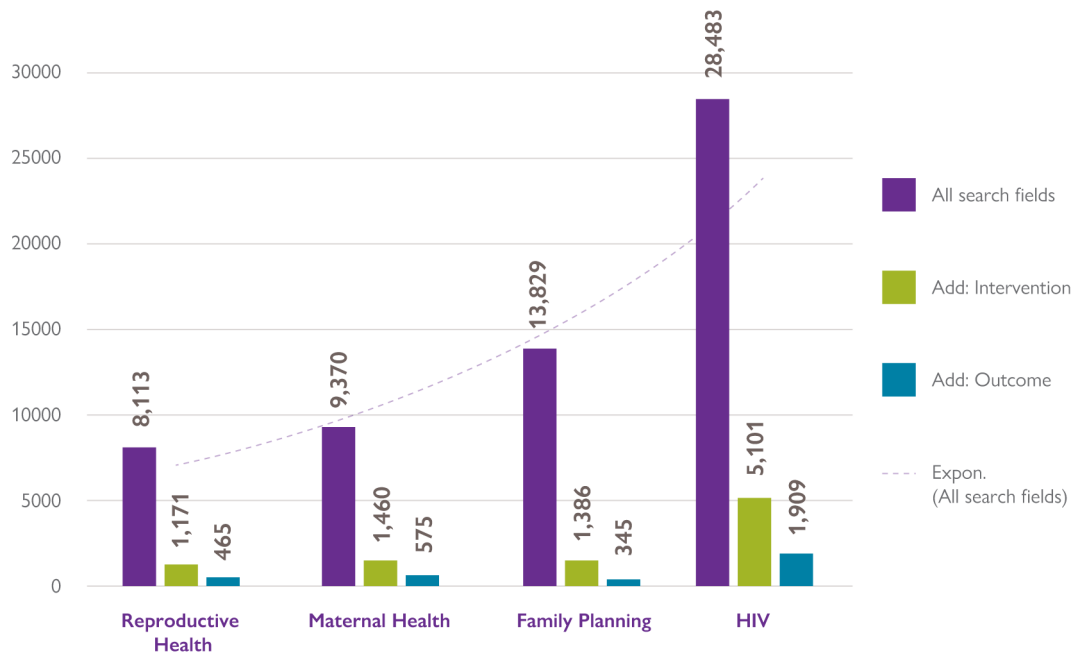


Figure 2: Number of articles retrieved by subfield: Embase search

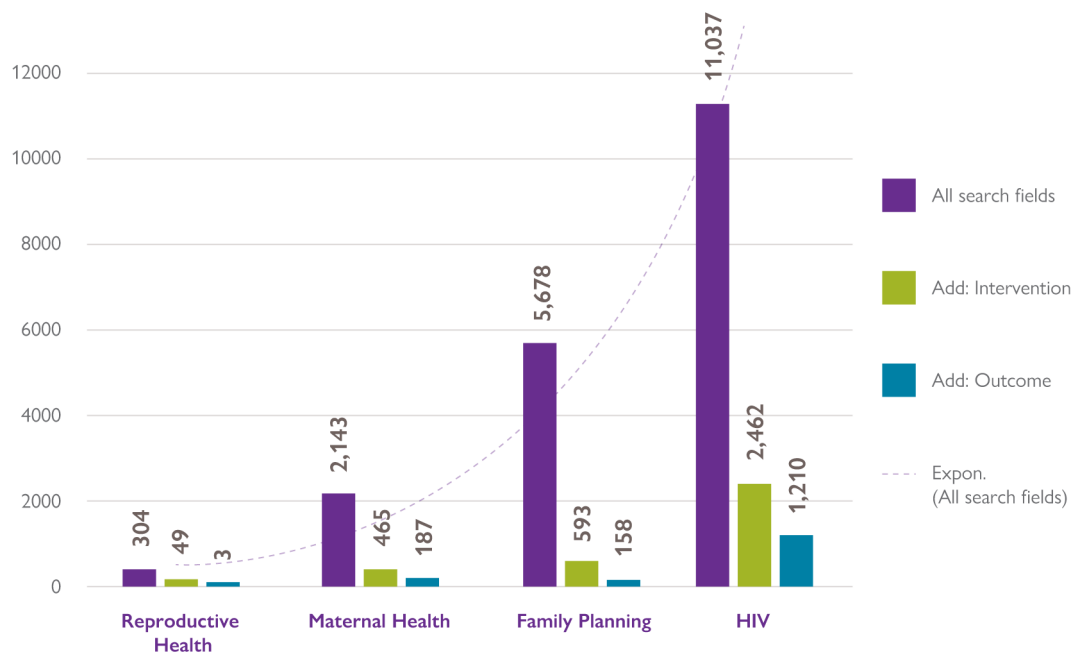
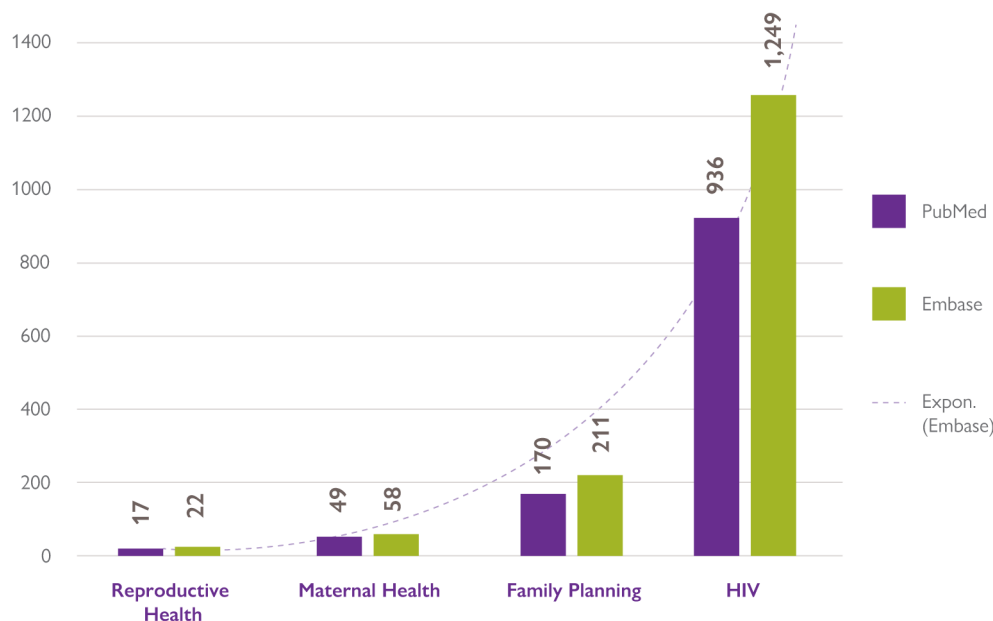


Figure 3: Number of articles retrieved by subfield, title field only: PubMed and Embase compared



FINDINGS

The majority of the studies explored in the literature review compared couple-focused interventions with interventions focused on individuals, and the bulk of these studies seem to show that CFIs are more effective in achieving intermediate and longer-term outcomes than interventions focused on a single sex or individuals. The interventions with positive results spanned the three reproductive health subfields. Studies that focused on family planning pointed to couple communication as the primary mechanism to achieve the couple's desired family planning outcomes. They found that couple communication could: 1) influence method choice and contribute to generating new users & more consistent use among current users (Zolna et al. 2009), 2) help to decrease discord and promote common understanding about FP and shared decision making, thus contributing to the couple's contraceptive utilization (Tilahun et al. 2015), 3) provide a forum for couples to discuss their fertility intentions and method preferences (El-Khoury et al. 2016), and 4) help to increase men's knowledge about contraceptive methods and thus help to promote contraceptive utilization (Lemani et al. 2016). However, none of the studies explicitly looked at women's agency and decision-making power as a result of improved or increased couple communication.

Studies that focused on maternal health demonstrated that support in the couple relationship—fostered by CFIs—played a role in reducing maternal stress and boosted women's self-esteem, contributing to improved outcomes (Feinberg et al. 2015, Yargawa and Leonardi-Bee 2015). This support could take many forms, including assisting women with child care and household chores, encouraging wives to use maternal health (MH) services (while men's knowledge of the same increased) (Mullany 2006, Yargawa and Leonardi-Bee 2015), and men's participation in birth preparedness and complications readiness planning and implementation (Becker and Robinson 1998).

Perhaps the most consistent and robust results come from the HIV sub-field. HIV-focused studies reliably show that CFIs increase condom use and reduce risky sexual behavior, contributing to reduced HIV transmission. This is true for women (increased

protective behaviors, ART adherence during pregnancy), serodiscordant couples (decreased risk of HIV transmission and reduced intimate partner violence), men (increased condom use in their primary and secondary relationships), and even infants (decreased infant HIV infection) (Koniak-Griffen et al. 2011, Crepez et al. 2015, El-Bassel et al. 2010, King et al. 2015, Mashaphu et al. 2018, Mashaphu et al. 2019).

Few articles explicitly addressed gender—either by problematizing (or acknowledging) power differences between the sexes (or members of the dyad, in the case of same-sex couples) or explicitly seeking to change the dynamics of power in relationships. However, there were some studies that were explicit in their treatment of gender, including the Villar-Loubet et al article (2013) which found that the PartnerPlus intervention in South Africa—which included, in part, sessions that emphasized behavioral skill-building around couple communication, especially sexual negotiation and conflict resolution—found that compared to the control group, HIV knowledge and consistent condom use among the couples in the intervention group increased and was maintained. Other studies, while not explicitly addressing gender, were sensitive to power differentials in many couples and the reality of IPV (Becker et al. 2014). A few articles also overtly addressed questions about culture and gender. For instance, Sarker et al. (2015), who examined the effectiveness of community-based reproductive health approaches for young married couples, found that traditional gender norms, primarily in South Asia, prevented many young women from participating in interventions. Becker et al. (2014) and Mullany (2006) both wrestled with the way to most effectively provide couple-focused interventions, keeping current gender norms in mind. Both papers criticized previous projects that built on traditional norms of masculinity—of leadership and dominance—to achieve reproductive health outcomes. Both authors saw these efforts as “misdirected” and supporting inequitable patriarchal gender norms. Rather, they believe a better way to frame the interventions is by asking ‘How do we build on positive notions of masculinity to promote shared responsibility for reproductive health and family health in couple focused interventions?’

DOCUMENTARY ANALYSIS OF GLOBAL REPRODUCTIVE HEALTH POLICIES

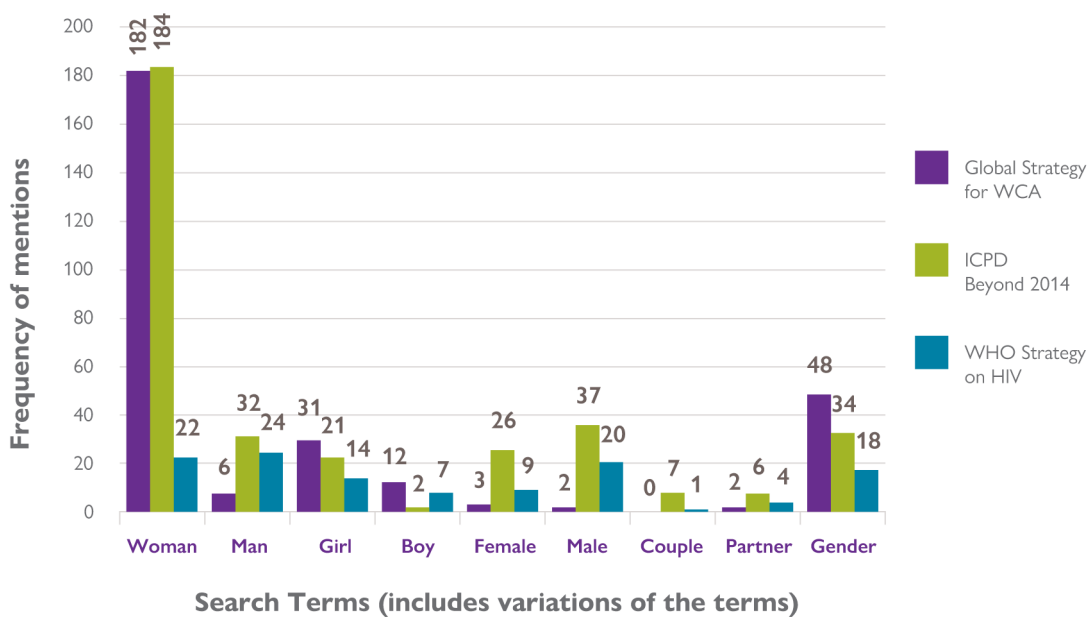
This section of the paper examined the conceptual frameworks, which guided the development of key global policy documents, and whether they enabled or inhibited an engagement with couple-based approaches. The review also examined how the policies addressed gendered power dynamics and women’s agency, autonomy and decision making. All three of the policies noted a fundamental link between reproductive health outcomes and increased gender equality. Furthermore, ICPD and the Global Strategy both saw the lack of women’s participation in civic society as compromising societal advancement and their own health. In addition, content and thematic analyses of The Global Strategy for Women’s, Children’s and Adolescents’ Health, 2016-2030; “Chapter Three – Health,” from the Framework of Actions for the Follow-Up to the Programme of Action of the International Conference on Population and Development Beyond 2014; and WHO Global Health Sector Strategy on HIV, 2016–2021: Towards Ending AIDS revealed—like the literature review—that the inclusion of men and couples as an explicit strategy to improve reproductive health outcomes is rare.

Even though the ICPD follow-up document and the Global Strategy for Women’s Children’s and Adolescents’ Health seemingly take a “gender and development” approach, this vision is not fully realized in these documents’ implementation guidance or monitoring frameworks. Particularly noteworthy is the Global Strategy’s depiction of women as somewhat atomized—individuals who seem to exist nearly free of social and even familial bonds. While the documents purport to be sensitive to the needs of women, they do not go far enough in laying the groundwork for a fundamental re-thinking of the configuration of services which include men and couples as integral components of RH services.

In contrast, the HIV strategy detailed in the WHO document takes a biomedical approach guided by the epidemiology of HIV, including the dynamics of transmission and patterns in health service utilization. In recognizing the diversity of sexual partnerings, the policy does indeed lay the groundwork for the inclusion of men and couples. However, the document’s largely biomedical approach gives little attention to the social dimensions of infection. For example, couples are mentioned, especially the importance of Couples HIV Counseling and Testing (CHCT). But changing the dynamics within relationships, like improving couple communication or promoting shared decision making, is not discussed as a means to avoid infection or promote adherence. Instead, couples are mentioned as one among a number of strategies to achieve individual-level goals along the HIV care continuum.

The content differences among the policies, especially the relatively heavy emphasis on HIV strategy in the WHO document, are reflected in Figure 4, which compares the term frequencies among the three documents. The differences mirror well the approaches taken by the different policies. For example, the ratio of mentions of the terms ‘woman’ and ‘man’ (and their variations) is highest in the Global Strategy, at approximately 36:1. On the other hand, in the HIV policy the ratio is nearly 1:1. Common to all three strategies is the paucity of mentions for the relational terms ‘couple’ and ‘partner’ and their variations.

Figure 4: Term frequencies compared



Taken together, this paper's literature review and policy analysis show some parallels with respect to receptivity to the inclusion of men and couples as an explicit strategy to improve reproductive health outcomes. The Global Strategy, with a primary focus on women's, children's and adolescents' health, largely ignores opportunities for male and couple engagement³, which corresponds well to the lack of literature on couples and maternal health—the lowest of the three subfields. The amount of literature on couples and family planning is significantly greater than in maternal health, mirroring the ICPD's openness to the involvement of men and couples, even though there is still a paucity of literature on this topic. Finally, the HIV-related policy includes men as an essential part of the epidemiological portrait of the infection, corresponding to comparatively much greater receptiveness in the literature to CFIs. But also like the policy, studies on couples in HIV do not demonstrate a relational approach and continue to use individual models and outcomes to understand change.

It is also important to note that none of the policies highlighted adolescent and young couples nor their particular needs. Findings from the literature and policy reviews showed that young couples were nearly as absent as men. The reviews revealed that reproductive health programs and policy continue to focus on adults or unmarried adolescents, while the needs of adolescent and young couples remain unaddressed. This is despite the fact that a large number of adolescents are in unions and that the majority of adolescent childbearing occurs in the context of marriage (Sarker 2015). This leads one to the conclusion that while CBAs are still relatively rare, reproductive health research, policy and practice related to same-sex couples, polygamous couples, and adolescent couples are rarer still.

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KEY INFORMANT INTERVIEWS

The key informant interviews conducted by the lead investigator focused on the topics which would be most helpful in making analytical sense of the findings of the literature review and policy analysis. This brief will focus on three major themes: (1) the definition of couple-focused interventions, (2) reconciling couple-based approaches with the realities of reproductive health service delivery and (3) supply and demand for couple-focused data. Additional themes—including usefulness of CFIs as a public health category and frequency of use of CBAs across the subfields—can be found in the full report.

DEFINITION OF COUPLE-FOCUSED INTERVENTIONS

Key informants generally agreed that in couple-focused interventions, the couple becomes the unit of intervention. For research participants, this meant that at least some component of the intervention brought both members of the couple (either as a single couple or in groups of couples) “to learn together, communicate together, and to understand their reproductive situation together—and possibly to make decisions together,” said one gender technical advisor.

It is important to note what key informants thought couple-focused interventions were not. Participants saw a distinction between CFIs and ‘male involvement,’ which they perceived as an all-encompassing term to denote the various ways and efforts to engage men in addressing diverse reproductive health challenges, including programs, behavior, and rights (Yargawa et al. 2015) for example through efforts to change gender norms and behaviors associated with intimate partner violence. Male involvement efforts, informants said, can either target men alone or be with their partners' involvement. They also thought CFIs did not mean gender-synchronized programming (Greene and Levack 2010), where one is aware of the relational aspects of gender, involves both men and women, and is “cognizant when things [between the sexes] need to move separately and/or where there are opportunities are to move things together and to coordinate programming intentionally,” whether the participants involved are coupled or not. Rather, they viewed CFI as a broader term that is not limited to just a couples focus as the unit of intervention.

Finally, key informants did not believe that a couple-specific outcome (e.g., increased shared decision making) was required to qualify as a couple-focused intervention. Referring to FP use, one informant, a reproductive health consultant, said, “It could be that the end result is that the woman makes the decision about usage on her own.” Participants thought any traditional health outcome, couple-specific or individual—such as increased uptake of family planning by women—was appropriate in CFIs as long as the couple was conceived of as the unit of intervention from the start.

RECONCILING COUPLE-BASED APPROACHES WITH THE REALITIES OF REPRODUCTIVE HEALTH SERVICE DELIVERY

Despite general consensus about the effectiveness of CFIs and the marginalization of men in family planning policy, practice, and research, the key informants all agreed that the promotion of

3 According to the USAID/PRH report titled “Essential Considerations for Engaging Men and Boys for Improved Family Planning Outcomes”, male engagement in FP refers to the involvement of men and boys across life stages as a) clients/users, b) supportive partners and c) agents of change. The goal of male engagement goes beyond the mere inclusion of men and boys as program beneficiaries. Integral to FP programs that engage males is intentional attention to challenging unequal power dynamics and transforming harmful forms of masculinity...to improve men and women's RH and contribute to gender equality outcomes”



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women's right to make the final decision about family planning use and method choice was critical. Given that, is it essential, or does it even make sense, to include couples counseling in family planning services or in other services? Key informants presented a series of issues that would need to be addressed to provide couple-focused interventions effectively.

First, if the service is to guarantee women's ultimate decision-making power over method use, a couple-focused approach may call for a certain level of inefficiency, according to one participant, as it may entail asking women first about their comfort level regarding their partners' involvement in joint counseling, then providing the counseling session to both, and finally confirming method choice (if any) with the woman alone. The same participant, a senior leader at an international NGO, questioned whether such a process would be realistic in a low-income country setting with human resource shortages in health. It is important to note that the complexities of consent raised by this informant would also apply to other areas, such as prevention of mother-to-child transmission (PMTCT), birth preparedness and complications readiness planning, and couple HCT.

A second issue that participants raised is the capacity of staff to assess whether partner participation is appropriate. What skills would the provider require to determine when partner participation is inappropriate, such as in cases of intimate partner violence or if some form of reproductive coercion (e.g., birth control sabotage)? Is it realistic in a low-income country with few providers and long patient queues to expect staff to be able to make these assessments quickly and effectively?

Third, nearly all participants highlighted the additional skills that the provider would need to counsel couples in a gender-sensitive or transformative fashion⁴. One informant discussed the complexity of counseling heterosexual couples where "the overlay of unequal gender norms" risks providers deferring decisions to men. In some cases, one gender technical advisor said, it "may not be a

realistic option that the couple will walk out with a contraceptive method." She added that it was important to acknowledge that "men and women don't come in on equal ground...in terms of power and knowledge." Providers would need to be skilled to ensure shared couple learning, conversation, and decision making in order to protect women's reproductive rights.

Fourth, the majority of informants, open to the idea of couple-based approaches, indicated that one rationale for their incorporation was that the sexual and reproductive rights of men should not be forgotten. One informant said that men's incorporation would not represent a move away from women's rights, but rather "keeping in mind patriarchy, we also have to think about men's rights to information and to manage their own sexual and reproductive lives." This informant went on to discuss some emerging research on the importance of reproduction to men, a field which has almost been entirely neglected, she said. In the process of incorporating men into couple work, she added that "it's possible to think about gender equality and uphold women's rights and recognize the asymmetry of their experience." Another informant, a senior leader of an international NGO, reflected on the near exclusion of men from RH services. He said that some women's rights efforts have been counterproductive. He argued that while these efforts have sought to protect women's autonomy, they have been less likely to recognize or address the unfair burden placed on women when they alone are responsible for matters related to reproductive health.

Finally, the need to modify or overhaul established systems and institutions emerged as a challenge to the incorporation of couple-focused interventions. Those already mentioned by informants include training for staff and changes in guidelines and protocols. Another informant, a university professor, mentioned that incorporating couple-focused work would mean "creating a health service space that was conducive to couple engagement, including adequate space, privacy, and that had IEC [information, education, and communications] material specifically geared to them."

⁴ Gender sensitive (or 'accommodating') interventions acknowledge existing gender norms and inequities and develop activities to adjust to and/or compensate for them. They do not actively aim to change norms, but strive to limit any harmful impacts they may cause either directly or indirectly. Gender-transformative interventions seek to challenge or transform power dynamics to promote the sharing of decision making, control of resources, and support for women's empowerment and gender equality (Gupta 2005)

SUPPLY AND DEMAND FOR COUPLE-FOCUSED DATA

Key informants also brought up the issue of data and its impact on the relationship among policy, research, and practice. The key informants collectively indicated that incentives to gather information from men as part of a dyad or on couples as a unit of intervention are virtually nonexistent in mechanisms such as DHS and international agreements that capture FP/RH-related targets. These comments point to the relatively closed system that the supply and demand for information can become between: 1) donors and ministries of health who determine the kinds of data to be collected by DHS at the national level, 2) the kind of information that is available for global health policymaking and, consequently the policies that are made and monitoring indicators that are developed, and 3) the role of policy in agenda-setting for both research and practice. As one researcher said, “DHS data really does shape the conversation. The people working in countries may not integrate socially appropriate interventions because they aren't things that are measured.”

DISCUSSION

Factors contributing to the scarcity of CBAs in policy and practice include: 1) the lack of global or national indicators, which disincentivizes programs from using and tracking the results of CFIs, 2) the lack of consensus about the roles that men can play in advancing the RH agenda, 3) the emphasis on biomedical approaches to reproductive health at the expense of broader social determinants (such as couples dynamics) of reproductive health outcomes, 4) the almost systematic exclusion of men from reproductive health (possibly stemming from an implicit assumption that reproductive health is only relevant to women), and the subsequent formation of particular service delivery structures that function as barriers to men and couples, and 5) the logistical and ethical challenges of implementing changes in service delivery needed to enable the adopting of this approach.

Nonetheless, CFIs are a promising approach to consider when working to improve reproductive health outcomes. CFIs, conducted with properly trained health workers, provide couples an opportunity to learn and discuss options together (including regarding risk reduction), provide mutual support (in case of disclosure), make decisions together, and plan for the future. Globally, increased advocacy for couples-based approaches could help shift the reproductive health framework away from focusing almost exclusively on women to also include couples, where both partners are seen as potentially contributing to improved couple and family health.

PHOTO Amy English



RECOMMENDATIONS

The following recommendations—built from the findings from the literature review, policy analysis, and key information interviews—are intended to provide guidance and promote greater cohesion among global RH networks in understanding men and couples as integral and necessary to RH promotion and care services. A higher degree of consensus regarding the role of CBAs in reproductive health programming could also potentially lead to policies that more effectively support concrete and sustained improvements in key reproductive health indicators, such as contraceptive prevalence, maternal and neonatal mortality, and HIV incidence, treatment, and ART adherence.

CONCEPTUAL, METHODOLOGICAL, AND PRACTICE CONSIDERATIONS

- Ensure a clear distinction between “couple-based approaches” and the broader umbrella term “male involvement” to give a better sense of what kind of programming is effective for each
- Encourage conscious model-building or the development of conceptual frameworks to understand couples, power dynamics in intimate relationships, gender norms, and behavior change related to RH. Using individual models of change is not adequate to account for the complexity of couple relationships and their health outcomes.
- Consider a diversity of “couple” types in intimate relationships (e.g., adolescent and youth couples, polygamous unions) and different gender and power dynamics to capture the complexity of couple relationships in different countries and contexts, and their health outcomes
- Strengthen the competency of health care providers and community health workers to counsel couples to facilitate informed and gender-equitable decision making through communication, negotiation, and skills development. The importance of couple counseling, and the normalization of couple communication generally around RH, cannot be over-emphasized.
- Ensure health facilities have protocols for: 1) service consent that guarantees women's autonomy to make informed reproductive health decisions about their own bodies, and 2) intimate partner violence (IPV) screening (where support services are available), to help ensure that men's involvement will not be harmful. Protocols should instruct providers to ask women whether they want couples counseling and should ensure that when couples are being counseled the provider has the skills to counsel couples and men in a way that upholds gender equity principles.
- Scale-up evidence-based interventions across the spectrum of RH, including couple-focused interventions
- Weigh the benefits of CFIs against additional costs to the health system to shore up needed capacity and resources

POLICY RECOMMENDATIONS

- Normalize the participation of men and couples, including adolescent and youth couples across the spectrum of RH services by promoting joint responsibility of the couple for reproductive and family health without compromising equity of access to services for women
- Incorporate specific gender equity objectives alongside objectives to achieve specific RH outcomes—be it at the policy or programmatic level
- Advocate for the inclusion of indicators for couple engagement in research and multilateral, national, and donor reporting frameworks to create demand for couple-focused programming
- Organize expert consultations that bring together governmental policymakers, donors, researchers, implementing NGOs, and advocacy groups to examine the research and promote discussions to advance the global conversation on couple-based approaches in policy and practice

SUGGESTIONS FOR FUTURE RESEARCH

- Explore how couples who utilize reproductive health services differ from those who do not, including examining whether it is couples who already demonstrate good communication patterns that use services or if services are attracting the “lowest hanging fruit”. Consider whether relationship quality and “connectedness” is a confounding factor in the relationship between utilization and health outcomes.
- Investigate the acceptability and effectiveness of diverse intervention sites outside of the clinical setting, including community, home-based, and institutional settings that may be conducive to couple engagement with skilled personnel, while ensuring women's autonomy to make decisions
- Determine the most effective ways to reach men, raise awareness about their roles, and encourage their participation in RH programming, including addressing and challenging gender and power dynamics
- Examine the extent to which CFIs are cost effective, humane (or offer respectful care), and equitable
- Explore the most effective ways to integrate and address gender and gender inequities and promote couple communication and shared decision-making in couple-focused interventions, particularly in health systems constrained by a shortage of human resources for health
- Learn more about the variety and dynamics of sexual relationships, particularly around decision making regarding reproductive health
- Seek to understand more about men's reproductive life course, including their reproductive and relationship aspirations (regardless of their sexual orientation), their roles in these relationships, and their roles vis-à-vis reproductive health services as partners in the processes of prevention, care, and treatment, and as users of services
- Further the research on adolescent couples, on which there is almost no literature. Given that substantial proportions of adolescent girls and boys are already in unions or are parents, in sub-Saharan Africa for instance, understanding the dynamics of these relationships, and the special challenges that adolescents face, becomes important. Further research is also needed on couples that include an adolescent girl with a partner that may be significantly older.

The Evidence to Action (E2A) Project is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and facilitating the scale-up of best practices that improve family planning services. The project is led by Pathfinder International, in partnership with ExpandNet, IntraHealth International, and PATH.

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