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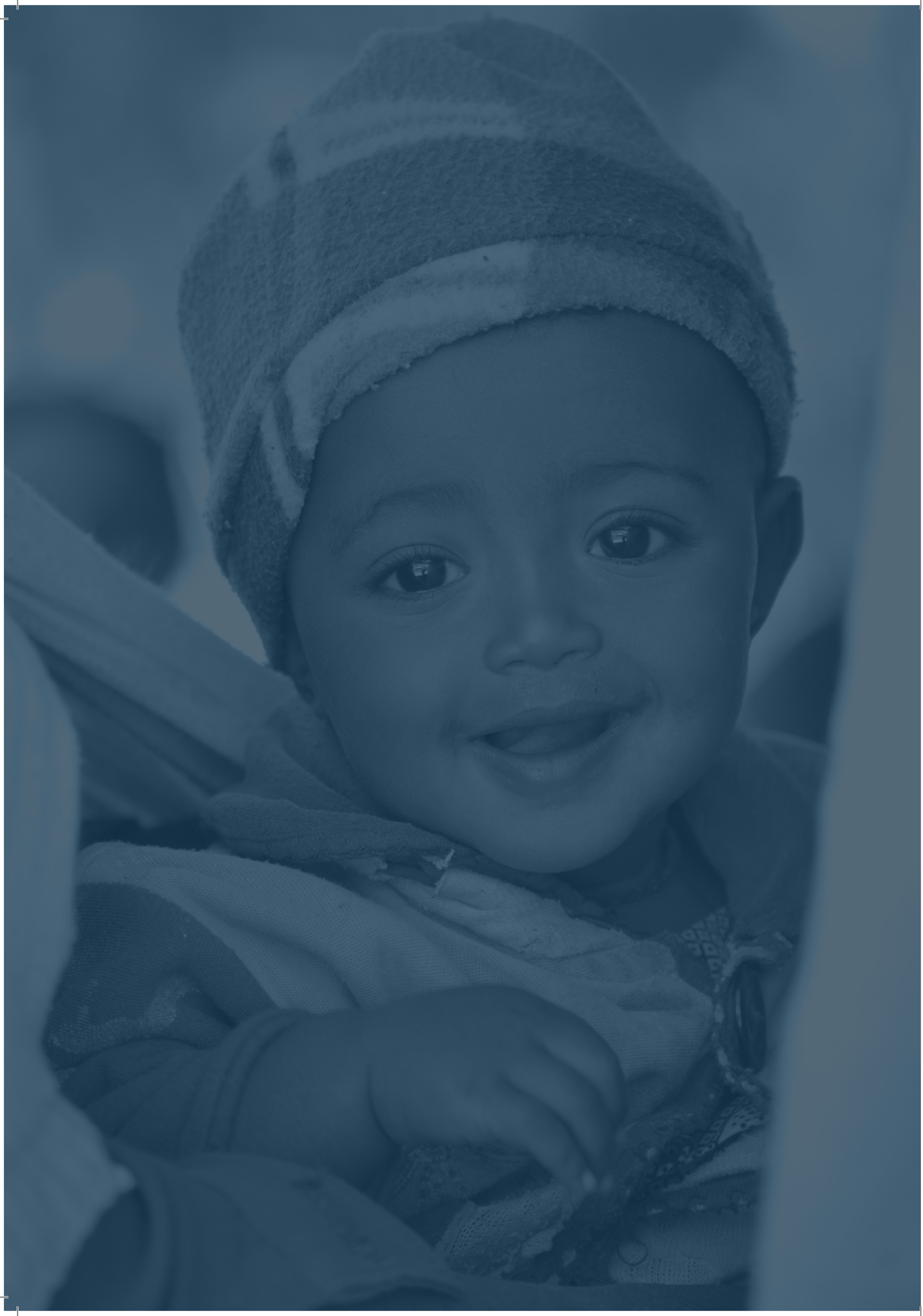
Nourish Life

Fathers as change agents in Ethiopia:
A scalable model for gender-transformative nutrition

A CASE STUDY

APRIL 2026



Introduction

Findings from Nutrition International's 2021 Sex and Gender-Based Analysis (SGBA) of the Adolescent, Maternal, Newborn, and Child Health and Nutrition (AMNCHN) program in Ethiopia revealed that deeply rooted gender norms and patriarchal structures continue to limit men's engagement in caregiving, decision-making, and support for women's and children's health. The study also found that when men are absent, women shoulder a disproportionately greater burden, with reduced time and fewer opportunities to attend to their own health and well-being.[1]

In response to these findings, Nutrition International developed a Gender Action Plan that centres on men's engagement. The Father-to-Father (F2F) initiative was established to provide a platform for fathers to engage in open dialogue on matters pertaining to family health, nutrition and caregiving. This initiative is led by peers and aims to address crucial issues affecting families in a constructive and collaborative manner. The sessions, conducted in the F2F setting, challenge the idea that caregiving is only for women and help men see themselves as active, supportive caregivers.[2]

This case study presents the findings of the pilot program for F2F in 32 kebeles[i] in Oromia, Sidama and Central Ethiopia. The case study illustrates the design and delivery of the approach, highlighting the aspects that were successful and the areas for improvement. It indicates that when fathers are supported to participate, families experience enhanced nutrition and health benefits, while communities undergo a transition towards more egalitarian and resilient lifestyles.

Methodology

This case study draws on several key sources, foremost the process evaluation of the F2F pilot. The process evaluation employed a mixed-methods design that included interviews with 33 participant fathers, six lead fathers and 17 intermediaries; spot checks of 22 sessions; and pre- and post-knowledge assessments with 401 fathers at baseline and 367 at endline. Program teams, including communications staff, also collected testimonies and success stories to illustrate how knowledge and attitudinal shifts were translated into daily practice. In addition, complementary documentation from program teams, alongside broader program reports and studies on male engagement in Ethiopia, were reviewed to identify promising practices, highlight gaps and situate the F2F approach within the wider evidence base. There are a few limitations to note, including the potential of social desirability bias among participant responses and limited generalizability due to a small sample and spot-checked observations. Furthermore, there are gaps in insight from those who withdrew their participation and were not interviewed.

i A kebele is the smallest administrative unit in Ethiopia, similar to a neighborhood or ward, responsible for local governance and community services

What is the father-to-father approach?

Studies show that husband involvement in AMNCHN care can be high in some contexts, reaching 66.2% in cities such as Gondar City in Ethiopia, for example.[3] Male partner attendance at antenatal care (ANC) is also associated with improved adherence to care guidelines, including a higher likelihood of receiving urine and blood tests and counselling on pregnancy complications.[4] Broader reviews confirm that male engagement interventions improve care-seeking behaviours, skilled birth attendance, facility births and enhance couple communication.[5]

Father-focused behaviour change programs have shown measurable effects on nutrition outcomes. A randomized trial found significant increases in paternal knowledge and improvements in child dietary diversity when both parents were targeted, compared to mothers alone.[6]

The F2F approach is a community-based behaviour change model that is peer-led and designed to engage fathers as active participants in the field of AMNCHN. The F2F approach recognizes the critical role fathers play in shaping family health and nutrition outcomes, and aims to foster more equitable parenting dynamics.

Core features of the Father-to-Father (F2F) approach

PEER-LED LEARNING GROUPS	Small groups of 15–20 fathers meet regularly, guided by trained lead fathers who act as facilitators and role models.
STRUCTURED DIALOGUE	Fathers discuss sensitive but critical topics, such as maternal health, child nutrition, caregiving, menstrual health and gender equality, that are often considered taboo for men.
EVIDENCE-BASED MESSAGING	Key health and nutrition messages are integrated with gender-transformative prompts that encourage men to question harmful norms and adopt equitable practices. (see Figure 1)
COMMUNITY ANCHORING	The model mobilizes local champions, including health extension workers, teachers, religious leaders and influencers, to legitimize and reinforce new norms.
SYSTEMS INTEGRATION	F2F sessions are designed to complement existing health and education platforms, ensuring alignment with government priorities and sustainability.

The primary delivery platform for the intervention is the F2F group, a peer-based structure engaging 15–20 participant fathers. Each group is led by one or two designated lead fathers who facilitate a series of four sessions, held biweekly at a predetermined venue and at a time agreed upon by participants. The sessions follow a structured and interactive format, supported by facilitation tools designed to maximize engagement and retention of key messages. The peer-led approach fosters a supportive, non-judgmental learning environment that extends beyond the group setting to reinforce behaviour change within households and communities. Peer-led methods are also proven to help men re-negotiate long-held beliefs and practices.[7] Figure 1 illustrates the facilitator manual which provides detailed guidance for session delivery, with structured discussion prompts and content aligned with AMNCHN packages, including maternal and newborn health and nutrition, Vitamin A Supplementation (VAS), child survival, and adolescent health and nutrition, alongside illustrated call-to-action messages. The participant manual complements this with thematic visuals that foster interactive learning and serve as ongoing reminders of key messages in daily life.

The F2F approach differs from conventional male-engagement initiatives by positioning fathers as peer change agents of health information. Instead of relying on one-off sensitization or facility-based outreach, F2F uses structured, peer-led group dialogue over time, engaging fathers across pregnancy, early childhood and adolescence. The model creates trusted, male-only spaces where fathers reflect on gender norms, caregiving roles and decision-making within the family. By embedding learning within community networks, F2F strengthens local ownership and supports more sustained shifts in caregiving practices. A summary of the pathway for change is included as an Annex at the end of this report.

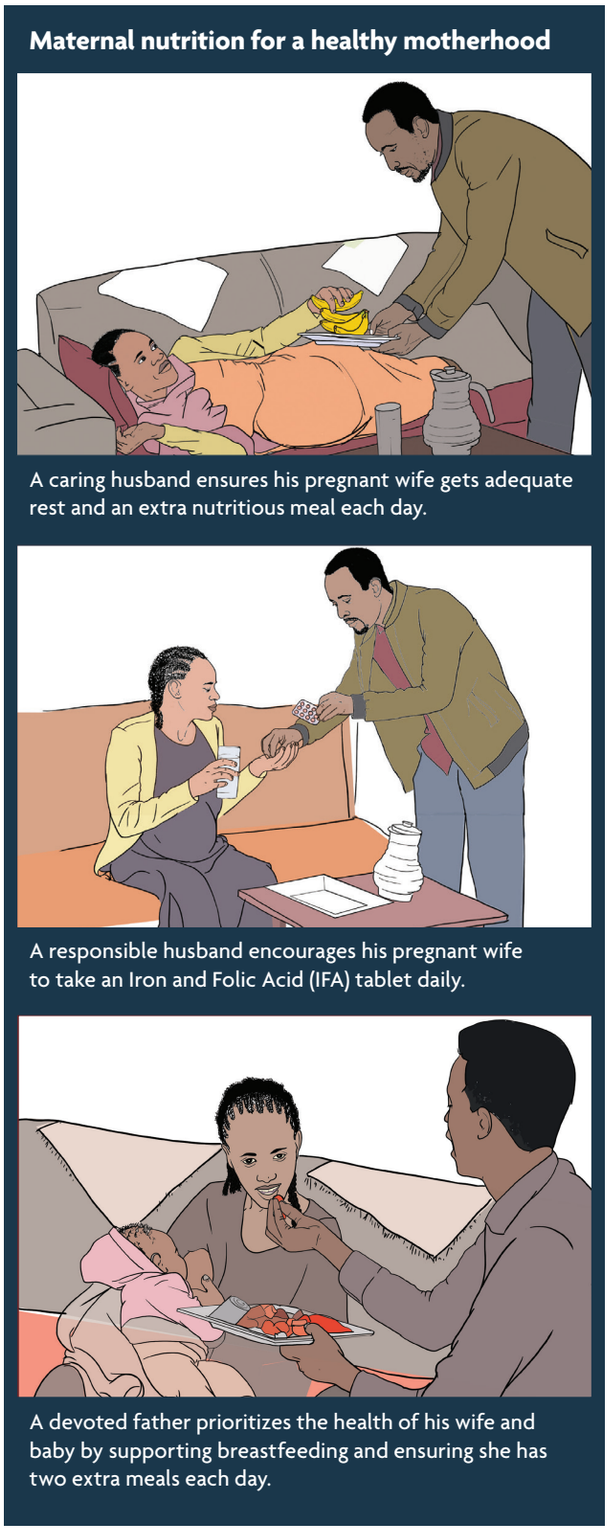


Figure 1: *Example of illustrated call-to-action messages*

Pilot implementation

The F2F model was piloted between June 2024 and January 2025 across 32 kebeles in Oromia, Sidama and Central Ethiopia. These chosen sites represented woredas with strong primary health care performance, accessible supervision systems and functioning schools that were already delivering adolescent nutrition services, such as Weekly Iron and Folic Acid Supplementation (WIFAS). This careful selection ensured that the F2F groups could both stand on their own and connect to existing health and education platforms.

The intervention specifically targeted fathers with pregnant or lactating spouses, children under five or adolescent daughters residing in these kebeles. To establish a functional implementation framework across woreda, Primary Health Care Units (PHCU) and kebele levels, 409 champions (332 men and 77 women) were trained and assigned clear roles through woreda-level facilitation trainings and PHCU-level sensitization sessions. These champions — which included PHCU staff, Health Extension Workers (HEWs), key intermediaries from the health and education sectors, designated peer-led fathers and community influencers — were equipped through woreda-level facilitation trainings and PHCU sensitization sessions to clearly define their roles and responsibilities.

These roles and responsibilities included:

- Cascading training and supervision by zonal and woreda teams;
- Coordination and documentation of fathers' participation by PHCU staff and linkage officers;
- Technical support and attendance tracking by HEWs;
- Facilitation and peer mentoring by lead fathers; and
- Community mobilization and advocacy by local influencers, such as kebele administrators and religious leaders.

Between late June 2024 and January 2025, 75 father-to-father groups were implemented in two cohorts across the 32 kebeles (2 urban and 30 rural), engaging a total of 1,394 fathers. Most participants were farmers, with 52% aged 24–35, with smaller proportions under 24 and above 42 years old. Sessions were held biweekly on weekdays, strategically scheduled to avoid market days, communal worship and other local activities. The majority of sessions (73%) took place at health posts or health centres, followed by kebele offices (11%), lead fathers' homes (8%), Idir compounds[ii] (4%) and mosques (4%). A summary of the implementation is showcased in Figure 2.

FATHER-TO-FATHER IMPLEMENTATION SUMMARY
June 2024 – January 2025

Implementation period: June 2024 – January 2025

Geographic coverage: 32 kebeles (2 urban and 30 rural) across target woredas

Cohorts implemented: Two cohorts (Cohort 1 and Cohort 2) were implemented sequentially

Number of F2F groups: 75

Total participants: 1,394 fathers engaged

Primary occupation: Majority of participants were farmers

Age Distribution: Most fathers (52%) were aged 24–35, with smaller proportions under 24 or above 42.

Session frequency: Biweekly (every two weeks)

Scheduling: Conducted on weekdays, deliberately avoiding local market days, communal worship, and other social events to enhance attendance

DISTRIBUTION OF F2F SESSION VENUES

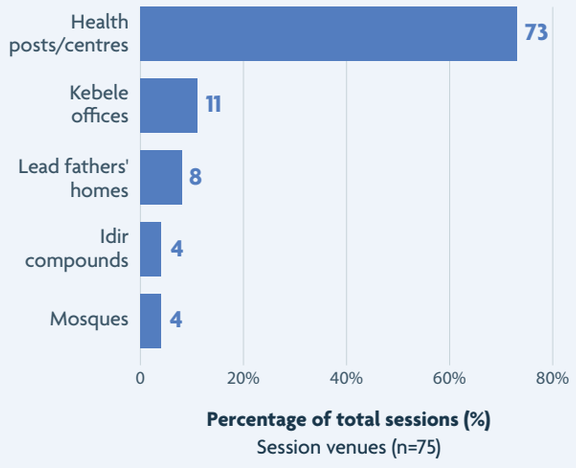


Figure 2: *Father-to-Father implementation summary*

ii Idir compounds in Ethiopia are traditional social institutions that serve as a community-based safety net. They provide mutual aid during times of bereavement, weddings, and emergencies, offering cost-effective services that alleviate financial burdens often unmet by formal institutions.

Key findings

A holistic family-centred model: The F2F intervention was designed to engage fathers through three primary entry points: having a pregnant or lactating partner, children under five or adolescent daughters. Nearly half of participating fathers (47%) belonged to households with at least two of the target groups and 6% represented all three. This overlap demonstrates that fathers' caregiving responsibilities span multiple life stages simultaneously and that interventions structured around a single household member risk overlooking these interconnected realities. The finding confirms the relevance of a holistic, family-centred model that engages fathers across maternal, child and adolescent health and nutrition domains simultaneously.

Participating fathers demonstrated consistently high engagement in the F2F sessions, prioritizing attendance despite competing responsibilities: Across 75 groups implemented in 32 kebeles, 92% of enrolled fathers completed the full four-session series, reflecting strong acceptance of the peer-led model. Fathers themselves reported appreciating the learning opportunity, explaining that the sessions helped them reflect on family roles and responsibilities they had not considered before, such as joint decision-making on health expenses, active involvement during pregnancy and childcare, and open communication with their adolescent daughters. This high level of participation was accompanied by significant improvements in fathers' knowledge of key AMNCHN messages. Recall of these messages increased from 4 to 15 percent at baseline to 70 to 75 percent at endline, showing both the effectiveness of the group sessions and the relevance of the topics discussed.[7]

Table 1: *Summary of fathers' engagement and learning outcomes in the father-to-father intervention*

DIMENSION	INDICATOR	EVIDENCE FROM THE PILOT
Implementation scale	Groups and coverage	75 Father-to-Father groups implemented across 32 kebeles
Participation and completion	Session completion rate	92% of enrolled fathers completed the full four-session series
Engagement quality	Fathers' reported experience	Fathers reported appreciating the learning opportunity and described the sessions as prompting reflection on family roles and responsibilities
Shifts in caregiving roles	Areas of reflection reported by fathers	Joint decision-making on health expenses; active involvement during pregnancy and childcare; open communication with adolescent daughters
Knowledge and message recall	Recall of key AMNCHN messages	Recall increased from 4–15% at baseline to 70–75% at endline
Interpretation	Effectiveness of the model	High participation and substantial gains in knowledge indicate strong acceptance of the peer-led model and relevance of session content

High engagement of fathers demonstrates potential for sustainable scale-up: Building on this strong engagement, review meetings conducted as part of the process evaluation highlighted how the F2F model has evolved into a promising platform for peer learning and local ownership. Stakeholders in targeted zones recognized the network's potential to sustain men's involvement in caregiving discussions beyond the pilot period. These meetings also surfaced lessons about implementation. For example, sessions held within health-facility compounds tended to limit participation, as distance discouraged regular attendance and the formal setting made discussions feel more like health service appointments than community dialogues. Despite these challenges, the momentum created through local collaboration suggests opportunities for institutionalizing the model within woreda structures. One education sector head pledged to leverage the network to support fathers whose children are at risk of dropping out of school or have irregular attendance due to family obligations, recognizing its potential to drive targeted dialogue and responsive action. "*Building on the success we learnt from the father-to-father implementation in two kebeles, we plan to use this network to tackle adolescent school dropouts and irregular attendance caused by family business demands,*" stated the education sector head.

The F2F pilot showed that venue selection and session timing influenced fathers' ability to attend regularly and engage actively in discussions: The F2F's pilot also revealed that fathers' involvement was shaped by practical constraints. Many faced competing demands on their time, including farming, household responsibilities and long trips to health facility–based venues. Overall, 13.5% of fathers reported challenges related to long travel distances and 20.6% cited competing responsibilities. Review meetings also pointed to challenges when sessions were held within health facility compounds. While this arrangement made it easier for HEWs to provide technical support, it created several unintended effects. Fathers living farther away faced longer travel times, which reduced regular attendance. The setting also made the sessions feel more like health service appointments than open community dialogues. As a result, discussions became more formal and less participatory, with greater dependence on HEWs and less peer-to-peer exchange. These patterns indicate that venue selection plays a key role in determining whether fathers can consistently attend and actively participate in caregiving discussions.

The process evaluation suggests that decentralizing sessions to village-level spaces and aligning schedules with local routines are key strategies for overcoming these barriers. Such adjustments reduce opportunity costs, broaden access and preserve the peer-driven integrity of the model. In doing so, they create conditions for sustained participation and strengthen the potential of the F2F model as a gender-responsive and scalable intervention.

Fathers show shifts toward gender equality, but deep-rooted norms remain: Post-intervention surveys with 33 fathers showed encouraging shifts in gender attitudes. Using a five-point Likert scale (where 1 represents *strongly disagree* and 5 represents *strongly agree*), participants were asked to respond to seven statements reflecting both equitable and inequitable norms. The results are shown in Figure 3 and demonstrate stronger support for equitable norms and greater rejection of inequitable ones. For example, fathers expressed high agreement with statements such as, "It is appropriate for men to discuss menstruation with one another, as well as with women and girls" and "Men should help with household duties" (mean score 4.88). Lower mean scores were recorded for statements reflecting inequitable norms, such as, "Giving the kids a bath and feeding the kids are the mothers' responsibility" (mean score 3.61) and "It is better to have more sons than daughters in a family" (mean score 3.97). However, the scores for inequitable norms are still above desirable levels and qualitative interviews revealed that barriers remain. Many fathers still described caregiving as a secondary role, hesitated to challenge son preference and avoided sensitive topics such as menstruation. Some attributed gender outcomes to divine will or limited discussions to narrow contexts.

These findings suggest that while change is possible, it requires deeper reinforcement. Strengthening behaviour change communication strategies will be important to improve comprehension, message retention and gradual transformation of norms. Sustained engagement with influential community actors, including religious leaders, can create the reinforcement needed to foster inclusive dialogue and embed gender-transformative practices in the wider community.

Greater involvement from fathers in healthcare and nutrition services highlights opportunities to leverage existing platforms for inclusive counselling: Interviewed fathers reported increased involvement in maternal newborn health and nutrition services, accompanying spouses to ANC, institutional delivery and postnatal care (PNC), and improved participation in VAS for their children under five. They expressed that health providers were receptive to engaging fathers during ANC visits. However, they noted they received little to no counselling on VAS benefits, despite their participation. These findings highlight a key opportunity: fathers spend extended time with their spouses in maternal waiting rooms and during the PNC visits in the first 24 hours, offering ideal platforms to reinforce the intervention's key messages. To capitalize on this, service providers need targeted training and tools to deliver focused, father-inclusive counselling whenever men engage with health and nutrition services and delivery platforms.

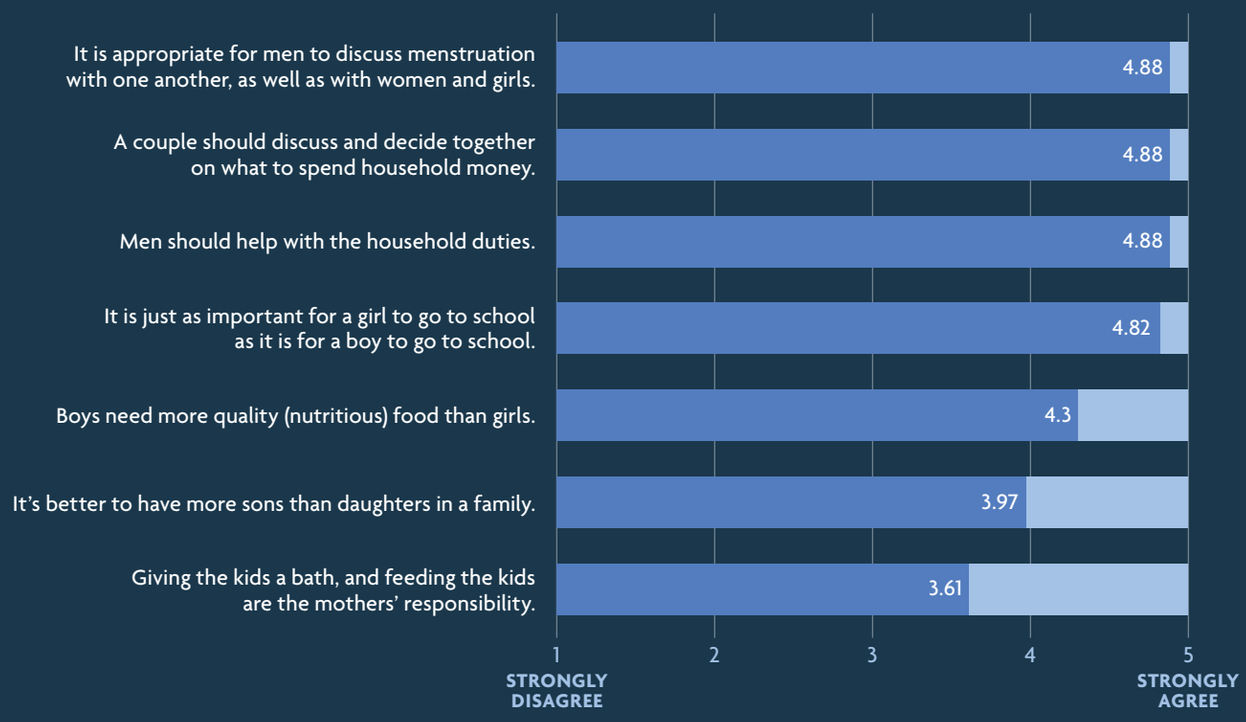


Figure 3: *Interviewed fathers' average level of agreement with gender-equal and inequality items using a Likert scale*

Conclusion and recommendations

The evaluation of the Father-to-Father Community-Based Behaviour Change Intervention showed that engaging fathers positively impacts maternal, newborn, child and adolescent health outcomes. Fathers reported greater involvement in ANC, institutional delivery, PNC and adolescent wellbeing, while also supporting gender-equitable norms. High participation rates indicate the model's scalability and gender-transformative potential. However, there are still gaps in fathers' involvement in their children's nutrition, specifically with WIFAS for adolescent girls.

The pilot demonstrates that engaging fathers was feasible and well accepted, but sustaining and scaling change requires deliberate action. To translate results into system-wide impact, four priorities emerge:

1	**Strengthen school-based SBCC platforms**	Link the F2F model with adolescent health initiatives such as schoolgirls' clubs to create a feedback loop where daughters share key messages at home. This reinforces fathers' knowledge and empowers adolescents as advocates for their own health.
2	**Invest in peer-led facilitation capacity**	Provide lead fathers with structured mentoring, facilitation tools and modest incentives to offset opportunity costs. Strengthening their capacity for gender-transformative dialogue will preserve the participatory character of the model and sustain momentum.
3	**Integrate fathers' engagement into routine health services**	Fathers' presence during ANC, PNC and waiting times remains an untapped entry point. Training health providers to deliver focused, father-inclusive counselling can extend the model's reach through existing service delivery platforms.
4	**Decentralize and adapt delivery venues**	Align sessions with fathers' daily routines and hold them in community-based venues to reduce opportunity costs and broaden participation. This ensures that the model is inclusive of diverse caregiving realities.

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Annex

Father-to-father pathway for change

From structural barriers, including deep rooted uneven gender norms, to **supportive norms and positive practices**.

1

Exposure to the interventions

- Optimal participation in Father-to-Father community-based behaviour change sessions.
- Peer learning and reflection on family health and nutrition roles.

2

Norm re-negotiation, shared understanding, and fathers' approval

- Improved fathers' awareness of key AMNCHN messages and understanding of how gender inequality influences desired behaviours and outcomes.
- Fathers' approval and appreciation for the included key messages.

3

Awareness and knowledge

- Fathers and key influencers discuss and re-negotiate social norms.
- Shared understanding of desired behaviours is established through dialogue and mutual reflection.

4

Intent (self-efficacy and confidence)

- Fathers expressed commitment and confidence about their capacity to meaningfully engage in desired behaviours.
- Strengthened provider readiness, capacity, and motivation to engage men equitably in AMNCHN services

5

Practice

- Fathers actively support AMNCHN services and delivery platforms.
- Fathers engage in equitable caregiving, including child feeding, illness prevention, and school attendance support.
- Fathers participate alongside their spouses and adolescent daughters in discussions on menstrual health, nutrition, and education.
- Champion fathers act as role models and community change agents, promoting gender-equitable practices.
- Fathers promote preventive and curative child health behaviours, including immunization, hygiene, diarrhea management with ORS/zinc, and timely health-seeking for sick children
- Enhanced autonomy and strengthened social support for women and girls

6

Optimal uptake of health and nutrition service

- Improved access to and utilization of health and nutrition services, products, and delivery platforms among pregnant and lactating women (PLW) and children under five
- Improved access to and utilization of health and nutrition services and products, including mentrual health and WIFAS, for adolescent girls.

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