

Social Programs That Work Review

Evidence Summary for the Bandedereho Couples' Program in Rwanda to Promote Maternal/Child Health and Prevent Domestic Violence

HIGHLIGHTS:

- **PROGRAM:** A couples' program that engages expectant fathers and fathers of children under five, along with their partners, in group education sessions designed to promote men's engagement in maternal, newborn, and child health; family planning; caregiving; and preventing domestic violence.
- **EVALUATION METHODS:** A large, well-conducted randomized controlled trial (RCT) with a sample of 1,199 men and their female partners in Rwanda.
- **KEY FINDINGS:** At follow-up 21 months after random assignment, the program reduced the incidence of intimate partner violence (IPV) by more than one-third, compared to the control group – an effect that was highly statistically significant.
- **OTHER:** The study was conducted in a single country – Rwanda. As a next step in the research, a replication trial in another country would be desirable to hopefully confirm the initial results and establish that they generalize to other nations with similarly high rates of domestic violence.

I. Evidence rating: **NEAR TOP TIER**

The standard for Near Top Tier is:

Programs shown to meet almost all elements of the Top Tier standard, and which only need one additional step to qualify. This category primarily includes programs that meet all elements of the Top Tier standard in a single study site, but need a replication RCT to confirm the initial findings and establish that they generalize to other sites. This is best viewed as tentative evidence that the program would produce important effects if implemented faithfully in settings and populations similar to those in the original study.

II. Description of the Program:

Bandedereho is a Rwandan program for expectant fathers and fathers of children under the age of five years, along with their partners, that is designed to promote men's engagement in maternal, newborn, and child health; family planning; caregiving; and preventing domestic violence. The program is delivered by the Rwanda Men's Resource Center – a non-governmental organization – and is part of a four-country initiative known as MenCare+.

The program consists of 15 group sessions for men (maximum 45 hours), of which their female partners are invited to attend 8 (maximum 24 hours). Trained community volunteers (local fathers) facilitate the sessions, meeting with the same group of 12 men/couples on a weekly basis. The sessions address gender and power; fatherhood; couple communication and decision-making; intimate partner violence (IPV); caregiving; child development; and male engagement in reproductive and maternal health.

The program's cost is not reported in publicly available program materials, but is likely to be modest given the nature of the program activities. The program manual is [linked here](#).

III. Evidence of Effectiveness:

The Bandedereho program has been evaluated in one large, multi-site RCT, conducted in Rwanda, with a sample of 1,199 men along with their partners.

Overview of the Study Design:

The study was conducted in 48 sites across four districts in Rwanda. Community volunteers facilitating the program partnered with local community health workers to identify and recruit men at each site meeting the following eligibility criteria: age 21-35 years, married or cohabitating, and expecting a child or parenting a child under five years old. The study randomly assigned 1,199 eligible men, along with their partners, to either a treatment group that was offered the Bandedereho program, or a control group that was not. The mean age of male sample members was 29 years, and more than 60% had only primary education or less. The men averaged 1.5 children and 65% were expecting a child. Most men were self-employed (89%) and struggling financially – *e.g.*, only 31% could consistently afford basic items. Final study outcomes were measured via administration of a survey to sample members 21 months after random assignment.

The program achieved high rates of participation: Men in the treatment group attended an average of 14 out of 15 offered sessions, and women attended an average of 7 out of 8 offered sessions.

Key Findings:

At follow-up 21 months after random assignment (16 months after completion of the program), the study found large, statistically-significant effects on incidence of IPV, as follows:

- 33% of women in the treatment group experienced physical IPV (*e.g.*, hitting, kicking) in the previous 12 months versus 57% of women in the control group ($p < 0.001$); and
- 35% of women in the treatment group experienced sexual IPV (*e.g.*, forced sex without consent) in the previous 12 months versus 60% of control women ($p < 0.001$).

We focus on IPV because it is a concrete, final outcome of clear policy importance. The study also measured numerous other outcomes and found an overall pattern of sizable positive, statistically-significant effects. These outcomes/effects fell within four areas: (i) reproductive and maternal health behaviors (*e.g.*, approximately a 40% increase in the number of antenatal care visits in which men participated); (ii) parents' use of physical punishment against children (*e.g.*, approximately a 14% decrease in both men's and women's likelihood of using such punishment); (iii) couples' division of childcare and household tasks (*e.g.*, approximately a 60% increase in men's time per day spent on such

care/tasks); and (iv) men's dominance in household decision-making (*e.g.*, approximately a one-third reduction in percent of households where men have the final say on decisions about income and expenses).

Discussion of Study Quality:

Based on our review, we believe this was a well-conducted RCT. Men in the treatment and control groups were highly similar in their pre-program characteristics (*e.g.*, demographics, education, employment, and participation in caregiving and household tasks).¹ The study appropriately obtained and analyzed outcomes for all members of the treatment group, regardless of whether or how long they participated in the program (*i.e.*, the study used an “intention-to-treat” analysis). The study had minimal sample attrition: It obtained outcome data for virtually all sample members (94% of men and 97% of women) in the 21-month follow-up survey. To encourage truthful responses on the survey, men and women were interviewed separately on different days by a gender-matched interviewer; only the women were asked about their experiences of IPV; and men were not informed of the inclusion of IPV questions in the women’s interviews. The interviews were conducted by an independent research firm that had no involvement in the Bandebereho program (however, interviewers were not blind as to whether sample members were in the treatment or control group, which would have been ideal to rule out the possibility of interviewer bias).

The study had modest limitations that hopefully can be addressed in a future replication RCT, as follows:

- The study relied exclusively on self-reports to measure key study outcomes, which can be prone to social desirability bias (*i.e.*, treatment group members overstating reductions in behaviors that the program has just taught as undesirable). However, concern about such bias is somewhat mitigated by the fact that the survey was administered 16 months after program completion, so the program may no longer have been top of mind when sample members were answering the questions.
- The study measured a large number of outcomes in the 21-month survey. It reported findings for many but not all of the measured outcome. While the reported findings were virtually all positive and statistically significant, the study preferably would have reported findings for the complete set of outcomes, to rule out possible concerns about selective reporting of positive results.
- The study’s measurement of a large number of outcomes also raises the risk of “false-positive” findings (since, for each outcome that a study measures, there is roughly a one in 20 chance that the test for statistical significance will produce a false-positive result when the program’s true effect is zero). In this case, the fact that the IPV effects were large and highly statistically significant ($p < 0.001$) makes it unlikely that they are false-positives. But, preferably, the researchers would have used a standard method to reduce the risk of false-positives, such as pre-specifying of one or a few primary outcomes by which the program’s effectiveness would mainly be judged (Schochet 2008, Food and Drug Administration 2017).²

¹ Due to funding constraints, the researchers only surveyed male (not female) sample members at the study’s inception to obtain their pre-program characteristics.

² The study’s [protocol](#) instead described a sizable number of outcomes to be measured, without specifying one or a few as primary.

IV. References:

Doyle K, Levtov RG, Barker G, Bastian GG, Bingenheimer JB, Kazimbaya S, et. al. (2018). “Gender-transformative Bandebereho couples' intervention to promote male engagement in reproductive and maternal health and violence prevention in Rwanda: Findings from a randomized controlled trial.” *PLoS ONE* 13(4): e0192756.

Schochet, PZ (2008). *Technical Methods Report: Guidelines for Multiple Testing in Impact Evaluations* (NCEE 2008-4018). Washington, DC: National Center for Education Evaluation and Regional Assistance, Institute of Education Sciences, U.S. Department of Education.

Food and Drug Administration, U.S. Department of Health and Human Services (January 2017). *Multiple Endpoints in Clinical Trials: Guidance for Industry* (Draft).