



# **FATHERS' ENGAGEMENT IN CHILDCARE TO PREVENT STUNTED GROWTH IN CHILDREN**

**A qualitative study at the primary healthcare level in Rwanda**

Bachelor program of science in nursing, 180 HE Credits

Bachelor thesis, 15 HE Credits

Examination date: 2 April, 2017

Course: 47

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## **ABSTRACT**

### **Background**

Rwanda has made great progress since the genocide in 1994, but is still facing the challenge of reducing the high prevalence of stunted children. Childhood stunting is an indicator for multiple pathological disorders and gives an elevated risk of chronic disease in adulthood. Engaging fathers and a shared responsibility between two partners in childcare could improve children's health and help decrease stunting among children in rural areas of Rwanda.

### **Aim**

The aim was to describe at the primary healthcare level in Rwanda, registered nurses' perceptions and experiences of fathers' engagement in childcare to prevent stunted growth in children.

### **Method**

A qualitative field study at three community health centers in Huye district with a semi-structured interview form. A qualitative content analysis was made.

### **Findings**

The perception among nurses was that it was important to engage fathers to prevent stunted growth in children. Fathers' low level of knowledge in childcare, and traditional gender roles were acting as the main barriers of fathers' engagement, communication campaigns and community training were presented as opportunities to improve the level of engagement of the fathers.

### **Conclusion**

Fathers participate in childcare. Though, the process of changing traditional gender roles is slow. In order to make further progress the nurses has to emphasize communication between spouses and a shared responsibility for the childcare. More attention needs to be paid to sensitization of families as well as healthcare personnel regarding damaging stereotypes in a traditional Rwandan household.

**Key terms:** Fathers' engagement, Nurse's perception, Rwanda, Stunted growth

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### **APPENDIX A-C**

## **ABBREVIATIONS**

CHW	Community Health Worker
CIA	The Central Intelligence Agency
DRC	The Democratic Republic of Congo
FCC	Family Centered Care
MDGs	Millennium Development Goals
MIYCN	Maternal, Infant and Young Child Nutrition
MNCH	Maternal, Newborn and Child health
NGO	Non-Governmental Organization
RWAMREC	The Rwanda Men's Resource Center
RMOH	Rwanda Ministry of Health
RNHS	Rwandan National Health System
SSF	Svensk Sjuksköterskeförening (Swedish Society of Nursing)
UN	United Nations
UNICEF	United Nations International Children's Emergency Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

## **INTRODUCTION**

For most people, Rwanda is mainly associated with the horrific genocide against the Tutsi in 1994. Less known is that Rwanda was one of the few countries on the African continent that succeeded in achieving the main targets of the United Nations [UN] Millennium Development Goals [MDGs] by 2015 (MDG Monitor, 2015) and has for the past decade made impressive progress within the healthcare sector (United Nations International Children's Emergency Fund [UNICEF] Rwanda, n.d). Since the MDGs ended in 2015, the world now strives to achieve the targets of the UN Sustainable Development Goals together by 2030 and Rwanda is challenged to reduce poverty as well as the large number of stunted growth, meaning low height for age.

In a country that scores in the top five of the Gender Gap Index (World Economic Forum, 2016), childcare is still mainly a mother's responsibility, and a Rwandan woman works an average of 20 hours more per week than a Rwandan man when unpaid domestic work is accounted for (Abbott & Malunda, 2015). National initiatives aim to change this, but governmental initiatives do not necessarily trickle down to affect daily life at the household levels in rural communities. Thus, this thesis aims to get an understanding of what it looks like on a community level and describe the registered nurses' experiences and perception of engaging the fathers to prevent stunted growth in children.

## **BACKGROUND**

### **Country context**

Rwanda is a small landlocked country located in Central East Africa, neighboring the Democratic Republic of Congo [DRC], Tanzania, Uganda and Burundi. With approximately 12 million inhabitants, Rwanda has one of the highest population densities in the world (The Central Intelligence Agency [CIA], 2017). Thirty to forty percent of the national budget comes from foreign aid, but this amount is decreasing yearly. By 2020, the country aims to transition from being an agriculture-based low-income country to a middle-income country with its main revenues coming from knowledge-based and service-oriented businesses (The World Bank, 2017a).

The country's societal foundation, as well as the physical infrastructure was demolished during the genocide against the Tutsi in 1994, when approximately one million Tutsis and moderate Hutus were killed. (UN, n.d). Since then, the country has made immense progress in economic – as well as in social – domains, including great recovery in the health sector (UNICEF Rwanda, n.d).

Still, when comparisons are made between Rwanda and Sweden, differences in health at the population levels are apparent. Rwanda has a maternal mortality rate of 290 deaths per 100,000 live births, while Sweden has four deaths per 100,000 live births. The infant mortality rate in Rwanda is 56.8 deaths per 1,000 live births while Sweden has 2.6 deaths per 1,000 live births. The average life expectancy is 65.9 years in Rwanda and 82.1 years in Sweden (CIA, 2017).

## The Rwandan National Health System

The Rwandan National Health System [RNHS] is built on the World Health Organization's [WHO] primary healthcare model and includes the public sector that offers more than 90 percent of the nation's healthcare, as well as government-assisted health facilities, mostly religiously affiliated, and a small number of private health facilities. The RNHS is a decentralized, multi-tiered system and organized in a three-tiered pyramid structure: At the base are community health workers [CHW], dispensaries, health posts and health centers. The intermediate level is comprised of district hospitals, while at the top, there are provincial and referral hospitals. Medical doctors are deployed at the hospital level, while nurses provide care and manage the health centers, dispensaries and health posts (Government of the Republic of Rwanda, 2017).

### **Stunted growth**

#### Definition of stunted growth

According to WHO (1997), stunted growth is defined as low height-for-age and reflects a failure to reach linear growth potential as a result of suboptimal health and/or nutritional conditions. It is defined as below two standard deviations for moderate to severe stunting and below three standard deviations for severe stunting according to WHO Child Growth Standards. For children younger than two years or less than 85 cm tall, the term length-for-age is used as it refers to measurements in a recumbent position (WHO, 1997). Instead of low height-for-age or low length-for-age, the term stunting and/or stunted will be used throughout this thesis.

Even though the WHO has defined the standards for what is considered a stunted growth and a normal growth, there is no exact mark for when a child is in or out of the risk zone for suffering from the consequences of being stunted and children within the standard growth rate can also face the negative effects caused by faltering growth. Thus, stunting should rather be considered a gradation of growth faltering (Onis & Branca, 2016).

#### Stunted growth in Rwanda

The UN MDG number four states that between 2000 and 2015, the mortality rate for all children under five years old should be reduced by two thirds. This goal was reached in Rwanda where the mortality rate for children, according to statistics, is significantly decreasing. From peak high in 2000, were 107 children out of 1,000 died before their first birthday to 31.7 in 2015 (The World Bank, 2017b).

However, the country is still facing major challenges when it comes to poverty reduction and children's health improvements. In 2015, approximately 37.9 percent of all children in Rwanda under the age of five had a stunted growth, a decrease compared to 2010 when that number was 44.2 percent (UNICEF Rwanda, n.d). Childhood stunting is considered the best overall indicator of children's wellbeing and is a reliable reflection of social inequalities (Black, 2013).

Rwanda is still largely rural and 86 percent of all children in Rwanda live in rural areas (UNICEF Rwanda, n.d). Children in rural areas have a higher prevalence of stunting, 47 percent, compared to children living in urban areas, 24 percent (Rwanda Ministry of Health [RMOH], 2015).

Food security differs from area to area but rates are the highest in the northern and western parts of the country that border the DRC. Regions that have the highest levels of food insecurity also have the highest stunting rates (RMOH, 2015). In communities where short stature is common, families and health workers often fail to identify stunted children, as it is so common and therefore considered normal (Onis & Branca, 2016).

#### The effects of malnutrition and infections on stunted growth

Poor nutrition and frequent infections play a role in creating a vicious cycle of increased receptiveness to infection and a decline in nutritional status. A malnourished body has a weaker epithelial barrier function and altered immune response. Infections on the other hand affect a person's nutritional status by reducing the appetite and intestinal absorption while increasing the catabolism and using energy to fight the infection rather than developing the body (Onis & Branca, 2016). This vicious cycle can result in stunted growth. In order to reduce stunting, researchers highlight advancement in the areas of water, sanitation and hygiene [WASH], food and nutrition security, education, healthcare, poverty reduction and the status of women as the way forward (Onis & Branca, 2016).

#### The first 1000 days is a critical period

Growth faltering often begins in utero and continues for at least the first two years of postnatal life – a time window of approximately 1000 days. During this critical phase, linear growth is most sensitive to factors related to feeding, infections and psychosocial care. Healthy children experience maximal growth velocity during the first few months of life and fast brain growth in the first two years. Thus, the first 1000 days are also critical for long-term neurodevelopment. As a result, focus on the first 1000 days is not merely based on the magnitude of faltering but also on long-term consequences in adult life (Victora, de Onis, Hallal, Blössner & Shrimpton, 2010).

#### The consequences of childhood stunting

Linear growth failure is an indicator for multiple pathological disorders associated with increased morbidity and mortality, reduced neurodevelopmental and cognitive function and an elevated risk of chronic disease in adulthood (Onis & Branca, 2016). Stunting can lead to an underdeveloped brain and diminished learning capacity, and is a major risk factor for anemia and nutrition related diseases (UNICEF, 2016). Illness and death from infections, especially pneumonia and diarrhea, are more present in a stunted population. Stunting is also associated with deaths related to tuberculosis, sepsis, meningitis and hepatitis (Olofin et al., 2013). But, there are also socioeconomic consequences of stunting in adult life: a one percent loss in adult height due to childhood stunting is associated with a 1.4 percent loss in economic productivity for that individual (The World Bank, 2017c) and stunted children earn as much as 20 percent less as adults compared to non-stunted individuals (Grantham-McGregor et al., 2007).

## **The nurse's professional responsibility and family centered care**

### The nurse professional responsibility

The nurse's professional responsibility as defined by the International Council for Nurses, is to promote health, to prevent illness, to restore health and to alleviate suffering (ICN, 2012). WHO defines health as when mental, social and physical well-being is complete (WHO, 1948). According to Whitehead (2006), the terms health promotion and health education are commonly mistakenly used interchangeably. Health education should rather be considered a part of a wider health promotion strategy. Health education usually focuses on an individual's or group's specific health status and related risk factors and aims to prevent illness by promoting behavioral change. Health promotion is a wider concept (Whitehead, 2006). Examples of health promotion could be; raising public awareness through mass media campaigns, supporting community development by encouraging the creation of local support groups, promoting structural changes within the domains of economics, environment and politics by for an example supporting the access of clean water. Other examples of health promotion are; creating supportive environments by working against stigmatization, improving healthcare access, improving cross-sectoral collaboration with for an example schools, and taking protective measures against an epidemic outbreak (Ansved & Lingerhed, 2016). It is common that nurses who state that they work with health promotion rather do health education interventions (Whitehead, 2006).

In order to provide the best care possible to all patients, Doss-McQuitty (2016) emphasizes the importance of professional development throughout the nurse's career. Being aware of your level of competence and striving to become an expert in your specific area of nursing is the nurse personal professional responsibility according to Doss-McQuitty (2016). Nurses should also be equipped with the best training and resources in order to be leaders in accelerating and improving health services (Doss-McQuitty, 2016).

In Rwanda, the work for reducing stunting in children is present at all public health levels – and especially at the community level, where nurses and CHWs play the main roles in promoting health and preventing stunting. The community based nutrition programs support the community to track children's growth, the families in the communities receives training in nutritional principles as well as initiate community or home gardens (UNICEF Rwanda, 2016). At the local health centers, the nurse is among other things responsible for family planning, prenatal childcare consulting, HIV prevention and treatment and immunization – all areas in which preventive interventions to reduce stunted growth of children take place.

### Family centered care

In family centered care [FCC], the family is seen as a system where each family member represents a part of the whole and is commonly used in pediatric care. According to Svensk Sjuksköterskeförening [SSF] (2015) this is a system where all the pieces together are bigger than their sum, and where all pieces affect each other. This perspective on the family suggests that each family member affects the other members' life and health. For the nurse, this implies that the family should be considered as one unit where the family can contribute to improved health, less suffering and increased wellbeing for anyone in the family.

The opposite also applies; each family member can contribute to decreased health and increased suffering for any member of the family (SSF, 2015). FCC reaches beyond patient-nurse interaction by including the needs of all family members, not just the child. The nurse professional responsibility in FCC entails that the nurse invite all family members to be apart of defining the problem, the solution and the decisions that affects the health of individuals of the family. With FCC, all competences and unique resources of the family should be taken into account to co-create overall healthcare. Family members and the nurse possess different competences regarding how health issues can be handled and how health can be preserved and it is the nurse responsibility to include everyone's competences in the care of the child (SFF, 2015). According to SSF (2015) it is essential that the patient, the family members and the nurse are seen as equals that in dialogue with each other understand the different elements of the situation. The nurse is responsible for creating a flat structure where everyone's competencies are equally valued.

Despite the lack of one agreed upon definition of FCC, several American organizations have agreed upon five FCC principles.

1. *Information Sharing*: The exchange of information is open, objective, and unbiased. 2. *Respect and Honoring Differences*: The working relationship is marked by respect for diversity, cultural and linguistic traditions, and care preferences. 3. *Partnership and Collaboration*: Medically appropriate decisions that best fit the needs, strengths, values, and abilities of all involved are made together by involved parties, including families at the level they choose. 4. *Negotiation*: The desired outcomes of medical care plans are flexible and not necessarily absolute. 5. *Care in Context of Family and Community*: Direct medical care and decision-making reflect the child within the context of his/her family, home, school, daily activities, and quality of life within the community (Kuo et al., 2012, p.299).

FCC can improve the outcomes as well as the experiences of the healthcare for the patient and the family, decrease healthcare costs, increase professional satisfaction of the nurses and lead to more effective use of healthcare resources (Dunst & Trivette, 2009; Dunst, Trivette & Hamby, 2007; Eichner & Johnson, 2012). According to Kuo et al (2012) a barrier for successful FCC is the lack of knowledge of the nurse and of the family, of what FCC contains. This can result in nurses delegating more tasks and decisions to the family than desired, rather than including the family in the processes. Another barrier of FCC relates to insurance coverage, financial difficulties and employment constraints. It is not all families who have the practical possibility to invest the, sometimes extensive amount of, time and be all engaged in the clinical visits for the child (Kuo et al., 2012) something that the nurse needs to take into consideration when applying FCC.

### **Gender equality and women's health in Rwanda**

Rwanda is number five in the world on the Gender Gap Index 2016, surpassed only by the Scandinavian countries. On the Gender Gap Index, Rwanda scores highest in the world when it comes to female representation in parliament, wage equality, labor force participation of women over men, sex ration at birth and enrollment in primary and secondary education. Women take an average of 84 days of maternity leave and men take an average four days (World Economic Forum, 2016).

Despite the high ranking on the Gender Gap Index, reports describe a Rwanda where political power is less equal at the district and community levels, where traditional gender roles and norms are strongly present and the gender based violence-rate it relatively high (Abbott, Mutesi & Norris, 2015).

Unpaid labor performed by women results in a workweek for the Rwandan woman that on average is 20 hours longer than the one of Rwandan men. The unpaid labor consists of childcare, domestic labor such as collecting water and wood and signing up for voluntary care work in the community. Testimonies from women in rural Rwanda have led researchers to suggest that the emphasis on gender equality burdens the woman as the husband now expects the wife to do more income generating activities as well as have the full responsibility for domestic and childcare work and for most of the farming. In Rwanda, men play a dominant role in decision-making and are commonly in charge of the household finances (Abbott & Malunda, 2015).

Stunting and women's health are strongly linked. Women who were stunted as a child have a higher risk of bearing stunted children. It is suggested that this is due to epigenetic effects, programming of metabolic changes, shared genetic characteristics and the reduced space in the uterus for fetal growth (Onis & Branca, 2016). Maternal stunting is also a risk factor for perinatal and neonatal mortality (Ozaltin, Hill & Subramanian, 2010).

## **Fathers' engagement**

### Definition of fathers' engagement

According to Montgomery, van der Straten and Torjesen (2011) there is not one single recognized definition of male or fathers' engagement in childcare. This thesis is using a definition of fathers' engagement based on the research done by Comrie-Thomson, et al. (2015a) on maternal, newborn and child health (MNCH). As the health of a child is strongly correlated to the health of the mother (Onis & Branca, 2016), this study will use the definition of fathers' engagement in MNCH, and is described as fathers taking an active role in protecting and promoting the health and wellbeing of their partner and children. The definition does not limit fathers' engagement to a specific set of actions, however, examples of fathers' engagement can be making informed decisions with their partner about family planning, promoting good nutrition, providing emotional support and encouraging appropriate health behaviors. Expectant fathers or fathers who participate in clinical service such as accompanying the pregnant mother or the child to the health center are other examples of fathers' engagement. Further, fathers' engagement accommodates fathers' participation towards creating a gender equitable family environment by, for example, promoting equal access to health service for girls and boys in the family, performing domestic care work, reducing gender based violence and improving couples communication (Comrie-Thomson et al., 2015a). Thus, this thesis does not limit fathers' engagement to clinical care but also recognizes actions at the community or household levels that promote and protect the health of the family.

### The effects of fathers' engagement

Men usually do decision making on family planning and the use of contraceptives family (Fink, Sudfeld, Danaei, Ezzati, & Fawzi, 2014).

Sufficient birth spacing and reduction of unplanned pregnancies as part of family planning does not only have a positive effect on maternal health, but also reduces the risks for stunted growth of the children in the family (Fink, Sudfeld, Danaei, Ezzati, & Fawzi, 2014). Decision making of the father also relates to areas such as breastfeeding, availability of transport to take mothers in labor to a clinic, childhood immunization and seeking healthcare if the child is sick. Educating men so that they can make informed decisions thus helps to promote and protect the health of the children and mother (Comrie-Thomson et al., 2015a).

The authors have not been able to identify sufficient research on the effects of fathers' engagement in maternal, infant and young child nutrition (MIYCN). In 2014, the WHO did a systematic review of male engagement interventions on maternal and newborn health. Thirteen studies were identified in low and middle-income countries. The conclusion of the review was that there is a big empiric gap of the impact that male engagement interventions have on essential health outcomes such as infant mortality and birth weight (Comrie-Thomson et al., 2015b) and that further studies are required. The review also concluded that engaging men in MNCH education and services could have positive effects on MNCH, such as maternal nutrition, the use of health facilities and reduced workload for the women (Comrie-Thomson et al., 2015a).

### Fathers' engagement in Rwanda

Improving MIYCN is a focus area worldwide through several international initiatives such as the WHO's resolution on MIYCN from year 2012 and the UN's Sustainable Development Goals. Traditionally, children's health and nutrition are domains that have been attributed to the woman. However, the UN now highlights the importance of the father's role in this domain. One of the targets of the Gender Equality Sustainable Development Goal is to recognize and value unpaid care and to promote shared responsibility within the household and family (UN, 2016).

At a national level, Rwanda has made efforts to engage men in children's health and nutrition. One example is the national communication campaign "First 1000 days in the land of the 1000 hills." The campaign aims to educate families and health workers of the importance of the first thousand days period. Launched in September 2013 and continued for one thousand days, one of the targets of the campaign was to influence positively the attitudes of men towards MIYCN within the household (RMOH, 2013).

A study in two districts of Rwanda from 2016 found that fathers see themselves as engaged in their child's nutrition mainly through resource and financial support as well as giving their wives permission to participate in activities around nutrition. The fathers commit less in other domains such as taking the child to the health centers, emotional support or direct caregiving. The study concluded that fathers have a good level of basic knowledge about key areas of nutrition but often lack more specific knowledge. Most fathers also expressed that they wanted to be more engaged and that their current level of engagement is not enough. Mothers recognized that the father's participation in childcare and nutrition is not equal, but there was no consensus regarding whether this was a problem or not (Catholic Relief Services, 2016).

## **The study problem**

Research shows that the Rwandan mother carries the main responsibility for childcare. Meanwhile, the Rwandan father is the family decision maker and in charge of the home finance (Abbott & Malunda, 2015). This results in a challenge for the children's healthcare; a nurse might tell a mother that the child needs to eat more protein, but it is the father who decides if the family should use household income for this purpose. This thesis argues that a shared responsibility for childcare and child healthcare results in healthier and fewer stunted children.

Traditional gender roles are still very present at the community level and initiatives to promote gender equality at this level are often top-down directives from the government or international non-governmental organizations [NGO's] (Abbott & Malunda, 2015). There are studies describing fathers, mothers and community leaders experiences and perceptions of engaging fathers in child healthcare and childcare in Rwanda. However, the authors have not been able to identify studies that describe the nurse's experience and perception on the topic. Changing mindsets and challenging gender roles requires actions at all levels of society – not only from the RMOH at the top level. This thesis argues that if the nurse at the community level sees the purpose of engaging fathers and is motivated to encourage fathers' participation, this will have a positive effect on the children's health and the prevention of stunted growth.

## **AIM**

The aim was to describe at the primary healthcare level in Rwanda, registered nurses' perceptions and experiences of fathers' engagement in childcare to prevent stunted growth in children.

## **METHODOLOGY**

### **Choice of research method**

The study was conducted as a qualitative field study at community health centers in rural areas of Rwanda. Research methodology was chosen based on the thesis aim. A semi-structured interviewing method was chosen as it was considered relevant to the subject, as the aim was to attain more extensive knowledge of the nurse's experience and perception. The semi-structured method contributes to flexibility in interview questions conducive to better rapport and more trust among the participants (Polit & Beck, 2012).

### **Inclusion criteria**

According to Polit and Beck (2012) it is important in the beginning of a qualitative study to ask who would be an information rich data source for the study. The study group chosen was registered nurses working at public health centers connected to the Kabutare Hospital in Huye, in southern Rwanda. Ninety percent of the healthcare services in Rwanda are offered through public healthcare (Government of the Republic of Rwanda, 2017), therefore public healthcare centers were chosen as the most relevant source of information.

To be included as a subject in this study, participants had to be registered nurses working in rural areas of Rwanda at a public health center or as a registered nurse working in different communities with home visits to patients. Working with child healthcare in any way was also requisite to be included in this study in order to be sure that participants had knowledge enough to provide valuable data.

In Rwanda, the majority of the population speaks Kinyarwanda. Some people also speak English and/or French. Originally, ability to speak English was also necessary for the registered nurses who participated in this study. However, after visiting the first health center, the authors soon realized that this inclusion criterion would severely limit the number of possible participants, as nurses in rural Rwanda rarely speak English well enough to participate in in-depth interviews. Thus, ability to speak English was removed as an inclusion criteria and an interpreter was used when the nurse spoke Kinyarwanda.

The choice of performing interviews at health centers was based on two factors: First, the health centers are located in rural communities where stunting is the most present (RMOH, 2015). Secondly, these different health centers also carry out many of the initiatives by the RMOH, such as the health education interventions related to the content of the “First 1000 days in the land of a 1000 hills” campaign and the National Immunization program.

### Description of the participants

Semi-structured interviews were performed with seven nurses. One of the interviews was later excluded from the data analysis. Two nurses were male and five were female. The included nurses interviewed were working with children’s health in different ways, or indirect by working with maternal health. One nurse was specialized in HIV treatment and prevention. One nurse was primarily working with family planning. Two nurses were working with parental counseling. Two nurses were specialists within MNCH. Two of the nurses spoke English in the interviews and five spoke Kinyarwanda. In the interviews performed in Kinyarwanda, an interpreter was used, translating from Kinyarwanda to English.

### **Data collection**

#### Topic Guide

To be sure to receive as valuable information as possible, a topic guide was created with several questions within different themes. According to Polit and Beck (2012) the purpose of a topic guide is to make sure that all of the important themes are covered while allowing for the participants to speak freely on each topic, sharing stories in their own words. The topic guide was arranged with more general questions on the top and more specific questions at the end. Participants have a tendency to volunteer more information at the end of an interview (Polit & Beck, 2012), thus the central themes of the thesis were purposely put at the end of the topic guide. After the first draft of the guide was made, the guide was scaled down based on relevance to the aim of the thesis.

The thematic question areas later selected were “stunting,” “fathers’ engagement - the nurse’s experience” and “fathers’ engagement - the nurse’s perception” (see Appendix A).

### Informing directors and nurses at the health centers

The health centers visited are all connected to Kabutare Hospital. Before arriving in Rwanda, the director of the hospital was contacted and permission to conduct the interviews was given. Staff resources from the hospital were allocated to assist the authors in reaching out to the health centers.

Directors of the health centers were contacted through the hospital staff and a written summary of the thesis, including the topic guide, was handed out (see Appendix B). Permissions to conduct the interviews at the three health centers were given in writing.

Henricson (2012) states that informed consent is based on the ethical principle of self-determination and protecting of the participants, all participants must be fully aware of whether or not participating in the interview can have any potential benefits or may be harmful to themselves in any way. Henricsson (2012) also states that there are several things that are required in order to fulfill what is called informed consent. First, the participants have to receive the information about the work before the actual interview. Second, participants need to have the possibility to understand the information entirely. Therefore, the participants in the study were informed about the work and asked to participate prior to the interviews, through a written letter translated to Kinyarwanda (see Appendix C). An authorized interpreter in Huye was used to translate the written letter from English to Kinyarwanda. All participants were also given an oral presentation of the thesis by the authors. The written and the oral information included the aim of the study, the study design and the methods used for collecting data. Further, Henricson (2012) adds that all participation has to be voluntary and in no way under threat or coercion. Therefore the nurses were informed that they at any time before, during or after the interview could end their participation without any given reason. Information on how to reach the authors as well as the supervisor if they wished to exclude their whole participation or something in particular from the interview at a later stage was also given to participants. The participants were also informed that the interviews would be audio recorded and that all information would be kept confidential and anonymous, as suggested by Polit and Beck (2012).

### Pilot interview

The first interview at the first health center was a pilot interview. According to Polit and Beck (2012) this is done in order for the authors to be aware of any challenges with the topic guide and the study method and to adjust accordingly. The nurse provided qualitative and relevant information supporting the aim of the study and findings from the interview was thus included in this thesis. No changes were made in the topic guide after the interview.

### Performing the interviews

The interviews were designed using a semi-structured model with a printed premade topic guide. Follow-up questions were asked and these varied depending on participants' answers. The first two interviews were performed in English and the other five were performed in Kinyarwanda, using an interpreter, translating from Kinyarwanda to English and vice versa. The decision of using an interpreter was made, as the authors wanted the nurses to speak as freely as possible without any language barrier. The interpreter chosen was a man from Huye who spoke English and Kinyarwanda fluently.

The interpreter had never visited the areas where the study was carried out and had no personal connections to any of the participants.

The interviews were conducted during two days at three different health centers where the nurse in question was working. As recommended by Polit and Beck (2012), the interviews were held in a room where the interviews could be conducted without disturbance.

The intention was to audio record the interviews using an audio recording device. However, the first two nurses did not want the authors to record the interviews and instead detailed notes were taken by one of the authors while the other was asking the questions. During the second day of performing interviews, the first participant agreed to be recorded. The authors were given the impression that this interview did not provide as much insight to the participant's experience and perspectives as the previous two interviews, because the answers were short and did not include personal reflections. After consulting with the local mentor, the authors made the decision that the following interviews would not be recorded. Rwanda's modern history as well as the current political situation has not encouraged free speech, and there is a known cultural tendency of mistrust in Rwanda. The authors were told that having one's opinions recorded has and is still today associated with severe consequences. This third interview was excluded from the analysis, but all others were included.

### **Data processing**

The Rwandan rhythm of speaking is slow, so it was possible during the interviews to write down full sentences exactly or almost exactly as said by the participant or interpreter. The same day each interview was performed, the authors looked through the notes, and the data collected during the day was compiled. As the interviews were not recorded, crosscheck of the material as advised by Polit and Beck (2012) was not possible. Before making any interpretations of the material, the typed interviews were read thoroughly as recommended by Polit and Beck (2012).

### **Data analysis**

A qualitative content analysis was made. The analysis began with each author reading the material separately in order not to impact each other's interpretation of the material. To become familiar with the data, this process was done multiple times, as suggested by Polit and Beck (2012). Individual notes were taken with the purpose of identifying data that could best answer the aim of the study. Color-coded notes were used to distinguish between data that was related to the nurse's experience of engaging fathers and the nurse's perceptions of engaging fathers. Further, as suggested by Polit and Beck (2012) the process entailed finding similarities between the different interviews as well as patterns and inconsistencies. In the next step, notes were compared and coded to identify recurring thematic areas relevant to the study. Units of information that shared the same or similar content received the same code, for an example "community training". Codes that had related concepts were grouped into the same category, where each category functioned as an overall thematic area, for an example "The nurse's perception and experience of opportunities for engaging fathers" (see Table 1). According to Polit and Beck (2012) new categories can emerge that had not been identified prior to the interviews. The categories identified were somewhat similar to the themes in the topic guide, but new categories also emerged. Four main categories and eight codes were identified (see Table 1).

The data was read again as a whole to detect any potential underlying themes and to ensure that nothing important had been left out (Polit & Beck, 2012). The authors studied the data a final time in order to identify any important findings based on what the nurses *did not* say in the interviews. For an example, if the nurses *did not* mention the mother, when asked about barriers for shifting traditional gender roles.

During the whole analysis process, the authors discussed the findings together. The authors discovered that some words had different meanings for the two. Discussing the different understandings of the words functioned as door openers to a deeper analytical process that helped the authors define and clarify content of the thesis further.

## **Ethical considerations**

### Consequences of participation

The authors needed to reflect on how the study could be affected by the fact that it was carried out by two researchers with relatively higher levels of wealth in a poor region, in one of the poorest countries in the world. It was important to consider the possibility that participants might anticipate some sort of benefit or award from the authors by engaging in the study. Thus, it was essential to gain an understanding of the motivations for participating as well as clarifying that there would not be any financial reward associated with participating. This was done through informal conversations with the nurses prior to the start of the interviews. The participants were also informed on how they could access the final result if they so wished. The purpose of this was to increase direct benefit to the participants (Kvale & Brinkmann, 2014). It was also important to consider potential negative consequences for the participants and for the group, nurses in Rwanda, that the participants represent. Anonymity and confidentiality were therefore essential (Kvale & Brinkmann, 2014) and were ensured by not asking for any identifying information, by keeping the notes from the interviews in a locked room at the office and by using password protected computers that were also kept in a locked room. The interpreter was also informed about the confidential nature of the interviews and was asked to sign a nondisclosure agreement.

### Data collecting

The authors needed to consider the power balance between the interviewer and the responders and that the respondent could feel pressured to answer questions (Kjellström, 2012). It was important that the participants knew that they did not need to answer any question that they did not wish to answer. This was emphasized both in the written letter to the participants and orally upon arrival to the health centers. In this phase, the interpreter could also affect the power balance. Thus, the selection of a suitable interpreter was done, taking the interpreter's age, education and social and professional position into account, to make the responders as comfortable as possible.

### Data analysis

The authors entered a cultural context where norms around, for an example, hierarchy and gender differ from Swedish norms. To understand the results from their cultural context, the authors needed to be culturally competent. In order to gain cultural competence as a nurse, cultural awareness and awareness of personal convictions and values are cornerstones (Friberg & Öhlén, 2014).

The authors needed to be aware of personal assumptions and norms, how questions were formulated as well as being critical to “Swedish” interpretations of the answers. To ensure that the analysis was as unbiased as possible, the authors wrote down all the assumptions that they had related to Rwanda and especially related to gender norms in Rwanda. The list also included personal convictions and values on the topic. In order to gain cultural awareness, the authors did some desk work as well spent time with locals in order to understand the history and the cultural context in which the study was carried out.

**FINDINGS**

The findings are presented in Table 1 in eight codes, gathered in four corresponding categories. The categories and codes emerged in the data analysis process. Further below, the findings are presented in the same order as they are displayed in the table, including particularly illustrative quotations.

**Table 1.** Categories and codes

Category	Code
The nurse’s perception of fathers’ engagement to prevent stunted growth	Importance of fathers’ engagement to prevent stunted growth  Development of fathers engagement
The nurse's experience of professional responsibility	Education Encouragement
The nurse’s perception and experience of barriers for engaging fathers	Fathers’ level of knowledge Traditional gender roles
The nurse’s perception and experience of opportunities for engaging fathers	Community teaching Announcements

**The nurse's perception of fathers’ engagement to prevent stunted growth**

The nurse is responsible for many of the interventions that can prevent a stunted growth by optimizing nutritional status of mother and child, while keeping infections to a minimum. Interventions can be, but are not limited to, counseling on family planning, activate individual nutrition plans, providing nutritional advices, immunization, maternal counseling and HIV prevention and treatment. The findings below describe the nurse's perception of engaging fathers in interventions such as the once mentioned above.

The findings also include the nurse's perception of fathers taking an active role in other less direct ways to prevent stunted growth, but nevertheless protecting and promoting the health and wellbeing of their children and partner at the community or household level. Furthermore, the development of fathers' engagement over time was a reoccurring theme. The codes that emerged were Importance of fathers' engagement to prevent stunted growth, and Development.

#### Importance of fathers' engagement to prevent stunted growth

The data presented a unified opinion from the nurses that it was important to engage the father in his child's healthcare as well as childcare generally. All nurses participating in the interviews could describe how fathers' engagement had a positive effect on the child's health and wellbeing, but not everyone directly related the engagement of fathers with the prevention of stunted growth. One nurse mentioned that it was important that the child experienced love from both of the parents, and caring for a sick child was a way to show love. Another nurse described that it was important to engage fathers more, so that the workload between spouses would be more equal.

*“Both parents should take care of children equally. The child is not only the mother's responsibility but also the father's.”*

Having the family make decisions associated to the health of the children based on recommendations from medical personnel was a recurring motivation for why the father should be engaged. If the father as well as the mother received information from the nurse - for example, breastfeeding recommendations - the nurses expressed that the family would be more likely to comply. This would promote optimal nutrition and thus prevent stunted growth.

The registered nurses described that a conflict, deriving from mistrust could occur; it was explained that skepticism from fathers regarding what the mothers said that they had been taught at the health centers was a common phenomenon. Engaging the father more in his child's healthcare was suggested to improve not only the health and wellbeing of the child but also the relationship of the parents.

*“If you only tell the mother what to do, she cannot take care of the whole family; they have to care for the family together. You have to tell them together if you want them to understand, otherwise the message can be wrongly translated to the other partner. It also has a better impact if it is a nurse who tells them [the fathers], not only the mother.”*

According to participants, the responsibilities of the children's healthcare had to be shared regardless of traditions and stigma around a father caring for a child. Some nurses mentioned changing diapers, cooking food, participating in health center counseling and taking the child to the health clinic as examples of how the father was or could be engaged. Other nurses mentioned engagement in terms of the father allocating more of the family budget to nutritious food, digging in the kitchen garden or providing the family with a healthcare insurance.

## Development

Education and encouragement of the fathers by the nurses had made it easier for the nurses to engage fathers, and all participating nurses had a shared understanding that progress has been made over the past few years.

*“Since I started it has been immense progress in the right direction.”*

*“In the beginning, the fathers seemed very ignorant about taking care of children or sharing responsibilities at home. When the project started in 2007, it was not easy to make the fathers come here, but now they come together with their wives to learn more.”*

Despite this development, the study group shared stories of how mothers today were experiencing a greater burden than the fathers in taking care of the children. While fathers tend to participate when it was mandatory and not participate when optional, the participating nurses agreed that the trend was going in the right direction. The data did not present a unified view on whether the fathers’ level of engagement today was enough. The data however showed that over time, fathers’ engagement has increased and the belief was that fathers’ engagement would increase in the future.

*“My opinion is that fathers’ engagement as it is today is not enough. The fathers now bring the children to school, but that isn’t enough.”*

## **The nurse’s experience of professional responsibility**

In this category, findings related to the nurse's experience of her professional responsibility to prevent stunted growth as well as engaging fathers in childcare, are presented. The two codes that were detected in the analysis process were Education and Encouragement.

### Education

Education was considered key among the participating nurses and a dominating task for a registered nurse at the health center. Their ambition was to educate families about the profits of sharing the responsibility as parents to prevent stunted growth. They offered group counseling, couples counseling and also counseling for mothers. No nurse mentioned that they do exclusively counseling for fathers. Counseling was offered on different topics and during different phases of the family's development: family planning, HIV prevention, maternal health and children’s health and nutrition.

*“We also tell them [the parents] that there should be at least two years in between pregnancies; if the mother gets pregnant again shortly after having the first child, there is a high risk that both of the children becomes malnourished.”*

The prenatal counseling for both of the parents included advice on breastfeeding and nutrition. The nurses also educated the families about prioritizing their money and the importance of having family discussions together. The reason given for doing prenatal counseling for both of the parents together was that the parents should have access to the same basic knowledge around nutrition and children healthcare, something that would support decision making processes within the family.

The nurses mentioned that some of the counseling sessions were mandatory for the father to participate in; other sessions were voluntary for the father.

*“The parents must come together to the first meeting, the first meeting is mandatory for both parents, after that they are free to do as they wish, which means that after the first meeting the mothers often come alone.”*

*“The key is to change the mindset of the people. The Rwandan culture has to be changed in this matter [shared responsibility] and the only way to do so is by education.”*

### Encouragement

The nurses encouraged fathers to be more engaged and explained the importance of their participation. Nurses encouraged fathers to see the family as a unit consisting of the children and both parents. All participants mentioned that they would give extra attention to the fathers when they arrived at the health center. They would welcome the fathers and spend more time talking to fathers who arrived to the health center. Participants said that they encouraged the father to come more often by telling them that they were good fathers by showing up and that it was very important that they came as often as the mother.

*“We say that they are good fathers and encourage them to come more often.”*

*“Now the fathers come here and wait together with the mother, but we have to encourage the fathers to bring their children here when the child is sick; they don't have to wait for the mothers to help.”*

### **The nurse's perception and experience of barriers for engaging fathers**

In order to understand how future practice can improve, it was important to understand the barriers that the nurses experienced when trying to engage fathers. The main themes that emerged from the analysis were related to systemic challenges and were coded as Fathers' level of knowledge, and Traditional gender roles.

#### Fathers' level of knowledge

Many nurses considered the fathers' low level of knowledge the biggest barrier to engage fathers. Fathers were lacking the incentives to engage and did not see how them contributing more or in alternative ways could benefit them or the family. Not knowing the long-term effects of being stunted was a knowledge gap with the fathers. Ignorance in practical childcare was also mentioned as a barrier to increased engagement in childcare. The fact that the fathers did not know how to cook or know when the child required medical attention limited their own initiatives and areas of engagement.

*“Fathers do not come if they are not told to do so.”*

According to the registered nurses, many fathers thought that their monetary contribution to the family was enough engagement with their children.

*“The fathers participate; they provide money for the family. Fathers in Rwanda are always the ones who are in charge of the money.”*

### Traditional gender roles

Stigmas around fathers in Rwanda who share the responsibility of the children with the mother were presented as a major barrier. The analyzed data showed that in Rwanda, traditional gender roles limited the fathers' opportunities to care for their children, sick or healthy.

*“Earlier, all men said it was the woman's responsibility.”*

Traditionally, the father was the head of the household, the main decision maker and the one in charge of the household budget. Nurses also described that the fathers spent more time than the mothers performing paid work assignments. Mothers were described as the one cooking, cleaning, washing and taking care of the children of the family. Also, the women carried out most of the voluntary, unpaid community work.

*“Mothers are often blaming themselves if their children are stunted because they are the ones in charge of the feeding.”*

The nurses expressed that even though the traditional division of responsibilities was somewhat dissolving, it was not uncommon in rural areas that the fathers could be by the neighbors be considered bewitched or poisoned by their wives if they were carrying around the child or doing other traditionally women's duties. For the registered nurses this meant that even though the fathers might be active and participating while visiting the healthcare center, it was difficult for the nurse to be sure that the families would comply with advice given once the family came back home.

### **The nurse's perception and experience of opportunities for engaging fathers**

As mentioned, the nurse plays a central role in interventions that prevent stunted growth. Questions were asked about what the nurses, as well as other stakeholders were doing or could do to support and increase fathers' engagement directly or indirectly to prevent stunted growth. The codes that emerged from the analysis process reflected opportunities that other stakeholders than the nurses could act upon. The codes that emerged were Community teaching and Announcements.

### Community teaching

All nurses stated that the CHWs and peer educators were making changes in the communities, and that they were contributing to an increase in fathers' engagement in their children. It was mentioned that many of the training programs at the community level aiming to improve children's health initiated by NGOs or by the RMOH were targeting the CHWs, not the nurses. This implied that a lot of the sensitization process of fathers' engagement was carried out by the CHW. With sensitization, the authors refer to the process of changing a behaviour by raising awareness around a specific topic. According to participants, the CHW spent more time out in the community than the nurse and thus would also function as the nurse's eyes, ears and mouth, communicating the nurse's message to a wider audience in the communities. The registered nurses explained that it was the CHW who had the closest contact with families and deeper knowledge about the specific challenges they were facing.

The peer-educators could be other families, mothers or fathers, selected to be role models in the communities, sharing best practices within areas such as cooking or household gardens with their peers.

*“In the beginning it was quite difficult actually to engage fathers and sons to participate in different educations (...) but you can see a difference now since community health workers and peer educators are spreading information in communities. The level of knowledge is better no; I wouldn't say it is high, but it is getting better.”*

*“When we have Umuganda, we always have different announcements that families should come to the health centers”.*

### Announcements

When asking the participants what they could do to increase participation of the fathers, the suggestions were few. The study group expressed appreciation towards the communication initiatives, such as the “1000 days in the land of a 1000 hills” campaign. The pedagogical pictures on big billboards placed strategically by the roads had made an impact on the fathers, according to the participating nurses. This was also the method suggested by the nurses on how to increase engagement.

*“The only way to encourage the fathers is to have announcements everywhere they are, at their work, on the radio, in every media.”*

## **DISCUSSION**

### **Findings discussion**

In this study, the main finding that emerged was the perception among nurses that it was important to engage fathers in order to prevent stunted growth in children, as well as to protect and promote the health of the family in general. While fathers' low level of knowledge in childcare, and traditional gender roles were acting as the main barriers of fathers' engagement, communication campaigns and community training were presented as opportunities to improve the level of engagement of the fathers.

The nurses had a positive perspective of engaging fathers in childcare and they could in different ways motivate how having fathers more involved in the childcare and child healthcare could benefit the health of the child and directly or indirectly prevent stunting. Even though the term family centered care was never mentioned by the participants, the authors could see how the nurses different motivations of why it was important to engage the fathers supported SSF's description of FCC, where the mother, father and child were all parts of the family system and were constantly affecting each other (SSF, 2015). In FCC, it is the nurse's professional responsibility to ensure that information sharing is done open, objective and unbiased (Kuo et al., 2012). The first step in doing so is to actually get everyone around the table. Kuo et al (2012) suggest financial difficulties as a main barrier of FCC as it requires some economical muscles to have both breadwinners participate in the clinical care. Rwanda is one of the poorest countries in the world and some of the nurses did mention poverty of the families as a barrier. However, it was not mentioned as a barrier for engaging fathers, but as a barrier to prevent stunted growth.

The findings in this thesis rather suggest traditional gender roles as a main barrier to engage fathers and to practice FCC in Rwanda. The participants' descriptions of how stigmatization of fathers being involved in practical childcare hinders fathers to be engaged, very much support previous research in Rwanda on the topic (Abbott, Mutesi & Norris, 2015; Abbott & Malunda, 2015). The authors further suggest that it is not merely the families who are affected by traditional gender roles. Despite the fact that the study group expressed the importance of fathers' engagement when asked direct questions on the topic, the authors suspect that the nurses sometimes had a slightly more traditional view on the division of family responsibilities, than what they wanted to portray. The authors observed that when the nurses were talking about childcare in general, the nurses more often referred to the mother as the one who should be responsible for different tasks. It is essential that the nurses practice what they preach and become aware of how/if their personal beliefs affect their practice. Doss-McQuitty (2016) emphasizes the importance of professional development throughout the nurse's career. Being aware of your level of competence and striving to become an expert in your specific area of nursing is the nurse personal professional responsibility. But how do you know what you do not know? The authors acknowledge this paradox and suggest further training of the nurses on the topic of gender equality and damaging stereotypes.

When the authors were shown around at the health centers before and after interviews, both authors could observe that the majority of people visiting the health centers with a child were women, observations that mirror current research done on the division of family responsibilities in Rwanda today (Abbott & Malunda, 2015; Abbott, Mutesi & Norris, 2015; Catholic Relief Services, 2016) . The women could have been mothers, mothers in law, sisters, grandmothers or others, but the fact still remains that an overwhelming majority were women who had taken the children to the health center, and not men. Of course, this is only a small part of what is to be considered fathers' engagement; however, during the interviews, some nurses described that taking a sick child to the health center was done as often by the fathers as by the mothers. With this in mind, it has to be taken in consideration that it is likely that the registered nurses in some cases provided responses about fathers' engagement that they believed would satisfy the authors rather than reflect the current reality.

The nurses described how they would educate families on the importance of sharing the responsibility of the children and the household, and what effects an engaged father could have on stunting. The nurses would also encourage and boost fathers if they showed up at the health centers. The opportunities for increasing the engagement of fathers were described as activities and actions that were not, according to the participants, in the scope of the nurse professional responsibility and that should be carried out by someone else, such as community training by CHW's and peer educators or through communication campaigns. The nurses' own lack of initiatives regarding how to increase the engagement of fathers was apparent. Despite the fact that many nurses expressed the view that engagement needed to be improved, they did not seem to see how they personally could support this development or do more than what they were already doing. The nurses participating in the study were primarily doing health education, as described by Whitehead (2006), targeting a specific risk factor- stunted growth, and suggesting different behavioral changes.

If the nurse would have had the mandate and also considered a part of her professional responsibility at the health centers to be health promotion in the wider sense, as described by Ansved and Lingerhed (2016), the participants might have suggested a wider range of opportunities of how to increase fathers engagement. The reasons for the nurses' lack of initiatives in this matter were not covered in the interviews. In addition to the nurses' view of their professional responsibility as health educators, rather than health promoters, the authors however suggest several factors that could have impacted this finding: a working climate that does not encourage personal initiative, a work overload that makes the nurses prioritize other tasks, lack of directives from management to the nurses that support an increase in fathers' engagement, a perspective that it is not the nurse's task and/or the fact that the nurses in reality did not think it is as important to engage fathers as they expressed in the interviews. Doss-McQuitty (2016) states that nurses should be equipped with the best training and resources in order to be leaders in accelerating and improving health services. The educational and organizational structures of the healthcare sector of Rwanda were beyond the scope of this thesis. However, based on the very limited amount of interviews and the observations made at the health centers, the authors are humbly questioning whether nurses in rural Rwanda are given the mandate, tools and resources for leading change within the Rwandan healthcare system. As mentioned, nurses are the ones in charge of many of the interventions that prevent stunted growth. The findings show that despite a good level of awareness around fathers' engagement, the nurses' full potential is not utilized. A lot of the responsibility to change mindset and challenge traditional gender norms is delegated to CHWs, community leaders and peer educators, something that the authors do not oppose. However, nurses are respected members of the community with a high education in rural Rwanda. If they were to be given more responsibility and concrete action plans on how to engage fathers in the interventions to prevent stunting that the nurses are already carrying out, this could help accelerate the engagement of fathers. The authors further suggest that the nurses at the health centers are involved in the design of such action plans, so that local ownership is secured. Also, if nurses focus more on engaging men in activities directly related to preventing stunted growth, the direct effects of engaging fathers' to prevent stunted growth would be easier to measure in future research.

Earlier on, most programs, campaigns and initiatives to prevent stunted growth were targeted to women. The findings suggest that there is a shift towards a more equally shared responsibility of the practical childcare where the father is more engaged than before. The findings also suggests that the nurses as well as the families still today expect women to take the main responsibility for the child, which is coherent with current research on the topic of gender roles in Rwanda today (Abbott & Malunda, 2015; Abbott, Mutesi & Norris, 2015). As described by Abbott and Malunda (2015), women in Rwanda work on an average 20 hours more per week than Rwandan men. Engaging only mothers in different activities related to children's health adds to the women's workload and could lead to mothers investing fewer hours taking care of domestic responsibilities and therefore could also be a source of conflict in the household. An increased workload and conflicts at home can potentially harm the mental, social as well as physical well-being of the Rwandan mothers. The nurse's professional responsibility as defined by the International Council for Nurses, is to promote health, to prevent illness, to restore health and to alleviate suffering (ICN, 2012). With this in mind, it becomes apparent that nurses in rural Rwanda need to take a bigger professional responsibility in engaging men in the work of preventing stunted growth, not only in order to promote the health of the child but also to promote the health of the mother. Further, the health of the mother and of the child is strongly linked.

A stunted mother has a higher risk of bearing a stunted child (Ozaltin, Hill & Subramanian, 2010). Comrie-Thomson et al (2015) describes that engaging men in MNCH education and service could have a positive effect on maternal nutrition, which then could reduce the risk of bearing a stunted child. This fact simply adds to the reasons for why the nurse needs to accelerate in her actions to engage fathers to prevent stunted growth. A very concrete example could be to challenge the frames and structures of current parental counseling and make more sessions mandatory for the men.

Despite the fact that the findings of this study did not support this, research in the field of fathers' engagement presented testimonies of fathers expressing a feeling of being left out (Catholic Relief Service, 2016). By changing ways of reaching out to the communities, the participation of fathers has increased, according to the participants of this study. New strategies to target men have been launched, such as monthly evening meetings, radio messages and announcements at places where men usually work. These strategies have according to the registered nurses made great impact on men. Yet, the participants explained that most fathers remained being in what seemed to be a comfort zone of what they could and could not do, which included providing financial support and prioritizing family resources. This finding was supported by previous research presented in Father Engagement in Nutrition: A Qualitative Analysis in Muhanga and Karongi Districts in Rwanda by the Catholic Relief Services (2016). Allegedly, neighbors and other influential people, such as community leaders, have had a great impact on fathers' behaviors in the communities. Thus the participating nurses as well as the authors are strongly supportive of peer educating. The peer educators can set an example for other fathers to learn from. This could lead to more direct engagement by men and could help eliminate cultural and social stigmas around fathers' participation in household domains and child healthcare. However, it is important when designing interventions to improve fathers' engagement that sensitization on gender inequality in general is included so that an intervention does not reinforce norms relating to men's control over women's health. A nationwide mass media campaign in Zimbabwe is a good example of how good intentions can have undesired side effects. Male sports celebrities were communicating different family planning messages, with the result that more men concluded that they solely were in charge of decisions regarding family planning (Comrie-Thomson et al., 2015a).

It is also important to recognize – despite not mentioned as a barrier by the participating nurses in this study – the role of women in transforming traditional gender roles in Rwanda. There was only one participating nurse in this thesis who at one moment, mentioned that mothers were also part of manifesting and sustaining traditional gender roles. A study carried out by The Rwanda Men's Resource Center [RWAMREC] found that 44.2 percent of the participating fathers considered "changing diapers, giving the kids a bath and feeding the kids" the responsibility of the mother. When asking the participating women, 78.3 percent of them saw it as the mother's domain (RWAMREC, 2013, Referred to in Catholic Relief Services, 2016). The reason for the 34 percent difference of the male- and female participants answers was not clear and it is not explained whether the women in the study considered the tasks the mothers' domain because that reflects the current situation, or because that is the desired division of work. Nevertheless, the systemic approach of FCC is also applicable in this case and implies that the resistance to change behaviors of one of the family members will affect the rest of the family.

It is noteworthy that this was not mentioned by the participating nurses. Merely approaching fathers with programs that aim to push gender boundaries is not sustainable. Women and men should be included.

One of the principles within FCC is to create a partnership and collaboration between the nurse and all family members involved in which “/.../ medically appropriate decisions that best fit the needs, strengths, values, and abilities of all involved are made together by involved parties, including families at the level they choose” (Kuo et al., 2012, p.299). This principle however somewhat assumes that the family it self has a flat structure. Research (Abbott & Malunda, 2015; Abbott, Mutesi & Norris, 2015) as well as the findings presented in this thesis suggest that the norm today in Rwanda is still that the father is in charge of decision-making. Strengthening the communication between spouses in order to increase fathers' engagement was a topic in several interviews. Spouses' communication should be seen as a way for both partners to talk and discuss together. Rotating traditional gender norms and changing from former power dynamics would allow couples to communicate more freely and openly with each other. If the father would no longer consider himself the only provider and the single stranded decision maker, the couple could rely on each other to find a common ground from which decisions were made. Making decisions together can be a way of seeing each other as equals and encouraging both parents to share the same feeling of responsibility towards childcare. In FCC, it is the nurse's professional responsibility to create the flat structure from which decisions can be made (SSF, 2015). By focusing on rotating traditional gender norms and strengthening the communication between spouses, the nurse also creates a platform from which she can perform FCC.

### **Methodolgy discussion**

In order to study personal beliefs and professional experiences and perceptions, a qualitative interview method is most suitable (Henricsson, 2012). The authors agreed with Henricsson that based on the thesis aim, this method was most valuable and this led to in depth conversations with participants. In accordance with Henricson (2012) the interviews were performed using a semi structured structure. The findings that were provided supported the aim of the thesis.

For this study, the authors chose to create an interview guide with open-ended questions, before interviews took place (Henricson, 2012). The questions in the beginning of each interview were the same, but the follow-up questions could differ depending on what answers were given by the participants. This was successful for the thesis, as it gave answers that were more complex than just “yes” and “no”-answers and led to a dialogue between the authors and participants. If this had been done with a quantitative method, answers wouldn't have been as explanatory and in depth, which was needed in order to fulfill the thesis' aim. Therefore, the authors were confident in the choice of choosing a qualitative method with semi-structured interviews. The option of doing a literature overview was quickly excluded, as the scope of scientific articles on this topic is very limited. The findings gathered included data from six nurses. In order to draw any conclusions of the study population's- Rwandan nurses', experiences and perceptions of fathers' engagement, the thesis would have benefited from a larger sample group.

To process the data correctly, Henricsson (2012) states that you should make a table to decode the different codes and categories that can be found. During the data collection, the interviews were not audio recorded and thus not transcribed.

The authors have discussed that if interviews had been recorded, the study would have had a bigger credibility. Since the authors cannot guarantee that the written script is correct, the details in the findings can therefore not be seen as fully reliable. The authors further discussed that by not audio record the interviews, it allowed the participants to speak more freely and led to answers that were truer due to that the participants were aware of that nothing that they said in the interviews could be tracked back to them. The authors concluded that despite the negative aspects of not audio record, the positive aspects carried more weight in supporting the aim of the thesis. In order to make a greater credibility for the thesis, in accordance with Polit and Beck (2012) the authors consulted each other during the whole process of the data analysis to eliminate any misunderstandings, which gave a trustworthy result for the thesis since the authors were sure all the time that they had the same perception of what had been communicated in the interviews.

The use of an interpreter had its positive and negative aspects. Using an interpreter meant that there was a wider selection of participants for the study. It also made it possible for the participants to speak their mother tongue, allowing for complex phenomena and thoughts to be expressed in detail, which is according to authors one of the strengths of the thesis. However, no matter what kind of relationship is created, one cannot ignore the fact that using an interpreter adds one more layer of interpretation of the answers given by the participants. The authors concluded that despite the negative aspects of using an interpreter, the positive aspects carried more weight in supporting the aim of the thesis.

As previously mentioned, spontaneous observations by the authors loosely indicated a discrepancy between how the nurses explained the fathers' engagement and what could be observed at the health centers. One reason for this could be the fact that in the initial letter to the participants, the authors included information about the 1000-days campaign, an RMOH-initiative. The fact that a governmental program was mentioned could have given indications to the participants of what kind of answers the authors and also RMOH would want. In hindsight, this part of the letter to the participants should have been excluded.

## **Conclusion**

The main finding in this study was that all participants expressed that fathers' engagement was important. In the public health sector there are initiatives and programs that the nurses implement in order to prevent stunted growth, but the emphasis is not put on fathers' engagement. In recent years, the government has begun to target male engagement and initiatives to improve the engagement of fathers have been put into action. Some nurses thought that male engagement was not sufficient and should therefore be increased. The nurses' ability to be resourceful was considered poor. They did not see other ways of improving fathers' engagement themselves, apart from what they were already doing in terms of encouragement and health education. Further, in order to make progress, more attention needs to be paid to sensitization of families as well as healthcare personnel regarding damaging stereotypes in a traditional Rwandan household.

## Further research

The authors suggest that a complementary observation study at the same health centers would be beneficial. Further, the authors suggest that a bigger sample and further data

collection in several districts would strengthen the quality of the thesis and make the results transferable to rural Rwanda as a whole. However, this was not possible given the framework of this thesis.

### Clinical importance

The nurse plays a critical role in preventing stunted growth. It is of importance to understand their experience and perception of fathers' engagement so that future training of nurses, interventions and nutritional programs can take this into consideration and increase fathers' engagement in childcare as well as excel the reduction of the high prevalence of stunted children in Rwanda. However, the authors' contribution was modest and the aim of the contribution was merely to inspire further research within the field.

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**Questionnaire to participants**

**Background**

Interview performed with or without interpreter

Sex: F or M

Age: Between 20 - 33, 34 – 47, 48 +

Years of experience: Between 0 – 5, 6 – 10, 10 +

**Intro**

Could you please describe a regular working day for you as a registered nurse?

**Stunting**

How do you work with stunting on a daily basis at you health center?

How do you cooperate with other health professions?

As a registered nurse could you please describe what you do in order to prevent stunted growth?

What are the consequences of stunting in your geographical area?

What are the barriers for you as a nurse at a health center to prevent stunting?

**Fathers' engagement - the nurse experience**

As a registered nurse could you please describe in what way the parents are involved in preventing stunted growth?

As a registered nurse could you please describe in what way fathers are taking part of their children's healthcare?

As a registered nurse could you please describe what you do to encourage fathers' engagement?

**Fathers' engagement - the nurse perception**

What is your impression of the fathers' attitude of being involved?

As a registered nurse, what is your perception of engaging fathers in their children's healthcare? Is it important? If yes, Why? If no, Why?

What, in your opinion, is the most difficult part of engaging the father in preventing stunted growth of their children?

As a registered nurse could you please describe if there is anything you would like to develop or do different to increase their participation?

**Outro**

Is there something we haven't asked you that you would like to share on this topic?

Kigali 2017-01-25

To the director of

During our studies at the nursing program at Sophiahemmet University College in Stockholm, Sweden we will perform a bachelor thesis in Rwanda January 22<sup>nd</sup> to March 18<sup>th</sup>.

The aim for bachelor thesis is to describe registered nurses' perception and experience of fathers' engagement to prevent stunted growth in children at the primary healthcare level in Rwanda.

Therefore we are interested to perform interviews with registered nurses at your health center.

Would you please take part of our summary that will give you an overview of our study and the questions we will ask the participants.

If you approve that we conduct the interviews at your health center, we are grateful for your signature of this document. If you feel hesitant to us performing interviews at your health center, please also inform us about this. If you have further questions regarding our bachelor thesis, please contact our supervisor or us.

Kind Regards

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## **Summary of the bachelor thesis**

### **Background**

The Millennium Development Goal 4 stated that between year 2000 and 2015 the mortality rate for children under five years old should be reduced by two thirds. This goal was reached in Rwanda where the mortality rate for children is quickly decreasing (WHO, 2015).

Rwanda has made large improvements and remarkable progress in increasing health services, but there is still one area that needs more focus. Approximately 37 percent of all the children in Rwanda under the age of 5 have a stunted growth, which strongly relates to malnutrition (All Africa, 2016). Improving maternal and child health and nutritional status have been and are in focus world wide through international initiatives such as the UN Millennium Development Goals and Sustainable Development Goals. Traditionally these domains have been attributed to the woman.

The national communication campaign “First 1000 days in the land of the 1000 hills” was launched in September year 2013 and continued for 1000 days, one of the targets in the campaign was to influence positively the attitudes of men towards maternal, infant and young children nutrition within the household (Ministry of Health, Rwanda, 2013).

### **Method**

The study will be conducted as a qualitative field study at different community health centers in rural areas in Rwanda during two weeks in the beginning of February. Semi-structured interviews will be held with approximately 6-8 registered nurses in total, 1-2 registered nurses at each health center.

We are interested in interviewing registered nurses who have experience in working with children’s healthcare.

The interviews will be carried out with or without an interpreter depending on the language spoken by the nurse. The interviews will be recorded and transcribed. All information will be treated confidential and all data will be anonymized. The recordings will be deleted after the thesis is finalized. We estimate that one interview will take approximately 45 min. The registered nurse can without giving a reason end her participation at anytime before, during or after the interview.

Below is the questionnaire we will use in the interviews; the purpose of sharing this is for you to get an understanding of the content of the interviews. We do not wish to share the questions with the participants before performing the interviews.

## **Questionnaire to participants**

### **Background**

Interview performed with or without interpreter

Sex: F or M

Age: Between 20 - 33, 34 – 47, 48 +

Years of experience: Between 0 – 5, 6 – 10, 10 +

### **Intro**

Could you please describe a regular working day for you as a registered nurse?

### **Stunting**

How do you work with stunting on a daily basis at you health center?

How do you cooperate with other health professions?

As a registered nurse could you please describe what you do in order to prevent stunted growth?

What are the consequences of stunting in your geographical area?

What are the barriers for you as a nurse at a health center to prevent stunting?

### **Fathers' engagement - the nurse experience**

As a registered nurse could you please describe in what way the parents are involved in preventing stunted growth?

As a registered nurse could you please describe in what way fathers are taking part of their children's healthcare?

As a registered nurse could you please describe what you do to encourage fathers' engagement?

### **Fathers' engagement - the nurse perception**

What is your impression of the fathers' attitude of being involved?

As a registered nurse, what is your perception of engaging fathers in their children's healthcare? Is it important? If yes, Why? If no, Why?

What, in your opinion, is the most difficult part of engaging the father in preventing stunted growth of their children?

As a registered nurse could you please describe if there is anything you would like to develop or do different to increase their participation?

### **Outro**

Is there something we haven't asked you that you would like to share on this topic?

I hereby approve that Eleonor Bergström and Olivia Söderström Högling can perform interviews at .....during January-February 2017.

---

Place and Date

---

Signature, Director

---

Name

### Information to participants in interviews

We are Eleonor Bergstrom and Olivia Soderstrom Hogling, two nurse students from Sophiahemmet University, Stockholm, Sweden. Between January 22<sup>nd</sup> and 18<sup>th</sup> of March we will be in Rwanda to write our bachelor thesis.

The aim for bachelor thesis is to describe registered nurses' perception and experience of fathers' engagement to prevent stunted growth in children at the primary healthcare level in Rwanda.

Therefore we are interested in coming in contact with nurses who work at health centers and are involved in the clinical practice.

#### Background

The Millennium Development Goal 4 stated that between 2000 and 2015 the mortality rate for children under five years old should be reduced by two thirds. This goal was reached in Rwanda where the mortality rate for children is quickly decreasing (WHO, 2015). Rwanda has made large improvements and remarkable progress in increasing health services, but there is still one area that needs more focus. Approximately 37 percent of all the children in Rwanda under the age of 5 have a stunted growth, which strongly relates to malnutrition (All Africa, 2016). Improving maternal and child health and nutritional status have been and are in focus world wide through international initiatives such as the UN Millennium Development Goals and Sustainable Development Goals. Traditionally these domains have been attributed to the woman.

On a national level, Rwanda has made efforts to engage fathers in children's health and nutrition. One example is the national communication campaign "First 1000 days in the land of the 1000 hills". The campaign was launched in September 2013 and continued for 1000 days, one of the targets in the campaign was to influence positively the attitudes of men towards maternal, infant and young children nutrition within the household (Ministry of Health, Rwanda, 2013).

#### Method

The interviews will be carried out with or without an interpreter depending on the language spoken by the nurse. The interviews will be recorded and transcribed. All information will be treated confidential and all data will be anonymized. The recordings will be deleted after the thesis is finalized. We estimate that one interview will take approximately 45 min. You can without giving a reason end your participation at anytime before, during or after the interview.

If you would like to participate in an interview or have any questions, do not hesitate to contact us.

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Supervisor  
Camilla Tomaszewski  
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I hereby confirm that I have read the information above and that I would like to participate in the bachelor thesis.

---

Place and Date

---

Signature, Nurse

---

Name in print

## **AMAKURU KU BAZAGIRA URUHARE MU BIGANIRO**

Turi Eleonor Bergstrom na Olivia Soderstrom Hogling, abaforomo babiri bo muri Kaminuza ya Sophiahemmet mu mujyi wa Stockholm muri Suwedi. Hagati y' itariki 22 na 18 Werurwe tuzaba turi mu Rwanda twandika igitabo cy' icyiciro cya mbere cya Kaminuza.

Intego y' igitabo cyacu ni ukumenya neza akamaro, ibikorwa n' imyumvire by' umuforomo kubigendanye no kurinda ndetse no kwita ku kugwingira mu bana b' icyiciro cyibanza mu Rwanda. icyindi kandi turashaka kumenya uruhare rw' umuforomo mu gushishikariza umubyeyi w' umugabo kwirinda igwingira. Bityo rero tunejewe no kuza kubonana n' abaforomo bakora mu bigo nderabuzima kandi bagira uruhare mu bikorwa by' ubuvuzi.

### **IMVO N' IMVANO**

Ingingo ya kane y' icyinyagihumbi ivugako hagati y' umwaka wa 2000 na 2015, ijanisha ry' impfu z' abana bari muni y' imyaka itanu rigomba kugabanyukaho bibiri bya gatatu. Iyi ntego yagezweho mu Rwanda aho impfu z' abana zigabanyuka cyane nkuko tubikesha Ishyirahamwe Rishinzwe kwita ku Buzima ku isi, (2015). U Rwanda rwateye intambwe igaragara mu guteza imbere ubuzima ariko hari uruhande rumwe rukwiye kwitabwaho. Nibura 37 ku ijana by' abana bose bo mu Rwanda bari muni y' imyaka itanu bafite igwingira. Ibyo bifitanye isano n' imirire mibi (All Africa, 2016). Kwita ku buzima bw'umubyeyi n' umwana ndetse n' uburyo bw' imirire byitaweho ku isi yose binyuze mu mbaraga z' amahanga nk'intego z' icyinyagihumbi z' Umuryango w' Abibumbye n' intego z' iterambere rirambye. Cyera ibyo byose byarebaga umugore gusa.

Ku rwego rw'igihugu, u Rwanda rwagerageje kumvisha abagabo uruhare rwabo mu buzima n' imirire by' abana. Urugero ni ubukangurambaga bwitwa "Iminsi 1000 ya mbere ku butaka bw' igihugu cy' imisozi 1000". Ubukangurambaga bwatangijwe muri Nzeri 2013 bumara iminsi 1000. Imwe mu ntego zabwo yari uguhindura imyumvire y' abagabo ku mirire y' ababyeyi, impinja ndetse n' abana bato mu muryango (Minisiteri y' Ubuzima, U Rwanda, 2013)

### **Uburyo**

Ibiganiro bizabaho hari umusemuzi cyangwa ntawe hashingiwe ku rurimi umuforomo avuga. Ibiganiro bizafatwa amajwi ndetse binandikwe. Amakuru yose azagirwa ibanga kandi ntamazina azashyirwamo. Amakuru yose azasibwa igitabo kirangiye. Tugereranyako nibura ikiganiro kizamara iminota 45. Ushobora kwikura mu kiganiro mbere cyangwa nyuma nta mpamvu utanze.

Niba ushaka kugira uruhare mu kiganiro cyangwa ufite ikibazo watubaza

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Ndemezako nasomye amakuru yo haruguru kandi nkaba nshaka kugira uruhare muri ubu bushakashatsi

---

Place and Date  
Ahantu n' itariki

---

Signature, Nurse/Nutritionist  
Umukono, umuforomo/ ushinzwe imirire

---

Name in print  
Izina