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for Strengthened Reproductive Health

**MARCH 2021**

# Couple-Based Approaches in Reproductive Health: Implications for Global Policy, Practice, and Research

**TECHNICAL REPORT | E2A PROJECT**



## **ABOUT E2A**

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 health care needs of girls, women, and underserved communities around the world by increasing support, building evidence, and leading the scale-up of best practices that improve family planning services. A Cooperative Agreement awarded in September 2011, E2A will continue until March 2021. E2A is led by Pathfinder International in partnership with ExpandNet and IntraHealth International.

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## ACRONYMS AND ABBREVIATIONS

<b>AIDS</b>	Acquired immune deficiency syndrome
<b>ANC</b>	Antenatal care
<b>ART</b>	Antiretroviral therapy
<b>CBA</b>	Couple-based approaches
<b>CFI</b>	Couple-focused interventions
<b>CHCT</b>	Couple HIV counseling and testing
<b>DHS</b>	Demographic and Health Survey
<b>E2A</b>	Evidence to Action project
<b>FP</b>	Family planning
<b>FTM</b>	First-time mother
<b>FTP</b>	First-time parent
<b>HCT</b>	HIV counseling and testing
<b>HIV</b>	Human immunodeficiency virus
<b>ICPD</b>	International Conference on Population and Development
<b>IPV</b>	Intimate partner violence
<b>MH</b>	Maternal health
<b>MSM</b>	Men who have sex with men
<b>NGO</b>	Nongovernmental organization
<b>PMTCT</b>	Prevention of mother-to-child transmission (of HIV)
<b>PrEP</b>	Pre-exposure prophylaxis (for HIV)
<b>RH</b>	Reproductive health
<b>SCS</b>	Safer conception strategies
<b>SDG</b>	Sustainable Development Goals (UN)
<b>STI</b>	Sexually transmitted infection
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Program on HIV/AIDS
<b>USAID</b>	United States Agency for International Development
<b>UTT</b>	Universal test and treat
<b>WHO</b>	World Health Organization

## KEY TERMS

**Couple-based approaches:** In this paper, the term couple-based approaches (CBAs) is used as 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.

**Couple-focused interventions:** The term couple-focused intervention (CFI) applies only to public health practice. CFIs conceptualize “the couple” as the unit that the intervention targets. CFIs seek to change one or more elements of that relationship to achieve an explicit couple-focused (e.g., couple communication) or individual reproductive health outcome (e.g., women’s utilization of a modern contraceptive method)—whether that intervention is conducted wholly with the couple as a unit, or working with each member of the couple toward the intervention goal, but not necessarily at the same time (Greene and Levack 2010).

**Epistemic community:** A transnational network of “professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy relevant knowledge within that domain or issue-area” (Haas 1992). The epistemic community plays a role in articulating the cause and effect relationships of complex problems, helping states identify their interests, framing the issues for collective debate, proposing specific policies, and identifying salient points for negotiation (LSHTM 2014).

**First-time parents (FTP) programming:** FTP programming provides life-stage responsive, small group health and life skills education to young women and men; home-based visits; and increased linkages to health services. This targeted programming is meant to increase family planning utilization, promote healthy spacing and timing of pregnancies, and address the social and gender issues that this underserved population faces.

**Gender-based interventions:** Gender-based interventions specifically promote social norms that support gender equality. These interventions make the target audience explicit (i.e., men, women, both, etc.). They also have separate programmatic and budget line items in program or project workplans.

**Gender transformative:** Gender-transformative interventions seek to challenge or transform gender and power dynamics to promote the sharing of decision making, control of resources, and support for women’s empowerment and gender equality (Gupta 2000).

**Gender sensitive:** 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-sensitive interventions can provide a first step toward gender-transformative programming (Gupta 2005).

**Health system:** This paper takes an expansive view of health systems. A health system includes “[a]ll organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities.” The World Health Organization (WHO) describes health systems through use of an analytical framework that disaggregates their essential elements into six core components: leadership and governance (stewardship);

service delivery; health workforce; health information system; medical products, vaccines and technologies; and health system financing (World Health Organization 2007). This paper also views “community” as an important building block of health systems, as communities are important sites for the generation and maintenance of health (Marston et al. 2016).

**HIV care continuum:** Sometimes also referred to as the HIV treatment cascade, the HIV care continuum is a model that outlines the sequential steps or stages of HIV medical care that people living with HIV go through, from initial diagnosis to viral suppression, and shows the proportion of individuals living with HIV who are engaged at each stage. These stages include HIV testing and diagnosis, getting and staying on antiretroviral treatment (ART), and achieving viral suppression (US Department of Health and Human Services 2018).

**Male involvement** is an all-encompassing term which refers to “the various ways in which men relate to reproductive health problems and programs, reproductive rights and reproductive behavior” (Green et al. 1995).

**Sexual and reproductive health and rights:** This paper uses the following definition and descriptor for this term: “Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have;
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence” (Starrs et al. 2018).

**Sexual and reproductive health services:** This paper considers the recommended package to include commonly provided services, such as contraceptive services, maternal and newborn care, and prevention and treatment of HIV/AIDS. “Additionally, the package includes less commonly provided components: care for sexually transmitted infections (STIs) other than HIV; comprehensive sexuality education; safe abortion care; prevention, detection, and counselling for gender-based violence; prevention, detection, and treatment of infertility and cervical cancer; and counselling and care for sexual health and wellbeing” (Starrs et al. 2018).

**Treatment as prevention:** Evidence shows that individuals on ART with an undetectable viral load cannot transmit HIV to others. WHO guidelines call for “test and treat” strategies—initiating all people diagnosed with HIV on ART as soon as possible after diagnosis—as a way to decrease community viral load and reduce the incidence of HIV (Perriat et al. 2018).

**Universal test and treat:** Instead of focusing solely on prescribing ART to those who are living with HIV to prevent transmission (treatment as prevention), universal test and treat offers HIV counseling and testing (HCT) to the population as whole, identifying HIV-positive individuals and providing immediate ART initiation and retention support (Perriat et al. 2018). The theory is that “if a high proportion of the population can be tested, with those found to be HIV-infected offered immediate ART, HIV infection could be reduced substantially within two years and could potentially be eliminated as a public health problem in the longer term” (Hayes et al. 2014).



## PREFACE

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. E2A’s focus on FTPs was triggered by efforts to understand the diversity of youth reproductive health (RH) experiences and needs. A review of global data revealed a large subset of young first-time mothers (FTMs) who are at increased risk of poor pregnancy, delivery, and child health outcomes, a situation compounded by multiple factors that limit their access to timely health information and services.

Despite these vulnerabilities, adolescent and youth family planning (FP) and RH programs have historically overlooked young FTPs, a global gap confirmed by E2A’s 2014 review of available literature. As young women and men who have started having children, FTPs’ needs often extend beyond the scope of many adolescent and youth programs. Similarly, the issues faced by young parents are not typically addressed in broader programs aimed at women of reproductive age or even married youth.

E2A has been working to close this gap by reaching FTPs in Nigeria, Tanzania, and Burkina Faso with health and gender interventions and by gathering new evidence on effective programming for this subset of youth. In doing so, we have learned a number of lessons. First, for many FTPs, their relationships may be transitional. Even if married, they are typically new to the nature and exigencies of affective/sexual relationships. We also found that the types of relationships that FTPs had vary from place to place. While all of the FTPs we worked with in Burkina Faso were married, for example, many FTMs in Nigeria and Tanzania identified as single and had more fluid relationships. Despite the variety of relationships, FTPs across contexts expressed interest in addressing key issues like communication and conflict management to improve their relationships. In response to this interest, E2A added its first couple-focused component to its Burkina Faso Phase II FTP project in Year 9, even though most of E2A’s FTP programs had previously reached young women and men separately.

However, in beginning to think through the possibility of couple-focused interventions, 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. Thus, given previous FTP programmatic experiences, including the relative powerlessness of FTMs in their relationships and the relative invisibility of young couples in the reproductive health literature and policy arena, E2A staff sought to examine the gender-transformative potential of couple-focused interventions within the FTP framework—and beyond—to improve reproductive health outcomes. One question we raised was whether FP/RH programs would achieve greater results by viewing the couple as the unit of intervention, compared to focusing on young members of the couple alone or separately. If couple-focused work does yield greater results, is this consistently true? In other words, what are the cultural and relationship factors that are important for success? What policy guidance, if any, exists to inform this type of work? Finally, what kinds of programmatic and health systems adaptations would be necessary to accommodate and encourage couple-focused interventions?

E2A commissioned this research paper to look further into these questions. The research comprises three components: a literature review, a global reproductive health policy analysis, and key informant interviews. The scope of the inquiry goes beyond family planning to include maternal health and HIV, a reflection of the growing scope of E2A's FTP programming and commonsense approach toward the integration of FP across the spectrum of the reproductive health area. Also, due to the paucity of literature on the topic, especially on young couples, this research included the diversity of pairings to glean insights into the possibilities of couple-focused interventions to achieve reproductive health outcomes.

The hope is that through dissemination of the findings of this report, E2A can lay the groundwork for future programming which recognizes both women and men as essential assets to reproductive and family health.

## INTRODUCTION

In pursuit of the Millennium Development Goals, and now the 2030 Agenda for Sustainable Development, states around the world have made substantial progress in the areas of family planning, maternal health, and HIV/AIDS. Between 1990 and 2015, the maternal mortality ratio decreased 44%, from 385 deaths per 100,000 live births to 216 (Alkema et al. 2016). By 2016, more than two-thirds of people living with HIV knew their status and over half were accessing antiretroviral therapy (ART) (UNAIDS 2017). Finally, the need for family planning is increasingly being met by modern methods in the developing world: in 2017, the proportion of unmet need being satisfied by modern contraception was 76% (Guttmacher 2017). However, several factors are hampering further progress in realizing reproductive health goals. In many low-income countries, these include weak political leadership, a lack of commitment and resources, and persistent gender and other social inequalities (Starrs et al. 2018). In addition, some advanced economies share the challenges seen in low- and middle-income countries of inequitable access to and low utilization and quality of health services, which compromises the wellbeing of particular communities (e.g., low-income and rural areas), and ethnic and sexual minorities within and between countries (Nelson et al. 2018, Starrs 2018).

The 1994 International Conference on Population and Development (ICPD) opened the way to couple-focused interventions by enabling a more inclusive vision of reproductive health. The resulting document represented a global shift in how family planning was conceptualized, from a focus on population control to a broader emphasis on sexual and reproductive health and rights (UNFPA 2014). This expanded vision acknowledged the role that gender, including questions of control, choice, and rights, plays in the ability of women to realize their sexual and reproductive health (United Nations 1995).

One of these factors was the influence of gender inequality on women's health, generally, and on adverse reproductive health outcomes, in particular. Since the ICPD, efforts to address gender inequality as a strategy to promote RH have resulted in programs and policies focused on the rights and empowerment of women. Significantly, and for the first time, the ICPD also acknowledged the role of men in women's lives and health. It called for the increased involvement of men in services, acknowledging men's responsibilities in reproduction and the prevention of adverse reproductive health outcomes. But despite this call for a more holistic approach involving both men and women and the ICPD's frequent reference to "couples and individuals," few efforts have focused on couples—especially young couples—as the unit of intervention in either reproductive health service delivery or health policy formulation. This is true not just of non-traditional "partnerings" (Wentzell and Inhorn 2014), such as polygamous unions and same-sex couples, but also of traditional unions. The failure to consider the couple as a unit reaches beyond family planning to other reproductive health subfields, including maternal health and HIV.

Although this approach is infrequently employed, couple-focused interventions in reproductive health are of compelling public health interest for three reasons. First and pragmatically, "most sexual, family planning, and childbearing decisions are made or may potentially (and perhaps ideally) be made by both partners of a couple" (Becker 1996). Further, 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 (e.g., cognitive and motivational factors) as the exclusive explanatory framework for infection. Instead, works of medical ethnography have highlighted not only the structural forces (Farmer 1999, Nguyen 2005) but also the complex range of social relationships (Padilla 2011), and especially the importance of understanding the nature and quality of the relationship between partners, including the “entanglement between sexual behavior and affective relations” (Cole and Thomas 2009) that drives sexual transmission. As a result, there is “growing consensus that HIV prevention research should address couples as a unit of behavior change and intervention” (Burton et al. 2010). Second, couple-focused interventions show promise. A preliminary review of the literature 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 alone (Becker 1996, Burton et al. 2010). Finally, although the motivations to employ couple-focused interventions (CFIs) and the obstacles to their utilization vary by reproductive health subfield (see Table 3), couple-focused interventions collectively represent an opportunity for gender-transformative programming to change the dynamics of power within relationships, promote couple communication and shared decision making, and alter the commonly held perception of male partners as obstacles to reproductive health to constituent components of reproductive health service delivery and policy (Theuring et al. 2009).

This paper examines the potential of couple-focused interventions as a valuable gender-transformative strategy to accelerate progress toward the achievement of the reproductive health-related Sustainable Development Goals (SDGs). In addition, this paper explores why the incorporation of couple-based approaches (CBAs) in global reproductive health policy and practice has been so limited, despite the emergent literature illustrating their effectiveness on key RH indicators, including contraceptive prevalence, maternal morbidity and mortality, HIV counseling and testing (HCT), initiation of antiretroviral therapy (ART), ART adherence, and viral suppression.

## **Research Aim and Objectives**

This research paper seeks to evaluate the effectiveness of couple-focused interventions in reproductive health and examine the conceptual frameworks that inform these approaches (or their exclusion) to better understand the reasons behind the relatively limited use of this approach to date, with the hope of adding to the evidence base regarding the effectiveness the approach in improving reproductive health-related outcomes. The specific objectives of this research were to:

1. Review the public health literature to examine the effectiveness of couple-focused interventions in reproductive health (including barriers and facilitating factors to effective implementation) and the differential impact that couple-focused approaches has on different RH areas: family planning, maternal health, and HIV.
2. Analyze key global reproductive health policy documents to examine how couple-based approaches are discussed and the conceptual frameworks that inform those discussions.
3. Elucidate the relationship between the findings of the literature review and policy analysis components of this research through semi-structured interviews.

4. Develop recommendations for couple-focused interventions as they relate to future RH policy, practice, and research and, more generally, couple-based approaches.

## METHODOLOGY

This study employed a variety of methods, primarily qualitative, to help ensure the validity of data. These included a desk review of the public health literature, an analysis of key global policy instruments, and standardized semi-structured key informant interviews. The four basic elements of qualitative research—triangulation, iteration, flexibility, and contextualization—were utilized to guide the effort (Oomman and Gittelsohn 2003).

Approval for the study protocol and tools was granted on June 19, 2017 from the London School of Hygiene and Tropical Medicine Research Ethics Committee (LSHTM MSc Ethics Ref: 12110).

### Literature Review

The study investigator developed the following questions to systematize the literature search:

- How effective are couple-focused interventions in achieving positive reproductive health outcomes?
- What does the literature reveal about the factors that inhibit and enable effective implementation of couple-focused interventions in reproductive health?
- What conceptual frameworks inform discussions about couple-focused approaches in both the public health literature and in key global reproductive health policy documents?
- What does the literature review reveal about the existing gaps in knowledge, where further research about couple-focused interventions is needed?

The investigator searched electronic databases PubMed, Embase, and POPLINE to identify relevant studies. Boolean operators were used to conduct searches which included synonyms and subject headings (where available) for terms such as “couple,” “reproductive health,” “family planning,” “HIV/AIDS,” and “maternal health,” for example, (couple\* OR married OR dyad) AND (family planning OR contracept\*). The investigator searched umbrella terms such as HIV and maternal health, first, as a broad category, and second, by their constituent service components. For example, for maternal health, the “couple” synonyms were combined sequentially with “prenatal” and “antenatal” care; “delivery” or “maternity” care; and “postpartum.” Similarly, HIV was broken down into HIV counseling and testing, prevention of mother-to-child transmission of HIV (PMTCT), ART, treatment, care, adherence, and prevention. All key studies identified were cross-referenced for further citations.

The literature review utilized the following inclusion and exclusion criteria:

- The search was limited to three primary areas of concern within reproductive health: family planning, maternal health, and HIV. Within these areas, preference was given to articles focused on key reproductive health outcomes, such as contraceptive use, maternal morbidity and mortality, HCT, ART initiation and adherence, and viral suppression.

- This study was limited to literature on clinical, community-based, and behavioral reproductive health interventions that target couples as the unit of intervention. This means that studies focused on male involvement and women’s empowerment efforts that did not explicitly seek an intermediate or long-term health outcome where the couple was conceptualized as the basic unit of intervention were excluded.
- The review included systematic reviews, studies with experimental or semi-experimental designs, and qualitative studies that appear in the academic, peer-reviewed literature.
- 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.
- Because a preliminary review of the literature indicated a limited number of items on couple-focused interventions in reproductive health, there was no exclusion of items based on geographic area.
- Because one objective of this study was to examine how conceptual frameworks in public health have historically helped to shape how couples are perceived in global health policy and practice, the review included items published post-1945, the year of the establishment of the United Nations and, with it, the emergence of more coordinated global thinking about population issues.
- The study was limited to English-language public health literature.

Finally, the study investigator used the following process to analyze the results of the literature review. First, using the criteria above, 61 articles were selected for inclusion based on a close reading of the abstract. The investigator then grouped articles into their primary reproductive health subfield, read them in their entirety, and developed an article review matrix to enable analysis, extracting specific information from articles to complete the matrices. This included information about: how “the couple” was defined, outcome variables, intervention approaches or strategies, barriers or enablers to couple-focused interventions, study findings, theorized mechanisms of action, and whether the study addressed any gender or equity goal explicitly. Once completed, the matrices were reviewed 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.

## Documentary Analysis of Global Reproductive Health Policies

The following three criteria guided the selection of policy instruments for review (PMNCH 2014):

1. Global perspectives: the selected policy instruments are considered to be the guiding documents for the multilateral organizations globally responsible for family planning, maternal health, and HIV: United Nations Population Fund (UNFPA), WHO, and Joint United Nations Program on HIV/AIDS (UNAIDS), respectively.
2. Technical relevance to reproductive health: the selected documents provide guidance for the delivery of essential evidence-based reproductive health interventions to national ministries of health and other global stakeholders.
3. Time frame: the selected policy instruments are all currently in force.

The document analysis component of this project included the following policy instruments:

1. The Global Strategy for Women's, Children's and Adolescents' Health, 2016-2030
2. "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
3. WHO Global Health Sector Strategy on HIV, 2016–2021: Towards Ending AIDS

These multilateral documents are significant not only because they provide broad guidance to ministries of health—who often work to ensure that their own national strategies align with these global documents—but also to other agenda-setting global stakeholders, including large bilateral donors such as USAID and the Department for International Development; private entities such as the Bill and Melinda Gates Foundation; and global health partnerships, including the Global Financing Facility for Reproductive, Maternal, Newborn, Child, and Adolescent Health, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria. In addition, these documents provide the conceptual frameworks or paradigms which shape how an issue is understood, including the nature of the problem, its causes, questions and forms of inquiry to probe the issue, suggested solutions to the problem, expected results, and indicators to help gauge progress (Kuhn 1970). In this sense, conceptual frameworks or paradigms may affect research, practice, and policy in precluding certain questions and answers while facilitating others.

To learn how the selected policies enabled or inhibited couple-based approaches in research and practice, the study investigator analyzed the policies with the following questions in mind:

1. **Gender:** Is the policy focused primarily on women? Does it include a role for partners or other family members? Are couples explicitly mentioned or discussed? What kinds of couples are discussed? To what degree is the broad spectrum of unions acknowledged?
2. **Implementation guidance:** What, if any, guidance is given for implementation of couple-focused interventions? For what kind of couples? Does this guidance acknowledge that partner involvement may not always be desirable? Is the guidance practicable at the national or sub-national levels, particularly in low-income settings? Does the guidance propose gender-



transformative strategies (Gupta 2000) (appropriate to local gender norms) aimed toward promoting gender equality and shared decision making?

- 3. Theoretical frameworks:** Which theoretical frameworks inform discussions of gender in the policy (e.g., “women in development” [Boserup 1970], “gender in development” [Rubin 1975], medical model/proximate determinants [Bongaarts 1978], etc.)? How does the model which frames the policy preclude or enable an incorporation of couple-focused interventions?

Implicit to the three areas of inquiry above was an interest in power dynamics: not only in the ways policies accounted for power differences in addressing RH outcomes, but also the power of the RH epistemic community to decide to what degree men—and thus couples—are part of the story of reproductive health. This would provide some clues about how the professional community’s notions about gender shape the ongoing development of the reproductive health field.

The process used in analyzing these policy instruments progressed from the specific to the general (Bowen 2009, Forrest et al. 2017). First, the investigator conducted content analysis, which included tabulating simple frequencies for references to the terms “couple,” “partner,” “married,” “dyad,” “men,” “women,” “boy,” “girl,” “gender,” and their variations. The investigator then read every reference to each of these terms in context to evaluate its meaning and intent; coded each into broad categories (e.g., “gender as a multi-sector enabler” or “couples and their contraceptive needs”); and thematically analyzed the entire document, paying special attention to the themes of gender and couples, implementation guidance, and the conceptual frameworks that guided the development of the policy documents.

### Key Informant Interviews

Semi-structured interviews were conducted with key informants who are active participants in the epistemic communities across the RH subfields that view either gender-based interventions or CFIs as being critical to the advancement of RH. The key informant interviews offered a means to further explore some of the issues the preliminary investigation uncovered: Why did the use of CFIs vary so much among the RH subfields? Why were men and couples “missing” from so much RH global policy? What were the broader historical and cultural patterns influencing what seemed to be a relative systemic poverty of CBA throughout the policy cycle? The semi-structured, iterative format of the interviews (allowing, for example, an exploration of new ideas that had emerged in previous interviews) enabled a clearer understanding of how this group of actors in the transnational expert network of RH perceived the issue of couple-focused interventions in their cultural, historical, and political context.

Purposive sampling was used to select eight key informants from North America (despite many attempts to recruit participants from Europe and Africa) and included four academicians/researchers, one independent consultant, two representatives from international nongovernmental organization (NGOs), and one representative from a bilateral donor.

The hour-long interviews, conducted via Skype, explored definitional issues surrounding couple-focused interventions, policy and implementation experiences with this type of intervention, the cultural discourses and conceptual frameworks underlying efforts to promote RH and how these influence the incorporation

of couple-focused approaches in policy and practice, and subjects' recommendations about couple-focused approaches for future research, policy, and practice.

The data were subjected to interpretive analysis (Marcus and Fischer 1986, Durand and Chantler 2014). The study investigator took detailed notes, including verbatim passages of significance, from each of the eight recorded interviews and identified patterns and common themes. The key informant interview questionnaire which guided the discussions can be found in the Appendix.

# RESULTS

## Literature Review

This literature review was not intended to be exhaustive, but rather to highlight the salient themes of the emergent literature on couple engagement in RH. The review focused on studies that assessed the effectiveness of interventions in the field of couple engagement in RH. Specifically, it sought to gain a better understanding of the relationship contexts of diverse couples and the mechanisms within those relationships that could lead to positive change in key RH outcomes. Consequently, the extent of research design rigor, such as randomized control trials, was a factor in selecting the 61 articles that were reviewed in detail for this paper. The review also sought to gain insight into other forms of understanding the dynamics of gender, power, and change involved in couple-focused interventions. This included a consideration of qualitative works, state-of-the-field thematic narrative reviews, and commentaries of subject experts.

Table 1 presents the distribution of the articles reviewed by study design and area of focus. Please note that the column “Reproductive Health” refers to articles that focused on more than one of the reproductive health subfields.

**Table 1:** *Distribution of reviewed articles by study design or objective, by RH subfield*

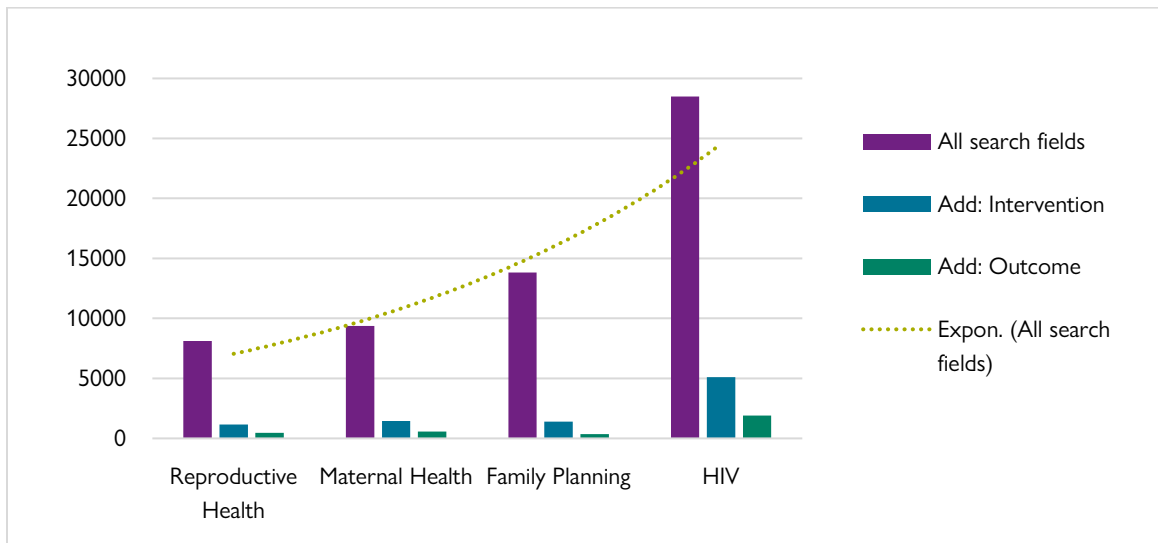
<b>Study Design</b> (Fisher et al. 2002)	<b>Reproductive Health</b>	<b>Maternal Health</b>	<b>Family Planning</b>	<b>HIV and AIDS</b>	<b>RH/HIV Integration</b>	<b>Total</b>
<b>Experimental</b>	1 study	2 studies	4 studies	6 studies	3 studies	16
<b>Quasi-Experimental</b>			2 studies	3 studies		5
<b>Non-Experimental</b>		2 studies	2 studies	13 studies	4 studies	21
<b>Literature Review</b>	1 study	2 studies	1 study	3 studies	2 studies	9
<b>Thematic Narrative</b>			1 study	9 studies		10
<b>Total</b>	2 studies	6 studies	10 studies	34 studies	9 studies	61

### The number of articles per subfield

When the search process began, the first issue of note was the large variation in the number of articles identified by RH subfield. Figures 1 and 2 highlight this variation from PubMed and Embase database

searches, respectively. The articles identified using the “all fields” filter in PubMed (the blue bar), for example, portray a nearly stepwise increase in the number of articles retrieved, from approximately 8,000 for “couples and reproductive health,” to about 9,000 for “couples and maternal health,” to just over 14,000 for “couples and family planning.” The pattern then changes, with a huge leap for “couples and HIV,” with the number nearly doubling to ~28,000. When the search terms “intervention” and “outcome” are introduced one at a time (the red and green bars, respectively), the number of articles identified across the subfields drops substantially, but the relative distribution pattern remains.

**Figure 1:** Number of articles retrieved by searching “couples” + subfield: PubMed search, August 2020



For the Embase search, the disparity in the numerical distribution of articles retrieved by subfield becomes even more pronounced. Although the number of articles identified falls by about two-thirds for each of the subfields, the trend line becomes much steeper.

**Figure 2:** Number of articles retrieved by searching “couples” + subfield: Embase search, August 2020

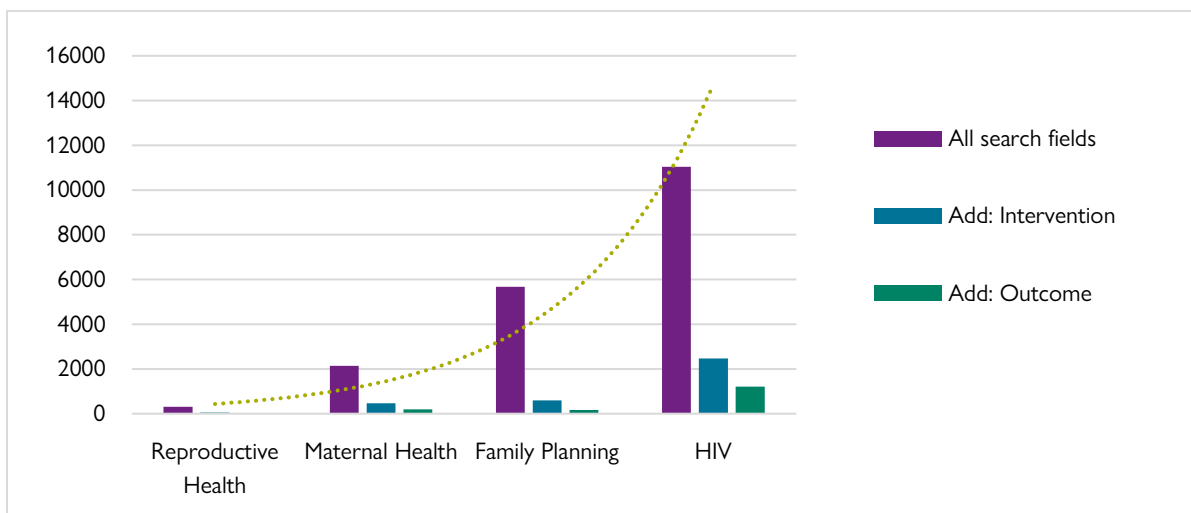
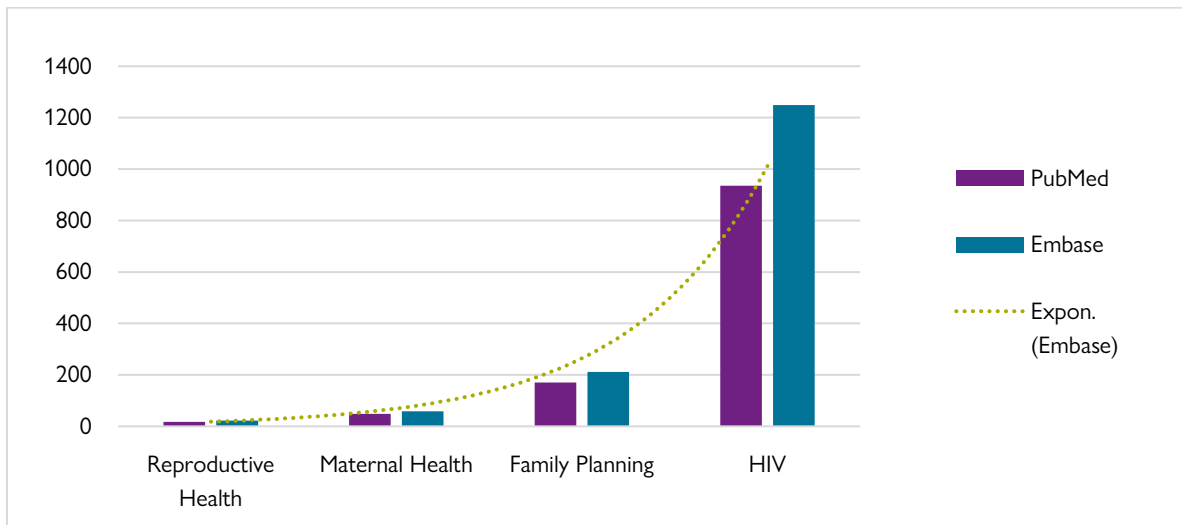
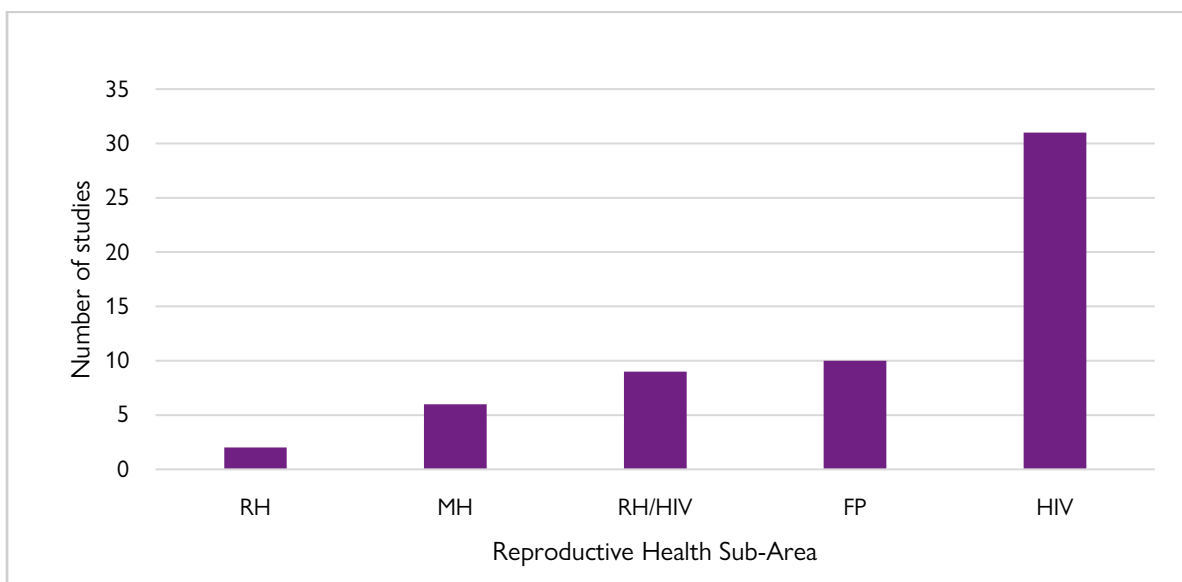


Figure 3 compares PubMed and Embase searches when the query is limited to searching only article titles. Not surprisingly, the number of articles retrieved across the subfields drops significantly, and the divergence in the number of articles identified between HIV and the other RH subfields persists. When looking at the Embase bars (red), for example, about 180 articles were identified for family planning, while this number increases five-fold for the “couple\* and HIV” search, standing at nearly a 1,000. Finally, Embase identified more articles in each of the subfield categories than PubMed when the search was limited to the title field.

**Figure 3:** Number of articles retrieved by subfield, title field only: PubMed and Embase compared, September 2020



**Figure 4:** Distribution of articles included in this study, by RH subfield



Several observations can be made from the literature search process. First, there was a relative paucity of articles about engaging couples in RH interventions, generally. Second, maternal health had the fewest number of studies that referenced any kind of couples engagement; the number of articles documenting this increases significantly for family planning. Finally, it is clear that the field of HIV/AIDS conducts a dramatically higher number of studies on couples than either maternal health or family planning.

### **Definition of the couple**

The articles reviewed for this study used a variety of definitions of “couple,” both implicit and explicit. This was true of studies across the reproductive health subfields and regardless of the study populations, including heterosexual and homosexual couples, youth, seroconcordant or discordant couples, and ethnic minority groups in lower and middle-income countries as well as highly developed economies. Studies ranged from providing no definitions at all (e.g., “pregnant women and their male partners”), (Zolna et al. 2009, Wall et al. 2017, Melo et al. 2013, Becker et al. 2008, Lemani et al. 2016, Feinstein et al. 2018, Gamarel et al. 2018) to couples who “self-identified” as such (La Croix et al. 2013) to relationships “characterized by romantic/sexual intimacy,” and legally married couples (Sarkar et al. 2015, El-Khoury et al. 2016). Cohabitation was an important criterion for coupledness in a good proportion of the studies reviewed. Mostly, the timeframe of this cohabitation was left undefined (Hartmann et al. 2012, Feinberg et al. 2015). However, a few studies used six months as a benchmark (Tilahun et al. 2015, Darbes et al. 2019, Kabalu et al. 2018), while one study in Malawi used the eligibility criterion of “spending at least one night per week together” (Becker et al. 2014). Two studies on family planning provided relatively specific definitions: “Any man-woman pair of reproductive age with an ongoing sexual relationship, where the definition of ongoing in terms of time may vary between contexts and a sexual relationship implies a risk of pregnancy” (Becker and Robinson 1998).

While Burton argues that the lack of definitional uniformity makes it difficult to draw conclusions about the types of couples and couple attributes that might contribute to the effectiveness of interventions (Burton et al. 2010), other studies suggest that rigid definitions might conceal as much as they illuminate. For example, two studies excluded polygamous unions because of the potential data redundancy their inclusion could introduce (Tilahun et al. 2015, Becker et al. 2014). Another author asserted that even though a substantial proportion of adolescents are parents and that 90% of their children were conceived in wedlock, youth are often overlooked in research, policy, and practice because they do not conform to traditional notions of “the couple,” making them somewhat invisible as subjects of inquiry and policymaking.

Mullany, in her study of barriers to male involvement in maternal health in Nepal, argues that resistance to couple-focused interventions arise in part because of the perceived “imposition of Western standards on gender roles and ideals, the reinforcement or perpetuation of patriarchal domination...” in their definition (Mullany 2006)—a point which will be revisited later. Mullany’s argument is reinforced by Grabbe and Bunnell (2010), who argue that HIV services must be responsive to the diversity of couples, which can “vary widely and may be polygamous or monogamous; casual or formal; between cohabiting or non-cohabiting partners; among heterosexual, same-sex, or transgender persons; and among low-risk or higher-risk individuals such as injecting drug users and sex workers.” Wentzell and Inhorn (2014)

encourage a more open and contextual approach, defining “the couple” more expansively with the concept of “partnering”: “instead of focusing on women as the central actors in reproductive health and male partners as supplemental, ‘partnering’ is a context-dependent interaction performed by gendered actors in ways that are intimately shaped by local social contexts (involving politics, economics, age distributions and the like)” in reproductive health contexts, an approach that this paper embraces.

### **Outcome variables**

Table 2, below, lists the variables that studies assessing couple-focused interventions used. One observation of note is that both couple-focused interventions and interventions that focus on individuals emphasize traditional health outcomes. In other words, outcomes still largely focus on individuals, as relatively few sought to change any variables related to the dynamics of the couple relationship. Another observation which may not be apparent from the table is that studies that focus on heterosexual couples are much further along in assessing concrete health outcomes than those focused on homosexual couples. Those that focus on gay couples—and they were all *male* couples—are still largely at the stage of assessing acceptability of interventions and their utilization, or they are exploratory studies on the effects of relationship factors that can contribute to health outcomes (Tan et al. 2018). Outcome indicators are listed only once in the table, even though they might have been used by more than one study.

### **Intervention approaches**

What strategies did the interventions use to achieve these outcome variables? Below are a few short examples, one from each of the RH subfields plus RH/HIV integration, to provide a sense of the diversity of the approaches utilized and the types of couples engaged. See Table 3 for findings from the interventions implemented in the examples below.

- **Maternal Health:** Mullany et al. (2007) focused on currently married women attending their first antenatal care (ANC) visit in Nepal whose husbands were present at the hospital compound. She aimed to assess the impact of involving male partners in antenatal health education on maternal health care utilization and birth preparedness. The education intervention consisted of two 35-minute health education sessions. The first session addressed topics related to pregnancy care and birth preparedness. The second session covered various topics associated with labor and delivery and the postpartum period. The education was delivered via face-to-face sessions administered jointly by one male and one female worker. This randomized control trial compared women who received education with their husbands to women who received education alone (a single female health worker delivered the education sessions with this group), and women who received no education.
- **Family Planning:** Subramanian et al. (2018) conducted a retrospective and comprehensive evaluation of the Promoting Change in Reproductive Behavior of Adolescents (PRACHAR) project, which was implemented between 2001 and 2012 in Bihar, India. The project was primarily community based. It used the socioecological model, with an emphasis on social and behavior change efforts, to reach various constituencies important to youth and young couples, including parents, mothers-in-law, community leaders, and health care staff, in addition to individual youth and couples themselves. The primary modalities were home visits and small group meetings. This

successful project used a gender-synchronized approach that engaged both male and female partners. It also calibrated the content and intensity of its interventions to different moments in the life cycle of adolescents and youth.

- **HIV/AIDS:** Remien and colleagues (2005) sought to assess the effectiveness of a couple-based intervention to improve ART adherence among lower-income serodiscordant heterosexual and homosexual couples at two outpatient HIV/AIDS clinics in New York, USA. The intervention aimed to increase adherence by fostering the support of their partners and helping them to address issues of sex and intimacy. The intervention consisted of a four-session, couple-focused educational intervention which addressed treatment and adherence, identifying adherence barriers, developing communication and problem-solving strategies, optimizing partner support, and building confidence for optimal adherence. A nurse practitioner delivered each 45–60-minute session to each couple over five weeks. The sessions were interactive and included structured discussions and instruction, as well as problem-solving and couple-communication exercises.
- **RH/HIV Integration:** Krakowiak and her team (2016) conducted a study in Kisumu County, Kenya to compare the effectiveness of two interventions to increase male involvement in PMTCT. Women attending their first ANC visit were randomized to receive either home-based HIV testing or facility-based testing, where written invitation letters were issued to male partners. A team of two health advisors met the woman and her partner at the couple's home within two weeks of study enrollment. The couples received HCT and education regarding facility delivery, exclusive breastfeeding, and postpartum family planning. Serodiscordant and concordant-positive couples received additional education on HIV prevention and treatment, PMTCT, and the importance of enrolling in HIV comprehensive services. The intervention resulted in higher uptake of male partner and couple testing, as well as higher rates of HIV status disclosure and identification of serodiscordant couples.



**Table 2:** Outcome variables employed by studies, by RH subfield

	Maternal Health	Family Planning	HIV and AIDS
Health Outcomes	<ul style="list-style-type: none"> <li>▪ Prematurity</li> <li>▪ Birth weight</li> <li>▪ Pregnancy complications</li> <li>▪ Cesarean section</li> <li>▪ Days in hospital for mothers and infants</li> <li>▪ Birth preparedness</li> <li>▪ Receipt of &gt;3 antenatal care (ANC) visits</li> <li>▪ Delivered in a health institution</li> <li>▪ Had a skilled birth attendant</li> <li>▪ Postpartum visit within 2 weeks</li> <li>▪ Maternal depression</li> <li>▪ Maternal health service utilization</li> <li>▪ Maternal mortality and morbidity</li> <li>▪ Use of safe abortion services</li> <li>▪ Exclusive breastfeeding at 6 weeks and 6 months postpartum</li> </ul>	<ul style="list-style-type: none"> <li>▪ Women's reported use of a family planning method</li> <li>▪ FP uptake</li> <li>▪ Contraceptive use</li> <li>▪ Couple reports on contraceptive use</li> <li>▪ Uptake of postpartum intrauterine contraceptive device</li> <li>▪ Family planning hormonal, IUD, or sterilization use at 6 week and 6 month postpartum</li> <li>▪ Use of long-term method</li> <li>▪ Use of dual protection</li> <li>▪ Condom use</li> <li>▪ Pregnancy rate/incident pregnancy</li> <li>▪ Abortion rates</li> <li>▪ Contraceptive demand</li> </ul>	<ul style="list-style-type: none"> <li>▪ Condom use</li> <li>▪ Identification of HIV-infected individuals in need of medical care</li> <li>▪ Sexual risk behavior</li> <li>▪ Unprotected sex with the study partner</li> <li>▪ Sex with outside partners</li> <li>▪ Number of concurrent sexual partners</li> <li>▪ Uptake of couple HIV counseling and testing (CHCT)</li> <li>▪ Incidence of HIV</li> <li>▪ Proportion of women receiving CHCT test results</li> <li>▪ Use of preventive measures against transmission</li> <li>▪ Receipt of nevirapine of women and infants</li> <li>▪ Drug use</li> <li>▪ HIV testing</li> <li>▪ ART adherence</li> <li>▪ Sexually transmitted infections/cumulative incidence of STIs</li> <li>▪ Proportion of condom-protected intercourse acts</li> <li>▪ % condomless anal sex partners</li> <li>▪ Alcohol consumption and problems</li> <li>▪ Serodiscordant couples identified</li> <li>▪ % of men tested for HIV</li> <li>▪ Reported use of at least one safer conception method among couples with immediate fertility desires or reported pregnancy</li> <li>▪ Availability and utilization of safer conception strategies</li> <li>▪ Transmission of HIV within couples</li> <li>▪ Pregnancy incidence among couples by HIV status</li> <li>▪ Pre-exposure prophylaxis (PrEP) and ART initiation</li> <li>▪ Couples' uptake of HIV self-testing</li> <li>▪ HIV infections averted (in a cost-effectiveness study)</li> </ul>

<b>Knowledge and Attitudes Outcomes</b>		<ul style="list-style-type: none"> <li>▪ Knowledge of and attitudes toward family planning</li> <li>▪ Knowledge, attitudes, skills, and practices on contraceptive use</li> </ul>	<ul style="list-style-type: none"> <li>▪ HIV knowledge</li> <li>▪ Knowledge of HIV serostatus of concurrent partners and condom use of concurrent partners</li> <li>▪ Female knows male serostatus</li> <li>▪ Subjective norms regarding HIV prevention acts</li> <li>▪ Intent to use condoms</li> <li>▪ Motivation to use condoms</li> <li>▪ Motivation to use relationship agreements</li> <li>▪ Motivation to get tested with one's partner</li> <li>▪ Motivation to use PrEP</li> <li>▪ Acceptability of men who have sex with men (MSM) of CHCT</li> <li>▪ Acceptability of home-based CHCT</li> <li>▪ Ability to identify safer conception methods (at least one, which methods)</li> <li>▪ Fertility desires among couples by HIV status</li> </ul>
<b>Relationship Quality</b>	<ul style="list-style-type: none"> <li>▪ Men's accompaniment at ANC</li> <li>▪ Partner support during pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>▪ Spousal communication about family planning</li> <li>▪ Quality of spousal communication</li> <li>▪ Frequency of communication</li> <li>▪ Shared decision making</li> <li>▪ Fertility preferences</li> <li>▪ Men's involvement in family planning (i.e., men's intention to seek services, women's perceptions of male involvement, and agreement on spousal communication about FP)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Dyadic Adjustment (relationship functioning scale)</li> <li>▪ Two components of dyadic engagement: involvement and reciprocity</li> </ul>

## Findings

Of the 61 studies identified in the literature review, 30 were selected for further review and analysis for this project (see Table 3). These include studies that were experimental or quasi-experimental in design, meta-analyses, and literature reviews. The Subramanian et al. (2018) study, discussed above, was included because it presented a synthesis of several studies of a specific project and is one of the few studies that focuses specifically on adolescents.

The table highlights studies across the subfields, although HIV-focused intervention evaluations are heavily represented, which is consistent with the general number of studies in this subfield.

A few broad findings emerge in reviewing the results. First, the studies were heterogeneous in terms of locations, study populations, and sites of interventions. Though a preponderance of the studies took place in sub-Saharan Africa, other research locations included the Middle East (Jordan), South Asia (India and Nepal), East Asia (China), Latin America (Brazil), and North America (USA). The studies mostly focused on adults of reproductive age, although a few concentrated on adolescents and young couples (Sarkar et al. 2015, Subramanian 2018, Raj et al. 2016, Koniak-Griffen 2011). All of the studies selected for further analysis focused on heterosexual couples because none identified in the literature review with interventions focused on homosexual couples (Stephenson et al. 2013, Malone et al. 2017, Feinstein et al. 2018, Tan et al. 2018, Wrubel et al. 2010, Newcomb et al. 2017, Gamarel et al. 2018) had reached the stage of rigorous evaluation. The interventions highlighted took place in facility- or community-based settings, or both.

Second, the majority of the studies compare couple-focused interventions with interventions focused on individuals. This is consistent with one of the objectives of this project, which is to evaluate the effectiveness of CFIs and their added benefit. On the other hand, some studies are included which used couples in both the intervention and control groups. These studies aimed to evaluate the effectiveness of specific interventions to determine what works best with couples. This was also useful for this project in terms of developing recommendations for policy, practice, and further research.

Third, the bulk of the studies seem to show that couple-focused interventions 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 RH subfields, with perhaps the most consistent and robust results coming in for HIV. HIV-focused studies reliably show that couple-focused interventions 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, Crepaz et al. 2015, El-Bassel et al. 2010, King et al. 2015, Mashaphu et al. 2018, Mashaphu et al. 2019).

Couple-focused interventions were also shown to increase the uptake of couples HIV counseling and testing (CHCT) (Darbes 2019, Kababu 2018). Given that nearly two-thirds of all new infections in sub-Saharan Africa occur in people in stable relationships (Chemaitelly et al. 2014) and the shift toward

“treatment as prevention” and now “universal test and treat” (Perriat et al. 2018), CHCT becomes crucial as it “allows both members of a couple to learn their HIV status and make informed choices surrounding antiretroviral prophylaxis...” (Crepaz et al. 2015). In addition, CFIs had an impact on knowledge and utilization of safe conception strategies (Hancuch 2018). Finally, given that men dramatically lag behind women in HIV service utilization and HIV-related mortality (UNAIDS 2017), it is significant that the studies reveal that the expansion of couple-focused services to the community and household level can dramatically increase the number of men and couples reached with various services to achieve HIV and reproductive health outcomes (Becker et al. 2014, Krakowiak et al. 2016, Sharma et al. 2017, Turan et al. 2018).

**Table 3:** Findings from evaluation research of couple-focused interventions, all subfields

Studies	Study Population	Research Design	Outcomes	Findings
<b>FAMILY PLANNING</b>				
<p>El-Khoury et al. Counseling Women and Couples on Family Planning: A Randomized Study in Jordan. <i>Studies in Family Planning</i>. 2016; 47(3): 222-228</p>	<p>Women who were married, living with their husbands, of reproductive age, fecund, non-pregnant, not planning to move in the next year, and not using a modern family planning method.</p>	<p>Baseline and endline cross-sectional surveys. Randomization to one of three intervention arms: women-only counseling (T1), couples counseling (T2), and no counseling (C).</p>	<p>1) Women's reported use of a family planning method, 2) knowledge of and attitudes toward family planning, 3) spousal communication about family planning, and 4) fertility preferences.</p>	<p>Couples counseling led to a 54% increase in uptake of modern methods. This effect is not significantly different from the 46% increase in modern method uptake as a result of women-only counseling.</p>
<p>Hartmann et al. Changes in Couples' Communication as a Result of a Male-Involvement Family Planning Intervention. <i>Journal of Health Communication</i>. 2012; 17(7): 802-819</p>	<p>Malawi—Men had to be at least 18 years old and married to or living with a female sexual partner who was younger than 25 and who was not currently pregnant or breastfeeding.</p>	<p>Baseline and post-intervention surveys, plus in-depth interviews with both men and women.</p>	<p>FP uptake, quality of spousal communication, frequency of communication, shared decision making</p>	<p>Participants reported improvements in spousal communication, increased frequency of communication, and an increase in shared decision making as a result of the intervention, which directly contributed to their family-planning use.</p>
<p>Tilahun et al. Couple-based family planning education: changes in male involvement and contraceptive use among married couples in Jimma Zone, Ethiopia. <i>BMC Public Health</i>. 2015;15:682</p>	<p>Legally married men and their wives living together during the six months prior to the baseline data collection in the study area.</p>	<p>Quasi-experimental design: baseline and post-intervention cross-sectional surveys re: spousal communication about family planning.</p>	<p>Contraceptive use, spousal discussions on family planning, men's involvement in family planning.</p>	<p>1) Higher levels of involvement of the husbands in the intervention group for each of the three assessed indicators: men's intention to seek services, women's perceptions of male involvement, and agreement on spousal communication about FP), 2)</p>

			respondents from the intervention arm reported higher levels of spousal discussion on FP than those from the control arm, 3) no significant difference in contraceptive practice, although the intervention arm showed a significant increase from baseline in contraceptive use (no change in the control arm).	
Lemani C, et al. Contraceptive uptake after training community health workers in couples counseling: A cluster randomized trial. PLoS ONE. 2017; 12(4): e0175879.	Malawi—The counseled women must have met the following eligibility criteria: 1) younger than 30, 2) had vaginal intercourse at least once in past 3 months, 3) have a male partner, 4) had never used any modern FP method (oral contraceptives, injection, implant, IUD, or sterilization).	Cluster randomized controlled trial—two arms: counseling with health surveillance assistant (HSA) who had received couples counseling training, and counseling with HSA who had not received the training.	FP initiation, use of long-term FP methods, continued use of hormonal or intrauterine methods 6 months after contraceptive initiation, and use dual methods of contraception.	Nearly all (99.5%) initiated a modern FP method, with no difference between groups ( $p = 0.09$ ). Women in the couples counseling group were 8% more likely to receive male condoms and 8% more likely to receive dual methods.
Raj A, Ghule M, Ritter J, et al. Cluster Randomized Controlled Trial Evaluation of a Gender Equity and Family Planning Intervention for Married Men and Couples in Rural India. PLoS ONE. 2016;11(5): e0153190.	Young married couples in rural Maharashtra, India.	Randomized control trial.	Contraceptive use and incident pregnancy, and secondarily, contraceptive communication and men's intimate partner violence (IPV) attitudes and behaviors were assessed.	Women from the CHARM condition, relative to controls, were more likely to report contraceptive communication at 9-month follow-up and modern contraceptive use at 9- and 18-month follow-ups, and they were less likely to report sexual IPV at 18-month follow-up. Men in the CHARM condition were less likely than those in the control clusters to report attitudes accepting of sexual IPV at 9-month and 18-

			month follow-up, and attitudes accepting of physical IPV at 18-month follow-up. No significant effect on pregnancy was seen.	
Subramanian L, Simon C. Daniel EE. Increasing Contraceptive Use Among Young Married Couples in Bihar, India: Evidence From a Decade of Implementation of the PRACHAR Project. <i>Global Health: Science and Practice</i> . 2018;6(2):328-342.	Married youth, ages 15-24, in Bihar, India.	Synthesis of monitoring, evaluation, and special study data from the Promoting Change in Reproductive Behavior of Adolescents (PRACHAR) project.	Contraceptive use.	Increased contraceptive use among young married couples, and these outcomes were sustained 4–8 years after project interventions ended.
<b>REPRODUCTIVE HEALTH</b>				
Wang CC, Vittinghoff E, Hua LS, et al. Reducing Pregnancy and Induced Abortion Rates in China: Family Planning with Husband Participation. <i>American Journal of Public Health</i> . 1998; 88(4): 646-648.	The target population was limited to 13,285 women of childbearing age working in 21 factories and 6 middle schools served by the LuWan Maternal and Child Health Hospital within Shanghai's LuWan District.	Three-arm randomized trial among 1,800 non-sterilized married women, educational interventions targeting both members of the couple and targeting the wife alone were compared with usual family planning care.	Pregnancy and abortion rates.	Among women not using IUDs, the intervention with husband's participation had an effect in reducing pregnancy rates and abortion rates compared with control subjects and a significant effect in reducing pregnancy rates and abortion rates compared with wife-only subjects.
Sarkar A, Chandra-Mouli V, Jain K, et al. Community based reproductive health interventions for young married couples in resource-constrained settings: <i>BMC Public Health</i> . 2015; 15:1037	Interventions focused on young married couples, defined as married or cohabiting couples in which the female partner was 15–24 years, mostly from South Asia.	Systematic review.	Knowledge, attitudes, skills, and practices on contraceptive use, the use of safe abortion services, and pregnancy care including ANC, delivery care, and postnatal care, and health impacts in terms of	Interventions consisting of counseling of young married women, and their husbands, family and community members, as well as capacity building of health workers, were some of the

		reduction in maternal mortality and morbidity.	effective measures in increasing contraceptive use, delaying pregnancy, and improving pregnancy care.
<b>MATERNAL HEALTH</b>			
Feinberg ME, Roettger ME, Jones DE, Jones DE, et al. Effects of a Psychosocial Couple-Based Prevention Program on Adverse Birth Outcomes. <i>Maternal and Child Health Journal</i> . 2015; 19(1): 102–111.	USA—169 heterosexual couples, predominately white. Eligibility requirements stipulated that couples were age 18 and above, living together, and expecting a first child at recruitment.	Randomized control study. Questionnaire at intake and one at 6-month follow-up.	Prematurity, birth weight, pregnancy complications, Cesarean section, and days in hospital for mothers and infants among 148 expectant mothers. Also tested the interaction of cortisol with intervention condition status in predicting adverse birth outcomes.
Mullany BC, Becker S, and Hindin MJ. The impact of including husbands in antenatal health education services on maternal health practices in urban Nepal: results from a randomized controlled trial. <i>Health Education Research</i> . 2007; 22(2): 166–176.	Currently married women attending their first antenatal care (ANC) visit (gestational age 16–28 weeks) whose husbands were present at the hospital compound.	Randomized control trial with 3 arms: women who received education with their husbands, women who received education alone, and women who received no education.	Birth preparedness, whether a woman received >3 ANC visits, delivered in a health institution, had a skilled birth attendant, or attended a postpartum visit within 2 weeks of delivery.
			Participation was associated with reduced risk of C-section (OR .357, $p < 0.05$ , 95 % CI 0.149, 0.862), but did not have main effects on other adverse birth outcomes. The intervention significantly buffered ( $p < 0.05$ ) the negative impact of maternal cortisol on birth weight, gestational age, and days in hospital for infants; that is, among women with relatively higher levels of prenatal cortisol, the intervention reduced adverse birth outcomes.
			Women who received education with husbands were more likely to attend a postpartum visit than women who received education alone or no education. Women who received education with their husbands were also nearly twice as likely as control group women to report making >3 birth preparations. Study groups were similar with respect to attending



Yargawa J, Leonardi-Bee J. Male involvement and maternal health outcomes: systematic review and meta-analysis. *J Epidemiol Community Health*. 2015; 69:604–612.

			the recommended number of antenatal care checkups, delivering in a health institution, or having a skilled provider at birth.
<p>Comparative observational studies or controlled trials assessing the impact of male involvement on maternal health outcomes in women of childbearing age (15–49 years) from developing countries (as defined by the World Bank).</p> <ul style="list-style-type: none"> <li>▶ There were three broad indicators of male involvement: Active participation in maternal health services and care (husband's attendance of antenatal care [ANC]; husband's presence at delivery room; and husband's support/help to wife during pregnancy, delivery or at post-partum);</li> <li>▶ Financial support given for pregnancy-related and childbirth-related expenses;</li> <li>▶ Shared decision-making powers on maternal health with wife.</li> </ul>	Systematic review and meta-analysis.	1) Complications, 2) Duration of postpartum stay at hospital, 3) Maternal depression, 4) Maternal health service utilization, 5) Maternal mortality	Male involvement was significantly associated with reduced odds of postpartum depression, and also with improved utilization of maternal health services (skilled birth attendance and postnatal care). Male involvement during pregnancy and at post-partum appeared to have greater benefits than male involvement during delivery.

Doyle K, LevtoV RG, Barker G, et al. Gender-transformative Bandedereho couples' intervention to promote male engagement in reproductive and maternal health and violence prevention in Rwanda: Findings from a randomized controlled trial. PLoS ONE . 2018;13(4): e0192756.

<p>Expectant/current fathers and their partners in four Rwandan districts.</p>	<p>Randomized control trial.</p>	<p>Women's experience of physical and sexual intimate partner violence (IPV), women's attendance and men's accompaniment at ANC, modern contraceptive use, and partner support during pregnancy.</p>	<p>Compared to the control group, women in the intervention group reported less past-year physical and sexual IPV and greater attendance and male accompaniment at antenatal care. Women and men in the intervention group reported less child physical punishment; greater modern contraceptive use; higher levels of men's participation in childcare and household tasks; and less dominance of men in decision making.</p>
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**HIV**

Darbes et al. Results of a Couples-Based Randomized Controlled Trial Aimed to Increase Testing for HIV. J Acquir Immune Defic Syndr 2019; 80:404–413

<p>KwaZulu-Natal, South Africa— Couples aged between 18 and 50 years, whose relationship was at least 6 months, were not in a polygamous marriage, and both partners indicated each other as their primary partner to whom they were committed and with whom they had sexual relations.</p>	<p>Randomized control trial. Eligible couples (334) attended a group session (3-4 hours) after which randomization occurred. Intervention included one couples-based group session followed by 4 couples' counseling sessions (1-2 hours). Assessments occurred at baseline, and 3, 6, and 9 months after intervention.</p>	<p>Couples HIV testing and counseling (CHTC) and sexual risk behavior.</p>	<p>Intervention couples were significantly more likely to have participated in CHTC (42% vs. 12%, P = 0.001). In addition, their time to participate in CHTC was significantly shorter (P = 0.0001) (N = 332 couples). There were no group differences in unprotected sex.</p>
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<p>Davey et al. A Systematic Review of the Current Status of Safer Conception Strategies for HIV Affected Heterosexual Couples in Sub-Saharan Africa. <i>AIDS Behav.</i> 2018; 22(9): 2916–2946.</p>	<p>HIV-affected couples in sub-Saharan Africa</p>	<p>Systematic Review: 41 studies (26 qualitative and 15 quantitative) that met inclusion criteria</p>	<p>Availability and use of safer conception strategies</p>	<p>Studies of provider training and couple-based education showed improvements in communication around fertility intentions and safer conception strategies (SCS) knowledge. Studies showed that provider training and self-efficacy in talking about SCS increased SCS availability.</p>
<p>Mashaphu et al. Psychosocial and behavioural interventions towards HIV risk reduction for serodiscordant couples in Africa: A systematic review. <i>S Afr J Psychiat.</i> 2018; 24(0), a1136.</p>	<p>Serodiscordant couples in sub-Saharan Africa.</p>	<p>Systematic literature review. Eight studies met inclusion criteria: 1) couples with serodiscordant HIV status; 2) reported on an intervention; and 3) had sufficient information available in English.</p>	<p>Unprotected sex, reduced HIV transmission, treatment adherence, efficacy of a behavioral intervention, and the general acceptability and effectiveness of such intervention programs.</p>	<p>Couples-focused counseling and educational programs were associated with positive outcomes including reduced HIV transmission, reduced unprotected sex, increased rates of status disclosure, and high levels of treatment adherence.</p>
<p>LaCroix JM, Pellowski JA, Lennon CA, et al. Behavioral interventions to reduce sexual risk for HIV in heterosexual couples: a meta-analysis. <i>Sex Transm Infect</i> 2013;89:620–627.</p>	<p>Studies were included if they 1) examined the efficacy of a couples-based HIV/AIDS-related behavioral intervention, 2) recruited and enrolled both members of a self-identified couple, 3) delivered some/all intervention content to both members of a couple either concurrently, separately, or in a group setting, and 4) reported condom use outcomes at baseline and follow-up.</p>	<p>Meta-analysis.</p>	<p>Condom use.</p>	<p>Significant increases in condom use with study (or unspecified) partner from baseline to first follow-up. Analysis also indicated significant reductions in reported partner concurrency from baseline to first follow-up.</p>

<p>Mashaphu et al. Effectiveness of an HIV-risk reduction intervention to reduce HIV transmission among serodiscordant couples in Durban, South Africa. A randomized controlled trial. <i>AIDS Care</i>. 2019. DOI: 10.1080/09540121.2019.1634785</p>	<p>Participants: 18+ years, self-identified heterosexuals, able to read and write in English; reported having unprotected sex at least once in the past 90 days; were both aware of the other's HIV status; were in a relationship for at least three months; and had no plans to relocate from the study site during the next year.</p>	<p>Of 62 couples screened, 30 serodiscordant couples enrolled, and randomized 2:1 to an immediate intervention-waitlist control study. Compared couples that received the intervention immediately and those who were waitlisted for three months. Data collected at baseline, 3 months, and 6 months.</p>	<p>Consistent condom use, HIV seroconversion and fidelity to the program.</p>	<p>Significantly higher mean proportion of condom-protected sex acts between the control and intervention groups.</p> <p>83% retention rate among enrolled couples—points to feasibility.</p>
<p>Melo M, Varella I, Castro A, et al. HIV Voluntary Counseling and Testing of Couples During Maternal Labor and Delivery: The TRIPAI Couples Study. <i>Sexually Transmitted Diseases</i>. 2013;40(9):704-709.</p>	<p>Brazil—Women receiving maternity care during labor and delivery and their partners.</p>	<p>Cross-sectional study of women receiving maternity services and their male partners.</p>	<p>Identification of HIV-infected individuals in need of medical care.</p>	<p>1,648 (95%) HIV-negative women consented to partner testing and 66% of partners accepted testing. Seven HIV-infected men (0.6%) with no prior diagnosis were identified. Testing strategies uncovered 7 additional serodiscordant couples, 4 HIV-infected women diagnosed at delivery, and 3 HIV-infected men who had not disclosed their status to their partners, for a total serodiscordance rate of 1.3% in 1101 couples.</p>
<p>Hailemariam et al. Uptake of couples HIV testing and counselling among heterosexual couples in Sub-Saharan Africa: a systematic review and meta-analysis. <i>AIDS Care</i>, 2019</p>	<p>Couples attending HTC services.</p>	<p>Systematic literature review.</p>	<p>Uptake of CHTC.</p>	<p>Uptake of CHTC was lower (17.85%; 95% CI: 11.19, 25.66) in couples testing concurrently compared with index partner first testing alone and then together as a couple (40.97%; 95% CI: 37.16, 44.88). However, studies that used</p>

			a mix of both approaches (i.e., index-partner first and testing as a couple concurrently) reported the highest uptake of CHTC (65.05%; 95%CI: 48.32, 80.07).	
Villar-Loubet OM, Cook R, Chakhtoura N, et al. HIV Knowledge and Sexual Risk Behavior Among Pregnant Couples in South Africa: The PartnerPlus Project. <i>AIDS Behav</i> , 2013;17:479–487	Pregnant women >18 years of age who had completed HCT and enrolled as couples with their male partners.	Randomized controlled trial design with a 2 X 3 comparison (experimental, control x time point, baseline, post-intervention, 3 month post-partum follow-up).	Sexual risk behavior, HIV knowledge, and condom use pre- to postpartum	Consistent condom use and HIV-related knowledge increased baseline to post-intervention (when compared to the control group) and was maintained at long-term follow-up postpartum among participants in the intervention.
Kababu et al. Use of a counsellor supported disclosure model to improve the uptake of couple HIV testing and counselling in Kenya: a quasi-experimental study. <i>BMC Public Health</i> . 2018; 18:638	Attendees at voluntary HIV testing & counseling (HCT) sites.	Pre-post quasi experimental study design with an intervention and comparison arm. Standard HTC was offered in the comparison arm and the counselor-supported disclosure model was administered in the intervention arm.	Uptake of CHTC: Uptake of CHTC was defined as the number of participants who brought back their partner for mutual HIV testing and disclosure within three months after the initial HIV test.	Uptake of CHTC was 28% in the intervention arm of the study compared to 7% in the comparison arm (p < 0.001). Participants in the intervention arm had eight times higher odds of taking up CHTC compared to their counterparts.
Wall KM, Kilembe W, Vwalika B. et al. Sustained effect of couples' HIV counselling and testing on risk reduction among Zambian HIV serodiscordant couples. <i>Sex Transm Infect</i> . 2017;0:1–8.	Heterosexual HIV serodiscordant couples recruited from CHCT services and enrolled in a longitudinal open cohort study of HIV transmission in Lusaka, Zambia between 1994 and 2012.	Longitudinal follow-up in an open cohort (1994–2012).	Unprotected sex with the study partner and sex with outside partners.	Reductions in self-reported unprotected sex after CHCT were substantial and sustained.
Burton J, Darbes LA, Operario D. Couples-focused behavioral interventions for prevention of	Studies were heterogeneous in terms of population and comparison groups.	Systematic review.	Various.	Results across studies consistently indicated that couples-focused programs reduced unprotected sexual intercourse and increased

HIV: Systematic review of the state of evidence. AIDS Behavior. 2010.

Becker S, Mlay R, Schwandt HM, Lyamuya E. Comparing Couples' and Individual Voluntary Counseling and Testing for HIV at Antenatal Clinics in Tanzania: A Randomized Trial. AIDS Behav. 2010;14:558–566

Crepaz N, Tungol-Ashmon MV, Vosburgh HW, et al. Are couple-based interventions more effective than interventions delivered to individuals in promoting HIV protective behaviors? A meta-analysis. AIDS Care. 2015 November ; 27(11): 1361–1366.

			condom use compared with control groups. However, because of the diversity of the studies, a meta-analysis to calculate pooled effects was not feasible.
1,521 women attending three antenatal clinics in Dar es Salaam.	Randomized control trial.	Acceptance of CHCT, use of nevirapine for PMTCT, sexual risk behaviors, domestic violence, and marital disruption.	The proportion of women receiving test results in the CVCT arm was significantly lower than in the individual HIV counseling and testing arm (39% vs. 71%). HIV prevalence overall was 10%. In a subgroup analysis of HIV-positive women, those who received CHCT were more likely to use preventive measures against transmission (90% vs. 60%) and to receive nevirapine for themselves (55% vs. 24%) and their infants (55% vs. 22%) as compared to women randomized to individual HCT.
Studies were eligible if they were controlled trials or prospective cohort designs, evaluated a couple-based, HIV-prevention intervention with an individual-level comparison group, assessed at least one HIV prevention outcome, reported data sufficient for calculating effect sizes, and were published between January 1988 and December 2014.	Meta-analysis.	Protective sex behavior (defined as consistent condom use or no sex without condoms), STIs, HIV testing, nevirapine uptake among pregnant women, and HIV medication adherence.	The results of random-effects models showed statistically significant intervention effects for protective sex, HIV testing, and nevirapine uptake.

El-Bassel N, Jemmott JB, Landis JR, et al. National Institute of Mental Health Multisite Eban HIV/STD Prevention Intervention for African American HIV Serodiscordant Couples: A Cluster Randomized Trial. Arch Intern Med. 2010 September 27; 170(17): 1594–160.

<p>USA—African American HIV serodiscordant heterosexual couples who were eligible if both partners were at least 18 years old and reported unprotected intercourse in the previous 90 days and awareness of each other's serostatus.</p>	<p>Cluster randomized controlled trial. Couples were randomized to 1 of 2 interventions: couple-focused Eban HIV/STD risk-reduction intervention or attention-matched individual-focused health promotion comparison.</p>	<p>Proportion of condom-protected intercourse acts and cumulative incidence of STDs (chlamydia, gonorrhoea, or trichomonas).</p>	<p>The proportion of condom-protected intercourse acts was larger among couples in the intervention group than in the comparison group when adjusted for the baseline criterion measure. The adjusted percentage of couples using condoms consistently was higher in the intervention group than in the comparison group. The adjusted mean number of (log) unprotected intercourse acts was lower in the intervention group than in the comparison group. The cumulative STD incidence over the 12-month follow-up did not differ between couples in the intervention and comparison groups.</p>
<p>HIV sero-discordant couples in Jinja, Uganda.</p>	<p>Prospective cohort study.</p>	<p>Reported condom use, number of concurrent sexual partners, knowledge of HIV serostatus of concurrent partners, and condom use of concurrent partners.</p>	<p>Reported condom use at last sex with spouse increased over time. Male participants reported reductions in the number of concurrent sexual partners, increase in the knowledge of the HIV serostatus of these partners, and a trend toward improved condom use among non-primary partners. Reported reduced risky behaviors did not wane over the study period.</p>

King R, Min J, Birungi J, et al. Effect of Couples Counselling on Reported HIV Risk Behavior among HIV Serodiscordant Couples by ART Use, HIV Status and Gender in Rural Uganda. PLoS ONE. 2015;10(9): e0136531

<p>Koniak-Griffin D, Lesser J, Takayanagi S, Cumberland WG. Couple-Focused Human Immunodeficiency Virus Prevention for Young Latino Parents. Arch Pediatr Adolesc Med. 2011;165(4):306-312</p>	<p>USA—Primarily Latino couples (168 couples; 336 individuals) who were aged 14 to 25 years, English or Spanish speaking, and co-parenting a child at least 3 months of age.</p>	<p>Randomized control trial.</p>	<p>Primary outcome measures included self-report of condom use during the past 3 months; secondary measures include intent to use condoms and knowledge about AIDS.</p>	<p>The HIV prevention intervention reduced the proportion of unprotected sex episodes and increased intent to use condoms at the 6-month follow-up; however, these effects were not sustained at 12 months. Knowledge about AIDS increased in both groups from baseline to 6 months and was maintained in the intervention group only through 12 months.</p>
<p>Krakowiak D, Kinuthia J, Osoti AO, et al. Home-Based HIV Testing Among Pregnant Couples Increases Partner Testing and Identification of Serodiscordant Partnerships. J Acquir Immune Defic Syndr 2016;72:S167–S173.</p>	<p>Women attending their first antenatal visit at Kisumu County Hospital in Kenya.</p>	<p>Randomized control trial. Women were randomized to home-based education and HIV testing within 2 weeks of enrollment (HOPE) or to written invitations for male partners to attend clinic (INVITE).</p>	<p>Male partner HIV testing and maternal child health outcomes were compared at 6 months postpartum.</p>	<p>Home-based HIV testing for pregnant couples resulted in higher uptake of male partner and couple testing, as well as higher rates of HIV status disclosure and identification of serodiscordant couples. However, the intervention did not result in higher uptake of maternal child health outcomes, because facility delivery and postpartum family planning were high in both arms.</p>
<p>Remien RH, Stirratt MJ, Dolezal C, et al. Couple-focused support to improve HIV medication adherence: a randomized controlled trial. AIDS. 2005;19:807–814</p>	<p>USA—Heterosexual and homosexual HIV-serodiscordant couples (n = 215) in which the HIV-seropositive partner had &lt;80% adherence at baseline. The sample was predominantly lower-income racial/ethnic minorities.</p>	<p>Randomized control trial. Participants were randomly assigned to a four-session couple-focused adherence intervention or usual care.</p>	<p>Medication adherence at week 8 (2 weeks after the intervention) compared with baseline.</p>	<p>The SMART Couples program significantly improved medication adherence over usual care, although the level of improved adherence, for many participants, was still suboptimal and the effect was attenuated over time.</p>



## Mechanisms of action

Of the articles reviewed, about half explained how they thought the desired behavior change took place in couple-focused interventions. Overall, the articles related to HIV and maternal health emphasized the importance of mutual support.

In the case of HIV, couple-focused interventions generally provided the opportunity for mutual disclosure and to address issues related to HIV in a variety of clinical settings. CFIs enabled members of the couple to engage one another both formally, in counseling, and informally, outside of the clinical/counseling space. Formally, the clinical/counseling encounter helped couples to improve communication, problem-solving, and negotiation skills that contributed to increased condom use (Mashaphu 2019). Related to the initiation of pre-exposure prophylaxis (PrEP) and ART, CFIs offered couples a sense of protection against HIV and the inviting prospect of condomless sex. PrEP was perceived as solving the problem of serodiscordance and as an aid in strengthening committed relationships (Nakku-Joloba et al. 2019, Odoyo et al. 2019). Mutual support was also seen as the critical mechanism of change/maintenance for adherence to ART (Melo et al. 2013, Karita et al. 2016, Mashaphu et al. 2018, Persson et al. 2019). Informally, traveling together to and from appointments and waiting to be seen gave couples an opportunity to talk, reflect on the information they had heard, and make joint decisions about prevention, care, and treatment (Ware et al. 2018).

In the area of maternal health, two studies investigating the impact of maternal depression on maternal and newborn outcomes found that support in the couple relationship played a role in reducing maternal stress and boosted wives' 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).

Studies in family planning almost exclusively pointed to couple communication as the primary mechanism to achieve desired family planning programmatic outcomes. They found that couple communication could: 1) influence method choice and contribute to generating new users and 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).

It is important to note that the majority of articles did not state a specific theory of behavior change to guide their research. The few that did employed individual models of behavior change, even though the couple was perceived to be the unit of intervention (Hartmann et al. 2012). Burton et al. (2010), in their comprehensive review of couples-focused behavioral interventions to prevent HIV, take issue with this approach. The authors assert that theory-building in the emergent area is important and that "[f]uture investigations of couples-focused [interventions] to HIV prevention should utilize analytic techniques that

illuminate dynamics both within and between couples, rather than comparing individual intervention participants to control participants.”

### **Explicit gender engagement**

One hypothesis that motivated this paper was that couple-focused interventions represent a valuable gender-transformative strategy to achieve additional gains in global RH outcomes. Yet, 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. One example is Lemani et al. (2016), who evaluated whether the training of Health Surveillance Assistants (a cadre of community health workers) in Malawi to counsel couples would increase family planning uptake. Even though the intervention employed a well-documented gender-transformative tool, the Malawi Male Motivators Curriculum, the article did not address how the Health Surveillance Assistants engaged with couples and how the curriculum themes were employed or received by women and couples; rather, it only described the generally positive behavioral outcomes. A recent review of couples counseling in reproductive health (Institute for Reproductive Health 2017) encourages interventions to avoid this pitfall and to be explicit and intentional about their strategies to address gender inequalities and power dynamics. The review suggests common “gender elements” for inclusion in proposed interventions. These include defining the overall desired outcome of the intervention, taking into consideration the particular cultural context of the intervention, training same-sex counselors, and incorporating selected gender themes and outcomes that have been identified as being influenceable by couples counseling.

Other studies reviewed for this paper were indeed explicit in their treatment of gender. Villar-Loubet et al. (2013) aimed to assess whether the PartnerPlus intervention in South Africa would increase HIV knowledge and lead to reduced sexual risk behavior during and following pregnancy. The intervention used a small, same-sex group educational format. The four sessions, conducted weekly, lasted between 90 and 120 minutes and were led by two trained lay counselors. In a culture where men and women are traditionally discouraged from discussing RH issues, the sessions emphasized behavioral skill-building around couple communication, especially sexual negotiation and conflict resolution. In addition, educational sessions focused on sexually transmitted infection (STI)/HIV prevention, condom use, PMTCT and medication adherence, and gender-relevant issues, such as intimate partner violence (IPV) prevention and sexual risk. The results were positive: compared to the control group, HIV knowledge and consistent condom use among the couples in the intervention group increased and was maintained at long-term follow-up. In another study in central Kenya, Vrana-Diaz and colleagues (2019) explicitly examined the association between gender equality and uptake of HIV self-testing among heterosexual couples expecting a child. They found that couples with male partners reporting low or medium acceptance of IPV were significantly more likely to use HIV self-testing. However, gender equality, as measured by decision-making power, was not associated with couples' uptake of HIV self-testing. Even so, the authors speculated that an intervention focused on reducing men's acceptance of IPV could yield a secondary benefit of increasing the men's willingness to self-test for HIV, especially with a sexual partner. Other examples of studies which explicitly examined the role of gender dynamics and RH include: Adanikin et al. (2019), who examined

power imbalances in negotiating contraceptive use and Davey et al. (2018), whose paper looked at the role that gender power dynamics in relationships affect the uptake of safer conception strategies.

Other studies, while not explicitly addressing gender per se, were sensitive to power differentials in many couples and the reality of IPV. For example, a pilot study on home-based HCT and FP provision for couples in Malawi established a protocol for service consent that helped ensure women's freedom of choice while protecting the privacy of both partners. The woman was seen alone first and asked what service, if any, she wanted to receive (HCT, FP or both). Having made her choice, the male partner was then offered the services that the woman accepted. If she did not accept any service, the man was not offered any service. But, regardless of their choices, both members of the couple received information about HCT and FP and referrals to their local health centers (Becker et al. 2014).

Kraft and her colleagues' (2014) review of the evidence regarding gender-integrated interventions in reproductive and maternal-child health revealed mixed results about the impact of couple-focused interventions. The authors state that it is not clear what interventions work, for which outcomes, and under what circumstances. The authors additionally assert that cultural contexts and their specificities play a big role—a claim which is likely true given how central cultural notions about gender and reproduction are to a society's vision of itself (Ginsburg and Rapp 1995).

A few articles 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. Community health workers had to expend considerable effort to persuade family members to allow young women to participate. Becker et al. (2014) and Mullaney (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. The authors saw these efforts as “misdirected” and supporting inequitable patriarchal gender norms. 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?”

## **Barriers and facilitators to CFIs**

Table 4 below highlights barriers and facilitators to the implementation of couple-focused interventions. Regarding barriers, there are three broad categories: factors associated with men's involvement, personal apprehensions of individual partners about their joint engagement in health services, and health system factors that may inhibit an effective response to men and couple-focused services.

The logistics of including men arose in all three subfields. This was related to every aspect of men's involvement, including how to effectively conduct outreach to men, their recruitment, availability both in community and facility settings, scheduling difficulties, their job responsibilities which might make it difficult for them to come for services, and that some masculine norms—for example, a denial of weakness or seeing health as a women's sphere of activity—act as barriers to use of health services (Ragonese et al. 2019).

Personal apprehensions of individual partners about their joint engagement in health services could take a number of forms: perceived potential for partner abuse; perceived difficulty of disclosing one's HIV status with a partner present; sensitivity to information that might be revealed about individual partners, particularly their sexual histories; unequal gender roles and power in couples; stigma around HIV-affected couples wanting children (regarding accessing safer conception services); perceived and anticipated provider stigma and discrimination; men's opposition to family planning utilization; and fear that couples services could reinforce patriarchal norms.

The last set of barriers pertains to demands on the health system that would arise with the added provision of couple-focused services. Common to these barriers, and related to gender norms, is health care/government policies and a lack of interest in engaging men and couples that inadvertently isolate/discourage men from using reproductive health services. Again, these barriers arose across the subfields. The highlighted barriers implicate all of the WHO building blocks (leadership and governance, service delivery, health workforce, health information system, medical products, vaccines and technologies, and health system financing + community) that constitute health systems. These health system demands become more compelling as the fragility of a state's health system increases.

Articles reviewed for this study rarely mentioned factors that would facilitate CFIs. The factors that were mentioned reveal no particular pattern across the subfields.

### **Recommendations for policy, practice, and research**

Almost all the articles reviewed had at least one policy, practice, or research recommendation. These were largely in response to the barriers highlighted above. These can be found in the "Recommendations" section of this paper.

**Table 4:** *Barriers and facilitators to couple-focused interventions*

	Barriers to CFIs	Facilitators to CFIs
<b>Maternal Health</b>	<ul style="list-style-type: none"> <li>▪ Logistically more difficult to involve men (Melo et al. 2013, Feinberg et al. 2015)</li> <li>▪ Low levels of knowledge of MH among men</li> <li>▪ Men's participation not in line with gender role expectations/shyness and embarrassment</li> <li>▪ Men's job responsibilities (Mullany 2006)</li> <li>▪ Health care/government policies that inadvertently isolate/discourage men from active engagement in maternal health programs (Yargawa et al. 2015, Mullany 2006)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Physical/visual accommodations to make facilities more inviting to men (Becker et al. 2008)</li> <li>▪ Providers' opinion that couples services would enhance quality of care and understanding of health information</li> <li>▪ Patient perceptions that couple services would improve spousal communication</li> <li>▪ Perception that husband's involvement would improve the quality of interaction between wives and medical staff (Mullany 2006)</li> </ul>
<b>Family Planning</b>	<ul style="list-style-type: none"> <li>▪ Logistical difficulties involving men, mostly related to scheduling, recruitment, unavailability, and outreach (El-Khoury et al. 2016, Institute for Reproductive Health 2017, Zolna et al. 2009, Becker and Robinson 1998, Lemani et al. 2016)</li> <li>▪ Limited resources for couple-focused services</li> <li>▪ Shortage of staff trained to provide such services</li> <li>▪ Perceptions of clinic administrators of low levels of knowledge and interest in couples' services</li> <li>▪ The perception that staff members were not always supportive or interested in couples' services</li> <li>▪ Lack of evidence for the effectiveness of such services</li> <li>▪ Concern about the potential for partner abuse and capacity of provider to identify such abuse (Becker and Robinson 1998)</li> <li>▪ Questions about cost-effectiveness</li> <li>▪ Collection, analysis, and use of couple data</li> <li>▪ Fear that couple services could reinforce patriarchal norms (Becker 1996)</li> <li>▪ Clinics are poorly structured to accommodate men</li> <li>▪ Need for providers who can handle the concerns of both sexes (Becker and Robinson 1998)</li> <li>▪ Young married couples are either overlooked by policies or are not reached by programs</li> </ul>	<ul style="list-style-type: none"> <li>▪ None were highlighted in the literature</li> </ul>

**HIV**

<ul style="list-style-type: none"> <li>▪ Married adolescents: confidentiality and privacy concerns and poor staffing at health facilities (Sarkar et al. 2015)</li> <li>▪ Barriers to women’s access to contraception include husbands’ opposition, religious beliefs, poor knowledge, and lack of communication between spouses (Husain et al. 2019)</li> </ul>	
<ul style="list-style-type: none"> <li>▪ Disparity by sex in the engagement, enrollment, and retention in HIV services (Medley et al. 2017)</li> <li>▪ Logistics of including men</li> <li>▪ Data collection tools included sensitive sexual history questions that were challenging to ask when husband and wife were together</li> <li>▪ Confusion about protocols regarding confidentiality</li> <li>▪ Inadequate counselors’ skills to counsel couples effectively (Karita et al. 2016)</li> <li>▪ Path dependency: Most HIV services have focused on individuals rather than couples</li> <li>▪ Fears about violence surrounding disclosure</li> <li>▪ Fears about straining overburdened staff</li> <li>▪ PMTCT environment that is inconvenient and unwelcoming to male partners (Grabbe et al. 2010)</li> <li>▪ HIV prevention tends to be based on individual models of behavior change</li> <li>▪ SCS acceptability was impacted by low client knowledge about safer conception services, stigma around HIV-affected couples wanting children, and difficulty with HIV disclosure in HIV-affected couples.</li> <li>▪ Provider limitations: lack of training in SCSs, SCS service delivery, and preconception counseling for people living with HIV; health workforce shortages undermining the quality of counseling; poor linkages to HIV care; and lack of integration of HIV and RH services (leading providers to think that SCS is someone else’s responsibility) (Davey et al. 2018)</li> <li>▪ Fear of HIV discordant test results, unequal household gender roles, and couple dynamics were barriers for couples to self-test together (Kumwenda et al. 2018)</li> <li>▪ Barriers to safer conception counseling include: clinicians do not initiate discussions with patients around fertility desires, reluctance to provide safer conception knowledge to patients perceived as not being prepared for</li> </ul>	<ul style="list-style-type: none"> <li>▪ Non-monetary incentives (Wall and Allen 2017, Sibanda et al. 2017)</li> <li>▪ Promotional campaigns normalizing CHCT performance-based pay to promote CHCT</li> <li>▪ Cost-effectiveness (Grabbe et al. 2010)</li> <li>▪ Difficulties with couples who did not disclose or disclosed inaccurately could be avoided</li> <li>▪ Government support from the highest levels</li> <li>▪ Collegial relationships among research, government, and implementation sectors (Karita et al. 2016)</li> <li>▪ Partner notification services, PrEP and ART integration and synergies (Odoyo et al. 2019)</li> <li>▪ How men see their role as caregivers and whether caregiving is reciprocal (Tan et al. 2018)</li> <li>▪ Studies show that provider training and self-efficacy in talking about SCS increased SCS availability (Davey et al. 2018)</li> <li>▪ Counselor-supported disclosure counseling, skills on partner invitation, and follow-up for partner invitation increased the uptake of CHCT. (Kababu et al. 2018)</li> <li>▪ Communication with providers and within couples is important for the successful uptake of safer conception strategies among HIV-1 serodiscordant couples (Hancuch et al. 2018)</li> </ul>

**Integrated Services**

<p>conception, lack of training to counsel patients about safer conception, and limited knowledge of safer conception strategies (Hancuch et al. 2018)</p> <ul style="list-style-type: none"> <li>▪ Barriers to couples-based self-testing for HIV include: Both men and women were afraid of disclosure of HIV-discordant relationships (fear of unfavorable dynamics within the relationship, including violence or dissolution of the relationship); fear of exposure of a suspected or known HIV-positive result; unavailability of partner at time the service was offered (Kumwenda et al. 2018)</li> </ul>	
<ul style="list-style-type: none"> <li>▪ Lack of integration guidelines for FP/pre-conception counseling into HIV services</li> <li>▪ Provider stigma and discrimination</li> <li>▪ Managing partner disclosure of HIV status</li> <li>▪ Shortage of trained health care workers.</li> <li>▪ Limited time for comprehensive services (Mason et al. 2017)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Particular characteristics of the male member of the couple (Melo et al. 2013)</li> <li>▪ Non-monetary incentives (Villar-Loubet et al. 2013)</li> <li>▪ Particular attributes of the couple (Becker et al. 2014)</li> </ul>

# DOCUMENTARY ANALYSIS OF GLOBAL REPRODUCTIVE HEALTH POLICIES

The previous section shows an emergent and substantial body of work on couple-focused interventions. Also evident was that the field of HIV is leading the way in this arena, followed distantly by family planning and maternal health, where studies of couple-focused interventions are comparatively rare. More significantly, the literature review revealed that CFIs are equally or more effective than interventions that focus on a single sex or individuals in achieving reproductive health outcomes. The review also demonstrates the extent to which CFIs across the different health elements seek to address, challenge, and shift gender and power dynamics, although surprisingly, not always explicitly.

One goal of this paper is to elucidate the relationship among research, policy, and practice in relation to couple-based approaches. Do the principal global health policies in the fields of family planning, maternal health, and HIV mirror the same level of engagement with couple-based approaches as the research literature across the reproductive health subfields under consideration? To what degree do these policies enable or hinder CBAs in practice and research?

The study investigator analyzed three policy documents—selected because of their power to shape the global reproductive health discourse—to gain insight on if and/or how CBAs are being considered as a strategy to improve reproductive health and related outcomes. These documents are: 1) Framework of Actions for the Follow-up to the Program of Action of the International Conference on Population and Development Beyond 2014 (Chapter 3, Health); 2) The Global Strategy for Women’s, Children’s and Adolescents’ Health, 2016-2030: Survive, Thrive, Transform; and 3) WHO Global Health Sector Strategy on HIV, 2016–2021: Towards Ending AIDS. What follows is a brief introduction to each of the policies, including the sponsoring body, purpose of the document, intended audience, and its broad goals; and a summary of content and thematic analyses to gain a better understanding of each policy’s approach to couple-based work.

## **Framework of Actions for the Follow-up to the Program of Action of the International Conference on Population and Development Beyond 2014, Chapter 3, Health**

The Framework for Action was written in 2014 in response to the United Nations General Assembly’s request for a review of the implementation of the original resulting document of the 1994 International Conference on Population and Development held in Cairo. The follow-up Framework of Action was developed specifically to provide “specific recommendations on steps Member States can take to realize the unfinished agenda of Cairo” (United Nations 2014). Broadly, the Framework “affirms the importance of sexual and reproductive health, including family planning, as a precondition for women’s empowerment. It calls for an end to gender-based violence and harmful traditional practices, including female genital mutilation. Further, the Programme of Action highlights the crucial links between sexual and reproductive health and rights with almost every aspect of population and development, from urbanization, migration and ageing to changing family structures and the importance of addressing the rights of young people. It



calls attention to the ways in which investing in women and youth, especially in their sexual and reproductive health, can impact environmental sustainability and population dynamics.”

### Thematic and content analysis—gender

The chapter on health focuses primarily on women. In reference to the sex-specific terms, “woman,” “girl,” and “female” combined appear 231 times in the document’s chapter on health, while “man,” “boy,” and “male” combined appear a total of 71 times. Despite this imbalance, it is clear women’s partners are acknowledged as playing a role in the promotion of sexual and reproductive health.

**Table 5:** Term frequencies, Framework of Actions, ICPD Beyond 2014

CONTENT ANALYSIS: SIMPLE FREQUENCIES											
	Female Sex			Male Sex			Relational				Social
Search Term	Woman	Girl	Female	Man	Boy	Male	Couple	Partner	Wife	Husband	Gender
Frequency of appearance in document	184	21	26	32	2	37	7	6	0	0	34

While the high frequency of the use of the female sex terms reflects the document’s emphasis on the importance of sexual and reproductive health for women’s health, women’s empowerment, and development in general, men are often mentioned in the same contexts as women—as being entitled to sexual and reproductive health services and rights. For instance, men are mentioned as needing equal access to SRH information, counseling, and services (two mentions) and having an unmet need for family planning. In addition, men are discussed in the context of family planning utilization, with men’s use of condoms being discussed eight times and male sterilization mentioned 11 times. Research into male contraceptives received two mentions. Other notable discussions of men included syndromic management of STIs (six mentions), HIV prevalence and knowledge (six mentions), and men who have sex with men (three mentions).

The document acknowledges the importance of couple communication and the role it plays in the use of contraception and decision making related to the prevention of unwanted pregnancy and abortion. It also mentions infertility and its impact on couples. The relational terms “couple” and “partner” appear in the health chapter a combined 13 times. Couple communication related to contraceptive use was mentioned three times, and couple infertility received two mentions. Other mentions of couples or partners were related to violence, disagreement over pregnancy, HIV prevention, and the right of couples (and individuals) to decide their fertility.

In terms of the diversity of groups mentioned, the spectrum of unions discussed is limited. Men who have sex with men, trans individuals, and sex workers are mentioned, but only “people who inject drugs and their partners” are discussed specifically in the context of unions as needing access to sexual and reproductive health services and rights.

The social term, “gender,” appears 34 times in the health chapter. By far, the most frequent use of the term—16 mentions—was related to the need for comprehensive sexuality education that critically examines gender norms and promotes gender equality and “honors non-violent masculinities.” The next most common use of the term was related to the prevention of gender-based violence (six mentions) and the importance of promoting gender equality as an essential strategy in the prevention of unwanted pregnancy and abortion (four mentions)

### **Implementation guidance**

No guidance is given for the implementation of couple-focused interventions, despite the acknowledgement of the role of partners in RH. The chapter makes very clear that men, as well as women, need access to comprehensive RH services. However, it never specifically mentioned clinic or community-based interventions directed toward partners.

The document does not label any of its suggested actions as gender-transformative, only as gender-sensitive, such as the need for comprehensive sexuality education that is “gender-sensitive.” However, the document is clear that gender inequality is an important structural cause of poor health outcomes and that gender equity is a prerequisite for the realization of RH. At one point, the chapter calls to work with community leaders to publicly promote gender equality and “non-violent masculinities,” hinting at the possibility of a gender-transformative activity and perspective.

### **Conceptual framework**

The document acknowledges structural factors that influence the realization of RH for all people, including couples. Overall, the document takes a “gender in development” perspective in emphasizing “the value of investing in women and girls, both as an end in itself and as a key to improving the quality of life for everyone,” and in highlighting the crucial links between sexual and reproductive health and rights with almost every aspect of population and development, from urbanization, migration, and aging to changing family structures and the importance of addressing the rights of young people.

Additionally, the document reflects an understanding of gender as being relational—that women and men do not live in isolation, but rather within a system of beliefs and norms that give meaning to both what it means to be a woman and a man. One example is in the insistence on comprehensive sexuality education for all adolescents that problematizes and examines gender norms and power to achieve concrete health outcomes.

This theoretical orientation, “gender in development,” with its emphasis on a relational understanding of gender, certainly enables an inclusion of couple-based interventions and approaches. But in this document, this vision is not yet fully realized.

## The Global Strategy for Women's, Children's and Adolescents' Health, 2016-2030: Survive, Thrive, Transform

The Global Strategy was published in 2015 by the Every Woman Every Child movement. This is a platform which unites diverse global actors and “mobilizes and intensifies international and national action by governments, multilaterals, the private sector, research and academia, and civil society to address the major health challenges facing women, children and adolescents everywhere” (Every Woman Every Child 2017). The movement is tasked with putting the Global Strategy into action. WHO led the development of the strategy itself, and the process included extensive consultation involving governments, civil society, the private sector, UN agencies, and other constituencies.

The document envisions “[b]y 2030, a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies” (Every Woman Every Child 2015). The three summarized objectives of the strategy are:

- **Survive:** End preventable deaths by reducing maternal, newborn, and child mortality; end epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases; and reduce premature mortality from non-communicable diseases and promote mental health and wellbeing.
- **Thrive:** Ensure health and wellbeing by addressing the nutritional needs of children, adolescent girls, and pregnant and lactating women; ensure universal access to RH; promote access to good quality early childhood development for girls and boys; reduce pollution-related deaths and illnesses; achieve universal health coverage, including access to services, medicines and vaccines.
- **Transform:** Expand enabling environments by eradicating extreme poverty; ensure that all girls and boys complete free, equitable, and good quality primary and secondary education; eliminate harmful practices and discrimination and violence against women and girls; achieve universal and equitable access to safe and affordable drinking water and to adequate and equitable sanitation and hygiene; enhance scientific research, upgrade technological capabilities, and encourage innovation; provide legal identity for all, including birth registration; and enhance the global partnership for sustainable development.

The strategy is envisioned to be implemented at the country level and to inspire political leaders and policymakers to promote change. In addition, the document is intended to serve as a tool to help communities hold their governments accountable.

## Thematic and content analysis—gender

This document focuses almost exclusively on women, children, and adolescents. In reference to sex-specific terms, “woman,” “girl,” and “female” combined appear 216 times in the document, while “man,” “boy,” and “male” combined appear a total of 20 times.

**Table 6:** Term frequencies, *Global Strategy for Women’s, Children’s and Adolescents’ Health*

CONTENT ANALYSIS: SIMPLE FREQUENCIES											
	Female Sex			Male Sex			Relational				Social
Search Term	Woman	Girl	Female	Man	Boy	Male	Couple	Partner	Wife	Husband	Gender
Frequency of appearance in document	182	31	3	6	12	2	0	2	0	0	48

While the high frequency of the use of the female sex terms reflects women’s and girls’ role as the central subjects of the document, the male sex terms appear in specific contexts. These include: 1) a call for the increased involvement of men and boys in RH programming and health services, 2) a call for entitlements for parental leave and for childcare for working parents, and the promotion of incentives for flexible work arrangements for men and women, and 3) voluntary medical male circumcision as an evidenced-based practice appropriate for countries with generalized HIV epidemics. The term “boy” was used most often in reference to the need for early and good quality childhood development programs and primary and secondary education for both girls and boys. Of the relational terms, only “partner” appears twice—both times in reference to IPV. Couples or unions are never mentioned. One is left with the impression that women, children, and adolescents exist independently of families (there are only three mentions of “family” in the document, when “family planning” is excluded), and certainly of men. Because of this, the broad spectrum of possible unions are certainly not discussed, although sexual orientation is mentioned as a human right.

The term “gender” appears 48 times in the document. The most frequent uses of the term are related to: (1) the importance of gender equality as a precursor to the realization of the right to health (11 mentions), (2) gender-based violence (eight mentions), (3) the promotion of gender equality as an investment leading to broad societal dividends (six mentions), (4) the significance of gender analysis in the formulation of site-specific interventions (five mentions), and (5) one of the guiding principles of the policy is that it is “gender-responsive” (two mentions).

## Implementation guidance

The document offer no guidance for the implementation of couple-focused interventions, although it encourages the involvement of men and boys in health programs. In addition, it suggests promoting positive attitudes among health care providers with respect to involving men and boys in services and creating a space for men and boys within facilities under the “Community Engagement” action area.

The document does not label any of its suggested actions as gender-transformative, only as gender-responsive. However, it makes clear that gender inequality is an important structural cause of poor health outcomes and that gender equity is a “multi-sector enabler.” The achievement of gender equality is seen as being essential to the realization of the right to health, which would yield broad positive societal outcomes.

Specific guidance for the promotion of gender equality includes: 1) integrate human rights-, equity- and gender-based approaches into health sector policies and programs, 2) promote women’s social, economic and political participation, 3) enforce legislation to prevent violence against women and girls and ensure an appropriate response when it occurs, 4) promote gender equality in decision making in households, workplaces, and communities, and at national levels, 5) prevent discrimination against women in communities, education, and in political, economic, and public life, and 6) ensure gender equality in the labor and trade sectors.

### **Conceptual framework**

The document reflects a concern with structural factors that influence the health of women, children, and adolescents. It calls for gender analyses to formulate intervention strategies that are specific to the cultural context of action, suggesting that a “gender in development” approach was considered in the development of the document. However, there is scarcely any evidence in this document that gender is seen as relational. In this sense, the policy is more reflective of the traditional “women in development” model. When women are seen in isolation, it is difficult to conceptualize approaches that are relational, like couple-focused interventions or even male involvement.

## **WHO Global Health Sector Strategy on HIV, 2016–2021: Towards Ending AIDS**

Published by WHO in June 2016, this document represents the health sector contribution to a broader multi-sectoral response as outlined in the UNAIDS Strategy, 2016–2021: On the Fast-Track. The strategy is intended to guide the work of both member states and WHO through 2021. The goal envisioned in the strategy is the “[e]nd of the AIDS epidemic as a public health threat by 2030.” Targets for 2020 include:

- A reduction in new HIV infections to fewer than 500,000
- Zero new infections among infants
- A reduction in HIV-related deaths to below 500,000
- 90% of people living with HIV tested, 90% treated, and 90% virally suppressed

The chief mechanisms or platforms of action that the strategy proposes to achieve these targets include the promotion of universal health coverage among member states, strengthening the continuum of services, and taking a population-based, public health approach.

## Thematic and content analysis—gender

This policy does not focus primarily on either women or men. With respect to the appearance of sex-specific terms in the document, “woman,” “girl,” and “female,” combined, appear 45 times, while “man,” “boy,” and “male,” combined, appear a total of 51 times. When one counts the term “men who have sex with men,” as one mention instead of two, the appearance of sex-specific terms are nearly equal for men and women.

**Table 7:** Term frequencies, Global Health Sector Strategy on HIV

CONTENT ANALYSIS: SIMPLE FREQUENCIES											
	Female Sex			Male Sex			Relational				Social
Search Term	Woman	Girl	Female	Man	Boy	Male	Couple	Partner	Wife	Husband	Gender
Frequency of appearance in document	22	14	9	24	7	20	1	4	0	0	18

The gender-specific vulnerabilities and considerations of men, women, transgender people, men who have sex with men (MSM), and others are highlighted. With a few exceptions related to pregnant and breastfeeding women (four mentions), “women” and “girls” were used together in a variety of circumstances. The most frequent mentions were related to: 1) the high incidence, prevalence, and burden of HIV among this group (six combined mentions); 2) their vulnerability to HIV (six combined mentions); and 3) the need for a combination HIV prevention strategy (six mentions). The most frequent use of the term “men” was in the phrase “men who have sex with men,” which appeared six times. MSMs were described as a key population, disproportionately affected by HIV. Men and boys were mentioned together in a variety of contexts—garnering either a single or double mention. These were related to the incidence of HIV, disparity in treatment (i.e., men and boys utilizing services less), male circumcision, gender-based violence, and the need for combination HIV prevention strategies for this group. Other notable mentions of men referred to their special vulnerability because they may fall outside of traditional surveillance systems because of their infrequent use of services, and due to circumstances where men take jobs in remote communities (e.g., in mining).

In terms of unions, sexual partners are discussed in terms of diverse strategies for prevention, treatment, and care. The relational terms “couple” and “partner” appear in the health chapter a combined four times. Couples are mentioned one time in a section on expanding HIV testing. Couples testing is listed as one of the new and targeted opportunities to rapidly expand testing coverage. The term “partner”<sup>1</sup> appeared in relation to: (1) the prevention of HIV infection in serodiscordant relationships (though the term “serodiscordant” is actually never used in the document), (2) WHO’s strategy for prevention, treatment,

<sup>1</sup> Mentions of the term “partner” in the context of “partner organizations” or “development partners” were excluded from the count.

and care for people who inject drugs and their sexual partners (two mentions), and (3) the need for combination HIV prevention for women and their male sexual partners.

In terms of the diversity of unions mentioned, men who have sex with men, transgender people, and sex workers are discussed. However, in terms of partnerships, only “people who inject drugs and their partners” and “women and their sexual partners” are explicitly mentioned as units in need of information or services.

The term “gender” appears 18 times in the document. Gender-based violence, as increasing vulnerability to HIV and the importance of combating it as an HIV prevention strategy, received eight mentions. Creating an enabling environment that promotes gender equity to reach diverse populations was discussed four times. Gender inequality, as a risk factor for both HIV and violence, received three mentions.

### **Implementation guidance**

This strategy offers no guidance for the implementation of couple-focused interventions. In the section on HIV testing, where couples testing is specifically mentioned, the document notes that the “[s]election of the most appropriate combination of HIV testing approaches and strategies will depend on HIV epidemic dynamics, the populations affected and the local health system” (WHO 2016). However, in an earlier document, WHO did offer guidance for the implementation of couples HIV counseling and testing. In 2012, WHO’s HIV/AIDS Program issued “Guidance on couples HIV testing and counselling—including antiretroviral therapy for treatment and prevention in serodiscordant couples.”

In terms of enabling change in gender norms, the document does not label any of its suggested actions as gender transformative or even gender sensitive. It simply mentions that the implementation of the strategy will contribute to gender equity, that gender inequality is a risk factor for infection and violence, and that addressing it is an important enabling factor in reaching diverse populations.

### **Conceptual framework**

The primary focus of this document appears to be epidemiological concerns and the biomedical tools available to prevent, treat, and care for people infected with HIV. However, it also more broadly acknowledges the importance of human rights, fighting stigma and discrimination, and involving communities. In addition, it contains the health-related components of the broader UNAIDS strategy.

This document’s biomedical/epidemiological orientation does not preclude the incorporation of couple-focused approaches; in fact, couples HIV testing is explicitly mentioned. However, partners are seen more as a means to prevent another infection, rather than the couple being seen as a meaningful unit of intervention.

## Summary

The ICPD follow-up document and the Global Strategy for Women's Children's and Adolescents' Health seemingly take a "gender and development" approach. On closer examination, however, these documents' implementation guidance and monitoring frameworks reveal a more traditional and narrower vision of gender. 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 lays the groundwork for the inclusion of men and couples. However, the document's largely biomedical approach gives short shrift to the social dimensions of infection. For example, couples are mentioned, especially the importance of 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 5, which compares the term frequencies among the three documents. The differences mirror 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.

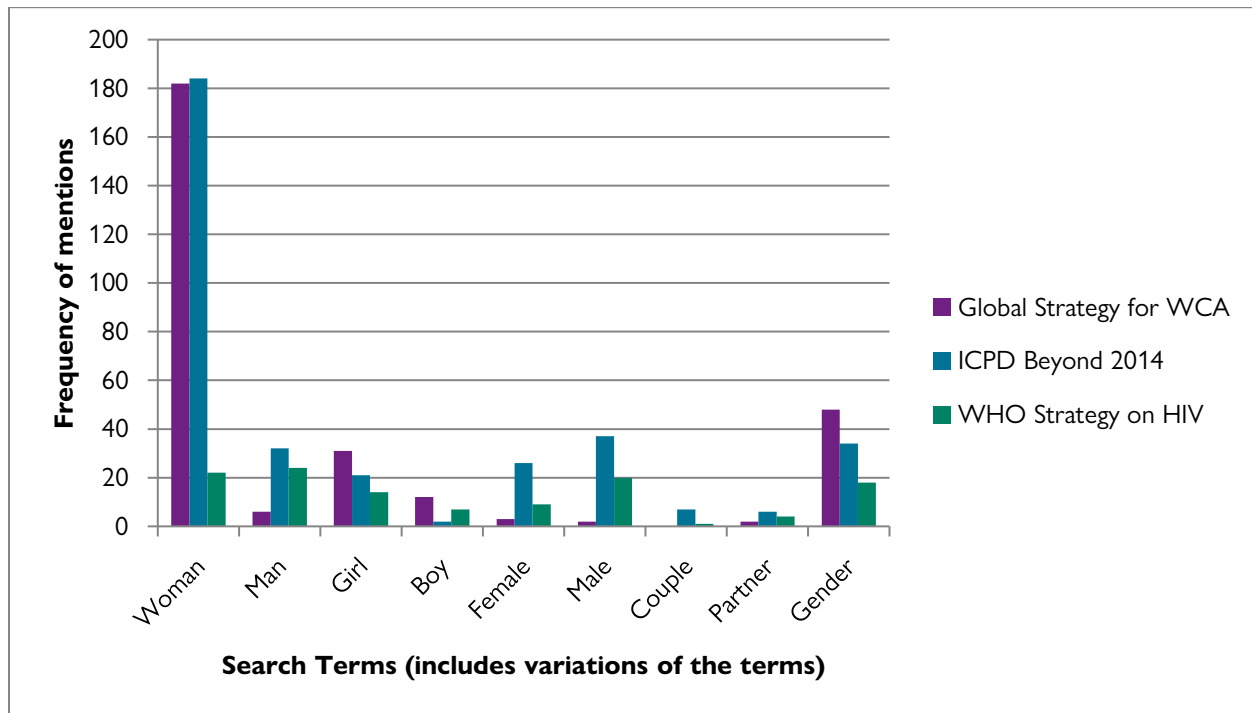
Taken together, this paper's literature review and policy analysis show some parallels with respect to receptivity to the inclusion of men and couples as an explicit strategy to improve RH outcomes. The Global Strategy, with a primary focus on women's, children's and adolescents' health, largely ignores opportunities for male involvement and couple engagement, 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 it does not go far enough. Finally, the HIV-related policy reviewed 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, instead continuing to use individual models and outcomes to understand change.

While the motivations to use CBAs across the subfields may vary, the effectiveness of CBAs is remarkably consistent. CFIs were found to be just as or more effective than interventions focusing on individuals across the spectrum of RH fields. The burden of disease avoided that can be correlated to CFIs across the subfields is important to consider to build the evidence base on this approach (e.g., comparing HIV



infection, maternal and neonatal mortality, unintended pregnancy, unsafe abortion, etc.) but is beyond the scope of this paper.

**Figure 5:** Term frequencies compared



## Key Informant Interviews

The time constraints associated with the key informant interviews did not allow full coverage of the interview guide that was prepared for the purpose. Therefore, the interviews focused on the topics which would be most helpful in making analytical sense of the findings of the literature review and policy analysis. Principally, this included the intellectual underpinnings and validity of CBAs in public health, trying to understand the differential utilization of CFIs in the RH subfields, and the comparative systemic rarity of CBAs in RH policy. Beyond these areas of interest, the informants also introduced new issues in trying to understand the systemic dearth of CBAs in the policy cycle. These included a concern with reconciling CBAs with sexual and reproductive rights, the demand for and use of data related to CBAs, and practical obstacles to integrating men in couples into health systems that have been configured with women in mind.

### Definition of couple-focused interventions

Key informants generally agreed that in couple-focused interventions, the couple becomes the unit of intervention. For informants, 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.”

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, where the opportunities are to move things together and to coordinate programming intentionally,” whether the participants involved are coupled or not. Rather, informants viewed gender-synchronization 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 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.

### **Usefulness of couple-focused interventions as a public health category**

Regarding perceptions related to couple-focused interventions as a useful public health category, there was some diversity in responses. Some saw a clear benefit in distinguishing CFIs in programming because they perceived that these types of interventions have produced concrete and beneficial public health outcomes. Others, though broadly supportive of the idea of couple-focused approaches, had concerns pertaining to methodological considerations. One researcher said, “It is difficult to know whether CFIs are more effective than interventions that target a single sex because of selection bias in studies.” He went on to explain that many of the studies looking at CFIs focus on health services users, which is problematic because that study population is already different than the general population which also includes non-users. Building on this point of bias, another respondent asked, “Are we hitting high-functioning couples who are ready to come in [for services]? We may not be hitting the couples who need it the most.”

Another informant stated that in thinking about the utility of the CFIs, it was critical to consider whether one had a gender equality goal in mind or simply a health goal. This informant thought that couple-focused approaches should be included in the repertoire of public health interventions because they “give way to better health outcomes and also operationalize gender equality efforts” in terms of shared knowledge, communication, and decision making. This informant strongly believed that implementation efforts should have explicit health *and* gender equality goals, and that couple-focused efforts represented one useful approach to achieve both goals.

### **Frequency of use of couple-focused approaches across the subfields**

Informants were asked to think about the extent of the use of couple-focused interventions across the subfields of maternal health, family planning, and HIV. Respondents agreed that more work had been done in the field of HIV than in the other two arenas, an assertion borne out by the literature and policy reviews conducted for this study. Informants were then asked to explain this variation and whether the particular histories of the subfields affected the uptake of couple-based approaches. Although no individual informant gave a comprehensive explanation for the discrepancy among subfields, key informants' responses, when taken together, constituted a highly coherent narrative.

In explaining the low numbers of couple-focused articles in the field of **maternal health**, the lowest of the three subfields, one informant wrote: “[I]n many cultures, care during pregnancy, delivery and the post-partum period is still considered inherently ‘women’s territory.’ Men’s involvement is often seen as disruptive for other women and providers and, therefore, not always welcome, even when the actual pregnant woman may feel otherwise. Logistical limitations, such as lack of space in labor rooms or schedule of antenatal care services, are often cited among the reasons why partners cannot participate in pregnancy care or be present at childbirth. Consequently, couple-focused interventions are not common.” Another informant supported this point about maternal health being decidedly within women’s sphere of action. She also noted that much of the literature and guidance on maternal health was excessively technical, which has also contributed, in practice, to a certain level of isolation of women from their male partners during pregnancy. The biomedical focus, she explained, can confer a sense that “the person [i]s not a social being in the context of a relationship that profoundly shapes her maternal health.”

Another informant set the lack of uptake of CFIs in the maternal health field into its broader context. The informant explained that when one thinks of diverse reproductive health issues in terms of the burden of experience and corresponding health service needs, maternal health and family planning are asymmetric, with the burden falling primarily on women. He argued that HIV, in contrast, is symmetric with the burden of experience and needs falling nearly equally on men and women (though the informant noted both the higher HIV prevalence rate among women and the problematic lower utilization of services among men).

Key informants had a lot to say regarding the frequency of uptake of couple-focused interventions in **family planning**, which was greater than in maternal health but significantly less than in HIV. For most informants, understanding the history of family planning was critical to understanding the subfield’s position vis-à-vis men and couples.

Subjects recalled the sentiments that surrounded the ICPD in 1994. The political atmosphere in 1994 was marked by women’s groups’ substantial mistrust of governments, agencies, and companies that were working on the development of new contraceptive methods. Given the provider-controlled nature of many of the methods, the fear was that the risk for reproductive coercion was too great. Furthermore, “the escalation of incidents in which women’s rights were transgressed by family planning programs suggested a sector-wide subordination of women’s health and human rights to population control imperatives (United Nations 2014).” The result, informants explained, was that women’s empowerment, women-centered decision making, and women-controlled methods became central themes of population and family planning discourses. One respondent explained: “In the case of contraception, women’s

autonomy to make decisions is considered a key component of programs and services. Targeting only women (or women and men separately) is at the crux of the distinction between contraception and family planning and is expected to give women a chance to decide on their own reproduction without interference from a partner, who may have different goals and expectations.” However, another respondent said that with this approach, “[W]e continue to keep men at bay, with inadequate information and an inadequate vocabulary to even be able to discuss these issues.”

Key informants pointed to other historical and intellectual dynamics that helped to cement the nearly exclusive bond between women and contraception. One informant, in reviewing the history of male involvement, made the case that prior to the 1960s, men were considered and studied in relation to family planning, partly because the methods that were available at that time (condoms, withdrawal, and the rhythm method) required some level of male involvement. The informant cited some important early works in this vein, including the studies of Reed and his colleagues in Indianapolis (USA) in the 1940s (Whelpton and Kiser 1943), and Hill and his associates in Puerto Rico in the 1950s (Hill et al. 1959). With the advent of the pill and IUD in the 1960s, the informant said, men receded into the background as subjects of reproductive health inquiry and programming until the onset of the HIV epidemic in the 1980s. In the field of demography as well, decisive works such as Davis and Blake’s “intermediate variables” (Davis and Blake 1958) and Bongaarts’s (1978) “proximate determinants” emphasized the biological realities of human reproduction as contributing to a focus on women’s bodies and births as the principal outcome of interest. As was noted with maternal health, such a biomedical focus may inadvertently discourage the involvement of men or couples in family planning. One informant explained that “FP is sexless,” in the sense that it does not deal with the complexities of relationships and sexuality. “It’s [a] safer, easier route to just focus on women given the focus on women’s bodies and autonomy of decision making. The default intervention is ‘her.’” Another respondent echoed this concern: “If you’re a physician and you only see your patients for 10 minutes, you give them a birth control method. [It’s] not so helpful to talk to the man. Why would you even intervene with men? The goal is to treat the condition/person that comes in.”

The role of men, when considered in reproductive health, has usually been as supporters of women in their use of family planning and, on rare occasions, getting men to use a method themselves. But even talking about men and family planning “is still so fringy,” said one informant. “The joys and sorrows of reproductive life are not seen as male territory... [men] don’t own their reproductive lives in the same way in a cultural sense.”

In addition to the enormous amount of available funding, informants pointed to the epidemiology of infection to explain the relatively higher frequency of utilization of CFLs in the field of HIV. The dynamics of transmission and the reality of serodiscordancy “ha[ve] forced the field to consider the couple-dyad,” said one informant. He added that when you consider pregnancy with HIV-affected couples and reproduction, it is “vital for both members of the couple be reached.”

However, informants were also aware that this increased focus on the couple in the field of HIV<sup>2†</sup> was an evolutionary process, shaped by advances in the common understanding of the biological and social

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<sup>2†</sup> It is important to remember, however, that individually based HIV services remain the norm nearly worldwide.

aspects of HIV transmission—particularly the key role of men in the dynamics of transmission. One informant discussed the revelation of transport corridors in Africa as HIV “hotspots,” and the increasing awareness and consequence of multiple concurrent partnerships, an issue which became the predominant focus of social and behavioral prevention efforts until the widespread utilization of biomedical interventions took root. Informants also cited the discovery of the positive impact of men’s involvement in PMTCT on a variety of health outcomes as contributing to an increased focus on men and couples. One respondent pointed to Rwanda as an example where “they have seen the benefits and [couple testing] has become the standard of care” in PMTCT. Finally, informants discussed the current focus on the identification of serodiscordant couples through improved partner HIV testing as another contributor to the increased frequency of couple-based approaches in research and practice. Though informants did not mention it by name, this focus was enabled by the landmark HTPN 052 study (Cohen et al. 2011), which demonstrated that ART was associated with a 96% reduction in HIV sexual transmission in HIV serodiscordant stable couples where the HIV-positive partner was randomized to receive ART, regardless of his/her stage of disease progression.

Interestingly, the conversations about the rationale for the relatively higher use of CFIs in HIV opened the door to discussions about how the global public health community has traditionally conceived of “the couple.” The general feeling was that HIV has forced a reckoning in the field of public health with the realities of people’s lives—that “sex is not happening just between ‘the couple.’” Another informant said that in the field of HIV, “their take does not assume monogamy, or is prescriptive about relationships. It has had to look at sexual networks, multiple partners, etc. The nature of the disease makes the field deal with the complexity of sexuality and relationships more.”

Two informants explicitly compared these more nuanced understandings with historical assumptions about “the couple” in the field of family planning. One explained: “We seem to have an unexamined romantic, Western view of relationships, the whole idea of what a couple is...an outmoded conception of the ‘harmony’ of the couple. What are we really saying? The reality is that there is a lot of conflict, disagreement, different agendas, lack of communication, but also some solidarity and shared experiences. There is a generation of white men that did work in this area that were not as questioning as they might have been.” The other concurred: “This family planning notion of a stable relationship is a Western, Protestant construct. When we consider sites like Brazil and Mozambique, the construct imposes a level of stability and monogamy that does not necessarily exist.” Another key informant, an experienced researcher, elaborated further on this Western construct of the couple and its limitations: “In Indian society, the intergenerational [familial] bonds are very strong. There are norms around those relationships and behaviors that are learned and passed down. So to think that the couple as a unit would take precedence in terms of decision making is probably not very realistic.”

As an example of the institutionalization of this traditional (and often unrealistic) notion of the couple and its impact on global public health, a few informants pointed specifically to the Demographic and Health Surveys (DHS) program. This program, funded by USAID, is generally considered the gold standard in the collection and dissemination of nationally representative data on family planning, maternal health,

HIV/AIDS, and other areas. This subject is discussed further in the section, “Supply and demand for couple-focused data” (below).

### **Reconciling the implementation of couple-based approaches with sexual and reproductive health and rights**

Despite general consensus about the marginalization of men in family planning, the key informants all agreed that the promotion of women’s right to make the final decision about family planning—whether to use and which method—was critical. This raises the question of whether it is essential, or even makes sense, to include couples counseling in family planning services or in other services. Key informants presented a series of challenges to providing couple-focused interventions effectively.

First, if the service is to guarantee women ultimate decision-making power over method use, one informant said that a couple-focused approach may call for a certain level of inefficiency, 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 informant questioned whether such a process would be realistic in a low-income country setting with human resource shortages in health. The complexities of consent raised by this informant would also apply to other areas, such as PMTCT, birth preparedness and complications readiness planning, and couple HCT.

A second issue that informants 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 is taking place (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 informants highlighted the additional skills that the provider would need to counsel couples in a gender-sensitive or transformative fashion. 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 informant 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 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 expressed that the near exclusion of men from RH services was unfair. He said that what some

women's rights colleagues have been doing is counterproductive to women's rights. He argued that while they have been protecting women's autonomy, they have been less likely to say that it is unfair that the brunt of the burden of reproductive health falls on women. "Why don't we expect more resources to be devoted towards method development [for men]?" He went on to give the example of hormonal contraceptive that was under development for men, but in trials, as soon as men reported mood swings—at much lower levels than the field has tolerated for women—it was pulled from further development. He went on to suggest that the efforts to rebalance the reproductive burden on the sexes has been hampered by many activists' inability to recognize the multi-dimensionality of men: "It's tough in the women's rights fields to say that 'some men' [and not others, may be 'bringers of harm']. We are so used to the idea that men [in general] are the bringers of harm."

Finally, the need to modify or overhaul established systems and institutions that would arise if couples-focused interventions were to be incorporated emerged as a challenge. Need changes already mentioned by informants include training for staff and changes in guidelines and protocols. Another informant noted 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." In considering the prospect of changing established systems, one informant said, "It is easier to tell a funder to focus on women. It also has become a funding stream...it has become a discourse of Global South women needing a certain set of services. If you want to add men, it becomes more complex: you have to add training. It becomes slower. Make sure you do no harm. Assess [for] violence. You suddenly have to ask a series of questions to both members of couples to assess that this involvement will do no harm. The research seems to indicate that you go farther and you get better outcomes when you do involve both, but you do make your staff have to work harder. And if your metrics are how many women come through the door, then you make your life a lot more difficult. Couple work is more complicated, but it is also more reflective of the reality of life. And many women will say that. But funders aren't listening to that."

### **Supply and demand for couple-focused data**

As previously mentioned, DHS and the issue of data and its impact on the relationship among policy, research, and practice arose spontaneously during discussions about traditional notions of the couple in public health. One researcher with DHS experience discussed the shift in thinking over time about men. The informant said that starting in the early 1990s, DHS started interviewing men about fertility expectations. The goal, she said, was not to try to understand men's experiences, but rather how their expectations about their desired number of children affected couples' fertility. Instead of interviewing all men, usually a subset of partners of women who were sampled for the DHS constituted the study population, which would make "a very biased sample," she pointed out. She went on to explain: "But with HIV, things changed. Now people were interested in the behavior of men, and not just as part of a couple. A lot of interest in concurrency"<sup>3</sup> was seen from both donors and national ministries of health. With this change, the sampled population included both men and women (less biased). The same researcher said, however, that we are now in the midst of yet another transition. The interest in behavior—of both men

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<sup>3</sup> That is, multiple and concurrent partnerships.

and women—has been largely dropped. “Even now, UNAIDS is reducing the demand for behavioral data. Now the interest is in both men and women but related to [ART] retention across the cascade.”

Indeed, the key informants collectively indicate 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 RH/FP-related targets. Traditionally, USAID country missions and national ministries of health invite DHS to the country to provide technical assistance in the development and conduct of the national surveys. Together they develop the content areas (modules) to be included in the survey. In discussing the specifics of content in the surveys, the DHS researcher informant said, “You really have to go to the beginning and figure out who requested this information and why. Because once it gets established, it is really difficult to get rid of. People take it for granted that information will be there.” She added, “In reproductive health, there has never been an interest in men.”

Discussing demand specifically, she said there were many influences in terms of what is included. One is international agreements—like the SDGs—which countries sign onto and then provide the data for specified indicators to measure their progress. One of the problems with couple data is that no international agreements require information about couples or global strategies that include CFLs in any significant way. The informants’ observations point to how supply and demand for information can become a relatively closed system in terms of: 1) determinations made between donors and ministries of health of DHS data to be collected 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.

The researcher said, “DHS data really does shape the conversation. The people working in countries may not integrate socially appropriate interventions because it isn’t things that are measured.” One informant, a leader of an international NGO, reflected on the consequence of these institutionalized attitudes about couples on public health practice. Echoing an earlier comment on a general failure to treat men as multi-dimensional, he said, “We have a couple of projects with CDC [US Centers for Disease Control and Prevention] on men and sexual assault, but our work has to be about more than men as a walking sexual assault or deadbeat dad waiting to happen. There are a whole series of assumptions about people’s sexual lives and moralizing about what a couple is.” It is an “artifact that may not reflect reality. We have been truly less than gender transformative in the way we think about reproductive health.”



## DISCUSSION

The central problem raised by this paper is the limited incorporation of CBAs in global public health policy, practice, and research. The literature review revealed that CFIs were more effective than, or just as effective as, interventions targeting a single sex or individuals. It also shows that CFIs are used much more frequently in HIV work than in the other two subfields. The policy analysis portion of this research showed that men—and thus couples—are largely missing from global FP and MH policies, which have largely taken a “women in development” approach to improve RH.

Conversely, an epidemiological/biomedical approach characterized the global HIV strategy, with equal interest in health outcomes of both men and women—particularly their retention across the HIV continuum of care, including HCT, ART initiation, adherence, and the achievement of viral suppression. However, this interest did not translate into a focus on the couple, per se, except as an additional strategy to achieve individually focused targets across the cascade. Men and women were found to be equally represented, but not necessarily in a relational way to one another.

The key informants interviewed for this paper highlighted two key overarching factors contributing to limited uptake of CBAs into RH policy and practice: 1) the logistical and ethical implementation complexities of CFIs, including assuring the reproductive rights of both men and women; and 2) a lack of demand for couple-focused data.

The findings from the literature review, policy analysis, and key informant interviews, taken together, capture five interrelated factors that contribute to the systemic scarcity of CBAs in the entire global RH policy cycle. These are discussed below. Table 8 provides more detail on the more specific factors, which emerged during the course of this research, that facilitate and hinder CBAs in research, policy, and practice, listed by subfield.

As key informants made clear with their frequent allusions to data, and particularly the DHS, the **first factor** that can be directly linked the systemic scarcity of CBAs is the **almost complete absence of global RH indicators that specifically monitor the use of sexual and RH services by men and couples**. Because the policy instruments guiding RH at the global level inform member states’ national policies, this is generally true at the country level as well—with Rwanda, perhaps, being a notable exception (Sarkar et al. 2015). Without indicators requiring data to gauge progress at the national level, the demand for information on couples simply does not exist. This also means that projects do not have a strong incentive to invest their resources in CFIs, as they will not be held to account for achievements in this arena. Also, without policy guidance or the need for program evaluations, research also suffers. Closely related to this near-absence of indicators is the lack of donor interest and funding—often drivers of policy change.

The **second factor** contributing to the systemic dearth of indicators and donor interest in CBAs is the **lack of consensus among members of RH epistemic communities regarding the roles that men can play in advancing the RH agenda**. Key informants alluded to this, pointing to the historic concerns of women’s advocates about reproductive coercion associated with FP around the time of the ICPD (United Nations 2014) (and which persist in some settings) (Pachauri 2014) and perceived risk

regarding IPV and guaranteeing women autonomous choice over their bodies in clinical settings. Another barrier to adopting CBAs is the common perception that the involvement of men is a zero-sum game—that the resources required to involve men would mean a reduction in resources to address the needs of women, or that empowering men necessarily leads to the disempowerment of women (Barker et al. 2007). In addition, the policy analysis portion of this paper revealed that the “women in development” framework is still the predominant paradigm in RH. A brief review of the policy positions of governments, multilateral organizations, and bilateral donors makes it eminently clear that it is still the guiding framework in international development, despite the often added and often misused word “gender” (i.e., as not relational by definition). As mentioned in the methods section, a primary interest of this study was to examine the questions or issues whose analysis are enabled and inhibited by particular frameworks or models. In this particular instance, the women in development framework precludes a more nuanced understanding of gender. Thus, we witness that relational approaches to gender, including CBAs, are simply not understood (as can be seen with the frequent misuse of “gender”) or rejected as threatening or not sufficiently rigorous.

**Table 8:** Factors that facilitate and hinder CBAs in research, policy, and practice, by subfield

	Family Planning	Maternal Health	HIV and AIDS
Barriers to Practice	<ul style="list-style-type: none"> <li>Male involvement is not considered essential</li> <li>The skill required to screen couples for IPV</li> <li><b>Time constraints and shortage of health professionals*</b></li> <li><b>Lack of clinic policies regarding men and client flow</b></li> <li><b>Clinics are considered “women’s spaces”</b></li> <li><b>No indicators regarding male or couple engagement</b></li> </ul>	<ul style="list-style-type: none"> <li>Male involvement is not considered essential</li> <li><b>Skill required to counsel couples together</b></li> <li><b>Lack of space</b> in both ANC and maternity services</li> </ul>	<ul style="list-style-type: none"> <li>Norms surrounding individually based services</li> <li>Stigma surrounding HIV and AIDS</li> <li>Fear of disclosure of other relationships</li> <li><b>Perceived threat of IPV, including reproductive coercion</b></li> <li><b>Lack of national standards and guidelines</b></li> <li>Appropriate consent process</li> </ul>
Facilitators to Practice	<ul style="list-style-type: none"> <li><b>Desire of women in many settings for men to be involved</b></li> <li>Men’s concerns about the impact of contraceptives on their partners</li> <li>Concern with children’s and family’s well-being (birth spacing)</li> <li><b>The normalization of couple communication generally around RH</b></li> </ul>	<ul style="list-style-type: none"> <li>Growing awareness of the benefits of male involvement in ANC</li> <li>Men’s desires for healthy partner and newborn</li> </ul>	<ul style="list-style-type: none"> <li>The epidemiology of transmission</li> <li>Involvement of men is considered essential to achieve epidemic control</li> <li>Abundance of funding for HIV/AIDS</li> </ul>
Barriers to Policy	<ul style="list-style-type: none"> <li>Most methods do not require male involvement</li> <li><b>Involvement of men is seen as threatening and potentially taking resources away from women</b></li> <li>“Women in development” approach</li> <li>Legacy of historical thinking regarding fertility that centers on proximate/biological determinants and minimizes the importance of social dimensions, including relationships</li> <li>Lack of data on CFIs</li> <li><b>Lack of advocacy/constituency groups for couples engagement</b></li> <li><b>Strong constituencies for woman-centered care</b></li> </ul>	<ul style="list-style-type: none"> <li>No perceived public health imperative to involve men</li> <li>“Women in development” approach</li> <li>Maternal health seen as women’s sphere of influence and action</li> <li>Lack of data on CFIs</li> <li><b>Lack of political leadership</b></li> </ul>	<ul style="list-style-type: none"> <li><b>Lack of data on cost-effectiveness</b></li> <li>Biological approaches to prevention, care, and treatment have de-emphasized social determinants, including relationships</li> <li><b>No or very few indicators on couples engagement in services</b></li> </ul>

Facilitators to Policy	<ul style="list-style-type: none"> <li>Increasing interest in FP/HIV integration</li> <li><b>Growing awareness or interest in men's role in reproductive health (as supportive partners at the very least) and masculinities and/or promoting men's role in gender equity in health</b></li> </ul>	<ul style="list-style-type: none"> <li>Growing awareness about the importance of male involvement in PMTCT</li> <li>Renewed global concern about newborn health</li> </ul>	<ul style="list-style-type: none"> <li>An epidemiological approach: there is a public health imperative to involve men</li> <li>Abundance of funding for HIV</li> <li>Growing literature on the effectiveness of CFIs</li> <li>Growing number of advocates/champions</li> <li>Increasing interest in RH/HIV integration</li> </ul>
Barriers to Research	<ul style="list-style-type: none"> <li>Lack of funding</li> <li>Low priority among policymakers</li> </ul>	<ul style="list-style-type: none"> <li><b>No indicators regarding male or couple engagement</b></li> <li>Lack of funding</li> </ul>	<ul style="list-style-type: none"> <li><b>Dominance of donors and international NGOs at the country level, closing out local researchers and often local priorities</b></li> </ul>
Facilitators to Research	<ul style="list-style-type: none"> <li><b>Funding from international NGOs and universities for selected topics</b></li> <li><b>Urgency of perceived public health threat</b></li> </ul>	<ul style="list-style-type: none"> <li>Need for evaluation studies on the part of practitioners</li> </ul>	<ul style="list-style-type: none"> <li>Abundance of funding for HIV</li> <li>Concern about achieving epidemic control: men seem to be the missing piece</li> <li>Increasing efforts toward integration—does it work?</li> </ul>

\*Bolted bullet points are common to all three RH subfields and are thus not repeated in every column

The third factor is the narrow emphasis on biomedical interventions and models at the expense of the social determinants of RH outcomes. One key informant described the overly medicalized approaches to MH that do not sufficiently recognize the importance of the social dimensions in women's care. Another questioned why a time-constrained family planning clinician would choose to spend time with partners, when dealing with women directly and providing a method would address the women's immediate concerns. Finally, both the HIV global policy document and a third informant discussed the increasing move in the field of HIV toward medical interventions—both for prevention and treatment—to achieve the global individual-level recruitment and retention goals along the HIV care continuum. What all of these approaches share is a de-emphasis of understanding the social dimensions of RH, including gender and the dynamics of affective/sexual relationships, and the potential they hold as possible sites of intervention.

The lack of consensus of epistemic communities about men's roles in RH, combined with a narrow focus on biomedical approaches to achieve RH outcomes, largely drive the fourth factor influencing the scarcity of CBAs in the global policy cycle: the well-documented and systematic near-exclusion of men, and thus, couples, from family planning and maternal health care—as actors, as fundamental holders of human rights related to RH, as integral parts of care, and in outcomes (Theuring et al. 2009, Guttman 2007, Dudgeon 2016, Rovito et al. 2017). The historical exclusion of men has led to the institutionalization of equating RH with women's health. This has concrete consequences—essentially, creating a barrier to men's and couple's utilization of services, as can be seen in Table 8 above. Some examples found through this research include the lack of national policy and guidelines, the scarcity of health facility policies regarding male and couples involvement and appropriate patient flow, and the perception of health facilities as “women's spaces.”

The fifth and final factor influencing the scarcity of CBAs in practice is the logistical and ethical challenges of reconfiguring services to better accommodate couples. In fact, the changes that would be required to implement CFIs at scale would touch upon every component of the health system. Challenges highlighted by key informants include the need for adequately trained staff, sufficient human resources for health, and adequate data for decision making; and the lack of demand for information about men in couples in global policy instruments. The extensive changes required would be a challenge to implement in fragile and weak health systems, which often bear the brunt of the global RH burden. Ultimately, the demands on a health system to implement CFIs would have to be balanced against the potential benefits to improved RH.

## CONCLUSION

The paper posits that several factors are contributing to the systemic scarcity of CBAs in the policy cycle: **(1)** the lack of global or national indicators, which disincentivizes couple-based approaches, **(2)** the lack of consensus among RH epistemic communities about the roles that men can play in advancing the reproductive health and rights agenda, **(3)** the emphasis on biomedical approaches to RH, which has overshadowed approaches that consider broader social determinants (such as couples dynamics) of reproductive health outcomes, **(4)** the almost systematic exclusion of men from RH, leading to the institutionalization of a mindset of “reproductive health as women’s health” and to the formation of particular structures of service delivery that function as barriers to men and couples, and **(5)** the logistical and ethical challenges of implementing changes in service delivery to enable relational, couple-based approaches.

Nonetheless, CBAs represent an opportunity for gender-transformative programming aimed at changing the dynamics of power within relationships, which is a driver of adverse RH outcomes that must be addressed to make progress toward the achievement of the SDGs (Starrs 2018). A shift toward a relational approach to gender—that is, where “gender norms, roles, and the particular cultural vulnerabilities of the sexes are continually constructed through individual and collective interactions between men and women throughout the life-cycle” (Ramirez-Ferrero 2012)—would aid this effort. So would the recognition of the persistence of patriarchal norms that compromise women’s bodily autonomy and decision making and that make women’s empowerment efforts fundamental to the gender-transformative potential of CFIs. Finally, maximizing the potential of CBAs requires a recognition of the diversity of sexual partnerings and a commitment to equality, regardless of the number and sexes of the partners involved. CFIs, conducted with a properly trained health worker in either a facility or community setting, provide couples the opportunity together to learn, discuss options (including regarding risk reduction), provide mutual support (in case of disclosure), make decisions, and plan for the future. On a more global stage, increased leadership advocating for CBAs could lend support to a growing number of global voices to re-conceptualize RH and rights away from an exclusive focus on women to a more inclusive focus on couples, where both women and men, heterosexual and homosexual, are seen as assets to improved couple and family health.

## RECOMMENDATIONS

This section links the findings of this study with recommendations culled from the literature review. These recommendations are intended to provide guidance and promote greater cohesion among epistemic communities 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 RH and other interventions could also lead to policies that more effectively support concrete improvements in key reproductive health and gender outcomes and indicators, such as contraceptive prevalence; reproductive empowerment; maternal and neonatal mortality; men's engagement across all RH areas; HIV incidence, treatment, and ART adherence; and sexual and gender-based violence

### Conceptual, Methodological, and Practice Considerations

- A clear distinction between couple-focused interventions (or couple-based approaches) and the broader umbrella term 'male involvement,' will help clarify the different objectives, approaches, and desired outcomes for each related to research, programming, and policy and give a better sense of what kind of programming is effective in each case.
- Researchers have called for conscious model-building or the development of conceptual frameworks to understand couples and change related to RH. Using individual models of change is not adequate to account for the complexity of couple relationships and their health outcomes. Couple-focused models or frameworks must be able to accommodate a diversity of couples and allow for the consideration of gender and power dynamics—including women's bodily autonomy and agency—peer networks, diverging attitudes and intentions of the members of the dyad, and their communication or interaction (Becker 1996, Burton et al. 2010, Hartmann et al. 2012).
- Health care providers and community health workers should be trained to counsel couples to facilitate informed and gender-equitable decision making through communication, negotiation, and skills development. Given the role that men play in family planning utilization (McMahon 2013), the benefit of their involvement to reduce vertical transmission of HIV (Ramirez-Ferrero 2012, Hancuch et al. 2018), and the high the proportion of couples with at least one HIV seropositive partner in sub-Saharan Africa (Bellan et al. 2018), the importance of couple counseling, and the normalization of couple communication generally around RH, cannot be overemphasized.
- Intimate partner violence (IPV) and reproductive coercion, a form of IPV, remain a reality for many women (Silverman and Raj 2014, Grace and Fleming 2016). Thus, while embracing men more fully as holders of reproductive rights, it is essential that health facilities have a protocols for: (1) IPV screening (where support services are available), to help ensure that men's involvement will not be harmful, and (2) service consent that guarantees women's autonomy to make informed reproductive health decisions about their own bodies.
- To realize the Sustainable Development Goals, scale-up of evidence-based interventions across the spectrum of RH is required (Starrs et al. 2018), including couple-focused interventions (Medley et al. 2017).

- CFIs represent a potentially useful addition to the repertoire of RH interventions, particularly in settings marked by significant health and gender inequities (LaCroix et al. 2013). In considering their use, the specific epidemiological context must be balanced against implementation demands, especially demands on the health system (e.g., is it possible to promote gender-transformative couple-focused interventions in health facilities with long patient queues and few providers?). CFIs are particularly recommended for settings with high HIV prevalence, low family planning usage, and high maternal mortality.

## Policy Recommendations

- Political and programmatic decision makers can demonstrate leadership, through policy and practice, for the institutionalization of couple-based approaches in reproductive health, including HIV services—for example by addressing conceptual obstacles to male and couples’ engagement (such as those highlighted in factor two in the Discussion section above), or developing and implementing global, national, sub-national, and health facility policies which can yield local results. One important action would be to help normalize the participation of men and the diversity of couples and sexual partnerings across the spectrum of RH services by promoting joint responsibility of the couple for reproductive and family health in both policy and practice (Mullany 2006, Grabbe et al. 2010, Yargawa and Leonardi-Bee 2015, Mason et al. 2017, Barker and Flood 2010), without compromising equity of access to services for women.
- To address the persistence of gender inequality and its fundamental role in compromising global progress on RH (Marston et al. 2016), global, state, and bilateral donors and NGO stakeholders need to incorporate specific gender equity objectives alongside objectives to achieve specific RH outcomes—at both the policy or programmatic level.
- Advocating for the inclusion of indicators for couple engagement in research (e.g., Demographic and Health Surveys) and multilateral, national, and donor reporting frameworks would not only help generate better information to address reproductive health challenges, but also serve to create demand for programming that is couple-focused (Karita et al. 2016).
- Given the ambivalence of the RH epistemic community about men’s involvement in services and programming and entrenched models which do not conceive of men as integral to RH, both the instrumental and conceptual use of research (Tulloch et al. 2011) should promote a shift in understanding of members of epistemic communities about men’s roles in RH and the potential impact of couple-focused interventions, which could then help generate demand for couple-based RH knowledge. Expert consultations that bring together governmental policymakers, donors, researchers, implementing NGOs, and advocacy groups to examine the research and promote discussions about values and gender inequalities will help advance the global conversation on couple-based approaches in policy and practice.



## Suggestions for Further Research

- How do couples who utilize RH services differ from those who do not? Are couples who already demonstrate good communication patterns the primary users? In other words, are services attracting the “lowest hanging fruit?” Is interpersonal relationship quality and “connectedness” a confounding factor in the relationship between utilization and health outcomes? (Ramirez-Ferrero 2012)
- Due to issues of health system weakness in many low- and middle-income countries (e.g., staff shortages) and barriers to services for many men, what are the most appropriate sites for CFIs? More research is needed regarding the acceptability and effectiveness of diverse sites, including facility, community, home-based, and institutional (e.g., religious institutions) settings that may be conducive to couple engagement with skilled personnel, while ensuring women’s autonomy to make decisions (Becker et al. 2014, Mullany et al. 2007, Mason et al. 2017).
- What are the most effective gender-equitable ways to reach men, raise awareness about their roles, and encourage their participation in RH programming (El-Khoury et al. 2016, Hartmann et al. 2012, Institute for Reproductive Health 2017, Mullany et al. 2007, Yargawa and Leonardi-Bee 2015, Becker and Robinson 1998)?
- In addition to effectiveness, other useful information regarding CFIs for policymakers and program decision makers includes the extent to which these interventions are cost-effective, humane (or offer respectful care), and equitable (Tsang and Cromwell 2016). Given the need to involve all components of the health system, it would be useful to conduct cost-benefit analyses (including on non-monetary incentives [Wall and Allen 2017]), using single-sex services as the comparison (Becker et al. 2008, Becker et al. 2014, Mullany et al. 2007). It would also be useful to know, given concerns about assuring women’s autonomy for decision making, whether users and the service providers perceive CFIs as promoting ethical, respectful and humane care, and equity of access and utilization.
- What are 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 (La Croix et al. 2013, Hartmann et al. 2012, Tilahun et al. 2015, Institute for Reproductive Health 2017, Kraft et al. 2014)?
- There is a need for more in-depth anthropological and socio-psychological studies of the variety and dynamics of affective/intimate sexual relationships to learn more about the dynamics of those relationships, particularly around couples’ decision making regarding RH (Becker 1996, Wall et al. 2017, Becker et al. 2010). “Increased understanding is imperative given the high rate of serodiscordancy, as well as the very positive potential of couples to serve as entry points to promote whole-family health and wellness” (Ramirez-Ferrero 2012). Are there particular kinds of relationships, or elements of relationships, that lend themselves to successful CFIs?

- More research is needed on adolescent couples, on which there is almost no literature. Given that substantial proportions of adolescents 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.
- We know very little about men's reproductive health and sexuality (Guttman 2007, Dudgeon 2016). If we truly do see gender as relational, then we must also understand 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 RH services both as partners in the processes of prevention, care, and treatment, and as the primary beneficiaries of these services. Research in this area would enable a more holistic understanding of gender in the context of RH and possibly open new avenues for relationally oriented approaches to the achievement of both RH and gender equality objectives.

# APPENDIX

## Key Informant Interview Guide

Couple-Focused Interventions in Reproductive Health: Implications for Global Policy, Practice, and Research

Principal Investigator: [REDACTED]

### I. Introduction

Thank you so much for agreeing to participate in this Skype interview. My name is [REDACTED]. I am conducting this interview as part of my MSc course in Global Health Policy at the London School of Hygiene and Tropical Medicine. Through this study, I want to learn more about how couple-focused interventions have been used in family planning, maternal health, and HIV programming and understand better how conceptual frameworks in sexual and reproductive health and rights have informed these approaches both in policy and practice. My ultimate goal is to be able to make some policy recommendations that will lead to improvements in reproductive health outcomes.

The interview should take less than an hour. Is it ok if I record the session? Even though I will be taking notes, I don't want to miss any of your comments.

I see that I have received your written informed consent form. Again, I want to remind you that all responses will be kept confidential. I also want to assure you that any information I include in my thesis will not identify you as a respondent. Remember, you don't have to talk about anything you don't want to and you may end the interview at any time.

Do you have any questions about what I have just explained? Are you willing to participate in this interview?

### II. Interview Questions

1. Could you start by telling me a bit about your experience with couple-focused interventions?
  - a. What do you think are the main opportunities or benefits for couple-focused interventions?
  - b. What do you think are the main risks or limitations for couple-focused interventions?
2. How would you define couple-focused interventions?
  - a. For example, are they different from male involvement efforts?
  - b. Are couple-focused interventions a useful public health category for policy and practice?
3. In thinking about the subfields of family planning, maternal health, and HIV, how have couple-focused interventions been used?
  - a. In your experience are couple-focused approaches more often used in one field than another? Why?

- b. Are couple focused interventions equally effective across the fields of interest? Please explain.
4. How do you think the particular histories of the subfields of family planning, maternal health and HIV have affected the uptake of couple-focused approaches?
  - a. For example, are couple focused approaches evident in the policies of the health organs of the United Nations (primarily UNFPA, WHO, UNICEF, and UNAIDS) or agenda-setting donors (such as USAID, DFID, and the Gates Foundation)?
  - b. Are they adequately prioritized in these documents or by these organizations?
  - c. How has this relative prioritization influenced programmatic implementation in the field by international and local NGOs?
5. How has the movement toward the promotion of sexual and reproductive health and rights (SRHR)—and away from less client-focused services—influenced the incorporation of couple-focused approaches in UN policies and programmatic implementation by NGOs?
6. When we examine the current configuration of reproductive health services (medical and health promotion efforts) and reproductive health policy as reflected in practice at the country level, or as suggested by the policy and guidance documents of the health organs of the UN or agenda-setting donors, what do they tell us about gender?
  - a. For example, what does it tell us about expectations of women, their agency, their role in families?
  - b. What does it tell us about expectations of men, their agency, their role in families?
  - c. What does it tell us about couples?
7. What are your suggestions for priority themes for analysis? In other words, where do you think I should focus my attention in this study?
8. What significant and recent literature are you aware on this topic that I should include in the study?
9. What are your suggestions for key policy documents that should be included in the document review component of this study?
10. What are your recommendations about couple-focused approaches for future policy and practice?

### **III. Closing Comments**

11. In closing, is there anything more you would like to add?

I'll be analyzing the information you and others have given me and I plan to have a completed draft of the thesis by the end of August. I would be happy to send you a copy to review at that time, if you are interested.

Again, thanks so much for your time.

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