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**Study on Gender Empowerment Outcomes in MAM@Scale Intervention Sites**

**FINAL DRAFT**

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The contents of this report are the sole responsibility of its authors.

**Abbreviations and Acronyms**

|  |  |
| --- | --- |
| ANC | Antenatal Care |
| DHMT | District Health Management Team |
| CHW | Community Health Worker |
| CHV | Community Health Volunteer |
| ETS | Emergency Transport System |
| GBV | Gender Based Violence |
| MAMaZ | Mobilising Access to Maternal Health Services in Zambia |
| MAM | MAMaZ Against Malaria |
| MAM@Scale | MAMaZ Against Malaria at Scale |
| MMV | Medicines for Malaria Venture |
| MOH | Ministry of Health |
| MORE MAMaZ | More Mobilising Access to Maternal Health Services in Zambia |
| NMEC | National Malaria Elimination Centre |
| NHC | Neighbourhood Health Committee |
| RHC | Rural Health Centre |
| RHP | Rural Health Post |
| SMAG | Safe Motherhood Action Group |
| SM | Severe Malaria |

**EXECUTIVE SUMMARY**

1. This is a report of a study on empowerment outcomes undertaken on behalf of the MAMaZ Against Malaria At Scale project (MAM@Scale). The study looked at the extent to which women and girls in the project’s intervention sites had transitioned from a situation where they had limited power to one where they could challenge power inequalities and access new opportunities for development.
2. The study was undertaken in December 2019. This was an internally commissioned study, designed and led by a MAM@Scale Senior Technical Adviser who worked alongside the project’s technical team in the project’s two core intervention districts: Chitambo and Serenje in Central Province.
3. In the project intervention sites a **number of gender empowerment-related gains were evident.** The extent of change varied depending on the length of time trained CHVs and ETS riders had been active in the community.
4. The study found thatsome of the **disabling social norms** that had discriminated against women and girls, and which had also prevented or delayed children’s health care access, had been eroded. **A significant increase in male involvement in children’s health has lessened the childcare burden on women, helping to share responsibility for children across the household.**
5. The study found that the **gains for women extended beyond the improved health of children**. Improvements in women's status were evident: many women reported a **greater say in household decision-making on health issues**, but in some cases on other issues; many indicated that they were more confident to challenge husbands if they did not agree with a decision.
6. There was evidence of a **reduction in gender-based violence (GBV)** in the old project sites and reports of **greater harmony** at household level. In the new intervention sites, where the training given to CHVs had a less significant focus on GBV, there was less evidence that GBV had begun to diminish.

1. Some small but significant **shifts in the gender division of labour** were evident, with some men taking on tasks that had previously been seen as women's responsibility (e.g. cooking, childcare, cleaning). Some male CHVs saw themselves as **role models and influencers** and were confident of their ability to help change disabling social norms and behaviours among their fellow men.
2. Women in the study communities were clearly showing signs of **increased voice, influence and agency** in relation to health issues. This stands them in good stead for being able to draw down other services, resources and opportunities in future.
3. There were also signs that the community mobilisation process had resulted in **improved social interaction** within the group of female volunteers leading to new opportunities for voice, friendship and social support. Some female community members argued that they **felt more confident** to share their new health-related knowledge and opinions with other members of the community.
4. The greatest empowerment gains were found amongst the female volunteers who had learnt to operate very effectively in the public domain, including in areas that were once the preserve of men. The volunteers' work gave them **credibility and authority within their communities, with positive impacts on their social status**.
5. The female volunteers benefitted from **greater physical and social mobility**. Their improved status hinted at new possibilities and opportunities for other women within the community. The fact that so many female community members want to join the group of volunteers suggests an ambition to improve their position in society, embrace new opportunities, and gain greater traction and independence within gender relations.
6. There were also some signs, primarily among female volunteers, that **women were starting to access and participate more in other development activities** (e.g. women's groups; agricultural co-operatives; other volunteering activities) and take on leadership roles (village head woman; board member etc). Although opportunities for paid employment were scarce in the study sites, some women’s involvement in new business ventures, evident in some sites, stands them in good stead to shift themselves and their families out of poverty. In situations where these ventures are co-operative, a wider group of women stand to benefit from new development opportunities.
7. Attribution can be an issue when measuring empowerment. However, in the intervention sites respondents **overwhelmingly attributed the changes at community level to the community mobilisation process** introduced by the various MAMaZ projects. Community health volunteers and riders talked about the situation before and after their training, while community members talked about the situation before and after the community discussion groups.
8. The seven **'gender-smart' strategies that comprise MAM@Scale’s gender empowerment approach were integral to driving the empowerment gains achieved** by the project. There are lessons here for other interventions wishing to achieve empowerment-related outcomes that extend beyond health.

**1. INTRODUCTION AND BACKGROUND**

**1.1 Background**

The MAMaZ Against Malaria at Scale (MAM@Scale) project (2018-2020) is being implemented with a grant from Grand Challenges Canada. Match funding is provided by Medicines for Malaria Venture (MMV) and the UK development organisation, Transaid.[[1]](#footnote-1) Implementation partners are Development Data, Zambia, Transaid, DAI Global Health and Disacare in partnership with the Zambian National Malaria Elimination Centre (NMEC), which is part of the Ministry of Health (MOH), and Medicines for Malaria Venture (MMV).

MAM@Scale was established in support of the Government of Zambia's strategy to eliminate malaria by the end of 2021. Building on the one-year MAMaZ Against Malaria (MAM) pilot project implemented in Serenje District over the period 2017-2018, MAM@Scale is supporting Zambia’s MOH to scale up a severe malaria innovation that will reduce preventable mortality and morbidity among children aged six months to six years in remote parts of the country.

Rectal artesunate capsules, commonly referred to as pre-referral rectal artesunate (RAS), is a cutting edge, life-saving drug for severe malaria. The pre-treatment is appropriate for hard-to-reach communities located at some distance from the nearest health facility. MAM@Scale has introduced RAS to 346 rural intervention sites in five districts of Zambia (Serenje and Chitambo in Central Province, Vubwi in Eastern Province, Manyinga in North Western Province and Chama in Muchinga Province). The population reached by the innovation is just under 300,000. RAS is supported by a community engagement approach which mobilises entire communities around a severe malaria agenda. An 'end-to-end' approach connects communities to health facilities ensuring that severe malaria case management is completed, adequate follow-up is provided, and that the health system is fully responsive to beneficiary needs.

MAM@Scale’s community engagement approach directly addresses the range of barriers and delays that prevent timely use of severe malaria and other child health services. Whole communities are empowered with information on how to identify severe malaria and what to do when signs and symptoms are recognised. Communities are supported to establish systems that help improve timely access to health services. These include food banks, emergency savings schemes and emergency transport schemes. The community engagement approach is underpinned by a number of ‘gender-smart’ strategies. These recognise that women’s and girls’ empowerment is critical to provoking and sustaining changes in health seeking behaviour. Empowerment of women and girls is also important in its own right and pivotal to achieving sustainable development.

This report presents the findings of a qualitative study on gender empowerment outcomes undertaken on behalf of MAM@Scale. The study aimed to answer the following research question:

"**To what extent does the emphasis on gender empowerment within MAM@Scale result in transformative change for women and girls and the wider community?"**

The study was undertaken in December 2019. The fieldwork focused on the project’s two core districts: Serenje and Chitambo in Central Province.

**1.2 Purpose of Assignment**

The purpose of the research study was to test the project’s gender empowerment theory of change by examining the extent to which women and girls in the project’s intervention sites have transitioned from a situation where they have limited power, to one where they have the capacity, confidence and agency to address inequities and challenge power inequalities. The study set out to examine the health-related effects of the MAM@Scale empowerment process, but also to look beyond health at other aspects of women's and girl's lives.

**1.3 Structure of Report**

The remainder of this report is organised as follows:

* **Section 2** describes the assignment methodology
* **Section 3** outlines the conceptual framework for the study
* **Section 4** presents key findings and analysis from the study
* **Section 5** provides a summary of the changes identified by the study
* **Section 6** concludes the report and looks at policy and programme implications.

Supporting documentation is included in Appendices 1 - 2.

**2. METHODOLOGY**

**2.1 Study Team and Timeframe**

The study team comprised Cathy Green (MAM@Scale Senior Technical Adviser) and the project’s district-based technical team: Ernest Chanda (Technical Co-ordinator), Ruth Nyirenda (District Programme Officer), Bernard Mpande (Emergency Transport Scheme (ETS) Officer) and Sebastian Simpasa (ETS Officer). In some sites the team was supported by MAM@Scale Community Facilitators (see acknowledgements section). Key members of the District Health Management Teams (DHMT) joined the study team during the fieldwork, participating in the interviews. This included Mrs. Namwinga Katowa, MCH Co-ordinator and Ms. Nyambe Mbumwae, Acting District Health Director from Chitambo DHMT and Mrs Cynthia Lesa, MCH Co-ordinator, Serenje DHMT.

Ernest Chanda and Ruth Nyirenda oversaw the assignment logistics in the study sites. Dennis Simuyuni, MAM@Scale Operations Manager supported other aspects of the research logistics. All district-based team members conducted interviews and, at times, acted as translators. The ETS Officers ensured timely travel to and from the study sites.

The research was undertaken over a seven day period from 16-22 December 2019. Specific dates for the fieldwork in each district can be found in Table 1.

**Table 1: Timing of Fieldwork by District**

|  |  |
| --- | --- |
| **District** | **Fieldwork Dates**  |
| Serenje  | 16-18 December 2019 |
| Chitambo | 20-22 December 2019 |

**2.2 Study Sites**

The study was implemented in the catchment area of eight health facilities, equivalent to 21 percent of intervention facilities in Chitambo and Serenje. Study respondents came from 18 intervention communities (or Neighbourhood Health Committee areas – NHCs), equivalent to ten percent of intervention NHCs in the two districts.

The study sites were selected by the research team and were intended to represent a cross-section of project communities. The following criteria informed the selection process: whether the site was new to MAM@Scale or had a history of intervention by earlier projects (e.g. Mobilising Access to Maternal Health Services in Zambia – MAMaZ (2010-2013); MORE MAMaZ (2014-2016); or MAM (2017-2018); performance levels (i.e. level of engagement of community health volunteers (CHVs) and the community in the severe malaria activities); and distance from the health facility.

Fourteen study sites were old project sites and four were new sites. The study districts, health facilities and research communities are listed in Table 2.

**Table 2: Study Sites by District**

|  |  |  |  |
| --- | --- | --- | --- |
| **District** | **Health Facility** | **Study NHC** | **Old / New Site**  |
| Serenje | Mulilima RHC | Fitebo | Old |
| Kebumba | Old |
| Chibwe | Old |
| Kabamba RHC | Teta | Old |
| Kansangwa | New |
| Serenje Urban Clinic | Kabwe Kupela | Old |
| Nchimishi RHC | Kalowa | New |
| Saninga | New |
| Ndabala RHP | Kamalamba | New |
| Chitambo | Mulaushi RHP | Nshimba | Old  |
| Yoram Mwanje RHP | Myenje | Old  |
| Static | Old  |
| Milumbe | Old  |
| Mwape | Old |
| Mpelembe RHC | Static | Old |
| Miseshi | Old |
| Chikandakanda | Old |
| Kaunda | Old |
| **Total** | **8** | **18** |  |

**2.3 Interviews and Respondents**

Semi-structured interviews were the main research method used. In addition, a couple of natural group discussions were also undertaken. Interview respondents fell into the following categories:

* Male community members
* Female community members
* Male community health volunteers
* Female community health volunteers
* Male ETS riders or custodians
* Female ETS riders or custodians

An interview checklist was compiled and used as an aide memoire by the study team (see Appendix 2). Interview questions were framed in an open-ended way and tailored to suit the target audience. Interviewers explored specific themes and issues with respondents, following the natural course of discussion.

A total of 60 interviews was carried out, comprising 58 semi-structured interviews and two natural group discussions. See Table 3 for a breakdown of the number of study respondents per district.

**Table 3: Respondents by District**

|  |  |  |
| --- | --- | --- |
| **District** | **Individual Interviews** | **Group Discussions** |
| Chitambo | 28 | 2 |
| Serenje | 30 | - |
| **Total** | **58** | **2** |

Table 4 below provides information on the number of each category of respondent interviewed. It is worth noting that in practice the distinctions between the various categories of respondent were not always straightforward. For instance, some male riders were also CHVs. Respondents in this group were categorised as male riders. In addition, some female community members had been trained as safe motherhood action group (SMAG) volunteers in the past, but had not received a malaria training from MAM or MAM@Scale. These women were categorised as CHVs since they were active volunteers within their community. Lastly, several of the respondents were also traditional leaders, combining this leadership role with being a volunteer.

**Table 4: Category of Respondent**

|  |  |  |  |
| --- | --- | --- | --- |
| **District** | **Serenje** | **Chitambo** | **Total** |
| Male community member | 5 | 5 | 10 |
| Female community member | 10 | 6 | 16 |
| Male ETS rider / custodian | 3 | 6 | 9 |
| Female ETS rider / custodian | 2 | 2 | 4 |
| Male CHV | 3 | 2 | 5 |
| Female CHV | 7 | 9 | 16 |
| **Total** | **30** | **30** | **60** |

Of the 60 respondents, 24 were male and 36 were female.

**2.4 Study Process**

This was a small-scale study with six days allocated to the fieldwork component and one day for compilation of field notes. The study team spent three days each in the field in both Serenje and Chitambo districts.

The material gathered during interviews and group discussions was recorded in notebooks. Findings were triangulated by interviewing representatives of different respondent groups within a single community. This included: traditional leaders, ordinary members of the community (male and female, young and old), and volunteers (male and female). Key facts and dates were checked with the MAM@Scale team and DHMT staff where appropriate.

During the fieldwork phase, briefing and/or debriefing meetings were held with the DHMTs where appropriate. In Chitambo, the team was accompanied to the field by the Acting District Health Director and MCH Co-ordinator and hence a debriefing session was not required. In Serenje, the research team debriefed with the District Health Director, Dr Moonga at the end of the fieldwork.

During the data analysis stage, the research findings were coded by theme. The findings were analysed to determine whether there were common views on particular issues and themes (i.e. the extent of change at community level), or a range of different perspectives. This part of the research was undertaken as a desk-based activity.

**2.5 Methodological Issues and Challenges**

The study was undertaken during the rainy season when households were busy planting their fields. The research team therefore had to be opportunistic and interview respondents who were available. This meant that it was not possible to interview an equal number of male and female respondents (40 percent were male and 60 percent were female).

The limited days available for the study and the wide-ranging subject matter meant that there was inadequate time for in-depth exploration of all focal issues. Some topics (e.g. gender-based violence) were therefore given priority, and this is reflected in the depth of analysis and amount of material presented in this report. The study does not claim to be exhaustive therefore. Rather, it provides a starting point for further fieldwork and analysis, perhaps in a follow-on programme.

During the research it was evident that community members and volunteers compared the changes that had happened in their community with the situation prior to the first project that was operational in their area, whether it was MAMaZ (2010-2013), MORE MAMaZ (2014-2016), MAM (2017-2018) or MAM@Scale (2018-2020). Behaviours evident before the first project were referred to as ‘the old way of doing things’ and after as ‘the new way of doing things’. Although MAM and MAM@Scale focus on severe malaria and other child health issues, respondents also referred to changes in social norms that affected women’s health, which was the subject of the earlier two projects (MAMaZ and MORE MAMaZ). This way of recognising and reporting change across many different domains is holistic. However, it also makes it more challenging for researchers to drill down into narrowly focused and project-specific research topics.

It is important to note that this study was an internal review. This combined with the fact that the study involved just ten percent of the MAM@Scale intervention sites in the project’s two core districts mean that it will be important to triangulate the findings in this report with the programme's end line survey which will be implemented in April 2020. It would also be interesting for future research to examine gender empowerment outcomes in the three districts in which the project has supported a less intensive implementation approach (Vubwi, Manyinga and Chama).

**3. CONCEPTUAL APPROACH**

**3.1 Implementation Context**

MAM@Scale’s design phase identified a wide range of contextual factors and social norms that affected women’s ability to respond in a timely way to child health emergencies. These included:

* The low priority afforded to women's and children’s health at community level. This led, amongst other things, to a lack of planning and preparedness for health emergencies;
* A wide range of social norms which undermined communities’ early response to child health emergencies, including:
	+ harmful health-related practices (e.g. use of traditional medicines to treat sick children)
	+ beliefs about the causes of sickness in children that led to life-threatening delays
	+ low male involvement in children’s health
	+ women's lack of voice and capacity to make independent decisions about their children’s health
	+ women's lack of access to finance / other resources that would enable access to care
	+ normalisation of gender-based violence
	+ normalisation of aggressive / destructive behaviour associated with alcohol abuse
* Significant practical constraints of access to emergency and routine child health care (e.g. long distances, challenging terrain, poverty, lack of information, lack of social support);
* Evidence of low reserves of social capital at community level and few examples of communities working together to support families experiencing a health emergency.

These demand-side constraints combined with a wide range of supply-side constraints (e.g. a weak referral system; and shortages of essential drugs, consumables and equipment) to limit uptake of child health services.

**3.2 Gender Empowerment Approach**

MAM@Scale adopted a gender empowerment approach to address the wide range of disabling social norms that constrained women's and girl's ability to respond to child health emergencies. Seven 'gender-smart' strategies were devised to promote empowerment within intervention communities. These were:

* Using an inclusive participatory **community engagement approach** to mobilise communities around a child health agenda. Empowering communities to establish, manage and sustain their own systems for addressing barriers and delays to use of health services.
* Addressing **social norms that disempower women and girls** in community discussion groups and other volunteer activities.
* Placing a strong focus on **male involvement**, acknowledging that women's access to health information and children’s timely access to health services were contingent on supportive gender relations.
* Adopting a **whole community approach** so that all women and girls were reached and empowered, including the socially excluded.
* **Training large numbers of community volunteers** to: ensure adequate capacity to reach every woman; create a network of male and female role models who could positively influence the community change process; and to motivate and sustain the work of the volunteers via creation of a mutual support network.
* Creating an **enabling environment for women's and girl's empowerment** by involving traditional leaders in the change process, and specifically encouraging changes to local by-laws and directives.
* **Working with front-line health providers** so that they proactively support women's and girl's - and their children's - rights of access to health-related information and quality services. Front-line health providers are trained as core trainers in the project’s gender empowerment and health equity focused community engagement approach.

The project’s gender empowerment theory of change is outlined in the figure below.



**3.3 Analytical Framework for Study**

The study examined gender empowerment-related changes in three interrelated areas:

* Changes in **formal and informal institutions** that mediate life chances and choices (Box 1)
* Women and girls' ability to exercise **voice, influence and agency**
* Women and girls' ability to **access and control resources / services**, take up opportunities and build their capability.

**Box 1: Formal and Informal Institutions of Power**

**Formal institutions** are the policies, processes and legal frameworks in wider society, the state or traditional governance systems, such as inheritance or ownership laws that discriminate against women.

**Informal institutions** are the rules by which societies operate and include the cultural values and norms that devalue and discriminate against women and girls, such as restricted mobility, early marriage, or rules about the division of labour within the household.

Discriminatory cultural values are often internalised through socialisation from a young age, and taken for granted as normal or natural.

The study was also informed by the 'four powers' framework’, which is based on work by Rowlands (1997)[[2]](#footnote-2) and VeneKlasen and Miller (2002)[[3]](#footnote-3). This measures changes in women and girls’ power in the following four areas:

1. ***Power within*** – Knowledge, individual capabilities, sense of entitlement, self-esteem and self-belief to make changes in their lives, and get the skills they need.
2. ***Power to*** – Decision making power within the household, community and more broadly, within areas traditionally within expectations for women, as well as to areas that go beyond these, expanding the scope of influence to those areas traditionally seen as male.
3. ***Power over***– Access to and control over financial, physical and knowledge-based assets.
4. ***Power with*** – Ability to organize with others to enhance the realization of rights.

Using a gender analytical framework, the study looked at shifts in power, opportunity and voice in a relational sense - shifts between men and women; between women and members of their extended family; and between women and social institutions at community level and beyond. The study looked for evidence of empowerment among male respondents, and specifically at changes in their self-belief, sense of being respected, motivation and sense of achievement. These changes were also analysed from a relational perspective i.e. “how do empowerment related changes among men impact positively on women?”

While primarily exploring the relationship between empowerment and improvements in health access and outcomes, the study also **looked at empowerment in other domains**. The social norms approach to measuring women's and girls' empowerment was a useful reference to this end.

Six empowerment indicators can be used to track changes in the social norms that hold women and girls back throughout women's lifecycle (Harper *et al*, 2014*)*.[[4]](#footnote-4) These are:

1. Women and girls exercise choice over their sexual and reproductive integrity
2. Women and girls enjoy freedom from violence
3. Women and girls enjoy enhanced decision-making ability over land and assets
4. Women attain enhanced participation in political and civic life
5. Equal value is given to girls and boys
6. Unpaid care is equally distributed between women and men, girls and boys

The research study explored the extent to which the project had impacted on some of these areas, including: freedom from violence; enhanced decision-making; enhanced participation in political and civic life; and unpaid care.

**4. FINDINGS AND ANALYSIS**

**4.1 Introduction**

The findings and analysis in this section have been organised according to the three key strands of the gender empowerment framework outlined in Section 3.3. These are:

* Changes in **formal and informal institutions** that mediate life chances and choices
* Women and girls' ability to exercise **voice, influence and agency**
* Women and girls' ability to **access and control resources / services**, take up opportunities and build capability

**4.2 Changes in Informal and Formal Institutions**

4.2.1 Changes in Social Norms

In rural Zambia various cultural values and social norms devalue and discriminate against women and girls. These affect their own and their children’s access to healthcare and, in turn, impact on their health status and outcomes. They can also have negative effects on other aspects of women’s lives. The gender empowerment study set out to examine the extent to which some of these disabling social norms have changed, or have started to change, as a result of the project’s interventions, creating opportunities for empowerment-related gains. The study focused on two key areas: the lack of male involvement in children’s health and gender-based violence (GBV).

*4.2.1.1 Lack of Male Involvement in Children’s Health*

Prior to the start of MAM and MAM@Scale childcare and child health issues were conceptualised as 'women's issues' in the projects’ intervention communities. Generally, every day care of children fell to women, sometimes supported by older children in the household. Responsibility for taking children to under-five outreach services (for immunisations and other screening services) or to the health facility when they were sick also fell to women. However, women were expected to consult with men before seeking healthcare for children, especially in the event of an emergency. Concerns about cost or about women not being around to fulfil other tasks such as cooking or care of other children influenced the decision-making process. If men were absent from the home because they were busy farming, meeting with friends, or looking for work outside the area, this would lead to delays in decision-making. The lack of male involvement in children’s health was grounded in a fixed gender division of labour, and was indicative of women’s overall low status within gender relations.

Recognising that women's and children’s access to health information and services is contingent on supportive gender relations, all the MAMaZ projects (i.e. MAMaZ, MORE MAMaZ, MAM and MAM@Scale) have made male involvement a centrepiece of their design. Male involvement is also important if disabling socio-cultural norms are to be contested. The strategies used to promote male involvement have included:

* Adopting a 'whole community approach'; engaging entire communities around a women’s and children’s health agenda.
* Recruiting and training equal numbers of male and female CHVs. This helps to ensure that community members have both male and female role models.
* Using multiple strategies to reach men, acknowledging their other activities and responsibilities (e.g. targeted door-to-door visits if men are unable to attend community discussion groups; scheduling discussion groups to take place at times when men are gathering in large numbers).
* Drawing on the support of traditional leaders to promote men's participation.
* Recruiting and training men as ETS riders.
* Encouraging men to help manage or contribute to community emergency systems (food banks, emergency savings schemes, ETS).
* Interacting with men in a respectful way; emphasizing household unity rather than confronting men about gaps in their support.

The gender empowerment study found that very considerable change had occurred in the research sites as a result of the projects’ emphasis on male involvement. This has manifested in several ways: men’s willingness to participate in community mobilisation activities and an appreciation of the importance of the new knowledge gained through these interactions; a willingness to take sick children to the health facility or to under-five outreach sessions; a willingness to play a more visible and proactive role in the care of children at home; and some evidence of men starting to take on other reproductive tasks[[5]](#footnote-5) (e.g. cooking, house cleaning, fetching food from the garden etc) which have traditionally fallen to women. These issues are discussed below.

Men's Participation in Community Mobilisation Activities

In the new project intervention sites, where communities have been exposed to child health-focused mobilisation efforts for approximately nine months, respondents reported that many men were participating in community discussion groups. Although a few men in these sites were said to be resisting the call to action, particularly younger unmarried men or men who were heavy drinkers, the CHVs felt confident of their ability to successfully reach and support these men.

The discussion groups provide an opportunity for ordinary members of the community to reflect on the barriers and delays that prevent sick children from reaching health care and encourage them to devise strategies to address these. The discussion groups are scheduled to take place at times when men are more likely to attend, for example, after a funeral or when men are involved in ‘community service’ (e.g. helping clear the grounds of the local school). In instances where men fail to attend the groups, door-to-door visits are used to reach them.

CHVs’ efforts to promote male involvement are reinforced by directives introduced by traditional leaders. Multiple strategies are therefore being used to promote male involvement. The quotations in Box 2 suggest that many men are actively participating the discussion groups.

**Box 2: Men's Involvement in Community Discussion Groups**

“The post-funeral meeting was the one that impacted on me and also my fellow men. Everyone was around when the CHVs were teaching. Men in this community are usually busy with farming and when they knock off they go drinking. Since that meeting I’ve been involved in community discussions and I encourage my fellow men to attend too. Luckily they are complying.” (Male community member, Teta, Kabamba, Serenje).

“Men have seen the value and appreciate the work that the CHVs and riders do for the community and now the male flock are getting involved in the community meetings.” (Male ETS rider, Kebumba, Mulilima, Serenje).

“I am now attending every community meeting that is held in our village.” (Male community member, Kalowa, Nchimishi, Serenje).

“What is encouraging is that men are encouraged to be part of the meetings. So it is not only women. Men are also learning. Mostly men who are married go, but younger men aren’t going. They shy out. We will try to get them to attend.” (Female community member, Myenje, Yoram Mwanje, Chitambo).

“I have seen men start to attend these community meetings.” (Male community member, Yoram Mwanje, Chitambo).

“Men are participating in the group discussions and also in community meetings and because of this we have seen change in our community.” (Male ETS rider, Chikandakanda, Mpelembe, Chitambo).

“Male involvement is very high. It starts with the headman who encourages men to participate in the discussion groups.” (Female ETS rider, Kebumba, Mulilima, Serenje).

“Men and women are involved in the community discussion groups. And they invite people of all ages to come and attend these meetings.” (Female community member, Mwape, Yoram Mwanje, Chitambo).

“There’s still more to do to encourage men. Not all have changed. Some still drink a lot and others don’t attend the discussion groups.” (Female community member, Mwape, Yoram Mwanje, Chitambo).

“In the past we would call meetings and men would not come. This time, because of the benefits to their children, there are a lot of men who attend the discussion groups.” (Male CHV, Nshimba, Mulaushi, Chitambo)

“Other men have realised that it’s important to be involved in the severe malaria discussions so that they can save their families and save the community. Men are making changes and getting involved.” (Male CHV, Teta, Kabamba, Serenje)

The recognition that very sick children were being dealt with promptly and professionally by CHVs, bicycle ambulances were working, and food banks and savings schemes were operational and supporting some families, inspired men who were slow to participate initially to get involved in the community discussions.

In the old sites where a process of change has been underway over a much longer timeframe, male involvement in women’s health has become the ‘new normal’. In contrast, their proactive involvement in children’s health and care was reported to be a relatively recent phenomenon.

Overall, the combined effect of the various strategies to promote male involvement has been transformative, leading to a high level of male acceptance of and support for the new ideas and more active engagement by men in children’s health. The quotations in Box 3 below provide examples of some of the strategies used by CHVs to promote male involvement.

**Box 3: Strategies Used to Promote Male Involvement**

"Some men were very stupid in this community. Sometimes they would refuse if you asked to spend some time with them. But when us CHVs intervene as a group, it’s changed their lives for the better. We work in sections[[6]](#footnote-6) and in groups so we make an appointment to see a family. If they refuse we would go to see them in a bigger group of CHVs.” (Female CHV, Chikandakanda, Mpelembe, Chitambo).

“Male involvement is improving. It starts with the headman who encourages men to participate in the discussion groups. He also works with the CHV chairperson who is very active and they bring people together.” (Female community member, Miseshi, Mpelembe, Chitambo).

Men's Severe Malaria and Child Health Knowledge

Men reported that they are more knowledgeable about child health issues as a result of their involvement in the community mobilisation activities. The key severe malaria messages disseminated by the CHVs (i.e. know the severe malaria danger signs; take a sick child with suspected severe malaria to the CHV for RAS; get a referral letter and go to the health facility; stay at the health facility to ensure that the child has three doses of injectable artesunate) were well known by men who had attended the group discussions. In addition, the message that men need to be more involved in caring for sick children, and helping with the care of children more generally, was well known (Box 4).

**Box 4: Men Reporting New Knowledge on Severe Malaria and Child Health**

“These meetings have benefitted me a lot. They taught me on severe malaria signs and they taught me on the new drug they are giving in the community and health education on how to take care of my children when they are sick. I’m taught how to take care of myself and my wife.” (Male community member, Milumbe, Yoram Mwanje, Chitambo).

“I have learnt the new knowledge with the help of my wife who invited me to the first meeting which turned out to the beginning of my new life.” (Male community member, Kalowa, Nchimishi, Serenje).

“I learnt about malaria, diarrhoea and pneumonia in children. I learnt a lot of things for example how to identify symptoms. I now know the symptoms of severe malaria.” (Male community member, Kalowa, Nchimishi Static, Serenje).

“The main topics that we’ve learnt are severe malaria, malaria, including the danger signs and the four actions. I can confidently teach others.” (Male community member, Myenje, Yoram Mwanje, Chitambo).

“Now with the knowledge of danger signs in children, I am able to make decisions promptly about my children’s health and this has changed the way we make decisions in my home. Now my wife or my in-laws can make a decision to take children to the clinic when they notice danger signs in them.” (Male community member, Mwape, Yoram Mwanje, Chitambo).

The study also generated evidence to suggest that the new knowledge is translating into behaviour change (Box 5). This includes taking sick children to CHVs and formal health workers rather than traditional healers (witch doctors). The use of traditional herbal remedies to treat children who are convulsing was said to be a thing of the past.

**Box 5: Men’s New Knowledge is Translating into Behaviour Change**

“In the past families would only consider taking the mothers to health facility when sick unlike children who were mostly treated from home risking their lives. There is a change now as both mothers and children find their way to the facilities when sick regardless of the time of the day. Community members are able to notice signs of severe malaria and take action. In the past signs of severe malaria such as fits were mistaken to be witchcraft attacks called *ümusanfu* and only herbs were given to the sick child. There was even a belief that every child had to undergo fits at some point.” (Male ETS rider, Chikandakanda, Mpelembe, Chitambo).

‘’I have seen my community changing from the old life to the new life. Change in this community has been evident and many of us are the beneficiaries. Life has been interesting. I’m seeing inspirational change among many people I know in this community.’’ (Male community member, Teta, Kabamba, Serenje).

“Men are even escorting their wives and sick children at night to the health facility. This is a new thing. Previously it never happened….The ETS riders and CHVs have had a big influence on men.” (Female ETS rider, Kebumba, Mulilima, Serenje).

“I remember treating *umusanfu* [fitting] with *umutuntula* roots which could not work. I am happy to have found my new knowledge, which I never used to know about.” (Male community member, Kalowa, Nchimishi, Serenje).

“There is a positive change in the men. If men see that a child is sick they will immediately take it to the health facility. They never used to do this. It was the women’s responsibility to take children to the clinic. Men are doing this because many children were dying.” (Male community member, Kalowa, Nchimishi, Serenje).

“Since I learnt this I have used the information. It’s helped me. My child got sick. When I saw the signs, I knew what it was. I immediately took my child to the CHV and then to the health centre. The child had very high fever. It was malaria.” (Male community member, Nchimishi Static, Nchimishi, Serenje).

As a result of the changes in men, household level barriers that used to prevent sick children from being transferred quickly to the health facility appear to be reducing. As one male community member (who is married to a female CHV) indicated:

*“There’s a difference with the men in the community. Once they’ve been taught, you see a difference. So many men have changed. I know at least three or four men who live near me who have changed and are helping on issues to do with the children. They are taking children to under five sessions. Some men are bringing their children to my place [to see his wife who is a CHV] and then taking the child to the health facility.”*

Men’s Involvement in the Care of Children

The research identified very significant shifts in men's attitudes towards their role in caring for sick children – and in caring for children more generally. Once categorised as ‘women’s work’, many men had a new perspective on their role in childcare. These changes were seen in both the old and new intervention sites. In the old sites men were already very involved in maternal health issues, accompanying their wives to antenatal care sessions, and to the health facility for delivery as a result of interventions implemented by the MAMaZ and MORE MAMaZ projects. However, even where maternal health-related changes were evident, men’s attitudes towards their role in the care of children had not shifted until recently (Box 6).

**Box 6: Changing Attitudes Towards Care of Sick Children**

“Men now want to help women when children get sick. In the past, it was only women alone who would do this.” (Female CHV, Teta, Kabamba, Serenje).

“In the past it wasn’t common for a man to take much notice of whether his children were sick. These days, if the wife isn’t at home, they are checking children, recognising signs and bringing the children to the CHV if they think they are sick. This is an amazing change. It never used to be like this.” (Male CHV, Nshimba, Mulaushi, Chitambo).

“It [the work of the CHVs] has really been helpful. If we have a sick child at home my husband takes them to the CHV. He never used to do that. This change is because of the lessons in the discussion groups.” (Female community member, Teta, Kabamba, Serenje).

“One man, even if his child was sick wouldn’t touch the child. The woman, his wife, would take the child to the health facility. Now he’s bringing the children to the health facility himself and he’s joined us as a rider. I was so surprised since he never used to get involved in anything. CHVs did door-to-door visits and they took an interest in his family. Once he saw that the CHVs were interested in his family’s welfare and showing him and the family respect, he started to take an interest.” (Female community member, Nshimba, Mulaushi, Chitambo).

“Male involvement has improved. Now many men bring sick children to the CHV. Men are also taking sick children on their back to the health facility. So many men are doing this.” (Female CHV, Kansangwa, Kabamba, Serenje).

“With men, so many things have changed. They are taking care of children.” (Female ETS rider, Kebumba, Mulilima, Serenje).

“In the past it was the mother who would take the sick children to the CHV. Now it’s both the mother and the father in case the child needs to be rushed to the health facility.” (Male ETS rider, Chibwe, Mulilima, Serenje).

“It feels really nice that my husband is looking after me more now. In the past, six of my children died from malaria. My husband never tried to get the children to the health facility. He didn’t try to help and six children died. There was no-one to educate him on the importance of taking children and his wife to the health facility. He’s now educated.” (Female community member, Teta, Kabamba, Serenje).

“Men used to be so negative. They told their wives to stay in the village. Now men have more respect for the women. It’s very common to see men with children on their backs walking with their wives and helping at home. If the child is sick, you’ll find the men here asking the CHVs for help and then taking the child to the health facility.” (Female community member, Nshimba, Mulaushi, Chitambo).

“Things have changed with men. If you go and check the health facility, it’s mainly men who are bringing their children there. Men are being told that children have a right to be cared for at the health facility. Men are also looking after children more at home.” (Female CHV, Fitebo, Mulilima, Serenje).

“There’s a big change in our community. In the past a father would tell his wife to take a sick child to the health facility. He would go drinking. When he arrived home he would discover that the situation was very bad and the child was very sick. Now men will stop what they are doing and even go with their wife to the health facility. This is because of the training they’ve received. I never used to see this previously. It’s because of the work of the CHVs.” (Male ETS rider, Mwape, Yoram Mwanje, Chitambo).

In the new intervention sites, where community mobilisation efforts have been underway for nine months, the changes were not consistent across the whole community. As one male community member in Nchimishi, Serenje argued:

*“Not all men are taking children to the health facility. Some are still refusing, saying that women are the ones who know about sickness in children. These men can change. They can learn.”*

This suggests that that it can take time for positive behavioural changes to reach the entire community. What was evident, however, was that men who were resistant to new ideas were criticised by their peers and seen as ‘behind the times’ and holding on to ‘the old life’. Male CHVs felt confident that these men would start to change as they observed other men in the community getting involved in the care of children. This shows the power of a whole community approach where ‘early adopters’ influence other men to change and ‘late adopters’ are subjected to peer pressure to follow suit.

Men’s Involvement in Other Reproductive Tasks

Other changes reported by respondents included: a willingness among men to take care of children who were experiencing minor health problems; and men’s increased involvement in the day to day care of children (e.g. cooking for or bathing or cleaning them). These changes represent small but significant shifts in the gender division of labour and hence have the potential to be transformative from a gender empowerment perspective (Box 7).

**Box 7: Increase in Male Involvement in Other Reproductive Tasks**

“When men are involved, they get to help the women. Sometimes we see them taking children to the health facility or to under five outreach clinics. You’ll see men carrying a child on their backs. This is a change in this community. Although there are few men who are doing this, it’s a change. Men are given priority in the queue for child health services when they turn up with their children. This is done to encourage them to attend. They don’t stay for long. They quickly return home. It is a good incentive. Women may stay for the whole day.” (Male CHV, Teta, Kabamba, Serenje).

“Before the community discussion groups, men never used to help women do household work. A man who would do that was looked down upon. However, nowadays a man who helps the wife is admired by other women and is referred to as model to emulate. Indeed, some men are really helpful and have become role models for others to imitate.” (Female community member, Mwape, Yoram Mwanje, Chitambo).

“Women are encouraged to clean the surroundings of the house to keep mosquitoes away when they go to under five child health sessions. When they get back home and explain to their husbands, some have started to help the women clean. There is a strong tradition that women do the cleaning so this is a big change.” (Male CHV, Teta, Kabamba, Serenje).

“There are so many men who are managing in a good way in the community. Some you would find cooking, some will take their children to the health facility. Only a few men are difficult – drunkards – but most men are really trying to help their wives. It’s the lessons that MAMaZ has brought that has brought about the change.” (Female ETS rider, Kebumba, Mulilima, Serenje).

“What we tell the men is that if the child is sick at home and the mother has another small child, men should help by taking the child to the health facility. We also tell them, if the mother is not at home they should be able to cook for the children. This is what we are telling the men. At first men used to say ‘why should we cook at home, that not our duty’. We kept insisting. We kept explaining. Some men said ‘actually it’s quite nice because I’m tasting the food as I work and it’s nice!’” (Female CHV, Kalowa, Nchimishi, Serenje).

“A long time ago before the programme, men never used to do anything. But after learning, they started cleaning their surroundings – cutting grass and covering standing water – to reduce the number of mosquitos. We went into the community to teach fellow men and women to take care of their homes. Men aren’t resisting anymore. They find that these changes are a good thing.” (Male ETS rider, Teta, Kabamba, Serenje).

“I have inspired many other men in my community, and they are now changing too, they are taking part in what we thought were women jobs like taking children for under five, cleaning the surrounding and fetching water.” (Male community member, Teta, Kabamba, Serenje).

“Men are not just being encouraged to help when their wives are sick. If she’s busy, sick or not, we should help as she has so much to do. If she is cooking *nshima* and she has to deal with another issue then men can continue the cooking. Most men respond well to these messages. I’m one of the ones who has changed and one of my friends. In the past, I used to sit and my wife used to do everything. After the community meetings, I realised that she can’t do everything. Now I go to the garden to fetch vegetables and I cook. You can even go and ask my wife. I’m not lying!” (Male community member, Myenje, Yoram Mwanje, Chitambo).

“Because I’m a man I try to set an example. I tell other men that you can copy what I do. You will have seen the clothes hanging on the line at my place. I washed those clothes. I’m sensitizing other men to be more involved at home. Men should take their children to the health centre. If their wife is pregnant, they should take her to the clinic so they can learn about the danger signs in pregnancy.” (Male CHV, Kalowa, Nchimishi, Serenje).

It will be important to monitor whether the task-shifting identified in the new MAM@Scale intervention sites has been sustained, leading to lasting changes in the gender division of labour. This could be the subject of future empowerment-related research.

*4.2.1.2 Gender-Based Violence*

GBV is unfortunately very common in Zambia: 45.9 percent of women and girls report having experienced sexual or physical violence in their intimate partner relationships during their lifetime; 26.7 percent during the last 12 months (UN Women, 2020).[[7]](#footnote-7) Ten percent of women have reported physical abuse when pregnant (CSO, MOH and ICF, 2014).[[8]](#footnote-8)

When homes are disharmonious and women feel under threat they are more likely to suffer from depression or exclude themselves from other members of the community. This can reduce their capacity to care for themselves or their children. Women who live in violent households may also be less able or willing to negotiate with their husbands if a decision needs to be made about a child health emergency. Hence **GBV is an important underlying social determinant of children’s health care access and status.**

At the start of MAMaZ and MORE MAMaZ violence against women and girls was a problem in the project intervention communities. The issue was largely hidden, treated as a 'family matter' and hence not commonly challenged. As a result, many women suffered in silence. In response, a GBV component was added into the training of CHVs. The volunteers were trained to facilitate a process of reflection and debate on GBV in community group discussions, door-to-door visits, and in community meetings. The linkages between heavy drinking and violence were discussed. 'Zero Tolerance for Wife Beating' songs were used to confront and challenge the way in which GBV has been normalised. As a traditional and widely accepted medium for communicating ideas and messages, the songs allowed the CHVs to raise the issue of GBV in a non-confrontational way. Traditional leaders were encouraged to support and reinforce the work of the volunteers by helping to arrange community meetings, and by introducing supportive local by-laws. In the malaria-focused projects MAM and MAM@Scale, although GBV was included in the CHV training curriculum, less time has been given to the topic.

The empowerment research therefore looked at the extent to which GBV-related changes were evident in the old and new intervention sites and what effect these changes had had, if any, on women’s and girls’ capacity to respond to child health emergencies or to care for their children more generally. The research found that GBV has reduced markedly in the old intervention sites, with reports of just a few individuals resisting change. These men are considered to be “not 100% normal”, in other words to operate outside acceptable social norms. This in itself suggests a change in perspective as GBV shifts from being normalised to being seen as ‘wrong’. CHVs and traditional leaders target these men as ‘problem cases’.

In contrast, GBV was reported to be a bigger problem in the new sites (Boxes 8 and 9).

**Box 8: Perceptions of Gender Based Violence in Old Intervention Sites**

“Men are now getting more into child health issues. They used to beat their wives. They used to be so drunk, but they’ve changed. They’ve reduced the amount they drink. These men are asking to join the group of CHVs. The men now know that if they beat their wife we will take them to the police. So many people can see the benefit of the work we’re doing. Those who want to change are inspired that others have changed. They see the bicycle ambulance riders and other men who have changed. This really helps.” (Female CHV, Chikandakanda, Mpelembe, Chitambo).

“There has been a huge reduction in GBV. Men no longer come from a drinking spree and beat their wives. I’ve never heard or seen anyone fighting. It has no benefit. Someone who is my partner, it’s better to resolve issues. Men need to look down on themselves and ask ‘what is the point of fighting and beating if you can work this out.’ You have to have self-respect as a man. If you beat a woman the community would look down on you and you’d lose respect.” (Male community member, Myenje, Yoram Mwanje, Chitambo).

“Domestic violence and beer drinking has reduced drastically in our community because of these community meetings which have taught us to share responsibility in our family between husbands and wives and respect each other. We are grateful to the CHVs.” (Male community member, Mwape, Yoram Mwanje, Chitambo).

“Most men have reduced beer drinking, and domestic violence is left only in few pockets of the community and men have started attending community meetings.” (Male community member, Mwape, Yoram Mwanje, Chitambo).

‘’There is evidence of reduction in the intake of alcohol drinking and relationships among both the youths and the elders. A few are still involved in GBV and there is big hope that these characters will soon be history.’’ (Female community member, Kebumba, Mulilima, Serenje).

“There are no longer problems in the community with wife beating. In the past it was common. Now it’s only one person in a thousand who does it.” (Male CHV, Nshimba, Mulaushi, Chitambo).

“At the moment there is no record of any wife beating in our community. Every 2-3 months we educate the community about wife beating. If it’s happening it’s happening quietly at home, but word would still get around so I don’t believe it’s happening any more.” (Male ETS rider, Chibwe, Mulilima, Serenje).

‘’During the community discussion groups, CHVs also talk about beer drinking and the need to love wives. They also discourage beating wives and the need for husbands to support their wives. Things have changed. Most men take very good care of their wives and children and take children to the facility when they are sick. Wife beating has reduced as CHVs work with traditional leaders to help husbands and families involved.” (Female community member, Miseshi, Mpelembe, Chitambo).

**Box 9: Perceptions of Gender Based Violence in New Intervention Sites**

‘’Some men are still beating the wives due to beer drinking, just as you can see I stay just behind the bar for my neighbour, people here drink a lot. If it’s the youths, its worse but with the coming of the CHVs we hope to see a difference.’’ (Female community member, Kamalamba, Ndabala, Serenje).

“’I leant during a meeting that beating my wife will never make me a man but will just ruin my family. There had been this tendency around here that beating a wife is a sign of ‘’love’’ but since I started attending meetings I have seen my self-reducing my unnecessary tempers.’’ (Male community member, Kalowa, Nchimishi, Serenje).

“We do have a problem with GBV in this community. I’m teaching men at church about violence against women. I have managed to change some men’s behaviour on this issue. Some of these cases are due to heavy drinking. Other men simply don’t want to dialogue with their wives. If they don’t want to do something they just beat them instead of talking.” (Male CHV, Nchimishi Static, Serenje).

“Wife beating is a problem here. We haven’t had any training on this issue.” (Male CHV, Saninga, Nchimishi, Serenje).

In the old MAMaZ and MORE MAMaZ intervention sites the GBV interventions have resulted in **transformative change for women.** The following changes are apparent:

* Reports of a very significant reduction in GBV, with these changes attributed to the work of the CHVs.
* Emphasis on reducing alcohol consumption in some areas in support of the anti-GBV initiative.
* Widespread perceptions of greater harmony in the home.
* Willingness of CHVs to intervene to address or prevent cases of wife battering.
* Traditional leaders championing the elimination of violence against women, creating an enabling environment for change.

One female CHV from Chitambo argued:

*“Our neighbour was beating his wife, but after I intervened he stopped completely. The Head Man approached me this year. He told me that another man was beating his wife. He asked me to intervene. I’m happy to improve other people’s marriages and to help other women. We have been doing this for some time and know how to approach these men. We don’t go to see them when they are being violent. We wait for them to calm down. When we reach their houses we are given a lot of respect because we are health workers. I gently take the men through the fact that they are supposed to take care of their wives. They listen to me. It’s not always alcohol that makes men violent. It’s just the attitude of some people.”*

A subject that was once taboo is now being discussed at community level. During the study, a number of both male and female respondents, CHVs and ordinary members of the community, freely admitted to having had a violent past (Box 10). Their readiness to talk openly about GBV encouraged other men in the community to reflect on their behaviour.

**Box 10: Personal Experience of a Violent Past**

‘’I have changed my lifestyle from a bully to a good husband, I used to beat my wife and drink a lot of beer, all this looked normal to me until after the CHV meetings. I now care for my family than before, children goes to school and I take my child for under five immunisation monthly sometimes.’’ (Male community member, Teta, Kabamba, Serenje).

“Quite a lot has changed in my own home….My husband used to beat me. He was a drunkard. He’s stopped doing that and our love life has improved. I used to invite my husband to discussion groups. My status [as a CHV] changed in the community. People gave me a lot of respect. My husband saw this and also began to change. He stopped beating me. He stopped drinking. He got inspired as I started to educate him. It has worked better, when sensitizing other men, to give an example of my own life history. Those listening take it seriously. If think that if my husband has changed then they can also change. My husband also shares his experience. He has given the example of his own life to others. It’s a big change. He says ‘what happened to me can also happen to you.’” (Female CHV, Static, Mpelembe, Chitambo).

The links between drunkenness and GBV were openly acknowledged by study respondents. CHVs in all intervention sites were aware of the need to address this issue (Box 11).

**Box 11: Reaching Men Who Drink Excessively**

“Our strategy is to give examples of those who have changed in the discussion groups. We say that we want men to follow this example. It’s usually of men who have reduced their intake of alcohol and this inspires other men to do the same. Both male and female CHVs are comfortable discussing these issues. We’re getting very positive feedback from the wives of the men who have changed. The relationships of these men have really improved. In the community they interact and in the meetings they have really improved. There’s no wonder men can care for their families now. We give examples of drunkards in our meetings. People who drink a lot are regarded as not 100 percent normal. Usually drunkards don’t care for their families. The community disapproves. The men think ‘instead of me facing disapproval, I will change.’” (Female CHV, Static, Mpelembe, Chitambo).

Hence the GBV intervention, established to address a disempowering and harmful social norm, has been highly effective in the old sites, with positive outcomes for women and girls. The slower and less widespread change in the new intervention sites points to the importance of mainstreaming a more significant GBV component into the training of CHVs in future. In the short-term, mentoring and coaching support visits to the new intervention communities can be used to provide a GBV training to CHVs, who can then share what they have learnt in their community mobilisation activities. This will be a priority for MAM@Scale going forward.

Positive changes in gender relations were reported as a result of the anti-GBV work of the projects (Box 12). This included a sense of greater harmony and peace, and also changes in the way men and women interacted with each other. Community members spoke about relationships based on male control over decision-making giving way to efforts to promote improved dialogue. The way in which CHVs have promoted the idea of husbands and wives working together in unity and partnership rather than criticising men as 'bad' or 'unsupportive', have helped the new ideas gain traction.

**Box 12: Evidence of Greater Harmony at Household Level**

‘’Love has improved in my house than before, my wife loves me more and we respect each other very well. I have inspired many other men in my community, and they are now changing too, they are taking part in what we thought were women jobs like “’taking children for under five”’ cleaning the surrounding and fetching water.’’ (Male community member, Kabamba, Serenje).

“Women are more relaxed now. They can do more things while men do some of their work.” (Female ETS rider, Kebumba, Mulilima, Serenje).

“My relationship with my family and especially my husband has greatly improved, in the past he never used to help me with my work at home, taking care of the children when am gone cooking and feeding our children, this makes me happy and l thank CHVs and MAMaZ.” (Female ETS rider, Miyenje, Yoram Mwanje, Chitambo).

‘’I never used to relate well with men in my community as I always used to think men are naturally not good including my husband, this was due to the treatment he was giving me. But after my training I focused more to change the thinking of men and I am happy this has worked well. My husband has changed and he gives me more respect since the first day he attended my meeting. I am happily living now than before and I relate very well with men in my community. My husband cares for me well even when I just have a ‘’simple flu’’ he cares for my children and he relates well with everyone now.’’ (Female CHV, Kebumba, Mulilima, Serenje).

‘’People’s relationships seems to be improving and you can see couples moving together which is a good move and a sign of change among our men in this community. Many people now including myself wish to join CHV groups in order to better our lives and help to change others like what CHVs are doing.’’ (Female community member, Kalowa, Nchimishi, Serenje).

4.2.2 Support of Traditional Leaders

The traditional governance system is one of the formal institutions that mediate women's and girl's life chances and choices in rural Zambia. Traditional leaders are powerful agents of change, and have the capacity to either reinforce or challenge prevailing social norms. It was therefore essential for the MAMaZ projects to engage with this system. The research looked at the extent to which and how the projects have engaged with the traditional governance system, and the difference this has made in terms of creating an enabling backdrop for women's and girl's empowerment.

The strategy for engaging with traditional leaders has involved the following:

* Initial sensitisation of Chiefs on the child health challenges in their area
* Initial community meeting involving traditional leaders to present the project
* Recruitment of Chief's Advisers and headmen as CHVs
* Involving local traditional leaders in community discussion groups
* On-going engagement with traditional leaders during community monitoring visits

Local traditional leaders (Chief's Advisers and area and village headmen) have helped to create an enabling environment for the work of the CHVs and ETS riders. They have been supportive in the following ways:

* Notifying communities of the timing and focus of forthcoming community discussion groups to ensure a high level of community participation
* Assisting CHVs with their efforts to engage with individuals who refuse to participate
* Creating opportunities for CHVs to engage with local people at official community meetings
* Encouraging community members to donate to community emergency systems (food banks, emergency savings schemes etc)

Examples of the support provided by the traditional leaders can be found in Box 13.

**Box 13: Support Provided by Traditional Leaders**

“The local headman asked me to intervene in a challenging situation. There are some men who are very resistant in the community. Some headmen will fail to get through to these people. So they sometimes come to the CHVs and ask us to intervene.” (Female CHV, Chikandakanda, Mpelembe Chitambo).

“I am using my role as CHV chairperson to talk to the village headman to organize a community meeting to talk to community members.” (Male ETS rider, Chikandakanda, Mpelembe Chitambo).

“Male involvement is improving. It starts with the headman who encourages men to participate in the discussion groups. He also works with the chairperson who is active and they bring people together.” (Female community member, Miseshi, Mpelembe, Chitambo).

“My work has been made to be peaceful and conducive by the interventions of the headman who is always there to remind the general populace to follow laid down procedures with regard to the use of the bicycle ambulance.” (Male ETS rider, Chikandakanda, Mpelembe Chitambo).

The good working relationship between the traditional leaders and CHVs was evident in the study sites, with both parties working together to promote change. Traditional leaders’ endorsement of the CHVs and ETS riders is essential to enabling the volunteers to operate effectively. The partnership between the volunteers as community change agents and traditional leaders has been critical for creating an enabling environment for women's and girls' empowerment.

**4.3 Changes in Voice, Influence and Agency**

A further aspect of empowerment relates to changes in women's voice, influence and agency. The empowerment study looked for evidence of positive changes in women's self-confidence, self-belief and self-esteem, and in their sense of entitlement to services and resources. It looked at changes in decision-making at household level and examined whether women had a stronger voice within the household. As part of the analysis, the study also looked at social interaction: whether women had greater physical and social mobility and freedom of association, and whether the latter had led to increased social support.

4.3.1 Confidence, Respect and Self-Esteem

*4.3.1.1 Volunteers*

CHVs and riders reported that they felt more respected by the community as a result of their voluntary activities. They felt that they were being listened to and that their advice was being followed. The CHVs and riders are seen as educated and informed; increased respect was strongly associated with being knowledgeable about child health issues. CHVs and riders also commented on the way in which they were recognised as they moved around the community. One CHV spoke about the fact that children in the community always greeted her by demonstrating a child health danger sign.

Some female volunteers remarked on their new-found confidence to stand up in front of the community and teach, something they attributed to the skills and confidence they had acquired from the training provided by the MAMaZ projects. For female volunteers, feeling respected by the community was particularly motivating. While some women had a previous track record of volunteering, many were new to the activity and, unlike some of the male volunteers, had not been very visible or active in the public domain prior to their training. These volunteers found themselves operating in new physical spaces. A few volunteers described how they had started to move out of their home area and visit other villages - a physical mobility they had previously lacked. There were some references to female CHVs who had come from ‘problem backgrounds’. For example, women who used to drink heavily or who were engaged in multiple affairs. Other community members commented on how they had changed and were more confident and stable. It is interesting to note that it is not always the individuals who already hold leadership positions in the community who are selected by the community to be CHVs. A couple of respondents talked of how individuals with problems were specifically nominated because it was felt that being in a position of authority would help them get their life on track.

Female CHVs’ increased mobility extended to the social sphere. Female volunteers were said to be more confident to interact with others, including traditional leaders. These changes in physical and social mobility will help to position the volunteers to access other opportunities in future (Box 14). The respect shown to volunteers by service providers at the health facility was also said to be motivating, helping to improve volunteers' confidence and self-esteem. Likewise, many female CHVs and riders reported that they felt more respected by their husbands.

**Box 14: Increased Confidence and Self-esteem Among Female Volunteers**

“I’ve been given quite a lot of respect now as compared to before. My family know that I’m doing a good job. Now I’ve become closer to the community and the community has become closer to me. People point to me and say ‘that’s the CHV’. I feel good to be recognised and respected in the community. I’ve been hearing people talk about me, that I am a good woman. People gossip positively that I’m a very good woman. This gives me a lot of courage. When I’m encouraged in that way, it encourages me to do more.” (Female CHV, Teta, Kabamba, Serenje).

“Before being trained, some of the female CHVs were in the Neighbourhood Health Committee. They would only talk on child immunisation issues. At that time, they wouldn’t say much. They didn’t have confidence. Since their training they have become more confident and can talk to anyone. This means that they are now contributing more at the NHC meetings. There is one female CHV who used to shy away from sensitizing people. We would try to encourage her to talk. Now if she has to sensitize the community, she doesn’t hesitate. Now she will even give a speech at a funeral house. She’s really changed. Previously when we were together in the NHC meetings I used to really talk to her and encourage her to participate in discussions. After training she improved so much. It’s the CHV training that brought about the change.” (Male CHV, Saninga, Nchimishi, Serenje).

“I’ve seen examples of female CHVs who have gone from being quiet to being more confident and able to talk to the community. A lot of the women started like that. Some of the female CHVs started at the Neighbourhood Health Committee, others came from the community. Some started shy and then their confidence built up and they got used to speaking in the community. Doreen [female CHV] was quiet when she started. She never used to talk much. Now she’s doing a great job. She stands up in front of the community and teaches.” (Male CHV, Kalowa, Nchimishi, Serenje).

“Before I joined the group I used to be a very shy person. MAMaZ has done a lot in my life. I’ve changed so much. I used to concentrate on work at school. I was very good at school, but I was shy. But after my training all the shyness left me and now I can do what I’m doing. My husband has seen a difference in me. He gives me a lot of support.” (Female CHV, Chikandakanda, Mpelembe, Chitambo).

‘’I have seen a lot of change among my fellow ordinary CHVs who have become responsible enough than the way they used to be, others were drunkards and others were too insulting and fight people but since they were trained to become CHVs they changed.’’ (Female CHV, Nshimba, Mulaushi, Chitambo).

“Quite a lot has changed in my own home….My husband used to beat me. He was a drunkard. He’s stopped doing that and our love life has improved. I used to invite my husband to discussion groups. My status changed in the community. People gave me a lot of respect. My husband saw this and also began to change. He stopped beating me. He stopped drinking. He got inspired as I started to educate him. I’m able to make decisions on my own. Waiting for a husband in the case of an emergency is a waste of time.” (Female CHV, Static, Mpelembe, Chitambo).

‘’I make decisions myself when in an emergency without the consent of my husband, I advise and I have taught many to respond promptly in times of emergencies in order to save lives.” (Female CHV, Kebumba, Mulilima, Serenje).

“Previously l was doing nothing in the community apart from going to the fields, at one point l lost my relative due to the fact that l had no idea on what to do. My relationship with my husband has greatly improved in all areas and am not sure if the reason is that we are all CHVs.” (Female CHV, Milumbe, Yoram Mwanje, Chitambo).

“I now have much more confidence now that I’m a trained CHV. The lead CHVs passed their knowledge onto us. When there is an under fives meeting we stand in front of others and share what we know. I do this freely without fear. Previously I never used to speak in public. It was very difficult for me. When I received my training, it built me up. Now I can stand before fellow men and women and talk on health issues. I know that I can help them. No-one can tell me what’s right now. I’ll defend what I’m teaching the community.” (Female CHV, Nshimba, Mulaushi, Chitambo).

*4.3.1.2 Female community members*

Female community members reported feeling more confident that they could respond to child health emergencies and other health problems because of what they had learnt from the CHVs. Interestingly, many women commented on the increased confidence and self-esteem of female CHVs and referred to these women as role models. The implication was that the female CHVs had opened doors and moved into new territory where greater life opportunities were available. Other women indicated that they aspired to doing the same (Box 15).

**Box 15: Female Community Members Recognise the Changes in Female CHVs**

‘’Traditionally men were the ones that conducted meetings but now with female CHVs conducting meetings, it has encouraged us to aspire for more responsibilities in the community and encourage women to stand for positions in cooperatives or religious groups so that we move our community forward.’’ (Female community member, Mwape, Yoram Mwanje, Chitambo).

“I have seen change in the CHVs themselves and some of them have grown in my eyes. Attitudes have changed towards everything and they are now leading by example.” (Female community member, Kansangwa, Kabamba, Serenje).

“CHVs are role models and they are respected in the community. The community will always listen to them.” (Female community member, Mwape, Yoram Mwanje, Chitambo).

The respect and regard shown to female CHVs and riders translated into a strong desire among ordinary members of the community to join the group of volunteers (Box 16). Many female respondents indicated that they would jump at the chance to become a volunteer. They felt that the female CHVs and riders were admired and respected; that they could move about the community freely; that they had influence over other men and women; that they had grown in confidence; and that in some cases CHVs’ own lives had improved greatly as a result of their voluntary work (i.e. improved relationships with husbands; access to new development opportunities etc).

**Box 16: Waiting List to be a Volunteer**

“I want to join the CHVs. Most of the women in this community want to join. I want to help pregnant women and children who are sick.” (Female community member, Teta, Kabamba, Serenje).

“Other women would like to be a volunteer because they admire my work. So many women are anxious to be a volunteer in this community. They are asking a lot of questions ‘what can we do to be like you? We want this work to continue in the community’.” (Female CHV, Kansangwa, Kabamba, Serenje).

“I would like to be like them [the CHVs] because they teach you about things that are so helpful in your life. It’s what they teach that is so inspiring. I want to be part of the team of CHVs, but I don’t know how to do this. I’ve never stood up in front of people and taught before. But I can do this.” (Female community member, Kamalamba, Ndabala, Serenje).

‘’The work of the CHVs is truly life changing because I used to have very bad anger but all this have disappeared. My change has inspired many and I wish I had joined this group because I have seen most of the CHVs themselves developing so fast than they used to be.’’ (Female community member, Kebumba, Mulilima, Serenje).

“It’s really good to help people and be respected in the community. Whatever you say, the community will listen to you.” (Female community member, Teta, Kabamba, Serenje).

‘’Through CHV meetings I met with other single mothers who are living normal and stable lives and I got to be inspired to work hard myself and raise my child. I wish to be a change agent in my community like the CHVs who encouraged me and taught me how to move on despite the life challenges I went through, I would also want to pay back to the community by educating others.’’ (Female community member, Kabwe Kupela, Serenje Urban, Serenje).

4.3.2 Voice, Influence, Decision-making Capability

*4.3.1.1 Volunteers*

Many of female CHVs interviewed during the research indicated that they had a stronger voice and greater capacity to influence decision-making within and beyond their own households as a result of their participation in the various MAMaZ projects (Box 17). Men were perceived to have changed. Some men remarked that women no longer needed their permission to take health-related actions. These changes had been achieved as a result of the CHVs’ emphasis on couples working in partnership. This challenged, although not overtly, the concept of the male head of household as the main decision-maker, creating space for women's increased voice and independence.

**Box 17: Changes in Voice, Influence and Decision-making Capability Among Volunteers**

“I was very shy…and couldn’t stand before the people. But I am now able to work with a lot of boldness for a positive change.’’ (Female CHV, Teta, Kabamba, Serenje).

“The CHV who was here earlier, she never used to talk. Now in church she stands up and talks. She used to keep herself to herself but now she goes out and talks to others. She has an openness and freedom to do things. I’ve seen a change in the way she has grown in confidence.” (Female CHV, Milumbe, Yoram Mwanje, Chitambo).

“I’ve got a voice in my home now. I make a decision and my husband respects it. It’s really changed from the situation before. My life wasn’t like this before. Before the training, my husband made the decisions at home. I used to be beaten. My husband would demonise me. He brought other women here and if I tried to say something I would be beaten. He would dominate me. I have a voice now and my husband respects me.” (Female CHV, Static, Mpelembe, Chitambo)

“I’m able to sit with my husband and discuss other things now. I wanted my daughter to continue at school, but my husband disagreed. I went to the school and collected forms and sat down with him. My daughter is now at school. My husband is now happy and proud of her. My training gave me the confidence to negotiate. It was easy for my husband and I to discuss which school. We sat down and discussed which one she should go to and how we would cover the school fees. I wouldn’t have been able to have this discussion with him if I hadn’t had the CHV training.” (Female CHV, Nshimba, Mulaushi, Chitambo).

Many female volunteers gave examples of ways in which their husbands had supported and facilitated their volunteering activities (Box 18). This ranged from moral support and encouragement to different types of practical support. In some cases women reported shifts in the gender division of labour as men began to take on tasks (e.g. cooking or childcare) that had previously been women's responsibility. Some men reported that they had received many positive comments about their wives’ voluntary activities and this had increase their own standing in the community.

**Box 18: How Husbands Support and Facilitate Women's Volunteering Activities**

“I’ve never received a complaint from the husband of any female CHV. The reason is that it’s not all the time that they receive sick children so they do have time to do their other work at home. Most of the time the men understand that the work is important and they step in and help.” (Male CHV, Kalowa, Nchimishi Static, Nchimishi, Serenje).

“At home they don’t stop me working. My husband even encourages me to go out. My family are proud of me. Usually when I’m committed to CHV work, my family helps me at home with my tasks. When I come home I’m then free to do other things. My husband, children and other members of the family all help.” (Female CHV, Static, Yoram Mwanje, Chitambo).

*4.3.1.2 Community members*

Many female community members mentioned that they were confident to make decisions about their children’s health, either in discussion with their husbands or independently. The implication was that the wider community had embraced the need to take prompt action in the event of a child health emergency – or even with routine child health issues – opening up space for women to decide and act. The result of the “act without delay” messaging to communities has been to shift the locus of health-related decision-making in favour of women. This highlights the importance of pursuing a whole community approach as a strategy to shift social norms and build social approval for change. The fact that entire communities have been exposed to the new ideas about child health had created an enabling environment for change. Women could refer to new community laws, draw on the support of the CHVs, and provide examples of other households that had changed in order to justify their actions and needs.

Being able to make an independent decision is an important step towards empowerment; improvements in women's confidence and self-esteem are likely to filter through and effect other parts of their lives in future. The quotations in Box 19 below suggest a new level of autonomy and an emerging sense of entitlement among ordinary women in the intervention communities.

**Box 19: Changes in Voice, Influence and Decision-making Capability Among Community Members**

“Women are no longer waiting for husbands to give permission for them to go to the health facility – for themselves or for their children. Previously women never took that decision. They used to wait for their husband. Now this has changed. The entire community has changed.” (Female CHV, Kansangwa, Kabamba, Serenje).

“Now I and my wife share the work load at home and my wife can make a decision freely even to take the child to the clinic.” (Male rider, Nshimba, Mulaushi, Chitambo).

“Women are also free to make decisions about their health. Pregnant women are telling their husbands that they wish to go to the health facility early to wait for delivery. Women are aware of their rights and won’t be kept at home. Women are now making the decisions and men are supporting them.” (Female community member, Nshimba, Mulaushi, Chitambo).

“What we do is to quickly make a decision to rush the child to the health facility. We tell husbands later. We can’t wait for someone who is not here to come and give permission.” (Female community member, Teta, Kabamba, Serenje).

‘’I have learnt a lot from the CHVs. I have learnt to be confident and believe in myself to change situations around myself. As you can see I am on my way from Nchimishi health centre. My child was not feeling well so I made a decision myself without consulting my family. It is half an hour walking this far from Kabwe Kupela which is actually in another health centre catchment but I decided to come here where at least I can walk to save my child’s life rather than going to Serenje where I needed to use public transport. I do not have money but I made a decision to save my child’s life by rushing him to the clinic.’’ (Female community member, Kabwe Kupela, Serenje Urban, Serenje).

“Now with the knowledge of danger signs in children I am able to make decisions promptly about my children’s health and this has changed the way we make decisions in my home. Now my wife or my in-laws can make a decision to take children to the clinic when they notice danger signs in them.” (Male community member, Mwape, Yoram Mwanje, Chitambo).

“During this discussion groups and under five meetings, when we are taught by the CHVs we in turn tell our husband what we have been taught and some change for better and we see women start making decisions in the community. These community meetings have made things better, lightened our work as women. When my child is sick I make the decision to take my child to the clinic.” (Female community member, Milumbe, Yoram Mwanje, Chitambo).

“Things have changed in the way that decisions are made. The community is told that severe malaria and other health conditions such as severe diarrhoea and pneumonia are emergencies. They are told not to wait, but to go quickly to the CHV and then to the health facility. Women are advised to set out quickly and to then tell their husbands that ‘you can find me on the way.’” (Female CHV, Nshimba, Mulaushi, Chitambo).

4.3.3 Social Interaction and Support

Many of the female CHVs reported that they had made new friends as a result of their voluntary work. This included members of the community who had been helped by the CHVs. These increased opportunities for social interaction have a positive impact on mental health and hence are enabling of women’s empowerment (Box 20). Women’s increased social mobility was linked to, and grounded in, their increased physical mobility (i.e. having a legitimate reason to move out of the confines of their homes).

The project’s emphasis on creating a large group of CHVs to ensure good coverage of the community, and to create a mutual support group of volunteers, has created opportunities for greater social interaction. In communities where there are fewer CHVs the social gains are likely to be less significant.

**Box 20: Improved Opportunities for Friendship and Social Interaction**

“Previously l did not have many friends in the community but now because of the work that am doing l have a lot of friends starting from men, women and children who sometimes call me with one of the danger signs.” (Female CHV, Milumbe, Yoram Mwanje, Chitambo).

‘’I have met and known many people I never used to know through CHV work and this work has made my church mission activities to be easier. People do welcome us when we go for church mission activities. They say “she’s the one who teaches us during meetings so we can trust her.” (Female CHV, Nshimba, Mulaushi, Chitambo).

“I have so many friends due to working in the CHV role.” (Female CHV, Kansangwa, Kabamba, Serenje).

‘’I feel very confident and well respected in my community than before and I have known more people through this work even family members who I never used to know.’’ (Female CHV, Kebumba NHC, Mulilima, Serenje).

“Before I became a volunteer, I never had the opportunity to move around the community. I did a little bit of work as a TBA and was sometimes called to help someone deliver at the health facility. But now I move around the community more than before.” (Female CHV, Static, Mpelembe, Chitambo).

**4.4 Changes in Access to Services and Resources**

The third strand of the empowerment framework that guides this research study focuses on women's access to services, control of resources and capacity to take up opportunities. The research focused specifically on two aspects of this theme: the changes brought about by women’s and the wider community’s improved access to a critical resource - health information. It looks specifically at the way in which unhelpful or disabling beliefs about child health have been eroded, creating space for women to acquire and use information that promotes their children’s health and well-being. The second focuses on changes in women’s capacity to take up new opportunities.

4.4.1 Access to Child Health Information

Information on severe malaria and other child health emergencies (e.g. severe diarrhoea and pneumonia) has been shared in intervention communities during discussion groups, during door-to-door visits, and in community meetings. This new information has been fully embraced by intervention communities. Some respondents referred to the ‘new way’ of thinking or the ‘new life’ that they were leading as a result of their access to new information on children’s health. Acceptance of the new information had helped to erode misconceptions about the causes of some symptoms which had shaped responses to childhood illness for generations and led to life-threatening delays. For example, in the past fitting in children was associated with the bewitchment of a child and hence the response was to seek assistance from a witch doctor. A female ETS rider gave the example of a grandmother who had been accused of bewitching a young child and who had thanked the rider for helping to clear her name:

*“One lady bought me a wrapper because of what I did. I carried their child who was so sick to the health facility. I was on my farm and a family was arguing that the child had been bewitched by the grandmother. I grabbed the child, gave it RAS and took it to the health facility on the bicycle ambulance. It had severe malaria. Luckily the child survived. The lady who gave me the wrapper was the grandmother. I had helped clear her name and she was very grateful.” (Female ETS rider, Kebumba, Mulilima, Serenje).*

The removal of misconceptions about the causes of major health problems such as severe malaria in children has enabled positive new health behaviours and improvements in children’s health care access. The disappearance of a belief system that delayed or prevented children’s access to life-saving care and treatment has created space for women to claim support from husbands and the wider community to respond to their children’s ill-health in an appropriate way. Hence improved access to health information had stimulated other gains for women.

**Box 21: Changing Beliefs About Causes of Severe Malaria and Use of Traditional Medicines**

“When we saw the signs we just thought that the child was bewitched and would take the child to the witchdoctor. People would spend a lot of money which would be wasted. The change started when MAMaZ came. We saw so many changes.” (Female CHV, Chikandakanda, Mpelembe, Chitambo).

“A woman called {name deleted} lost some of her children. She didn’t know very much. She had a baby and then a slightly older child. Children used to fit or fall unconscious and she never paid them much attention. She went to the witch doctor and was given herbs. She lost the two children. She learnt that the witch doctor couldn’t do anything helpful. But now we’ve taught her about severe malaria. She’s now very active and attends the discussion groups. She has three other children and they are all fine.” (Male CHV, Nshimba, Mulaushi, Chitambo).

‘’We used to treat malaria using traditional herbs, I was very good at herbs as taught by my mother, people started going for health services recently. We never knew that the signs we were treating with herbs were severe malaria danger signs. I personally lost two children before I was trained how I wish I had known earlier about this.’’ (Female CHV, Nshimba, Mulaushi, Chitambo).

‘’I know many herbs and I used to assist people with traditional herbs but all this have been changed and I am able to make faster decisions when in an emergency, just recently my child had severe malaria and he was well treated and he is alive, if it was those days i wouldn’t have rushed him to the clinic.’’ (Female community member, Kebumba, Mulilima, Serenje).

Women's enthusiasm for their new knowledge, and the various ways in which they have applied it in their own lives can be seen in the quotations in Box 23 below. Men's control over household decision-making in rural Zambia meant that their exposure to and acceptance of the new child health-related information was vital if women were to be able to act on their new knowledge. The project’s strategies of male involvement and reaching the entire community were specifically designed to achieve this.

**Box 22: Women’s Perspectives on their New Health Knowledge**

“I’ve learnt about malaria. How to cut grass and get rid of or cover stagnant water. This keeps mosquitoes away. I’ve also learnt the importance of sleeping under a malaria net. It’s helpful to have attended the discussion groups. I now know how to prevent malaria. I’ve shared what I’ve learnt with other people. I’ve met some families with children who have the signs of severe malaria. I tell them that its severe malaria.”

(Female community member, Kamalamba, Ndabala, Serenje).

‘’I have learnt a lot through the work the CHVs are doing. They helped to save the life of my child and are saving many other lives within the community. Also, my life is no longer the same. I was a drunkard but I have stopped drinking and other women are stopping too. I am among the women that have benefited from the work of the CHVs and I have inspired many other women to comply. I care for my family very well compared to before.’’ (Female community member, Kebumba, Mulilima, Serenje).

‘’I have leant about the danger signs in severe malaria and about the treatment of RAS. My child got severe malaria and I was assisted by the CHVs. The boy was noticed to have signs of severe malaria when the CHVs came for door to door visits.‘’ (Female community member, Kamalamba NHC, Ndabala RHP, Serenje).

“After one discussion group meeting I was able to notice that my son had fever and he cried a lot. I took him to the CHV and when she did an RDT my son was found to have malaria. He was given coartem and has since recovered. Thanks to the discussion group, I was able to identify the signs of malaria.” (Female community member, Miseshi, Mpelembe, Chitambo).

The rapid and far-reaching changes in health-seeking behaviour that had occurred in the project intervention sites were reported to have translated into lives saved (Box 23). Child deaths were reported to have reduced in all study sites. Improved health in children can help free up women’s time so that they are better able to respond to other development opportunities, with potential gains for gender equality.

**Box 23: Reduction in Child Deaths**

“There were a lot of child deaths before I was trained. Most people never took their child to the health facility when they were ill. Now they are doing this and this has reduced deaths. They have made this change because of what they’ve learnt. Before, they didn’t know the importance.” (Male CHV, Saninga, Nchimishi, Serenje).

“Deaths have reduced in the community since the training was conducted. More people are accessing health services. Before, there used to be a lot of child deaths, perhaps four or three in a month….” (Female CHV, Chikandakanda, Mpelembe, Chitambo).

“There are very few child deaths in the community these days. This is a change.” (Female CHV, Kansangwa, Kabamba, Serenje)

“There are now no maternal or child deaths. There’s been a big change. Before the malaria projects, children used to die. I can think of four child deaths that happened before the first project started, but that’s just in my immediate area. There may have been others in other areas.” (Female ETS rider, Kebumba, Mulilima, Serenje).

“Previously we’d see a lot of children dying in this community. But ever since the training of the CHVs a year can pass without us losing a child. This makes me feel very happy.” (Female CHV, Milumbe, Yoram Mwanje, Chitambo).

4.4.2 Access to New Opportunities

The research also looked at whether the changes described above have helped to empower women in other areas of their lives. A key question for the research was whether women who had taken on leadership positions within the community (e.g. as CHVs or ETS riders or custodians) would encounter new development opportunities as a result of their volunteering. This was borne out in practice; many female volunteers were able to provide examples of new opportunities that had come their way as a result of their volunteering (Box 24). These ranged from being invited to be a board member of the local agricultural co-operative (a prestigious position usually held by men or ‘very important women in the community’ for example those who have been involved in politics) to being invited to be head woman. The recognition that being a volunteer opens doors to new opportunities seemed to drive female community members desire to join the CHVs. Many women were very aware of the fact that being a CHV was a route to obtaining the skills they need and desired.

**Box 24: Women’s Improved Access to Resources and New Opportunities**

“I’m now part of an agricultural co-operative. This happened after I was trained as a CHV. The community selected me to be a board member….The community has a lot of respect for me now.” (Female CHV, Teta, Kabamba, Serenje).

‘’My CHV work has exposed me to many other platforms, I am a committee member in our women’s empowerment group and I am a leader in other village committees for village council together with my husband.’’ (Female CHV, Teta, Kabamba, Serenje).

“Recently the community wanted me to be head woman and I agreed. Also an agricultural co-operative was recently formed and the community wanted me to be the chairperson. My work as a rider and CHV is the only reason I was asked. I have gained trust so the community want me to do more.” (Female ETS rider and CHV, Kebumba, Mulilima, Serenje).

**‘**’I have personally learnt to do business which I copied from the IGA we are doing as a community and decided to do something as well, I have inspired many other women in the community and they wish they joined the group earlier.’’ (Female CHV, Kebumba, Mulilima, Serenje).

**“**We have even chosen her [female ETS rider] to be our treasurer in the Luombwa scheme which looks after our rice field.” (Male ETS rider, Kaundu, Mpelembe, Chitambo).

‘’My work has exposed me to other opportunities like I am one of the top leaders at church and I am a board member in our agriculture committee for FISP programmes.” (Female CHV, Nshimba, Mulaushi, Chitambo).

Paid work opportunities in remote, rural communities of Zambia are few and far between, especially for women. However, opportunities to establish small profit-making enterprises do exist. MAM@Scale’s (and the earlier projects’) emphasis on communities working together to establish food banks and emergency savings schemes had inspired some volunteers go further and establish income generating activities (IGAs). The idea was that the IGAs would generate a profit which could then be ploughed back into the community safety net schemes, putting the food banks and savings schemes on a more sustainable footing. The IGAs varied from planting a particular crop and farming it communally to rearing livestock. Some female CHVs spoke about being inspired by these experiences to set up their own business.

**5. DISCUSSION**

**Measuring the visible results of empowerment** (e.g. more women accessing health information and using this to change their health-seeking behaviour) is often easier than **measuring the process of empowerment**. Changes in the latter may well be intangible. Sometimes respondents may not be willing or able to articulate the changes that are underway in their intimate and other relationships, especially if the changes are subtle. Throughout the research it was evident that trained CHVs, both male and female, were able to articulate the changes that had occurred in their lives, including in a relational sense (i.e. between men and women), with greater ease than other members of the community who were interviewed.

The research identified that a **number of empowerment-related gains were achieved over a relatively short timeframe** in the new MAM@Scale intervention sites. In the old sites where trained CHVs and riders have been active for much longer, there is evidence of a deeper transformation.

The study clearly identified that women have improved access to health information and are accessing child health services promptly in the event of an emergency. It also found that some of the social norms that had discriminated against women, preventing or delaying children’s health care access, had been eroded. The **emphasis on male involvement** and the efforts to involve and draw on the support of traditional leaders had helped to create an **enabling environment for change**.

The study found that the **gains for women extended beyond health**, affecting other aspects of their lives. Improvements in women's status were evident: many women reported a **greater say in household decision-making on health issues**, but in some cases on other issues; many indicated that they were more confident to challenge husbands if they did not agree with a decision; there were reports of **greater harmony** at household level and, especially in the old intervention sites, evidence of a **significant reduction in GBV**. The latter had symbolised women's low status within gender relations. In the new intervention sites **GBV remains a problem** and needs to be a focus of future coaching and mentoring support given to CHVs.

Some significant **shifts in the gender division of labour** were identified, with some men taking on tasks that had previously been seen as women's responsibility (e.g. cooking, cleaning, washing clothes, bathing children). These changes have by no means spread across entire communities. However, men are noticing the actions of ‘early adopters’ and some are starting to follow suit. These changes are more profound in the old intervention sites but are also evident in the new sites.

Women in the study communities showed signs of **increased voice, influence and agency** in relation to health issues. This stands them in good stead for being able to draw down other services, resources and opportunities in future. The changes at community level were framed as being an outcome of improved partnership working between men and women. There was evidence to suggest that the use of rights-based language as a framework for change may be more confronting.

The MAM@Scale CHV training places considerable emphasis on the development of facilitation and problem-solving skills among volunteers. CHVs in all research communities had started to **address social and other problems in the community** such as heavy drinking, anti-social behaviour and promiscuity, helping to create pathways for change for men – and also some women.

There were also strong signs that the community mobilisation process had resulted in **improved social interaction** among women, especially within the group of female volunteers, leading to new opportunities for friendship and social support. Many female community members also argued that they **felt more confident** to share their opinions in community fora - within the discussion groups and more generally and to share what they had learnt with other people in the community.

The greatest empowerment gains were found amongst the female volunteers who had learnt to operate very effectively in the public domain, including in areas that were once the preserve of men. The volunteers' work gave them **credibility and authority within their communities, and hence a higher social status**. The female volunteers benefitted from **greater physical mobility** (i.e. freedom of movement) **and social mobility** (freedom to interact). Their improved status hinted at new possibilities and opportunities for other women within the community. The fact that so many of the female community members wanted to join the group of volunteers suggests an ambition to improve their position in society, embrace new opportunities, and gain greater traction and independence within gender relations.

There were also some emerging signs, primarily among female volunteers, that **women were starting to access and participate more in other development activities and leadership positions.** These broader empowerment gains may become increasingly evident as time goes on.

Despite probing, there were no reports of any **unintended negative consequences** resulting from the changes underway in the intervention communities. However, a couple of female respondents indicated that the changes described in this report had almost completely bypassed them. They appeared to be isolated from the rest of the community, living with husbands who were resistant to change. It is important that women in this position are given priority support by the CHVs.

**6. CONCLUSION**

The study identified considerable perceived improvements in children’s health care access and status in all the study sites. These changes resulted from an effective community engagement process which, in turn, was firmly rooted in a gender empowerment approach. Promotion of male involvement in support of children’s health has been pivotal to the changes seen in the MAM@Scale intervention communities. The emphasis on improved partnership working among men and women has begun to erode the rigid gender division of labour that constrains women’s and girls’ life opportunities. The reports of greater harmony within the home as the changes begin to take root are very positive. The training given to female CHVs has strengthened their agency and self-belief and increased their aspirations. In some cases, CHVs are already benefitting from new development opportunities and are inspiring other women in the community to follow suit. Ensuring that all women within the intervention communities are reached and benefit from the change process will be vital going forward. The new intervention sites in particular, where CHVs have been active for nine months, have more work to do to ensure that every woman is reached.

The seven 'gender-smart' strategies that comprise MAM@Scale’s (and the earlier projects’) gender empowerment approach were integral to driving the results outlined in this report. There are important lessons for other projects and programmes that wish to achieve empowerment-related outcomes that extend beyond health.

The empowerment gains seen in the MAM@Scale intervention sites would not have been possible without the large number of trained CHVs in each community. The project’s strategy of training between 15-20 volunteers in each site meant that a whole community approach can be operationalised, resulting in rapid social approval for behaviour change. Zambia’s MOH aims to train one CHV per 500 people. In this approach each CHV has a much larger population to cover and may be unable to fully mobilise their community or support the change processes that have stimulated the dramatic behaviour change seen in the MAM@Scale sites. This is a key lesson for the MOH and for future scale-up of the severe malaria innovation. Reducing the CHV to population ratio to at least 1 CHV: 250 would have a large impact on the CHVs’ effectiveness.

The earlier MAMaZ projects demonstrated the feasibility of integrating an emphasis on GBV and associated social problems such as alcohol abuse, into a demand-side health intervention. These issues are important social determinants of women’s and children’s health and hence need to be addressed. The absence of a substantive GBV component in the MAM@Scale approach is a gap. The project’s technical team can rectify this by providing focused coaching and mentoring support on GBV to CHVs over the remaining months of the project.

**APPENDIX 1: RESEARCH ITINERARY**

|  |  |
| --- | --- |
| **Date** | **Activity** |
| Thursday 16  | * Meeting with Cynthia Lesa, MCH Coordinator, Serenje DHMT
* Research team meeting
* Field work, Teta, Kabamba, Serenje
* Field work, Kansangwa, Kabamba, Serenje
 |
| Friday 17 | * Team meeting, District Health Office, Serenje
* Field work, Kebumba, Mulilima, Serenje
* Field work, Kamalamba, Ndabala, Serenje
 |
| Saturday 18 | * Field work, Kalowa, Nchimishi, Serenje
* Field work, Saninga, Nchimishi, Serenje
* Field work, Kabwe Kupela, Serenje Urban, Serenje
 |
| Sunday 19 | * Writing up and analysis
 |
| Monday 20  | * Meeting, DHMT, Chitambo
* Fieldwork, Milumbe, Yoram Mwanje, Chitambo
* Fieldwork, Mwape, Yoram Mwanje, Chitambo
 |
| Tuesday 21 | * Fieldwork, Static, Mpelembe, Chitambo
* Fieldwork, Chikandakanda, Mpelembe, Chitambo
* Accompanied by Mrs Cynthia Lesa, MCH Coordinator, DHMT
 |
| Wednesday 22  | * Fieldwork, Nshimba, Mulaushi, Chitambo
* Writing up
 |
| Thursday 23 | * Debrief, Serenje DHMT
* Travel to Lusaka
 |

**APPENDIX 2: KEY QUESTIONS FOR THE STUDY**

**Female Community Member**

* Have the community discussion groups or door-to-door visits organised by the CHVs helped you make faster/better decisions about your children’s health? Have you noticed positive changes in your confidence? Or your ability to say what you think?
* Have the severe malaria / child health community discussion groups or door-to-door visits changed the attitude of any of the men in your household? How have their attitudes changed? How does the fact that men’s views have changed affect you and your ability to make decisions?
* To what extent would you say that female CHV’s training has empowered them in the community? Please give a few examples of how female CHVs’ lives have changed because of the work they are doing on child health?
* What do you think of the work of the female CHVs in the community? What do other women in the community think about the work of the female CHVs? Have the female CHVs inspired you to change anything you do or the way you think? If yes, in what ways?
* Are the actions that are being taken by the community to save children’s lives making a difference in your own life? In what ways?

**Male Community Member**

* To what extent are men in the community involved in the severe malaria community discussion groups or door-to-door visits organised by the CHVs? To what extent are you involved? What are the benefits to your involvement? What are the constraints to your involvement?
* Have the community mobilisation activities around severe malaria helped you make faster/better decisions about your children’s’ health? Has the way in which decisions about children’s health within your household (e.g. between you and your wife or you and your parents or in-laws) changed? In what ways?
* Have the severe malaria / child health community discussion groups or door-to-door visits changed the attitude of men in this community? In what ways? How does this affect relationships between husbands and wives?
* To what extent would you say that female CHV’s training has empowered them in the community? Please give a few examples of how female CHVs’ lives have changed because of the work they are doing on child health?
* What do you think of the work of the female CHVs in the community? What do other men in the community think about the work of the female CHVs? Have the female CHVs inspired you to change anything you do or the way you think? If yes, in what ways?
* Are the actions that are being taken by the community to save children’s lives making a difference in your own life? In what ways?

**Female CHV**

* As a female CHV are you doing anything in the community that you didn’t do before? If yes, please explain what these changes are?
* Are there any ways in which your relationships with men in your household or in the community have changed because of the work you are doing as a female CHV? Please can you explain what these changes are?
* In what ways do you think you help and inspire other women in the community as you go about your work? Please can you give examples of any positive effects that you work has on other women in the community?
* Would you say that you have been empowered by your CHV training and activities? In what ways do you feel empowered?
* Have there been any negative changes as a result of your work as a CHV? Please can you share with us what these are?
* Are there any other benefits to you as a result of your work as a CHV? (e.g. have you made new friends; are you meeting with other women on income-generating activities etc; do you feel more respected by other women or men in the community)?
* Do you know of any instances where female CHVs have gone on to take on paid work as a result of their volunteering activities? Please give some examples. This could be paid community work or other income generating activities.

**Male CHV**

* As a male CHV are you doing anything in the community that you didn’t do before? If yes, please explain what these changes are?
* Are there any ways in which your relationships with women in your household or in the community have changed because of the work you are doing as a male CHV? Please can you explain what these changes are?
* In what ways do you think you help and inspire other men in the community as you go about your work? Please can you give examples of any positive effects that you work has on other men in the community?
* Would you say that you have been empowered by your CHV training and activities? In what ways do you feel empowered?
* Have there been any negative changes as a result of your work as a CHV? Please can you share with us what these are?
* Are there any other benefits to you as a result of your work as a CHV? (e.g. have you made new friends; are you meeting with other men on income-generating activities etc; do you feel more respected by other women or men in the community)?

**Female ETS Rider / Custodian**

* Please describe your role as an ETS rider or ETS custodian. What are you doing that is new?
* How does the community respond to the work that you do? What feedback do you get? How does this make you feel?
* Are other women in the community inspired by the work you do as a female ETS rider or custodian?
* How do your husband/family support you as you carry out your ETS rider responsibilities?
* Are there any ways in which your relationships with men in your household or in the community have changed because of the work you are doing as a female ETS rider or ETS custodian? Please can you explain what these changes are?
* How do you balance being a rider with your other work?
* Have there been any other benefits to you as a result of your work as an ETS rider or custodian? (e.g. have you made new friends; are you meeting with other women on income-generating activities etc)?

**Male ETS Rider / Custodian**

* Please can you describe the work you do as an ETS rider?
* What feedback do you get from the community because of the ETS role that you play? How does this make you feel?
* Have you learnt any new skills or developed in any other ways since you became an ETS rider?
* Are there any ways in which your relationships with women in your household have changed because of the work you are doing as an ETS rider? Please explain what these changes are.
* How do you help and inspire other men in the community as you go about your work as a male ETS rider?
* How do you balance being a rider with your other work?
* Have there been any negative changes as a result of your work as an ETS rider? Please share what these are.
* Have there been any other benefits to you as a result of your work as an ETS rider or custodian? (e.g. have you made new friends; new income-generating activities; improved relationships with traditional leaders etc)?
* What do you think about female ETS riders? Are there any in this community? Are the female riders inspiring other women?
* Would you say that everyone in the community supports female ETS riders? Please explain your answer.

**Traditional Leaders**

* Have the training and activities of female CHVs changed the way they are seen or treated at home or in the community? In what ways?
* Have the training and activities of female ETS riders changed the way they are seen or treated at home or in the community? In what ways?
* What evidence is there that men are more involved in child health issues as a result of the severe malaria community engagement efforts in this community?
* Can you give any examples of men and women working better together in support of their children’s health?
* Are you seeing any challenges arising from the work of female CHVs or ETS riders? What can be done about these?
* Are you seeing any challenges arising from the work of male CHVs or ETS riders? What can be done about these?
* Are you seeing any evidence that the community is empowered in the way that it is responding to the severe malaria challenge? For example, how has the establishment of food banks, emergency savings schemes and ETS empowered the community?

**In asking the above questions, we need to probe the following:**

* Are female CHVs or ETS riders more confident to move around the community, advise other women, speak to men etc

Do female CHVs or ETS riders feel that they have a stronger voice at home or in the community as a result of their severe malaria / child health activities

* Do female riders or CHVs have improved scope for decision-making in the household? Are men listening to them more? Is there evidence of more joint decision-making with husbands?
* Do female riders / CHVs feel more respected by other members of the community?
* What do men in the community thing about female CHVs and ETS riders? Do they approve of their activities and growing confidence?
* Has women’s training and their CHV/ETS rider activities opened up other opportunities for them (e.g. to join savings groups / income-generating groups / paid work etc) or new friendships?
* Do women in the community (i.e. those who are not CHVs or riders) look up to these women as role models? Do they inspire them to be more confident? To make quick decisions? To challenge barriers and delays that could harm their children?
1. A large proportion of the Transaid funding has been raised by the UK corporate sector, including the road haulage, warehousing and logistics sectors. [↑](#footnote-ref-1)
2. Rowlands, J., 1997, **Questioning Empowerment: Working with Women in Honduras**, Oxford, UK: Oxfam. [↑](#footnote-ref-2)
3. VeneKlasen, L., Miller, V., 2002, 'Power and empowerment', **PLA Notes**, 43: 39-41, International Institute of Environment and Development (IIED). [↑](#footnote-ref-3)
4. Harper, C, Nowacka, K., Alder, H, Ferrant, G., 2014, 'Measuring Women's Empowerment and Social Transformation in the Post-2015 Agenda', ODI and OECD Development Centre. March. [↑](#footnote-ref-4)
5. Reproductive tasks are all the activities that are necessary for the maintenance and survival of human life. Examples include child bearing, looking after and educating children, preparing food, washing clothes, cleaning the house, or growing or finding food. [↑](#footnote-ref-5)
6. Communities are divided into sections. CHVs carve out a section and work in these in pairs. This approach helps to ensure that every part of the community is reached. [↑](#footnote-ref-6)
7. https://evaw-global-database.unwomen.org/fr/countries/africa/zambia. [↑](#footnote-ref-7)
8. Central Statistical Office, Zambia, Ministry of Health, and ICF International, 2014, **Zambia Demographic and Health Survey 2013-14**, Rockville, Maryland, USA. [↑](#footnote-ref-8)