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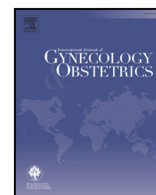

CLINICAL ARTICLE

Qualitative study of the role of men in maternal health in resource-limited communities in western Kenya

Kathryn Brubaker [a,b], Brett D. Nelson [a,b,*], Heather McPherson [a], Roy Ahn [a], Monica Oguttu [c], Thomas F. Burke [a,b,d]

[a] *Division of Global Health and Human Rights, Department of Emergency Medicine, Massachusetts General Hospital, Boston, MA, USA*
[b] *Harvard Medical School, Boston, MA, USA*
[c] *Kisumu Medical and Education Trust, Kisumu, Kenya*
[d] *Harvard T.H. Chan School of Public Health, Boston, MA, USA*

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ABSTRACT

Objective: To better understand the beliefs of men and women in western Kenya regarding the appropriate role of men in maternal health and to identify barriers to greater involvement. *Methods:* Between June 1 and July 31, 2014, a cross-sectional qualitative study enrolled lay men, lay women, and community health workers from Kisumu and Nyamira counties in western Kenya. Semi-structured focus group discussions were conducted and qualitative approaches were utilized to analyze the transcripts and identify common themes. *Results:* In total, 134 individuals participated in 18 focus group discussions. Participants discussed the role of men and a general consensus was recorded that it was a man's duty to protect women during pregnancy. When discussing obstacles to male involvement, female participants highlighted gender dynamics and male participants raised financial limitations. *Conclusion:* There was considerable discrepancy between how men described their roles and how they actually behaved, although educated men appeared to describe themselves as performing more supportive behaviors compared with male participants with less education. It is suggested that interventions aimed at increasing male involvement should incorporate the existing culturally sanctioned roles men perform as a foundation upon which to build, rather than attempting to construct roles that oppose prevailing norms.
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1. Introduction

Maternal mortality has decreased worldwide by more than 45% over the past 20 years [1]. Despite this enormous shift, some low- and middle-income countries have struggled to improve maternal mortality ratios (MMRs). The MMR in Kenya remains unacceptably high at 362 per 100 000 live deliveries and some regions, such as Mandera County (approximately 3500 per 100 000 live deliveries), have MMRs that are among the highest in the world [2].

Since the International Conference on Population and Development [3] and the Fourth World Conference on Women [4], increased male partner involvement has been emphasized as a strategy to improve reproductive and maternal health outcomes. Greater male involvement during pregnancies has been associated with increases in family birth plans [5], increases in women undergoing delivery with skilled birth attendants [6], increases in first-trimester prenatal care visits [7], and reductions in low birth-weight neonates [8].

* Corresponding author at: Division of Global Health and Human Rights, Department of Emergency Medicine, Massachusetts General Hospital, 125 Nashua St. Suite 910, Boston, MA 02114, USA. Tel.: +1 617 643 4294; fax: +1 617 643 8772.
E-mail address: brett.d.nelson@gmail.com (B.D. Nelson).

Little is known about the views of both men and women regarding male roles during pregnancy and childbirth, as well as any barriers to fulfilling those roles. To gain increased understanding regarding perceptions of male roles in reproductive health in Kenya, focus group discussions were conducted with men whose partners had given birth, women who had given birth, and community health workers (CHWs). The aim of the present study was to better understand the current role of men in maternal health and how their involvement might be increased.

2. Materials and methods

A cross-sectional qualitative study enrolled women, men, and CHWs from the city of Kisumu, Kenya, the seven surrounding sub-counties, and Nyamira County between June 1 and July 31, 2014. Participants were recruited by an experienced CHW employed at the Kisumu Medical and Education Trust using purposeful sampling to ensure that the focus groups included women who delivered at facilities and women who underwent delivery at home. Recruitment continued until thematic saturation was reached. The study received ethical approval from the institutional review board of Partners HealthCare (Boston, MA, USA) and the ethical review board of Maseno University

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School of Medicine (Maseno, Kenya). Verbal informed consent was obtained from participants prior to beginning the focus group discussions.

A semi-structured instrument was used to guide focus group discussions of 45–90 minutes in length. Focus groups ranged in size from three to 15 participants, with the majority of groups having between six and nine participants. The topics included participants' delivery experiences and preparations, individual and community expectations surrounding male roles, and obstacles to male involvement. One of the researchers (K.B.) facilitated the conversations with the assistance of a local Kenyan translator who was also a CHW. All discussion members were encouraged to participate. Audio recordings of the focus group discussions were subsequently transcribed. Participants were compensated 200 Kenyan Shillings (approximately US$ 2.25) for their time.

A hybrid approach was employed whereby two researchers (K.B. and H.M.) independently analyzed and coded the interviews via a previously described "integrated approach" including "a combination of an inductive (ground-up) approach to the development of codes with a deductive organizing framework for code types (start list)" [9]. The analyses began by a thorough reading of transcripts before developing the code structure. The data were reviewed line by line and codes were assigned to reflect emerging concepts. Coding reliability was established between the two coders; line-by-line coding was performed independently before the researchers compared results and resolved any discrepancies through discussion. Once the code structure was finalized and the themes identified, NVivo 9 (QSR International, Victoria, Australia) qualitative research software was used to organize and analyze the data.

3. Results

In total, 18 focus group discussions included 134 participants (Tables 1–3). The focus groups including CHWs contained both male and female participants; all but one of the remaining focus groups were segregated by gender. The focus groups ranged in size from three to 15 participants, with the majority having between seven and 12 participants. Qualitative analyses of the discussion transcripts yielded a number of recurring major topics and themes that are outlined with examples in Table 4.

Delivery and childbirth were seen as the domain of women, with all of the male participants reporting that there was an important role for the male as the head of the family. At every focus group discussion it was asserted that in Kenya, the husband has a duty to provide for the family. Actions suggested in the focus groups as male responsibilities included the provision of food and other material goods, as well as physical and emotional support during the pregnancy.

Several male participants described a responsibility among men to provide their wives with sufficient nourishment for a healthy pregnancy and, consequently, healthy children. Food was the most frequently discussed provision; however, some male participants spoke of commodities needed at hospitals and items for the neonate following delivery. Alongside the material provisions and monetary means identified, one of the most important male roles described was to secure transportation in advance of the onset of labor.

A majority of female participants indicated that men should offer material assistance during pregnancy. Many also described saving their own money and saving some of the money that their partners had given them for other uses.

This topic was described by a female participant, "I can also say that nowadays women are involved in some income-generating activities so they are not depending on their husband that much. They are also earning their money."

In addition to material support, male participants in every focus group discussed the importance of supporting their wives with household tasks and chores that were increasingly challenging during pregnancy. To avoid the potential negative consequences of heavy lifting and hard physical labor, male participants reported that they offered assistance so that their partners could avoid increased physical stress.

The most common response from female participants, when discussing the role of men during pregnancy, was the importance of men working around the home and assisting with manual labor.

A theme described several times was that men needed to not only protect their wives from physical factors that could endanger the pregnancy, but also assist in protection from emotional stressors, such as domestic disputes. Some male participants suggested that women were at times unreasonable during pregnancy but that men should try to get along and avoid adding stress. A few male participants described the importance of behaving in a loving and supportive manner during pregnancy.

The focus on emotional support in some male focus group discussions was not mirrored in the discussions among female participants regarding important roles for men during pregnancy. Compared with the six male participants who explicitly mentioned the need to love and be kind during pregnancy, only one woman specifically mentioned love. The female participants who discussed emotional support from their partners described the importance of not being beaten but instead, feeling supported.

After discussing the role that men should play during pregnancy, participants identified factors that prevented them from doing so.

When asked about barriers to male involvement during pregnancy, male participants in every focus group spontaneously indicated that poverty limited their ability to support their partners. A point of

Table 1
Focus group participants.[a]

Focus group features	Value
Focus group discussions	18
Discussions in Kisumu County	15
Discussions in Nyamira County	3
Discussions including lay women	8
Discussions including lay men	4
Discussions including CHWs only	2
Discussions including CHWs and lay men	1
Discussions including CHWs and lay women	2
Discussions including mixed-gender community members	1
Focus group participants	134
Lay women	70
Age, y	24.9 (15–40)
Lay men	40
Age, y	27.5 (18–50)
CHWs	24

Abbreviation: CHW, community health workers.
[a] Values are given as number or mean (range).

Table 2
Education level of lay focus group participants.[a]

Education level	Male participants (n = 40)	Female participants (n = 70)
No formal schooling	0	1 (1)
Some primary	1 (3)	13 (19)
Completed primary	11 (28)	30 (439)
Some secondary	3 (8)	11 (16)
Completed secondary	16 (40)	7 (10)
University	5 (13)	2 (3)
Data missing	4 (10)	6 (9)

[a] Values are given as number (percentage).

Table 3
Family history of lay focus group participants.[a]

No. of children	Male participants (n = 40)	Female participants (n = 70)
0 or expecting	13 (33)	0
1–3	18 (45)	48 (69)
4–6	3 (8)	19 (27)
≥7	1 (3)	3 (4)
Data missing	5 (13)	0

[a] Values are given as number (percentage).

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