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Introduction

The promotion of healthy and equal relations among men and women, as well as strategies to combat and prevent violence against women and children has been one of the priorities of the European Union (EU), (e.g. Stockholm Program 2010-2014, EU Regulation No 6060/2013, Directive 2012/29/EU. 2011/99/EU, 2011/36/EU, among others), not to mention that gender equality is one of the founding values of the union. Great strides have been made when it comes to gender equality by promoting equal treatment legislation and the integration of a gender perspective into all other policies (gender mainstreaming); however, gender gaps, perpetuation of stereotypes and violent acts against women and children, still persist in today's EU society. These have encouraged the EU to adopt multiple strategies to encompass priority areas including women's economic independence, the promotion of equality in decision-making, combating gender-based violence and supporting victims.[1] Common to all these priority areas and challenges is the need to use gender synchronised-approaches[2], that recognise different gender-based roles and seek to dismantle gender stereotypes and inequitable gender roles.

Particular groups may face greater risks of gender-based violence for example, due to having been dislocated from families and communities, or having witnessed or been exposed to violence such as child, refugees, migrants and those with disabilities. While the associations are complex and should not be oversimplified, numerous studies confirm that men who witness and experience violence growing up are more likely to use violence against children and women later in life.[3] Evidence demonstrates the impact that experiencing violence in childhood can have on the use of violence as an adult. Intergenerational transmission (IGT) of violence has been a main theoretical consideration to explain the link between interparental aggression in the family of origin and intimate partner violence (IPV) in subsequent intimate relationships.

While the intergenerational transmission of violence has been increasingly discussed, less attention has been given to the intergenerational transmission of caregiving and gender equality. Research from the International Men and Gender Equality Survey (IMAGES) and other sources suggests that boys who experience a positive caregiving influence from men in the household are more likely to have gender-equitable attitudes, more likely to participate in care work and less likely to use violence against a female partner later on.[3] Girls growing up in such households are also less likely to be subservient to men.

When it comes to care work, data presented in several EU debates, studies and strategies stress that there is still a persisting gender gap. Overall, the largest gender gap is in terms of political

[1] Examples of such strategies include the Strategic Engagement for Gender Equality 2010-2015 & Strategic Engagement for Gender Equality 2016-2019.

[2] Greene, M. E., & Levack, A. Synchronizing Gender Strategies - A cooperative Model for Improving Reproductive Health and Transforming Gender Relations. Interagency Gender Working Group (IGWG), 2010. Available from: https://www.engenderhealth.org/files/pubs/gender/synchronizing_gender_strategies.pdf

[3] Fleming, P. J., McCleary-Sills, J., Morton, M., Levtov, R., Heilman, B., Barker, G. (2015). Risk Factors for Men's Lifetime Perpetration of Physical Violence against Intimate Partners: Results from the International Men and Gender Equality Survey (IMAGES) in Eight Countries. PLOS One, 10(5): e0118639. Doi: 10.1371/journal.pone.0118639

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empowerment, yet, the economic gap between men and women is expected to take 267.6 years to close despite improvements. Specifically in Europe, the ILO estimates that at the current pace, gender parity may be reached in wester Europe in approximately 52.1 years and over 100 years in Eastern Europe. Differences in childcare responsibilities contribute to the gender gaps observed, especially but not exclusively those related to employment and income, in employment.[4] Women across the EU spend more time per day on unpaid family caregiving activities than men.[5] Such a gap has resulted in the recognition of the value of unpaid care and domestic work and has encouraged member states to take action through the provision of public services, infrastructure and social protection policies as a way to promote shared responsibility within the household.

While there is growing recognition of the integral role that men play in children's caregiving and that "massive changes in the workplace and in households are bringing changes to men's participation as caregivers"[6], too many still hold the belief (mirrored in regulation) that women should bear the greater responsibility in reproduction, caregiving and domestic chores. In fact, a recent study conducted in the Netherlands has demonstrated that most fathers and mothers have few stereotypical gender norms regarding their role in the house, except for the role of women in the care for their children.[7] Women must have the right to determine when to have children, have access to quality health services, and gain economic independence, but men must also be engaged as allies in supporting women's access to services and to the ability to work outside the home. To strengthen the foundations of a more equitable division of caregiving, men must be encouraged to take on equal responsibility for raising children and broader unpaid care work, without the use of violence, and contribute more equally in domestic work and sexual and reproductive health matters.

The push for gender equality is a global challenge that requires results-based gender transformative programming. Gender transformative programs are interventions that challenge gender norms to promote critical reflection and change of the power dynamics that perpetuate gender gaps. **Gender synchronized** approaches take the gender transformative approach one step further by intentionally implementing efforts to reach people of all genders, specifically including men and boys and women and girls of all sexual orientations and gender identities. This approach uses a synchronized strategy to reach a variety of stakeholders in recognition that we are all impacted by and perpetuate harmful gender norms.[8]

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[4] World Economic Forum. Global Gender Gap Report 2021. Insight Report. Geneva, 2021. Available from: https://www.weforum.org/reports/global-gender-gap-report-2021.

[5] Eurostat. "How do women and men use their time - statistics". Available from: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=How_do_women_and_men_use_their_time_-_statistics&oldid=463738

[6] Levtov, R., van der Gaag, N., Greene, M., Kaufman, M., Barker, G. (2015). *State of the World's Fathers: A MenCare Advocacy Publication*. Washington, DC: Promundo, Rutgers, Save the Children, Sonke Gender Justice, and the MenEngage Alliance.

[7] Nikkelen, S. & Blécourt, K. (2017). Visies op vaderschap: Een panelonderzoek onder Nederlandse vaders. Available from: https://www.rutgers.nl/sites/rutgersnl/files/PDF-Onderzoek/20170124_Visies_op_vaderschap.DEF.pdf

[8] Greene, M. E., & Levack, A. Synchronizing Gender Strategies - A cooperative Model for Improving Reproductive Health and Transforming Gender Relations. Interagency Gender Working Group (IGWG), 2010. Available from: https://www.engenderhealth.org/files/pubs/gender/synchronizing_gender_strategies.pdf

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The success of these programs can be measured in different ways, but it is important to seek to understand if your program works, why it works and how it can work better, as well as, what types of intended and unintended consequences a project generates to allow practitioners to reduce harm, promote benefits in the target communities and optimize scarce resources. Implementing a monitoring and evaluation (M&A) plan can help provide these insights.

This chapter is designed to help groups working on gender transformative programs to conduct M&A. By building on the example of PARENT, it aims to provide a real world experience to highlight the basics of M&A, in addition to specific considerations that should be taken when conducting M&A of gender transformative programs. First, the chapter will introduce some of the key concepts of M&A. Then we dive further into the M&A process of PARENT.

A gender-synchronized results-based evaluation

Step 1: Understanding the program

When designing a results-based evaluation of a gender synchronized program the first step is to get a clear idea of the problem the program wants to address and how your program will address it. In this context, PARENT – **P**romotion, **A**wareness **R**aising and **E**ngagement of men in **N**urture **T**ransformations – was a partnership to pilot a gender-synchronised approach aimed to promote gender-transformative and synchronized approaches by engaging men in co-responsible parenting and caregiving and their participation in an equal share of unpaid care work in 4 European countries. By doing this, the project also aimed to contribute to prevent domestic and intra-familial GBV.

The **specific objectives** of the PARENT pilot were to:

1. Address the gaps in the EU related to engaging fathers in caregiving by providing the public health sector with tools and targeted training to promote the greater involvement of both mothers and fathers in maternal and child health.
2. Increase awareness of GBV and the importance of engaging men in the strategies to combat violence against women and children.
3. Increase gender equity in caregiving and promote engaged fatherhood.

The **expected results** of the PARENT pilot were:

- Increased **awareness** and **activities** on the importance of engaging men in active fatherhood and gender-equitable caregiving to promote the eradication of violence against women and children.
- Increased **engagement** of men as fathers, more **gender-equitable attitudes** and **behaviors** in caregiving and a decrease in violence against women and children.

To reach these objectives, project implementing partners, together with local partners providing services directly to families, in Portugal (PT), Austria (AU), Italy (IT) and Lithuania (LT),

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designed and implemented context-specific adaptations of the Program P methodology developed by Promundo[9] through four (4) work packages, as summarized in Table 1.

Table 1. Description of PARENT work packages (WP)

WP	WP Title	Lead Partner	Description
1	Management and Coordination	CES	General management and coordination of the project, communication and dissemination activities
2	Fatherhood in the Health Sector	CES	Promotion of health care professionals' engagement of men in the health sector and promote active fatherhood. Focuses on the interaction between health professionals and fathers from prenatal through to postnatal stages and how to encourage their participation in caregiving
3	Engaged Fatherhood	CES	Implementation of education groups for fathers and their partners, as well as other men engaged in care work
4	Mobilizing your community	CES	Implementation of national campaigns designed for health sector and education workers and activists who are interested in developing and implementing social-awareness-raising activities in their communities that promote the benefits of active fatherhood as a way to achieve gender equality, benefit children and improve the lives of men and women

This methodology recognized the need to work at multiple levels through a series of complementary activities, including: a) engagement directly with health care workers to prepare them to involve men in the health sector and promote active fatherhood, b) group education for fathers and their partners to promote questioning of gender norms and challenging of gender-inequitable attitudes and practices, and, c) community/ institutional mobilization and campaigns focused on promoting active fatherhood in an intersectional perspective, displaying the diversity of masculinities at the community level. This three-pronged approach utilizes a **socio-ecological model** to foster and sustain change in attitudes and behaviours at multiple levels (Figure 1) and catalyses change by stimulating critical reflection on the status quo and questioning of gender stereotypes (Figure 2).

[9] More information on Program P is available at https://promundoglobal.org/programs/program-p/.

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Figure 1. Levels of intervention of PARENT.

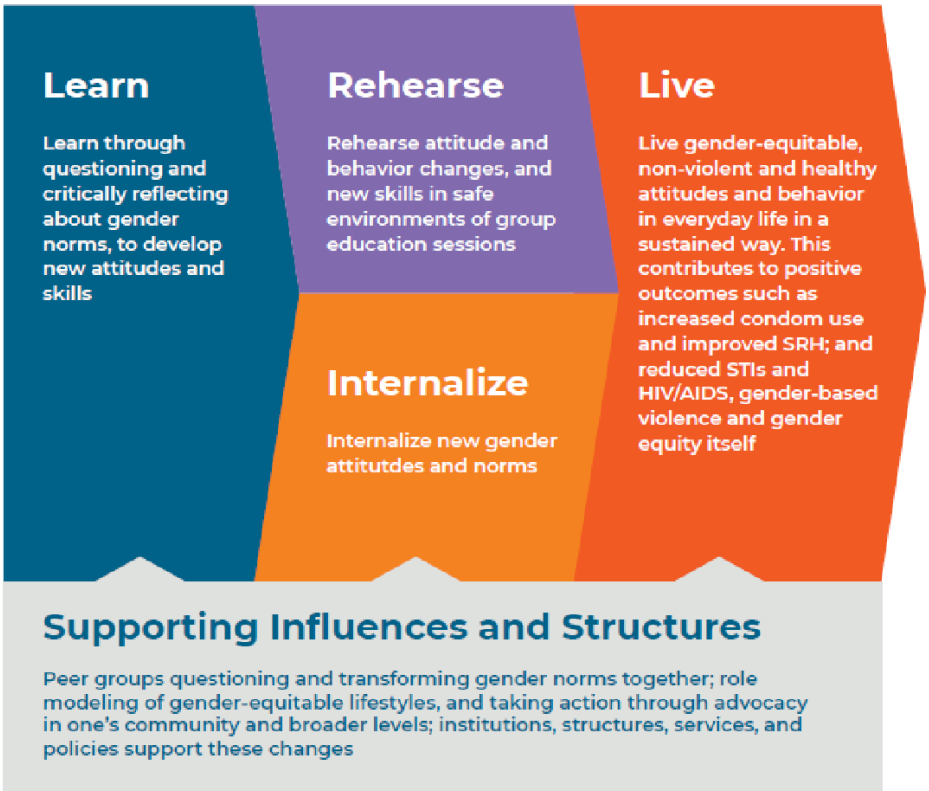

Figure 2. General change model of the Program P methodology.

The **key assumptions** underlying the project design were:

- Intersectionality is required to address different power relations and has to be always present in the interventions addressing gender attitudes and roles.
- Everyone is affected by gender norms and attitudes. Gender norms are restrictive, narrow and unrealistic and most people fail to fulfil these requirements.

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- Gender attitudes are an underlying cause of GBV and violence as a means of conflict resolution.
- Modifications of gender attitudes can result in modifications of gender norms and of behaviours.
- The health sector is an appropriate space for delivering the program and provides a productive space for participants to promote the participation of fathers in caregiving.
- Health professionals and men who participate in the intervention will apply lessons in interactions in their daily lives.
- Emancipative pedagogy, which allows a reflection of the gender requirements, is preventive to violence.

Considering the aims of the project to promote more gender-equitable attitudes and behaviours across individuals and communities, following an intersectional perspective, the project identified as main **target groups**: parents and caregivers, professionals who interact directly with these families, and institutions. The groups, shown in Figure 3, were chosen to gain a broad reach of actors engaged in the project who work in various areas of gender-based violence prevention and gender-equitable caregiving promotion and additional related areas. It covered a wide range of professionals in health service and those who work with refugees and children with disabilities. The implementing partners identified from within each group of beneficiaries, the specific target beneficiaries that would be most relevant in their country contexts.

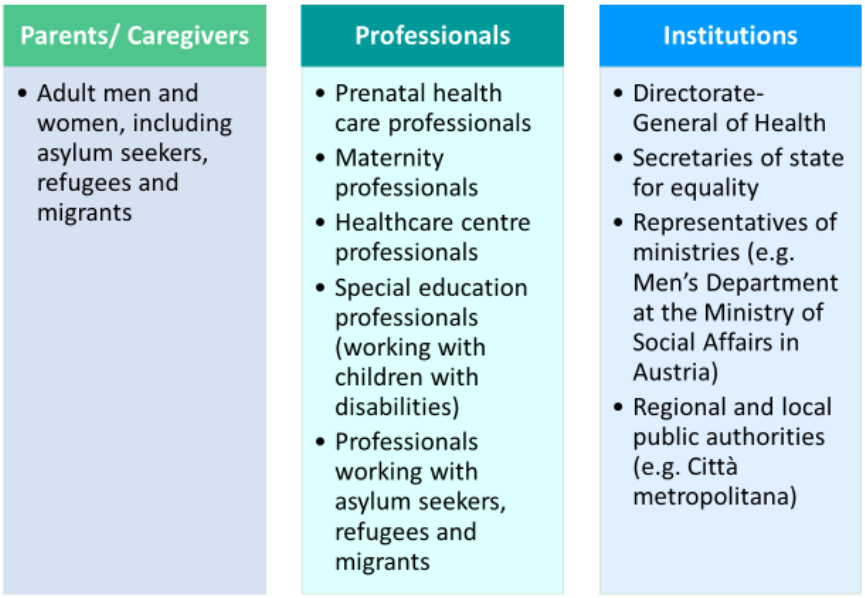

Figure 3. Primary beneficiaries of PARENT.

The **professionals** received training on themes related to gender, GBV prevention and the promotion of engaged fatherhood. The training was focused on preparing professionals to incorporate gender-synchronized approaches into their professional roles as they engage with parents/ caregivers, their colleagues and the institutions in which they are embedded. Although WP 1 focused on health professionals, the beneficiaries were expanded to allow the implementing teams to also include special education professionals and those working with asylum seekers, refugees and migrants as they determined appropriate.

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In addition to the work with professionals, the project directly engaged **parents/ caregivers**, as part of WP 3, in education and discussion groups.

Curriculum Development

At this stage, PARENT was a pilot program to develop and pilot adapted curriculums based on the Program P methodology. The implementing partners received trainings on Program P and monitoring and evaluation. They were responsible for conducting needs assessments in their settings and then developing their program curriculum and implementation plan. This process allowed for the flexibility to develop a curriculum specifically designed to attend the needs related to the promotion of gender equality, engaged fatherhood and GBV prevention in each local context.

Program Delivery

The interventions were implemented according to the needs of the context and each country's implementation of the pilot varied. It is important to note that every team had to significantly adjust their program delivery as a response to the COVID-19 pandemic by developing mitigation plans, based on the specificities of the local context, that were submitted and approved by the funders. For example, in **Austria** training courses for health professionals were developed in multiple formats: e-learning curriculum and tools (in case in-person training remained impossible due to COVID-19), or as face-to-face trainings with different lengths (short trainings of 1-2 hours or longer trainings of 2 to 3 days). In **Portugal,** due to the pandemic, all health and education services adopted strict measures that did not permit the implementation of in-person workshops and training – with both health and education professionals, and also with fathers. As such, the team adapted the curriculum to be implemented through a virtual platform with all of the target groups.

Ethical Considerations

All appropriate measures were taken to follow the European Convention on Human Rights and preserve ethical principles of avoiding harm, maintain confidentiality and preserve consent through voluntary participation.

Beneficence – The pilot dealt with sensitive themes relating to the private lives of families. The implementing partners also recognized that the health care setting itself carries considerations of vulnerability and power dynamics. To guarantee the principle of beneficence, critical reflection regarding the ethics of addressing gender, GBV prevention and caregiving occurred among the implementing partners before and during the design of the curricula.

Confidentiality - Confidentiality was a priority for the evaluations of the pilot. To ensure confidentiality, the implementing partners did not collect the names or any other identifying information of participants when collecting data. All partners were trained on privacy and confidentiality. All forms with identifying information (e.g. attendance sheets, field diaries, etc.) were kept separate from participants' questionnaire and interview responses.

Voluntary Participation – All participants invited to participate with the pilot program were informed that their participation was voluntary and that they would also be asked to participate in the evaluation of the pilot by providing data through surveys/ questionnaires or individual / group interviews. Participants in WP 2 (i.e., health professionals) were informed that they would not be negatively impacted by their participation or non-participation by supervisors or colleagues in their

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workplace. Participants in WP 3 (i.e., parents / caregivers) were informed that their quality or access to healthcare or other services would not be impacted by their decision to participate or not participate in the pilot program.

However, due to the nature of the program as a pilot of new adaptations of a methodology and the creation of new training curricula among small groups of beneficiaries, not all partners submitted their pilots to ethical review boards.

Step 2: Planning the evaluation

The evaluation design needs to be based on the purpose of the evaluation and what is possible based on the program design, timeline, budget and evaluation questions. In general, evaluations occur at the end of the program or at benchmarks, usually specific transition points during the program such as between project phases, to determine if and why the program reached its objectives with a focus on the results and goals. There are different types of evaluations depending on the questions you want to answer about the program and based on when the evaluation was designed. Although important contributions come from implementation monitoring and theoretical evaluations, in this chapter we will focus on impact evaluations using specific examples from PARENT.

The results of a project are the changes that can be attributed to the activities of the project and the impact are the long-term results. Typically, practitioners, funders and policy makers prioritize results-based evaluations as they speak directly of the effectiveness, or the ability to achieve the intended results in the target population, of the project. In addition to effectiveness, results-based evaluations look at other domains, such as efficiency, sustainability, and impact. The **purpose of the evaluation in the PARENT pilot** was for each PARENT pilot implementing partners to compile and analyse existing program data in order to understand the **effectiveness of the pilot in obtaining its expected results** and to guide future implementations or scale-up. As such, the evaluation focused on the reach and effectiveness, or the extent to which the project achieved the desired results, and the key evaluation question was: *to what extent were the expected results obtained and how?*

To do this, the expected results were broken down into 5 specific research questions:

1. What changes can be identified in **awareness** among (health) professionals on the importance of engaging men in active fatherhood and gender-equitable caregiving to promote the eradication of violence against women and children?

2. To what extent were **activities** regarding the importance of engaging men in active fatherhood and gender-equitable caregiving to promote the eradication of violence against women and children implemented?

3. What changes can be identified in terms of the **engagement of men as fathers** in health services?

4. What changes can be identified in **men's gender attitudes**?

5. What changes can be identified in men's **behaviour** in terms of caregiving and the use of violence against women and children?

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Considering these guiding research questions for the evaluation, the focus of the evaluation was on two groups of target beneficiaries: parents/ caregivers & professionals. For this chapter, data was consolidated and synthesized from the implementing partners to highlight examples that answer the research questions.

Based on the purpose of the evaluation, the evaluation methodology can be determined. There are many types of indicators and evaluation designs that can be used. For more information, please refer to the document of recommendations from a previous gender-transformative programming in the EU (EQUI-X).[10] Regardless of the types of indicators selected by the project team, indicators need to be **useful** for your project and meet the practical criteria associated with the timeline, budget, team, and activities. You should be able to collect the required data for your indicator through the reasonable and responsible use of resources. In the context of PARENT, the evaluation strategy had to be implemented in the context of the COVID-19 pandemic which provided a drastic example of prioritizing the immediate context needs. For example, service providers and caregivers were pushed to extreme stress during this period which meant that priorities and resources shifted to addressing essential and/or emergency services. This also meant that monitoring and evaluation strategies had to be adjusted to fit the context.

Step 3: Implementing the evaluation

In the PARENT pilot, all implementing partners utilized non-experimental designs to evaluate their pilot programs. The most common technique was the use of pre and post-test instruments. The country teams received training on monitoring and evaluation tools, specifically on evaluating gender transformative programs. Overall, the trainings covered suggestions regarding research design and instrument construction, application, and analysis. It is important to emphasize that each country team had the flexibility of developing their own context-specific adaptation of the instruments and designing, implementing and analysing the research. As such, evaluation methodologies varied between countries. For example, in **Austria**, only post-evaluations were used for e-learning training courses and for short training up to one day.

To support the development of the evaluation tools, the Portuguese team shared their tools as models, specifically emphasizing the use of the Gender Equitable Men (GEM) Scale as a tool to assess gender attitudes. The GEM Scale was developed in 2001 by the Population Council/Horizons and Promundo based on qualitative research regarding gender norms in Rio de Janeiro, Brazil. Although it was developed in the context of 18-29 year-old Brazilian men, it has been successfully adapted with different age groups ranging from 10 years to 59 years, including women and girls in schools and middle/high income communities in various countries. The Scale includes statements related to gender roles divided into five categories: home & child-care; sexual relationships; health and STI prevention; violence; and, homophobia and relations with other men.[11]

[10] The Engaging Youth in the Promotion of Non-Violent and Equitable Masculinities (EQUI-X) project manual provides a chapter exclusively focused on gender-transformative evaluations that provides further background on key terms and the theory behind results-based evaluations. The publication is available from: http://equixproject.eu/wp-content/uploads/2019/11/Guide-EU.pdf

[11] Pulerwitz J, Barker G. Measuring Attitudes toward Gender Norms among Young Men in Brazil: Development and Psychometric Evaluation of the GEM Scale. *Men and Masculinities*. 2008;10(3):322-338. doi:10.1177/1097184X06298778. Available from: https://promundoglobal.org/resources/measuring-attitudes-

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As the global pandemic of COVID-19 altered the implementation of the curriculum, the **data collection** also had to adapt accordingly. In light of this challenge, the change model is used to identify results that should be correlated with the implementation of the project and the most **ethical**, **feasible** and **methodologically rigorous** strategy should be implemented to try to establish a causal relationship between the project and those results. Each team designed and implemented evaluation strategies to meet the needs of their contexts.

Quantitative instruments were used to assess baseline and endline characteristics (knowledge, attitudes, and practices) of health professionals in Italy, Lithuania and Portugal. Overall, the teams conducted the pre-test virtually with the professionals and caregivers, direct beneficiaries, before beginning workshops, educational sessions, or any other intervention. The post-tests were conducted as early as immediately after the implementation of the workshops. Data analysis was also conducted by each implementation partner who then developed their own databases, database technical notes and country reports.

This publication combines each country's reports to extract contextual information, themes and key data. As such, a limitation of this document is that each implementation teams' analysis of their data varied in terms of methods and complexity of analysis, and this report will primarily present descriptive analysis of the common core items. This evaluation is summative in the analysis of the effectiveness of the interventions and formative in the production of knowledge to guide future iterations of similar programs.

Step 4: Understanding the data

Once the data has been collected, the analysis needs to focus on answering the evaluation questions. Below data from Italy, Lithuania and Portugal have been used as examples of how to answer the evaluation questions. The examples use a variety of data collection methods (Tables 2, 6 and 7) with both quantitative and qualitative techniques.

First, data from **Italy** is used to answer the evaluation questions focused on health professionals (Table 2). Table 2 shows the evaluation questions, the data sources and the questions used in the instruments to gather data from health professionals.

Table 2. Example of PARENT evaluation question data sources related to health professionals from Italy

Evaluation Question	Data source	Questions
What changes can be identified in **awareness** among (health) professionals on the importance of engaging men in active fatherhood and gender-	Questionnaire to assess healthcare workers attitudes	Level of (dis)agreement with the following items: - The involvement of the father / partner during pregnancy visits is important - Written protocols promote the involvement of the father / partner during the birth process (pregnancy, childbirth, first years of life) - Healthcare facilities should organize meetings for fathers / partners and mothers on the birth path - The presence of the father / partner during labour and delivery is important - Healthcare facilities should provide specific educational material intended

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equitable caregiving to promote the eradication of violence against women and children?		for fathers / partners - Healthcare facilities should allow free access to fathers / partners - Healthcare facilities should provide a changing table in the men's room - Healthcare professionals should encourage the presence of the father / partner during the child's health visits - Posters and pictures on the walls of health facilities should include pictures of fathers Gender attitudes: - It is ridiculous for a boy to play with dolls. - It is the woman's responsibility to avoid pregnancy. - The couple should decide together whether to have a child. - To be a man you need to be strong. - Women have the same right as men to work outside the home. - Changing diapers, giving the kids a bath, and feeding the kids are the mothers' responsibility. Level of "usefulness" of the following items: - the care of the child and domestic work, between father and mother, are shared
What changes can be identified in terms of the **engagement of men as fathers** in health services?	Questionnaire to assess healthcare workers' practices Questionnaire to identify the adoption of protocols within the health centres	Self-declared frequency of behaviours: - If the mother comes to the antenatal visit alone, I ask about the father / partner - When the father / partner is present, I provide information and guidance on how he can support the mother during pregnancy - I actively offer information to the father / partner on the [paternity and/or parental] leaves available in Italy - I provide information directly to the father / partner on antenatal and postnatal care - I encourage the father / partner to be present during labour and delivery (after verifying the mother's consent) - I offer guidance on how the father / partner can provide support (physical and psychological) to the mother during labour and delivery - I explain to the father / partner how to register the boy or girl in the registry office - I talk to the father / partner about the possibility of registering the boy or girl with the surname of both parents - When the father / partner is present I encourage his future participation - I record the presence or absence of the father / partner during labour and delivery - I provide information to the father / partner on how to support the mother during breastfeeding - I encourage skin-to-skin contact between the newborn and the father / partner, e.g. during the hospital stay, during the hospitalization in NICU or after returning home - I actively invite the father / partner to hold the infant or child in their arms - When the father / partner is present, I provide him with information and guidance on the health and development of the child - I promote father / partner participation and fair sharing in all care and domestic activities Protocols adopted by the health centre - Are there written protocols in your facility that involve the father / partner during antenatal visits? - Are there written protocols in your facility that involve the father / partner

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		during labour and delivery? - Are there written protocols in your facility that involve the father / partner during child health visits? - Is there screening on domestic violence during the birth process in your facility? - Is there a treatment path in your facility for cases of domestic violence in the birth path? Open question: As a result of this training, have there been any proactive actions by you or by others to involve the fathers? (e.g., protocols, meetings, networks between services or with the territory, etc ...)

In the Italian example, 129 health professionals from 0 to 46 years of professional experience (average 20.6 years) answered the pretest questionnaire. 91.5% (118) of the respondents were women and 7.0% (9) were male. In the post-test, 105 health professionals participated. No statistically significant differences were detected among the demographic characteristics of the participants between the pre and post-tests.

Table 3. Level of (dis)agreement of health professionals in Italy with gender roles and attitudes (before and after)

Item	**Level of (dis)agreement (n, %)**				
	Pre-test (n= 129)		**Post-test (n=105)**		Percentage point change in Agreement
	Agree or totally agree	Disagree or totally disagree	Agree or totally agree	Disagree or totally disagree	
The involvement of the father / partner during pregnancy visits is important.	124 (96.1)	3 (2.3)	103 (98.1)	1 (1.0)	+2.0
Written protocols promote the involvement of the father / partner during the birth process (pregnancy, childbirth, first years of life).	82 (63.6)	20 (15.5)	64 (61.0)	17 (16.2)	-2.6*
Healthcare facilities should organize meetings for fathers / partners and mothers on the birth path.	124 (96.1)	2 (1.6)	104 (99.0)	1 (1.0)	+2.9
The presence of the father / partner during labor and delivery is important.	119 (92.2)	3 (2.3)	104 (99.0)	1 (1.0)	+6.8
Healthcare facilities should provide specific educational material intended for fathers / partners.	121 (94.5)	2 (1.6)	103 (98.1)	1 (1.0)	+3.6
Healthcare facilities should allow free access to fathers / partners.	122 (94.6)	2 (1.6)	102 (97.1)	1 (1.0)	+2.5
Healthcare facilities should provide a changing table in the men's room.	108 (83.7)	3 (2.3)	97 (92.4)	0	+8.7

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Healthcare professionals should encourage the presence of the father / partner during the child's health visits.	126 (97.7)	2 (1.6)	105 (100.0)	0	+2.3
Posters and pictures on the walls of health facilities should include pictures of fathers.	121 (93.8)	2 (1.6)	103 (98.1)	0	+4.3
It is ridiculous for a boy to play with dolls.	4 (3.1)	117 (90.7)	4 (3.8)	98 (93.3)	+0.7*
It is the woman's responsibility to avoid pregnancy.	3 (2.3)	123 (95.3)	2 (1.9)	101 (96.2)	-0.4
The couple should decide together whether to have a child.	124 (96.1)	2 (1.6)	104 (99.0)	1 (1.0)	+2.9
To be a man you need to be strong.	4 (3.1)	107 (82.9)	3 (3.0)	93 (88.6)	-0.1
Women have the same right as men to work outside the home.	121 (93.8)	4 (3.1)	101 (96.2)	3 (2.9)	+2.4
Changing diapers, giving the kids a bath, and feeding the kids are the mothers' responsibility.	3 (2.3)	123 (95.3)	1 (1.0)	103 (98.1)	-1.3

Table 4. Self-declared frequency of behaviors of health professionals in Italy (before and after)

Item	**Self-declared frequency of behaviours (n, %)**				
	Pre-test (n= 129)		**Post-test (n=105)**		Percentage point change in "Always or often"
	Always or often	Rarely or never	Always or often	Rarely or never	
If the mother comes to the antenatal visit alone, I ask about the father / partner.	49 (38.0)	42 (32.5)	52 (49.5)	20 (19.0)	+11.5
When the father / partner is present, I provide information and guidance on how he can support the mother during pregnancy.	95 (73.6)	10 (7.8)	77 (73.3)	10 (9.5)	-0.3*
I actively offer information to the father / partner on the [paternity and/or parental] leaves available in Italy .	48 (37.2)	57 (44.2)	49 (46.7)	44 (41.9)	+9.5
I provide information directly to the father / partner on antenatal and postnatal care.	71 (55.0)	38 (29.5)	83 (79.0)	14 (13.3)	+24.0
I encourage the father / partner to be present during labor and delivery (after verifying the mother's consent).	93 (72.1)	7 (5.4)	77 (73.3)	5 (4.8)	+1.2
I offer guidance on how the father / partner can provide support (physical and psychological) to the mother during labor and delivery.	95 (73.6)	8 (6.2)	74 (70.5)	8 (7.6)	-3.1*

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I explain to the father / partner how to register the boy or girl in the registry office.	79 (61.2)	23 (17.8)	64 (61.0)	13 (12.4)	-0.2*
I talk to the father / partner about the possibility of registering the boy or girl with the surname of both parents.	35 (27.1)	67 (51.9)	38 (36.2)	43 (41.0)	+9.1
When the father / partner is present I encourage his future participation.	102 (79.1)	15 (11.6)	94 (89.5)	5 (4.8)	+10.4
I record the presence or absence of the father / partner during labor and delivery.	28 (21.7)	42 (32.6)	22 (21.0)	33 (31.4)	-0.7*
I provide information to the father / partner on how to support the mother during breastfeeding.	96 (74.4)	23 (17.8)	83 (79.0)	18 (17.1)	+4.6
I encourage skin-to-skin contact between the newborn and the father / partner, eg. during the hospital stay, during the hospitalization in NICU or after returning home.	90 (69.8)	17 (13.2)	70 (66.7)	14 (13.3)	-3.1
I actively invite the father / partner to hold the infant or child in their arms.	101 (78.3)	14 (10.9)	89 (84.8)	9 (8.6)	+6.5
When the father / partner is present, I provide him with information and guidance on the health and development of the child.	95 (73.6)	10 (7.7)	79 (75.2)	8 (7.6)	+1.6
I promote father / partner participation and fair sharing in all care and domestic activities.	101 (78.3)	15 (11.6)	83 (79.0)	14 (13.3)	+0.7

Table 5. Protocols in the health centers as reported by health professionals in Italy (before and after)

Items	**Protocols adopted by the health center (n, %)**				
	Pre-test (n=129)		**Post-test (n=105)**		Percentage point change in "Yes"
	Yes	No	Yes	No	
Are there written protocols in your facility that involve the father / partner during antenatal visits?	12 (9.7)	102 (82.3)	9 (8.7)	57 (54.3)	-1.0*
Are there written protocols in your facility that involve the father / partner during labor and delivery?	26 (21.5)	89 (73.6)	27 (25.7)	38 (36.2)	+4.2
Are there written protocols in your facility that involve the father / partner during child health visits?	19 (15.4)	97 (78.9)	11 (10.5)	57 (54.3)	-4.9*
Is there screening on domestic violence during the birth process in your facility?	47 (36.4)	67 (51.9)	44 (41.9)	25 (23.8)	+5.5
Is there a treatment path in your facility for cases	68 (52.7)	46 (35.7)	66 (62.9)	12 (11.4)	+10.2

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of domestic violence in the birth path?					

The data from Italy (Tables 3, 4 and 5) shows the greatest improvement in terms of health professional's self-reported behaviours, especially those related to the provision of information on antenatal/ postnatal care, parental leave, encouragement of his continued future participation, and registration of the child. This finding supports PARENT's first specific objective of supporting the public health sector with the tools needed for them to promote greater involvement of both fathers and mothers in maternal and child health. From the Italian data, suggested improvements in future iterations of PARENT could be greater attention to tools for fathers to support their female partners directly, such as information on family/ paternity leave and emotional support.

In general, the health professionals presented generally equitable attitudes at the pre-test. At baseline, the least equitable attitudes were presented with the items: "Healthcare facilities should provide a changing table in the men's room" and "The presence of the father / partner during labour and delivery is important". Both items showed significant improvements in attitudes at the post-test.

The percentage point changes in tables 3 to 5 with an asterisk indicate change in an undesired direction. It should be noted that undesired changes were much smaller than the desired changes and are influenced by the small sample sizes of the samples. The protocols in the health sectors faced particular challenges to desired changes because the sanitary precautions related to the COVID-19 pandemic further limited the possibilities for men to engage in the healthcare centres with their partners. This contextual information is important for understanding that the greatest undesired change was in terms of protocols that involve the father in child healthcare visits. This example highlights the importance of not interpreting your data in an isolated manner. In addition to the intervention itself, the results are influenced by the entire context in which the intervention was implemented. Both the intervention and the context likely influenced the large increase seen in terms of the adoption of protocols for domestic violence as part of the birth path, since domestic violence concerns increased across the region during the confinement measures.

The questionnaire applied to health professionals in Italy also included an open-ended question ("As a result of this training, have there been any proactive actions by you or by others to involve the fathers? (e.g., protocols, meetings, networks between services or with the territory, etc.)"). Of the respondents, 41.0% (43 people) provided positive responses, meaning that changes had already been applied or referred to a concrete plan. 59.0% (62 people) responded that activities have not yet been implemented. Of the respondents who reported no new proactive actions, reasons provided were related to the limited time since the trainings to develop and implement new processes and the biosecurity guidelines related to the pandemic.

Overall, the Italian findings suggest increased awareness and activities on the importance of engaging men in active fatherhood and gender-equitable caregiving to promote the eradication of violence against women and children. The support for protocols related to the promotion of fathers' involvement in maternal and child health, their creation and implementation are the areas where continued work to further advance specific objective 1 of PARENT should focus.

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Next, data from **Lithuania** and **Austria** are used to answer the evaluation question focused on activity implementation (Table 6).

Table 6. Example of PARENT evaluation question data sources related to activity implementation in Lithuania

Evaluation Question	Data source	Questions
To what extent were **activities** regarding the importance of engaging men in active fatherhood and gender-equitable caregiving to promote the eradication of violence against women and children implemented?	Implementation records	What activities were implemented in terms of: - Service provider trainings - Fathers/ male caregivers trainings - Communication campaigns

In **Lithuania**, the implementing team conducted 11 trainings for social workers reaching 125 participants. The course load for these trainings was 24 hours training: 16 hours of Synchronous learning and 8 hours of asynchronous, independent learning. The team also implemented educational groups with fathers: 2 separate groups and reaching 49 people. The course load for fathers groups was 8 hours.

The team also conducted two cycles of training of trainers totalling 19 participants: one on 25 Nov 2019 - 10 trainers and the second - on 24 Feb 2020 - 9 participants. Additionally, the Lithuanian team conducted three meetings of the Technical Advisory Board.

As part of the communications campaigns, 11 leaflets[12] for the parents in LT language were distributed at kindergartens to reach the parents. Even in the context of the COVID lockdown, kindergarten directors reported that 714 families received the material in the period from April to June 2020. A National PARENT Fatherhood campaign was developed in a workshop with experts, pretested, and launched through the program website, social media, a podcast and written articles (blogs and newspapers). The national campaign included fathers' stories with pictures highlighting positive examples of engaged, caring fatherhood. Media monitoring was also used to analyse how the topic of fatherhood was portrayed across media channels during the initial national campaign. A second national campaign focused on breaking the myths about child care as the mothers' mission in life, and highlighting the benefits of active fathers in the role of child-care for children and for men.

In **Austria**, 25 educational groups with 72 participants (fathers, fathers to be) were implemented either in-person or virtually. The first 6 of all 25 trainings were structured 12 modules that were originally designed to be applied in 6 consecutive dates with two modules per 4-hour session. However, it was not possible to recruit enough fathers for a program of this level of intensity. Thus, the structure and duration of the father's workshops were adapted to a single session of up to 2 hours. Although the "low-intensity" sessions did not provide the in-depth training originally envisioned by the team, the implementers had to make strategic decisions based on the context and priorities of the action. It was selected to prioritize spaces of initial reflection around masculinity and active fatherhood for a greater number of fathers, over more transformative spaces with a

[12] The educational materials can be found at http://gap.lt/projektai/parent-vyriskumo-normu-kaita-isitraukiant-i-atsakinga-tevyste/

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restricted number of participants. Among the results of the post-session survey, it was found that more than 80 percent of the participants were very satisfied with the session.

The activities implemented by the **Lithuanian** team show that activities on the importance of engaging men in active fatherhood and gender-equitable caregiving to promote the eradication of violence against women and children were implemented as expected. The **Austrian** data highlights that implementers need to be flexible to adopt adaptations to meet the demands of the contexts and be prepared to use monitoring data to make changes.

Finally, data from **Portugal** is used to answer the evaluation questions focused on fathers. Table 7 shows the evaluation questions, the data sources and the questions used in the instruments to gather data from health professionals. These evaluation questions are focused on assessing the PARENT pilot's results related to increased engagement of men as fathers, more gender-equitable attitudes and behaviours in caregiving.

Table7. Example of PARENT evaluation question data sources related to fathers/ male caregivers from Portugal

Evaluation Question	**Data source**	**Indicators**
What changes can be identified in **men's gender attitudes**?	Questionnaire to assess fathers'/ male caregivers' attitudes	Level of (dis)agreement with the following items: - Men should defend their reputation even with force if necessary. - A gay man is not a real man. - A man who talks too much about his problems, fears or concerns does not deserve respect. - A man must always be willing to have sexual relations. - A real man should have as many sexual partners as he can. - A man shouldn't have to do domestic chores. - It is a woman's responsibility to avoid getting pregnant. - A woman's most important role is to take care of her home and cook for her family. - Changing diapers, giving the kids a bath, and feeding the kids are the mothers' responsibility. - It is important that a father is present in the lives of his children, even if he is no longer with the mother. - It is important to have a male friend that you can talk about your problems with. - Prenatal services are only for women - Men's participation of prenatal services are unnecessary - Men are not well received in prenatal services
What changes can be identified in men's **behaviour** in terms of caregiving and the use of violence against women and children?	Questionnaire to assess men's intended behaviours	Self-declared intended behaviours: - Take parental leave when the child is born - Take 15 days or more of parental leave when the child is born - Prepare my child's bottle or food (even if someone else is available to do so) - Change diapers (even if someone else is available to do so) - Give my child a bath (even if someone else is available to do so) - Change my child's clothes (even if someone else is available to do so) - Take care of my child's health (even if someone else is available to do so) - Take my child to medical appointments (even if someone else is available to do so)

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		- Wash clothes (even if someone else is available to do so) - Play with my child (even if someone else is available to do so) - Sweep and do other cleaning chores (even if someone else is available to do so) - Prepare food for other adults (even if someone else is available to do so)

In the Portuguese implementation of PARENT, 23 fathers participated in the Portuguese pre-tests and 17 participated in the post-tests. Overall, the average age of fathers was 37.

Table 8. Level of (dis)agreement of fathers/ male caregivers in Portugal with gender roles and attitudes (before and after)

Item	**Level of (dis)agreement (n, %)**				
	Pre-test (n= 23)		**Post-test (n=16)**		Percentage point change in Agreement
	Agree or totally agree	Disagree or totally disagree	Agree or totally agree	Disagree or totally disagree	
A real man should have as many sexual partners as he can.	0	23 (100.0)	0	15 (93.8)	0
A man who talks too much about his problems, fears or concerns does not deserve respect.	0	21 (91.3)	0	16 (100.0)	0
A man shouldn't have to do domestic chores.	0	23 (100.0)	0	16 (100.0)	0
Men should defend their honor/ reputation even with force if necessary.	2 (8.7)	17 (73.9)	1 (6.3)	13 (81.3)	-2.4
A gay man is not a real man.	0	19 (82.6)	1 (6.3)	14 (87.5)	+6.3*
It is a woman's responsibility to avoid getting pregnant.	0	21 (91.3)	0	15 (93.8)	0
A woman's most important role is to take care of her home and cook for her family.	0	22 (95.7)	0	16 (100.0)	0
Changing diapers, giving the kids a bath, and feeding the kids are the mothers' responsibility.	0	23 (100.0)	0	16 (100.0)	0
It is important that a father is present in the lives of his children, even if he is no longer with the mother.	23 (100.0)	0	16 (100.0)	0	0
It is important to have a male friend that you can talk about your problems with.	19 (82.6)	0	13 (81.3)	1 (6.3)	-1.3*
A man must always be willing to have sexual relations.	1 (4.3)	13 (56.5)	0	12 (75.0)	-4.3
It's an outrage for a girlfriend to ask her	1 (4.3)	22 (95.7)	0	16 (100.0)	-4.3

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boyfriend to use a condom.					
Prenatal services are only for women.	0	22 (95.7)	0	16 (100.0)	0
Men's participation in prenatal services are unnecessary.	0	22 (95.7)	0	15 (93.8)	0
Men are not well received in prenatal services.	1 (4.3)	13 (56.5)	0	15 (93.8)	-4.3

In general, the male participants in Portugal had very equitable gender attitudes. The items where participants exhibited less desirable gender attitudes at the pre-test were mostly related to attitudes around masculinity (what it means to be a real man and how real men should behave). Although the sample size was very small, it should be noted that items related to masculinity (specifically, around heteronormativity and male relationships of "real men") saw percentage changes in the undesired direction. "Masculinity" refers to roles, behavioural patterns, and features within a specific society considered to be characteristic of or desirable for men and related to the idea of being "a real man." The predominant view of the characteristics that "real men" should have changes over time and place and there are several "masculinities", or plural and dynamic ways that masculine norms, attitudes, identities, power dynamics, and practices are lived.[13] Social understandings of masculinity significantly influence people's lives and current, hegemonic masculinity reinforces harmful stereotypes like hypersexuality, heteronormativity, acting tough and using violence, and rigid gender roles in the home. These rigid ideas of men's superiority and dominance are related to the use of violence (in particular, against women and girls), as violence in the traditional masculinity model can be seen as an acceptable way of maintaining one's status.[14] Ideas on masculinity may also lead to intolerance and discriminatory practices; believing that sexist or intolerant actions or views are part of "being a man" can spark injustice and violence. These rigid attitudes are harmful to women, children, and men themselves. Maternal and child health services should address gender attitudes directly related to women and children, but also masculinities more generally because rigid ideas around masculinity underlie and influence indirectly many negative behaviours that health services are addressing.

Only slightly over half of the men disagreed at the pre-test with the statement "men are not well received in prenatal service", but at the post-test 93.8% of the men disagreed. This suggests that it is possible to work with health service providers and with men to provide welcoming prenatal services that clearly include both women and men in their capacity as future and/or current parents.

Table 9. Self-declared intended behaviours of fathers/ male caregivers in Portugal (before and after)

	Self-declared intentions (n, %)

[13] Heilman, B., Barker, G., and Harrison, A., (2017). *The Man Box: A Study on Being a Young Man in the US, UK, and Mexico.* Washington, DC and London: Promundo-US and Unilever.

[14] UN Women. (2016). *Self-learning booklet: Understanding masculinities and violence against women and girls*. https://trainingcentre.unwomen.org/RESOURCES_LIBRARY/Resources_Centre/masculinities%20booklet%20.pdf

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Behaviour items	Pre-test (n=23)		Post-test		Percentage point change in "Yes"
	Yes	No	Yes	No	
Take parental leave when the child is born.	18 (78.3)	0	14 (87.5)	2 (12.6)	+9.2
Take 15 days or more of parental leave when the child is born.	7 (30.4)	-	6 (37.5)	-	+7.5
Prepare my child's bottle or food (even if someone else is available to do so)	21 (91.3)	2 (8.7)	15 (93.8)	1 (6.3)	+2.5
Change diapers (even if someone else is available to do so)	22 (95.7)	1 (4.3)	16 (100.0)	0	+4.3
Give my child a bath (even if someone else is available to do so)	22 (95.7)	1 (4.3)	15 (93.8)	1 (6.3)	-1.9*
Change my child's clothes (even if someone else is available to do so)	22 (95.7)	1 (4.3)	16 (100.0)	0	+4.3
Take care of my child's health (even if someone else is available to do so)	22 (95.7)	1 (4.3)	15 (93.8)	1 (6.3)	-1.9*
Take my child to medical appointments (even if someone else is available to do so)	21 (91.3)	2 (8.7)	15 (93.8)	1 (6.3)	+2.5
Wash clothes (even if someone else is available to do so)	15 (65.2)	8 (34.7)	12 (75.0)	4 (25.0)	+9.8
Play with my child (even if someone else is available to do so)	23 (100.0)	0	16 (100.0)	0	0
Sweep and do other cleaning chores (even if someone else is available to do so)	22 (95.7)	1 (4.3)	16 (100.0)	0	+4.3
Prepare food for other adults (even if someone else is available to do so)	18 (78.3)	5 (21.7)	14 (87.5)	2 (12.5)	+9.2

In terms of intended behaviours, most men intended to participate in childcare and domestic tasks even when someone else was available to do them. The activities with the lowest intended participation were related to general domestic tasks unrelated to childcare, such as washing clothes and preparing food for other adults. This finding suggests that gendered domestic roles may continue to exist even when men present gender equitable attitudes or behaviours related to caregiving. Fortunately, after the training, the tasks with the greatest increased intent were washing clothes and preparing food for other adults, suggesting that activities directed at fathers in the context of childcare can also address other gendered behaviours in the household. In the post-study, men also were more likely to intend to take parental leave and leave of 15 days or greater.

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Step 5: Identifying key lessons

When implementing gender-synchronized programming, a common barrier includes a lack of understanding on the importance of using an intentional intersection of gender transformative efforts reaching beyond just women or just men. As such, many times programs begin originally with one gender in mind and then realize that they need to develop creative and participatory strategies for expanding their work to become more responsive to both sexes. In PARENT, the need to include a synchronized approach was clear from the beginning, because maternal and child health services and interventions focused on caregiving in general have historically been directed towards women. This predominantly feminine approach ignores the roles that men can and should play in caregiving from even before conception. No one is born a 'specialist' in caregiving and men are just as capable of providing the emotional and physical care needed by children. In addition to being capable of direct parenting, research shows that globally men also want to actively engage as caregivers: on average, 85% of fathers say that they would be willing to do anything to be very involved in the early care of their child and, among the participating countries in the region, that average was 91%.[15] Yet, pressures faced by men from social norms limit their involvement as active caregivers.[16], [17] These pressures can be related to perceptions regarding what men and women are expected to do, or injunctive norms, according to key members of their reference groups, which may be co-workers, family members, friends, or service providers.

Despite the shared ability and desires to be actively engaged in their roles as parents, fathers still do not feel completely comfortable participating in prenatal services. Research shows that professionals may serve as gatekeepers to men's participation in caregiving by reinforcing traditional roles of mothers as the primary actors responsible for children through institutional practices, such as using the mother's name to identify the newborn in the maternity ward, to social cues utilized during interactions, like predominantly focusing discussions, questions and orientations on the mother.[18] The PARENT pilot found that a continued area for improvement can be in working with health professionals to recognize the importance of establishing gender equitable, inclusive protocols and following them within their institutions to promote the expectation that fathers be actively involved in the preconception, prenatal and postnatal phases into childhood.

The pilot program also shows that work with men to advance maternal and child health must use a transformative approach which reflects upon and questions the underlying gender norms, specifically related to masculinities, that perpetuate unequal caregiving practices and gender inequality more generally. This lesson is key and can support future programs in advancing their strategies from gender-sensitive to gender-transformative and synchronized.

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[15] Van der Gaag, N., Heilman, B., Gupta, T., Nembhard, C., & Barker, G. *State of the World's Fathers: Unlocking the Power of Men's Care.* Washington, DC: Promundo-US, 2019.

[16] Thebaud, S. (2010). Masculinity, bargaining and breadwinning: Understanding men's housework in the cultural context of paid work. Gender & Society, 24(3), 330-54. Doi: 10.1177/0891243210369105

[17] Kaufman, G. (2018). Barriers to equality: why British fathers do not use parental leave. *Community, Work & Family*, 21(3). Doi: 10.1080/13668803.2017.1307806

[18] Frascarolo, F., Feinberg, M., Sznitman, G. A., Favez, N. (2016). Professional gatekeeping towards fathers: A powerful influence on family and child development. *World Association for Infant Mental Health*, pp. 4-7.

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