

# Male partner involvement in health interventions: A systematic review of best practices in Sub-Saharan Africa

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**Abstract:** Health promotion programmes aimed at the involvement of men are implemented in a complex cultural and socio-demographic context that reifies persistent unequal gender relations. The explanations and evidence for the mechanisms by which male involvement facilitates health and wellness, are, however, less clear. Drawing on findings from a qualitative systematic review of peer-reviewed studies, this article synthesises the literature on health, social policy, and programme interventions for improving male partner involvement to promote sexual and reproductive health, HIV and AIDS health outcomes in sub-Saharan Africa (SSA). Findings suggest that combining approaches such as mass education campaigns and health and social care programmes, targeting both men and women, improves male participation. Finally, enhancing participation of both men and women in the planning, implementation, and evaluation of health program programmes, can lead to positive gender role transformations and positive health and social care outcomes in Sub-Saharan Africa.

**Keywords:** HIV; AIDS; male involvement; health interventions; Sub-Saharan Africa

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## **The why of male partner involvement**

Globally, child survival has significantly improved since the invention of antiretroviral therapies, however, significant disparities in child survival remain between the more developed and less developed regions of the world. As of 2020, under-five child mortality has diminished by more than 50 percent since 1990 (UNICEF, 2020). Despite significant improvements in child survival, the sub-Saharan region (SSA) recorded more than half of under-five deaths (over 5,2 million) in 2019. (UNICEF, 2020).

Globally, the maternal mortality rate (MMR) – representing the number of women who die while giving birth or within 42 days of termination of pregnancy from any cause connected to or worsened by pregnancy – remains unacceptably high. What is worrying is that 94 percent of these deaths occur in low and lower-middle-income countries and 66 percent in SSA Africa (Ansu-Mensah et al., 2019). Maternal mortality in SSA, South Asia and high-income countries is, respectively, 1 in 39 live births, 1 in 160 live births and 1 in 3800 live births (Ansu-Mensa et al., 2019). In 2017, roughly two-thirds of maternal deaths occurred in SSA (WHO, 2019), indicating that maternal mortality remains a policy concern in this region.

In SSA, most maternal deaths from obstetric complications could be avoided, with optimal ante-natal care and early diagnosis (WHO, 2019; McLean, 2020; Ansu-Mensa et al., 2019). The utilisation of quality antenatal and childcare health services during the postpartum period has been linked to reduced maternal and under-five mortality (Mekonnen, Dune & Perz, 2019). Yet, pregnant mothers rarely complete the minimum of four antenatal visits required before delivery, putting them at risk of dying while giving birth or in the postpartum period (Ahinkorah et al., 2021).

In recent decades, male partner involvement (MPI) – also known as male involvement (MI) or men's involvement – has been identified as the underlying cause for the low utilisation of maternal health care and child health services (Maluka et al., 2020). It helps to clarify the key concepts upfront. In their systematic review of the conceptualisation of men's involvement, Galle, et al. (2021, p. 1) defined men's involvement as 'involvement, participation, engagement or support' in activities related to women's maternal health. This systematic qualitative review identifies best practices for using MPI to promote health outcomes. A best practice is an intervention that has demonstrated effectiveness in a particular

setting, with potential for replication in other situations or populations with similar results (Ng & Colombani, 2015).

In SSA, cultural factors discourage men from participating in their spouse's maternal health care. In most African cultures, the management of pregnancy and childbirth is considered the preserve of women, with men providing the necessary resources (McLean, 2020). Such norms reinforce the traditional division of labour, reducing men's likelihood of accompanying their spouses during antenatal care and delivery (Chibango, 2020). Consequently, far fewer men are comprehensively involved in preparing for childbirth and anticipating maternal complications. For example, according to Mersha (2018) comprehensive birth preparedness and complication readiness is lacking among men in Tanzania. Similarly, despite the importance of MPI in the prevention of mother-to-child transmission (PMTCT) of HIV, male partner participation in PMTCT is reportedly low in SSA (Chibango, 2020).

Furthermore, in most African cultures, men control key decisions and have a bearing on women's sexual reproductive choices. MPI interventions recognise men's power and seek to transform it into a positive relational resource for optimal health outcomes for all. Given men's culturally embedded power to control decision-making processes, designing interventions to enhance male engagement in maternal and childcare is critical, especially in resource poor countries where families struggle to make ends meet (Chibango, 2020; McLean, 2020).

In 2015, the World Health Organisation (WHO) recommended men's involvement in maternal and new-born health as a strategy for achieving health for all. Subsequently, several studies have echoed the World Health Organisation's (WHO) recommendation, demonstrating that MPI in health programmes has positive health benefits for men, women, and children (McLean, 2020). And what is more, MPI potentially brings about positive gender transformation on various levels (Clark, Sweet, Nyoni, & Ward, 2020; Nkwonta & Messias, 2019). For example, Comrie-Thomson et al., (2020) have observed that positive health outcomes resulting from MPI in health, positively influenced a couple's lived experiences, including communication and emotional dimensions.

Many governments, the world over, are implementing health interventions with an MPI component, seeking to reverse the exclusion of male partners from maternal services and achieve national health delivery targets (McLean, 2020). According to Comrie-Thomson et al. (2020, p. 722), health system stakeholders, including academics, recognise

men's involvement in maternal and child health as 'a valuable strategy to improve health care seeking and uptake of optimal home care practices for women and children in developing countries,' and to achieve Sustainable Development Goals (SDGs). Indeed, men's involvement in maternal and child health contributes to efforts to 'ensure healthy lives for all at all ages (SDG 3) and 'achieve gender equality and empower all women and girls' (SDG 5) (UN, 2020).

While MPI in health interventions is desirable, some researchers have found the theoretical bases of men's involvement in programmes faulty. McLean (2020) has argued that the instrumental frame, which presumes that men participate in maternal health for pragmatic reasons (that there is something in it for them), underpins the current male partner involvement thinking. Chibango's (2020) observation, that men get involved because they also want to increase their knowledge and make informed decisions on family planning and contraceptive use, is a case in point. McLean (2020) argues that younger men's willingness to learn about women's reproductive health and pregnancy care, may be explained by non-pragmatic reasons. A desire to discontinue parental norms and forge more egalitarian marital relationships may explain young men's involvement in women's reproductive health and pregnancy care (McLean, 2020). Whatever motivates men to participate in maternal health care, studies recognise that men's involvement increases not only their knowledge of maternal health, but also their utilisation of sexual reproductive health care services (Chibango, 2020; Komakech, 2020; Kanyongoa & Miller, 2019; Stern et al., 2015).

Ani et al. (2016) observed that male intervention improved couples' knowledge of, and communication about, family planning in Nigeria, with the wife's perception of her husband's participation in deliberations positively influencing her contraceptive use. Therefore, MPI interventions may lead to positive behavioural and social outcomes.

## **The how of male partner involvement**

The rationale for MPI in health interventions – the Why of MPI – has been comprehensively articulated in the literature. On the contrary, the *How* of MPI, that is, the explanations for the mechanisms by which MPI facilitates health and wellness, are less clear. Most available studies adopt an instrumental view of MPI. They assume that men's direct involvement

in pregnancy care will unlock men's potential for behavioural change, enabling them to participate more responsibly in maternal care, thus leading to optimal and better child well-being outcomes (Comrie-Thomson, 2019; McLean, 2020).

From the instrumental optic, interventions seek to achieve men's observable clinic-based behaviours. For example, men's presence during antenatal clinic visits and being there during consultations and delivery are presumed to 'lead to an increased likelihood of institutional delivery and skilled attendance at birth and postnatal service utilisation ... and preparedness in the case of pregnancy complications' (McLean, 2020, p. 2). Mersha (2018) postulates that men's antenatal clinic attendance broadens their exposure to health professionals and access to health information. This increases their preparedness for childbirth and possible complications.

However, the critics of the instrumental perspective of MPI take issue with its narrow, clinic-based bias and Western-oriented focus, arguing that it leaves no room for cultural factors which influence men's breadwinning and intimate caring roles. The instrumental frame, McLean (2020) has argued, misses the point by assuming that men only 'act out of pragmatism, independent of culturally prescribed gendered norms' (2020, p. 113479). What is more, from a programme design perspective, focusing on observable behaviours excludes 'couples' gendered subjective experiences, meaning-making, and emotions, indicating that the instrumental view 'has limited power to support deeper gender-transformative change' as observed by Comrie-Thomson et al. (2020, p. 735).

The alternative to the instrumental approach is a holistic framework of MPI, which accounts for subjective experiences, love, and emotions that, strictly speaking, are indispensable aspects of the relational space within which maternal and childcare unfold (Comrie-Thomson, 2019; McLean, 2020). Therefore, we contend that a holistic perspective is more suited for identifying and understanding the unintended impacts of men's involvement on maternal health outcomes. For example, Stern et al. (2015) reported that male participants in a study related their spouses' resistance to shifting gender norms and roles, suggesting that women may be unwilling to change gender norms or unintentionally complicit in creating obstacles to their counterpart's engagement, resulting in low male involvement in contraceptive decision making and uptake.

## Rationale and focus of study

Despite the growing corpus of research on MPI, gaps remain in the knowledge base regarding what interventions work best, with what kind of population, and for what health issues and outcomes. In recent years, systematic reviews have examined the evidence base on MPI interventions. For example, Galle et al. (2020) conducted a systematic review of peer-reviewed articles on the impact of MPI on maternal health, affirming the relevance of men's involvement for positive health outcomes. However, by and large, men's involvement in maternal health is measured by common instrumental proxies such as their presence at the health centre during prenatal visits or at delivery, providing transportation, and finances. As already indicated, such measures do not adequately explore the subjective experiences and emotional dimensions implicated in couple dynamics. Clark, Sweet, Nyoni, and Ward (2019) presented what they termed a realistic review of studies conducted in low and middle-income countries to establish 'how, when, and for whom male involvement in antenatal care works best' (p. 1). Although this review speaks to the how of male involvement, it is limited to antenatal care and does not explicitly focus on SSA. A scoping review of MPI in reproductive health interventions in SSA by Nkowna and Messias (2019) confirmed men's willingness to participate in health programmes, with improved outcomes, but falls short on best practices. Therefore, a rigorous qualitative systematic review of best practices of MPI interventions for improved health outcomes, is relevant. This review broadly focused on the research question:

*What are the best practices of MPI in sexual and reproductive health, maternal and child health care, and HIV interventions in Sub-Saharan Africa?*

## Methodology

Researchers distinguish a quantitative systematic review – which is informed by a rationalist quantitative research approach – from a qualitative systematic review. The latter focuses on qualitative findings and draws on several synthesis strategies, leading to a synthetic product – for example, a thematic synthesis – from which policy inferences about an intervention or a new theory can be made (Tong, et al, 2012). Similarly, Seers (2015)

observes that a qualitative systematic review can extend the theoretical knowledge base by answering the ‘why’ question, furnishing us with new knowledge and helping to build theory.

A qualitative systematic review synthesises qualitative findings from either a qualitative study or mixed-methods research (Seers, 2015). To synthesise is to combine separate elements to form something new (Henning, 1999). Synthesis represents an activity in which disparate parts are brought together to form a ‘whole’ (Pound & Campbell, 2015). Nevertheless, this blending of separate elements entails some level of innovation such that the outcome is greater than all elements put together (see Barnette-Page & Thomas, 2009 for different approaches to systematic review).

## **Eligibility and screening**

Thematic synthesis and meta-study guided the analysis and synthesis procedures (Barnette-Page & Thomas, 2009). We used pre-determined search strategies with search terms comprising the male partner involvement concept, the relevant health topic (sexual and reproductive health, maternal health, family planning, HIV and AIDS), and context (Sub-Saharan Africa). In some searches, variations of male partner involvement (MPI) such as male involvement and male participation were used. An exhaustive search was conducted in April 2021 on the following databases: MEDLINE, CINAHL, PsycInfo, Embase, and ASSIA. Different platforms were used for individual databases. For example, Ebsco platform was used for MEDLINE, CINAHL, and PsycInfo while Ovid was used for Embase and ProQuest for ASSIA.

## **Screening and selection**

We planned to include studies that reported on male interventions, programmes, or policies in Sub-Saharan Africa that have:

- a male involvement component combined with, or used in the context of,
- a sexual and reproductive health or maternal health or HIV and AIDS component or intervention, which is designed,
- to achieve maternal health outcomes, HIV and AIDS health outcomes, and health outcomes, broadly.

Initially, we read abstracts to determine whether the study focuses MPI combined with a health intervention.

As shown in Figure 1, 2 309 scientific papers were identified through search of online databases accessible through Anglia Ruskin University Library. The three reviewers/authors (AC, JM, and NN) reviewed all 2 309 records in XLS files, striking out duplicate titles, before adding 15 records identified through the University of Johannesburg's Ujoogle search engine. A PRISMA flow chart (See Figure 1 below) shows the screening and selection process details.

AC and NN reviewed the substracts of 875 records remaining after duplicates were removed leading to the exclusion of 854 records. Twenty-one (21) records remained for closer assessment. The excluded records drew entirely on quantitative methods or were not primary studies or were not based on research conducted in SSA. Throughout the selection process, the three researchers jointly discussed and resolved disagreements over whether to include or exclude a record.

A closer reading of the 21 eligible full-text articles revealed that eight (8) records were ineligible for the reasons cited above.

Figure 1  
Prisma Flowchart

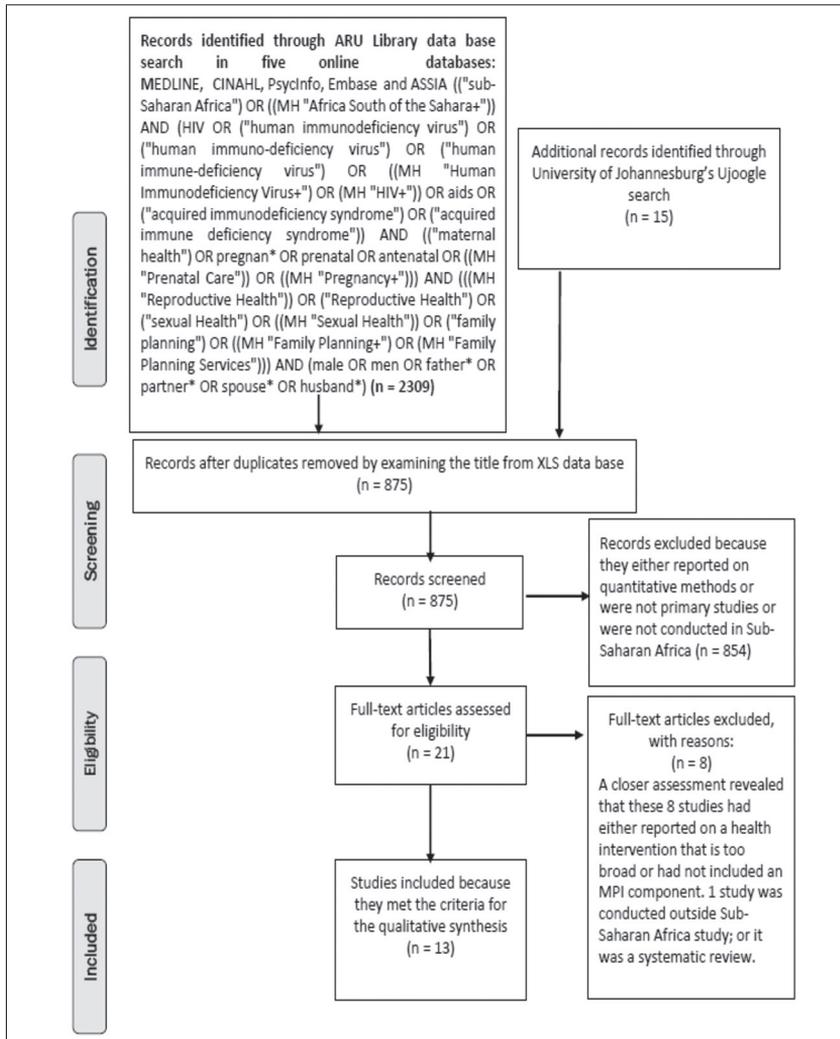


Table 1  
Summary of eligible studies

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**Aarnio et al. 2009.** *Male involvement in antenatal HIV counselling and testing: exploring men's perceptions in rural Malawi*

**Methodology:** Focus group discussions and a cross-sectional survey

**Key findings:** Men were largely unaware of available antenatal HIV testing and counselling services and perceived it overall problematic to attend female-oriented health care. Most men supported provision of antenatal HIV testing

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**Chibango, 2020.** *Factors associated with male partner involvement in the prevention of mother-to child transmission of human immunodeficiency virus in Zimbabwe:*

**Methodology:** A qualitative study

**Key Findings:** Local traditional leaders played a role in mobilising men in communities. Awareness campaigns enhanced communities' knowledge about PMTCT. Couple communication proved to be vital in promoting male involvement. Men feel a stigma and fear of HIV results and a lack of knowledge of the practices.

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**Comrie-Thomson et al. 2020.** *Male involvement interventions and improved couples' emotional relationships in Tanzania and Zimbabwe: 'When we are walking together, I feel happy'*

**Methodology:** A qualitative study

**Key Findings:** There are key pathways by which male involvement interventions were able to improve couples' emotional relationships which can motivate and support men's behaviour change, to improve care-seeking and home care practices. Men's and women's subjective experiences of partner relationships following male involvement interventions have not been well documented to date.

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**Jefferey's et al. 2015.** *Official invitation letters to promote male partner attendance and couple voluntary HIV counselling and testing in antenatal care: an implementation study in Mbeya Region, Tanzania.*

**Methodology:** Assessment of acceptability of written invitation letters for male partners attendance at antenatal care (ANC) and couple voluntary counselling and testing (CVCT) sessions

**Key Findings:** Where invitation letter for the partner was used there was a marked increase in women returning with their partners for a joint ANC session; of these, 81 % proceeded to CVCT, with significant variations between rural and urban attendances (rural being higher than urban). Majority of women assessed the joint ANC session as a favourable experience.

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**Komakech, 2018.** *Under-the-Mango-Tree: a theatre-based male EMTCT engagement intervention in post-conflict northern Uganda*

**Methodology:** Theatre-based intervention

**Key Findings:** Theatre-based intervention was suitable for social persuasion; role modelling and moderating mastery of experience through effectively combining simple songs, dances, and drama; testimonies of successful adherence by expert clients; and through reflective group discussions

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**Maluka, et al. 2020.** *Leaving no one behind: using action research to promote male involvement in maternal and child health in Iringa region, in Tanzania*

**Methodology:** Participatory action research (PAR)

**Key Findings:** The use of participatory approach not only empowers communities to diagnose barriers to male involvement and develop culturally acceptable strategies but also increases sustainability of the interventions beyond the life span of the project

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**Mark, et al. 2019.** *Male Partner Linkage to Clinic-based Services for Sexually Transmitted infections and HIV in Kenya*

**Methodology:** A secondary analysis within a RCT of pregnant women attending antenatal care.

**Key Findings:** Home-based couple education and testing increased STI consultations among male partners of pregnant women, but were insufficient to overcome the barriers in linkage to HIV care and medical circumcision

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**Mufune, 2009.** *The Male Involvement Programme and Men's Sexual and Reproductive Health in Namibia*

**Methodology:** Focus group interviews with participating males exposed to the programme.

**Key Findings:** Male participants increased their knowledge of human sexuality and sexual health. There were, however, differences in the extent of knowledge gain among the different male groups

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**Nkoma, et al. 2019.** *'What Will I Be Doing There Among So Many Women?': Perceptions on Male Support in Prevention of Mother to Child Services in Malawi*

**Methodology:** Focus group discussions and in-depth individual interviews

**Key Findings:** Alcohol consumption, pressure from workplaces, stigma, role conflict, denial, or nondisclosure of HIV status among women, and lack of awareness were among factors found to hinder male participation in PMTCT services

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**Roberts, et al. 2019.** *Impact of Male Partner Involvement on Women's Adherence to the Dipivefrine Vaginal Ring During a Phase III HIV Prevention Trial in Malawi, South Africa, Uganda, and Zimbabwe*

**Methodology:** A randomised, double-blind, placebo-controlled phase III trial to assess the safety and effectiveness of the dipivefrine vaginal ring for HIV prevention

**Key Findings:** Although the vaginal ring is relatively discreet, lack of support from male partners remains a relevant barrier to use. Both disclosure and clinic attendance may increase partner support, disclosure may also increase partner opposition.

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Stern, et al, 2015. **Lessons learned from engaging men in sexual and reproductive health as clients, partners, and advocates of change in Uganda.**

**Methodology:** Interviews, focus groups and structured surveys with self-reported heterosexual men

**Key Findings:** A significantly greater number of men were accessed, and supported their partners in accessing sexual health services, gained sexual and reproductive health awareness, reported sharing domestic duties and contraceptive decision-making, and displayed a decreased tolerance for domestic violence

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**Theuring, et al. 2010.** *Partner involvement in perinatal care and PMTCT services in Mbeya Region, Tanzania: the providers' perspective*

**Methodology:** Interviews based on a semi-structured questionnaire

**Key Findings:** There was overall approval of male partner integration into the services, but this approval decreased when specifying for different service types, especially in those related to perinatal examinations or labour and delivery. Divergence between general attitudes and self-reported individual behaviour was observed, querying the reliability of expressed attitudes.

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**Williams, et al. 2021.** *Predictors of postpartum family planning in Rwanda: the influence of male involvement and healthcare experience*

**Methodology:** Secondary analysis of data from a cluster randomised control trial used information abstracted from open-ended questionnaires

**Key Findings:** Male partner involvement and improved quality of maternal health services may improve PFP utilisation

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## Quality assessment

To ensure the quality of included studies, we used the Enhancing Transparency of Reporting the Synthesis of Qualitative (ENTREQ) research framework proposed by Tong et al, (2012). In addition, the meta-study approach to synthesising qualitative data (Barnette-Page & Thomas, 2009) emphasises the analysis of methodological decisions and tools used in the included study, which impacts scientific rigor and quality of findings. Therefore, as per Domain 4 of the ENTREQ, we considered the assessment of the methods used in included studies.

Ascertaining the trustworthiness of included studies remains a challenge for all qualitative systematic reviews because studies rarely report on these critical dimensions. Nonetheless, where the study discussed theoretical dimensions, we evaluated these to ascertain robustness. While studies were less transparent about the theoretical frames employed, they adequately provided quotations from data sources, allowing the reader to make an informed judgment about the credibility of interpretations in the original study. That said, we are confident that the findings of this review are, to a more significant extent, dependable. Most studies we included can be categorised as cross-sectional case studies, which do not easily satisfy the criteria for generalisability. However, in social and health programming, the most pertinent utility of cross-sectional findings is transferability, which suggests that lessons evaluated from a logical and systematic observation in one context, could be replicated in a different context.

## Data extraction and analysis

In line with thematic synthesis, we used computer software-aided line-by-line coding of the results of included studies to generate descriptive themes and build analytical themes (Barnette-Page & Thomas, 2009).

ATLAS.ti version 9 was used to analyse the philosophical underpinnings, methods, and findings from the studies included in this synthesis. The lead author (AC) assigned free codes to relevant sections of the included studies and developed ATLAS.ti code groups and themes reported in the findings. Findings were exported from ATLAS.ti to MS Word and Excel files. This process was rigorously reviewed by NN and JM, leading to a discussion of the findings before the write-up stage.

## Findings and discussion

### How Best? Male Involvement Best Practice

Most included studies examined MPI in HIV interventions described as antenatal HIV testing and counselling (Aarnio et al., 2009; Jefferys et al., 2015), PMTCT/EMTCT (Chibango, 2020; Komakech, 2018; Nkoma et al., 2019; Theuring et al., 2010) and HIV prevention trial (Roberts et al., 2019). Other studies (Maluka et al., 2020; Stern et al. 2015; Theuring et al, 2010; Williams et al. 2021) speak to MPI in maternal and child health, broadly, while Mark et al, (2019 and Mufune (2009), respectively, interrogate MPI in STI and HIV services and SRH (see Table 2 below).

The findings address the question ‘how best’ to involve men in maternal and child health programmes for the benefit of all. We found several interesting best practices that speak to getting men on board be it by accompanying their spouses to antenatal clinics, delivery or helping with postpartum care, or joining them in HIV-interventions.

#### *Reaching out, mobilising, and making men want to act*

Our findings suggest that strategies that have a community mobilisation component will more likely increase male involvement or participation, than ‘supportive measures, like health talks. These are held in facilities [which] reach only those who are already there but fail to reach out for those who really are missing in the scenario’ according to Theuring et al. (2010, p.6). Yet, we found evidence to suggest that health workers can still encourage female spouses to persuade their male partners, leading to desirable male participation in antenatal care, antenatal HIV testing, and PMTCT. Theuring et al. (2010) and Jefferys et al. (2015) learned that sending invitation letters to engage men who have not accompanied their spouse before, could reach all the male partners, potentially ensuring participation through pregnancy and during the postpartum period. In their study on partner involvement in perinatal care and PMTCT services in Tanzania, Theuring et al. (2010, p. 1567) observed that ‘systematically disseminated invitation letters [have] potential to reach all male partners who have not accompanied their wife.’ Jefferys et al. (2015, p.8), echoes this observation, revealing that, in their study conducted in Tanzania, they found ‘high levels of acceptability of invitations by women, with almost 100 % giving the letter to their partner.’ We, therefore, believe sending out official invitation letters may well be best practice to reach

out to men and get them involved through the following actions (Jeffereys et al., 2015; Theuring et al. 2010).

Table 2: Summary of studies included and areas of MPI interventions

Publication <sup>1</sup>	HIV Intervention			Maternal & child health	STI & HIV services	Sexual & reproductive health
	Antenatal HIV testing & counselling	PMTCT/ EMTCT	HIV prevention trial			
Aarnio et al. 2009	✓					
Chibango 2020		✓				
Comrie-Thomson et al., 2020				✓		
Jeffereys et al 2015	✓					
Komakech 2018		✓				
Maluka et al 2020				✓		
Mark et al. 2019					✓	
Mufune 2009						✓
Nkoma et al. 2019		✓				
Roberts et al., 2019			✓			
Stern, et al. 2015				✓		
Theuring, et al, 2010		✓		✓		
Williams et al, 2021				✓		✓

1. See table 1 for details

Our findings indicate that, in the context of antenatal HIV testing and maternal health, knowing when to involve men and significant others in clinic-based health interventions is of paramount importance. Some of the best practices identified include

- In maternal antenatal HIV testing and counselling, include men early on (Aarnio et al., 2009).
- Combine early involvement of men with the promotion of spousal communication on HIV-testing and a comprehensive educational component for men (Aarnio et al., 2009).
- While it is desirable comprehensively involve men in maternal health, they should be present during consultations but not examinations and delivery (Theuring et al., 2010).
- In the context of HIV-disclosure, the presence of professionals and significant others increases the likelihood of men taking an HIV test with a female partner while lowering the likelihood of a divorce in the event of a positive diagnosis (Aarnio et al., 2009).

We considered these best practices because they provide insights into how best to persuade men to get involved and expose them to knowledge that could transform their beliefs about male involvement. Yet, while it may be adequate to include men in maternal and child health early on, their participation in some activities may well be at variance with the dominant culture. As gendered beings, men and women in Africa tend to play different roles during pregnancy, delivery, and postpartum care (McLean, 2020).

Even though MPI aspires to transform gender norms that preclude men's involvement in the intimate care of their female spouses, male involvement ought to be designed in a culture-sensitive manner. On the face of it, disclosing HIV-test results in the presence of professionals and significant others – especially extended family elders – may fly in the face of biomedical notions of consent. However, in African societies where communal forms of life remain resilient (Mugumbate & Chereni, 2019), such unique forms of extended family group conferencing may prove effective, even if they seem to violate individual privacy. Culturally, younger men are expected to defer to older men in African communities. Furthermore, in some SSA countries, some traditional leaders still hold sway in most aspects of communal living and can encourage – or at times, instruct – men to get involved, with positive results (Chibango, 2020). It is no surprise that, in the context of HIV testing, the presence of elders who are part of couples'

extended family may prevent couples from making hasty decisions in the wake of a positive diagnosis (Aarnio et al., 2009).

Studies we included do not argue for the abandonment of ‘conventional’ clinic-based forms of engaging men in antenatal care and ante-natal HIV-testing. Far from it, they accentuate the need for comprehensive and extensive community mobilisation and of out-reaching activities, since relying on women to involve men, is inadequate. According to Aarnio et al. (2009), even the most comprehensive antenatal HIV counselling intervention with a male partner notification component, may fall short of making men want to act and take responsibility.

Meta-data and thematic analysis of findings from included studies generated key lessons on framing a message and getting it across to persuade men to get involved. Maluka et al. (2020), Comrie-Thomson (2020), and Chibango (2020) provided useful insights into messaging for male partner involvement mobilisation. For example, some best practices identified include:

- Messages should clarify the importance of involving men in antenatal care (Maluka et al. 2020), and the health benefits of birth spacing (Williams et al., 2021).
- Naming the campaign, sloganeering can help to simplify the campaign message reminding people of the cause (Chibango, 2020).

Messaging is integral to community mobilisation. Therefore, messages for sensitisation campaigns should be carefully crafted to make men want to get involved. In a study that used action research to promote male involvement in maternal and child health, Maluka et al. (2020) concluded that effective messages clarify the importance of male participation in antenatal care, such as birth preparedness, complication readiness, and family planning use. Chibango (2020) noted that while each campaign serves a specific purpose, *naming* is a powerful force for communicating the rationale for involving men and mobilising communities (*italics, our emphasis*). Reflecting on men’s involvement campaign in maternal and child health was dubbed ‘Operation *Perekedza Mukadzi Wako*’ (Operation Accompany Your Female Partner), arguing that, ‘assigning a special title to the male involvement campaign played a role in reminding people about the cause of the campaign’ (p.4). Among the included studies for this systematic review, Comrie-Thomson et al. (2019) and Chibango (2020) provide examples of using *sloganeering* and *catchphrases* to name male

participation interventions and campaigns (*italics, our emphasis*) helps to put the message across. For example, Comrie-Thomson's et al. (2019) report on data generated with men and women who participated in male participation health interventions, namely *Wazazi naMwana* implemented in Tanzania and *Women and their Children's Health* (WATCH) accomplished in five countries, including Zimbabwe.

While this nomenclature captures the rationale for male involvement, naming should be well-thought-out in MPI interventions to avoid misunderstanding. In the context of Zimbabwe where Chibango (2020) conducted her study, the term 'Operation' can have some coercive political and military connotations associated with other common uses of the word. Some studies conducted on child rights in Zimbabwe elaborate the idea of naming and could shed some light here. For example, Chereni' (2017) on birth registrations in Zimbabwe suggests that naming, which entails constructing an effective *motivational frame* – that is, a perspective of the problem and solutions – and culturally-relevant semantics to express it, was inadequate in birth registration activism. He highlighted the need for empirically driven motivational frames that communicate relevant research data in easy-to-grasp ways, such as stories.

In addition to lessons learnt about messaging, included studies illuminate other potential best practices and impacts for persuading men to take part in health interventions, as outlined below:

- Ensuring active participation of men and women in developing strategies for male involvement will likely lead to sustainability of male involvement in interventions (Maluka et al. 2020).
- Involving different stakeholders, including traditional leaders and gatekeepers may increase sustainability (Maluka et al., 2020).
- Using community leadership effectively mobilises the community and involves men (Chibango, 2020).
- Combining a male participation intervention in health with income-generating activities (IGAs) can attract men to get involved in health interventions and influence positive, couple relationship dynamics (Chibango, 2020; Stern et al., 2015).
- A multi-stakeholder approach including men, women, health professionals, community leaders and gatekeepers, will likely encourage sustainable MPI (Maluka et al., 2020).
- Education interventions that emphasise the value of men in maternal and child health could transform entrenched gender norms and

positively impact male attitudes and behaviour (Nkoma et al., 2019; Stern et al. 2015; Mufune, 2009).

- Men are more likely to engage with male champions or peers in a health intervention programme, than female health professionals (Stern et al., 2015; Maluka et al., 2020).
- Establishing women's support groups can create a safer space for women to teach each other on couple relationship issues (Maluka et al. 2020).
- Community-based approaches to utilising point-of-care HIV testing, including home-based testing strategies, improve male involvement (Mark et al. 2019).
- Using theatre, comprising dance, song, and testimonies, has potential to improve MPI by operationalising social persuasion, role modelling, and social experience in the community (Komakech, 2020).

The above best practices speak of the importance of going out there, engaging men and women in their communities, collaboratively designing MPI interventions, and jointly participating in developing health programmes (Maluka et al., 2020), leading to optimum health outcomes and positive gender transformations.

A multi-stakeholder approach that enlists the support of gatekeepers, including community leaders, ensures that the programme reaches targeted male partners and ensures long term sustainability of the programme. Chibango's (2020) study demonstrates that traditional African leaders may have the prerogative to instruct men to participate in health interventions and sanction those who fail to get involved. While this supports the necessity of being sensitive to and utilising culture to magnify the programme impact, we believe that MPI programmes should rely more on persuasion than condone coercion.

A theatre-based intervention such as Komakech's (2020) intervention which 'combined simple songs, dances, drama and testimonies from successful EMTCT couples' will more likely resonate with the role of the dominant culture. Furthermore, theatre can recognise the status quo of gender relations while changing it in subtle ways. Whereas songs and drama and expert client testimonies captured 'moments where the traditional male role is prominent,' it also helped men to see 'a positive role for themselves in the prenatal period without losing touch with their traditional masculinity' (p. 7). Therefore, interventions that adequately address cultural sensitivities have the potential to keep men engaged. Studies by Stern et al. (2015) and Maluka et al. (2020) suggest that men are known to engage more actively

with male peers, strategically known as male champions.

*What about the health facilities and health workers?*

The emphasis on community-based strategies to include men suggest that health professionals should work with men, women, and significant others in the community. However, health care workers may need more training in male involvement and cultural sensitivities. Moreover, since health care workers operate in contexts in which communities tend to stigmatise SRH and HIV, they may be prone to stress and burnout. Hence, support within the workplace to address their own mental health needs, for example, in the form of confidential ‘care for the caregivers’ programmes, can be considered (Theuring et al., 2010, p. 6).

We considered the following best practices relevant to healthcare facilities and health professionals:

- Health facility authorities should develop guidelines and not leave male involvement to the benevolence of health workers (Theuring et al. 2010).
- Health care workers need self-care orientation and their own version of ‘care of the caregiver’ (Theuring et al., 2010; Maluka et al., 2020).
- Health governing committees have the potential to address male involvement barriers and could be an effective strategy for bottom-up approaches leading to health facility policy changes (Maluka et al., 2020).

The need for clear guidelines for male involvement at the health facility need not be emphasised. It is possible that without guidelines, health workers may perpetuate gender norms that frame antenatal care and reproductive health issues, as women’s issues. Numerous men’s involvement studies focus on barriers to male involvement, citing factors such as long waiting time and perceived lack of male-friendliness at the health centre. However, Maluka et al. (2020) established that a health governing committee could interface the health care facility and the community, ensuring that barriers to male involvement have been addressed.

*Reported outcomes of MPI interventions*

A few studies reported some findings on outcomes of MPI interventions. We consider such findings to provide a glimpse into the potential of men’s involvement for improving maternal and child health outcomes

and gender transformation. Stern et al. (2015) conducted a study in Uganda and found that income generating activities broadened men's and women's access to sexual and reproductive health services. It was observed that 'some male beneficiaries reported using money from IGAs to care for their own and their families' sexual and reproductive health' (p. 8). Komakech's (2020) pilot study conducted in Uganda demonstrated that, with the use of theatre-based intervention comprising song, dance, client expert testimonies and role modelling, couples reflected, negotiated, and agreed to cooperate, thereby recognising certain behaviours and decisions that prevented women from accessing EMTCT services. If anything, this suggests that theatre potentially provides culturally aligned safer spaces to renegotiate gender norms and improve men's involvement in maternal and child health care. Another study carried out with some men and women who participated in male involvement interventions in Zimbabwe and Tanzania, reported that MPI interventions nurtured loving partner relationships, with improved partner communication and intimate forms of care (Comrie-Thomson et al., 2019).

## **Limitations of studies**

### **Meta-methods**

Articles we included draw on cross-sectional research utilising qualitative and mixed methods design, with either analysis of primary data or re-analysis of primary data. Some studies, for example, Komakech (2020) and Maluka (2020) report on findings of observations from earlier stages of interventions. While these studies yield engaging insights for best practice, the absence of large-scale, longitudinal, and comparative research designs limit the scope of their contributions to MPI interventions.

### **Meta-theory**

Except for Comrie-Thomson et al. (2019), Komakech (2020), Stern et al. (2015), and Roberts et al. (2020), most of the included studies were not explicitly theoretically driven. Furthermore, they do not comprehensively specify any aspects of a frame guiding or influencing their research designs

and analysis of findings. Yet, on closer inspection, it seems that most studies implicitly adopt the instrumental frame of male involvement and treat MPI as essentially an instrumental phenomenon. In maternal and child health care, the instrumental view holds that when men accompany their spouses to the antenatal care health facility, they will become better at birth preparedness and readiness for complications. As already demonstrated, the instrumental frame has been criticised for being narrow, Western, and biomedical because it focuses on observable clinic-based behaviours, leaving out cultural factors and men's and women's subjective experiences of couple relationships (McLean, 2020).

Incorporating couples' subjective experiences, love, and emotional aspects in their relationship may hold significant heuristic potential because 'love can motivate an individual to act,' argue Comrie-Thomson et al. (2020). Focusing on love and emotional intimacy in MPI interventions can also drive men's behaviour change, fostering care-seeking behaviours and intimate forms of care in couple relationships (Comrie-Thomson et al., 2019, p. 734).

In the same vein, Stern et al. (2015) used a model that, in our view, can be broadly applied to studies of male involvement. Their model conceptualised men on three intersecting levels, namely, *men as clients* (consumers of SRH services), *men as equal partners* (a focus on gender-equitable attitudes and roles), and *men as advocates of change* (men encouraging other men to participate in MPI interventions and transform attitudes). The model used by Stern et al. (2015), speaks to social outcomes of MPI interventions and can be used to illuminate changes in couple dynamics due to interventions.

Komakech's (2020) study speaks to both the instrumental approach and the holistic frame. He adopted the social cognitive theory, identifying motivational and self-regulatory mechanisms which are enabled through efficacy – that is, one's belief in his or her own capabilities to think up and carry out courses of action required in a situation —as attributes which men need for 'disclosure and adherence to treatment' (p. 114). However, Komakech (2020) reports that theatre-based male involvement intervention enabled men and women to question, reflect and renegotiate gender norms, demonstrating broader social outcomes resulting from the study. Lastly, Roberts et al. (2020) utilised a conceptual framework that is more aligned with the instrumental frame, which clarified pathways by which MPI influences vaginal ring adherence, starting from disclosure and or clinic attendance. The framework assumes that active male partner support leads to high vaginal ring adherence while opposition reduces

compliance. This framework could be useful in studies examining male partner involvement in HIV-interventions. Nevertheless, as already shown, the instrumental framework may have very limited utility in understanding the subjective experiences and emotional aspects of couples' relationships (Comrie-Thomson, 2019).

## Conclusions

This qualitative systematic review identified best practices of MPI in sexual and reproductive health, maternal and child health care, and HIV interventions in Sub-Saharan Africa. This paper has presented a synthesis of the literature on health, social policy, and programme interventions for improving male partner involvement and promoting positive sexual outcomes. The synthesis identifies several best practices that have implications on reproductive health behaviours aimed at improving maternal health, HIV and AIDS health and for improving MPI in health interventions. While clinic-based MPI interventions that rely on women already accessing health services to recruit their male partners should not be abandoned altogether, this qualitative systematic review found that community-based MPI interventions will more likely increase male involvement in maternal and child health care practices and health service utilisation. However, such studies *must* carefully navigate cultural terrain and employ culturally sensitive strategies even as they seek to transform those gender norms that detract from active male partner involvement. The findings for this study also offer important lessons for social work practice and social work education that seeks to influence gender norms in the delivery and access to health and social care. Our findings raise a concern about the quality of qualitative studies. Far fewer studies specified philosophical assumptions and theoretical aspects influencing the study. Yet, in our view, theoretically founded MPI intervention studies could yield deeper insights for the design and implementation of MPI interventions and theory building, we recommend the following:

- MPI intervention studies require a well-thought-out theoretical framework to give rigor and enhance the credibility and transferability of findings.
- When designing social care and health interventions in SSA, close

attention should be paid to context-specific cultural aspects, such as gender and the traditional division of labour. One-size-fits-all approaches may create cultural friction thereby reducing impact in SSA.

- Social care and health programmes and interventions in SSA should be more inclusive and be rooted in partnership working between both men and women, professionals, and the local leadership at all stages.
- Social work training should empower students with community organisation skills and strategies for increasing cultural competency. Community-based approaches will likely yield results in interventions where the men's involvement is critical.

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