

Exploring the Gender-Specific Impact of Educational Film on Maternal and Child Health Knowledge and Behavior: A Qualitative Study in Serenje District, Zambia

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Abstract

Background: Educational film is a communication tool that helps to present complex information simply and clearly, keeping audiences interested for longer and helping to reinforce important learning. Medical Aid Films produces educational films targeted at communities and health workers, with a focus on maternal and child health (MCH) content. Pilot work suggests that film screenings have attracted male as well as female viewers and have started to increase male involvement in MCH care. We explored stakeholder perspectives and gender-specific responses to educational films screened in a rural district of Serenje, Zambia.

Methods: A qualitative study using focus group discussions and in-depth interviews with men and women who had viewed the films at least once, and key informant interviews with health workers who helped deliver the film screenings. Thematic framework analysis was used to derive themes and subthemes, and illustrative quotes are used to substantiate interpretation of the findings.

Results: Men's and women's perspectives are clustered around the influence of the films on knowledge and behavior in relation to MCH topics and male involvement and overall community responses to the films. The three themes summarizing key informant perspectives relate to their impressions of the influence of the films on male involvement in MCH and their views on using film to deliver health information.

Conclusion: Educational films have the potential to improve women's and men's knowledge and awareness of MCH topics, including healthy nutrition and welfare of women during pregnancy, the need to seek skilled care during pregnancy and for childbirth, and the importance of male involvement in supporting the care of women and children. Before widespread implementation, decisions must be made about whether and how to integrate the films with community health education programs, the needs, values, and preferences of men and women and how to present and deliver the film content in a way that maximizes participation of men and women in MCH but does not undermine women's rights, autonomy, or safety.

Keywords

maternal health, child health, male involvement, health education, educational film, outreach services

In Zambia, maternal, newborn, and child mortality remains high.^{1,2} Inequitable geographical and financial access to health facilities combined with low literacy levels means that mortality is most intractable in rural areas. For example, in rural Zambia, the neonatal mortality rate is higher (27 deaths per 1,000 live births) than the national average (21 deaths per 1,000 live births) and much higher among the poorest households (31 deaths per 1,000 live births).³ Forty-two percent of births in rural areas occur at home³ without skilled attendance, where the risk of complications is even greater for already vulnerable women.

Health literacy is a driver of sustained improvement in maternal and child health (MCH) outcomes, and there is a

strong link between women's education and empowerment and health outcomes^{4–8} as well as the health of communities.^{7,8} However, women's agency to seek care for themselves

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and their children is also strongly influenced by gender power dynamics within households and communities, which is why World Health Organization and others recommend working with women, men, families, and communities to ensure women and their newborns have access to the skilled care they need, when they need it.⁹ Factors that contribute directly and indirectly to reducing maternal and newborn deaths include knowing when to seek skilled assistance and increased awareness and knowledge of the danger signs of pregnancy complications.^{10,11}

The Nairobi Call to Action for Closing the Implementation Gap in Health Promotion, the statement that emerged from the seventh global conference on health promotion in 2009, outlines the importance of making information about women's and child health more available and accessible and of the need to increase use of health services and enhance women's confidence to make health decisions.¹² Providing this health information to women during and after pregnancy has traditionally relied on interaction between health workers and women during antenatal and postnatal care. More recently, health programs are incorporating the use of media, such as film, into health promotion strategies, as a more engaging and effective tool for education and training.

Educational film helps to present complex information simply and clearly, keeping audiences interested for longer and helping to reinforce important learning. Evidence from neuroscience research reveals that images are processed far more efficiently than text¹³ and the dominance of visual information absorbed by the brain.^{14,15} It is also a powerful tool for overcoming the barriers to learning created by low literacy and geographical remoteness from facilities. In resource-limited settings, using film for health education can provide a sustainable resource that can be duplicated and reused.

Medical Aid Films produces educational and training films targeted at communities and health workers in Africa, Latin America, and Asia, with a focus on MCH content.¹⁶ The films aim to provide simple, clear factual health education messages and are developed for a female audience. The films are not designed as social and behavior change communication interventions, but they may encourage healthy behaviors. Increasingly organizations using MCH films developed by Medical Aid Films have reported that film screenings also attract male viewers and have started to increase male involvement in maternal and child health care.¹⁷

Individuals, families, and communities play important roles in providing appropriate care for women, mothers, and newborns.^{9,18} In many cases, men are the main decision makers and gatekeepers to access to maternal and newborn health services, yet often do not consider they have a role to play in caring for their partners and children.¹⁹⁻²¹ There is evidence that men would like greater involvement but are dissuaded by sociocultural attitudes²² and feel undermined

by a lack of knowledge.²³ Moreover, many health services are not set up for men to accompany their partners, and health providers may not have the skills to work with men.²⁴ There are also concerns that male involvement should not reduce women's autonomy or reinforce gendered stereotypes of men as decision makers which could be disempowering and nonsupportive.¹⁸

Available evidence suggests that increasing male knowledge around MCH issues has an impact on care seeking behavior and health outcomes, such as attending antenatal care/checkups (ANC)²⁵ and seeking skilled attendance for childbirth.²⁶ However, there are critical gaps in the evidence around factors that lead to program success or program failure when targeting male engagement,²⁷ and there is only very limited literature examining men's responses to strategies to encourage active involvement of men for improved maternal and newborn health outcomes.²⁸ It seemed worthwhile to explore how the educational films produced by Medical Aid Films have informed and influenced both men's and women's knowledge and attitudes. In this article, we report the findings of a qualitative study to explore men's, women's and health worker's perspectives and responses to educational films screened in a rural district of Serenje, Zambia. We explored the acceptability of the educational films produced by Medical Aid Films, the influence of the films on men's and women's knowledge and behavior in relation to MCH, and gender-specific responses to the film content.

Program Description

In 2015, following a pilot project in Chitambo district, Medical Aid Films worked with the district health management team and members of the district environmental health team in Serenje to develop a community health film outreach project at seven rural health facilities in the district (Table 1) that aimed to provide MCH information to women and their families. These rural areas are characterized by low literacy levels, including low levels of understanding of well-being in

Table 1. Catchment Area Data and Facility-Level Population.

Catchment area population	80,882
No. (%) of women of reproductive age	17,794 (22%)
No. (%) of pregnancies	4,368 (24.5%)
No. (%) of deliveries	4,550 (96%)
No. (%) of live births	4,018 (92%)
Population served by health facilities	
Mulilima	17,154
Nchimishi	15,983
Chibobo	10,436
Kabundi	15,754
Kabamba	11,356
Kanona	6,070
Miswema	4,129

Source. District Health Management Team.

pregnancy, warning signs in pregnancy and illness in newborns,²⁹ and lower uptake of ANC and facility delivery. Many of these women live more than 10 km (more than an hour and a half's walk) from staffed facilities equipped for safe delivery, and around 50% give birth without the support of a skilled provider.³⁰

Serenje has a population of 134,804, with 18 health facilities that refer to Chitambo district hospital. Generally, facilities are understaffed with just one nurse (and sometimes a midwife), supported by a number of community health volunteers. Each facility has between 5 and 16 outreach posts that health staff and/or volunteers visit each month to deliver health education sessions and provide basic health care such as vaccinations and family planning. These volunteers are largely responsible for delivering education at the outreach posts, although health workers are available to answer questions and explain any issues in more detail. In some facilities, volunteers are supported by certified employees who are general members of staff but with no health or medical qualifications. Safe Motherhood Action Groups (SMAGs) have also been introduced in Serenje District and are integrated with the outreach education teams, with the role of identifying pregnant women who are at risk, encouraging them to deliver in facilities, and providing a bicycle ambulance for emergency cases.

The Ministry of Health (MoH) selected eight educational films produced in the local language, Bemba, by Medical Aid Films. Each film aims to provide a factual health education message and covers a different topic: warning signs in pregnancy, what pregnant women need to eat, focused antenatal care, the first hours after delivery, breastfeeding, what and when to feed your child, the sick child, and cervical cancer. The films focus on women's well-being and needs in terms of caring for themselves and their babies, understanding the level of care they are entitled to receive, and encouraging support from partners and families, as well as emphasizing key messages around preparing for birth and the importance of ANC, skilled birth care, and facility delivery. All the films are available to view and download for free from the Medical Aid Films website (www.medicalaidfilms.org).

Films were shown as part of the health education outreach sessions run by the health facilities; four films were screened at each outreach post per month. Three sets of film screening equipment (handheld projector, speakers, screen, and external battery pack) were provided to the district health team, and 53 staff and volunteers were trained in using the equipment and how to integrate the screening into their sessions. One set of equipment was used to screen films in health posts in Mulilima and Nchimishi, one for screenings in Chibobo and Kabundi, and one for health posts in Kabamba, Kanona and Miswema. The first films were screened in May 2015, and they continue to be shown, organized by the district environmental health team, without financial support from Medical Aid Films.

Monitoring data from May to August 2015 indicated a total of 17,266 attendees for all screenings during that period (it is assumed that many were repeat viewers) and that attendance varied between the seven sites (Supplementary Table 1). Informal interviews with health workers and district environmental health team members confirmed the value of the films to the communities and suggested more women were attending ANC, giving birth in facilities and seeking more timely care seeking for child illness. Health workers also indicated an increase in men's involvement in ANC and child health as well as more men accompanying women to facilities to give birth and attributed this to the high number of men watching the films. This was an unexpected outcome of the project because the educational film content was aimed at a female audience. This prompted the project team to explore in more detail, in a qualitative study, the acceptability of the educational films, their influence on men's and women's knowledge and behavior in relation to MCH, and gender-specific responses to the film content.

Methods

The study was conducted in health facilities and the catchment areas of Serenje District, where the film screening project was implemented. Three health facilities and their catchments (Kanona, Kabamba, and Nchimishi) were purposely selected because at the start of the study these facilities had the highest recorded cycles of screening and the highest number of people viewing the films.

Two groups of participants were included in the study: (a) men and women living in the health facility catchment areas and (b) health workers who helped deliver the film screenings. We conducted focus group discussions (FGDs; $n=6$) separately with women and men who viewed the films at the health facilities or community locations. A total of 26 women and 23 men took part in the FGDs—9 women and 9 men in Kanona; 10 women and 7 men in Kabamba; 7 women and 7 men in Nchimishi. To be included as study participant, community members had to live within the health facility catchment area and to have viewed the films at least once. The ages of study participants ranged fairly equally between the ages of 20 and 45, although male participants were on average slightly older than female participants (average age of men was between 30 and 35, compared with between 25 and 30 for women), and all had at least 1 child. The majority of participants were subsistence farmers or small kiosk/market sellers, and most had completed primary education or basic education up to Grade 9, although a small minority had limited levels of literacy.

Community health workers and health facility staff helped to identify eligible men and women, who were then recruited to participate through letters, phone calls, or home visits. Written informed consent was obtained from all participants before taking part in group discussions. Questions in the topic guides were informed by communication theory^{31,32}

that assumes attitudes and behaviors can be influenced by the media content and format and expectations of the target audience. The following topics were explored in each FGD: the acceptability of the educational films, their role in community education, their influence on men's and women's knowledge and behavior in relation to MCH, and gender-specific responses to the film content. We conducted four in-depth interviews with men ($n=1$), women ($n=1$), and two couples ($n=2$) who attended antenatal or postnatal clinics at the selected health facilities to explore general perspectives on the films including the role the films played in couples' relationships and male engagement in maternal child health care. Men, women, and couples were identified by community health workers and were purposefully selected because they were reported to have received increased partner support (for women) or offered increased support to their partner (for men) in accessing maternal and child services after watching the films.

Focus groups and interviews were conducted in private areas at the health facilities by trained research assistants, conversant in Bemba and experienced in qualitative data collection techniques. We also conducted key informant interviews (KIIs; $n=4$) with two MCH nurses, one environmental health technologist involved in delivering the film screenings, and the district MCH coordinator with oversight of the MCH services in the district. The topic guide included questions on acceptability of the films by men and women and the role they played in community education and male engagement on MCH issues. KIIs were conducted in English by an experienced researcher.

All interviews and FGDs were digitally recorded with participants' permission. The audio files were transcribed and translated by a trained research assistant. We followed principles of thematic framework analysis to analyze the data.³³ Initial coding was to some extent deductive, informed by aspects of communication theory, while at the same time, we were careful to inductively derive additional codes from the data. Over a period of 8 weeks, two authors read the transcripts and independently identified an initial list of codes, which were then compared and discussed to derive the final coding framework that was used to code the entire dataset. NVivo software (version 12)³⁴ was used to code the data and develop matrices to explore relationships within and between the segments of coded data. Potential themes were identified and discussed in detail among the multidisciplinary research team, with each summary statement checked against quotes. The whole team then took time to consolidate themes and to confirm that all quotes were relevant to those themes.

These themes were fed back to community members in the study areas through two validation workshops held Kanona and Kabamba in November 2018. Through this process, we were able to check that our interpretation of the data resonated with the experience of men, women, and health workers. Following the validation workshops, we finalized the themes and their descriptions in the article.

Data were collected between January and March 2018 following ethics approval from the University of Zambia Biomedical Research Ethics Committee (ref: 004-11-17) and approval to conduct the study from the National Health Research Authority of Zambia. Permission to conduct the study was also secured from the District Health Office in Serenje and the Chiefs from the areas where data collection took place.

Findings

Seven main themes were identified during analysis—four themes were derived from data collected with men and women and three from KIIs. The themes relevant to men's and women's perspectives are clustered around the influence of the films on knowledge and behavior in relation to MCH topics and male involvement and overall community responses to the films. The three themes summarizing key informant perspectives relate to their impressions of the influence of the films on male involvement in MCH and their views on using film to deliver health information. A narrative description of the content and characteristics of each theme is provided later, with illustrative quotes presented in corresponding boxes.

Perspectives of Men and Women

Impressions About Men's Support and Involvement

Men's Involvement in Antenatal Care Visits. Women from all three facilities expressed how, in the past, men were "unconcerned" about women during pregnancy and that they did not "respond to women's stuff." Men voiced similar views, saying that "in the past" there was no involvement of men in registering at ANC and that men would mostly "shun" accompanying women to ANC or detach themselves "from the side of women"; some said they used to think it would "cause embarrassment" if they attended ANC. There were suggestions from women that after watching the films, "things have changed" and "the men have changed," and watching the films had "encouraged men" to participate more in supporting pregnant women (Box 1).

Both men and women identified ways in which they felt men's involvement had changed, including men accompanying women to register for antenatal care as well as to subsequent antenatal checkup visits. Women also had the impression that men had "started caring more" about pregnant women's needs, understanding what is required to care for a newborn and "preparing for the child before birth." Preparation for birth was described by women as men providing items such as clothes, napkins, blankets, and soap as well as saving money and "budgeting for how much is required" to take care of the baby, which men had not previously taken responsibility for. Men talked about how the films had made them realize the importance of accompanying

Box 1. Impressions About Men's Support and Involvement—Illustrative Quotes.*Men's involvement in antenatal care visits:*

"Even me I did not know that I am supposed to accompany my wife to antenatal. Because us we grew up a long time ago when women were giving birth right in our villages . . . so that was difficult for me until I was helped. Having watched the films, I saw that it is true I am supposed to accompany my partner to go to the clinic. That is where she is supposed to give birth from and again we know how her health is and how the baby is coping" (FGD, men, Nchimishi)

" . . . but because some of them [men] are watching the films when they come for antenatal and especially when coming to register, they have accepted and now are even following and consistently bringing the women. So even when a woman is asked to come back on a particular day for checkup, they are taking it seriously because they have watched the films that encourage a man to look out for his woman, taking her for checkups"(FGD, women, Kabamba)

"It is true, men mostly, we were detaching ourselves from the side of women. A woman conceives and then we now leave it all to her like the pregnancy just came on its own and yet we are the ones responsible. We are happy and we have benefited from it [film] and we are supposed to get involved as men to accompany our women for antenatal That thing [film] has helped us very much and as men we were detaching ourselves from women but now we are involved. And we should be going with women to antenatal so that we know what is happening to their health . . ." (FGD, male, Nchimishi)

Knowledge of healthy nutrition and welfare during pregnancy:

"and then another thing that is good about it is that some men do not take good care of women when they are pregnant. Now having watched these films, most of the men are getting involved in taking care of expectant mothers, what they are supposed to eat and just preparing. So these films are good." (FGD, women, Nchimishi)

"Men sometimes were unconcerned that maybe my wife is unwell, the signs they could not know well enough. A wife is unwell, but the man seems unconcerned. But after watching films there was awareness that the person who should be the first to know is the person at home who then should take a step" (FGD, women, Kanona)

" . . . Like what we learnt in the film that if a woman is pregnant she should eat this and this, he has changed, when I'm pregnant he tries to find the right foods that I should be eating so that the baby is strong and healthy . . ." (Interview, woman, Kabamba)

"From the time we watched the films, things have changed like our spouses they know what responsibilities in our homes to give us when we are pregnant and knowing the kind of food we could be eating at home so it is like things have changed at our homes" (FGD, women, Kabamba).

Awareness of the need to seek skilled care for pregnancy complications and childbirth:

"The film I liked very much is the one which was based on the risks expecting mothers face. I am a community worker. Most women do not want to go to the clinic, so that film helped me know the risks that expecting mothers face, without it I can only give her Panadol but that film was an eye opener as it has helped me know the problems and risks such that I can now advise a woman to go to the clinic, telling her that this is how far I can go in helping" (FGD, men, Kanona)

"The films encourage us because men, our spouses, were stopping us from giving birth at the clinic. So now, through the films they have agreed that well it is a good thing to give birth from the clinic and it has stopped us women from dying in homes" (FGD, women, Kabamba)

"Those films we watched encouraged the men because there were many problems that were there; giving birth from home . . . there was a film the men watched that at the clinic it is easier, it cannot be difficult when a person is at the clinic. She is taken good care of by the nurses and doctors" (FGD, women, Kabamba)

"I learnt after watching the films is that women in the past were dying so much because of giving birth from homes. . . .Now this time, after watching the film, I am not the only one. Even my other friends in the community but we have advanced in our thoughts. We saw that if we continue working like this women's deaths will reduce . . . after watching these films, many have started taking a role in coming to deliver from the hospital unlike the way it was in the past" (FGD, men, Nchimishi)

Involvement in child health and development:

"Men in the past, even just at U5CI they were never there. But now I see men that come with their partners and have helped with carrying children . . . in the past, we had to carry children all by ourselves. So now if you have two children below the age of five, one would be carried by the father then the other by their mother so that they can be checked at the clinic. Back in the day, there was no such things" (FGD, women, Kanona)

"Men have now learnt to take children to the clinic. A long time ago when a child falls sick and even when you are not around, it is to wait that first the mother should return then she can take him/her to the clinic. Now this time, men when they just see the body temperature of a child high it is to put the child on the back and take him/her to the clinic or. And sometimes, when couples have a new born. For example, they had a child in 2017, and they have another one in 2018, they would stop taking the one they had in 2017 to under five. A woman alone would fail to carry the children but now men are involved and they would carry the older one while the woman carries the younger one" (FGD, women, Nchimishi)

Note. FGD = focus group discussion.

women to clinic when they are pregnant and the need for their participation in antenatal care visits. Some men from Kanona and Nchimishi gave examples of how the films had encouraged them to support their partners to register the pregnancy and attend antenatal care.

Knowledge of Healthy Nutrition and Welfare During Pregnancy. Women talked about how the films had improved men's knowledge of nutrition and specifically healthy pregnancy and childhood nutrition. For example, women thought that men were now more concerned about what food to give pregnant women and how best to feed children for improved health. Men also spoke about their increased knowledge of nutrition and that pregnant women required different food to keep the unborn baby healthy. Some women felt that, after viewing the film, men were more supportive of their welfare at different times during pregnancy. Some claimed the films had changed their husbands' perspectives on the importance of "good health," and they became more concerned about their wives being unwell during pregnancy (Box 1).

Awareness of the Need to Seek Skilled Care for Pregnancy Complications and Childbirth. Some men indicated that by watching the films they had learnt the "risks women face" in pregnancy and the danger signs that women may encounter. Some men explained the importance of seeking care at health facilities when the danger signs occur, and others felt that facility births had increased because more men had information on the dangers of giving birth at home. Men described how through the films they had learnt about the importance of giving birth in hospital to avoid "deaths in home births."

Some women reported that men would generally not take women to give birth at a health facility. They claimed that the information contained in the films showed men that staff give women good care when giving birth at the clinic. They felt that having seen these scenarios, men would agree to take their wives to give birth at the health facility. This perspective was particularly prominent in Kabamba area (Box 1).

Involvement in Child Health and Development. Women and men thought the films had led to an increase in men helping to take sick children to clinic, which would usually be the responsibility of women. Further to this, both men and women said they had learnt the importance of "responding quickly" to child illness. Women also noticed that men showed more interest in taking children to under-five clinics, whereas before, they were never visible at the clinic, and women had to carry children by themselves. Some men in Nchimishi also said they had actually escorted their partners to under-five clinic and helped to carry children.

Men talked about how the films had raised their awareness of the effects of smoking on pregnant women and children. They mentioned how they had learnt from the films that "cigarettes can contaminate," that smoke has adverse effects

on newborns, and that smoke from indoor fires could "cause health problems" for children. Some mentioned how they had changed their behavior by trying to "keep a distance" when smoking a cigarette or not taking the baby "when visiting those who smoke" (Box 1).

Men Interpret Male Involvement in "Tangible" and Stereotypical Ways

Rather than talking about changes in their actual involvement and support of women and children, men tended to discuss what they had seen and learnt about male involvement in the films and how this had confirmed what they were "supposed to do." When reflecting on what they had learnt, men commonly referred to tangible and practical ways of supporting women during pregnancy, childbirth, and after birth. Men in Nchimishi discussed how "involvement" for them meant a financial responsibility including "preparing money in advance of birth," and "we should prepare money not spend it." Male involvement also seemed to be interpreted as the physical process of accompanying women, some said they should be involved in accompanying women "over long distances," and others explained that men should provide the transport for women to clinic and that men had the physical strength to help when a woman cannot manage. For some men, male involvement was still interpreted as a responsibility within their traditional role as the "head of the household." For example, men spoke about not leaving everything to women and "showing concern as the head of the house" and "we men are heads of house, the films have taught us that even us men should put in effort" (Men's FGD, Nchimishi) "and how it is important as 'heads of families' to get involved" (Box 2).

Women Desire "Deeper" Involvement of Men

Despite the overall impression that men had learnt from the films, were more concerned for women and children, and had changed their perspective in many ways, women in Nchimishi wished for men to be more "deeply involved." They described how men should be accompanying women to clinic to give birth as well as attend antenatal care. Women explained how they would like men to be more involved in helping with children born "following each other" in quick succession. They also felt that men could help more in the homestead, for example, providing a clean environment to protect against illness from malaria and diarrhea and that this had been endorsed in the films that showed men doing practical cleaning around the homestead (Box 3).

Community Responses to the Films

People in the Films Are "Just Like Us". Women and men at all three facilities seemed to share the same reaction to the film characters and setting, saying the people in the films "are just like us" and "resembled us, our skin." For many, this was

Box 2 Men Interpret Male Involvement in Tangible and Patriarchal Ways—Illustrative Quotes.

- “... when she conceives, we are supposed to be keeping a coin, a coin. When months increase we should prepare the money because time is usually not specific. So any time she might go into labour, it is better to have even a K100 in the house...” (FGD, men, Nchimishi)
- “As men it would be nice to be preparing in advance like they have already mentioned to see to it that my partner is like this, it is to prepare in advance. If it is to prepare money not to spend unnecessarily because most importantly, her health is fragile and if we neglect her she would die” (FGD, men, Nchimishi)
- “I am encouraging my fellow men that no we should be working together when we see a problem with our women in a home whether she is pregnant or just unwell, we are supposed to work together. Because we men are heads of a house, now when you see that a child is sick you are not paying attention. So those films have taught us that even us men we should put in effort so much” (FGD, men, Nchimishi)
- “And one thing as men, we saw the benefit that, us we are, in homes they know us that we are the heads like it is very common to know that we are heads of the families, us men. So, it showed us that me the head, I am the one that seemed behind (uninformed) in not knowing the importance of the children at home when they are sick. So now through the film, it showed me that since me as the head of the family, I must be in front caring for my wife, and the children at home in health-related issues” (FGD, men, Kabanda)
- “Even me the issue that I have is that, we men are supposed to be an example to the people in the community. We are supposed to be accompanying our wives, we should also be on the bandwagon, we take a bicycle, we carry our wives on the bicycle we bring them here. This will be an example that we men have involved ourselves we are not neglecting our expectant mothers that go there” (FGD, men, Kabanda)
- “Just to add on a bit there, us men have more man power where there is need for strength especially carrying a person, walking a long hill with a bicycle, us men we are supposed to get involved and help because the problems encountered by women that require power that is needed, and a woman cannot manage. So, if we work together with the expecting mothers and us men, we can see that we defeat so many problems” (FGD, men, Kabanda)

Note. FGD = focus group discussion.

important because the people in the films faced “the same challenges.” Some recognized the diseases were the same and said “we get sick too, just like the people we are watching.” Some women expressed that because they are the same as the people in the film, they “should emulate them”; others said the familiar settings, people, and language helped them to learn quickly. Interestingly, the men were of the view that because the films reflected their daily lives, they were more interested; they explained that if the films contained “White people” or “brought things from overseas,” then “we were not going to bother with them” or would “continue searching for traditional medicines” (Box 4).

The Films Challenged Traditional Care Seeking and Treatment Practices. Men and women reflected on how the films had helped them distinguish between “old and current” practices. They said they learnt that traditional ways of treating illness were “not correct” and that elders were “wasting our time” with traditional practices. Men and women intimated that the films had made them question their traditional beliefs around pregnancy and causes of maternal deaths and treatment and care seeking for common childhood diseases. Men and women from all three facilities described how watching the films helped them to “understand problems with child-birth” they had seen in the past, and the films “challenged traditional beliefs” about the causes of maternal deaths. Women described how there was now “less reliance” on traditional medicine for sick children and gave examples of how their care-seeking and treatment practices had changed for childhood malaria, pneumonia, and diarrhea (Box 4).

Value of Health Facilities Recognized. Men and women also talked about learning the importance of “going to the clinic” and the benefits of care seeking at health facilities. They explained how they now thought “creating friendship with the clinic is good” and how views had changed on the value of health facilities, whereas before, for example, people thought this type of formal health care applied only “to our friends in the towns.” In several FGDs, men and women discussed how the films had changed their view on attending facilities for antenatal care and for giving birth, and how this would help “protect” the health of the mother and baby (Box 4).

Women and Men Noticed the Films United Couples and Influenced Relationships. Some women claimed that the films had “changed” or improved their relationship with their husbands because they were now more concerned about her health and that of their children. The films were seen as an instrument that “united husband and wife” and even made unmarried women in their communities’ desire marriage because they had seen the benefits of a good marriage portrayed in the films. Women associated their improved relationships with husband’s involvement in the care of sick children, particularly their willingness to accompany them to the health facility, for example, “we go together to seek care for a sick child,” and “now I never walk alone to hospital when a child is sick” (IDI Female, Nchimishi). This perspective was particularly prominent in communities where men traditionally paid little attention to child health care as compared with women. However, women noted that some men were interested only in having children but not taking

Box 3 Women Desire “Deeper” Involvement of Men—Illustrative Quotes.

“Me what I would wish for so much is for men to be deeply involved. Male involvement. They should be so involved in caring for expectant mothers” (FGD, women, Nchimishi)

“I would also be happy if they could be accompanying us to the clinic and help us as we give birth” (FGD, women, Nchimishi)

“Me I would also want men to be helping care for those children that are hardly spaced. Yes. Even though the cases have somehow gone down because some are using family planning. But others, it is still happening. Children following each other. They should be helping women how to care for those children, knowing what kind of food they can be given” (FGD, women, Nchimishi)

“And then I would also like men to be helping us in homes so that malaria and diarrhoea does not get to us quickly. They can be helping with slashing, cleaning toilets and digging rubbish pits” (FGD, women, Nchimishi)

Note. FGD = focus group discussion.

responsibility for the care of those children, such as taking their children to the clinic if they (children) fall sick.

Some men echoed these thoughts that the films brought “unity” or “united couples” to the extent they were better able to talk to each other about different topics, attend under-five clinic together, and even show more support for each other post-HIV testing antenatally. In addition, some men alluded to being able to talk more openly with other men about MCH issues after having seen the films and even being encouraged by their male friends to watch the films (Box 4).

Key Informant Perspectives

Health Workers Perceived an Increase in Male Involvement

In line with men’s and women’s views, key informants were also of the impression that male involvement had increased after the film screenings. They explained how men seemed to be more aware of the importance of antenatal care and be more involved in escorting women to antenatal clinic after watching the films. The MCH nurse in Nchimishi had seen more men carrying sick children and attending clinic together with their wives and had also observed more men accompanying women to outpatient clinic, especially those traveling a long distance (Box 5).

The MCH coordinator thought the urban clinics had done well with male involvement because the clients are literate and that the involvement of headmen in sensitization had been important in encouraging men to facilities. The coordinator was able to identify facilities in her district where male involvement had improved after the screenings.

The MCH nurse in Nchimishi explained how after she started to show the films in clinic she felt it would be interesting to “come up with a plan” to see if they “worked” and she chose five routine indicators to monitor. During the interview, she revealed attendance data (including men’s attendance) for antenatal clinic, family planning, facility birth, child health clinic, and voluntary counseling and testing charted over a 12-month period; each indicator showed improvement. She elaborated that when the film screenings project had just started, men would come with women but

would not “reach the facility” and would remain in shops or elsewhere. She also felt men were “shy” and would not participate in health education talks, but once they had watched the films and had seen other people like them, they started to understand better and were encouraged to attend.

Male Involvement—There’s More to It

Key informant’s views tended to align with those of men and women, that in the past men perceived MCH issues were “for women” or women’s concerns, and the films had challenged this and encouraged men to come forward. However, they expressed concern that men are not really “involved,” apart from “escorting women for antenatal,” and they were keen to emphasize that “there is more to it [male involvement].” They felt there was still a lot to be done to encourage proper “male involvement.” Some expressed that men think if they escort women and “they stand somewhere, or they are noticed, they have done their part” (KII, MCH coordinator), and some think that accompanying women to antenatal is “male involvement.” They explained the films need to place more emphasis on male involvement in other aspects of MCH, including supporting women postnatally, caring for newborns, and in consenting and accompanying women for family planning. The MCH coordinator indicated that men need to be much more involved after the woman has given birth, for example, being aware of complications in the mother and the baby and that women are still “in danger” 6 weeks after birth, as well as taking care of the newborn and understanding nutrition and breastfeeding. The key informant in Kabamba clarified that they are still behind on male involvement in postnatal clinic; it is just women who bring their children (Box 6).

Films Have Advantages Over Traditional “Health Education”

Most key informants recognized advantages of film compared with more traditional health education talks. The MCH nurses and the coordinator reported that the “pictures” used in the films made all the difference compared with teaching “only with words” that people easily forget.

Box 4 Community Responses to the Films—Illustrative Quotes.

People in the films are “just like us”:

“It did not worry us because we knew that these people we are seeing are just like us” (FGD, women, Kabamba)

“It is very true . . . that is our everyday life. That is what we also do in our lives. So, it is very familiar and that is what made us to begin elevating and learning quickly because those are things we encounter and do every day” (FGD, men, Nchimishi)

“ . . . then those people are suffering from those diseases we saw . . . we can also get sick so we need to do what those were doing” (FGD, women, Nchimishi)

“Yes, it is true they are people that very much like us . . . so if they had taken white people and brought them that they are the ones we should be watching in films, maybe we were going to continue with the programme of going on a search for traditional medicines” (FGD, men, Nchimishi)

Films challenged traditional care seeking and treatment practices:

“These films have enriched us . . . in the past, deaths were so many in villages. Here in our area, they were calling it ‘inchila’ (failure of an expectant mother to deliver because of the presupposition that the man responsible is having an affair, which can lead to the death of a mother or unborn child, or even both). But now this time many of us have started learning that it is not like that. It is just negligence and desire of wanting to deliver from home” (FGD, men, Nchimishi)

“On diarrhoea, when a child has a running stomach like my friends have mentioned there was just searching for traditional medicines. But even then, so many things were not clear. We did not know to say what does ORS mean? No, as long as you find Mutondo (a type of tree) and give the patient and then diarrhoea will stop. So, we were just causing problems for those children. Many children were even dying that is why they were dying. Just giving him the concoction, you just find his stomach starts bulging and the child even dies. What is it? That it is the witches. We were blaming it on witchcraft but maybe we were just quite negligent in not knowing what we were doing. Now this time after the film we know” (FGD, men, Nchimishi)

“These films they taught us about malaria. Like the previous speakers has mentioned, in the past we were just using traditional medicines. When a person is sick of malaria, they would use the traditional way of relieving flu and chills where people take a blanket to cover up both the person who is unwell and a steamy pot of hot water (which may or may not contain herbs) just like that. They put that person in a blanket that by tomorrow s/he will have recovered. But now this time, there has come that medicine we use for malaria. So, the films have taught us so many things” (FGD, men, Nchimishi)

“They were saying that when a child is gasping for air like that, then that child has pneumonia, so you have to get a cigarette and press it against his/her nose. And when it chokes him/her then the pain would have vanished. But I learnt that what those people were saying is not correct, so you have to rush a child to the hospital. And again, when s/he is releasing stools with traces of blood, the moment I see that I should immediately, even if I have something to do, I need to come to the clinic” (FGD, men, Nchimishi)

Value of health facilities recognized:

“Having watched the films, I saw that it is true I am supposed to accompany my partner to go to the clinic. That is where she is supposed to give birth from and again, we know how her health is and how the baby is coping” (FGD, men, Nchimishi)

“But now things have changed. They have shown that it is to accompany them there. In the films I also watched accompanying wives, reaching them at the clinic to the nurses that check women who are pregnant until they begin being examined. I found the beauty because I am not seeing problems arising from child delivery that women experience” (FGD, men, Nchimishi)

“ . . . those films we watched encouraged the men because there were many problems that were there; giving birth from home . . . there was a film the men watched that at the clinic it is easier it cannot be difficult when a person is at the clinic, she is taken good care of by the nurses and doctors” (FGD, women, Kabamba)

“So, you will find that films made things become easy concerning women because they are taking part in coming to use the clinic so that they are protected well, the health of the expectant mothers themselves and children” (FGD, men, Kabamba)

“Now what was touching me was that we were seeing for instance things to do with the hospital that this only applies to our friends in towns, we in the villages we did not value them. But knowing we knew that hospitals help but we were just thinking that it is for those in towns. Now that it has come here, it will help us so much” (FGD, men, Nchimishi)

Women and men noticed the films united couples and influenced relationships:

“Because in the past before we watched the films just imagine where we come from it is very far now just alone coming to the clinic. As if you conceived by yourself and yet you were the two of you. Now this time no I have seen something good, things have become easy because whatever we do then we are with our husbands” (FGD, women, Nchimishi)

“Even those things like when a child gets sick and he sends you alone to say me I am going to the farm you go alone, no. Now he is willing to leave his farming activities so that we could go to the clinic” (FGD, women, Mchimishi)

“They did well because my life has been enhanced. We have started living well with [my husband]. Even at the hospital when a child is sick he reaches me there, I never walk alone, no” (FGD, women, Nchimishi)

“And then the way, the relationship was in my view was different from nowadays. So now the films came, added on what is called love or marriage and it becomes concrete. When people are coming to watch they even encourage others. The unmarried women see that when I get married, my husband will be taking care of me. And a man envy that so when I also marry we will be taking care of each other because the relationship becomes clear even to passers-by” (FGD, women, Kanona)

“So the films have improved the lifestyles of married people and the standards of marriages have been raised by these films . . . traditionally, what we knew was that if a man helped with washing then the wife used some love charms on him. But it’s just loving and supporting a partner so that she can be healthy and continue looking good, not for her to age while the man still remains looking as young as when they met, no. So they have learnt that it helps improve a woman’s appearance when a man is being supportive in a home” (FGD, women, Kanona)

“I can say that they are working because I have seen, after watching there are these two couples I have seen that are so united. Even during under five, I had seen them together. There are a few couples that have not watched the films and are struggling but the number keeps reducing because when they watch they keep learning” (FGD, men, Kanona)

“Another form of union does exist. During antenatal, there are couples that when tested, one is sick (HIV +) and the other one is not. That has become so bitter to accept because what will be there is that you are sick so you can may land me into trouble. But unity is there because the videos and teachings from the health personnel. So even when a woman is sick and the man is not, they do not separate because they remember what they watched in videos and also the lessons they received at the clinic/hospital. This shows that they have embraced it and that the films are effective” (FGD, men, Kanona)

Note. FGD = focus group discussion; ORS = oral rehydration solution.

Box 5 Health Workers Perceived an Increase in Male Involvement—Illustrative Quotes.

“Then on the part of antenatal, men are really helping . . . and they are I think the ones who have even made the . . . deliveries to increase in that long ago when the women came here for antenatal . . . when they go back, they were been beaten to say, ‘where did you go, you have taken long, what, what.’ But after they saw the video . . . they knew that it is important - one go for antenatal and also for them to come and find out what really happens here when there is antenatal. Also for them to know that . . . when they come here, we also tell them the requirements, they are supposed to prepare as birth plan” (KII, Nchimishi)

“Yes on the men it has also have a good impact. I will give an example when children are sick . . . we only used to see women in the queue . . . only women used to come maybe with three or four kids alone from far distance maybe the highest kilometres in my catchment area is 40 . . . kilometres away from the facility. . . But after the video you will find that this woman will come with the husband together . . . carrying those children who are sick” (KII, Nchimishi)

“Yes. Out-patient, even in in-patient. Most at the time they will come together. There is nothing like where a woman will come alone especially those ones who are coming from far places . . . they both come together” (KII, Nchimishi)

“I think those that have done well include the urban because they are literate I think . . .” (KII, MCH coordinator)

“Yes . . . people are coming up now. And with the help of – of headmen or traditional leaders, we had to go out and sensitise them, have meetings, come out tell them what their role is in these issues; that they are not just for women but they are also part and parcel of the same issues if we’re to protect or improve the health of women and children . . .” (KII, MCH coordinator)

“Among the- the facilities that had films . . . I think they- they were four: Inchimishi, Chibale was also . . . Mwililima would see male involvement. Inchimishi, Chibale there is male involvement; Kabamba, Kanola; it’s not marked maybe I have just missed it the time I left this DHO and went back to the hospital . . . yah . . .” (KII, MCH coordinator)

“2016 I think in February . . . that is when I started showing them. So, after I started showing the video in 2016, I had come up with a plan to see if these videos will be working. So, I picked on indicators, from 2016 I had recorded, I only picked on four indicators . . . which is the antenatal the family planning, facility delivery, child health and VCT. Then from 2016 I had January up to December . . . after almost showing almost a year then I had gone to 2017 from January to December, I was also now putting the figures. Then after putting on those figures I started comparing 2016 when we just started plus 2017 as we are going on . . . how the figures are picking. Yes” (KII, Nchimishi)

“Yes in terms of male involvement, what we do here in first antenatal, first antenatal when a mothers are, when they are pregnant and they are coming for the first antenatal visit, they are supposed to come with their husbands . . . yes. Outpatient, even in inpatient. Most at the time they will come together. There is nothing like where a woman will come alone especially those ones who are coming from far places” (KII, Nchimishi)

“You find, when we just started this video . . . like men coming for antenatal they used to come but they won’t reach at the facility . . . they will feel shy, they will remain in the shops . . .” (KII, Nchimishi)

Note. KII = key informant interview; MCH = maternal and child health; VCT = voluntary counseling and testing.

Box 6 Male Involvement—There’s More to It—Illustrative Quotes.

“Thank you for that question . . . ah generally when we talk about male involvement, the community, the few that have been coming forward, the males that have been . . . involved themselves into such issues, they think escorting the woman to ante-natal that is male involvement” (KII, MCH coordinator)

“But we are saying there is more to it, they need support we have . . . in family planning, we have women that would like to go on family planning, but the consent has to come from the husband because of the cultural background, he is the head” (KII, MCH coordinator)

“So that we still have a lot for males to come in. They know if they escort and then they stand somewhere, or they are noticed, they have done their part” (KII, MCH coordinator)

“ . . . generally, the belief is that when a woman has delivered, the mother and the baby are well, it ends there. But we know that there are other complications and any other thing that can come up . . . You know men need to understand that so that women are supported even in exclusive breast feeding, postnatal check up; they are still in danger six weeks after delivery. Can they still . . . anything can come up.” (KII, MCH coordinator)

“You know with our background, 2 weeks after delivery, we are expected to be back in the field . . . back in the field for ploughing . . . eh . . . cultivating land . . .” (KII, MCH coordinator)

“No, on postnatal (pause), ahh we are still behind . . . because on postnatal its just the mothers who bring their children, six days, six weeks, its just the mothers” (KII, Kabamba)

Note. KII = key informant interview; MCH = maternal and child health.

The MCH coordinator summarized this as “what you see, you don’t forget.” MCH nurses thought the films made their work easier because there is “no more talking,” and there was less need for them to “explain” because the film provides the explanation. They described how after traditional health talks people tended to ask lots of questions, but after watching the films, fewer questions arise. The MCH coordinator expressed that the films help when clinics are short or understaffed because they can run in the background to provide information and education and staff can then take questions (Box 7).

The MCH coordinator also explained that an additional benefit of the films is that they help to train SMAGs, especially when they cannot manage to “get them to refresher training”; she explained that the films are like a “reminder” for topics they have been taught.

Discussion

This research explored stakeholder perceptions of gender-specific responses to educational films in terms of their impact on MCH knowledge and behavior and on male involvement. Men and women shared their impressions of the influence of the films on men’s involvement in accompanying women to antenatal clinic visits and in taking care of sick children. Men tended to interpret male involvement

in “tangible” and practical ways, whereas women expressed a desire for men to be more deeply involved in caring for them during pregnancy and accompanying them to give birth. The research also documented community responses to the films. Women and men valued, and could relate well to, the local characters in the films and suggested the familiar settings, people, and language helped them to grasp the content quickly. Men and women also reflected on how the films challenged their traditional care seeking practices. Key informants shared their views on the appropriateness of film for delivering community health education; many recognized the advantages of film compared with traditional health education talks, and some felt the detailed explanations offered by the film content made their work easier.

This was a small qualitative study conducted with selected participants who had been exposed to screenings of films produced by Medical Aid Films at antenatal care clinics and outreach sessions at rural health posts in Serenje. The findings may be generalizable to other rural districts with similar socioeconomic profiles, but men and women living in urban areas may respond differently to the films and have distinct perspectives on the films’ influence on knowledge. A strength of the study is that data were validated through workshops with community members in the study areas; through this process, we were able to confirm that the themes identified resonated with men, women, and health

Box 7 Films Have Advantages Over Traditional “Health Education”—Illustrative Quotes.

“uhmm, the films, they are more of advantage . . . because, with this health educations (door opens), we have been doing all along. Well since I came here, we have been doing health educations, but there were no changes” (KII, Nchimishi)

“I think when someone is being taught something, this is supposed to be done like this and this. They will forget earlier than where you show them . . . like for example when a child is sick. They have shown where you are able to see maybe the child will be shivering, they have shown the photo of shivering like when you are just doing it as a talk you just tell them he will be shivering but you won’t show them the signs. So they see the shivering they will be remember . . . if they see a child is doing that, then they will remember to say ohh, this thing, then the child is sick we have to take them to the hospital” (KII, Nchimishi)

“Yes . . . I think films are better because what you see . . . what you see you don’t forget and they you know it makes them realise that it’s not just here in our section . . . even another area. It’s not just here in Serenje so even in . . . Solwezi we have similar problems and this . . . - what . . . these same things that were being taught have helped others become better . . .” (KII, MCH coordinator)

“ . . . you know we have SMAGs; they have been teaching but they really don’t get it but with the pictures it is like they are confirming what they have been taught before and for those that have missed or where there are no SMAG members, they get it first hand and it’s practical” (KII, MCH coordinator)

“And the good part is those pictures which were being shown in the videos has really helped because long ago we only used to teach, with the words. And usually when people you just tell them they easily forget. But where they are able to see the pictures it will always be clicking to say, ohh they talked about . . .” (KII, Nchimishi)

“Okay . . . uhmm it has made our work easier from the community because if they have watched the video then you have no more of talking . . . yes . . . it will be like when you start an health education, it will be like question and answering session . . . it won’t be like you will need to explain more for them to understand because the video will help you to explain” (KII, Nchimishi)

“Yah . . . questions will come but with this videos they are clear videos such that you don’t have even their like . . . there are topics you teach . . . then after teaching them, there will arise a lot of questions but with this video when they watch . . .” (KII, Nchimishi)

“Yes . . . you don’t arise so many questions like you have people . . . madam we watched this video we want to find out on this . . . No . . .” (KII, Nchimishi)

“ . . . it’s just now that we have good staffing . . . where you have a shortage and the film is running . . . ai . . . it’s giving IEC and the staff is able to wait for the questions . . . to clarify on the few points that they didn’t get properly . . . so in that area it was helpful . . . where we have understaffed . . .” (KII, MCH coordinator)

Note. KII = key informant interview; MCH = maternal and child health; SMAGs = Safe Motherhood Action Groups.

workers. In terms of limitations on the methodology, initially, one couple was interviewed separately, but based on the recommendation of MoH staff and community health workers in the field, the research team moved to paired interviews with the remaining two couples. In fact, this led to more detailed information from a couples' perspective and provided deeper insights than the separate interviews. It was also not possible to conduct a validation workshop in Nchimishi due to planned Ministry community engagement events taking place that week.

Following the successful pilot outreach project in 2013,³⁵ the MoH supported this follow-up project, which has provided further evidence of the influence of the films on knowledge of MCH topics, awareness of male involvement, and the potential for positive engagement of men in MCH. These findings concur with results from studies of MCH educational film interventions with rural populations in Uganda and Nigeria^{36,37} and one study of an urban population in Zambia³⁸ that community videos and educational film can be effective in communicating knowledge and disseminating information about MCH.

A critical decision for the MoH is whether to support rollout of the project to other rural health posts within and beyond Serenje District. This would need careful consideration of the local context and conditions, a sustainable funding source and commitment from national and district level to ensure implementation is well planned and adequately monitored and evaluated. The findings may have specific relevance to the Zambian health promotion policy and strategic plan currently being developed by the Directorate of Health Promotion and Social and Environmental Determinants, which was established in 2017 and prioritizes health promotion in helping achieve public health goals in Zambia.³⁹ This provides an opportunity to consider health films as one of the tools adopted and integrated into health promotion practice and supporting male involvement strategies within the MCH agenda.

At the outset of this study, an assumption was that the film screening outreach project had influenced male involvement in maternal, newborn, and child health care, and the findings from this study do point toward changes in knowledge and understanding and the potential for changes in men's engagement in MCH. Although interventions such as this that aim to harness the support and involvement of men are recommended by World Health Organization,⁴⁰ and promoted by other donors and development partners,⁴¹ there is a palpable concern among international policy and health decision makers that they have the potential to undermine women's autonomy and decision-making power.^{42,43} Research exploring the potential of health-related educational films aimed at improving male involvement, to reinforce harmful patriarchal practice has yet to emerge, although findings from studies of people affected by HIV have urged careful assessment of the inferred possible impact of using film upon marginalized groups, for example, men who have sex with men.⁴⁴ There are indications in our research that

men interpret male involvement as an extension of their patriarchal role as head of household, and this could reinforce gender stereotypes of men as decision makers. If the educational films produced by Medical Aid Films become further integrated in community health education programs in Zambia, there is a need to ensure that implementation promotes gender equality and egalitarian decision making in households. Such programs should also respect women's rights and facilitate women's choice and autonomy in decision making and encourage men to support women in taking care of themselves and their newborns. Further to this, it could be mutually beneficial for the rural community health program to link to other gender transformative programs,⁴⁵ for example, those promoting women's empowerment or education, or those working with men and boys to encourage their more active, direct role in activities that are currently part of women's normative gender role. The films could also be offered as part of community health education activities for younger or unmarried men and women.

Key informants recognized advantages of using film for health education, especially the value of images compared with words that are easily forgotten. The MCH workers suggested that the films removed the need for lots of talking, and this raises a concern about the risk of health staff substituting health talks with the films and removing the opportunity for women to engage with them and ask questions. While we do not have evidence that this is happening, unintended consequences such as this need to be considered should the project be scaled up, and health workers must be empowered to use film to complement and not replace existing health education activities. Similarly, the films were regarded as a potential resource for refresher training for SMAGs, and while we do not have evidence that they were used in this way, the films should never replace formal training when it can be offered.

Men, women, and the wider community seemed to respond positively to the film, helped by the fact the settings and characters were familiar. There is clear demand for the film screenings to continue and demand for additional content. Existing research points to men's interest in greater understanding of pregnancy, including care of women during pregnancy,⁴⁶ maternal and household nutrition, infant illness and immunizations,⁴⁷ and household nutrition and supporting family health.⁴⁸ Medical Aid Films should consider the options available to fund the production of additional films. Findings that could help inform the content of any future films produced included the following: The films can attract other community members beyond the target audience (women of reproductive age), and so appropriate content should be developed for a wider audience; capitalize on unmarried women's interest in the films and find ways to engage them in developing content for younger audiences with information about the benefits of male involvement; hold further dialogue with men and women about their needs, values, and preferences concerning male involvement in MCH and use this to inform future films

or other strategies to encourage male involvement; and consider dedicated film content for men, and men of different ages, on their own health needs and sexual and reproductive health behavior.

Research Implications

Overall, men and women had the impression that men's involvement had improved in relation to supporting women to access antenatal care, welfare during pregnancy, and preparing for birth as a result of watching the films. However, these are impressions only, and we do not know the actual impact in terms of the number of men accompanying women to antenatal or outpatient clinics; the study was not designed to capture this information. Evidence is needed on the impact of the films on care-seeking behavior during pregnancy, childbirth, and after birth for women and newborns and on key maternal and newborn health outcomes. In addition, it would be helpful to capture changes in the proportion of women accompanied by men to antenatal, outpatient, and under-five clinics.

If it is decided to rollout the film screenings to other districts in Zambia, there is a need for rigorous monitoring and evaluation during implementation to determine the influence of the films on household decision making, women's autonomy and choices, and men's support of women to take care of themselves and their newborns. This research should also be designed to explore changes in women's autonomy in decision making, gender stereotypes, and household power dynamics over time.⁴⁹ A recent study of a film intervention focusing on violence against women in rural Uganda also suggests that communal exposure to films may influence social norms around gender and violence more than if the films are watched privately.⁵⁰ Studying interactions between community members during and after screenings was not possible within the scope of this study, and so further research could also explore whether communities perceive that communal exposure to men's engagement messaging has greater effect on social norms than private/individual exposure.

That women desire deeper involvement of men in MCH and were able to articulate the broader aspects they wanted or needed men's support with is not a surprising finding in itself. However, it does raise an important point about the need to understand men's and women's preferences and needs in relation to male involvement. Little is known about whether and how men want to be involved in supporting women before, during, and after birth, nor do we have much information about women's values and preferences and whether and how they would like their partners to be involved.⁵¹ Further qualitative research is therefore needed on the values and preferences of women and men relating to male involvement and to explore changes in men's behaviors over time as well as to document women's experiences of male involvement.

Conclusions

Overall, this study has shown the potential of educational film to improve women's and men's knowledge and awareness of key MCH topics, including healthy nutrition and welfare of women during pregnancy, the need to seek skilled care during pregnancy and for childbirth, and the importance of male involvement in supporting the care of women and children. There was a perception that behavior had changed with respect to men accompanying women to antenatal, outpatient, and under-five clinics and that traditional care-seeking and treatment practices had changed, but reliable and accurate data from facility and health post level are needed to confirm this. It was clear from the findings that men perceive male involvement in tangible and stereotypical ways, and in contrast, women were quite clear that they needed and wanted more and different types of support from men across the continuum of care. Before widespread implementation, decisions must be made about whether and how to integrate the films with community health education programs, the needs, values, and preferences of men and women and how to present and deliver the film content in a way that maximizes participation of men and women in MCH but does not undermine women's rights, autonomy, or safety.

Key Message

Medical Aid Films produces educational and training films targeted at communities and health workers, with a focus on maternal and child health content. Qualitative research with key stakeholders indicates that the films have potential to improve women's and men's knowledge and awareness of maternal and child health topics and increase male involvement in antenatal, outpatient, and under-five clinics, but further research is needed to confirm this.

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