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Male involvement interventions and improved couples' emotional relationships in Tanzania and Zimbabwe: 'When we are walking together, I feel happy'

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ABSTRACT

Male involvement in maternal and child health is recognised as a valuable strategy to improve care-seeking and uptake of optimal home care practices for women and children in low- and middle-income settings. However, the specific mechanisms by which involving men can lead to observed behaviour change are not well substantiated. A qualitative study conducted to explore men's and women's experiences of male involvement interventions in Tanzania and Zimbabwe found that, for some women and men, the interventions had fostered more loving partner relationships. Both male and female participants identified these changes as profoundly meaningful and highly valued. Our findings illustrate key pathways by which male involvement interventions were able to improve couples' emotional relationships. Findings also indicate that these positive impacts on couple relationships can motivate and support men's behaviour change, to improve care-seeking and home care practices. Men's and women's subjective experiences of partner relationships following male involvement interventions have not been well documented to date. Findings highlight the importance of increased love, happiness and emotional intimacy in couple relationships – both as a wellbeing outcome valued by men and women, and as a contributor to the effectiveness of male involvement interventions.

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Introduction

Male involvement in maternal and child health is recognised as a valuable health promotion strategy in low- and middle-income country settings. Recent systematic reviews demonstrate that engaging male partners and fathers¹ in maternal and child health can improve care-seeking for essential health services, as well as home care practices, with plausible benefits for mortality and morbidity (Tokhi et al. 2018; Yargawa and Leonardi-Bee 2015; Takah et al. 2018). However, there is limited empirical evidence of how these effects are achieved – especially the subjective factors that can motivate men and women who participate in male involvement interventions to behave differently. While it is known, for example, that male involvement interventions can affect couple relationship dynamics, particularly couple communication (Tokhi et al. 2018; Davis, Luchters and Holmes 2012), few studies have explored the mechanisms leading to observed changes in communication patterns. Indeed, an established critique of the male involvement literature is that many studies report narrowly on men's behavioural outcomes, such as financial support and accompaniment to health services, with limited consideration of men's and women's subjective experiences of behaviour change in the context of couple and family relationships (Comrie-Thomson, Tokhi et al. 2015).

This focus on observable behavioural outcomes, rather than the subjective experiences of couple relationships, reflects a broader pattern whereby emotion – including, specifically, love (Bhana 2013b) – is under-investigated in low- and middle-income country settings. Historically, many Western anthropologists identified romantic love as a culturally specific, and therefore uniquely Western, construct (Lindholm 1998). The effects of this can be seen today in the academe's relative silence about love in non-Western settings (Hunter 2010). Compounded by the legacy of early public health responses to HIV, intimate relationships in low- and middle-income country settings, particularly settings in Africa, are typically framed in a risk discourse that focuses on behaviours and surveillance, rather than subjectivity (Haysom 2013; Cole and Thomas 2009). Reducing couple relationships to sexual behaviours, and avoiding the topic of emotional intimacy, contributes to 'dehumanis[ing]' and 'racist' narratives (Bhana 2013b, 5), such that women's and men's affective experiences are not acknowledged and 'Africa is still often thought of and written about as loveless' (Hunter 2010, 14). While various studies have explored intersections between HIV risk and love, desire and intimacy (Tavory and Poulin 2012; Conroy et al. 2016; Hunter 2010; Onyango et al. 2019), and there is a growing literature on health interventions targeting couples in sub-Saharan Africa (Mashaphu et al. 2018; Turan et al. 2018; Speizer et al. 2018), the maternal and child health literature rarely considers the emotional dimension of parents' couple relationships.

In response to this gap in the literature, the 'emotional act of intimacy' that is expressed and experienced as love has been proposed as an important and analytically valuable domain of academic analysis (Bhana 2013b, 3). Men's and women's lived experiences of couple relationships encompass not only gender power relations, and transactional or material considerations, but also emotions (Bhana 2013b). Examining emotional experiences thus supports a more complete understanding of how couple relationship dynamics influence outcomes for women and men.

While love has been proposed as an important topic of analysis, it remains a complex and dynamic term. Love is constructed, experienced and demonstrated differently in different sociocultural settings and under different material conditions (Beall and Sternberg 1995; Lindholm 1998). Demographic, social and economic change is reshaping love within couple relationships at a global level. Increasing age of marriage and access to contraception, and changing economic opportunities, are reconfiguring gender roles and ideals within relationships, particularly for young people (Jackson 2012b). It has been suggested that love in couple relationships becomes more important to individuals and societies as broader family and kinship networks and meaning-making structures, such as religion, fragment following economic liberalisation and globalisation (Lindholm 1998; McCullough, Brunson and Friederic 2014). While this proposition has been criticised for applying Western history to non-Western settings, globally, companionate or 'love' marriage is increasingly idealised, and many people, particularly young people, actively position themselves within 'discourses of love' that are perceived as modern (Jackson 2012b, 4).

In rural Tanzania and Zimbabwe, couple relationships are influenced by these global changes, as well as local factors that affect relationship formation. Both settings are patrilineal, with adult men typically considered the head of the household while women are subordinate (Montgomery et al. 2012). While polygynous marriage is legal in both countries, monogamous cohabiting couple relationships, generally within the framework of marriage, form the main household unit. Multi-generational patrilocal households, or neighbouring households, remain common, although younger couples increasingly choose to live away from the man's parents (Jackson 2012a; Wight et al. 2006). In Tanzania, a man's sister has culturally sanctioned influence over his household and children (Porter 2004). *Lobola* (bride wealth) is common in both settings and is commonly understood as compensation for women's labour, reproductive capacity and sexual availability, which is effectively purchased by the husband or his family (Mugweni, Pearson and Omar 2012; Wight et al. 2006). Established couples typically have highly differentiated gender roles, meaning some partners may spend little time together (Mugweni, Pearson and Omar 2012; Montgomery et al. 2012). In the recent past, men have been primarily responsible for economic provision and women primarily responsible for reproduction and domestic work. This gendered division of labour has contributed to a legacy of what Hunter (2010, 14), in work in South Africa, has called 'provider love', where a man's love and care is enacted through his capacity and willingness to provide materially for his partner – meaning that love and economic provision can become conflated (Stark 2017). However, escalating economic insecurity in both settings in recent decades has changed the options available to both men and women, and economic provision has become a more fluid and contested role (Silberschmidt 2005; Wamoyi et al. 2011; Hunt et al. 2015). Studies from both countries indicate that many men feel their established dominant gender role has become 'precarious' as a result of economic change (Silberschmidt 2005, 195) and may seek to exert increased dominance in the private sphere, including couple relationships, as a result (Silberschmidt 2005; Wamoyi et al. 2011; Hunt et al. 2015). In both countries the HIV epidemic, and public health response, has influenced couple relationships and gender relations, including by reframing male sexual behaviour in

terms of women's health (Jackson 2012a) and normalising a degree of 'husband-taming' to protect women's safety, a power dynamic which can lead to push-back from men and demands for greater control from women (Goebel 2002). In the context of these changes in gender roles, many women and men actively and self-consciously manage their identities and couple relationships by positioning themselves within, or separate from, discourses of modernity and gender equality (Wight et al. 2006; Montgomery et al. 2012), which include ideals of romantic love and companionate marriage as markers of a modern, egalitarian couple relationship (Jackson 2012b).

Male involvement interventions typically seek to influence men's and women's behaviour in the context of established couple relationships. Using data from a qualitative study of women's and men's experiences following interventions to engage men in maternal and child health, this paper aims to describe how male involvement interventions can foster more loving couple relationships and explore how these changes in couples' emotional relationships may be a plausible mechanism supporting the overall effectiveness of male involvement interventions.

Methods

We conducted a qualitative study to explore men's and women's experiences relating to male involvement in maternal and child health in underserved locations in resource-constrained countries. This paper reports on a secondary analysis of data. Data were collected as part of a wider three-country study that also included Bangladesh (Comrie-Thomson, Mavhu et al. 2015); however, due to differences in participant recruitment strategies this paper reports on data from Tanzania and Zimbabwe only.

Interventions promoting male involvement had been implemented in study sites for at least three years at the time of data collection and were nearing completion. The interventions – Wazazi na Mwana in Tanzania, and Women and their Children's Health (WATCH) in five countries including Zimbabwe – were implemented between 2011 and 2015 by Plan International offices in Tanzania and Zimbabwe with support from Plan International Canada. The purpose of these interventions was to increase men's overall support for maternal and child health, including financial, emotional and physical support,² and promote equitable couple communication and joint decision-making, while at the same time engaging men as change agents in addressing gender inequality and gendered determinants of poor health outcomes. Components common to both interventions included community-based men's discussion groups designed to foster reflection on negative masculinities, peer outreach by male role models, couple counselling and education led by traditional and religious leaders. While couple relationship dynamics were not the main focus of the interventions, intervention messages promoted mutually respectful, equitable couple relationships. In Zimbabwe, WATCH was implemented in 180 rural and remote villages across three districts (Chipinge, Mutare and Mutasa). Wazazi na Mwana was implemented in 511 rural, remote and peri-urban villages across five districts in Tanzania (Ilemela, Kalambo DC, Nkasi, Sengerema and Sumbawanga).

Data collection was led by a local investigator in each country, working with a team of experienced local qualitative researchers. Participants were parents of young children, and expectant parents, who had been directly exposed to the male involvement interventions. Maximum diversity sampling was used to purposively select two project villages per country³ that were culturally, socio-economically and geographically different from each other in order to capture a broad range of participant experiences. In each site, focus group discussions and in-depth interviews were conducted separately with adult women, adult men, adolescent girls and adolescent boys, totalling four focus group discussions and four in-depth interviews in each of the four study sites. We defined adolescents as young people aged 15–19 years and adults as people aged 20 years and older in all sites. Participants were recruited through snowball sampling using community-based networks that had been used to implement the male involvement interventions.

Focus group discussion guides comprised 8–10 broad questions exploring community norms and normative behaviour, and how the interventions had influenced these (e.g. 'What makes you most happy or proud to be a man/woman?', 'What role should men have in boys' and girls' health?', 'How has the role of men in women's, boys' and girls' health changed in this community in the past two or three years?'), while in-depth interviews were used to provide participants with an opportunity to discuss sensitive information and non-normative behaviour participants. Interview participants were asked to describe their reasons for participating in male involvement interventions, their experience of the interventions and how participation had affected their households.

Data collection was conducted in local languages (Shona in Zimbabwe and KiSwahili in Tanzania) by native speakers of the same sex as participants. Interviews and focus groups were held in community locations with auditory privacy. Each session was audio-recorded with permission from participants, transcribed verbatim and translated into English for analysis. Translations were reviewed and checked by the Zimbabwe and Tanzania lead investigators, who are native speakers of Shona and KiSwahili, respectively, and fluent in English. Data were collected in October and November 2014 in Zimbabwe, and December 2014 in Tanzania. Following completion of data collection in Zimbabwe, the Zimbabwe lead investigator participated in data collector training in Tanzania to promote shared understanding of research objectives and key concepts.

Initial coding was completed separately for each country by the country lead investigator, drawing on high-level codes defined *a priori* based on existing literature and study objectives, such as 'ideas about men and women', 'perceived benefits of male involvement' and 'barriers to men's participation'. In February 2015, the research team held a workshop to synthesise findings across countries. During this workshop we also explored findings outside the *a priori* coding framework and identified that female and male participants in all study sites consistently reported changes in couples' emotional attachment to each other as a result of the interventions. This finding was first raised by the Tanzania lead investigator and tested back against data by each country lead investigator for validation.

Findings of the broader study are reported in Comrie-Thomson, Mavhu et al. (2015). This paper reports on a secondary analysis conducted to further explore the

unexpected, incidental finding that participants reported positive emotional changes in their couple relationships. A new coding framework was developed over three cycles, according to emergent themes, to identify and explore how participants experienced any emotional effects of the interventions on their couple relationships. Participants frequently used the term 'love' when commenting on couple relationships, and we have used this as an organising concept in our secondary analysis. We recognise that there are different forms of love, as described in the literature (Stark 2017; Hunter 2010). For this secondary analysis, we privilege participants' descriptions of love, and explore how their self-expressed experiences of love in couple relationships interact with male partner practical support. We do not seek to further tease out what participants meant by 'love', or to unpack the broader emotional milieu of couple relationships, as this was not captured in the study. We have allocated pseudonyms to participants to protect their confidentiality.

The study was approved by Alfred Hospital Ethics Committee in Australia (293/14), the Ifakara Health Institute Institutional Review Board (20-2014) and the National Institute for Medical Research (8a/IX/1856) in Tanzania and the Medical Research Council of Zimbabwe (A/1863). No adverse events occurred during data collection.

Findings

Ninety women and 81 men participated in the focus group discussions (FGDs) and in-depth interviews (IDIs). Participant characteristics are summarised in Table 1. Relationship status was not a selection criterion; however, most participants were in couple relationships – although a substantial minority of young women in Tanzania and young men in Zimbabwe were unpartnered. In both countries, many adolescent male participants were expectant parents, with no current children.

Local gender roles

Participants in both countries reported highly differentiated gender roles, underpinned by unequal gender norms and relations that allocate domestic work, pregnancy-related tasks and childcare exclusively to women.

I was told by my parents that you should not dominate the man [...] you are supposed to respect him. (Kemi, Adolescent female IDI, Tanzania)

Moderator: Is a man expected to do anything [for a newborn]?

Tendai: We do not do anything [...] We consider it to be the mothers' responsibility. (Adult male FGD, Zimbabwe)

At the same time, women and men noted that established gender roles are changing, with women taking on more responsibility for tasks that were previously part of men's role, such as paid farm work. For some participants, more equal gender roles were perceived as a normal, although not necessarily desirable, aspect of modern living.

Moderator: Let us be realistic, do all men help their wives doing household chores? [...]

Jamali: Those roles are inevitable nowadays. (Adult male FGD, Tanzania)

Table 1. Participant characteristics.

	Tanzania				Zimbabwe			
	Adolescent		Adult		Adolescent		Adult	
	Female	Male	Female	Male	Female	Male	Female	Male
Number of FGD participants	16	12	18	23	24	18	24	20
Number of IDI participants	2	2	2	2	2	2	2	2
Age (range, mean)	15–18, 17.3	17–18, 17.8	20–40, 27.5	24–56, 35.1	15–19, 18.4	15–19, 17.7	20–57, 35.2	24–76, 42.4
Partnered (%) ^a	72%	100%	95%	100%	100%	55%	96%	100%
Number of children (range, mean)	0–2, 1.1	0–1, 0.5	0–10, 3.5	0–9, 3.3	0–3, 1.2	0–2, 0.5	0–7, 4.0	0–12, 4.6

^aIncludes participants who are married, co-habiting, and in a relationship but not co-habiting. FGD: focus group discussion. IDI: in-depth interview.

Yet, while many women, particularly adolescent girls, and a small number of men expressed dissatisfaction with unequal gender roles and were supportive of increased equality, many men and some older women were very resistant to any changes to gender roles and associated power dynamics.

Parents should teach children that any job can be done by both boys and girls [...] The girl is the one that is overburdened: she sweeps the yard, she fetches water. So, we should teach our children to do the same duties. (Happy more, Adolescent female FGD, Zimbabwe)

Mafanikio: I am proud to be a man because I can order my wife to cook for me at any time I want, but she cannot order me. [...]

Jumanne: I am proud to be a man because whatever I order gets done at home. [...]

Moderator: That is what you want to be maintained?

Jumanne: Yes. (Adult male FGD, Tanzania)

The mother-in-law will say [...] 'We were never treated that way. What's so special about her pregnancy?' (Rudo, Adult female FGD, Zimbabwe)

Male partner practical support for maternal and child health in study settings

In the context of entrenched gender inequality, gender norms that allocate domestic work and childcare to women and not men and shifting gender roles, men's practical support for maternal and child health was perceived in terms of gender power relations within couple relationships. Men who provided practical support to their female partners and children were seen to be completing tasks that were part of women's gender role, and were consequently perceived as emasculated and dominated by their female partner. In both countries, male partner practical support was linked with the idea of a woman giving her partner a 'love potion' to control him.

Moderator: How was the community perception the first time you took your child to clinic?

Noeli: Honestly it was a challenge. The community perceived it badly, they were saying that this man has been dominated by his wife. (Adult male IDI, Tanzania)

Farai: Aa, they [community members] will say, 'This man is subjugated; we saw him cooking on the fire, yet the wife was just seated'. [...]

Gift: [They will say] 'He was given a love potion'. (Adolescent male FGD, Zimbabwe)

As a result, men providing practical support and their female partners were frequently stigmatised by family and community members. Men were mocked or shunned, while women were accused of disrespecting their male partners and not fulfilling their normative role. Women were particularly vulnerable to criticism and conflict, including violence, from male partners' families.

If you do that [wash nappies] people will end up looking down upon you. [...] If you go to men's gathering, they will start to make fun of you. (Trymore, Adolescent male IDI, Zimbabwe)

Your husband's mother will say, 'My son is now emasculated; he doesn't have time to rest. What is your role? Didn't he pay *lobola* [bride wealth]?' (Tsitsi, Adolescent female FGD, Zimbabwe)

The wife was beaten by her sister-in-law when they found [the husband] fetching water [...] after that, the sister-in-law chased that woman from her brother's house. (Esta, Adolescent female FGD, Tanzania)

Young male participants, in particular, identified men's practical support as a form of female domination, and were wary of offering support. Several adolescent boys expressed suspicion that mothers would seek to leverage co-parenting as an opportunity to manipulate and control men. Many young male study participants were expecting their first child, and a substantial minority were not in an ongoing relationship with the expectant mother. Their concerns may therefore reflect norms, ideals and concerns around gender role changes, rather than personal negative experiences. Some women noted that young fathers were more resistant to providing practical support compared with older, more experienced fathers, indicating that a strong aversion to offering support may be tempered over time and with increased experience of co-parenting.

If you wash the nappies when she has flu, the next time she will argue that she has a headache, knowing that you would wash the nappies again. (Tinashe, Adolescent male FGD, Zimbabwe)

An old man who is now using a walking stick can actually help his wife with household chores. [...] However, a young man who is still very active can't do that for the sake of his wife. (Happymore, Adolescent female FGD, Zimbabwe)

Indeed, while men's practical support for maternal and child health was publicly stigmatised in all study sites, some men, particularly more experienced fathers, reported providing support to ensure all necessary domestic and childcare work could be completed within the household.

It is not strange to help her out – if the workload is huge, I can go and fetch water and so on. It is not only during pregnancy [but] even in normal days and life goes on. (Nuhi, Adult male FGD, Tanzania)

Moderator: Who feeds young children? [...]

Maxwell: It is the mother.

Xholani: But you can assist if the wife is busy; you cannot leave the baby crying. (Adolescent male FGD, Zimbabwe)

Critically, however, this support was typically provided in ways that did not challenge established gender power relations. Many men reported providing support only in private, or only when their partner was sick. Multiple men in both countries described their support as a 'favour' to women: not a permanent part of their role, and something women were not entitled to expect from them. Some men carefully defined tasks they completed in ways that differentiated their work from women's normative role.

Xholani: I may be doing it at my own home, helping my wife, but if I see someone doing it, I may laugh at him. [...] You do not want to be seen.

Moderator: But you will be doing it?

Xholani: Yes. (Adolescent male FGD, Zimbabwe)

Norman: [A]t times she asks me to help with the plastering [...] That is when I tell her that I can only prepare the mortar, but she has to do the plastering herself.

Moderator: Is she going out of bounds?

Norman: Yes, some things are too much. [...] It is a duty for women. (Adolescent male IDI, Zimbabwe)

Effects of the interventions on couple relationships

Many women and men in both countries reported that men's practical support for maternal and child health had increased in their communities following the interventions, although change was not consistent across all households. These findings, together with the influence of the interventions on care-seeking, mortality and morbidity, are described further elsewhere (Comrie-Thomson, Mavhu et al. 2015).

Many participants who reported that male partner practical support had increased in their households stated that this had improved their couple relationships. While couple relationships were not included as a topic in question guides, and not all participants commented on their relationships, participants consistently raised the positive impact of male partner practical support on couple relationships. Adolescent and adult women and men across all study sites, in both focus group discussions and in-depth interviews, reported their relationships had become happier, more loving, more peaceful and more mutually supportive following increased male partner practical support. Both women and men valued these changes.

We are living a very happy life [...] When I'm helping her, I think it comes to her mind that I love her, I didn't do that before. Now we are happy, and we have peace in our house. (Nuhi, Adult male FGD, Tanzania)

We enjoy our marriage when we do what they teach us. (Kemi, Adolescent female IDI, Tanzania)

Explaining the impact of men's practical support on couple relationships

In the study sites where women generally have limited decision-making power and autonomy, men's practical support made a substantial, positive difference to women's daily lives. Multiple women described how practical support had increased their personal comfort and dignity, for example by enabling rest and self-care and increasing their capacity to make minor decisions about daily life.

Well, previously when I fell ill, he would say, 'Get up and cook'. [...] [W]hen I fall ill [now], he takes a bucket of water to the bathroom and says, 'You can now go and bathe'. He will then cook for me after asking me, 'What is it that you want to eat?' (Talent, Adult women's IDI, Zimbabwe)

Nowadays I can tell him that I need your 'thing' [I need something from you] and he doesn't refuse [...] or if I say can you please give me some money I want to buy beans

today I'm tired with *mboga* [vegetables] he just provides, and that doesn't make him angry. (Gloria, Adult women's IDI, Tanzania)

Women also described how a reduction in their workload and more equitable division of labour in their households had supported them to 'get along' better with their male partners.

[B]ack then there was no love, it was a struggle to get along because you would come [home] tired from where you had spent the day working [...] and find him sitting waiting thinking, 'If only my wife would get back and cook'. Ever since the programme [...] you get home and find the water has been fetched or if he realises you are late, you get there finding he has cooked [...] and then we eat together. (Primrose, Adolescent female IDI, Zimbabwe)

Women, and some men, recognised that men's increased understanding of maternal and child health made it easier to complete important tasks such as testing male partners for HIV during pregnancy, which is recommended in both countries, as well as preparing for childbirth, arranging emergency transport and family planning. Both women and men linked this improved practical cooperation with fewer arguments, and in some cases reduced violence. Some women and men also noted that couple relationships had improved because men no longer suspected women of lying when they passed on health worker advice, and because men had a greater appreciation of women's needs during pregnancy and childbirth.

[W]hen your husband does not like to hear anything about the clinic, and you are interested in going to the clinic, it becomes a challenge for you to get along well. [...] [I]f he hears about these things from the programme and he likes them, you do get along well. (Zawadi, Adolescent female IDI, Tanzania)

[Previously] when you come to your husband and explain to him you are supposed to go to clinic, he will say no don't lie to me [...] honestly it was so difficult. (Upendo, Adult female FGD, Tanzania)

When you deliver [...] he finds the transport, and at home you will find the good food already been prepared, but in the past it was not like that, he didn't know that his wife has suffered a lot with that pregnancy, what he knew was just walking around. But nowadays they care. (Yusta, Adult female FGD, Tanzania)

Some women and men explained that men's increased participation in activities related to maternal and child health, such as attending antenatal clinic and providing practical support at home, had increased couples' emotional intimacy through these shared experiences.

[I]t is good because I am now working together with my family. I do not leave it [my family] alone; we will be together most of the time. (Xholani, Adolescent male FGD, Zimbabwe)

I can see love has increased; when we are walking together, I feel happy, I feel he loves me because in all tasks we are helping each other. (Upendo, Adult female FGD, Tanzania)

Influence of couple relationships on men's provision of practical support

Women and men valued improvements in their couple relationships that followed men's increased practical support for maternal and child health, as described above,

and some men explained that these relationship changes motivated them to keep providing practical support. These findings suggest a positive feedback loop between increased male partner practical support and improved couple relationships.

Moderator: Do you think those changes will continue?

Mrisho: Yes, I will continue.

Moderator: Why?

Mrisho: Because my family has been happy and has peace. (Adult male IDI, Tanzania)

Additionally, emotional intimacy in couple relationships emerged as integral to understanding why men may provide practical support. Some men identified love and care for their partner as a strong motivation to provide practical support, despite the fact that doing so diverged from family and community expectations.

Noeli: They were telling my wife, why does she allow her husband to do activities which are not his [...] I told her that all of what I am doing is because I don't want to see her in pain [...]

Moderator: How do you find your status as a man when you participate in these activities?

Noeli: Honestly – I think I was doing that from my heart. (Adult male IDI, Tanzania)

Some women and men also reported that emotional intimacy had supported them and their partner to overcome the stigma associated with men's practical support. While this stigma remained a potent force at community level, and was reportedly insurmountable for some people, emotional intimacy within couple relationships enabled others to disregard stigma and associated sanctions.

Moderator: [S]ome were saying if other people see you washing [clothes] they talk badly about you or they say you are brainwashed. Don't you think about what people say if they see you doing it?

Innocent: I do not think about that because I know that my wife is not feeling well. (Adult male IDI, Zimbabwe)

Moderator: Some people do not help their wives?

Gloria: Ooh yes, they are many. Mine was the first to implement. They say this man loves his wife and they are not happy.

Moderator: How do you feel when other people talk about you?

Gloria: I do not have a problem with them.

Moderator: How does your husband feel?

Gloria: He doesn't care at all; he just cares about me and I care about him too. (Adult female IDI, Tanzania)

Discussion

The sociological and public health literature demonstrates that supportive behaviours build emotional intimacy between partners and are particularly valued at emotionally and logistically demanding times (Beall and Sternberg 1995), such as during pregnancy and when caring for a newborn. Evidence from South Africa also indicates that more equitable relationships are associated with greater emotional intimacy

(Conroy et al. 2016). Some programme approaches in low- and middle-income country settings incorporate couple relationship changes into programme logic, such as the MenCare suite of programmes that promote nonviolent, loving relationships as part of a broader strategy to achieve equitable caregiving (José Santos 2015).⁴ Yet a link between male partner practical support and improved couple relationships is absent from much of the academic literature on male involvement interventions in low- and middle-income country settings (Comrie-Thomson, Tokhi et al. 2015).

Our findings, however, indicate that changes in couple relationships are an important part of men's and women's experiences of these interventions. In resource-constrained settings, where hardship and vulnerability are exacerbated for women by unequal gender roles, male partners' practical support can have profoundly positive impacts on couple relationships. Happy, peaceful and mutually supportive couple relationships are valued by women and men and are therefore a wellbeing outcome in their own right. Furthermore, love and emotional intimacy in couple relationships emerge as important to understanding how interventions can effectively promote men's behaviour change for improved health outcomes, since our data indicate that improvements in couple relationships may contribute to increases in men's practical support. These findings underline that love in couple relationships is an important, and currently under-investigated, domain of inquiry that should be considered when seeking to fully understand male involvement interventions in low- and middle-income country settings.

Reorienting academic perspectives on male involvement interventions to include an increased focus on love in couple relationships has broader conceptual implications. First, this approach can help to explain variation in the effects of interventions. Couple relationships are constructed through multiple 'micro-level processes', encompassing emotional ties as well as power relations (Bhana 2013b, 7). Recognising these emotional ties as a legitimate domain of inquiry supports a more complete understanding of why, for example, the same behaviour by a male partner makes one woman feel supported while another feels infantilised (Sahip and Turan 2007). Critically, unpacking the emotional dimension of partners' interactions can deepen our understanding of why known risks of male involvement interventions, such as decreased women's autonomy and backlash among men, eventuate among some couples and not others, and how this can be averted.

Second, focusing on love and emotional intimacy in couple relationships illuminates individual agency, supporting a deeper understanding of how male involvement interventions can contribute to processes of social change. Social norms, including gender norms, are a product of the interplay between dynamic individual, interpersonal, social and structural factors (Heise 1998; Jewkes, Flood and Lang 2015). Our findings indicate that love can motivate an individual to act, as study participant Noeli phrased it, 'from [the] heart' in ways that contravene strong social norms. Couples' relationships can also be a site where younger women and men ally to push back against parental norms and negotiate new ways of doing things (Gram et al. 2018), and our findings indicate that a strong emotional bond would plausibly facilitate this. While, ultimately, change at the level of structural gender inequality is required to enable all couples to better negotiate their relationships as they choose (Bhana 2013a), our findings nevertheless illustrate that the lens of emotion in couple relationships can illuminate

individuals' and couples' agency under existing social and structural constraints. This does not reduce the imperative to address structural inequalities, but, to the extent that individual and interpersonal changes contribute to broader processes of social change (Heise 1998), exploring love in couple relationships can improve understanding of why and how social change may occur (Haysom 2013).

Third, engaging with the emotional aspects of couple relationships supports an approach to male involvement that humanises the men and women involved. A theoretical approach that omits emotion has limited capacity to provide insight into subjective experiences or recognise subjectivity. An established critique of male involvement programmes and interventions is that they have often been conceptualised and implemented in an instrumental way, with a focus on men's observable behaviours divorced from how these behaviours are understood and experienced by men and women (Comrie-Thomson, Tokhi et al. 2015). This instrumental approach is considered unsustainable because it promotes change in behaviours, rather than underlying norms and relations that give rise to these behaviours, and therefore has limited power to support deeper gender-transformative change (Barker et al. 2010). An approach to male involvement that recognises the importance of women's and men's emotional responses to changes in couple relationships helps to unify observable behaviours with subjective experiences, engaging with the broader system of meaning-making around men's and women's actions and interactions to support deeper, more sustainable change. In addition to the potential for increased effectiveness, there are intrinsic benefits to this person-centred approach to programming, which combats established 'dehumanising' narratives about women and men in low- and middle-income country settings (Haysom 2013, 1).

Our findings signal the need to document the emotional effects of male involvement interventions in low- and middle-income country settings, in order to strengthen the explanatory power of research and the effectiveness of evidence-based policy and programming. This would include any negative emotional effects, not captured in our data, for example where partners' changing gender ideals may become a source of relationship tension that constrains emotional intimacy. Indeed, documenting interventions' emotional impacts may enhance understanding of backlash to male involvement interventions, and how to mitigate this to effectively promote male partner support within gender-equal couple relationships. Additionally, since love is constructed in a broader context of gender and social relations (Haysom 2013), it is important that future research explore how love and emotional intimacy are experienced and expressed in context. Future research could also usefully explore how effects of increased male partner practical support on couple relationships may vary over time, particularly since parenthood is often a transformative experience for fathers, mothers and parents' relationships.

Our findings are limited by the fact that our study involved a secondary analysis of data, meaning it was not feasible to follow up specific questions or test assumptions. This is particularly important for the central concept of love. Participants using the term 'love' were not asked to explain how they understood this concept, and so our team, including members from Tanzania and Zimbabwe, have inferred their meaning. While we are confident in our interpretation of how love in couple relationships *as experienced by participants* contributed to their experiences of male involvement interventions, our understanding of love, which focuses on emotional intimacy, may differ

in subtle but important ways from how participants understand and express love. Additionally, the impact of social desirability bias on data collection may mean that some participants repeated intervention messages relating to positive couple relationships where these did not reflect their true beliefs or experiences (Watkins et al. 2011). While interventions in all study sites included messages promoting love and respect for partners, we are confident that the variety of ways in which emotional changes in relationships were described, and the critical self-reflection shared by some participants, goes beyond intervention messages to reflect actual changes in participant experiences. Finally, since different researchers led data collection in each country, it is not feasible to entirely disentangle differences in context from differences in researcher perspective. This was mitigated by the Tanzania and Zimbabwe lead investigators meeting, between the completion of data collection in Zimbabwe and its commencement in Tanzania, to develop a shared understanding of the study purpose and tools.

Conclusion

Our findings illustrate that love and emotional intimacy in couple relationships are integral to understanding the impacts and mechanisms of interventions promoting male involvement in maternal and child health in low- and middle-income country settings. This highlights an important gap in current academic literature on male involvement interventions, which rarely interrogates couples' emotional relationships. What constitutes love in a couple relationship, and how this affects each partner's wellbeing and behaviour, is highly contextualised and individually specific, and thus presents substantial measurement challenges. Nevertheless, our findings indicate that love between partners can be a powerful motivator and enabler for men's practical support for maternal and child health, and that improved couple relationships are identified by men and women as a key positive outcome following male involvement interventions. It is therefore imperative to consider how these interventions affect couples' emotional relationships – the alternative is to be unable to fully understand the underlying mechanisms that help to make male involvement interventions effective, and to overlook important wellbeing outcomes against which interventions' effectiveness should be assessed. Extending the established approach to male involvement interventions to include an enhanced focus on love and emotional intimacy can be expected to strengthen the explanatory power of research and the effectiveness of policy and programming, as well as advancing conceptual approaches to male involvement in maternal and child health.

Notes

1. The literature refers to fathers and male partners interchangeably. Both roles are important for male involvement interventions which seek to increase support provided to mothers and infants and are not limited to biological fathers.
2. Such as accompanying a female partner to the health facility, contributing to household chores and contributing to child and elder care work.
3. Selected villages were Milepa in Rukwa district and Igumamoyo in Mwanza district in Tanzania, and Nyamhere in Mutare district and Kaguvi in Chipinge district in Zimbabwe.

4. Further information about MenCare's gender-transformative father engagement programmes Program P and MenCare+, which have been adapted in over 15 countries, is available online at men-care.org.

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