



## RESEARCH ARTICLE

# Health care providers' perspectives on delivering gender equity focused family planning program for young married couples in a cluster randomized controlled trial in rural Maharashtra, India [version 1; peer review: 2 approved, 1 approved with reservations]

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## Abstract

**Background:** There is increasing programming and research on male engagement and gender-equity (GE) counselling in family planning (FP) services. However, there is a lack of data on healthcare provider's perspectives on delivering these interventions. The objective of the paper is to present providers' perspectives on delivering a GE-focused FP intervention, CHARM, to married couples in rural India.

**Methods:** In-depth interviews were carried out with 22 male village health care providers who were delivering a GE-focused FP intervention, CHARM, to 428 husbands (247 couples) rural Maharashtra, India. Providers were interviewed on their experiences and perspectives during delivery of CHARM. Major domains were identified during a thematic analysis.

**Results:** Local male health providers are interested and can be engaged in delivering a GE-focused FP intervention. Providers believed that the CHARM intervention improves couples' communication, contraceptive use and strengthened their own capacity to provide FP services in accordance with national FP programmatic efforts. Providers found the low-tech

## Open Peer Review

Reviewer Status

	Invited Reviewers		
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flipchart including pictures and information helpful in supporting their service provision. Providers reported some challenges including lack of privacy and space for counselling, limited access to contraceptive options beyond pill and condom, numerous myths and misconceptions about contraceptives. Providers also reported persistent social norms related to expectancy of pregnancy early in marriage, and son preference.

**Conclusions:** Providers in rural areas with high fertility and related maternal health complications are interested in and can successfully implement a GE-focused FP intervention. Future efforts using this approach may benefit from greater focus to support broader array of spacing contraceptives particularly among first time parents, none or one child parents. There is a need to better support engagement of wives possibly through female provider led sessions parallel to male programs, i.e. gender synchronized rather than couples' sessions.

**Trial registration:** ClinicalTrials.gov [NCT01593943](https://clinicaltrials.gov/ct2/show/study/NCT01593943), May 8, 2012.

### Keywords

Contraceptive use, family planning, male involvement, gender equity, providers perspectives, India

Any reports and responses or comments on the article can be found at the end of the article.

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## List of abbreviations

AYUSH: Ayurveda, Yoga, Unani, Siddha and Homeopathy  
 BAMS: Bachelor of Ayurvedic Medicine and Surgery  
 BEMS: Bachelor of Electropathic Medicine and Surgery  
 BHMS: Bachelor of Homeopathic Medicine and Surgery  
 CHARM: Counseling Husbands to Achieve Reproductive health and Marital equity  
 DHMS: Diploma in Homoeopathic Medicine and Surgery  
 FP: Family Planning  
 FP2020: Family Planning 2020  
 GE: Gender Equity  
 ICMR: Indian Council of Medical Research  
 IEC: Information, Education and Communication  
 LARC: Long Acting Reversible Contraceptives  
 MBBS: Bachelor of Medicine and Bachelor of Surgery  
 MD: Doctor of Medicine  
 NIRRH: National Institute of Research on Reproductive Health  
 PHC: Primary Health Center

## Introduction

Globally, more than 220 million women lack access to modern contraceptives<sup>1</sup>. Of these women, 70 million live in South Asia<sup>2</sup>. In India, over one-tenth (13%) of women report an unmet need for contraceptives, and rural women are less likely to use contraception<sup>3,4</sup>, and more likely to have unwanted pregnancies<sup>5</sup>. India's national family planning program has historically promoted permanent sterilization methods, which have failed to address a high rate of unintended pregnancy<sup>6</sup>. More recent government efforts prioritize an expansion of modern reversible contraceptive options, including more effective long-acting reversible contraceptives (LARCs)<sup>7,8</sup>. These approaches fail to engage husbands, who are often key decision-makers in families on issues of fertility and family planning (FP)<sup>7,9,10</sup>. FP providers' engagement of men in India is important, given research documenting that couple communication, and husband's support for contraceptive use are key facilitators in married couples' FP use<sup>11-15</sup>.

The FP intervention CHARM (Counseling Husbands to Achieve Reproductive Health and Marital Equity)] engaged male health care providers in India to deliver counseling on FP and gender equity (GE) to couples via engagement of husbands<sup>16,17</sup>. Trained providers first implemented FP counseling to husbands in two sessions, and addressed GE concerns related to FP, including son preference, partner violence, respectful couples' communication and joint decision-making. A third final session was inclusive of both the husband and wife where family planning counseling, couples' communication, and joint decision-making were discussed, practiced and reinforced. A cluster randomized controlled trial evaluating this intervention

found significant increases in contraceptive use and couples' communication, as well as a reduction of marital sexual violence for CHARM participants compared to a control condition<sup>17</sup>. These findings are consistent with studies from other national contexts documenting the value of engaging male providers to deliver integrated FP and GE counseling to men<sup>18-21</sup>.

To provide further insight into how male providers engage men on issues of family planning and contraceptive use, we analyzed qualitative data from male village health providers delivering the CHARM intervention. Health providers in CHARM were inclusive of both private and public health providers, allopathic (i.e., medical doctor) and AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy i.e., doctors trained in traditional medicine), providing health services in rural communities. This approach is consistent with research recommendations for India, which seek to extend public health services by engaging private and AYUSH providers in FP counseling<sup>7</sup>. While research examining providers' perspectives on engagement of men in family planning counseling has been studied in sub-Saharan Africa and the Pacific<sup>19,22</sup>, little research engaging male providers has been conducted in the Indian context. This paper examines qualitative data from male village health care providers trained to provide a GE-focused FP intervention, CHARM, to couples in rural Maharashtra, India.

## Methods

### Data source

Data for the study are drawn from in-depth interviews that were part of a cluster randomized control trial to evaluate the impact of the CHARM intervention aimed at increasing utilization of family planning methods and promoting gender equity attitudes among young married couples in rural Maharashtra. In-depth interviews were conducted with the village health care providers after they had completed delivery of the CHARM intervention. This male involvement FP intervention was delivered to 428 husbands (247 couples) over the period of April 2012 to March 2013, and data from providers were collected from August 2013 to September 2013. The project engaged both allopathic (n=9) and non-allopathic (n=13) male health care providers practicing in the selected rural areas where the study was being conducted; all providers who delivered CHARM agreed to and participated in this qualitative study. No financial incentives were given to the providers to participate in the surveys. The study, methodology and CHARM intervention module development are provided in detail elsewhere<sup>16,17</sup>. This trial is registered at ClinicalTrials.gov under registration identifier [NCT01593943](https://clinicaltrials.gov/ct2/show/study/NCT01593943). Questions for which quantitative responses were given are available as *Extended data*<sup>23</sup>.

### Interviews

In-depth interviews (n=22) were conducted with male providers at their clinics subsequent to completion of intervention delivery for the study. Prior appointment was sought and interviews lasting an average of 30 minutes were conducted after obtaining their informed consent. The interviews collected information on experiences of the providers in delivering intervention, challenges they faced in conducting the sessions,

experience with delivery of contraceptives, their perspective of program effectiveness, and their recommendations for program improvement and continuation (see *Extended data*<sup>23</sup> for interview tool).

All interviews were conducted in Marathi or English by trained research staff from the National Institute of Research on Reproductive Health (ICMR-NIRRH), with a Masters-level qualification. Interviewers took notes with direct quotes throughout interviews in the language of the interview, which they expanded upon immediately after each interview was completed in order to record further detail. These files were translated to English, de-identified and sent to project investigators for analysis. Audio recording was not utilized due to providers discomfort with it. All procedures were approved by the Institutional Review Boards of the Indian Council of Medical Research - National Institute for Research in Reproductive Health (D/IECCR/76/2009 and D/ICEC/Sci-01/163/2012, most recent approval on 01/04/2012), University of California San Diego (project #111334, most recent approval on 7/2/2015), and Population Council (Protocol no. 451, most recent approval on 1/15/2014). Written informed consent from participants was obtained by the CHARM Research Team before data collection. All participant data are anonymized.

#### Data analysis

Data were analysed using ATLAS.Ti v.7, guided by grounded theory approach where open coding was done and themes were attached to observations during analysis<sup>24</sup>. Under the supervision of a project co-investigator, two project staff members with master's degrees in psychology and trained in qualitative analysis independently read the interviews and identified mutually exclusive but possibly linked codes or themes across interviews. Blind coding was done by the coders, where neither was aware of the codes assigned by the other. Additional codes and sub-codes were identified iteratively in this coding process, and reapplied to previous interviews as needed. Coders discussed any coding disagreements; if agreement was unable to be reached, a decision was made by the Co-Investigator who was overseeing the coding process. The four major themes identified were: (1) provider views on how to deliver the CHARM intervention, (2) facilitators and challenges to delivery, (3) perception of intervention effectiveness, and (4) recommendations for the intervention. Quotes best illustrating the themes are presented.

## Results

### Characteristics of health care providers

Providers were, on average 33.6 years old (range 27 to 47) with 3–32 years of experience. Of the 22 providers, 13 had private clinics, and 9 were public providers at government health facilities. There were 13 AYUSH providers with qualifications of Bachelor of Homeopathic Medicine and Surgery (BHMS), Bachelor of Ayurvedic Medicine and Surgery (BAMS), Bachelor of Electropathic Medicine and Surgery (BEMS), or Diploma in Homoeopathic Medicine and Surgery (DHMS). Of the providers, eight were allopathic with Bachelor of Medicine and Bachelor of Surgery (MBBS) and some were currently pursuing their

residency Doctor of Medicine (MD) degree. A further eight providers were allopathic with Bachelor of Medicine and Bachelor of Surgery (MBBS) and some were currently pursuing their residency Doctor of Medicine (MD) degree. FP counseling was not part of their routine services; however, they were attending to patients for regular illness. They were trained as part of the study since they had a good rapport with the community around their clinic, high number of clientele, and expressed desire and agreement to be part of the intervention. Raw quantitative results of the survey are available as *Underlying data*<sup>23</sup>.

### Delivering the CHARM intervention

Providers highlighted the importance of engaging men in family planning and maternal health in the context of a society where men typically make household decisions. They highlighted the importance of utilization of reversible methods of contraception (spacing methods) in addition to sterilization to support healthy birth spacing.

*“It (low contraceptive use and unintended pregnancy) is because of a male dominant culture. We can bring gender equality. Women think that they should use methods but in-laws or husband don't pay attention to it due to their old thinking or may be because they are not aware about it...if they (couple) adopt spacing then it will be helpful.”* (AYUSH provider, age 32 years)

Providers also discussed the importance of encouraging communication between married couples for jointly deciding the number of children they wished to have, spacing between pregnancies and choice of contraceptives.

*“Many clients have understood that due to 2–3 children and continuous pregnancies many couples get many problems...but they were not getting the right guidance and were avoiding going to government hospital or PHC to take information. We can say that we identified their need and reached them at right time.”* (AYUSH provider, age 32 years)

*“Previously major decisions about family planning were taken with the permission of in-laws but after getting information on family planning methods, men are taking decision jointly by considering their wife's opinion.”* (AYUSH provider, age 28 years)

They recognized, through the CHARM intervention, the importance of village health providers like themselves for India's national family planning program, to help improve and sustain contraceptive use among young couples.

*“It is government activity. Till now whatever government has done in the field of family planning or family welfare, it is not successful as per their expectations. So they decided that they will include general practitioners who have reached grassroot level and carry forward CHARM program.”* (AYUSH provider, age 43 years)

They also believed that such expansion would provide opportunity to men and women to freely discuss issues such

as spacing of births, son preference, domestic violence, male involvement with these providers.

*“When we were asking in detail about violence, they replied “yes, I physically abuse my wife, but...I rarely slap my wife”. But when I asked them about decision making about contraceptive use, some of them said that they [the couple] took all the decisions though some said that decision about contraceptive use was only his [the man’s] and in-laws.”* (Allopathic provider, age 29 years)

*“-he [the husband of a couple] asked me whether I could do test to confirm the sex of child, or if I could give reference of anyone who can do sonography. I tried to convince him a lot against this, but he said that these things were there in his community, if they got only girls then their community would ban them.”* (AYUSH provider, age 43 years)

At a personal level, health care providers felt that CHARM increased their clientele.

*“because of this program good relation has developed between me and patients who came for session. They had good follow-up and also started discussing their general illness and illness of family members. Couples, who were not coming to me earlier, also started coming for general treatment.”* (AYUSH provider, age 28 years)

#### Facilitators and challenges to intervention delivery

##### Facilitators.

**(a) Interest from participants:** Providers said that they could deliver the programme (the sessions and contents as planned) without much difficulty as recruited participants were interested in receiving the information.

*“One good thing I observed is that people were interested in getting this information, from my four years practice in this area...I was not sure that they will listen to us but when we started giving information, I understood that people feel it is important to listen.”* (AYUSH provider, age 32 years)

**(b) Intervention communication tools:** They also felt that the flipchart provided to them for intervention helped convey messages in an effectively to the participants who had limited ability to read.

*“We gave them basic information, like those who work on vitbhatti [brick kilns] they don’t know what nirodh [condom] is and they have never seen it. We told them and showed them demonstration and flipchart, flipchart is the best thing, flipcharts were very helpful in this program.”* (Allopathic provider, age 29 years)

**Challenges.** There were two major levels at which barriers to intervention delivery was reported.

##### (a) At the participant level

###### (i) Privacy

Since it was not normative for the health care providers to discuss topics such as contraceptive use and gender equity,

they had to conduct sessions according to the comfort level of the participant and the availability of privacy for discussions on contraceptives.

*“They used to feel shy after listening to topics like condom, IUD or menstruation and all “(Allopathic provider, age 28 years).*

*“Difficulties were from other patients since we have system here that once patient comes he directly gets in doctor’s cabin, and this discussion is so personal that we cannot suddenly open up. Our clinics are not such that there are closed rooms, this disturbance was present, so we had to adapt to it.”* (AYUSH provider, age 32 years)

##### (ii) Limited participation of women

Most providers experienced difficulty in organizing the couple’s session, and consequently participation of women in these sessions was limited. Some providers reported carrying out FP counseling during non-FP health visits by clients or talking to groups of women as well.

*“In the beginning 3-4 husbands came for third session without their wife but later when wife came, then I covered it. Ladies have their own work, ---so it was not possible for them to come. Sometimes when husband or wife got ill at that time they both came and we completed session. But they had not come specially for couple session. Hardly 6-7 couples came for couple session.”* (AYUSH provider, age 32 years)

##### (b) At the provider level

Despite extensive training and careful selection of providers for the intervention, a few providers held biases regarding contraception and gender equity, which affected their intervention delivery. For example, some felt that newly married couples did not need the intervention, as they would not desire contraception due to pronatalist preferences and expectations of these couples. Some also felt that pregnant women were not in need of the intervention since it was not immediately relevant.

*“There were some pregnant women and some just married couples who had desire for child so they should not have been involved, we gave information to them but they didn’t take contraceptive from us.”* (AYUSH provider, age 40 years)

A few providers also felt that promoting reversible methods would not be as useful as sterilization camps to help couples reach their desired contraceptive goals and number of children.

*“I feel that main thing is doing operation [sterilization], whatever we are doing aims at idea that operation should be done on time, so telling verbally or writing down, they will not support us...organize camp and do operations in nearby place.”* (AYUSH provider, age 43 years)

Many providers found it difficult to discuss issues related to marital violence, sometimes due to biased attitudes assuming that it is not an issue.



*“Issues on violence is not that much helpful...those who came to me they don’t have much fights and argument, so I didn’t have to tell them much about it. I used to ask couple whether they had fights or not and they reported that they don’t have fights.”* (AYUSH provider, age 40 years)

#### Perception of intervention effectiveness

##### (i) Contraceptive knowledge, communication and use

Participants described the intervention impact on couples’ contraceptive knowledge and use, which corresponds to quantitative findings. In terms of contraceptive knowledge, they felt that their counseling helped clarify how to use contraceptives and myths related to side effects associated with different types of contraceptives.

*“like if we say about condom then 95% people know of condom but no one knew about how to use it. Even among literate people, 80% didn’t know how to use it, after our session they come to know about it.”* (AYUSH provider, age 32 years)

*“They had misconceptions, like someone had told them that it (IUD) got stuck in uterus and had to be operated, or some said that wife told there is problem of itching or there are chances of bleeding, but after giving proper information, even I referred 1–2 patients for IUD insertion.”* (AYUSH provider, age 32 years)

Providers also described that male participation led to the men sharing information about contraceptives with their wives. This helped the couples consider contraceptive use jointly. Male participation also facilitated men being more open to condom use.

*“For some couples, communication has increased. Whatever information was given in second session, they [the husband] had communicated to wife which was seen in third session. When I asked question to wife, she gave answers to it.”* (Allopathic provider, age 27 years)

Improved demand for contraceptives was noted, but providers were not always in the position to meet that demand. Referrals were often given to facilitate uptake from the public facility. But private and AYUSH providers were reported being best suited and able to provide condoms to the participants.

*“People gave very good follow-up, some people used to come repeatedly to ask condom or some used to ask where tablets are available, pills were not available with me so I used to recommend them to go to PHC and take pills from there.”* (AYUSH provider, age 29 years)

*“Yes, people were interested, they also demanded pills or condom, but few had misconceptions about IUD then I explained that there are many advantages of IUD, some also demanded IUD then I referred them to PHC. But preference was given to condom by many respondents than IUD or pills.”* (AYUSH provider, age 42 years).

##### (ii) Gender equity issues: marital violence and son preference

Many providers discussed changes in attitudes of husbands toward their wives, with women indicating being heard and respected more.

*“I had good report from one patient in this context, one respondent’s wife had come to me and said that my husband’s behaviour is better than before, and he is responsive to me now.”* (AYUSH provider, age 47 years)

*“No, they didn’t report [marital violence] but we came to know from neighbours, that there is decrease in violence. Actually there is high rate of alcoholism, after coming home from work they are tired so they drink and if they take more drinks then they beat wife or say bad words.”* (Allopathic provider, age 29 years)

Providers observed that despite intervention efforts to reduce son preference, there had been very little impact on this issue as reported by respondents. The larger social context and family pressures supporting son preference were reported as affecting non-use of contraceptives.

*“In this area, problem is that in-laws pressure couples to have children. They have son preference, if couple wants operation after 2 daughters then they cannot do it. Decision is with in-laws or family members, so I’m satisfied that I explained this information to such people.”* (AYUSH provider, age 42 years)

##### Recommendations for the intervention

Overall, providers indicated that they enjoyed delivering the program and felt that the intervention should be sustained. Nonetheless, they had some recommendations to strengthen implementation in future efforts. They recommended that more proximal delivery to clients and booster sessions would be helpful. They also felt more emphasis on son preference was needed based on the inadequate change that occurred for this issue.

*“Instead of bringing each couple one at a time to clinic, we should do this program in their village because bringing these couples to clinic is big challenge, if you gather husband’s in their village and give information then it will be helpful and they will spread this information to other couples who will also get motivated to participate in this program.”* (AYUSH provider, age 32 years)

*“We should do continuous follow up, and emphasize more on son preference, this program is successful in all other issues but this we were not able to emphasize. Health providers and PHC staff should give this information in their program and visits so that there is awareness about this issue.”* (AYUSH provider, age 32 years)

A few mentioned the need for such programmes periodically for couples for retaining the awareness levels of contraceptives and motivate the use among the couples. They also felt that incentives to rural health care providers involved in the programme could motivate them to continue these efforts.

*“These things should be emphasized more. This program should be repeated, if we do survey and again we don’t provide program then there will be no use of whatever done now.”* (AYUSH provider, age 43 years)

*“You should give some incentives to those doctors who participate in this program. This will motivate such providers.”* (AYUSH provider, age 28 years)

## Discussion

Male village health care providers can be engaged in GE and FP intervention to successfully facilitate involvement of men in family planning. The providers reported that participants were responsive to the program, which corresponds with good participation rates reported in the evaluation trial<sup>17</sup>, and providers indicate that they were able to deliver the program, and the intervention materials such as flipcharts aided in this delivery. The providers’ narratives indicate the value of the male involvement strategy, in improving couple’s communication and family planning outcomes, and in ways that can support the national FP program.

Task shifting has been identified as an effective solution to shortage of healthcare providers, including for family planning services in India<sup>25,26</sup>. These findings demonstrate the capacity of both allopathic and AYUSH providers who do not typically focus on family planning to provide family planning interventions. Furthermore, they are able to do this with a GE approach.

While the engagement of these providers shows great promise, important challenges were identified that should be considered for future male engagement intervention program in family planning. Rural providers described difficulty in ensuring a private and comfortable space for open communication for the patients, as well as difficulty being able to provide couples’ counselling due to conflicting schedules between spouses. Parallel sessions for women may be useful. Women’s sessions may benefit from female providers, given the sensitive nature of issues discussed. Provider biases and deeply entrenched norms related to fertility and marriage can make interventions such as CHARM difficult to deliver. Such provider biases have been reported in previous literature in family planning in India and Africa<sup>27–29</sup>. Comprehensive training, as well as careful selection of providers is key to effective implementation, and a greater emphasis on person-centered family planning counseling may be useful<sup>30</sup>. Studies have shown positive effect of training on counseling skills and improved restrictive practices<sup>31,32</sup>.

A major challenge in increasing contraceptive use across different types of contraception, including more effective LARCs<sup>17</sup>, was limited method mix availability. Since the local providers were not trained in certain FP procedures such as IUD insertion or provision of injectable contraceptives, they referred clients to public health facilities for these. Further, the reach of the male CHARM providers was primarily to the male participants and not surprisingly this resulted in distribution often of condoms<sup>17</sup>, a less effective form of contraceptive relative

to LARCs. A gender-synchronized approach, focusing on the values and perspectives of both men and women, and utilizing sex matched providers may improve women’s participation and provision of the full contraceptive method mix available in India is needed. Delivery of the intervention closer to couples’ residence, rather than just the clinic, as recommended by the providers, would also likely support uptake of services. Prior research from India suggests that home visits from community-level health providers may increase use of contraceptives<sup>33</sup>. Home-based services might be particularly useful but less amenable for FP services that require surgical procedures like IUD insertion, which could be done at a proximally located sub centre.

Findings from this study should be considered in the context of certain study limitations. Providers are from a single intervention conducted for the purposes of a randomized controlled trial, and not in the context of a larger initiative. These study findings may not be generalizable to different settings across India, given that it was limited to a small sample from a single intervention study site in the state of Maharashtra. As interviews were conducted in person by the study team, providers’ responses are subject to both social desirability and recall bias. Finally, interviews were recorded using notes by study staff, but they were not audio recorded, and are therefore susceptible to inaccuracies. Despite these limitations, the study does have a number of strengths. It provides rich and nuanced evidence from providers and corresponds with quantitative findings, offering validity to these. It offers important insights into intervention implementation from providers perspectives, in ways that can help improve future use of the CHARM model and other gender equity focused family planning interventions at community level, especially rural settings.

## Conclusions

This study provides a deeper understanding of implementation of a family planning intervention by the providers and can guide future implementation programs aimed at engaging men in family planning. It shows that the CHARM intervention approach has value, given that providers are interested and responsive, and there were notable effects matching the quantitative findings on contraceptive use, spousal communication, and marital violence. These findings support the value of adding a gender synchronized approach to family planning interventions focused on male engagement, to better engage women and enable provision of a broader array of effective contraceptives.

## Data availability

### Underlying data

openICPSR: CHARM Male Engagement Family Planning Intervention Study Data; Thane District Maharashtra, India, 2012–2014. <http://doi.org/10.3886/E100194V4><sup>23</sup>.

This project contains the following underlying data:

- CHARM-COUPLES-master-1-12-15\_no\_created\_variablesV3 (complete raw data from the quantitative aspect of the study).

- Copy-of-CHARM-Codebook (codebook used for the dataset).

We cannot provide the qualitative data because even de-identified, these data reveal detailed information on individual participants that can be identifiable (e.g., stories of marriage or family). However, requests for these data can be made by emailing [geh@ucsd.edu](mailto:geh@ucsd.edu), and including in the subject line “request for CHARM data.” Please include your research question, data analysis plan, and IRB approval with your request.

#### Extended data

openICPSR: CHARM Male Engagement Family Planning Intervention Study Data; Thane District Maharashtra, India, 2012–2014. <http://doi.org/10.3886/E100194V4><sup>23</sup>.

This project contains the following extended data:

- CHARM-baseline-Women-s-survey-with-descriptive-stats (containing questions to and pooled responses from women at baseline)
- CHARM-baseline-Men-s-survey-with-descriptive-stats (containing questions to and pooled responses from men at baseline)
- CHARM-9-month-Women-s-survey-with-descriptive-stats-3-26-14 (containing questions to and pooled responses from women at 9 months).
- CHARM-9-month-Men-s-Survey-with-descriptive-stats-3-26-14(containing questions to and pooled responses from men at 9 months).
- CHARM-Women-18-Month-Survey-with-descriptive-stats (containing questions to and pooled responses from women at 18 months).
- CHARM-Men-18-Month-Survey-with-descriptive-stats (containing questions to and pooled responses from men at 18 months).
- CHARM-IDI-GUIDELINES-VHPs (in-depth interview guidelines)
- CHARM-Variables-Log-1-12-15\_no\_created\_variables (details on variable codes used).

Please note that access to data hosted on openICPSR is unrestricted but will require free registration.

Data are available under the terms of the [Creative Commons Attribution 4.0 International license](https://creativecommons.org/licenses/by/4.0/) (CC-BY 4.0).

#### Grant information

This study was supported by the Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health, USA (grant numbers: R01HD084453-01A1 and R01HD61115); Department of Biotechnology, Government of India (grant #BT/IN/US/01/BD/2010); and Bill & Melinda Gates Foundation (grant #OPP1163682).

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#### Acknowledgements

The authors would like to thank the funders, the National Institutes of Health, US, Department of Biotechnology, Government of India, and the Bill and Melinda Gates Foundation. We wish to acknowledge the CHARM Research Team for their support, the village health care providers who conducted the CHARM intervention sessions. Finally, we appreciate the couples for their time in participating in the intervention study.

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# Open Peer Review

Current Peer Review Status:



## Version 1

Reviewer Report 26 March 2020

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**Kate Doyle** 

Promundo-US, Washington, DC, USA

The authors provide an interesting insight into the CHARM intervention, highlighting the feedback from male health care providers who implemented the intervention with men and couples in their communities. The article provides interesting insights, but could be strengthened - most particularly by a) further describing the rationale/approach/definitions of gender equity and male engagement that they employed; b) how this was reflected in the training and materials provided to the health care providers; and c) providing more insights into the opportunities and challenges of such an approach (both in the Results and the Discussion sections).

Introduction:

- The authors describe CHARM as a "gender equity" intervention and note that it has been described in greater detail in previous papers. I think it would be good to provide more information in this article for the authors/implementers to describe what their gender equity goals and approach are for CHARM and how this was operationalized within the intervention. It would also be helpful to include a box on the content of the intervention. This would provide the reader with a greater understanding of the depth to which the intervention aimed to promote gender equity.
- Within the paper it is clear that the intervention aimed to engage men as part of its GE approach, but it is not clear if a gender-transformative approach was used - i.e. one that sought to engage men in challenging and transforming inequitable gender norms (that may limit men's involvement in FP, but also hinder women's decision-making and autonomy over their FP choices). Throughout the article, the providers and authors refer to the importance of engaging men in their roles as decision-makers (a more 'instrumentalist' approach to engaging men). Greater description of the GE approach and rationale of the male engagement approach would be helpful to put into context the findings shared.
- Linked with the above, it appears that the intervention only worked with male health care providers. It would be great to provide more background to this - it can be assumed this is because the implementers believed men would be more easily reached/persuaded by male providers, but this is not explicitly made clear. It would be helpful to know if this was informed by formative research,

etc. It is also not clear what proportion of health care providers engaged in FP service provision in the locations of implementation are male - this information would be helpful to understand how the intervention operated within the local context.

- The authors note that "These findings are consistent with studies from other national contexts documenting the value of engaging male providers to deliver integrated FP and GE counseling to men." This statement is not factually accurate. Some of the studies included engaged male facilitators - but not health care providers - to deliver gender-transformative programming to men and couples, with the aim of promoting FP and GE. These studies speak more to the importance of gender-responsive or gender-transformative male engagement approaches, rather than the use of male facilitators/providers (which may be but one aspect of why those programs were successful). The statement could be made more factual.
- It would be good to provide more information on what the training for the health care providers entailed particularly from the GE standpoint. Were providers' own gendered attitudes challenged during the training? What supports were provided to the health care providers to discuss violence with their clients?
- I agree with a previous reviewer, that it would be helpful in the second paragraph to provide more background on the CHARM intervention - who is implementing, where, and when.

#### Methods:

- In the 'Interviews' section there is a grammatical error in the statement: "Audio recording was not utilized due to providers [note: should be providers'] discomfort with it."

#### Results:

- As noted by a previous reviewer, some of the quotes 'suggest additional points that would be worth highlighting'.
- In the 'At the Provider level' section, the authors note that despite extensive training and careful selection of providers, some still had gender biases. As noted above, it would be great to describe in more detail the training and selection process in the introduction.
- In the 'Contraceptive knowledge, communication and use' section, there are some very important reflections on the importance of promoting couple communication and the providers' feedback on this. It would be wonderful to expand upon this and have this be of greater focus in the article.
- The article highlights some of the challenges that the providers described during their interviews, but not all of these are referenced in the 'Recommendations' section. It would be wonderful to highlight/add any of the suggestions that they had for how to overcome these challenges.
- In the 'Delivering the CHARM intervention' section there is a grammatical error in the statement: "They also felt that the flipchart provided to them for [note: 'the' is missing] intervention helped convey messages in an [note: remove 'in an'] effectively to the participants who had limited ability to read."

- In the 'Delivering the CHARM intervention' section there is a grammatical error in the statement: "They used to feel shy after listening to topics like condom, IUD, or menstruation and all". [Note: period is missing after all, and the quotations should be reversed.]

Discussion:

- As noted by a previous reviewer, 'There is no mention of any findings related to potentially negative effects on women of the intervention, and it is not clear whether this was because the providers were not asked about this or because providers did not talk about it.' It would strengthen the paper to provide any insights that were gleaned from the providers on this point and to address this in the discussion section.
- The discussion section could also be strengthened by referring to additional sources (such as those cited by Holmes in her review) and through further reflection similarities/differences in findings from the other male engagement FP approaches the authors cite in the introduction.

**Is the work clearly and accurately presented and does it cite the current literature?**

Partly

**Is the study design appropriate and is the work technically sound?**

Yes

**Are sufficient details of methods and analysis provided to allow replication by others?**

Yes

**If applicable, is the statistical analysis and its interpretation appropriate?**

Not applicable

**Are all the source data underlying the results available to ensure full reproducibility?**

Yes

**Are the conclusions drawn adequately supported by the results?**

Partly

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Male engagement; Gender-transformative approaches; Reproductive, maternal, newborn and child health; qualitative methods

**I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.**

Reviewer Report 11 December 2019

<https://doi.org/10.21956/gatesopenres.14134.r28278>

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**Wendy Holmes**

Nossal Institute, School of Population and Global Health, University of Melbourne, Melbourne, Vic, Australia

Within a randomized controlled trial of an intervention to increase men's engagement in family planning the researchers undertook a qualitative study using in-depth interviews to seek the views, knowledge, attitudes and experiences of the male providers of counselling about contraception, and topics related to gender equity such as shared decision-making and partner violence.

The authors have made a valuable contribution to efforts to reach international goals to increase use of contraception and to engage men more in sexual, reproductive, and maternal health more generally.

*Introduction:*

- The introduction appropriately begins by noting the high number of women, globally, that lack access to modern contraceptives, but the data referenced is from 2014. More recent data is available reflecting recent progress and the figures given could be updated (United Nations, Department of Economic and Social Affairs, Population Division (2019). *World Contraceptive Use 2019* (POP/DB/CP/Rev2019).)
- The rationale in the Introduction could be strengthened by referring to the 2030 Agenda for Sustainable Development, target 3.7: "By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes", and to the need to inform the efforts of partnerships that contribute to reaching this target, such as Family Planning 2020 and FIGO (the International Federation of Gynecology and Obstetrics, <https://www.figo.org/news/global-unmet-need-modern-contraceptives-0016065>).
- In the second paragraph of the Introduction it would be helpful to know who is implementing the CHARM intervention program and when it began. Rural Maharashtra is mentioned in the first paragraph of the Methods section, but I think it is worth also mentioning in the introduction rather than simply "in India".

*Methods section:*

- The descriptions of the conduct of the interviews and the data analysis are good and clear, and the methods used were appropriate. It would be helpful to have a short description of how the question guide was developed.

*Results:*

- There is a useful description of the health care providers, but it is worth mentioning again here that they were all men. This is a relevant fact that is mentioned briefly only once in the Methods section.
- The choice of illustrative quotes is good, but some quotes suggest additional points that would be worth highlighting.
- For example, the quote after "At a personal level, health care providers felt that CHARM increased their clientele" suggests more than this. It suggests that the program enabled good patient-provider relationships and that the counselling acted as an entry point to other health care services. It is worth noting that this is significant because men are less likely than women to have contact with

health services, and the increase in chronic diseases makes it important that men feel comfortable to visit a doctor for detection and management.

- It was interesting that a few providers felt that sterilisation camps would be most useful. This suggests that providers' past experience will influence their attitudes, and that this is worth addressing in such programs.
- Sometimes quotes raise questions that it would be helpful to address, for example, "*Our clinics are not such that there are closed rooms, this disturbance was present, so we had to adapt to it.*" It would be useful to know how they adapted to it. The quote illustrating the point 'Some also felt that pregnant women were not in need of the intervention since it was not immediately relevant' raises the question whether counsellors talked with couples about possible future use of contraception.
- The quote under the sub-heading "Limited participation of women" is more about limited participation by couples rather than women.
- There is no mention of any findings related to potentially negative effects on women of the intervention, and it is not clear whether this was because the providers were not asked about this or because providers did not talk about it.

#### *Discussion:*

- The Discussion section is good but could usefully be expanded.
- I think it is worth mentioning here that involving men in family planning is a useful entry point to increasing their engagement in reproductive and sexual health more generally.
- The potential to inadvertently cause harm by reducing women's autonomy in care-seeking and decision-making and the need to avoid reinforcing gendered stereotypes of men as the decision-makers should also be discussed (WHO recommendation on interventions to promote the involvement of men during pregnancy, childbirth and after birth (2015). WHO Reproductive Health Library; Geneva: World Health Organization.). The important finding that men's participation led to sharing information with their wives could be mentioned further in relation to this point.
- Several points in the findings, such as the influence of family and community in relation to son preference, and the provider's suggestion that husbands should be given information in their villages, highlighted the need for greater community advocacy and this could be a recommendation in the Discussion. In particular, the need to work with older men and women to change attitudes could be recommended.

#### *References:*

There is a reasonable range of references, but not very comprehensive. Although this is not a systematic review I think there are benefits to including some more examples of similar work in order to convey the level of interest and significance of engaging men in reproductive and sexual health, including in family planning. For example:

- World Health Organization (2010<sup>1</sup>).
- Char (2011<sup>2</sup>).

- Sharma *et al.* (2018<sup>3</sup>).
- Adelekan *et al.* (2014<sup>4</sup>).
- Kura *et al.* (2013<sup>5</sup>).
- Kabagenyi *et al.* (2014<sup>6</sup>).
- Bloom *et al.* (2000<sup>7</sup>).
- Bishwajit *et al.* (2017<sup>8</sup>).

Efforts to increase men's engagement in family planning are also important because it is a valuable entry point to their greater involvement in antenatal and postnatal care, and in the prevention of STIs and HIV:

- Davis *et al.* (2013<sup>9</sup>).
- Singh and Ram (2009<sup>10</sup>).

#### Writing:

- On the whole the paper is well-written but could benefit from some editing for clarity and to reduce some instances of repetition. For example, "Trained providers first implemented FP counselling to husbands in two sessions," would be better as: "Trained providers first counselled husbands about FP in two sessions." And "A third final session was inclusive of both the husband and wife..." would be better as "A third final session included husband and wife...".
- "Gender equity" is an important concept and I think worth writing in full because some readers will not recall what GE stands for. There is also some inconsistency because there are also some uses of "gender equity" in full.
- In the third sentence of the paragraph "Interviews" there is a typo: "The interviews collected information..." rather than "The interviewers...".

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**Is the work clearly and accurately presented and does it cite the current literature?**

Partly

**Is the study design appropriate and is the work technically sound?**

Yes

**Are sufficient details of methods and analysis provided to allow replication by others?**

Yes

**If applicable, is the statistical analysis and its interpretation appropriate?**

Not applicable

**Are all the source data underlying the results available to ensure full reproducibility?**

Yes

**Are the conclusions drawn adequately supported by the results?**

Partly

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Reproductive health; Women and children's health; healthy ageing; qualitative methods.

**I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.**

Reviewer Report 23 September 2019

<https://doi.org/10.21956/gatesopenres.14134.r27800>

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**Seema Sahay**

ICMR-National AIDS Research Institute (NARI), Pune, Maharashtra, India



This study delves on gender equity which is an important area of study especially when it is considered in context of male involvement in the family planning issues. The authors have used qualitative research methods and the study highlights the role of health care providers on family planning among young married couples. The authors have been able to show the strengthening of capacities of HCPs to provide family planning services. The study is linked to a trial. In context of the CHARM intervention, some of the comments/suggestions are as follows:

1. A brief description of topics covered under CHARM can be added in the methods section. This would assist readers in understanding the context of the findings.
2. Since this is a qualitative study, I see a limitation of using only IDI. There is a need for triangulation: It would add strength if beneficiary data was also added otherwise the results are difficult to hold. It would be prudent to have something (even if it is from a larger study...either refer if published or add the information) to show confirmation of what HCPs are saying. This would add methodological strength to the paper.
3. Men being the key decision makers in India, still data in this paper shows limited participation of women. Only being busy with work cannot be the reason for a woman not accompanying her husband if he asks her. What could be the gaps and was it explored? This needs to be elaborated and presented to show couple's communication issues. It will also inform CHARM intervention for future improvisations.
4. Biases due to provider's views on marriage etc. have been discussed in the discussion section but strong data needs to support this. Results do not augment this.
5. The authors have critically discussed limitations such as surgical procedures/IUD insertion. However, integration of AYUSH for FP is an important recommendation by the authors. But it seems this is concluded based on implementation of CHARM by the AYUSH HCPs. Example: "*... I'm satisfied that I explained this information to such people.*" What was the response? The authors talk about 'little impact'. This requires more supportive data in terms of both argument and counterargument.
6. The results are tilted towards AYUSH practitioners. The authors can use allopathic HCP's data to provide reliable findings.

**Is the work clearly and accurately presented and does it cite the current literature?**

Yes

**Is the study design appropriate and is the work technically sound?**

Partly

**Are sufficient details of methods and analysis provided to allow replication by others?**

Yes

**If applicable, is the statistical analysis and its interpretation appropriate?**

Not applicable

**Are all the source data underlying the results available to ensure full reproducibility?**

Partly

**Are the conclusions drawn adequately supported by the results?**

Partly

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Social and Behavioral Research, Qualitative Research

**I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.**

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