Engaging men for improved family planning and nutrition outcomes

REFLECTIONS FROM A TWO-YEAR JOURNEY TO DESIGN AND LAUNCH PROGRAMS IN RURAL BIHAR

January 2020 - June 2022

engagemen.in

PCI + Dalberg

Supported by

Bill & Melinda Gates foundation

Table of contents

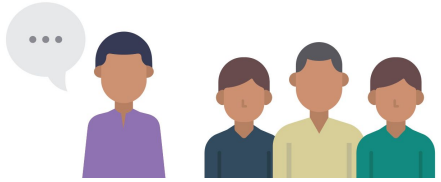
Note: This document contains a condensed version of our report. Find the complete report with all sections at engagemen.in

1 PREMISE: WHY ENGAGE MEN?

PCI + Dalberg

PREMISE: WHY ENGAGE MEN?

Rationale and opportunity



Engaging men in health and nutrition programming provides an opportunity to move towards better health and gender outcomes.

Historically, the development sector has anchored on family planning and nutrition programs that focus on women, both as end-users and as providers (e.g. ASHAs, ANMs, SHGs)[1]. While many of these programs have seen considerable success in their outcomes, challenges have emerged in the long-run:

1. **A disproportionate burden** has been put on women, both as end-users and as the ones to deliver health programs.
2. **These programs reinforce the imbalanced gender norms** that underlie women's unpaid care work and time poverty, and relatedly their mobility and workforce participation.[2]
3. **Men have been further alienated** from the *"female"* domains of family planning and nutrition.[3]

Evidence shows positive improvements in health, nutrition, and gender outcomes when men's engagement increases, but falls short of showing lasting behaviour change at scale. There is a need for innovative programs that can fill this gap.

[1] Morgan, R., Ayiasi, R. M., Barman, D., Buzuzi, S., et al. (2018, Jul 6). Gendered health systems: Evidence from low- and middle-income countries. Health Res Policy Syst, 16(1), 58.
[2] Ved, R., Scott, K., Gupta, G., Ummer, O., Singh, S., Srivastava, A., & George, A. S. (2019, Jan 8). How are gender inequalities facing India's one million ASHAs being addressed? Policy origins and adaptations for the world's largest all-female community health worker programme. Hum Resour Health, 17(1), 3.
[3] Vouking, M. Z., Evina, C. D., & Tadenfok, C. N. (2014). Male involvement in family planning decision making in sub-Saharan Africa: What the evidence suggests. Pan Afr Med J, 19, 349.

PREMISE: WHY ENGAGE MEN?

Final programmatic solutions

PCI India and Dalberg, with support from the Bill & Melinda Gates Foundation, set out in 2019 to answer the question: *How might we engage men in nutrition and family planning through innovative and gender transformative programs in rural Bihar?* Our two-and-a-half-year journey of research, design and testing culminated in two innovative programmatic solutions:

1. Dekh-Rekh provides parents the tools to visualise their nutrition habits and relate them to their aspirations, along with a financial planning course. This encourages them to have more conversations on food choices and make more informed and collaborative decisions on what they purchase, prepare and feed their children.

2. Hamari Shaadi, Hamare Sapne uses a financial education course to help newly-wed couples better understand how they can achieve their aspirations. This serves as a platform to incorporate conversations on family planning, delaying, spacing and limiting as a way to reach their financial goals.

Note: This work builds on the learnings from ICRW and Vihara's Couple Engage project; along with multiple other organisations working in the space of family planning, nutrition and male engagement, including Promundo, PATH and IFPRI.

2

PROCESS: DESIGNING THE PROGRAMS

PROCESS

Our interdisciplinary approach

1. HUMAN-CENTRED DESIGN RESEARCH AND CO-CREATION

We conducted in-depth interviews, small group discussions & ideation sessions, intercept interviews, observations and shadowing with a diverse mix of **92 participants in two districts of Bihar** (see details). We engaged with couples, their families, and other stakeholders across the ecosystem to uncover their needs, behaviours and aspirations, understand their reactions to early ideas, and generate nuanced insights.

2. BEHAVIOURAL SCIENCE

We used behavioural frameworks to understand couples' aspirations and motivations. We ideated rigorous **behaviourally-informed solutions** for male engagement to drive nutrition and family planning outcomes, organised around knowledge, motivation, and enabling environments, and developed **impact pathways** to keep us anchored to the behaviour change frameworks.

3. LITERATURE REVIEW & EXPERT INTERVIEWS

We conducted a literature review of **40 reports and studies** (see details), as well as learnings on couples' engagement in family planning generated by ICRW and Vihara. This helped us identify actionable learnings on program design and men's behaviour that formed the basis of our program ideas. We also interviewed **six sectoral experts** (see details) to gain a swift understanding of the evidence landscape.

4. RAPID PROTOTYPING

Rapid prototyping enabled us to stress-test the key features and interactions of the programs in real-world conditions and further refine the program design. We conducted this live prototyping of the programs with **10 diverse couples** and **11 community stakeholders.**

5. PROOF-OF-CONCEPT

We rolled-out and assessed the full programs with **almost 2000 couples participating**, and used a qualitative and quantitative data collection approach to assess the programs' effectiveness in delivering on outputs, and get early indications of their influence on behaviours and outcomes. Learnings gathered during this stage helped us make final refinements to the programs and their implementation.

6. COMMUNITY PARTICIPATORY RESEARCH

At various points in our journey, we collaborated with **community representatives as partners for research, design, and testing**. Community representatives were closely involved with gathering feedback and sharing their learnings to inform refined programs during the prototyping and proof-of-concept phases. Community participatory research served not only as a way to gather rich insights, but also to shift power dynamics between stakeholders.

PCI + Dalberg

PROCESS

Summary of key insights

1 Financial planning as a gateway

- Using financial planning as an entryway offers couples the license to discuss family planning without the stigma.
- Financial planning also shifts the perception that nutrition habits are rooted in affordability, and hence unchangeable.

2 Spousal communication and decision making

- Couples get their information on child nutrition and family planning in silos, with little opportunity to discuss and make decisions together. This, along with strictly divided household gender roles, drives the gap between awareness and action.

3 Program delivery through couples

- Young couples find comfort in speaking with other married couples, who they perceive as “role models”, about topics like child health, financial and family planning.
- Receiving information on these topics together as a couple opens up a trusted space for spousal communication.

4 Cross-generational behaviour change

- Food and family planning are household decisions, with older family members influencing young couples’ choices.
- At the same time, older family members are amenable to change, and are particularly motivated when they can see how family planning and food choices relate to financial goals and improvements in child health.

PROCESS

Summary of key insights

5 Generating social proof

- Young couples are influenced by the opinions of their peers and socio-cultural norms that protect existing gender roles.
- Providing visual cues of the program in the community and the support of other community members can generate social acceptance of new behaviours, lead to sustained change and mitigate backlash.

6 Edutainment for deeper engagement

- Gamification of program features makes it easier for parents to stick to the habit of tracking their children's nutrition and offers visible cues of progress. Weekly feedback on parents' progress keeps them accountable and motivated.
- Introducing family planning concepts through relatable characters and audio-visual stories makes it more engaging and accessible for couples and their families, and helps them apply these concepts to their own lives.

7 Digital channels for wider reach

- Digital channels help override the tentativeness that communities feel about welcoming outsiders and attending group meetings during the COVID-19 pandemic.
- Digital channels ensure that couples are not left out of programs when one partner migrates, or families have to travel during special events.

Pathways to behaviour change

The programs are grounded in social and behaviour change models, organised around knowledge, motivation, and enabling environments – and adapted from the Fogg behavioural model. We also drew from the Integrative Model of Behaviour Prediction and Socio-Ecological Model of Behaviour Change.

PCI + Dalberg

PROCESS

Structure of the impact pathways

Each program has clear and specific impact pathways. They outline relevant barriers, outputs, nudges, behaviours, and outcomes to keep us anchored to the behaviour change frameworks.

Where are we intervening?

BARRIERS →	OUTPUTS +	NUDGES →	BEHAVIOURS →	OUTCOMES
Existing circumstances that prevent individuals from acting towards improved family planning or nutrition outcomes; categorised as falling within the buckets of knowledge, motivation, or enabling environments	Direct results of activities undertaken within programs, observed at the level of individual users and their households; categorised as falling within the buckets of knowledge, motivation, or enabling environments	Intentional triggers in the programs' designs to ensure individuals move from intention to action	Desirable actions users undertake as a result of increased knowledge, motivation, or ease of use due to a more conducive enabling environment	Longer-term health and nutrition objectives the programs aim to accomplish

PROCESS

Pathways to men's engagement in nutrition

BARRIERS

KNOWLEDGE
- Low awareness of need for regular intake of nutritious food for each household member
- Low awareness among food purchasers of actual preparation and consumption habits of each household member
- Low awareness of the health consequences of poor nutrition or lack of dietary diversity

MOTIVATION
- Perception of changes to food habits as costly
- Perception of nutrition as remedial or only worth considering in times of pregnancy, childbirth, and illness
- Perception of nutrition as the woman's responsibility
- Limited time available for nutrition-focused activities (especially to cater to child nutrition) due to unpaid work burdens or long working hours

ENABLING ENVIRONMENT
- Notions of unsuitability of certain foods for women and children, perpetuated by household and community members
- Lack of cheap healthy alternatives to existing foods purchased by men for children
- Gender-based availability of information on nutrition from health and service providers

OUTPUTS

KNOWLEDGE
- Increased awareness among men of nutritional needs of household members
- Increased awareness among decision-makers of which family member consumes which food at what intervals

MOTIVATION
- Increased men's perception of nutrition as being important to work towards
- Increased perception among household members of the regular need for nutritious food
- Increased value attached by men to specific needs for pregnant/lactating women
- Improved parental perception of suitability of diverse food items for children

ENABLING ENVIRONMENT
- Engagement of household members to sanction couples' participation, challenge norms, and channel aspirations
- Engagement of SHG members to reinforce messaging and build broader support
- Engagement of community leaders to reinforce positive behaviours and challenge norms

MOTIVATION
- Increased perception among decision-makers of diet changes as affordable
- Improved allocation of resources by households for procurement of nutritious food

ENABLING ENVIRONMENT
- Availability of tasty nutritious food options for purchasers

KNOWLEDGE
- Increased knowledge of preparation techniques for nutritious foods

MOTIVATION
- Increased consideration of household members' food preferences by men

KNOWLEDGE
- Increased parental awareness of specific feeding requirements for children
- Increased understanding among household members of the effects of food consumption on health

NUDGES

- Reduced cognitive load due to use of familiar digital interfaces
- Ease of adoption due to piggybacking on existing behaviours
- Minimized present bias due to use of commitment mechanisms
- Enhanced trust due to use of trusted figures to dispel misinformation and boost motivation
- Reinforcement of need to act through visual aids and calls to action
- Sustained engagement through micro non-financial incentives and social recognition

BEHAVIOURS

PROCURING
Men produce or purchase nutritious food to ensure sufficient availability of diverse food groups in the household on a daily basis

PREPARATION
Men promote nutritious food preparation and consult with their wives who make decisions on household food preparation

FEEDING/ CONSUMPTION
Men and women jointly ensure that children and women eat meals of minimum diet diversity at recommended frequencies

OUTCOMES

DIET DIVERSITY FOR THE HOUSEHOLD
- Improved diet diversity for young women, particularly pregnant women and lactating mothers
- Increased initiation and completion of exclusive breastfeeding
- Improved diet diversity for children under 2 years, particularly those between 6 and 12 months

Note: Our programs operate within but are not designed to address such structural constraints as extreme poverty, supply-side constraints, and legal mandates

PCI + Dalberg

PROCESS

Pathways to men's engagement in family planning

BARRIERS

KNOWLEDGE
- Low awareness about need and benefits of family planning, particularly of delaying and spacing of children
- Myths and misconceptions about various family planning methods, including on side-effects of use
- Low awareness about availability and access to family planning methods

MOTIVATION
- Perceived lack of stigma-free avenues for discussion, education, or adoption of family planning methods
- Negative associations of family planning methods such as condoms or male sterilisation
- Lack of agency to discuss or decide on family planning goals and methods

ENABLING ENVIRONMENT
- Incentive-based method promotion from health providers
- Gender-based availability of information on family planning from health providers
- Lack of positive examples or role models for men to emulate in terms of family planning uptake
- Perceived pressure from families to prove fertility and achieve son preference

OUTPUTS

KNOWLEDGE
- Improved knowledge of the menu of family planning options, including cost, side-effects, and benefits of each method

MOTIVATION
- Increased agency to make choices that are best suited to a couple's needs
- Reduced perceived pressure on new couples to prove fertility through early childbirth
- Reduced pressure from men and their family members to achieve son preference
- Increased perceived family support for planning for small families

ENABLING ENVIRONMENT
- Explicit invitations to men to engage with health providers on family planning
- Engagement of household members to reduce pressure to prove fertility and achieve son preference
- Creation of role models for men to learn from and emulate

KNOWLEDGE
- Improved knowledge of family planning benefits

MOTIVATION
- Connection between family planning and life aspirations

MOTIVATION
- Increased perceived acceptability of different methods

KNOWLEDGE
- Improved knowledge of availability/access of different methods

MOTIVATION
- Increased perceived acceptability of method purchase

KNOWLEDGE
- Improved knowledge of how to use chosen family planning method while minimising side-effects

MOTIVATION
- Increased perceived acceptability of discussing family planning outside the family
- Improved attitude to receiving family planning advice

NUDGES

- Reduced cognitive load due to use of familiar digital interfaces
- Ease of adoption due to piggybacking on existing behaviours
- Minimized present bias due to use of commitment mechanisms
- Enhanced trust due to use of trusted figures to dispel misinformation and boost motivation
- Reinforcement of need to act through visual aids and calls to action
- Sustained engagement through micro non-financial incentives and social recognition

BEHAVIOURS

GOAL-SETTING
Men discuss family planning intent with their wives and jointly set goals

METHOD CHOICE
Men and women jointly choose appropriate family planning methods

PROCURING
Men purchase or support their wives in accessing appropriate methods

USE
Men regularly use or encourage their wives to use appropriate methods

ADVOCACY
Men encourage peers to discuss and adopt family planning with their wives

OUTCOMES

FULFILLMENT OF COUPLE'S FAMILY PLANNING GOALS
- Delaying of first child to 2 years after marriage and spacing of at least 3 years between children
- Limiting of family size through gender-equitable adoption of family planning methods

Note: Our programs operate within but are not designed to address such structural constraints as extreme poverty, supply-side constraints, and legal mandates

3

PROGRAMS: DEKH-REKH AND HAMARI SHAADI, HAMARE SAPNE

PCI + Dalberg

1

Dekh-Rekh

NUTRITION

Make healthy habits your family goal

Couples are provided with tools to visualise their nutrition habits and relate them to their aspirations, along with a financial planning course.
This encourages them to have more conversations on food choices and make more informed and collaborative decisions on what they purchase, prepare and feed their children.

2

Hamari Shaadi, Hamare Sapne

FAMILY PLANNING

Build savings, build a 'happy family'

Newly-wed couples enrol in a financial education course that helps them better understand how they can achieve their aspirations. This serves as a platform to incorporate conversations on family planning, delaying, spacing and limiting as a way to reach their financial goals.

Note: Learn more about our process to prioritise these programs and our other early program designs here.

PCI + Dalberg

PROGRAMS: DEKH-REKH

Designing program features

MOTIVATION

- **Building accountability**: Weekly visits by CRPs hold parents accountable for tracking their child's nutritional intake. CRPs may suggest potential roles to the couple based on their current practices, while leaving them enough agency to make the final decision.
- **Novelty of program materials:** Before enrolling in a program, parents look out for short-term benefits (such as rations to support their child's nutritional needs). However, long-term behavioural change will require enrolled couples to build nutritional habits that can be self-sustained. Program materials such as a tote bag, calendar, photo frames can incentivise program compliance and build excitement about receiving nutritional information through novel tools.

KNOWLEDGE

- **Reducing cognitive load:** Parents can feel overwhelmed with the multiple features of a program and the amount of new information they are receiving. Allowing sufficient time for the onboarding process and introducing new features in phases can reduce their cognitive load and encourage compliance.
- **Holistic nutrition and purchasing information**: Parents are hungry for holistic nutritional information as they progress along the program journey. Equipping CRPs with easy-to-follow guidance on various aspects of nutrition, such as quantity of food, texture of food, etc. can answer parents questions and avoid risks of oversimplification by anchoring on dietary diversity alone. Changing food choices may appear more expensive than it actually is as purchase is driven by perceived affordability, rather than nutritional value. CRPs should guide parents with strategies to hit their nutritional goals while staying within their budget.

ENABLING ENVIRONMENT

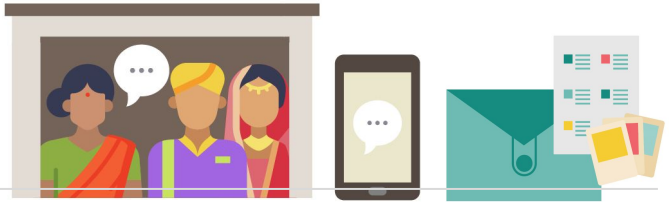
- **Building trust with CMs and SHG members:** CMs and SHG members are excited about the program but are concerned that it will amount to additional work for them. Furthermore, SHG members are concerned about CRPs taking over responsibilities that they think of as their own. Orienting SHG members about their crucial role in the program and the benefits they will receive (social recognition, improved health of family members) will help generate buy-in.
- **Partnering with other health programs:** CRPs can partner with VHSNC members to reinforce the program's benefits in the community and follow up with couples for sustained behaviour change after the program ends. CRPs can leverage the relationship VHSNC has with SHG members to build trust.

Note: These insights are based on user research, prototype testing and literature review

PCI + Dalberg

PROGRAMS: HAMARI SHAADI, HAMARE SAPNE

Designing program features



MOTIVATION

- **Signalling credibility:** Credibility is essential for couples to trust CRPs. Introducing the program as endorsed by external organisations like PCI might help signal credibility, particularly to educated couples that already have fundamental financial and family planning knowledge and are keen to receive additional information beyond local resources. At the same time, CRPs will need to remain approachable to low-literacy couples by signaling endorsement from SHGs and local health care workers (that couples tend to trust) to boost openness to participation.

- **Encouraging spousal communication:** Prevailing socio-cultural dynamics make it challenging for recently married women to share their opinions when disagreeing with their husbands in front of strangers. CRP facilitated activities, like the question-answer booklet that couples fill out separately and then discuss, enables more open sharing and sparks conversations about differing opinions. The program can promote open communication between spouses as a fun activity and one that is good for the relationship and its longevity, e.g. via the audio/video narrative. This can help address women's concerns that voicing their ideas and desires may be seen as challenging their relationship with their husbands.

- **Building on existing desires:** Newly-wed couples are keen to get to know each other in the early months of their marriage. There is enthusiasm to plan their new family's finances and meet their aspirations for themselves and their future children. Newly-wed couples spend time together and often use phones for entertainment, particularly at night in the privacy of their bedroom. Initiating the program when couples are excited to get to know each other and designing program features that leverage phones will go a long way in onboarding.

KNOWLEDGE

- **Connecting couples to credible health resources:** Connecting couples with resources to access contraceptives relevant to their goals can address the intention-action gap. For example, CRPs may connect interested couples with health workers such as ASHAs and ANMs at the right time in the program based on the couple's readiness to action their goals (e.g. by providing their phone number or making an in-person introduction if appropriate). CRPs should be trained to remain alert to the needs of the couple.

ENABLING ENVIRONMENT

- **Building trust with CMs and SHGs:** Engaging CMs and SHGs remains crucial for the success of the program. However, there is a risk of backlash as SHG members might be skeptical about new family planning programs, particularly due to the historical promotion of female sterilisation and singular focus on limiting. CRPs should introduce family plannings as the means to achieving financial goals, and use that framing to gradually build comfort with talking about family planning.

- **Engage the broader health ecosystem:** CRPs can establish trusting relationships with healthcare workers (ASHA, ANM) by demonstrating how the program can benefit them. CRPs can encourage healthcare workers to use program material for building community awareness and reinforcing the goal of the program. Establishing collaborative relationships with healthcare workers at the program's start will help connect them to the couples ready to receive further information about contraceptives.

Note: These insights are based on user research, prototype testing and literature review

Learnings from community engagement

The following section outlines how community partnerships have been used to support the delivery of the programs, and lessons from these partnerships.

LEARNINGS FROM COMMUNITY ENGAGEMENT

1

Role and recruitment

Community resource persons are couples who deliver the programs to enrolled couples and belong to the same communities as them. CRPs have typically been married for a few years, so that enrolled newly-wed couples can look up to them, while remaining accessible and trustworthy to talk to about sensitive issues.

ROLES AND RESPONSIBILITIES

CRPs conduct block-level activities to build awareness about the program and work closely with JEEViKA and SHGs to recruit eligible couples. CRPs build familiarity with enrolled couples and their families over the first few weeks and introduce them to the program and activities. CRPs visit the enrolled couples on a weekly basis to engage them in program activities and materials and facilitate conversations about nutrition/family planning. CRPs also provide enrolled couples with feedback on their progress and connect them to resources to get further information (local health care workers etc.)

Through their role, CRPs engage the enrolled couples throughout the program and facilitate a safe, trusting space to talk about their nutritional and family planning needs, aspirations and challenges.

IDENTIFYING CRPs

Potential CRPs can be identified with the support of the JEEViKA platform and other community groups (e.g. VHNS committees). Couples with some experience in delivering nutrition or family planning-related information would make a good fit for the role. However, prior experience is not mandatory, as CRPs receive in-depth training about the programs.

CRPs are required to have basic literacy to read and interpret program documents and document and report back on program activities.

Additionally, CRPs need to travel to enrolled couples' locations, so those having access to some means of transportation are preferred.

However, enthusiasm for the program and a commitment to community welfare are the biggest requirements for the role.

LEARNINGS FROM COMMUNITY ENGAGEMENT

2

Training recommendations

CRPs and other on-ground staff will need to be trained on program objectives, materials, timelines and delivery logistics. Listed below are a few recommendations on the approach to CRP training.

ENSURE TRAINING FOR CRPS IS INTERACTIVE

Making a training interactive helps with retention and deepens the CRPs' engagement with the concepts. Options include role playing sessions, asking CRPs to play back details of the programs to the trainer, assigning "homework" like thinking of challenges they might face on the field and potential solutions, etc. Allowing space for interactivity requires an investment in longer training sessions. Account for additional time needed to review translations of the programs and training material in local languages.

PROVIDE ONGOING TRAINING TO CRPS

Understanding and getting comfortable with the entire program in one training alone places a significant mental load on CRPs, particularly since the program curriculum involves new content each week. CRPs require training that is broken up into smaller parts. Provide ongoing training to CRPs, that are "just in time" and in the form of sessions that are easily digestible and relate to their upcoming series of activities. Provide a list of FAQs to help with common challenges that CRPs might face. Consider setting up WhatsApp groups with CRPs and their coordinators for regular communication on the challenges faced and for on-the-go problem solving.

PROVIDE WRITTEN MATERIALS THAT FOCUS ON DAILY OR WEEKLY ACTIVITIES

Include steps the CRPs need to undertake the activities of that day/week, questions they need to ask participants and information they need to provide them, as well as space for general note-taking, recording of questions they got from participants, and problems the CRPs had to encounter and can thus follow up on. Coordinators felt that this structure would enable CRPs to share in-time learnings with their team/supervisors and keep track of changes in specific couples over time.

EMPHASISE NEUTRAL AND NON-JUDGMENTAL MINDSET

CRPs are the face of the program for participants and are thus critical to the programs' success. In such settings, it is essential that they remain non-judgmental and are perceived as such. CRPs should be trained to create an environment in which couples feel comfortable being honest with them when they have not been able to complete the program's activities. This might be achieved by demonstrating altruistic intentions, which helps build participants' trust.

3

LEARNINGS FROM COMMUNITY ENGAGEMENT

CRP: Do's and Don'ts

While trainings often cover what trainees should "do", the sensitive and personal nature of gender dynamics and behaviour change means that training on what CRPs should "not do" is equally important.

DO'S

- Provide a **thorough introduction** of yourself in order to build trust and familiarity with the couples
- Be respectful of **the couple's privacy** and unique dynamics with their family.
- Build rapport with the couple by **connecting with them** on details of their life beyond the program (eg. agriculture, neighbourhood)
- **Engage both husband and wife** actively in the sessions. Take note if either are participating less actively, potential reasons for this, and strategies to counteract this (e.g. counteracting disinterest with more interactiveness, counteracting discomfort with open discussion by having one CRP take other family members out of the room)
- Make an active effort to **involve other members of the family** during the onboarding process and beyond that with the couples discretion, as part of building buy-in

DON'T'S

- While the programs focus on male engagement, **do not prescribe roles** to husband and wife. Ask about their current roles, emphasise why it is important for the husband to participate in nutrition/family planning, and suggest how others have divided responsibilities (i.e. wife cooks, and husband puts stickers), but provide agency for the couple to decide what works best for them
- Don't involve older family members in the sessions without the **consent of the couple** (training should include strategies of how to handle this sensitively)
- Don't provide answers to the couples in sessions. Provide prompts to push the conversation forward, but refrain from **imposing the "right solution"** so that couples engage in the content themselves
- Make couples **feel empowered** and help them focus on possibilities and what is in their control, rather than focusing on fears/worst-case scenarios that might leave the couple feeling helpless (when talking about budgets and expenses)
- Don't respond to participants' **technical questions** if you don't have the right information. Tell them you will get back to them, and check with a qualified authority or connect them to the right resource.

LEARNINGS FROM COMMUNITY ENGAGEMENT

4

CRP: Needs and support

The sensitive nature of the program means that the CRPs delivering it need sustained support to set them up for success and mitigate backlash.

ENSURE CRPS HAVE THE TECHNOLOGY THEY NEED FOR SUCCESS

Both programs utilise a video-based curriculum and CRP-facilitated engagement model, in which couples watch videos together with the CRP. This model requires access to a smartphone. Given smartphone access is likely to vary among participants, CRPs should be outfitted with a smartphone that is sufficiently set up to access and playback the curriculum videos.

ENSURE CRPS RECEIVE FAIR PAY

Since both husband and wife deliver the program, CRP couples' other opportunities for household income are reduced. Furthermore, the delivery of programs requires intense time and resource investment with weekly visits to participant homes, significant training time, and sustained follow-ups with participant couples. To value CRP's efforts, and make this role sustainable for couples to perform, consider paying CRPs a competitive rate above the minimum daily pay rate as recommended by the government.

DESIGN IMPLEMENTATION CALENDAR WITH FLEXIBILITY AND LOCAL HOLIDAYS IN MIND

Keep in mind local holidays and disruptions (e.g. monsoon, harvest season) and how this may affect CRPs ability to operate efficiently in the field. Train CRPs to agree explicitly on the timing of their next visit with each family, and build in buffer time into their fieldwork schedules so that CRPs have bandwidth to follow up with participants if they are unexpectedly unavailable during their agreed time.

PROVIDE CRPS WITH TIMELY SUPPORT AND COUNSELING WHEN FACED WITH BACKLASH

CRPs deliver programs that deal with the personal nature of spousal dynamics and societal pressures to perform specific gender roles. This poses considerable risk of backlash for CRPs, at the cost of their own reputation in the community. While the program incorporates strategies to mitigate backlash (e.g. signaling credibility by associating with SHG, extensive time spent on building trust with households), timely support and counseling must be available to CRPs in case of reprisal. The program team should accept that the demands of the CRP role might be challenging for some couples despite the support provided and prepare for CRP dropouts rather than putting CRPs through uncomfortable situations that can have lasting impacts on their lives beyond the program.

LEARNINGS FROM COMMUNITY ENGAGEMENT

5

Additional community partnerships

Partnerships with community groups and leaders (like JEEViKA/SHGs, VHSCNC, frontline workers) can help with functional aspects of the program, like enrolling couples, as well as with building community trust and buy-in.

ROLES

Identify eligible participants. Community partners like JEEViKA can identify couples who meet the criteria for enrolment in the program. Because they are trusted in the community, by both men and women, it can also be easier to approach potential participants through them.

Awareness building. Various community channels like kirana stores, SHG meetings, can be partnered with to build awareness about the program.

Family and community buy-in. Support of community leaders such as VHSCNC members can make it safer and easier for CRPs to run the program. This buy-in is also an important part of the enabling environment that can improve behavioural outcomes.

Additional program delivery support. There are certain roles that CRPs cannot play. For instance, for the family planning program, frontline workers were needed to deliver technical information and contraceptives.

Rewards and recognition. Partnering with community leaders during reward and recognition activities can encourage participants as well as incentivise local partners like SHGs to participate.

BEST PRACTICES

Build trust with partners and relevant authorities from the very beginning. Orient community partners across block- and cluster-levels to the program in order to build their support.

Sensitivity towards partners' capacity and norms: Be mindful of partners' competing responsibilities and concerns they might have about a new program (e.g. fear of encroaching on what they consider to be their role or discomfort with certain topics).

Post-program engagement: Following the program, maintain engagement and close the loop to help community partners see the benefits of the program and build support for sustaining behaviour change or for future programming.

Explore overlaps with community partners' other activities. Program materials or activities could be leveraged by community partners for their other activities, with the right permissions. For instance, ASHAs reported using the course videos for "Saas Bahu Sammelans" and there was indication of an increase in these activities.

4 PROOF-OF-CONCEPT: LEARNINGS FROM PILOT

PROOF-OF-CONCEPT: DEKH-REKH

Participation in the program: Dekh-Rekh

963 couples with a child aged 6-23 months enrolled in the program.
Program participants represented the broader demographics of the area.

Demographic characteristics		Intervention villages		Comparison villages	
		Baseline (Women's survey/Men's survey)	Endline (Women's survey/Men's survey)	Baseline (Women's survey/Men's survey)	Endline (Women's survey/Men's survey)
Gender of child	Male child	55% / 50%	51% / 57%	52% / 56%	50% / 54%
	Female child	45% / 50%	49% / 43%	48% / 44%	50% / 46%
Religion	Hindu	85% / 90%	90% / 92%	89% / 92%	91% / 91%
	Muslim	14% / 8%	9% / 8%	10% / 7%	9% / 8%
	Other	1% / 2%	<1% / 0%	1% / 1%	1% / 1%
Caste	OBC	59% / 61%	66% / 69%	60% / 58%	59% / 64%
	SC / ST	33% / 33%	29% / 28%	34% / 38%	35% / 33%
	General	8% / 6%	5% / 5%	6% / 4%	6% / 4%

Most of those who dropped out of the program left because of migration-related reasons. Of the 963 couples enrolled in the program, 123 dropped out over the 18-week duration. Of these 123 couples, 52% left before the mid-point of the program (week 9), and the remaining 48% left after. 91% of couples left due to migration-related concerns (when both husband and wife migrated), with most other refusing to participate in the program without providing a reason. The religious and caste makeup of those who dropped out were in line with the overall population distribution.

PCI + Dalberg

PROOF-OF-CONCEPT: DEKH-REKH

Summary of findings: Dekh-Rekh

1. **Minimum dietary diversity (MDD):** Women in intervention villages reported a 30% point increase in MDD for children (aged 12-23 months) and men reported 25% points, significant compared to the 15% point increase reported by women in comparison villages and the 12% reported by men.

2. **Mother's dietary diversity:** The percentage of mothers (of children aged 6-23 months) eating five or more food groups increased by a net of 14%.

3. **Men's involvement in nutrition:** Women in the intervention villages reported a net increase of 5% points in their husbands providing enough funds to meet their children's food requirements, compared to those in the comparison. There was a net increase of 20% points in men reporting they "always" or "sometimes" discussed or participated in food preparation in intervention villages, relative to comparison villages. Finally, there was a net increase of 18% points found among women in intervention villages saying their husband's participated in feeding, relative to comparison villages.

4. **Knowledge:** Awareness among mothers about the minimum dietary diversity for children (aged 6-23 months) increased by a net of 34% among those exposed to program interventions compared to those not exposed. The net increase reported by men was 22% points.

5. **Spousal communication:** Couple's communication about child nutrition increased by 24% among the couples exposed to the program, compared to those not exposed.

PCI + Dalberg

PROOF-OF-CONCEPT: DEKH-REKH

Summary of findings: Dekh-Rekh

6 **Program features:**

Calendar usage: Women were much more likely to fill the tracking calendar than men, but regardless of who put the stickers, women and men reported similarly (44% and 45%) on “always” or “often” discussing what to put on their calendar with their spouses.

Watching of videos: Participants who watched all 5 videos were more likely to meet MDD requirements for their children.

Tote bag: Use of the tote bag was linked with program behaviours and outcomes- 47% of men and 59% of women who used the tote bag had children meet MDD, compared to 38% of men and 46% of women who didn’t.

7 **Enabling environment:** In joint families, in-laws were receptive to information on improving their grandchildren’s nutrition and shifting household roles, and some changed their purchasing decisions accordingly.

8 **Impact of COVID-19:** Loss of income in the early stages of the pandemic impacted baseline MDD rates in both comparison and intervention villages, and recovery before the endline survey explains improvements in the comparison village. The depletion of savings during COVID-19 means that some families might still have a hard time adopting new habits that involve re-allocation of budgets. Yet, the fear of disease has parents prioritising their children’s health.

See detailed findings here.

PROOF-OF-CONCEPT: HAMARI SHAADI, HAMARE SAPNE

Participation in the program: Hamari Shaadi, Hamare Sapne

1083 couples with zero or one parity enrolled in the program.
Program participants represented the broader demographics of the area.

Demographic characteristics		Intervention villages		Comparison villages	
		Baseline (Women's survey/Men's survey)	Endline (Women's survey/Men's survey)	Baseline (Women's survey/Men's survey)	Endline (Women's survey/Men's survey)
Religion	Hindu	93% / 93%	96% / 98%	96% / 94%	95% / 95%
	Muslim	7% / 7%	5% / 2%	5% / 6%	5% / 5%
Caste	OBC	59% / 56%	55% / 54%	57% / 52%	59% / 61%
	SC / ST	37% / 36%	41% / 43%	39% / 42%	36% / 36%
	General	5% / 8%	4% / 4%	3% / 6%	5% / 3%
Migration status[1, 2]	Migrant husband	66% / 5%	60% / 15%	82% / 3%	68% / 28%
	Non-migrant	34% / 95%	40% / 85%	18% / 97%	32% / 72%
Parity	Zero (no children)	43% / 45%	35% / 39%	47% / 45%	39% / 41%
	One (one child)	57% / 55%	65% / 61%	53% / 55%	61% / 60%

Most of those who dropped out of the program left because of migration-related reasons. Of the 1083 couples enrolled in the program, 168 dropped out over the 14-week duration. 31% of couples who dropped out left in the second week of the program, mostly refusing to participate (no further reason provided). A further 17% left in week 9, which coincided with major religious festivals. 51% of the couples who left the program before completion left due to migration-related reasons (i.e., where both partners moved away from the program location). Interestingly, 14% of participants left the program due to pregnancy-related reasons, highlighting the lack of perceived value for couples who are already pregnant.

[1] Migration status was determined through the question, "Where do you usually work in a year?"
[2] The large difference in migration status figures in men and women's surveys is likely because migrant men were less likely to have been reached by surveyors, since the surveys took place in-person at their homes

PCI + Dalberg

PROOF-OF-CONCEPT: HAMARI SHAADI, HAMARE SAPNE

Summary of findings: Hamari Shaadi, Hamare Sapne

1. **Contraceptive use:** There was a net increase of 16% points in current use of contraceptives among women exposed to program interventions, compared to those not exposed.
2. **Joint goal-setting:** There was a net increase of 18% points in the proportion of women in intervention villages reporting that they had discussed delaying or spacing with their husbands in the preceding 3 months, and a net 25% point increase in men reporting discussing delaying or spacing in the intervention village, relative to the comparison village.
3. **Knowledge:** As a result of the program, 48% of women and 82% of men knew about family planning at endline in the intervention villages, a net increase of 33% points for women and 31% points for men.
4. **Spousal support:** A significantly higher number of women (16%) from intervention villages reported increased support from their husbands on contraceptive use, and men similarly reported support for their wives' views around family planning and contraceptive use.

PCI + Dalberg

PROOF-OF-CONCEPT: HAMARI SHAADI, HAMARE SAPNE

Summary of findings: Hamari Shaadi, Hamare Sapne

5 **Program features:**

Watching of videos: Most men and women reported watching videos, with the majority watching most of the six videos in the program. 58% of women who watched a video reported having seen six or more, compared to 51% of men.

Videos and outcomes: The number of videos was correlated with the likelihood of talking with a healthcare worker about family planning, although the total number of men and women reported talking to an ASHA or ANM was small.

6 **Enabling environment:** Parents-in-law were receptive to new information around spacing and delaying. These messages particularly resonated when put in the context of long-term savings and future grandchildren's education.

7 **Impact of COVID-19:** Heightened financial pressures leading to affordability constraints, as well as concerns about visiting a health centre/hospital to access contraceptives during the pandemic might have influenced the rates of contraceptive use in both intervention and comparison villages.

See detailed findings here.