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Engaging Mozambican men in a couple-based therapy to reduce intimate partner violence and improve mental health: Community stakeholders' perspectives

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1. Background

Intimate partner violence (IPV) is a devastating public health problem that affects one in three women globally (Garcia-Moreno et al., 2006) and can lead to numerous mental health (Devries et al., 2013), physical health (Coker, 2007), socioeconomic (Adams et al., 2012), and intergenerational sequelae (Gartland et al., 2019). Reducing situational IPV – when discord and conflict in couples escalates to mild or moderate physical violence (McCollum and Stith, 2008) – and improving marital accord in couples can help address a mental health treatment gap for women with common mental disorders (depression, anxiety, and PTSD). Mozambique has extremely high prevalence rates of IPV. A national sample showed that approximately 30% of women reported experiencing physical or sexual IPV in the past 12 months (Instituto Nacional de Estatistica, 2011), and a sample from Maputo City reported a rate of~50% for exposure to sexual, physical, or psychological IPV(Zacarias et al., 2012), consistent with other countries in sub-Saharan Africa (Garcia-Moreno et al., 2006). IPV is associated with emotional distress (Ellsberg et al., 2008), posttraumatic stress disorder and anxiety (Lagdon et al., 2014), serious mental illness (Chandan et al., 2020), suicidal ideation

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CRediT authorship contribution statement

Jennifer J. Mootz: Conceptualization, Formal analysis, Funding acquisition, Investigation, Methodology, Supervision, Writing – original draft. **Palmira Fortunato dos Santos:** Conceptualization, Methodology, Supervision, Writing – review & editing. **Katia dos Santos:** Formal analysis, Methodology, Project administration, Writing – review & editing. **Sandra Stith:** Conceptualization, Supervision, Writing – review & editing. **Milton L. Wainberg:** Conceptualization, Supervision, Writing – review & editing. **John Oliffe:** Conceptualization, Supervision, Writing – original draft, Writing – review & editing.

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(Halim et al., 2018) and past attempts (Ellsberg et al., 2008), and is a potent risk factor for depression (Howard et al., 2013) – doubling or tripling women's odds of having this common mental disorder (Islam et al., 2017).

Research in high-income countries has shown that when couples choose to stay together addressing IPV in a couple modality can reduce IPV levels more than treatment of individuals (Karakurt et al., 2016). Interventions targeting IPV disproportionately focus on treating the offender or the victim and mental health sequelae of their experiences of IPV (Mootz et al., 2023). In high-income countries, mandated treatment for IPV perpetrators that involves gender-specific men-only treatment is generally ineffective (Crane et al., 2014; Dutton and Corvo, 2007) but remains widespread due to concerns of victim advocates that couple-based treatment might provoke or exacerbate violence (Armenti and Babcock, 2016). Studies have also demonstrated that couple-based treatment for IPV can be both safe and effective (Antunes-Alves and Stefano, 2014; Stith and McCollum, 2011), and with careful screening to ensure IPV is situational, rigorous training of providers, and ongoing risk assessment and safety planning, couples can reduce IPV and improve their relationship through enhanced communication and problem-solving skills (Antunes-Alves and Stefano, 2014; Armenti and Babcock, 2016; Hurless and Cottone, 2018). In a meta-analysis of RCTs of couple-based therapies for IPV, this modality showed significantly greater reductions in IPV than individual treatments and control conditions (Karakurt et al., 2016). However, these studies were all conducted in the US.

Despite decades of research establishing the ubiquity of IPV and its consequences for women's mental health, less is known about how to prevent or reduce IPV experienced by women with common mental disorders in low-and middle-income countries (LMICs). A recent review indicated that only two studies in LMICs had adapted interventions for common mental disorders in women to address IPV (with reduction in symptoms) (Keynejad et al., 2020). Another review of 11 studies in LMICs found that targeted mental health interventions performed better in reducing symptoms of mental health problems and IPV, although substance use or integrated interventions produced mixed results (Tol et al., 2019). Our team conducted a systematic review of intervention studies in LMICs that addressed family violence (IPV or child maltreatment) as well as mental health or substance use problems. From 19 studies across 13 LMICs, we found that there was a high degree of variability in effectiveness of interventions. Taken together, the reviews show the need for future research on adapting feasible, acceptable, and effective evidence-based treatments for common mental disorders that address IPV in LMICs.

While sparse, there have been some couple-based trials in LMICs. A couple-based HIV prevention study in Zambia measured IPV levels and showed significant reductions in situational, but not severe IPV in the 4-session intervention (Jones et al., 2014). Another study in India conducted three sessions with a focus on gender equity and family planning. The first two sessions were with men. The third session was with the couple jointly. While only about 50% of recruited men received a couple-based session, suggesting potential challenges with retaining men in the intervention, women reported less exposure to sexual IPV at the 1.5-year follow-up, and men exhibited less accepting attitudes towards IPV (Raj et al., 2016). With a primary emphasis on reducing risk of HIV infection among

pregnant women, a randomized controlled trial in South Africa included men for the *PartnerPlus Intervention* by running four concurrent, gender-segregated groups for men and women that covered conflict resolution, communication, sexual risk behavior reduction, and gender-related topics (D. L. Jones et al., 2013). They found that at least one form of IPV reduced post-intervention. Finally, in an urban setting in Zambia, a study using the Common Elements Treatment Approach (CETA), a transdiagnostic intervention, randomized couples to CETA or treatment as usual plus safety procedures to reduce alcohol use among men and IPV in couples. While participants were randomized to condition as a couple, they were treated individually. They found that CETA performed better than treatment as usual in reductions of IPV and alcohol use (Murray et al., 2020).

Our prior work has shown that, as in other sub-Saharan African countries, when IPV was present, sociocultural factors interacted with family relationships to discourage women's separation due to stigma, lack of legal rights to children following a separation, and economic reliance on male partners (Mootz et al., 2020). Low infrastructural resources affect availability of formal support services, such as shelters. As a result of these challenges, women have employed coping strategies to minimize exposure to IPV within their relationships that have included building personal resources, accessing informal support networks, enduring the violence, and avoiding or minimizing triggering situations when possible (Wood et al., 2021). A meta-analysis of 503 studies and 60 risk markers of male IPV perpetration found relational risk markers, such as demand withdrawal relationship patterns, verbal arguments, infidelity, and perpetrator's power in the relationship, to be the strongest (Spencer et al., 2022). These studies suggest that in addition to providing support for women who desire to leave violent family spaces, interventions that can improve family relationships and reduce violence within families should be developed and considered for those who express a desire not to leave (Mootz et al., 2020).

Yet, there remains a gap in understanding of men's experiences, especially as they relate to treatment for and prevention of IPV. Men as perpetrators of IPV can be expressing depressive symptoms through anger, aggression, substance use, posttraumatic stress, and risk-taking (Spencer et al., 2019; Spencer et al., 2022). A meta-analysis of 207 studies examined mental health indicators of IPV and found that common mental disorders and antisocial and borderline personality disorder were associated with both perpetration and victimization (Spencer et al., 2019). Our team conducted a meta-analysis of 51 studies from sub-Saharan Africa to identify risk markers for IPV (Mootz et al., 2022). For men, there were small effect sizes for IPV perpetration and substance use and medium to large effect sizes for witnessing parental IPV and being abused as a child, potential indicators of other mental health struggles (Wathen and MacMillan, 2013). In Nigeria, adolescent and young adult males who reported perpetrating IPV showed over double the odds of feeling worthless and consuming alcohol in the past month when compared to those who had not perpetrated IPV (Stark et al., 2020). In Zimbabwe, risk markers of IPV perpetration included prior exposure to traumatic events, among other factors (Machisa and Shamu, 2018). Thus, engaging men in a couple-based intervention for IPV holds possibilities for treating men's mental health problems as well.

Our previous research has suggested that there are barriers to engaging men in interventions to treat IPV (Mootz et al., 2021). Gender role socialization influences preferences and acceptability of interventions, decision-making among individuals and families, especially in patriarchal settings, organizational structure, relations, and hierarchies (i.e., who holds leadership positions and makes decisions that guide programming), and implementation strategies (Tannenbaum et al., 2016). A qualitative study with men found that program logistics and perceived relevance or applicability of the content were barriers to engagement with an IPV intervention (Bouchard and Wong, 2021). Another qualitative study suggested that men may be open to digital interventions for IPV prevention, especially given the privacy that this modality could offer (Tarzia et al., 2023). However, participants recognized that accountability could suffer with the absence of interpersonal interaction (Tarzia et al., 2023). Most available studies that focus on men's engagement in IPV interventions have been done in high-income settings, demonstrating a significant literature gap for engaging men in LMICs.

1.1. Theoretical framework

The Consolidated Framework for Implementation Research (CFIR) guided our participatory qualitative methods to capture how contextual vulnerabilities regulate IPV and determine optimal intervention adaptation and implementation strategies that consider multiple domains and processes. The CFIR compiles multi-source cross-disciplinary implementation constructs to examine barriers and facilitators in five domains: intervention (adaptability, fit); provider (training, attitudes); inner setting (organizational culture, structure); outer setting (sociopolitical context); and implementation process (planning, engaging, executing, reflecting/evaluating) (Damschroder et al., 2009). To tailor a couple-based intervention to engage men, we focused more precisely on constructs in the outer setting domain of the CFIR where patients are conceptually situated. The outer setting domain has four constructs: cosmopolitanism (extent to which an organization is networked), external policies and incentives, peer pressure (external organizations that are similar or competitive), and patient needs and resources. Only the latter is focused on patient characteristics, although literature has shown that successful implementation happens when services are patient-centered (Rycroft-Malone et al., 2002).

Thus, gender and associated societal power structures have received little explicit attention in implementation theories and frameworks (Tannenbaum et al., 2016), CFIR included. Snell-Rood et al. argued for a more sophisticated analysis of social context that affects patient uptake to garner change (Snell-Rood et al., 2021). Examining structural factors can help facilitate understandings about barriers to care in particular settings (Snell-Rood et al., 2021). To enhance the depth of understanding men's engagement at the patient needs and resources level, we applied a masculinities framework to specifically ask about, and consider how gender can inform the tailoring of a couple-based intervention (Connell, 2005). Given the lack of specificity of patient needs and resources in the CFIR, we applied the masculinities lens to enhance depth of analysis by considering how social structures of power and interconnected identities (e.g., age, socioeconomic status, gender, race) might influence barriers and facilitators of engagement.

1.2. The present study

Mozambique is a diverse country located on the Southeastern coast of sub-Saharan Africa bordering the Indian Ocean. Its population of over 30 million consists of several ethnic groups: Makua, Tsonga, Makonde, Shangaan, Shona, Sena, Ndau, and others (World Health Organization, 2018). Almost half of the population is below age 15. Mozambique, one of the world's lowest-income countries, suffers from some of the highest HIV prevalence and death rates in the world, and has a low life expectancy rate of 61-years-old. Most of Mozambique's population lacks access to mental health care (Schwitters et al., 2015). Our study is part of a collaborative effort with the Mozambique Ministry of Health and academic partners in the US, South Africa, and Brazil to scale-up comprehensive, task-shifted (i.e., delivered by non-mental health professionals) care for mental disorders. The effort to expand care has included training and supervising nonspecialized personnel, such as community health workers and primary care providers, who work in the public healthcare system to deliver mental healthcare at the local clinic and community levels (authors blinded). The scale-up of mental health services, however, has not considered coordinated treatment of common mental disorders and the co-occurring and widespread problem of IPV among couples. Qualitative data collection took place in Nampula City, Mozambique's third largest city (population of almost 1 million) and capital of the Northern-located Nampula Province. Over 50% of the population in Nampula Province lives below the poverty line (World Bank, 2011).

In preparation for a pilot trial in Nampula City in two public hospitals to test the feasibility and acceptability of a couple-based treatment of IPV to improve common mental disorders among women, the aim of this study was to describe gender dimensions for engaging Mozambique men in couple-based treatment to reduce IPV and improve mental health from the perspectives of community stakeholders. Nampula Province differs from other provinces in that its population is matrilineal. It is situated on the "matrilineal belt" of south-central Africa that extends from Mozambique through the Democratic Republic of Congo (Johnson, 2016). Women remain associated with their kinship network following marriage and retain rights to their children. Marriage is viewed as transitory where discretional extramarital sex is permissible and divorce easier to obtain than in other parts of the country (Arnfred, 2021). Given this unique sociocultural context and to avoid making assumptions about gender roles and their expression in this region, our guiding research objectives were to: (1) understand local conceptions of gender roles and (2) examine how gender might affect engagement of men in this couple-based intervention.

2. Methods

2.1. Procedures

Ethical approval was obtained by New York State Psychiatric Institute and Comité Nacional de Bioética em Saúde in Mozambique. We used a participatory approach that involved collaborating with local stakeholders to reduce disparities, facilitate co-learning, and build community participation and capacity (Israel et al., 2008). The research was guided by a local Community Advisory Board (CAB) of Ministry of Health representatives and district and local officials from diverse backgrounds. We also partnered with a Community

Technical Team, a group of professionals who have specialized knowledge in mental health and gender-based violence services.

2.1.1. Participant selection—Participants were identified with purposive sampling through the CAB, Community Technical Team, word-of-mouth, neighborhood secretaries, and recruited through hospital waiting room areas from August–December of 2021. The project coordinator or research assistants contacted key informants via face-to-face, phone, or email. Three people refused participation or did not attend the focus group as planned. The project coordinator (KS), a female psychologist with experience in conducting FGDs and trained by the Principal Investigator JM in qualitative methods, conducted all focus group discussions (FGDs) and key informant interviews (KIIs) in the local Portuguese language with 85 participants. The project coordinator had a professional relationship previously established with CAB members and some providers. To adhere to COVID-19 regulations about physical distancing, we began by facilitating three KIIs. When regulations allowed for small-group gatherings, we proceeded to facilitate 11 FGDs (6–8 people per group) with elders (n = 6), community leaders (n = 8), district officials (n = 7), providers (n = 3 FGDs with a total of 20 providers), CAB members (n = 8), gender-based violence specialists (n = 7), and gender-segregated groups of men (n = 6) and women (n = 2 FGDs with a total of 15 women). FGDs were 45–60 min long. An additional five KIIs were conducted with mental health or IPV policymakers. FGDs and KIIs were held in private settings at the hospital, participants' workplace, or in the community. Data saturation was discussed in weekly team meetings.

The FGDs and KIIs began with the research assistants obtaining signed informed consent and then collecting demographic information. One or both research assistants joined the FGDs and KIIs to take notes. The Project Coordinator used a semi-structured interview guide developed by the Principal Investigator JM and reviewed and edited by the project team to facilitate the audio-recorded FGDs and interviews. The guide was organized by CFIR domains and additional questions were included to inquire about male engagement. Central topics were about barriers and facilitators of engaging men in a couple-based therapy to reduce IPV; adapting the therapy to be acceptable to both men and women; and ensuring safe implementation throughout assessment and intervention. We also inquired about men's mental health and substance use challenges to understand how these issues identified in formative research affect engagement, acceptability, and adaptations. The interview guide was iteratively adapted throughout the course of the interviews and FGDs to remove redundancies, simplify the questions, and add questions about how the COVID-19 pandemic has affected services for IPV.

2.2. Data analysis

All transcripts were transcribed verbatim by two research assistants. A team of four (1 US researcher and 3 local research team members) hand-coded four transcripts together and met weekly to discuss emergent open coding using Grounded Theory methods. Open codes were first assigned inductively according to sections of narrative that focused on a topic (i.e., meaning unit). The US researcher then developed an initial codebook and the team of four discussed the contents of the codebook, clarifying points of confusion

and adding codes, if needed. The local team members then uploaded the codebook into Dedoose, an online qualitative coding software. Two local research assistants, along with the Project Coordinator, coded all transcripts together, and added codes with full agreement from the team. Any questions were addressed through weekly meetings with the fourth US researcher and the codebook was continually updated. The team, along with another local researcher, then organized the codes into themes (axial codes = 24). Codes for certain topic areas were entered into a table along with their frequency of application, according to Dedoose. The team then discussed how codes could be combined conceptually, which codes were discussed most consistently across FGDs and interviews, and any exceptions that arose (mentioned once or twice). These themes were then organized into an overall thematic framework (selective coding). We presented the overall thematic framework to the Community-Partnered Team and CAB in separate in-person meetings to receive their input on the themes regarding relevance and face validity. (Do the themes make sense given their experiences working with the community?) Supporting excerpts for the themes were translated into English. Connell's (2005) masculinities framework was used to interpret the data in each of the codes and overarching themes. Herein, we interpreted the gender dimensions that might facilitate men's engagement along with the potential barriers for men aligning to dominant ideals of masculinity (i.e., self-reliance, competitiveness, control). Beyond these masculine states, we also analyzed the gendered dimensions of the structures with which men (and women) interacted.

3. Results

3.1. Demographic characteristics

Of the 85 participants, 47 (55%) identified as women and 38 (45%) as men. Their ages ranged from 18 to 75 years ($M = 38.9$). Most participants (95.3%) identified as Black African. Two participants (2.4%) identified as White, one (1.2%) identified as mixed race, and one (1.2%) identified as other. Over half of respondents (58.8%) were single, about one-third (30.6%) were married, 7.1% had a civil union, and 3.5% were widowed. Half of the respondents indicated having a secondary education, 29.8% university degree, 11.9% primary education, 3.6% postgraduate degree, and 4.8% reporting no formal education. All were Mozambican and 72.6% from Nampula Province. There was a range of employment activities: 50% reported having formal employment, 13.1% doing domestic work, 11.9% being self-employed, 9.5% doing something other (community leader, activist), 6% being unemployed, 4% working as volunteers, and 4% studying.

3.2. Barriers to engaging men

Four principal themes arose related to barriers to engaging men. These themes were about masculine culture and gender role expression, socioeconomic considerations, and mental health status (See Table 1).

3.3. Gender role expressions

All FGDs and interviews discussed masculine culture ("o machismo") at length, almost always framing it as a barrier to engagement in mental health care. These discussions sometimes alluded to restrictive gender norms as being taught in childhood and reinforced

throughout men's life. Participants described gender as learnt by boys with men being influenced to embody power, authority, and hierarchical relations. Masculinities as relational emerged through interpersonal interactions as a social signaling of strength idealized. For men, it was important to unilaterally communicate socially sanctioned messages of strength and avoid expressions or implied vulnerabilities culturally associated with weakness (i.e., emotional restraint for fear and sadness). Participants' narratives demonstrated how gender roles could be policed and reinforced by other men, wives, and there could be a fear of men that providers might hold similar judgments. A key informant FGD member talked about the learned nature of gender and the use of violence to maintain the social perception of strength (in this case, portrayed through sexuality):

> *We were taught that at no time should we show our feelings, share our pain. A concrete example is that man does not like to share his pain, his emotion, because if he does, he is seen as weak in society. For example, if I have difficulties with my partner, at no time will I tell her. Why won't I tell her? One of the examples that I will associate is the example that [#71] ended up sharing here with us in which a man killed his wife just because she knew he was sexually impotent. So, because of the society he finds himself in, in which he never had to share his impotence with another person, he preferred to eliminate the woman because she knew that he was impotent. If she conveys this message to other people, he would have felt a... one that doesn't exist, one that maybe is not worth living in a society.* – Key Informant FGD

The participant's example shows how dominant ideals of masculinity that prize virility and sexual prowess can determine social belonging and gendered hierarchies. Other participants explained that sharing with others about problems and hardships risked amplifying those vulnerabilities, in essence, communicating weakness confirmed weakness and subordinate status. A provider shared, "*Your sexist side that says, 'I can't expose myself. I can't say this to a person like me. Maybe he'll notice me as a weakling,' among other thoughts and that can make it difficult."* Exposure of vulnerabilities evoked fear in men. Another key informant shared, *"and there is often that fear of participating on the male side",* indicating the risks with being seen to need (and take) help rather than resolutely solve or conceal and stoically withstand one's own challenges.

3.4. Power and healthcare interactions

The expression of traditional masculinity idealized men as decision-makers, owners and allocators of resources, and authority figures in *their* households and broader communities. A key informant shared, *"Machismo makes him feel that…he is the owner of everything, that he is the ultimate boss and that after him no one can speak, that after him no one else can make decisions above what he has already taken."* In this power orientation, actions, knowledge, and education differentials could affirm gendered hierarchies wherein receiving input or advice from others threatened men's authority and drew their defenses. A male participant succinctly stated, *"Man is very hard to take advice."* Receiving advice was often framed as being influenced (rather than self-reliant and decisive) and it was a common observation that men with strong character could not be influenced. Perhaps for this reason, many respondents described men as "difficult," afraid of being exposed as uncertain or

weak, and concerned about their reputation which was reliant in large part on their peers' perceptions of their controlling actions. A member of the women's FGD shared, *"Many men are difficult, very difficult. They deny it and I don't know why."*

Participants often defined men by contrasting them with women or femininities and women's subordinate social status. An elder shared, *"As for the ladies, they are easier to influence, because most consider themselves weaker, inferior, the man is in charge, the law comes from the man, so we can influence and sensitize [them]."* Women's malleability was also often connected to their varied (and oftentimes stereotyped volatile) emotions, as this key informant shared, *"You can easily perceive that emotional part of them [women] that is more fragile."*

Narratives indicated that participants perceived healthcare interactions in general and in relation to therapy to have an inherent hierarchy built into their relations through patients seeking help and the providers giving expert advice and direction. For example, a member of the men's FGD exclaimed, "*But if the wife says to the husband, 'Let's go to the hospital for advice,' the man can say, 'What am I going to do there? What are they going to tell me there? The nurse will tell me what?'"* Another participant added how receiving help threatened men's social positioning. The provider said, *"Because usually the man should have this and that posture and the therapist is giving him another instruction. This may interfere with the position of the man himself who is participating in the therapy."* Conversations about knowledge sharing in the healthcare system demonstrated the potential for men's resistance to institutional powers for fear that they would stigmatize and marginalize them further.

In Mozambique, neighborhoods elect leaders called neighborhood secretaries. These leaders communicate policy and other important information and mediate conflicts between families and within households. Participants frequently referenced these governing structures when talking about hierarchy and power in knowledge-sharing such that they observed men as reticent to attend community meetings and/or act on community leaders' instructions. The narratives highlighted contention for social position in everyday but symbolic interactions with others, including healthcare providers and neighborhood leaders, demonstrating, prescribing, and coaching subaltern masculine performances. Given the hierarchies in the healthcare and patient interaction, all FGDs and interviews expressed that men generally had low motivation to seek (or fully accept) healthcare.

3.5. Socioeconomic considerations

Several participants also described barriers due to men having obligations that they prioritize over healthcare. They particularly highlighted men's occupational demands and difficult logistics for balancing work with scheduling healthcare appointments. A participant from the men's FGD stated, *"It's just that it won't be easy to bring the men to the hospital because the men are so busy."* Another participant from the women's FGD elaborated: *"In my opinion, others may say that maybe 'It's because I'm doing a job without a break. I'm going to work, or I'm going to do something.'"*

3.6. Mental health status

Another barrier to engagement was men's mental health status. Men rarely, if ever, discussed struggling with common mental disorders. Mental health struggles, especially, might be denied, which could further reduce the priority and motivation of addressing those challenges. A provider shared, *"First, by nature, man is the one who wakes up and stays there worrying about other things and that's it, if he's not "sick" then it's okay and to look for a psychologist or a therapist without having any visible disease has become difficult."* Even in the case of health problems, participants suggested that typically men did not seek healthcare until the problem became severe.

Participants did, however, frequently mention men's use of substances. Almost all groups and key informants connected substance use with perpetration of IPV. A key informant explained, *"Sometimes we also have men who are drug users and alcohol consumers, alcohol and drugs make him have deviant behaviors that make him violate both his wife and children."* Thus, men eligible for a couple-based intervention that focuses on IPV might be especially likely to be men with substance use problems. This reality can further detract from men's participation, depending on their willingness to change. A member of the men's FGD stated, *"Another thing, many men consume drugs, drink alcohol and are very ignorant so it is not easy to bring them here in the hospital."*

3.7. Facilitators of engaging men

Despite the acknowledgement across FGDs and interviews that there were numerous barriers to engaging men and that these barriers were often grounded in pervasive gender norms, participants also communicated several facilitators for engaging men. First, there was overwhelmingly high acceptability for including men in couple-based approaches to resolve IPV and improve women's and men's mental health. Second, there was a recognition of diversity in men and a sentiment that this plurality could be leveraged. Finally, several participants proposed ideas regarding targeted community-level possibilities for how to facilitate engagement.

3.8. High acceptability of engaging men

Almost all participants thought that engaging men was important and that their involvement could pose several benefits. First, they noted that IPV is a challenging problem for women to solve on their own. Engaging men provides an opportunity for both partners to learn, and participating makes the experience more intrinsically motivating.

> *It is actually necessary for the man to be associated in this fight, to be involved in this fight. Because the moment I face a problem, I am the one who caused it, it is stronger, it is more touching, because I know the existence of this problem was due to my insistence. How am I going to reverse it? I will revert it if I do not get fully involved in that problem in the sense of doing it differently from what I have been doing until today, and which I no longer intend to do tomorrow.* – GBV Specialist FGD

They identified that men need help, too, and involving them provides an opportunity to do so and address connections between their gender ideals, mental health and violence.

Participating in a couple-based intervention could increase men's awareness of the risks of IPV and how their actions are affecting themselves, their spouses, and their children.

> *It is essential to work with him because he needs help. That voice that a woman hears when she is depressed that says, "Nobody likes you. You are worthless. It is worth dying and going to rest." The voice the man hears first is, "This one doesn't respect you."…You must show her that you're a man." It's a voice that stays inside. Then to hear that voice was to beat his wife.* – GBV Specialist FGD

Participants also outlined specific components they thought could be improved through couple-based work. These were better conflict resolution skills and ability to communicate harmoniously with one another, more alignment in their vision for the family, and increased couple satisfaction through improved connection.

> *I think the interesting part is when the two of them are there without shame and without fear, they are talking in a free way about what happens, so everyone involved in therapy is listening at once. And it is different, for example, doing sessions in parts, in which first the woman enters, she goes explaining, then the man enters. And this at some point creates some limitations. As it is often said in my tradition, "Coconut water tastes better when it is drunk directly from the fresh coconut." What I am trying to explain is that the person cannot hear from a third party but hear directly, giving the possibility of the patient to think, "I thought I was doing it right, so it bothers you and it is not correct."* – Provider FGD

3.9. Diversity among men

Another facilitator of engagement was acknowledgement that there is diversity among men with some being open to receiving healthcare. These diversities were noted to depend on regional differences, urban/rural distinctions, age, and individual traits. A woman shared that in general, *"Some are more open, and others are not. You already know that different types of people live in the community."* Another person explained regional differences as follows:

> *There is a cultural diversity between people who live inland and on the coast, in which at some point the cultural roles are typically different when we talk about gender. This can also be a factor that at some point can lead to the male's part in this.* – CAB FGD

Another respondent identified that men living in urban settings might be more likely to join. A respondent from the women's FGD said, "*In my opinion, the men of Nampula [City] can do it. They will join."* Several respondents offered anecdotal examples of men they know who sought or were accepting of healthcare.

> *My husband, for example, he found me with this disease. As soon as they found out at the hospital that I had that disease, I got home and calmly told him, "Husband, let's sit down. There's something I want to tell you. There at the hospital where I was going, they discovered this." My husband reacted a little and, as I had not reacted aggressively, my husband thinks, and he said, "If you have this disease, and I leave you, and if I have it, too? How will I do? You'd better be taking those*

medicines of yours, and so will I. I'll look for a day to go there for an analysis. – Women's FGD

Finally, respondents mentioned individual states, such as humility, being calm, being willing to receive advice, and feeling regret following violence, as indicators of variation that facilitated engagement. They also described younger men as more flexible and willing to engage with healthcare.

4. Recommendations for engagement of men

Most recommendations for how to engage men were situated at the community level and included providing targeted information through the intervention. They noted that community-spread misinformation about health services was common and that without community awareness programming, there was a risk that men might misinterpret the intervention goals and content. A member of the district official FGD commented:

We are talking about a province in which the culture is Makua, man in his masculinity. When there is a misinformation in the community, man is the first to receive the information. Then his participation can be negative. The information easily circulates from one man to another until it affects a certain program. = District Official FGD

Hence, participants suggested that increasing public awareness through community messaging (e.g., radio or TV) could help facilitate building a positive relationship with the community while providing accurate information. A provider observed:

They may have that fear at first, but in their conscience, they will also know that "I may be suffering here but there is a place where I can receive help." There should be more expansion of the message through some radio or television services, some pamphlets, or not even in a few minutes in an advertisement, to be able to expand this information men really need. - Provider FGD

Many key informants expressed that using respected men in the community could also facilitate engagement. These men could be elders, religious leaders, role models, and other influential men who would garner respect and be listened to. Additional recommendations were to partner with and leverage nongovernmental services that have programming for men. Finally, FGDs of gender-based violence (GBV) stakeholders and community leaders talked about initiation rites for boys as being opportunities for socializing and teaching boys about intimate partner relationships and IPV prevention. Boys are circumcised during these rites and receive education about how to behave as men. Respondents described these rites as mostly being positive, but also as a time when boys receive messages about dominant masculinity and the subordination and marginalization of women. A GBV stakeholder noted:

At least we here in the North have the issue of male initiation rites, I want to believe that in addition to being a space where men are circumcised, it could also be a time when they will transmit content related to what will be transmitted in the therapy space between couple, not in an advanced way because they are boys, but being able to teach them from an early age would be good. - GBV Specialist FGD

5. Discussion

To our knowledge, this is one of the first studies in an LMIC to examine barriers and facilitators for engaging and including men in a couple-based intervention to reduce IPV and improve mental health. Given Nampula's unique matrilineal context, assessing factors relevant for men's engagement was warranted. Other studies in Africa that explored kinship and IPV have found that that the matrilineal context has served as a protective factor for women and children (Lowes, 2022). A qualitative study, for example, in Eastern Ghana interviewed 15 women with matrilineal backgrounds and 15 women from patrilineal backgrounds and found that, while IPV exposure was present in both contexts, women with a matrilineal kinship network discussed physical IPV as more isolated than women with a patrilineal kinship system (Sedziafa et al., 2016). Another study in Malawi established that belonging to a matriarchal society and prioritization of women for education showed positive associations with prioritizing women for healthcare (Azad et al., 2020). Despite Nampula Province having a matrilineal population, the descriptions of masculinity among our participants are consistent with expectations of masculine gender roles in other patriarchal contexts (Levant and Wong, 2007). Main barriers were men's alignments to masculine norms including strength, control, and self-reliance in denying weakness and power orientations. Thus, while some studies have shown matriarchal kinship systems to be protective for women, more research is needed to understand the complexities of men's gender role socialization within matriarchal systems and how that affects couple relationships, healthcare engagement, and outcomes.

While HIV and perinatal healthcare services in Mozambique have provided targeted engagement programming for men to accompany female partners for HIV testing and perinatal appointments, this study is the first to consider men's engagement in public mental health services. A scoping review of 56 studies from 14 countries in sub-Saharan Africa summarized provider perceptions of men's health and described how perceptions may have affected intervention content and design (Beia et al., 2021). They categorized men to four domains: (1) *man as gatekeeper* placed emphasis on men's involvement because of their social status, particularly in the family and as it relates to sexual health reproduction; (2) *masculine man* highlighted men's masculinity as it associates with unhealthy behaviors; (3) *marginal man* referred to men whose engagement in programming (e.g., HIV services) is key, but structural obstacles prohibit access to care, especially among minoritized men; and (4) *man as client* focused on specific health needs without emphasizing cultural influences (Beia et al., 2021). Participants in our study emphasized the conception of *masculine man* through their focused discussion on gender, power, and how those constructs influence help-seeking. Applying these domains can benefit other implementation studies that seek to engage men. Future research and programs could explore other conceptions of men to tailor interventions using an intersectional lens (Crenshaw, 1991), for example, by including the conception of *marginal man*, and considering men's health and mental health needs beyond their role as gatekeepers to family members' healthcare access and health status.

Recognition of diversity underlines an opportunity for adopting an intersectional masculinities lens (Connell, 2005) that considers gender along with other sociodemographic characteristics to tailor services to be more acceptable and engaging for specific sub-groups

and a wider population. The scoping review reported variability in men's health-seeking according to education level, marital status, and exposure to health campaigns across the studies. However, while higher age was associated with increased healthcare-seeking in the review (Beia et al., 2021), participants in our study indicated that younger men were more amenable to receiving help. A qualitative study of men's mental health help-seeking in Wales confirmed the varied pathways of men's help-seekingand noted the importance of social networks in the help-seeking process (Vickery, 2021).

Local specific tailored mental health services for men are scant. In a special series that focused on sex and gender differences in mental disorders, researchers commented that most mental health research has failed to analyze or stratify outcomes according to sex and gender (Howard et al., 2017). Thus, there is a subsequent lack of gender-sensitive services, and it is unknown to what extent sex and gender associate with risk or moderate outcomes (Howard et al., 2017). Participants in this study recommended several community-based interventions to facilitate awareness about the intervention and mental health services and education about less restrictive masculinities that de-emphasize dominance in relationships. Participants suggested to include respected men in the community as examples, which could soften concern about social ramifications for not observing a traditionally masculine role. Possible leverage points for improving men's engagement included tailoring community messaging to facilitate and norm the uptake of services. Framing interventions to align with traditional masculine values of provider and protector could further support engagement. A qualitative study with stakeholders and providers in Canada and Australia who have expertise in working with men found that men's accountability in and dedication to acknowledging areas for growth and strengths as well as recognition that self-work was imperative for relational success were optimal conditions for building better relationships. A group of researchers shared eight lessons learned for delivery and scale-up of community-based programs for men's mental health. These lessons highlight a focus on addressing and shifting masculine norms with men's permission, addressing social determinants of mental health, and incorporating activity-centered programming (Oliffe et al., 2020). While not specific to men, a meta-analysis of mental healthcare help-seeking interventions in LMICs found that the successful interventions tended to incorporate multiple components of identification and outreach (Broek et al., 2023). Programs, such as *One Man Can* based in South Africa, support that finding through implementation of multiple forms of community outreach and awareness programming to engage men in advancing gender equality, reducing gender-based violence, and improving HIV and AIDS outcomes (Sonke Gender Justice, 2021).

Few implementation frameworks explicitly address gender (Tannenbaum et al., 2016), and failure to consider gender in implementation perpetuates inequities. Our data clearly indicate that acceptability and reach of services must consider masculinities in the plural as well as prevailing patterns that norm IPV. Means et al. (2020) conducted a systematic review of 34 studies across 21 LMICs that used the CFIR to understand the framework's utility for low-resource settings. They also surveyed 21 authors of these studies to elicit feedback about their perceptions of domain/construct relevance for their work and areas for improvement. They concluded that there remains a need to consider patient needs, including

sociocultural norms, and that it is important to test whether prioritizing patient needs affects implementation effectiveness.

Recent work has applied an intersectional lens to CFIR domains and constructs by providing example prompts to explore intersectionality (Knowledge Translation Program, 2019). Some inner setting prompts include exploring who holds power within the organization and how that might affect implementation or the intervention. Outer setting prompts consider diverse patient needs and experiences and how intersecting identities might influence the experience of the intervention (Knowledge Translation Program, 2019). Our findings extend this framework to consider power dynamics between the inner and outer settings represented by the hierarchical provider-patient power dynamic where providers have the upper hand. Participants' narratives also emphasized the power dynamics inherent within the healthcare hierarchy and provider exchanges. These narratives captured men's sense of subordination and marginalization, in the context of perceived problems and ensuing advice, thereby amplifying many men's vulnerabilities. Men who uphold traditional masculine norms might be especially hesitant to engage in an interaction where this power dynamic places them in an inferior (in terms of power and control) position. Designing interventions and services that appreciate this potential underlying threat to participation will be paramount.

Not all implementation interventions that consider gender should be targeted towards male service-users. Health systems and programming can also be tailored to consider that simply having a problem poses a vulnerability for men that compromises their social role. Health system services with restricted weekday schedules have not accommodated men's work schedules (Beia et al., 2021), supporting our participants' perceptions that men's work obligations and schedules were a barrier to engagement. In rural Kenya, to address concerns about men's uptake of services, "male clinics," male-friendly separate spaces staffed by male healthcare providers, were implemented (Dowden et al., 2019). These clinics showed better uptake among men and more seeking of preventive healthcare (i.e., checkups) than control clinics (Dowden et al., 2019). While our study focused on the outer setting of the CFIR to better understand patient characteristics, next steps should explore how gender roles affect organizational factors of implementation of a couple-based intervention for IPV and mental health. Additional consideration should be given to implementation of a dyadic intervention where both partners are involved, and intersecting identities play a role in their experiences of the intervention.

5.1. Limitations

There are some limitations to consider when interpreting the findings. Because this intervention will be implemented in Nampula City, we focused our data collection there. Given participants' education levels, formal employment type and rates, and data collection in the context of an urban setting, the findings are likely not transferable to a more rural setting and with populations with lower levels of education who are not affiliated with the healthcare system. Further research about men's engagement should occur in rural settings given participants' observations that there is regional and urban/rural variability among men and differences in attitudes towards male engagement based on education level and employment type. While we held FGDs and interviewed diverse stakeholders to

collect a range of perspectives, providers were employed within the public health system. As such, social desirability could have influenced their responses and skewed them to be more positive towards the intervention. Additionally, the couple-based intervention will be implemented in hospital settings, which is from where we recruited men and women. These participants may be more likely to seek healthcare than other community members and less representative of the larger community. Furthermore, we did not select participants based on exposure to or perpetration of IPV. Given the high rates of IPV in Mozambique, we anticipated that people would have familiarity with the topic. Including personal experience with IPV as eligibility criteria could have expanded our findings.

6. Conclusion

This study examined barriers and facilitators for engaging and including men in a couple-based intervention to reduce IPV and improve mental health in Mozambique. Main barriers to engagement were traditional masculine socialization and hierarchies of power within the patient-provider relationship, socioeconomic considerations, and men's mental health problems. Facilitators were high acceptability of including and engaging men, variability among men that could be leveraged, and recommendations to implement community-based messaging. To achieve health equity, attention to these gendered implementation factors is essential. Future programming should consider options for restructuring availability of services to address men's scheduling and financial barriers, frame interventions to align with men's traditional masculine values, and train providers about gender role socialization so they can better understand and lessen power dynamics with patients.

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Table 1

Barriers and facilitators of engaging Mozambican men in a couple-based IPV and mental health intervention.

Implementation Factors	Themes	Subthemes
Barriers	Masculine culture ("o machismo")	Alignments to masculine norms prizing strength (i.e., avoid showing vulnerability or expressing vulnerable emotions of fear and sadness); others reinforce those roles; healthcare provider and patient interactions include power dynamics of giving/receiving advice and influencing/being indebted and marginalized within gender hierarchies; potential low acceptability among men
	Socioeconomic considerations	Occupational demands limit availability to attend appointments
	Mental health status	Mental health not viewed as an illness requiring attention. Substance use common; a dual focus on alcohol and illicit drug use
Facilitators	High acceptability among stakeholders	Engaging men is important; provides an opportunity for both partners to learn; can enhance motivation; helps men; enhances intervention effectiveness
	Diversity related to the prospective implementation among men	Some men are open to seeking healthcare; there are sociodemographic differences (regional, urban/rural, age); some individual states promote help-seeking
	Recommendations to promote engagement	Increasing community awareness through media to combat public misinformation; using respected men in the community to teach others; leveraging initiation rites of boys