FACTORS INFLUENCING MALE INVOLVEMENT IN YOUNG CHILDREN FEEDING PRACTICES: A CASE OF DAGORETTI INFORMAL SETTLEMENTS.

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RESEARCH PROJECT SUBMITTED TO THE INSTITUTE OF ANTHROPOLOGY GENDER AND AFRICAN STUDIES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN GENDER AND DEVELOPMENT STUDIES OF THE UNIVERSITY OF NAIROBI

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DECLARATION

This research project is my original work and has never been submitted for a degree in any other University.

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Signature:…………………… Date: …………………

This research project has been submitted for examination with my approval as the University supervisor.

Prof. Salome Bukachi

Signature………………………..Date...

DEDICATION

This project is dedicated to men involved in child feeding practices in Kenya. Strive to directly engage in child feeding practices so as to enable better health outcomes for growing children.

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ABSTRACT

The involvement of men in maternal and child nutrition, presents an opportunity for improvement child and maternal nutrition as men often play a key role in decision-making particularly regarding access to foods and spending on healthcare. While most research of men's involvement has focused on men's participation in gender-based violence programs, sexual and reproductive health (family planning), this research focused on men's involvement in maternal and child health specifically involvement in child feeding pratices .The purpose of this study was to explore factors influencing male involvement in young child feeding practices in Dagoretti informal settlements. The study identified knowledge, attitude and beliefs regarding male involvement in child feeding practices; it also investigated factors hindering male involvement and finally strategies to involve men in child feeding practices. Through a qualitative approach, 20 women and 30 men with children aged 6 to 23 months participated in in-depth interviews. Local key informants were used to validate information given by men and women. The transcripts were reviewed for quality and a code tree developed following review of the transcripts to identify emerging codes. Coding was done on NVivo and themes were directly drawn from the data to inform the study results. Most participants reported that men had basic knowledge regarding appropriate foods for children and pregnant women. Men also reported on avoiding accompanying their wives to the clinic giving underlying reasons for the behavior. In addition, most of the women reported that men were being mindful of what the predominant culture defined as a man's role in child feeding and therefore only did activities that fit within their roles. Therefore, the study recommends that nutrition education should be taken up by various stakeholders so that the men can improve their knowledge on child feeding practices , flexibility of health outreaches so as to accommodate men and finally direct messages and sensitization the the importance of male involvement in child feeding and nutrition.

LIST OF ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
ASF	Animal source food
APHRC	African Population and Health Research Center
CHV	Community Health Volunteer
CRS	Catholic Relief Services
GAF	Gender Analysis Framework
IDI	In-depth Interviews
IFPRI	International Food Policy Research Institute
IGWG	Interagency Gender Working Group
KDHS	Kenya Demographic and Health Survey
KII	Key Informant Interviews
MLICs	Middle and Low-Income countries
MCH	Maternal-Child Health
MIYCN	Maternal Infant and Young Child Nutrition
MNCH	Maternal Newborn and Child Health
MOH	Ministry of Health
PAHO	Pan American Health Organization
PMTCT	Prevention of Mother-to-child Transmission of HIV
PNC	Postnatal Care
SSA	Sub-Saharan Africa
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

CHAPTER ONE: BACKGROUND OF THE STUDY

1.1 Introduction

Undernutrition in children is a persistent global challenge that not only threatens a child's survival but also contributes to a high disease burden and damages the economic productivity of individuals and societies worldwide (Black et al., 2013). Over 33% of maternal and child deaths is often attributed to undernutrition and 11% of the total disease burden globally (Black et al ., 2013 ; De Onis & Branca , 2016). For those who do survive, undernutrition in the first 1000 days can lead to impaired cognitive development, increased susceptibility to infectious diseases, increased risk of non-communicable diseases and diminished economic prospects in the future. Also, undernutrition results in stunting among children (Black et al., 2013).

According to WHO,(2008) stunting, an indicator of chronic undernutrition, is recognized as one of the most significant barriers to human development and affects approximately 149 million of children under 60 months in 2017 particularly in middle and low-income countries (MLICs). WHO further states that stunting affects under 60 months specifically in Asia and sub-saharan Africa (SSA). According to WHO/UNICEF, SSA and Asia more than 30% of stunting rates are still being recorded (UNICEF/WHO 2016). The consequences of undernutrition often continue into adulthood and are passed on to the next generation as stunted adults reproduce children who are also stunted presenting a cycle of nutritional challenges (De Onis & Branca, 2016) therefore, the first 1000 days is a critical time for proper nutrition for the child and the mother.

Undernutrition has been responsible directly or indirectly, for 33% child and maternal deaths deaths annually among children under five(Black et al ., 2013 ; De Onis & Branca , 2016). A little over two-thirds of these deaths, are often linked to improper feeding practices especially during the first year of life. Not more than 39% of children worldwide were exclusively breastfed during the first six months of life in 2014 (IFPRI,2016). Complementary feeding (too early or too late) along with poor feeding practices are often nutritionally inadequate resulting in impaired development and becoming a major threat to socioeconomic development (Mutua, 2017).

Poor child feeding practices are one of the factors that contribute greatly to undernutrition in children.These practices, as reported from MLICs often include lack of exclusive breastfeeding in the first six months, late initiation of complementary feeding and lack of dietary diversity especially in regards to protein-rich animal source foods (ASF; WHO Stunting Policy Brief). WHO and UNICEF describe complementary feeding as the "process of starting solid, semi-solid or other food to the child along with breastfeeding when breastmilk alone is no longer sufficient to meet nutrtitional requirements of infants" (WHO,2003). Complementary feeding between 6-24 months of age is considerably critical, despite the fact that breastfeeding beyond two years may continue (PAHO,2003). An adequate complementary feeding consists of foods that are adequate in micronutritients such as iron, zinc, calcium,vitamin A and C and also energy all in an appropriate amount (WHO, 2003). WHO further recommends introducing complementary feeding only from the seventh month onwards because, at this age, the breastmilk alone is no longer sufficient to maintain the child's optimal growth. Children are often fed on small portions of solid and semi-solid foods while still breastfeeding upto the age of 2 years or beyond.The amount of food is increases gradually from 6 to 23 months, as they move into eating the usual family diet. The stage of complementary feeding is often marked by an increase in the prevalence of undernutrition due to poor feeding practices (Cumming, 2010). Feeding practices that do not meet the need and requirements of children increases the risk of becoming undernourished and other health consequences even resulting to death (Kimani-Murage; 2011; Dewey , 2013)

The Kenya Demographic Health Survey (KDHS) 2014 reported that 31% of of children are fed in accordance with the three recommended infant and young child feeding practices and this was a decrease from 39 % between 2008-09 and 2014(KDHS 2014). Although there is slight improvement, these data suggest that there is still need for more attention on improvement and monitoring of these practices. The KDHS (2014) concluded that complementary foods were introduced at a timely manner for all children in Kenya as 81% of infants had been given complementary foods by the age of 6-9months. However, minimum meal frequency was low ranging between 40 to 51 % for children between the age of 6-23 months. While consumption of recommended food groups for children and minimum meal frequency ranged between 17 to 28% for children between 6-23 months(KDHS, 2014). The introduction and use of appropriate

complementary feeding are essential in determining the health growth and development of children.

There has been a growing recognition that to reduce child undernutrition, structures need to come up that support men as they have a major part to play to by providing support to mothers and children (Matovu et al., 2008). However, male involvement has largely been overlooked as nutrition programs in most cases focus largely on women, particularly the expectant and lactating (Mkandawire & Hendriks, 2018). According to Mkandawire & Henderiks (2018), such policies often use information that indicates that the empowerment of women leads to improved child nutritional outcomes. Nutrition policies such as the first 1000 days' addresses adequate food consumption and related nutritional knowledge, importance of appropriate child care and the mother's socio-economic status (Olivier & Marc, 2012). Studies have shown that the adoption of optimal practices related to child undernutrition associated with complementary feeding depends greatly on decision-making and influence within the context of family or household (Ganle & Dery, 2015;Yargawa & Leonard-Bee, 2015). In public health literature there is considerable need to adopt an approach that considers not only women but also men nutrition who most times are key influencers in adoption of optimal feeding practices.

Some studies in LMICs have reported positive outcomes where men are engaged in maternal and child health (MCH). In Brazil, a study found that where fathers were included in breastfeeding education programs, exclusive breastfeeding increased (Susin & Giugliani, 2008). A similar intervention study in Vietnam found that where fathers were provided with counselling, household visits and breastfeeding education materials, there was higher exclusive breastfeeding at 4 and 6 months in comparison to women whose spouses were involved in the intervention (Bich et al., 2014). A similar intervention study in Turkey found that where a group of men and women received breastfeeding education, exclusive breastfeeding was higher in comparison to a group where only breastfeeding women received such education (Ozluses & Celebioglu, 2014).

Other studies emphasize the need to engage males as partners in MCH for example studies in Bangladesh, Nepal, Liberia, and Sierra Leone found that where women's movement requires male permission, (Balk , 2015 ;Burgert-Brucker et al ., 2015 ; CARE , 2015), sub-optimal breastfeeding practices are likely to increase greatly as such women do not have the ability to provide or access support of breastfeeding from their peers (Mc Fadden et al., 2017). In Benin, a

study also revealed that the control as well as access to resources often gave the men control of major decisions concerning healthcare and nutrition (World Bank, 2012).

In a study done in Tanzania, involving men in child nutrition was seen as having importance due to the father's role in offering psychosocial support for mothers in addition to the provision of resources during the weaning period to contribute to the total well being of the individual and family (Young et al., 2009). The role of fathers in feeding practices of children and provision of physical , psychological as well as provision of resources during lactation has also been highlighted by Uganda's Ministry of Health (MOH) policy guidelines on infants and child feeding. The guidelines also highlight the importance of fathers developing interest by supporting and promoting young child feeding for optimal nutritional outcomes (Uganda Bureau of Statistics) (UBOS, 2010).

Dinga et al., (2018) study in Kenya found that breastfeeding practices and optimal child feeding improved when men were engaged in men MCH. The study further found that interventions that focused on enhancing father's knowledge on breastfeeding and infant feeding practices would be essential to improving nutritional outcomes since fathers often have limited knowledge on optimal breastfeeding and child feeding practices (Dinga et al,2018).

Although evidence shows men as key influencers in young child feeding practices, there are limited studies in Kenya on men's involvement in feeding practices of young children. The study aims to therefore explore factors influencing male involvement in young child feeding practices in Dagoretti informal settlements.

1.2 Statement of the Problem

Few studies have tried to understand the complex processes that underlie optimal child feeding practises at the community, household and individual level (Menon , 2012 ; Chapagain , 2013 ; Issaka et al., 2014 ; Ogbo et al ., 2015). Furthermore, the studies done have focused on economic and social factors such as household poverty, maternal level of education, and inadequate knowledge on optimal feeding practices (Menon , 2012 ; Chapagain , 2013 ; Issaka et al ., 2014 ; Ogbo et al., 2015). Consequently, many efforts to improve nutrition target pregnant women, with the contribution of the father in the nutritional well-being of both mother and children rarely being focused on. This target on women-only does not take note of the fact that beliefs and behaviours of women do not exist in a vacuum but that many times are influenced by their

partners who also make decisions that generally affects the household's health and nutrition. Such decisions include what foods to buy and how much to spend on foods, who eats what, and decisions on health care spending.

Also, in most cases, the efforts to involve men in MCH have put more emphasis on sexual and reproductive health , gender based violence programs as well as HIV programs as compared to efforts to involve them more in a child's nutritional well-being.

It is in the context of this gap in research that this study will explore factors influencing male involvement in young child feeding practices in Dagoretti informal settlements. The study was guided by the following research questions:

- What are some of the knowledge and attitudes that men have in relation their engagement in child feeding practices?
- What factors act as barriers to the involvement of men in child feeding practices?
- What are the best strategies that can be used to engage men in child feeding practices?

1.3 Objectives of the Study

1.3.1 Overall Objective

The explore the factors influencing the involvement of men in young child feeding practices in Dagoretti informal settlements.

1.3.2 Specific Objectives

- To identify knowledge and attitudes that men have in relation to their engagement in child feeding practices.
- To determine the factors that act as barriers to the involvement of men in child feeding practices.
- To determine the best strategies that can be used to engage men in young child feeding practices.

1.4 Assumptions of the Study

- Male involvement in child feeding is often limited due to inadequate knowledge and negative attitudes.

- There exist numerous barriers to male involvement in child feeding practices both in the household and community.
- There are strategies that could be used to increase the level male involvement in child feeding practices.

1.5 Justification of the Study

This study focused on the factors influencing male involvement in child feeding practices in Dagoretti informal settlements. Child feeding practices in most communities are often reserved for the women especially because they are the ones who are mostly actively responsible for taking care of the children. This study sought to highlight the factors influencing male involvement in child feeding practices.Findings from this study provides information on these factors as well as the importance of engaging them in child feeding practices. Therefore, the kind of information that was generated from this study could be useful to policymakers in influencing policies on child nutrition and well-being by coming up with systems that can accommodate men to be active participants in their child feeding practices. In addition, the finding of this study will be useful to other researchers and academicians since it has generated information that will contribute to the growing body of knowledge on male involvement in child feeding practices and child nutrition in general.

1.6 Scope and Limitation of the Study

This study was conducted in Dagoretti sub-county in Nairobi Kenya. It targeted men with spouses who had children aged between 6-23 months and sought to understand factors influencing male involvement in child feeding practices. Through this, it collected data on men's level of understanding on child feeding and attitude on child feeding practices as well as hindrances to male involvement in child feeding practices and the best strategies to improve male involvement in child feeding practices. Single men were not included in the study since the study only targeted men and women who were living with their spouses .In-depth and key informant interviews were conducted with community leaders and nutritional officers from different wards.

Two main limitations were experienced in this study. Considering the fact that the main study participants were men, most of the time they were not available since most were very busy during the weekdays. This was solved by conducting interviews during lunch break or in the evening. In addition, the key informants were equally busy during work hours and hence

unavailable for interviews. This was solved by contacting them and scheduling the interviews over the weekend.

1.7 Definition of Key Terms

Male Involvement/Engagement: To take part in or make men take part in exercising positive influence child feeding practices.

Social norms: Customary rules shaped by how men and women are expected to behave concerning child feeding.

Knowledge: Information gained from experience or education that supports or discourages the involvement of men in child feeding practices.

Attitude: The way that men and women members of a community think or behave towards the involvement of men in child feeding.

Child feeding practices: Refers to how men participate in various activites within the framework of child nutrition such as preparation of meals, feeding the child, attending clinics, giving advice and financial support to purchase nitrtitious foods.

Men: Refers to married men who had children aged between 6-23 months.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter generally gives an overview of literature on men's involvement in child feeding and nutrition. It serves to provide the context of informing the research undertaken. The chapter also includes the conceptual framework that guided the study.

2.2 Male involvement in child feeding practices

In this study male involvement is defined as exercising positive influences on child feeding practices. Men can be involved in the following ways; offering financial support; social support and physical support such as attending to clinics or accompaniment to clinics and joint decision-making in the household and shared responsibility for the nutritional well-being and health of the child. The literature on MCH has shown that positive nutritional outcomes in children can be brought about by male involvement in different aspects of child care as seen by a study in Ethiopia which found that for children aged between 6-23 months, dietary diversity in the household increased by 13.7 % (Gebremedhin et al., 2017) . From this study, it was concluded that to promote optimal feeding practices in children, there is a need to increase the direct involvement of fathers. This is further supported by Sheriff et al ., (2009) who suggested that for breastfeeding rates to be on the increase, interventions must examine a father's involvement in reinforcing complementary feeding practices.

Sanghvi et.al., (2017), did a comparison of complementary feeding in Bangladesh, Malawi, Peru, and Zambia. From their comparative study of the different countries, the targeting of fathers with messages of nutrition was one of the recommendations for the behavior change to optimal complementary feeding practices of their children (Sanghvi et al., 2017).

The author was of the idea that to promote the acceptance of optimal complementary feeding practices in diverse settings, there was a need to understand what was driving the child feeding behaviours in different contexts (PAHO, 2003, WHO, 2008). Studies that were done in Cameroon, DRC Congo and Nigeria, revealed that stunting was higher in children who had mothers only as compared to children who had both parents (Ntoimo & Odimegwu, 2014). A randomized controlled trial from Nepal revealed a reduction in breastfeeding rates and negative long term outcomes for the children due to the exclusion of fathers. (Mullany et al., 2007) Child feeding surveys in Kenya have shown that involving fathers at the community, household and

individual level as key influencers improves child feeding practices in the long run (Dinga et al.,2018). The importance of male involvement during the breastfeeding period and the complementary feeding period is therefore critical.

2.3 Maternal child nutrition and the role of men in child feeding practices

Different roles of men and women are clearly defined across many traditional societies with cultural norms prescribing what men and women ought to do. These traditional societies often place responsibilities of men family members with the primary responsibility provision and this could be financial resources for basic activities within the household such as food items; resources for receiving services in health facilities and resources for other activities that are essential for a household's existence. Women, on the other hand, have a responsibility to manage tasks within the household such as planning for meals, preparing meals, feeding of the children and of raising children (Thuita, 2011). The result is that over time, the roles of both men and women become gender-specific and this results in the specialization of certain tasks both in the household and in the community (Aubel, 2011).

In Niger, a study found that a father's responsibility according to the prescribed role in the community was limited to paying for health expenses and provision of food for infants and new mothers (Keith & Kone, 2007). McGadney-Douglass and Douglass found that most men in urban Accra, did not take part in looking out for the undernourished children. The care for such children was often arranged by the older family members who were also the primary caregivers (McGadney-Douglass & Douglass, 2008). In rural Mexico, the findings revealed that men do not play a part in child care including feeding activities (Perez-Gil-Romo et al., 1993). A similar research in rural and urban Nicaragua showed that there was a limited engagement of men in newborn care (MOH, 2005). Waltensperger's study in Malawi found that newborn child care and feeding practices are adopted by women who have small children especially during the early months of life. This practise was common in patrilineal and matrilineal societies (Waltensperger, 2001).

Many times, men's involvement in MCH is often hindered by cultural and social institutions that prescribe gender roles to women and men in society (Kululanga et al., 2011; van den Berg et al ., 2015). Those who engage in childcare or food preparation, are often laughed at, sanctioned and face stigma from their fellow men in the community. This is due to the belief that such men

behave contrary to their socio-culturally prescribed gender roles(or perform roles that are considered inappropriate to their gender), (Dery & Ganle, 2015; Osman, et al., 2015). These rules that dictate roles appropriate for both men and women play a big part in why men are not involved in child feeding practices or realize that they have a duty to ensure their child's nutritional well-being(Audet et al., 2015).

2.4 Decision-making within the household and child feeding practices

In many settings, men often make all the decisions regarding household matters, hence referred to as the household head (Njai & Dixey, 2013). This is the case especially in developing countries as men have a greater economic and social power as well as significant control over their spouses. The family unit in most African cultures, not only acts as support mechanisms for children and women but also constitutes an essential social institution (Aubel, 2011). The ranking among members of a household as well as their decision-making power within the household is an influential component of those cultures (White & Klein, 2002). It is because of this that men often hold most of the decision-making power at the household level and decide independently how family resources are saved, spent, and invested (Bich, 2014).

Optimal complementary feeding practices depends mainly on the adoption of proper child feeding behaviours and an individuals decicion-making power at the household (Acharya et al ., 2004). Most household studies (Ambler et al., 2017; Anderson et al., 2017) have found that with greater decision-making power on resource use, more resources are spent by women on nutritious food and health care and as a result, such households experience better food security and nutrition at all levels. A study in the Democratic Republic of Congo (DRC)by Burns et al. (2016) noted that lack of purchasing power of the mothers as one of the hindrances to accessing nutritionally suitable foods for children. The study further noted that because men controlled most finances within the household they decided on how finances should be used, including spending on nutrition and healthcare for the family (Burns et al., 2016).

A study carried out in Rwanda by the United States Agency for International Development (USAID) highlighted limited control women tend to have over household decisions and workload as creating missed opportunities for new practices such as negotiating for the allocation of more of the household budget to nutritious foods (USAID, 2015) . The study concluded that where the home environment for practising positive child feeding was not

supportive of women, the adoption for optimal feeding practices in children would be hard to fully adopt. Also, it was recognized that fathers either played a positive or negative part or had some level of influence and that how they either support or do not support their partners (the mothers) was linked to the decision mothers make regarding some child feeding. This was mostly the case at the time a child was being introduced to foods. Additionally, a study by Acharya and collegues also demonstrated that adoption of complementary feeding and feeding during childhood illnesses, depended largely on decision-making and behaviours at the family or household level (Acharya , 2004).

These studies show the importance of understanding gender norms in assigning men and women with responsibilities and other socially approved roles. This is because, in most cases within the households, nutrition-related decisions such as what is eaten and how, when, and in what quantities, who can access nutritious food and responsibility for buying and cooking food are often shaped by these norms. These norms most often than not are not well thought of in designing nutrition interventions that seek to address poor nutritional outcomes especially in children (Giulia et al., 2018).

Nutritional practices and health-related attitudes of the community and household members are often interrelated parts of larger value systems, and therefore difficult to change just one part of the system (Glass & McAtee, 2006). This focus on one element clearly shows the limitations of nutrition interventions. Such interventions disregard the fact that women are not sole actors but are in many social relationships that might affect their caregiving and nutrition practices.

2.5 Perceptions around male involvement in traditional female roles

A man may avoid taking part in any activity that he believes is a woman's job such as feeding and caring for the children (Vollmer et al., 2015). A study done in a community living in the northern part of Nigeria by Illiyasu et al.,(2010) found that men viewed attendance of child's clinic for example taking the child for immunizations, as activities that were not within their domain. Also, men made decisions concerning the size as well as spacing of children as well as the use of health care services that were available to their wives (Bilal et al ., 2016). Studies in Nigeria Bilal et al., (2016) and Dougherty et al., (2017), found that a major factor that contributed to fathers not visiting the health centres was that men had the perception child care was the sole responsibility of women. Additionally, a study by Muraya et al., (2017) on gender

and decision-making in the community based child interventions in rural Kenya, observed that 'women's business' was a term that men used to describe child nutrition . As a result, men did not show concern in "engaging in such discussions during household visits(Muraya et al., 2017). According to the men, their work was only to provide a means to fulfil the basic needs of the household.

McBride et al.,(2005) suggest that regardless of the man's understanding of what he is supposed to do in relation to his child's needs,perceptions of a woman about a man's duty is also a determining factor in the man's engagement in their child's well-being. Hence,the woman may behave in a certain way or have an attitude that discourages a man from getting more involved or directly involved in child feeding practices if the man is not perceived as important. A man's involvement in child feeding and nutrition also could be affected by a man's perception of the opinion the woman holds (Pasley et al ., 2002). Arabi et al.,(2012) examined how men with children understood their role in their infants' feeding practices, and found that the experience the men had with their first born children and also guidance from other men influenced their perceptions about infant-feeding practices.

A study done by Perez-Gil-Romo et al.(1993)in rural Mexico revealed that men did not consider infant care and feeding as part of the activities they were to be involved in. Instead the men believed that care of their malnourished children was a responsibility of specific members of the family who in most cases were the women. Other studies [(Matinga 2002) in Malawi, (Fouts & Brookshire , 2009) in Congo, and (McGadney-Douglass & Douglass, 2008) in Ghana], revealed that knowledge and the engagement of men in their child feeding practices are in most cases limited.

Aubel's (2011) literature review advocated for a more family-focused approach in child feeding interventions by involving men as influential household actors. Recommendations such as examining of roles within the household and relationships to analyze men's role have been emphasized. These recommendations actively engage men in strategies that promote optimal child feeding by viewing men as resources instead of sidelining them (Aubel, 2011).

2.6 Barriers to male involvement in child feeding practices

Less attention has been paid in regards to male involvement in maternal and child nutrition with more focus being on their involvement in PMTCT (Dery & Ganle, 2015; Ditekemena, et al.,

2012; Kalembo et al., 2013 ; van den Berg et al., 2015 ; Audet et al., 2015). Barriers such as poor couple communication, shame associated with becoming “too involved,” inadequate services tailored for men in the health facilities are some of the factors that have been reviewed by studies around barriers to male engagement in MCH in SSA, specifically antenatal care or PMTCT programs (Ditekemena et al., 2012).

A study done in Western Kenya found that awareness creation among women was essential in creation of male friendly environment at ANC and PNC clinics and enhancing male particiaption (Ongolly & Bukachi, 2019). The study concluded that health facility barriers, cultural and economic factors hindered men from direct engagement in antenatal care (ANC) and postnatal care (PNC).

A study carried out under US Agency for International Development (USAID)-Inant and Young Child Nutrition(IYCN) on involving grandmothers and men in health programs, hindrances to male engagement specifically in child feeding practices have rarely been looked into. In a study by looking at male involvement in Kenya Thuita et al., (2015), it was found that some men were willing to learn more about child health and caregiving practices despite the cultural limitations of the male’s role.

2.7 Strategies to increase male involvement in child feeding practices

Benefits of interventions to improve health outcomes of mothers and children by engaging men more in MCH have been documented. Findings by research by Catholic Relief Services (CRS) in Nicaragua revealed a benefits of engaging men in child and maternal survival programming.The study also revealed positive outcomes particularly when it came to mobilizing resources for the preparation of the birth of a child and making sure that birthing is conducted by an experienced person (CRS, 2012). Male involvement in reproductive health (Peacock & Levack, 2004) , particularly in the prevention of HIV transmission to both mother and child (Kalembo et al., 2013) and interventions in maternal health(Yargawa & Leonardi –Bee, 2015) have realised benefits on the attendance of postnatal consultation. The effects of male engagement in maternal health have broadly been looked into in literature. This is not the case with child feeding and nutrition where related behaviours and outcomes and the degree to which men are involved have been largely ignored (Dumbaugh, 2014).

However, the International Center for Research on Women, male involvement-focused programmes, noted that programmes that are well tailored to meet men's needs often have positive outcomes on maternal , newborn and child health (MNCH). This is only true when such programs take up an approach which emphasizes shared decision-making, equitable relationships and communication (Barker et al., 2010). Maternal-child Health (MCH) male involvement activities carried out in Bangladesh, Zimbabwe and Tanzania, revealed that there were different ways that partcipants who took part in program activities highlighted as ways of enhancing male involvement in MCH. The study highlighted the need to use a variety of strategies such as "edutainment," visits at homes, outreach programmes and facility based and community meeting strategies and focus on addressing gender norms, attitudes, and beliefs that push men into action, rather than isolating or promoting few specific behaviours (Comrie-Thomson et al., 2015).

A study conducted in Kenya concerning maternal , infant and young child nutrition (MIYCN) , assessed if strategies such as use of peer to peer and dialogue-focused approach were effective in pushing fathers and mothers-in-law in providing more support in feeding practices of infants. The study concluded that not only did the approach have a positive effect on some infant feeding practices, but it also led to more support for mothers most especially the physical and material support (Mukuria et al.,2016). It is from these findings that the authors highlighted the need for further research on these efforts and also emphasized on the importance of dialogue-based approaches to male involvement (Mukuria et al., 2016).

2.8 Conceptual Framework

2.8.1 Gender Analysis Framework

This study applied the gender analysis framework (GAF) to explore factors influencing male involvement in child feeding practices. The framework was developed by Deborah Caro for the IGWG (Interagency Gender Working Group) in 2009. It was developed as a tool for collecting and analyzing context-specific information on gender relations and identities.

The framework is known to help program designers responsible for conducting a gender assessment or synthesizing information from existing research and analyses. The framework has four important components, which focus on specific aspects of social and cultural relations within a given context. They are as follows:

Access: This basically explains the capability to use resources needed to become a productive member of society. It can be access to resources, income , services and also knowledge and information.

Knowledge, beliefs, and perceptions: This are value systems shaping ideas about appropriate roles and responsibilities for both men and women thereby shaping patterns of behaviour. For example, the association of women with child and caregiving practices shape opportunities for women to learn more about these practices than men. Also, beliefs about the appropriateness of women in certain domains may restrict men from those domains that are considered as women's only.

Practices and participation: This component of GAF refers to ideas about gender that usually shape how people behave and influences who does what and how. Gender roles influence participation activities such as child feeding practices, accepting and seeking out services, attending clinics and meetings like community meetings, and other development activities.

Power and decision-making: This can be understood as the ability of a person to decide, to influence, and to control. Also, the capacity to make decisions freely and to exercise power within an individual's household and community. This can include the capacity of partners to decide about the use of household resources as well as how to spend income.

The framework has been employed in a variety of ways in the health sector to understand the many strategies of incorporating gender into HIV programs and other reproductive health programmes. In the case of men's involvement in child feeding and nutrition, women have increasingly been viewed as the only target for most nutritional programs and policies involving children such as the first 1000 years (Black et al., 2013).

It therefore looks into the interaction of both genders within relationships, hence directly target gender relations which will help understand how men are women are expected to behave concerning child feeding and nutrition. GAF also acknowledges the capacity of men as partners and accelerators to the needed change, and therefore provide support for men to challenge pre-existing roles and norms surrounding masculinity in child nutritional well-being. It's therefore important to understand local context in relation to decision-making power and and also what is considered as a woman's or man's space. One cannot therefore consider male involvement

without understanding the norms that guide relationships not only in the communities but within the households.

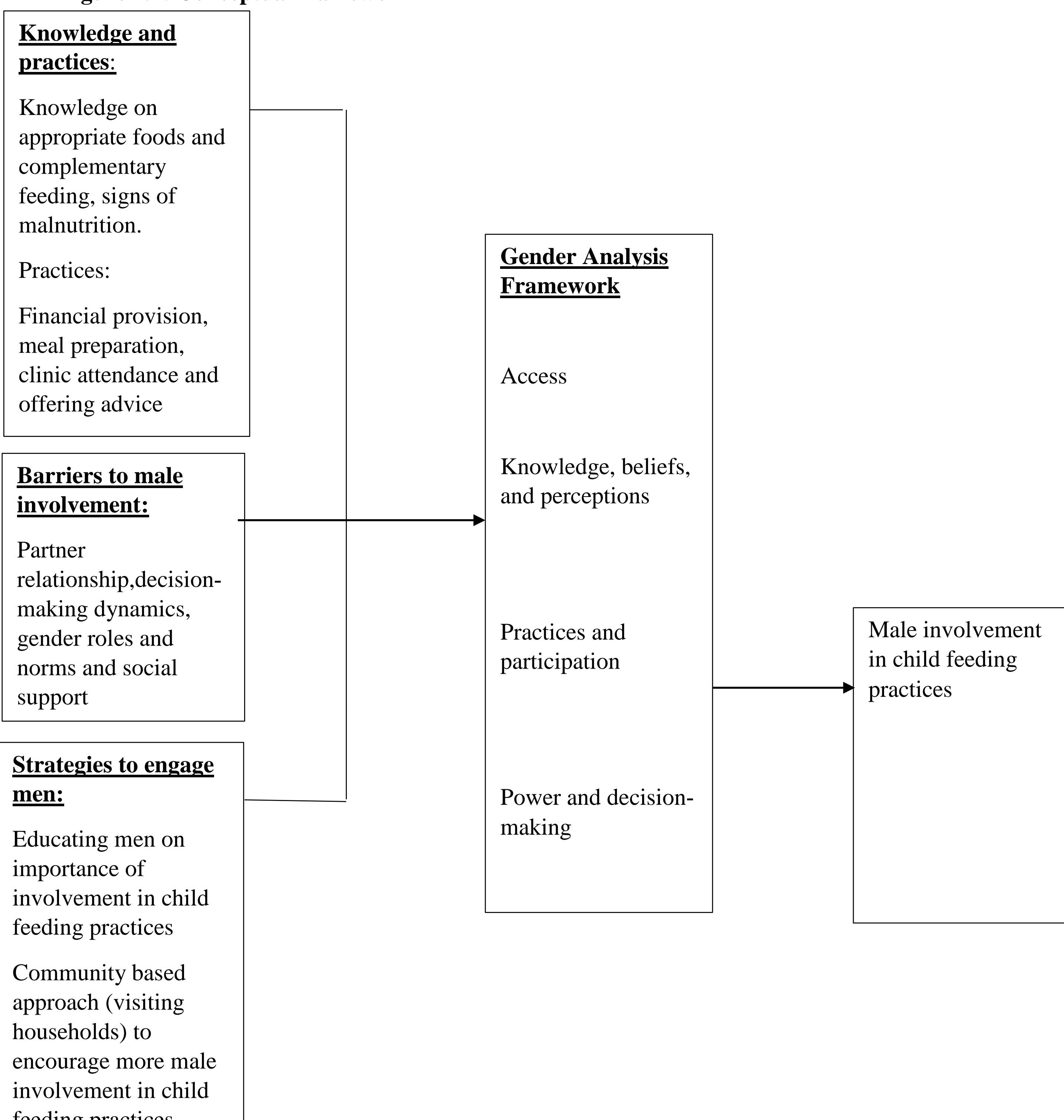
The framework is important as it offers a gender-transformative approach therefore providing opportunities to support child nutrition outcomes by challenging gender relations and the structures that reproduce them and changing gender roles and norms.

2.8.2 Relevance to the study

The proposed study sought to specifically find out factors influencing male's active involvement in child feeding practices. Therefore, the GAF came in handy in guiding it through the specific objectives courtesy of its four constructs. The concepts practices and participation and power and decision-making create a clear foundation in understanding to what extent men should actively participate in child feeding practices and how men make decisions. On the other hand, the component of knowledge,beliefs and perceptions was important in informing the study objective on barriers to male involvement in child feeding practices. Through this, the study was able to understand how men's perception of barriers hindered them from actively participating in child feeding practices. Also, the access component informed the study on resources such as knowledge, information ,access to income and resources influenced male involvement in direct activities related to child feeding practices.

The study was guided by the conceptual framework in figure. 2.1 below.

Figure 2.1: Conceptual framework



CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter outlines the methodology that was used in carrying out this research. It constitutes of the research design, study population, sampling design, data collection methods, data processing and analysis as well as the ethical considerations that were observed before and during the study.

3.2 Research Site

The study was conducted in low-income areas of Nairobi county: specifically the informal settlements in Dagoretti sub-county(Fig.3.1) namely Kawangware, Kabiro, Gatina and Riruta, with the exclusion of high-income areas in Dagoretti namely Kilimani ,Muthangari and Kileleshwa. The areas were selected based on earlier studies that showed these areas have malnutrition and stunting rates that are high (Fotso,et al.,20102; Kimani-Murage et al., 2015 ; Dominguez-Salas et al.,2016).

Majority of people living in these informal settlements come from different ethnicities in which most have a patriarchal system where male members of the household are considers as the providers of the family. To this regard, roles are culturally defined along gender lines with each gender expected to behave in a particular way. There are those roles and responsibilities assigned to women and those assigned to men. For example, matters concerning child feeding practices are considered within the realm of women's activities with very few men being actively involved.

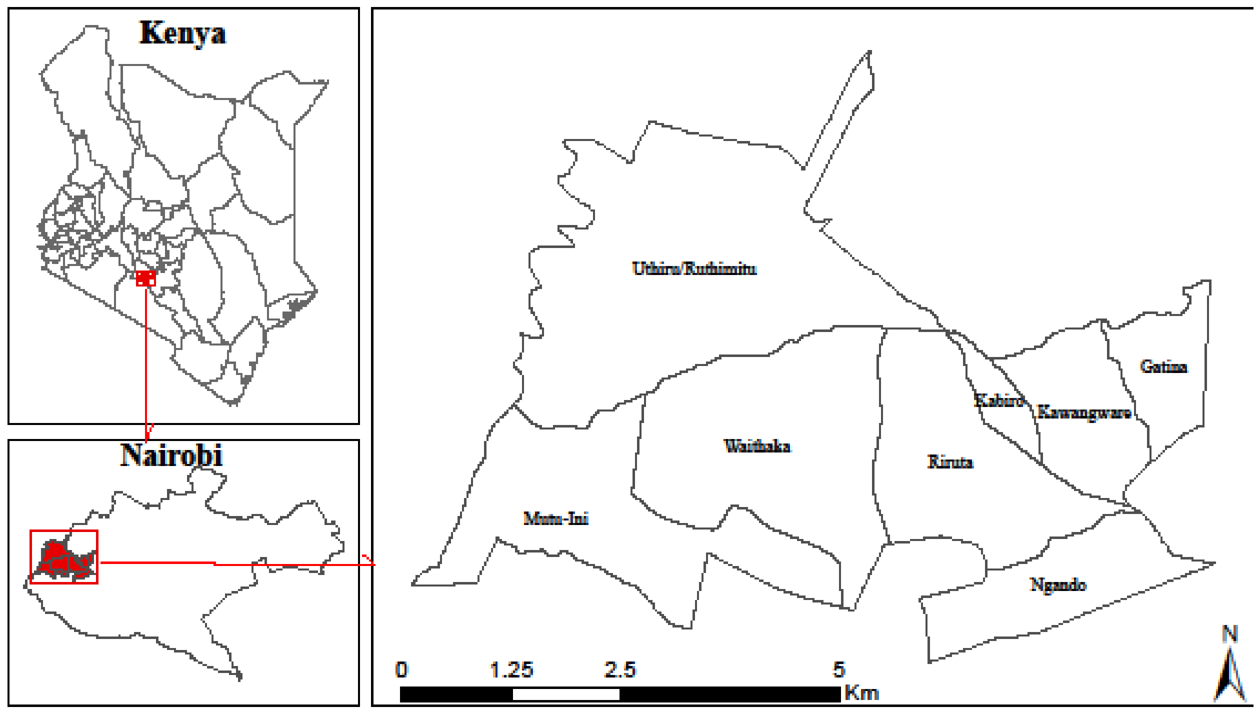


Figure 3.1: A Map Showing Kenya, highlighting Nairobi county-Dagoretti subcounty(Source: *https://en.wikipedia.org/wiki/Dagoretti_Constituency)*

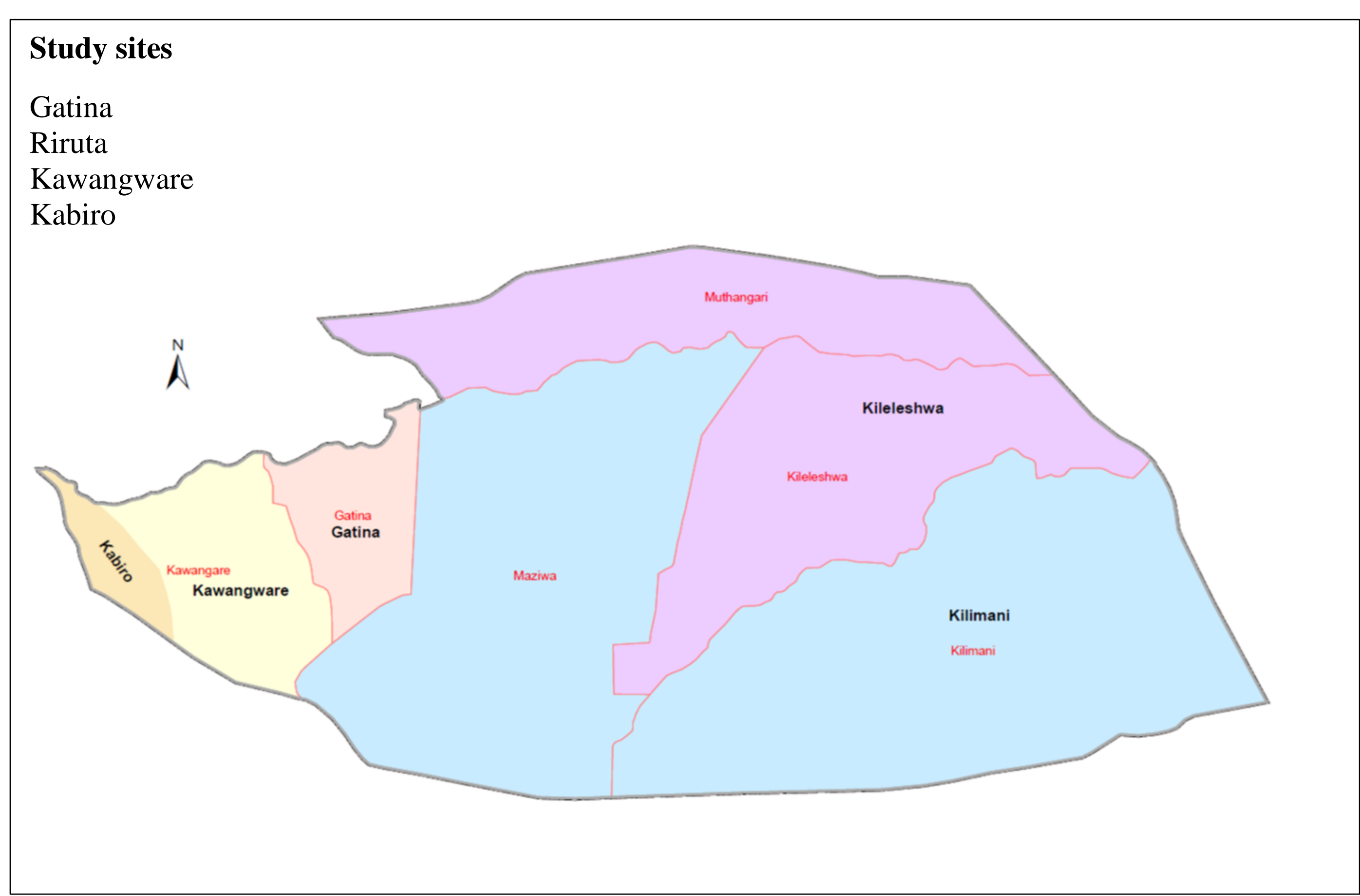


Figure 3.2 : Map of the study area: Dagoretti North constituency (Source: *https://en.wikipedia.org/wiki/Dagoretti_North_Constituency*)

3.3 Research Design

This current study was nested in a bigger study, "Drivers of Demand for Animal-Source Foods in Low-Income Informal Settlements in Nairobi, Kenya," funded by the Drivers of Food Choice (DFC) Competitive Grants Program.

The study employed an explanatory cross-sectional research design featuring qualitative methods. This kind of study allows for greater in-depth research into a problem that was not well researched before. It gives room for giving detailed explanations to the questions asked to help understand the problem more effectively. (Mack et al., 2005). Because this is an area with little

research, according to (Malterud, 2001), a qualitative approach gives in-depth information on the experience of men in the feeding practices of their children. The research data was collected through in-depth interviews and key informant interviews. The in-depth interviews were conducted through telephone calls. The contact numbers were drawn from participants lists generated from the records of respondents who were originally recruited in 2019 and early 2020 for the qualitative component of the Drivers of demand for animal-source foods in low-income informal settlements in Nairobi, Kenya in 2019 and early 2020. Before the interviews, contact was established with potential participants to set an appropriate time and date and seek verbal consent. The key informants, on the other hand, were recruited with assistance from community health workers who in the study area. Contact was then established with the key informants and an appropriate time and date was set for the interview.

The research sought to obtain a detailed understanding of the local context (Carter and Henderson 2005) by describing as well as analyzing the culture and behaviours of humans from the participants' point of view (Hudelson 1994). The data collected was analyzed thematically and presented along emerging themes and presented through verbatim quotes to represent the voices of the informants and study participants.

3.4 Study Population and Unit of Analysis

The study population comprised of married men living in informal settlements in Dagoretti sub-county with children between the ages of 6-23months and who were living with their spouses in the same household. These men were selected on the basis that they have children between the ages of 6-23months and therefore should have had an experience of child feeding practices. The unit of analysis was the individual married man.

3.5 Sample Size and Sampling Procedure

The study took place in 4 wards in Dagoretti sub-county (Riruta, Kawangware, Gatina and Kabiro). These wards were picked purposely due to presence of many informal settlements. Fifty respondents were selected from various households within the study area using purposive sampling. The size of the sample was based on the estimated number of people appropriate to reach data saturation (Guest et al., 2006).

3.6 Data Collection and Procedures

3.6.1 In-Depth Interviews

The primary method of data collection was in-depth interviews. (See appendix III). In-depth interviews were an important qualitative technique that allowed conducting of detailed individual interviews. These involved a small number of respondents to explore their views about the main objective of this study. According to Mack et al. (2005:30) IDIs are an effective method for getting people to talk about their personal feelings, opinions and experiences". In-depth interviews allowed the researcher to get detailed explanations on the fathers' knowledge and their understanding of child feeding and nutrition. The study drew 50 participants from participant lists generated from the qualitative records of respondents who were originally recruited as part of a sample from the bigger project on Drivers of demand for animal source foods. For this study, all interviews were conducted over mobile phones and lasted around 45-60 minutes and this was dependant on the availability of the participant. Phone interviews served as an efficient way to conduct interviews and made it possible for those living in Dagoretti Sub-county. Further, phone interviews were the only practical ways for the researcher to connect with participants from different parts of Dagoretti Sub-county especially during the period of the COVID 19 pandemic. All interviews were conducted in Kiswahili, a language spoken by most people and were audio recorded using a phone during the call with permission from the study participants.

3.6.2 Key Informant Interviews

The key informants were purposively sampled for the interviews. Up to 15 informants were recruited to participate in the study. They addressed issues related to male involvement in child feeding and were individuals identified as knowledgeable and with relevant expertise in the research subject (See appendix V). These potential informants included health practitioners, nutritionists, community health workers (CHWs), community leaders, and community health assistants (CHA). Telephone interviews were conducted with the key informants and lasted around 15-25 minutes. The interviews were recorded using a phone during the call with permission from the informants.

3.7 Data Processing and Analysis

Data collected from IDIs and KIIs was transcribed and translated where necessary. The transcripts were reviewed for quality and a code tree developed following review of the

transcripts to identify emerging codes. Coding was done on NVivo and themes were directly drawn from the data as guided by the specific objectives to inform the study results .

3.8 Ethical Considerations

All necessary ethical considerations were followed throughout the study and permission to conduct the research was obtained from the National Commission for Science, Technology Innovation. All participants were informed of the purpose as well as methods of the study, and informed consent(verbal) was requested, including permission for publishing the findings obtained. Participants were informed of their rights and the voluntary nature of taking part in the study with the assuarance that withdrawal from the study was possible with no penalty. Also, the researcher ensured that no harm or risk fell on the participant as there were no sensitive questions. The researcher ensured no risk to the participants' time or comfort during the interview by allowing the participant to set their appropriate or convenient time for the phone interview. Finally, the anonymity and confidentiality of the partcipants was respected and maintained in the data collection and subsequent analysis.

CHAPTER FOUR: PRESENTATION OF RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the findings and discussion on factors influencing male involvement in child feeding practices. The chapter provides insights into the practices, knowledge and attitudes of men in the study population concerning their involvement in child feeding practices and the barriers inherent in their involvement. The chapter will then attempt to suggest some of the best strategies to engage men in child feeding practices.

4.2 Demographic Characteristics of the Respondents

The section details the characteristics of the informants, age, educational level and occupation

4.2.1 Age of the Respondents

The mean age for the sample was 35 years with the youngest man aged 24 years and the oldest 51 years. Majority of the participants (67%) were aged below 40 years. Table 1 below provides a representation

Table 1: Age of male respondents

Age	Frequency	Percentage
20-29 Years	8	27
30-39 Years	12	40
40-49 Years	9	30
50+ Years	1	3
Total	30	100

4.2.2 Level of Education of the Respondents

Twelve of the male respondents reported as having a post-secondary education. Fourteen and four of the male respondents reported as having achieved secondary and primary education respectively as shown in table 2 below.

Table 2: Male respondents level of education

Level of education	Male	Percentage
Primary	4	13
Secondary	14	47
Post-secondary	12	40
Total	30	100

4.2.3 Occupation of respondents

The occupation of the male respondents were measured in four categories namely; security guards, employed (causal), employed(formal) and self-employed. Those in employed (formal) worked either in government or the private sector as field officers, facilitators, teachers and data officers. Employed casual are those who did not work on a permanent basis, whereas self-employed fell under the category of those who were running their businesses outside their residence or outside their residence inclusive of *boda-boda* riders and those doing online work. Most of the respondents were security guards (43%) while only 20% were formally employed. Figure 4.1 provides a representation

Figure 4.1: Male respondents occupation

Male respondents occupation

50
45
40
35
30
25
20
15
10
5
0

Security guards
Employed(Casual)
Employed(Formal)
Self employed

The socio-demographic characteristics were in an effort to compare the influence of age, education and occupation of men in their involvement in child feeding practices. With age, results showed that male respondents and female respondents whose partners were aged 20-29 years were more likely open to direct involvement to their child's feeding practices, as compared to those who were aged 40-49 and 50 + years. With the education level, results showed that there was no significant effect between level of education and adoption of optimal child feeding practices. Further, analysis by educational level revealed that there was also no significant effect between level of education and knowledge on appropriate foods during complementary feeding period. With occupation of male respondents, results showed that men's occupation had no influence on direct child feeding practices such as clinic attendance regardless of the fact that there were those working as private guards and others who were self-employed.

4.3 Practices, knowledge and attitudes around male engagement in child feeding practices.

The study found different practices, knowledge and attitudes around male engagement in child feeding practices as expounded on in the following sub-sections;

4.3.1 Knowledge on child feeding

Analysis of the data revealed that a majority of the men (56.6%) had basic understanding of food considered appropriate during the complementary period. About two thirds of the men in the study group cited milk as the most appropriate food for a child during weaning. Most indicated that weaningshould begin betweeen the age of six to eight months. They further indicated that when weaning, milk can be given with an accompaniment of other foods such as porridge, pumpkin, bananas and mashed potatoes. However, in many cases the informants were not able to give detailed explanations as captured in the following excerpts:

> *After breastfeeding, he needed to take light foods, like porridge, glucose and water. I encourage consumption of milk and avoid meat. As for the information I know, milk has vitamins and other nutrients.* **(IDIM2724)**

> *I know fruits wash the stomach and increase blood as for sausage, you know, children prefer sweet things because they make them happy.* (**IDIM2844**)

> *I know pumpkins, bananas, weetabix and cerelac are good for children. I hear from other places that giving the child eggs and meat at that very tender age is not good.* **(IDIM3934)**

Only few men (16.6%) were able to elaborate more on the importance of some of the foods they mentioned as shown in the excerpts;

> *After six months when we started weaning, my wife would make porridge by grinding peanuts, omena and cassava and millet, so that the baby can get the energy needed.* **(IDIM3235)**

> *I would often give my child a glass of packaged milk from time to time after it stopped breastfeeding because it was quite important for the cells of the child.* **(IDIM2151)**

> *I was advised that fish oil was rich in nutrients, so we used to buy fish from the market and extract fish which was fed by the child. The fish oil is rich in vitamins which boosts the child immune system*. **(IDIM3624)**

Foods such as meat, eggs and soup were not seen as important during the complementary feeding period. About half (50%) of the male respondents reported that such foods were

only appropriate when a child was older, citing different reasons for the practice as in the excerpts below:

The way I view meat is more complex and difficult to digest. The small intestines of the child won't be able to absorb the food. So the child needs less complex food that would be easier to digest. **(IDIM2231)**

Food such as meat and eggs are given when the child is about 10 years that is when the digestive system is fully developed and can be able to digest such type of food. **(IDIM4434)**

*The baby had breastfed for sometimes like one year and above, so the baby has not yet reached the age of taking soup because the fat will be too much for the baby so there is time for giving the child milk, there is that warm water mixed with some sugar and salt, that one is better and healthy to the child***. (IDIM2644)**

From the discussions, male respondents also demonstrated an understanding of the specific foods that pregnant women required. Some of the foods mentioned by a majority (53.3%) of the men were mainly vegetables, starch and fruits;

Food such as vegetables and fruits should be taken in large quantities and food rich in iron. I can't recall foods rich in iron but she should take food rich in iron, vegetables, and fruits but not too much proteins since the mother would become obese and it can block blood vessels causing high blood pressure and it would also cause complications when giving birth. **(IDIM2533)**

They should not feed on a lot of proteins because the child might overgrow while in the uterus and may cause complications when giving birth and may lead to surgery. They should feed on fruits and starch. **(IDIM4434)**

Local and traditional vegetables like managu and terere. She would eat meat once in a while since a lot of meat is not good for a person's health. So, I had to balance the diet some ugali, some greens and a fruit. **(IDIM2151)**

Few respondents (26.6%) mentioned other foods such as animal source foods as being important for a pregnant woman and were able to give a few details on the importance of such foods as in the excerpts;

> *Yes, I wanted her to eat fish or omena. I didn't want her to eat vegetables like kales because they would cause her to get a heartburn. Where I come from, I've grown up eating that food. It helps a lot when it comes to memory because of the omega 3 that helps in proper brain development of the child.* **(IDIM3331)**

> *I think they need more of iron rich foods such as liver and black beans as it improves their immunity and for blood formation.* **(IDIM4136)**

For other respondents (20%)who mentioned specific animal source foods, talked of the need to provide pregnant women with fish, liver and soup so that they would satisfy their cravings. There was no mention of any nutritional benefit of consumption of such foods as in the excerpts:

> *When my wife was pregnant there were foods I would give to her because there were some types of food which she would ask for such as fish and liver. I thought it's because she had a certain craving for such food. (***IDIM2427***)*

> *Mostly my wife liked meat soup, she would use it for energy for movement. She would mostly want to eat proteins. She also liked the fish. I don't know the importance, but she liked to eat fish. (***IDIM3825***)*

> *When my wife was pregnant, I would buy bones and we would boil soup. She was the one who suggested soup, I think it might have been cravings or something***. (IDIM3235***)*

4.3.2 Knowledge on signs of malnutrition

Eight out of every ten men in the study group could outline signs of poor nutrition, albeit with little details on the specific causes of the aforementioned signs. Stunted growth, weight loss, brown hair and general body weakness stood out as the most common of the signs.

> *Yes, they can have eyes discolorations, large stomach and the knees can be indicators.* **(IDIM4543)**

> *Yes, the eyes appear sunken or big, the legs are also small and the baby has a protruding belly and appears unhealthy.* **(IDIM3432)**

*Lack of growth. There is a way that you can see the child is not growing, even when the months and the days are increasing the child is still stagnant***. (IDIM3825)**

*The child will be unhealthy, the hair won't be black, the sight wouldn't be clear, the baby will also lose appetite, and weight too***. (IDIM3731)**

Additionally, a number of men could also tell signs of malnutrition when their wives were pregnant. Majority of the men (66.6%) mentioned a craving for or chewing some soil or stone;

Yes, she used to chew some marram stones so I advised her to visit the clinic. I used to buy fish, but I mainly advised her to visit the hospital to know where the problem was. **(IDIM2644)**

*When she starts eating that rock that has iron whereas we were educated that she should eat food like omena to give her those minerals***(IDIM4048)**

The skin was pale and had changed colour and her feet were swollen, there was also a time when she wanted to eat that soil/rock and that was when I knew that there were some minerals she was lacking. **(IDIM2151)**

About a third of the men also reported dizziness, skin changes, swelling, body aches and weakness as additional signs.

It's difficult to tell, but she can seem to be thin and the skin changes. That is what I usually observe on pregnant mothers. **(IDIM2231)**

Swelling of legs, swelling of eyes, feeling tired, and vomiting often. **(IDIM4434)**

4.4 Source of information

Female respondents seemed to be in agreement that men had some kind of knowledge on child feeding practices. Three quarters of the women respondents reported sharing of information acquired from clinical sessions, the internet, television and or clinic books hence felt responsible for passing specific knowledge to their husbands:

*I don't tell him directly but in the evening I tell him where I was and what I had gone there to do and also what we were taught He also looks at the clinic book when he is free***(IDIF520)**

There is a television show that I like to watch about the health that is on air from around six-thirty to seven in the morning so when I hear something there, I usually inform him and tell him that we should watch the repeat of the show at eleven in the evening. If the doctor is talking about something that we have observed in our child, then we listen. Even if it's not something we have observed, they teach a lot of other good things. **(IDIF645)**

Maybe from advertisements on the radio about the pregnant mother's nutrition and diet, he would listen but he did not pay a lot of attention to what was being said, what was being aired is related, he would listen passively, if he wanted to leave, he would leave and tell me to continue listening. **(IDIF1235)**

The rest of the female respondents mentioned that their husbands got information from peers, school or the internet as in the excerpts:

He got the information reading and sometimes he would google how a baby can get a good diet and nutrition. Sometimes he told me that he got the information from school. **(IDIF1435)**

Yes, you know our husbands are not always in one place, it could be he got that information from friends or other people he comes across out there. **(IDIF1834)**

4.5 Attitudes and practices around male engagement in child feeding practices

Men considered their role in their children's feeding practices as pivotal. As heads of their families, men perceived themselves as having a greater responsibility as bread winners of their families, with 86.6% citing provision of money for purchasing of food and facilitation of clinical appointments as the key ways in which they provide for their families:

Yes, I provide for my family because I am the man of the house and I must come home with something in the evening. **(IDIM2724)**

I understand that I am the head and I have to struggle to provide. Milk for example if it has to be drank three times, I can organize so that it is drank two times a day by the child, then I have to ensure that it is available. **(IDIM2151)**

I ensure that they are well and safe and providing the money to cater for transport, to the clinic and back. **(IDIM2929)**

The role of men as providers of their families was also emphasized by 65 % of female respondents:

According to me, from the way I observe my husband, he leaves the responsibility to me so that I can take care of the baby, he provides the money and leaves that responsibility to me. **(IDIF520)**

*He gives me money to buy food***. (IDIF821)**

He provides money for buying food and also caters all clinic appointments. **(IDIF1935)**

The findings further revealed that there were other ways that some men (20%) contributed to their children's feeding practices and this was by providing advice on what to consume and sometimes accompaniment to clinics:

Sometimes, I advise because a child will have a meal or rice and potatoes day in day out and such a meal is not essential to the body. So I advise my wife to change diets, maybe she can prepare rice and beans and add some carrots, and also add meals like meat and beans, and she would heed my advice. **(IDIM2533)**

When we started introducing food to the baby, he would tell me to always make sure that the food had some greens such as spinach, he would say even if it was just one leaf, I should make sure that the food had some greens. **(IDIF645)**

He tells me about the child's food and what I should prepare, sometimes he even comes up with the program when he observes that a certain food maybe is not as good for the child and that I should change **(IDIF1323)**

Interestingly, for those men who accompanied their wives to clinics did not necessarily get into the health facilities as reported by CHVs and female respondents:

When I went with my husband he would escort me to the gate. **(IDIF925)**

*When they go to the clinic[*men*] they stay out and wait for the woman at the gate. Most men miss the information in this way.* **(KIIF6)**

4.6 Perception of men's level of involvement

It was evident from the study that men placed more importance to their economic contribution to the household than they did in other ways of direct involvement in child feeding practices. However, slightly less than half (43%) of men and (40%) of women also reported that men sometimes assisted their wives in areas such preparation of meals when their wives were away or attending clinics when the child was sick or tending to their sick wives. However, study findings showed that direct involvement would not be tolerable except for times when mother was not around at home or unwell:

> *Sometimes I have to personally prepare the food in the kitchen because my wife is not always around and we live in Nairobi so I have to do it myself and feed the child when she is not around.* **(IDIM2724)**
>
> *If I had the chance, I would take her. The problem is that we as men have to provide so we don't get that opportunity. If the child is very sick, that when we can go together so that we can know the problem the child has.* **(IDIM2427)**
>
> *During that time, he was not going to work, so I asked him to accompany me to the clinic, as part of a nature walk. After I gave birth, he used to go to the clinic by myself. He would tell me when I was weak he helped me, but when now that I am well I should go in alone.* (**IDIF340)**
>
> *In the evening am usually not around home. The oldest child who is a girl prepares food for the baby and it's my husband who gives the baby food. That is very good because the baby eats more when he is feed with the father unlike when he is fed by me or his sister.* **(IDIF645)**

70% of men in the sample expressed their dissatisfaction with the level of their involvement, wanting to do more by provision of more financial resources to purchase more nutritious foods:

> *I would like to improve on the financial part because I can only provide what I can afford.* **(IDIM2644)**
>
> *I would like for my children to be eating fruits every day but I cannot be able because the money I earn cannot allow me to spend on such foods* **(IDIM3133)**

However, few men (10%) expressed other ways that they would want to be involved other than through provision;

> *I can't say it is enough, I can do better. But what I do for now is enough. If I could, I would like to spend more time with my child but sometimes that is a problem because most of the time, I'm at work*. **(IDIM4227)**

A majority of the women (75%) on the other hand did not perceive monetary support from their spouses as enough. Women talked of other activities especially accompaniment to clinics as being equally important. Women believed that if the men received the information first hand from the health providers, they would do better in terms of provision:

> *He should get more involved by taking me to the clinic and knowing how the child will grow in terms of the child's diet and nutrition. If he goes with me, he will know the progress of the child, we will help each other, if the doctor says that the child needs something, if he is there then he will easily agree unlike when he is absent*. **(IDIF130)**

> *From what we are told at the clinic, I may want to follow that and buy something but the money to do that is not there, but to him, he is okay with that. If he went to the clinic and heard what we were being told to do, then I would be more satisfied. Sometimes he thinks it's a lie and when I show him the clinic book and what is noted there, he ignores it.* **(IDIF520)**

> *I get angry sometimes because when I come from the clinic, I am told the baby has lost weight because there is something the baby needs that is not there. When I come home from the clinic, I complain that the baby has lost weight because of how the child is eating and most of the times he does not respond* **(IDIF1834)**

From the findings of the study, it was revealed that men had basic knowledge specifically on complementary feeding practices, appropriate foods during pregnancy and signs of malnutrition both in children and pregnant women. Although this was the case, most men were not able to explain more on some of the things they had talked about such as appropriate foods to be consumed when a pregnant mother or child suffers from malnutrition and the importance of some foods for a growing child. In addition, some men were not able to place certain foods to their respective food groups as in some of the discussions where men mentioned milk as

providing vitamins to the child. These findings are not unique to our study, a study conducted in Rwanda found that men did have had some level of knowledge on nutrition principles ; breastfeeding, complementary feeding, dietary diversity, signs of malnutrition but in most cases were unable to give details on some of the information that they had given. There were also instances where incorrect assumptions were expressed by some of the participants (CRS, 2012). A similar study by (Dinga et al., 2018) on involvement of fathers in breastfeeding processes showed that inadequate knowledge on breastfeeding had an impact on success and length of breastfeeding. In this study, the father's knowledge level was considered the leading factor for supporting mother's breastfeeding decisions. The study by Dinga et al (2018), concluded that it was important for nutrition education strategies to engage fathers so that they could positively impact their knowledge. In as much as it is important to increase men's knowledge, increasing levels of knowledge alone cannot ensure continued male involvement in child feeding practices. Increasing knowledge should therefore be followed up by investigating other issues at play that prevent greater male involvement in child feeding practices. Further,the study also revealed that women saw themselves as having the responsibility of giving knowledge to their husbands whether it was through information received from the clinics, from the clinic booklets or even from televisions and radio shows. The findings are similar to studies by (Mitchell-Box & Braun, 2012; Brown & Davies, 2014; Mithani, Premani, Kurji, & Rashid, 2015) that showed that most men got information about breastfeeding directly from their partners. According to the findings of these studies, women were seen to be better informed hence had more knowledge on child feeding practices.

Findings from the study revealed that men saw the provision of material and financial support as one of the most important ways that they participated in ensuring proper feeding practices of their children, whether by providing money to buy food at the household as well as paying for clinic appointments and facilitating clinic visits. All the respondents emphasized this type of support as a critical contribution of males to the child feeding practices. These findings are consistent with studies by (Douherty et al., 2017; Bilal et al., 2016; Thuita 2011) that found that men typically saw themselves as playing mainly a 'provider' or 'breadwinner' role when it came to their children's feeding practices. Other forms of involvement such as accompaniment to health facilities and preparation of meals by the men were not uncommon as revealed by our findings although only during special circumstances like when the child was very ill, when the

woman was pregnant or unwell and when the woman was away from home. This finding concurs with other studies by Aubel, et al., (2003) and Moyo & Schaay (2019) where other forms of men's involvement only went up during emergency situations.

From our findings, there does not appear to be any significant effect between child feeding practices and the male's level of education. Although a majority of the male respondents had secondary and postsecondary level studies, most of them were not open to direct involvement in child feeding practices. Furthermore, majority of the male respondents were also not able to properly categorize different foods into their respective food groups. This finding contrast a study from Uganda by Byamugisha et al., (2010) who showed that men who went beyond primary level education were likely to get involved twice in prevention of mother to child transimisson programmes than those who had a less level of education. The findings are also in contrast to those Olugbenga-Bello et al., (2013)on attitudes and practices of men towards ANC that showed that the higher the men's level of education was, the greater the participation.

4.7 Barriers to male involvement in child feeding practices

The study identified men's belief that child care and feeding practices are women's domain, the view that clinics are women's spaces and misunderstanding in the households as some of the barriers to men's involvement in child feeding practices.

4.7.1 Nature of work

A majority of men (70%) cited being unable to be involved in the child feeding practices such as accompanying their spouses to clinics due to the nature of their work as captured in the following excerpts:

> *Most of the time men are breadwinners, the man must wake up early to go to work, so the mother goes to the clinic. The challenge is income because the man must go look for work even if it's at a construction site*. **(IDIM3235)**

> *In our culture men are providers and sometimes we are busy with our jobs and we lack the time*. **(IDIM2724)**

> *At many times the clinic sessions take place on weekdays and during that period most of them are working, so it's difficult for them to visit the clinic and also go to work. I thank*

God that many of our sessions were on a Saturday and I wasn't working on those days. I would assist with the children since they were two. **(IDIM3825)**

From the findings, men believed that financial provisioning for their family was a way of participating in their children's feeding practices hence the need to work, as justified in the following excerpts:

Most are at work, where if you ask for permission from work constantly then you can be fired. I think there is also embarrassment, where some men don't want to get involved in doing such things, they just want to be able to provide food just that. **(IDIM3331)**

In many families, men are looked up to, I can't blame them because many times when clinic visits are supposed to be held, the men are at work. **(IDIM4227)**

Similarly, a few women (40%) agreed with the perception that men do not accompany their wives to clinics due to nature of their works, as captured in the following excerpts:

*Because he is a busy man and he is mostly at work, he gives me the finances to go to the clinic but we have never attended any clinic sessions together***. (IDIF1732)**

*He is usually at work most of the time that is why he never goes with me to clinic appointments***(IDIF443)**

However, some (26.6%) of male respondents reported that not all men were engaged in work during clinic visits. They cited reasons such as lack of interest, women's responsibility as some of the reasons as in the excerpts:

Yes, just as I said before the men are usually occupied with other things and let their spouses attend to such matters. Even when the man is free you can find telling the children to wait for their mother to attend to them. What the children need is left to their mother. There is also that law that until a child attains 18yrs is when they can look for their dad. **(IDIM3542)**

To some extent, there is also that disinterest. Some men believe that going to the clinic is the wife's responsibility. **(IDIM3028)**

This was also corroborated by some (30%) of the female respondents and the CHVs who were key informants. The respondents cited that most men worked as security guards hence were available during the day hence work was not really a barrier for them to attend clinics :

It's not even an issue of time, he could be at home after working night shifts but I don't know why he doesn't want to go. He has that mentality that those clinic visits are for women, he tells me he can't sit down with women. **(IDIF821)**

For a man, it is hard for them to accompany the wife with the baby to the clinic. He did not seem interested, sometimes a man can be at home and prefer to stay at home, they tell the wife to go to the clinic (**IDIF130**)

No, time is not a factor, it is all based in ego and the misplaced traditions and culture. **(KIIF6)**

Sometimes men are not interested, you will just find them seated in the house as women attend clinics (**KIIF8**)

Some (16.6%) men and few women (20%) cited had fear of the unknown such as impromptu HIV testing at the clinics and the nature of questions asked at the clinics as some of the other barriers to their involvement in their children's feeding practices as captured in the following excerpts:

I also don't trust him, if he can't walk with me because there could be something he is hiding, like that his wife pregnant and maybe he doesn't want to be seen by one of his women **(IDIF1834)**

Many of them are afraid like me when I went there I was asked difficult questions that I was not able to reply. So most of them are afraid of tough questions. **(IDIM2533)**

The first one is, that men are afraid of knowing their HIV status because when the spouse is pregnant you have to be checked on your HIV statuses so they don't want to keep on going to the clinic **(IDIM3731)**

Most men are afraid to walk with the wife. That is a very big issue. **(IDIM2346)**

4.7.2 Conflicts within the household

The study findings noted that some (40%) of men were discouraged from being "too involved" in their children's feeding practices by the fact that too much involvement would cause problems at home. The men reported that "too involved" meant doing additional roles to their work as providers such as offering advice on what to feed the baby, how to feed the baby or preparation of meals:

Your wife can see as if you know a lot on the matter than her. Which can lead to her getting angry at you. **(IDIM2427)**

The wife might take it as if the man wants to control the kitchen, something of the sort and what needs to be eaten. **(IDIM3133)**

He may rub shoulders with his wife because his wife will think that he is showing her that she does not know how to do her job. Also, the man might concentrate too much and neglect his responsibility to provide. **(IDIM2929)**

Some of the women (40%) and CHVs (16.6%) also reported that direct engagement by men would be a cause of conflict in the house giving different reasons as in the excerpt:

Yes, because you don't give her the chance to get involved as a mother, she may think that way, people are different another one doesn't want the man to buy fruits, pampers and such, she thinks the man should give her the money to do that so that she can budget that money **(KIIF6)**

To those who don't understand, the wives may get angry because they want to do the budget but for those who are understanding, they know it's very good when the man involves himself because he has the money so you can sit down and discuss the budget. Others want to make the decision and the budget so that maybe they can take some of the money for themselves. **(IDIF925)**

There might be conflicts because the woman thinks she knows more about what the child needs. So you find that in a household there are some disagreements when a man tries to suggest something. It might look to the woman that they are competing. **(IDIF520)**

4.7.3 Support from different actors

Findings from the study show that support from peers was varied. Most male respondents (56.6%) mentioned that support from other men was often through encouragement. Furthermore, the men were able to mention positive role models who have influence on the behavior of their peers;

> *It depends, there are those friends who will think that you are not supposed to get involved in such things. The ones who are educated and have the information can support me. They know the importance of knowledge of their child's nutritional needs and diet* **(IDIM3624)**

> *They say that these are our children and we have to raise them together. I went to the hospital a few days ago and I went with my wife. I met a man and he told me that I am doing a good thing. Unfortunately, we are only two, such encouragement is important to men and should be given to other people.* **(IDIM3825)**

> *There is a friend of mine who got a baby before me and I followed his example of not having to follow the cultural beliefs. There are those friends who will say that you are being controlled but I decided to go with what that other friend was doing because he was always involved*. **(IDIM4227)**

Others on the other hand cited pressure from peers who do not share the same view that helping out their spouses is something "manly":

> *Some speak ill of me and view the work is for women.* **(IDIM2151)**

> *Some men talk about you behind your back, they despise you and discourage you, when I am walking with my wife and I happen to be carrying the child and I was treated badly.* **(IDIM5032)**

> *I told him that am doing that because my baby had to be attended to, it was not every day but a time like that one I had to help her. He got very angry and got out of the house and did not tell me what he wanted to tell me*. **(IDIM2533)**

From the study, ideas about male involvement was also seen to face resistance from a majority of the older members of the family as they were seen as non-conforming to traditional men's

household roles. This view wash shared by almost all men and women in the study. Respondents highlighted stigma, gossip and taboos as factors that prevented some men from direct involvement in child feeding practices:

> *Even the wife's brothers will also ask the wife why she is letting her husband do such work, I once saw it my cousin helped me out and they talked about it. When I noticed it, I stopped letting him help me with the child.* **(IDIF746)**

> *My father would discourage me from carrying the baby around; he would tell me that the child is not food for me to keep carrying it around. That a man should keep himself busy with things to do.* **(IDIM4930)**

> *When a man does that, he is rebuked by the community elders and a person can be cursed since you are doing things that have never been seen before in that community. I think that's what makes most men not attend clinics so that they are not seen to do things that are against their culture and traditions***. (KIIF5)**

However, some young men between the age of 20-29 years (16.6%) reported their mothers as embracing their involvement as depicted in these excerpts:

> *One time my mother visited while my wife was sick and saw me helping out with preparing food and feeding the baby, she was so happy. She told me am a responsible family man* **(IDIM2427)**

> *My mother would support me accompanying my wife to the clinic because she knows it is the right thing to do***. (IDIM4227)**

4.7.4 Cultural and social norms around gender roles

Slightly more than half of the male respondents talked of how they are hindered from participating wholly in their children's feeding practices due to the existing social and cultural norms. The participants noted that men traditional gender roles were still practiced by most people with women engaged with domestic sphere such as preparation of meals, attendance of clinic appointments and ensuring the child is clean while men having the duty of providing material and financial resources for meeting the family's need. The interviews revealed that the effect of traditional gender roles were still strong, although few respondents especially young men 20-29 years (16.6%) and women (20%) argued that attitudes were beginning to change:

Because of the economy, the woman can also provide by finding something to do to make money, it's not like past times. The mother can even have a kibanda so that she can provide for the family. **(IDIM3331)**

I think that is enough but there are challenges from his peers and relatives to stop doing a woman's job, but he doesn't listen to them, I like him because he loves me and we are together in God's grace and we take of our family, then we pray that we sustain our family. **(IDIF1834)**

Although some of the men (33.3%) tried to play a more direct role in the different aspects of child feeding, some cultural barriers were still seen as a hindrance to a high-level involvement. Manipulation and control were some of the words used throughout the different discussions to describe a man who was too involved in tasks that were seen as "women's business". Nearly all respondents (male, female and key informants) mentioned manipulation and control to depict a woman having influence over her husband to the extent he is open to perform tasks that a man would not typically be open to do. Idleness or being mean with their money was also mentioned by respondents as reasons why men would not be too involved**:**

They think the man is being controlled. They can think that the mother is lazy. **(IDIM3731)**

Also that the man does not want to give the mother money, he is mean. The man buys the food himself, he sees as if he gives the mother money, some will be left and the wife will take keep some. **(IDIF443)**

People will say that the man is controlled, when the man hears that, he thinks that if he goes there, he will be not respected and people will think that he is being controlled. **(IDIF240)**

Men fear how their image will be perceived in the community and especially by their peers and friends. They also have pride because they think women are controlling them and that makes them feel as if their manhood is violated. **(KIIF3)**

Despite this, some responses (26.6%) in the discussions revealed that men were increasingly willing to disregard the negative ideas of others, showing a changing viewpoint**.**

Some men talk about you behind your back and but I am myself and I do not worry about such things. **(IDIM3235)**

You know in the community people must talk, some will say that he is controlled, that is why he goes to buy things at the market, other will tell him that is the woman's work but for someone who is used to it, he will pay them no mind. **(IDIM2844)**

4.7.6 Environment at the health facility

It was apparent from the study that it was mainly women who took children to health facilities during clninic appointmnts. For the few men (23.3%) who had at least gone once or twice reported having been welcomed well and in many cases reported receiving special treatment from the staff at the health centre.

When I accompanied my wife, we were served faster so if I ever have time again, I will go. **(IDIM2231)**

*The reception was very good for the first time. I was informed that most men don't want to accompany their spouses. So I was encouraged***. (IDIM4434)**

There was a time when I went with my wife and in line were other some men. I remember that we were served faster as couples than the other ones who came along. We were surprised why we were placed first in line **(IDIM3432)**

Findings from the study further revealed that community-based services such as monitoring growth of children, follow ups and household visits by CHVs were also perceived as more of women's domains. Men did not generally pay attention to these critical visits.

Most men get up and leave and say that is the information for women only. Some hide in the house. **(KIIF5)**

*My husband can be there physically yet not pay attention to what is being said, at another time I can point out what was being said and he acts surprised that it had been said because he wasn't paying attention***. (IDIF340)**

When you are talking to men, they seem to be listening to you but their mind is far away you can explain but afterwards no one will ask questions. **(KIIF1)**

Further, the findings show that community meetings, locally known as *barazas* that were concerned with child health and nutrition were also seen as pro-women. Although men cited unavailability due to other commitments, slightly less than a half of men and women reported intentionally avoiding such meetings mentioned the presence of many women and very few men as a reason for avoiding such. When asked why men do not attend such meetings, "wasting time" and work were the main reasons that came up as in the excerpts below:

> *It is not easy to see men going for most community meetings such as the one's concerned with mothers and children because they view it as a waste of time and no benefit to them* **(IDIF1030)**
>
> *Some will say that they cannot miss going to work so that they can be taught about such things. They will think that it is waste of time.* **(IDIM2929)**
>
> *Most men are at work. The ones who are at home think that it's a waste of time to attend such meetings.* **(IDIM2427)**

From the study, the level of male involvement in child feeding practices is largely determined by social and cultural norms. Provision of financial resources for household activities, including food were primarily the role of men while women were responsible for managing the household and managing daily task of raising children which included nutrition and health issues. Therefore,from the study we can conclude that the division of roles affected men's participation in child feeding practices. Men placed more value to earned income hence the perception that they had less responsibility in direct engagement in their children's feeding practices. This is similar to what Bilal et al., (2016) and Thuita et al., (2016) found in their studies that the key role of men in child feeding as provision of food and resources to provide food for the family. The study further found that decision-making regarding when to exclusively breastfeed, time to start complementary foods and type of food to start complementary feeding was the activity that men participated in the least in. This finding was accredited to cultural norms that the responsibility of child feeding is the mother's and that young children spend most of their time with their mothers. Other studies done in Ethiopia to increase male participation in child feeeding (Dewey & Begum, 2011) and an assesment of male's participation in infant and young child feeding in Kenya by Thuita et al., (2015) agree that men participate less in decision-making for child feeding. However, few respondents especially young men 20-29 years (16.6%) argued that they

were more open to adopt direct child feeding practices due to encouragement from their mothers or other role models. Similarly, these findings confirm findings by Doe (2013), where significant association was found between the level of male involvement and age with younger males directly involved in ANC activities as compared to the older people.

Also, most of the male respondents reported not accompanying their wives to clinic appointments but played the role providing money for the appointments and transport to the clinic. From the study findings, time, fear of unpleasant questions from healthcare workers, fear of men being seen accompanying their wives and also fear of undergoing HIV testing were some of the reasons cited for men not attending clinics. It was clear that from missing out on clinic appointments, men often missed opportunities to access appropriate messages about child feeding from trained health workers. Similarly, another study in Uganda related to maternal health issues revealed that inadequate knowledge of male partners about maternal and child health issues was a huge barrier to attending skilled antenatal care, where health talks about appropriate child feeding practices are usually given (Tweheyo et al., 2010).Through these findings and those of our studies it is clear that men accompanying their wives for clinic appointments is an important part of their involvement in their child feeding practices.

Lack of support from peers and other community members was found to be an important barrier to male's direct involvement in chld feeding practices. Men who were see to embrace such are seen as social deviants or under a spell from their wives. These is due to the traditional gender roles that place men as breadwinners and women's caretakers of the family. These roles are further reinforced by other extended families and elders in the community. From the study, men avoided being too involved in child feeding practices such as offering suggestions on what the child should eat for various reasons. The main reasons reported by all study respondents were that the men are likely to forget or neglect their main duty as the provider and the fact that over involvement would result to conflicts within the household. This was attributed to rigid roles in different cultures that associated with male engagement in specific domains within the household.

Men reported receiving special treatment from the health care workers when they accompanied their wives to the clinics an activity that happened during special circumstances. Those who attended clinic before mentioned being served first and a warm welcome as the special

treatments they received. For community based interventions such as household visits by CHVs, most men did not take part in such activities as they were perceived to be for women only. From the study, discussions with women and CHVs revealed that men did not take part in discussions with CHVs during household visits as men would either not pay attention, hide or leave the house. Findings similar to this by Muraya et al., (2017) on gender and decision-making in the community based child interventions in rural Kenya, observed that ‘women’s business’ was a term that men used to describe child nutrition. As a result, men did not show concern in “engaging in such discussions during household visits” (Muraya et al., 2017). According to the men, their work was only to provide a means to fulfill the most basic needs of the household.

According to findings of the study,most men are considered the breadwinners hence must earn a living to ensure the needs of the family are fully met. These findings further reveal that men’s direct involvement in child feeding practices such as clinic attendance , employment is a structural determinant.However, some women, CHVs and few men disagreed with this as most of the men worked as security guards and were available during the day for clnic visits. This finding is similar to that of Tweheyo et al.,(2010) that revealed that men’s occupation had no influence on clinic attendance as 64% of 286 manual workers frequently attended antenatal visits with their spouses. This percentage was found to be similar to that of professional participants who attended antenatal care visits with their spouses(Tweheyo et al., 2010).

4.8 Strategies to engage men in child feeding practices

4.8.1 Introduction

The study also explored at how some of the leaders who encourage men to be involved, messages that people have heard about male involvement and ways to ensure that men can be more involved in child feeding practices. The section expounds more on these findings.

4.8.2 Information on male involvement in child feeding practices

When asked what information they heard specifically on their involvement in child feeding practices, most of the men (70%) reported that they had not heard of messages on the need to become more or directly involved in child feeding practices. Men reported that most messages on male involvement have largely focused on financial support.

In the church, there was a day men were asked to meet after the service. The pastor told us that it is our responsibility to always take care and provide for our families **(IDIM3825)**

There was a time the chief called a meeting, he told us not to expect anyone else to take care of our families. He talked about the importance of having a stable home and trying our best to meet to the needs of our families. **(IDIM3624)**

Apart from focusing on financial domains, some male respondents (40%) reported that some local leaders such as the chief focused more on activities related to security and maintenance of order, as depicted in the following excerpts;

*They usually do little in terms of encouraging us because when you go to the chief's camp you find that there is a sticker but the chief is more involved in ensuring the laws are followed***. (IDIM3133)**

Most of the time, the chief gives us information about security where he has done a good job by calling for barazas. If the chief could educate people on the importance of the involvement of men in the child's diet and nutrition then it would be better, most times it's on security. **(IDIM3028)**

Interviews with key informants and some women brought to the fore the fact that men were encouraged by specific messages on challenging gender roles at the household level.

*There is this organization related to unpaid care which would encourage men to involve themselves more and help their wives and children. For them to know that they should help each other in doing work not saying that this work is for women only and that men should not do it. They were letting men know that both of them can do the work that men should not leave everything to the mother***. (IDIF645)**

Yes, the pastor has talked to us and motivated men to take responsibility, about what is important and what is not, how to assist the women in the job of raising the child and in the role men should take despite what our tradition and culture tells us **(IDIF925)**

We encourage them that it is good to share responsibilities within the household. We also try to show them that doing so is for the benefit of the family **(KIIF1)**

4.8.3 Ways to engage men in child feeding practices

Use of social media, home visits, use of male Community Health Workers and sensitization meetings are some of the common methods responds thought were able to achieve more male direct involvement as captured in the following excerpts;

> *If he doesn't want to come to the clinic and is not doing his responsibilities, the doctor should write a note for him to convince him, a note with the hospital stamp. If he sees that, he will want to come. People should also talk to men by making home visits.* **(IDIF1235)**

> *I think other men or CHV men mostly should educate them when they are in groups and teach them about the child's needs and encourage them that they should be more involved in the child's diet***.** *A man will be more encouraged if it's a man educating him if I tell him as a woman, he thinks I want to follow him around everywhere.* **(IDIF340)**

> *The social media platforms should be used since it will have wider coverage to our people and should be at the forefront of creating awareness. It will hit you differently when viewing the information alone than when you're many because of the peer pressure but when alone you have no choice but to adhere to the message***. (KIIM6)**

> *Forums and meetings to sensitize men on such issued. Also, when the mother goes to visits the clinic, they should insist that she comes with her husband. If the doctors insist on the man's involvement, the men will be more involved* **(IDIM3028)**

> *We, need help from other organizations to help in the training and men should be involved in educational seminars. The civic education door to would help especially if we train the men in the house. I believe it can help* **(KIIM5)**

When asked how sensitization or awareness creation should be created whether as couples or groups of men alone, all respondents expressed mixed views on this. 40% of the men preferred to be sensitized alone giving different reasons for this. This is captured in the following quotes:

> *Take me for instance, if I go for those meetings with my wife and a question is asked which my wife can answer but I can't, I will look bad or inferior. That will be a problem***.** **(IDIM3432)**

There is a time when I have experienced that, when the wife is together with the husband, they start accusing one another, when one person gives an example, their partner looks at them suspiciously because the example can be what is happening at home and it leads to chaos. Its, therefore, better when they are alone or when they are mixed but not partners from the same household it will be easier, they open up **(IDIM2724)**

When men are alone, they open up much more and they can say a lot more, unlike when the wife is there, they are afraid to say things that make them look like they didn't go to school. **(IDIM2644)**

On the other hand, 33.3% of men preferred if they were taught together with their spouses as in the excerpts;

*It will be better if they are together, because the information will reach them both and there won't be many differences arising***. (IDIM4434)**

*They might not attend a you expect, when they are together they will share more in those forums, it will work much better***. (IDIM3235)**

Slighlty half of women on the other hand and community health workers preferred such meetings to be held with couples citing different reasons for this:

*With their partners, because there is a lot of influence from their peers who would tell them that such kind of work is for the women only. When with their partner's men will see some sense to it but when alone it won't have any impact. When with your spouse you will find out that it affects both of you***. (IDIF1323)**

*When the men are given this information some may forget but if they are together the man or woman can remind the other***. (IDIF1435)**

*I prefer both genders together. A mix of both genders will increase the chances for them remembering and the men can teach other men in the community***. (KIIF1)**

In a group of men, and in a couple too so that both can receive the information so they can both contribute and hear the opinions of the other **(KIIM2)**

From the findings, there were no specific messages on the involvement of men in child feeding practices. The messages that men heard from chiefs, pastors and CHVs were generally about fulfilling their responsibility as providers. Our findings are similar to those of CRS (2012) that showed that most community meetings that men attended majorly put more emphasis on sensitization of men to address gender based violence and also encouraged men to be involved largely in financial support. Lack of specific messages on male involvement in child nutrition could be a reason why men did not see their need to be directly involved in their children's feeding practices. However, from our study, few women reported on a specific organization that sensitized people on unpaid care. Women cited that the organization encouraged dialogues relationg to household division of roles. Even with these organizations, there were no specific messages on direct involvement by men in child feeding practices and benefits of such involvement.

The study findings show that majority of the men wanted their space when learning or acquiring new information regarding their children's feeding practices, this is in contrast to most women wanted to receive information with their spouses. There were also some male CHVs who were in favor of the concept for men to be taught alone. This is similar to a study in Ethiopia by Bilal et al., (2016) where some few health workers disagreed on teaching both women and men together. This was mainly attributed to the culture where women would feel ashamed to talk in front of the men. Few respondents (female and some of the KIIs) and a few men expressed interest in couples learning together as it offered opportunities to learn together as childcare is a collective responsibility. In addition, discussions from all informants revealed that it would be important for the training of male community health volunteers as it easier for men to listen to other men. Similarly, an assessment done in Eastern and Western Kenya showed that interventions that seek to engage men, should ensure well-trained male facilitators who are fathers of young children to enlist respect of other men (USAID, 2011; WHO, 2018; Ongolly & Bukachi, 2019). From the study both women and CHVs informants emphasized on house to house education involving both the father and mother as an ideal way to reach more men.

CHAPTER FIVE

SUMMARY OF THE FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter consists of summary of key findings, conclusion and recommendations as guided by the study findings. The chapter is structured in line with the three specific objectives of the study, which were: knowledge and practices around male involvement in child feeding practices, barriers to male involvement in child feeding practices and strategies to engage men in child feeding practices

5.2 Summary

The engagement of men in child feeding practices was high especially in regards to provision of financial support whether providing wives with money for purchasing different foods or facilitate clinic appointments and this is because culturally men are considered as providers and control resources in most households. All interviews with men, women and key informants backed up this type of involvement as a the main contribution of men to their children's well-being. Accompaniment to clinics and preparation of meals was less common than financial support. However, there were certain instances that men took part in other routine child care activities, although this was often mentioned as a way of helping the woman during a difficult pregnancy, when the wife was away from home or when the child was too sick. This view was also confirmed by women and CHVs who agreed that men limit themselves to financial provision due to the traditional beliefs and practices at the community level that child feeding activities are solely the mother's responsibility.In general, most men expressed that they would like to do more regarding their involvement in child feeding practices, however they limited themselves to issues of providing more money for the purchase of nutritious foods for their children.

Few men expressed that knowledge was a barrier, although there is need for improvement in knowledge. From the findings, more than half of the male respondents interviewed did not know or give appropriate message about child feeding. This may be explained by the low number of male respondents who accompany mothers to child clinic appointements. Attending child clinics together gives an opportunity for both the father and mother to access appropriate messages about child feeding from trained health workers. However, as revealed by our study , knowledge

alone is not enough to ensure sustained increased levels of male engagement in promoting child feeding practices.

From the findings, it was evident that men's involvement in their children's feeding practices was limited due to a number of barriers that the study sought to find out. As much as they supported these practices through financial provision, majority of the men avoided direct involvement such as accompanying wives to the clinics, preparation of meals and feeding the child.

Support from peers and other actors was found to be an important barrier. There may be negative reactions from other men as those who are involved in direct child feeding practices are seen as being inappropriately influenced by their partners. This is linked to traditional gender roles that place men as providers of material and financial support .Women on the other hand, focusing on the domestic spheres as part of their responsibilities as dictated by culture. Family members also often reinforced these roles. However, a gradual change in attitude, coupled by men who make the choice to become more actively involved and serve as role models for others was reported by some respondents as a source of motivation.

Within the health centers, men reported receiving special treatment by health facility workers when they did attend for clinics –a practice which according to the discussions is still more or less an uncommon occurrence. The study findings also revealed that men were discouraged from accompanying their wives for clinic appointments and community meetings on nutrition because such spaces were characterized by a dominant number of women and very few men. Since most would be odd ones out at the clinic, few men would choose to go as far as the entrance of the clinic or never just attend such clinics. Their absence at the clinic denies them a chance to get further informed about proper child feeding and nutrition through health talks that are held at the clinics in the morning.

5.3 Conclusion

From the study, it is evident that men 's involvement in their children's feeding practices is more of indirect than direct, mostly through financial provision. It is clear that although they provide resources, most do not have the information guiding them on nutritious foods making it easy for them to downplay the importance of specific foods to the well-being of their children. It is

conclusive that culture indeed plays a huge role in influencing men's involvement in their children's feeding practices and therefore acts as a barrier.

To achieve total eradication of malnutrition, the need for more men's involvement in their children's feeding practices cannot be overemphasized. It is therefore imperative that approaches to more men involvement should be geared towards a holistic understanding of the barriers from all the community's influencers-the men, women and the community leaders from an emic perspective.

5.4 Recommendations

Based on the findings of the research, the study makes the following recommendations:

1. Outreach programs should endeavor to change beliefs and increase their understanding of their children's feeding practices and challenge their assumptions about various foods. In addition, interventional messages should directly underscore the benefits of male involvement in their child feeding practices.

2. Effective implementation of male involvement in child nutrition initiatives should address the barriers to men's participation so as to motivate men to be engaged directly in their child feeding ractices.

3. Health outreaches should be flexible to accommodate most men who are mostly at work during week days when they are held.

Recommendations for future research

1. A study of motivators to male involvement in child feeding practices will be useful since findings from the study show that some men had been involved directly in their child feeding practices in different ways. It will therefore be useful to understand what motivates their involvement.

2. A study on the influence of men's financial provision and the dietary practices adopted by their families would also be useful.

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APPENDICES

APPENDIX I: INFORMED CONSENT

CONSENT FORM FOR PARTICPANTS

FACTORS INFLUENCING MALE INVOLVEMENT IN YOUNG CHILD FEEDING PRACTICES: A CASE OF DAGORETTI INFORMAL SETTLEMENTS

Principal Investigator\ and institutional affiliation:

Ann Wambui Muthiru

Institute of Anthropology, Gender & African Studies, University of Nairobi

Introduction:

Dear Mr., Ms.,

I would like to tell you about a study being conducted by the above listed researcher. I am asking you to participate in this interview for a research project. The research is trying to understand the factors influencing male involvement in young child feeding practices here in Dagoretti sub-county. The interview will last for at least one hour. If you need to excuse yourself at any point during the interview, please feel free to do so. You may leave the interview at any time and you can choose not to answer questions you do not wish to answer.

With your permission I would like to record this interview on an audio recorder so that I may not miss anything that we talk about. No one else will access this recording and all the information that you will provide will be kept confidential. Results will be communicated anonymously and merged with information from other households.

Your participation is very important for the success of this study. I would very much appreciate your collaboration in this research project.

Do you have any questions?

"I have heard the information read to me and understood the nature and extent of my participation and the risks and disadvantages. I had the opportunity to ask all questions about the different aspects of this study and received answers to my satisfaction. Understand that my

participation in this study is voluntary and that I may choose to withdraw any time. I freely agree to participate in this research study.

By giving a verbal consent, I confirm that I give my consent to participate in the study according to the information that has been given to me.

For more information, contact Ann Muthiru on 0707135220 or Prof. Salome Bukachi on 0726771808

APPENDIX II: IN-DEPTH INTERVIEW GUIDE

Men

Knowledge of ASF Child feeding

What do know about child nutrition and health? Probe for

- Appropriate weaning foods)
- ASF and child feeding
- Nutrition during pregnancy and consumption of different food groups? With an emphasis on ASF
- Signs of malnutrition and the consequences of malnutrition. Probe for pregnant women and children

What are some of your sources for the above information? Probe from where or specific individuals

In what ways are you directly involved in your children's nutritional well-being? (Probes: offering advice or suggestions on what to eat (ASF), financial support to buy ASF encouraging consumption of ASF during pregnancy or child feeding, or accompaniment to child's clinic appointments).

In your opinion, is your involvement in your child's nutritional well-being is enough? Or are there ways would you like to be engaged more in your child's well-being? What are some of the ways that you would like to become more involved?

According to you, what are some of the benefits of a man being involved in their child's feeding and nutritional well- being? What do you think are the disadvantages?

Barriers/enablers at the individual,household and community level

What are the expected roles of women in ensuring her child's optimal ASF feeding practice and nutrition?

What are some of the expected roles of men in ensuring his child's optimal ASF feeding practice and nutrition?

Do you and your partner have discussions about your child's feeding and nutrition? (probe for decisions made on what to eat or give a child in regards to ASF). Why do you have discussions or why there are no discussions? How often?

How are decisions made about:

- Household's spending on food? (probe on spending on ASF)
- Meals to prepared in the household? (Probe for ASF).
- Which foods young children should eat? (Probe for ASF)
- Attendance of child's clinic?

How will other men take it, when you are involved in your child's feeding practices? will they support or discourage you? Why do you think so?

Are there leaders in your local community that encourage you to be in the front line matters of nutrition? Probe for different leaders in the community and how they encourage. (local chiefs, CHVs, CHAs, church leaders).

Are there relatives (parents or other family members) who push you or discourage you to get involved in the well-being of your children? Who and how do they do that?

Do you go go for your child's clinical appointements? How many times? How are you treated at the clinic? Do you feel welcome? Why or why not?

How has the COVID-19 outbreak impacted your child feeding practices? Probe for the consumption of ASF, clinic attendance)

Strategies to engage men in child feeding

What messages or information if any have you come across on the benefits of male involvement in their child's feeding practices?

Where did you come across the specific message? (Probe: community sessions *(barazas),* TV or radio shows, advertisements or at the health facility).

How would you like to learn about any new information about your child's nutritional well-being? (together with partners, in a group with other men or alone?Why do yu feel this way?

Is there any type of information you would like to receive on child feeding practices? Why? Do you think the information will help you? How

APPENDIX III : IN-DEPTH INTERVIEW GUIDE

Women

What do you think your husbands know about children's feeding practices and nutrition? Probe:

- Complementary feeding in regards to ASF
- Signs of malnutrition
- Consumption of ASF during pregnancy
- Signs of malnutrition and consequences

How did your husband know about the above? (TV, radio stations, community mobilization, peers or health facility).

Are there some ways that your husband has shown support for your child's nutrition? What are some of those ways? (Probes: Providing advice on foods to consume, financial support to buy nutritious food such as ASF, accompaniment to clinic appointments).

How do you feel about your partner's support for child nutrition and level of involvement? (too involved, not involved)? Why do you feel this way? How would you wish your partner would show more support?

According to you, are there advantages or disadvantages of a father being very involved in their child's feeding practices?

Do you have discussions with your spouse about your child's feeding practices and nutritional well-being? What are some of the things you discuss? How often?

Who makes decisions in your household about:

- When to introduce food to the child?
- Which foods to introduce to the child?
- Spending money on nutritious food such as ASF?
- Spending money on healthcare

How often does your partner get involved in your child's clinic appointments? If not often why? Do you think it is important for your partner to accompany you to clinic appointments?

Enablers and barriers at the level of the individual , household and community/social norms

What are the responsibilities of women in regards to child's feeding practices?

What are the responsibilities of men in regards to the child's feeding practices?

How will other men treat am man that is very involved in the health of his child? Why?

Are there local leaders in the community who encourage or discourage men to take an active role in their children's feeding practices? How and who are some of these leaders?

Do other relatives (mothers or in laws) encourage ir discourage your partner to get involved in the feeding practices of your children?

Strategies to involve men in Child feeding

How do you involve your partner on anything that you have learned or any information that you have heard concerning your child's nutrition?

Have you heard of the messages about importance of male involvement in their children's feeding practices?

What was the specific message that you heard? Where did you hear it? Probe: community sessions*(barazas),* TV or radio shows, advertisements or at the health facility)

Are there specific recommendations you can think of as a way to encourage men to be more involved in their child's nutritional well-being?

How has the COVID-19 outbreak impacted child feeding practices in your household? Probe for clinic attendance.

APPENDIX IV: KEY INFORMANT GUIDE

This part will be used on all the key informants

To begin with can you please tell me a little about your community?

What role do you play in your community?

In your role what are some of the achievements or challenges in involving men child's feeding specifically concerning ASFs?

In your opinion, do men in this community have an understanding of child feeding practices?

In the role you play in this community, have you come across males who support their partners in ensuring their child's optimal feeding practices?

In your work in the community, have you seen or heard behaviours or attitudes that are aimed at discouraging men from actively being involved in the health of their children? Explain.

This part is to be used on CHWs and Community leaders

Enablers and barriers at the level of the individual, household and community/social norms

In your opinion, are there specific cultural or social norms that play a part in the engagement of men in child feeding practices? How do they play a role?

In this community what roles are men and women expected to do?

Do these expectations influence the attitudes and behaviours of men and women concerning child feeding practices?

Do the men in this community offer support or discourage each other, in taking charge of their child's feeding practice? How?

Have you or other people tried to address male involvement in child feeding and nutrition? In what ways have you or these other people influenced?

This part is to be used by nutritionist and clinician

From your experience what has been the role of men when they accompany their wives to the clinics?

What do you think are some of the factors that could limit men's engagement in child feeding practices?

What do you think are the benefits of involving men in a child's nutrition?

Strategies to improve male involvement

Have you come across any men who are very involved and supportive of their child's nutrition? How are some of the ways they have been involved?

In your line of work, what specific messages about men's involvement have you spread around and how did you deliver these messages?

Have these messages been effective in changing men's behaviours or attitudes towards child feeding practices?

How have you tried to involve men more in their child's nutritional well-being? (examples of specific ways)

What shortcomings, if any, have you noticed with these efforts?

Do you have any recommendations for getting men more involved in their child's nutrition?

How has the COVID-19 outbreak impacted the consumption of nutritious food in the community?

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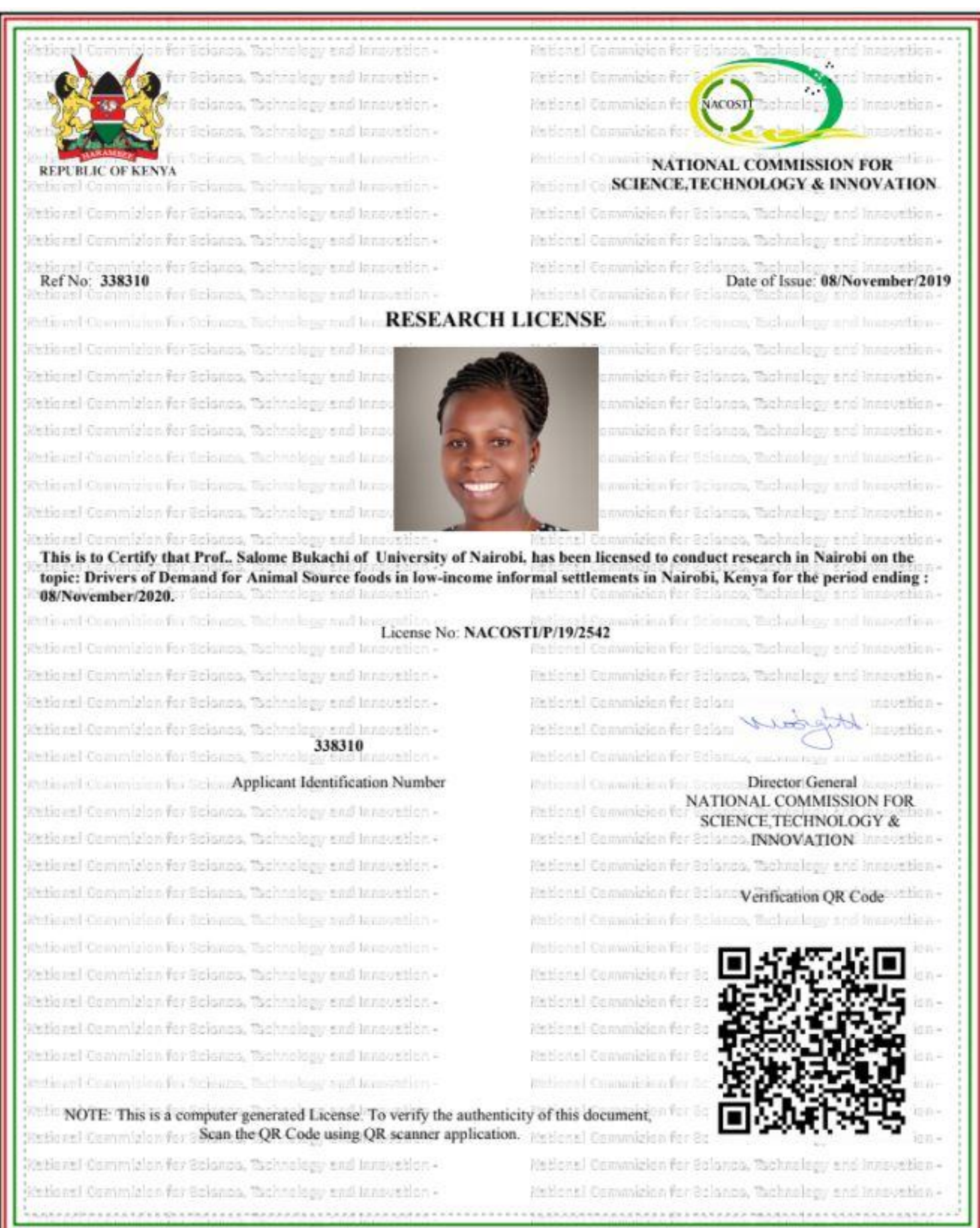

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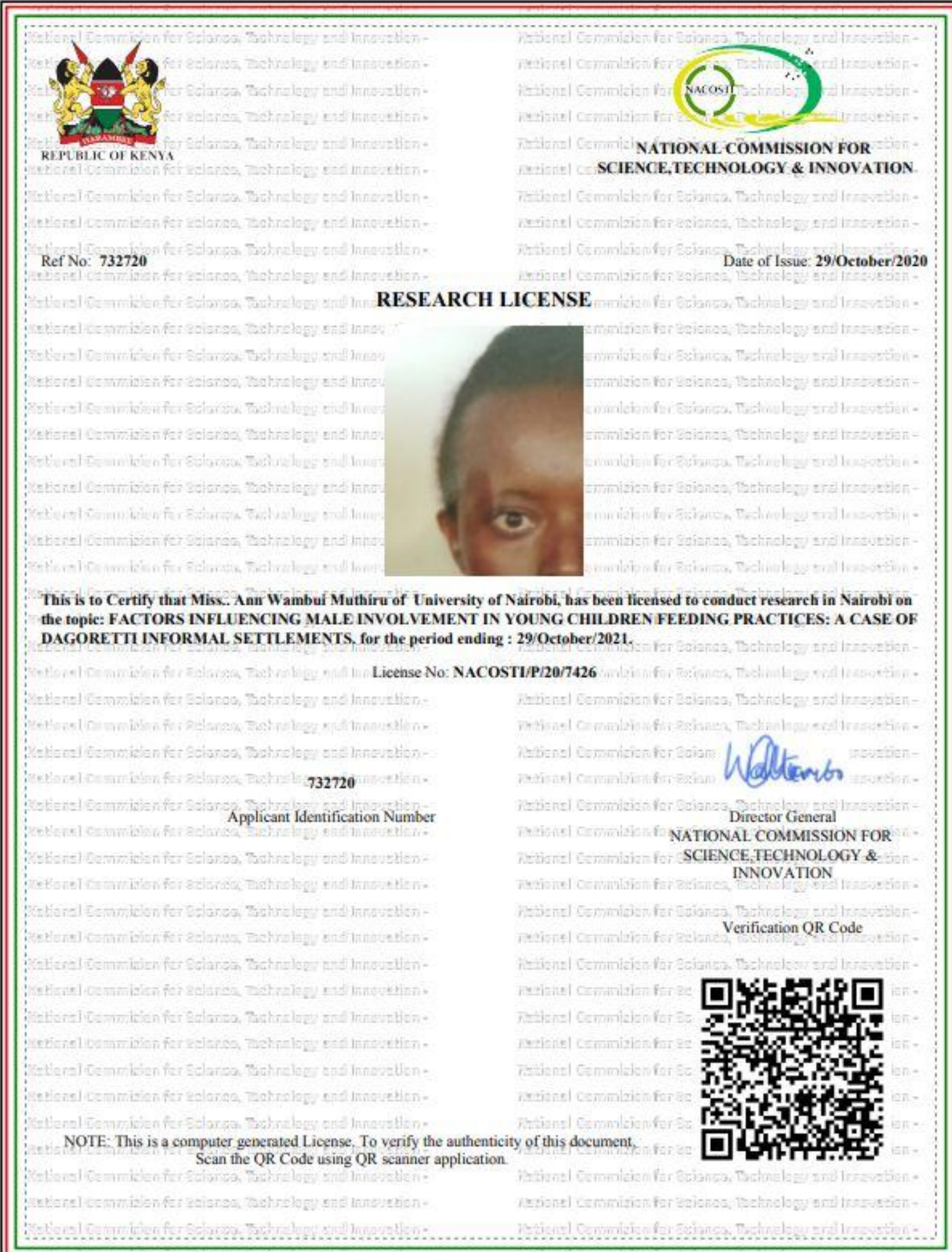

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