BARRIERS TO MALE INVOLVEMENT IN ANTENATAL CARE IN KANDUYI SUB-COUNTY IN BUNGOMA COUNTY

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A RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT 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

I declare that this project paper is my original work and has not been submitted for examination at any other university.

Signature: _____ Date: 16/07/2023

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This project paper has been submitted for examination with my approval as the university supervisor.

Signature: _____ Date _____

Prof. Tom Ondicho 25/7/2023

DEDICATION

To my Husband, Ken Wanyama &

Son, Ryan Wanyama.

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I sincerely thank the Almighty God for his love and mercy and for giving me good health throughout my M.A. study. My heartfelt gratitude goes to my supervisor Prof Tom Ondicho whose guidance made me complete this project paper. Thank you for your constructive criticism of my work and for never giving up on me but always advising me to keep pushing to complete this research project. My special appreciation goes to the staff at the University of Nairobi and specifically the Department of Anthropology, Gender, and African Studies for their- support throughout my academic journey. I wish to thank my parents, Phillip Mutiso and Agnes Mutiso, for their undying love and support throughout my academic life. Last but not least, my sincere mention goes to my study participants, who supported me and cooperated as participants.

God bless you all.

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LIST OF ACRONYMS AND ABBREVIATIONS

AMREF	Africa Medical and Research Foundation
ANC	Antenatal Care
CHW	Community Health Worker
CIDP	County Integrated Development Plan
FGDs	Focus Group Discussion
HBM	Health Belief Model
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus
IEBC	Independent Electoral and Boundaries Commission
KIIs	Key Informant Interviews
LMICs	Low- and Middle-Income Countries
NACOSTI	National Commission for Science, Technology, and Innovation
NASCOP	National AIDS and STI Control Programme
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
SSA	Sub-Saharan Africa
TBA	Traditional Birth Attendant
UN	United Nations
WHO	World Health Organization

ABSTRACT

This academic study investigates the socioeconomic and cultural barriers that impede male engagement in antenatal care (ANC) within Kanduyi Sub-County, Bungoma. Employing a cross-sectional descriptive survey, utilizing Focus Group Discussions (FGDs), In-Depth Interviews (IDIs), and Key Informant Interviews (KIIs), the study applies the Social Relations Approach framework to analyze the collected data. The research reveals that various sociocultural factors, such as stigma, gender norms pertaining to pregnancy responsibilities, socialization processes, and men's social and peer networks, contribute to the limited involvement of men in ANC. Furthermore, socioeconomic considerations, including men's livelihood activities, social standing, expertise levels, and the financial burden of ANC, also deter their active participation. While both sociocultural and socioeconomic factors influence men's decision-making negatively, sociocultural factors emerge as the primary impediment to male engagement in ANC. The study concludes that interventions, such as awareness campaigns on the significance of men's active involvement in their partners' pregnancies, should be implemented through formal and informal community platforms. This research can be used as a model for other Kenyan communities with similar social structures seeking to promote behavioural modifications in male ANC participation.

Keywords: ANC, socioeconomic, sociocultural, Kanduyi, Bungoma.

CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 Introduction

Participation of men in antenatal care (ANC) is considered by both professionals in health and policymakers as an essential component of a mother's health (Guspianto et al., 2022). This is because when men become involved in their partners' pregnancies and childbirths, they provide an important support system resulting in positive mothers and neonatal outcomes (Ampin et al., 2021; Clark et al., 2020). In this regard, men's engagement in ANC is associated with a tremendous reduction in maternal deaths,, fetal growth restriction, challenges of birth before term and reduced mortalities of infants (Ongolly & Bukachi, 2019; Boniphse et al., 2021; Mahiti et al., 2017; Vermeulen et al., 2016).

ANC is conceptualized as comprehensive attention, education, treatment and supervision of mothers who are pregnant as soon as they get pregnant to the period when labour starts and includes services such as contraceptive education, protection from tetanus through vaccine services, human immunodeficiency virus (HIV) informal counselling testing and health education on mothers wellbeing among others (Muloongo et al., 2019; Mahiti et al., 2017; Brown et al., 2008).

Globally, the participation of men in ANC and during delivery has remained low, rendering it a great challenge to safe motherhood (Boniphse et al., 2021). Statistics indicate that about 210 million women worldwide have become pregnant (Abebe et al., 2022). From this, an estimated 15% end up in complications, of which 0.5 million die annually (Ampin et al., 2021). In 2021, it was estimated that 6400 newly born babies died daily globally, with slightly more than 36% of

them dying at birth on the day they were born. In the same year, 2.5 million neonatal deaths were recorded in the world, with 89% of the deaths occurring in the Global South (Ampin et al., 2021; WHO, 2022.

Further, World Health Organization (WHO) statistics show that 89% of the deaths associated with childbirth complications happen in developing countries with 50% of these deaths experienced by populations in Sub-Saharan Africa (SSA) (WHO, 2019). This high number of infant and maternal deaths in the LMICs is partly due to men's limited involvement in ANC (Mekonen et al., 2022). In most developing countries, cultural norms and practices assign women and child's health roles. Cultural norms play an integral role in dissuading men from active mother and child health involvement. As a result, they rarely accompany their partners to ANC clinics and maternity wards during birth (Audet et al., 2016; Fleming et al., 2017: Ongolly & Bukachi, 2019: Kaye et al., 2014; WHO, 2019).

Active participation of male partners in supporting their wives during pregnancy is considered one of the pathways to achieving positive mothers' health outcomes, especially in developing countrie. Despite sustained efforts to engage more men in their spouses' ANC, success remains marginal. to actively encourage men to participate in their spouses' pregnancy and childbirth, men's engagement in ANC remains small. This could be linked to the prevailing cultural norms in many developing countries, especially in Sub-Saharan Africa, which impedes male engagement in ANC (Clark et al., 2020; Masaba & Mmusi-Phetoe, 2020). Male support may include accompanying partners to a health facility to attend the antenatal clinic, receive other mothers' health services, and provide funds and emotional support (Aluisio et al., 2016; Clark et al., 2020).

Men's low level of participation in ANC has been widely reported in many previous studies in developing countries such as Kenya, Uganda, and Zimbabwe. A study by Kaye et al. (2014) in Uganda's Mbale district revealed that men's engagement in their spouses' pregnancy journeys and childbirth was so minimal. The study also recorded a low level of engagement of men as key partners in supporting the prevention of mother-to-child transmission (PMCT) of HIV- (Kaye et al., 2014). A study in Busia, Kenya, recorded low numbers of infant delivery by trained and skilled health providers because the men in their lives did not provide the required financial resources and support to enable their spouses to access formal health care and delivery services existing in the area (Ongolly & Bukachi, 2019).

The support offered by men during pregnancy and childbirth is, however, affected by many sociocultural factors. Studies show that social and gender norms and long-standing beliefs and practices define the power and social relations between men and women (Kaye et al., 2014). The resultant outcome is that men and women are accorded different gender roles, with men featuring as key decision-makers in their households, including on SRH. Men's decision-making power gives absolute control over their spouse's SRH and health-seeking pathways, especially during pregnancy (Byamugisha et al., 2010; Ampin et al., 2021; Audet et al., 2016; Boniphase et al., 2021; Davis et al., 2018). In other instances, men may control women's sexuality and dictate where the child may be delivered (Warren et al., 2017).

According to Ganle et al. (2016), in Africa, pregnancy and ANC were traditionally a female domain, and as a result, men were not allowed to indulge in such activities. These age-old cultural beliefs and practices continue to dissuade men from playing an active role in their partners' pregnancies, including ANC. As Ongolly & Bukachi (2019) aptly observe, "these cultural practices serve to serve to exclude the men from attending health facilities or clinics to seek

mothers' health care with their spouses and for delivery." The customary practices by their design when men participate in ANC and childbirth, many cultural undertones that drive the non-involvement of men can be challenged through behaviour change strategies. Challenging the social and cultural norms perpetuating and validating the ANC as a space for women and excluding men to can lead to inclusive mothers' reproductive programming (Fleming et al., 2017; Jennings et al., 2014).

Previous studies by Aura (2014) and Davis et al. (2018) reported low men's engagement with their spouses during pregnancy in Kenya. The limited male engagement in mothers' and infant health-related activities has been attributed to various socioeconomic and sociocultural barriers. There was, thus, the need to conduct in-depth research on the aforementioned variables as barriers that prevent men from engaging in pregnancy care and the area that the study recommends the need for further research (Aura, 2014; Fleming et al., 2017). This study navigated this terrain by delving into the sociocultural and socioeconomic barriers that hinder male engagement in ANC in Kanduyi Sub-County in Bungoma County of Western Kenya.

1.2 Statement of the Problem

The involvement of married or cohabiting men in ANC is an essential component of reproductive health as it contributes to better mothers' health outcomes (Mekonen et al., 2022). Male engagement in ANC is associated with reduced time to seek mothers' reproductive health care during pregnancy. Also, the time used to reach health facilities during labour leading to childbirth is linked to male roles in ANC (Fleming et al., 2017). Men's involvement during pregnancy and labour is a key aspect that can reduce materna infant mortality. In this regard, healthcare professionals and policymakers alike have called for the meaningful participation of men in ANC.

While some studies point to the fact that men's engagement in ANC engenders better mothers' and child outcomes (WHO, 2019; Davies et al., 2018), the reasons for men's low involvement in ANC remain largely unknown, especially in Kenya. In Kenya, few studies have been undertaken to try and understand the factors that prevent men from supporting their spouses during pregnancy and childbirth. Deeper insights into the socioeconomic and sociocultural factors that hinder men from supporting their spouses fully during pregnancy and childbirth are critical in improving and providing comprehensive mothers' health. Support provided by men to their spouses during pregnancy and before birth is necessary for improving the well-being of the mothers and the newborn baby. The support is critical since pregnancy is a challenging experience for women in many ways and hence becomes a crucial time for promoting healthy reproductive behaviour and better parenting skills (Ongeso & Okoth, 2018; Clerk et al., 2020).

Peneza and Maluka (2018) postulate mothers'care ensures that pregnant women and their families/spouses are connected to the formal health system. The link to the formal health system increases the chances of expectant women receiving care and treatment from trained healthcare professionals during pregnancy and birth, which brings about positive health outcomes for the mother and the newborn throughout their life cycle. Studies show that poor care during pregnancy cuts the connection in the professional care continuum, leading to genitive health outcomes for both the mother and child (Peneza & Maluka, 2018; Ongeso & Okoth, 2018; Ongolly & Bukachi, 2019).

Within mothers' health discourse, the participation of men continues to be touted as an important aspect of ANC with a positive health outcome. Thus, men have the right to access and use mothers 'reproductive health information that is used for their health and that of their wives and children (WHO, 2019). Statistics from Kenya show that nationally, male partner participation in ANC

services varies in the former regional provinces. For instance, Nyanza leads by 6.4% in partner involvement in ANC clinics, followed by Eastern at 6%, Western at 5.3%, Nairobi at 5.2%, Rift Valley at 4.6%, Coast at 3.4% and Northeastern trailing by 2%. The above figures present a national average of male partner involvement in ANC clinics at 5.1% (Sakala et al., 2021; NASCOP, 2014; WHO, 2019; Kaye et al., 2014). The observed regional differences in male partners supporting their spouses during pregnancy could be due to different regional sociocultural and economic dynamics. Such variables influence the manner and rate of men's participation in ANC during pregnancy until labour sets in.

With limited involvement in ANC, men miss out on critical services and information such as education on mothers' health, family planning and contraceptive use, among others which could be important to themselves and their spouses. As heads of households, men often govern or make decisions associated with allocating resources, sexuality and access to services, including health care. Men's participation of men in care-seeking during their wives' pregnancy is considered a substantial pillar in the comprehensive mothers' reproductive health framework. However, barriers related to socioeconomic and sociocultural issues serve to derail the efforts of incorporating men's an mothers' health care. Therefore, this research sought to fill the gap by investigating the issues preventing men from engaging in ANC in Bukembe West in the Kanduyi Sub-County in Bungoma County. The study was anchored on the following key research questions.

i. What are the sociocultural barriers to men's participation in ANC in the Kanduyi Sub-County in Bungoma County?
ii. What are the socioeconomic barriers to men's participation in ANC in the Kanduyi Sub-County in Bungoma County?

1.3 Objectives of the Study

1.3.1 Overall Objective

To investigate hindrances to men's engagement in antenatal care in Kanduyi Sub-County, Bungoma.

1.3.2 Specific Objectives

i. To establish the sociocultural barriers to men's involvement in antenatal care in Kanduyi Sub-County in Bungoma County.
ii. To determine the socioeconomic barriers to men's involvement in antenatal care in the Kanduyi Sub-County in Bungoma County.

1.4. Assumptions of the Study

The study made the following assumptions:

i. The main sociocultural factors affecting male involvement in ANC in Kanduyi Sub-County are stigma and social norms.
ii. The main Socioeconomic barrier to males' involvement in ANC in Kanduyi Sub-County is the cost of transportation to the health facilities.

1.5. Justification of the Study

This study focuses on the barriers to men's engagement in ANC in the Kanduyi Sub-County in Bungoma County. Like many other cultural settings, care and service provision during a woman's pregnancy is largely a domain of women and men's participation is limited. While pregnancy is the responsibility of both men and women often do not actively participate as expected. This study, therefore, investigated the social, economic, and cultural factors that prevent men from involving

themselves in ANC. As such, the study findings provide new and welcome empirical information on the barriers to men's participation of men in ANC. This new evidence will greatly interest policy planners, markers, and other stakeholders.

The findings generated from this study on the sociocultural issues that served to prevent male partner involvement in ANC provide new empirical evidence that would be used in program design and interventions geared towards improving men's engagement in ANC and childbirth. The program design could be developed based on evidence to ensure that they are tailored to meet the specific and unique needs of both men and women. The findings generated from this study will fill the gaps in knowledge and provide new perspectives in the literature on the social, economic and cultural determinants of male active participation in mother and child's health. The knowledge will be useful in providing support to challenge and remove the observed limiting factors.

The study will also act as a point of reference for researchers and academicians interested in understanding the barriers to male partner engagement in their wives' pregnancy in remote or rural settings. The findings of this study will be used as a point of reference when developing new lines of inquiry. It will also form the basis for comparative studies as well for gauging change over time. These researchers could use the findings to substantiate and support their theories. The analysis and theoretical discussions presented in this study would be useful in enriching existing knowledge on the major barriers that serve to deter male spouses from engaging in antenatal or pregnancy care.

1.6 Scope and Limitation of the Study

This cross-sectional study was conducted in the Kanduyi Sub-County in Bungoma County in Western Kenya. Specifically, the study was conducted in Bukembe Ward in Kanduyi Sub-County.

The target respondents for this study were married men who had sired at least one child and were living with their wives or spouses. The target study respondents were also aged 18 years and above and were residents of Bukembe Ward in Kanduyi Sub-County in Bungoma County. This study did not cover the residents of other wards in Kanduyi Sub-County as they were beyond its geographical scope. Equality, the study did not cover unmarried men and men who were married or cohabiting but had not sired at least one child.

In terms of methodology, the study used a cross-sectional descriptive research design to identify the obstacles males in Kanduyi Sub-County face when seeking prenatal care. This study used key informant interviews, in-depth interviews, focus groups, and other qualitative data collection techniques because it was strictly a qualitative study. The focus group discussions and in-depth interviews were done with married men with at least one child. Key informant interviews were done with people who had first-hand or expert knowledge of the study's subject matter, including ANC center staff and community health volunteers, among others. The health belief model served as the theoretical foundation for the study, serving as the lens through which the investigation and conceptualization of the key study variables were conducted.

1.7 Operational Definition of Key Variables

ANC is conceptualized as all or any type of care or support offered to pregnant women or mothers and their spouses at formal healthcare facilities such as clinics during pregnancy.

Men: In this study, this refers to married men who are married or in cohabiting relationships and have at least one child.

Men's participation refers to how men get involved or participate in various capacities, like escorting their spouses to ANC clinics during pregnancy. The activities are drawn from the framework of ANC service provision.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

The chapter's literature review portion includes articles on male ANC participation, sociocultural and socioeconomic factors that may affect such participation, and the theoretical framework that underpinned this study. The significance of the theoretical framework to this investigation is discussed in the final section.

2.2 Literature on Men's Engagement in ANC

Men's engagement in ANC is important for several reasons. According to various studies (e.g., Mullany et al., 2010; Pulerwitz et al., 2010), men's engagement in ANC has been associated with improved mother and child health outcomes. In particular, men's involvement in ANC has been linked to increased use of maternal health services, improved mothers' nutrition, increased adherence to recommended health behaviours, and increased likelihood of delivery at a health facility with skilled birth attendants.

Moreover, men's engagement in ANC has been shown to have positive effects on family dynamics and relationships between partners, including increased communication and support between partners, improved spousal relations, and increased involvement of men in child care and household tasks (Ditekemena et al., 2012; Yargawa & Leonardi-Bee, 2015).

Overall, the evidence suggests that involving men in ANC can have positive effects on mother and child's health outcomes, as well as on family relationships and dynamics.

While it is widely acknowledged that pregnancy is not an illness, the demands of it require a lot of emotional, social, economic, and physical support. Pregnancy is understood to create many demands for and from the mother, hence the need for support from their spouses and families (Ongolly & Bukachi, 2019).

According to Audet et al. (2016) and Ampin et al. (2021), understanding the challenges of being pregnant such as tiredness and discomfort by the male spouses and other family members, is the beginning of meaningful support for their wives and women during pregnancy and childbirth. Knowledge among men and other family members on the demands and challenges associated with being pregnant is critical to ensure that women are continuously supported during these important phases of mothers health and motherhood (Davis *et al*., 2018).

Across the globe, policymakers and healthcare professionals must deal with the challenge of limited or lack of participation of men when women are pregnant, a situation that has persisted over the years despite over two decades of policy legislation and investments. For instance, after the Cairo International Conference on Population and Development, many programs were rolled out to enhance men's engagement in ANC (ICPD) (1994). Equally, over 25 years after the Beijing World Conference for Women (1995), which laid the ground for the support of women in reproductive roles, much progress has been made in emphasizing the suffering of women during pregnancy and hence encouraging more men to support their spouses' reproductive health. This is also linked to the desired reproductive behaviour (WHO, 2019; AMREF, 2014; Ampin et al., 2021). As part of the actions in the above conferences, key actions were laid down, including

norms and culture change to influence behaviour. Knowledge and attitudes of men toward sexuality were also championed to influence men's meaningful participation in reproductive health issues (Audet et al., 2016). The results have been smooth and progressive partnerships between men and wives on matters of reproductive behaviour and the health of mothers in general (UN, 2019; Brown et al., 2018; Wilunda et al., 2017).

A study in Nepal (Bhatta, 2013) investigated how men are involved in ANC, childbirth readiness, exclusive child breastfeeding and vaccination immunizations. The study revealed that men in Kathmandu are minimally involved in matters dealing with childbearing health care needs and child health care such as immunizations (Bhatta, 2010). Men in the study stated that they do not see the value of accompanying their spouses to seek health care during pregnancy, during delivery and even for vaccinations of the born child. The major sources of support that pregnant women and mothers received from their spouses in Kathmandu, Nepal, were financial support for ANC care and delivery services and transport; sometimes, men would support them with domestic chores. The study concluded that men in the study area had little awareness and knowledge of the benefits of their engagement with mothers' health; hence they considered roles associated with motherhood and activities during pregnancy and childbirth as strictly the role and preserve of women.

Other studies (Kaye et al., 2014; Ampt et al., 2015) found that in cases where men agreed to accompany their spouses to health facilities to receive ANC services, some also attended reproductive health education and consultation sessions at the health facility. However, most men would only wait for their wives outside as they seek ANC services (Kaye et al., 2014; Mullick et al., 2005). Results from the two studies revealed that the women were less willing to allow men to participate or get involved in the maternity or labour ward during childbirth.

A study conducted in Kwazulu Natal State investigated the involvement of men in maternity support and care through a mixed-method study. The results showed that both male and female participants held a positive attitude towards the idea of men being a key support system for their partners in mothers' health, including attending clinics and receiving mothers' health education. However, other studies have highlighted that while women are willing to involve their male partners in reproductive and mothers' health activities, men are often hesitant to participate. The participation of men in delivery or childbirth was particularly mentioned as an area where women were less reluctant compared to men, according to Kabanga et al. (2019), Haget et al. (2014), and Ganle et al. (2016).

In most communities in Sub-Saharan Africa, pregnancy and childcare are considered the responsibility of women (Kaye et al., 2014). Men are rarely expected to accompany and support their spouses to health facilities to obtain antenatal clinics or maternity rooms during childbirth. While male engagement in these fronts is limited, men in Sub-Saharan Africa continue to have absolute control over women's reproductive behaviour and outcome. This suggests male domination over spouses hence their great social standing and power, including on issues of household economic behaviour (Sakala et al., 2021; Aluisio et al., 2016; Muloongo et al., 2019).

With their social status and economic power, many men make major decisions about sexuality and healthcare access. Men prescribe their family sizes with decisions on contraceptive use and how their spouses will access available mothers' health care services, including ANC. Thus, men in many SSA countries are key players in mothers' reproductive health decisions at the household level. It then calls for more efforts and initiatives to increase their involvement in the health of SRH/the child and mothers. Such efforts are key contributors to reducing current and persistent

mortalities such as newborn and maternal deaths, which are common occurrences in the region (Sakala et al., 2021).

Male engagement is, however, constrained by the structure of service delivery at antenatal clinics. In a study in Ghana, men who had accompanied their spouses to the ANC stated that they were made to wait in spaces away from the service delivery rooms by facility administrators and, as such, did not receive any form of education or advice from health professionals. Even after setting or sitting or staying outside and not listening or engaging in the consultations, the findings show that their wives rarely share or discuss with their men the information received in the consultation room (Davies et al., 2018). Kariuki and Seruwagi (2016) have also made similar observations in rural Uganda men working hours in their daily jobs or income-generating activities were one of the greatest impediments to the availability of men to allow them to take or escort their wives to attend during the period of pregnancy or childbirth in health facilities such as hospitals and clinics.

2.3 Barriers to Men's Involvement in Antenatal

Across the world, sociocultural factors influence health care in many prisms. Sociocultural factors define and shape how populations and cultures experience and are affected by diseases and illnesses. This includes susceptibility and aspects of vulnerability to diseases, behaviours, habits and practices of great risks, the successful initiatives promoting health, the status of health care access and the quality of health care that is provided within a community (Fleming et al., 2017; Mahiti et al., 2017). All these factors combine to mediate the level of support community members of a certain culture are accorded regarding health care use. In this case, pregnancy may be considered fitting in e general healthcare provisions.

Studies by Davis et al., 2020; Ongolly & Bukachi, 2019; Mahiti et al., 2017; Ampin et al., 2021 show that sociocultural determinants are key in defining how people and communities perceive and initiate issues of childbearing or health in general. Cultures define what is considered illness and disease and their causes and provide the approach members take in seeking medication (Brown et al., 2008). The perceptions and response mechanisms overall affect individuals' health and well-being within the community. Equally, the sociocultural factors provide an avenue for understanding the different population and demographic dynamics extant within the societies, such as the varying rates and range of mortality, morbidity, infant and survival (Mahiti et al., 2017; Ganle et al., 2016).

Studies have documented that in most cultures, beliefs and perceptions prevent men from getting involved in ANC and child delivery (Clerk et al., 2020; Audet et al., 2016). The studies documented that most men perceive and see or have been socialized to view maternal care as an area or responsibility for women alone. Men shy away from engaging in such domains with the view that they will be considered weak by their wives and the general community. Therefore, men in African culture consider childbirth and pregnancy to be the sole responsibility of women (Byamugish et al., 2010).

A study by USAID (2014) on Machismo Culture in Nicaragua revealed that some of the men studied were prevented and deterred from getting involved in reproductive and mothers' health by their culture (Machismo Culture) (USAID, 2014). While this is the scenario in many other developing countries, men still hold decision-making powers over their wives and households. Men make key decisions in many aspects of the lives of their families (Dharma, 2013).

With the cultural traditions preventing male engagement in ANC more prevalent in African countries, incorporating male spouses in seeking ANC and child health care programs is more critical for such countries. This is due to the high numbers of HIV and AIDs infections leading to transmissions between mothers and children during pregnancy through the onset of breastfeeding (WHO, 2019; Fleming et al., 2017). The current issue that is rampant in sub-Saharan African countries like Kenya is adolescent or teenage pregnancies which greatly impact the life chances of young girls (Ampin et al., 2021). Some of these teenage pregnancies are associated with high rates of infections leading to further transmission of HIV.

Sociocultural factors such as gender and social norms have strong rooting in many communities. The social norms dictate behaviour and practices around mothers' reproductive health. As such, the limited or low participation of men in activities supporting their spouse during pregnancy, those associated with childbirth as well as those activities of health care support to the mother after delivery is all informed by the extant sociocultural (Kelvin et al., 2013; Debra et al., 2014). Such cultures prescribe mothers 'health and reproductive roles as pure duties of women, and men are shamed from engaging even though women act as agents of supporting men not to participate.

According to Shiyagaya's 2016 study in Namibia, cultural dynamics challenge male engagement in ANC. One of the key cultural issues that can affect men's engagement in ANC is gender roles and expectations. In many Namibian communities, men are traditionally seen as the providers and protectors of their families, while women are expected to take care of domestic duties and childcare. As a result, men may not see ANC as their responsibility and may leave it to the women to handle. Another cultural issue that affects men's engagement in ANC is the stigma surrounding men's participation in reproductive health. In some communities, men may feel embarrassed or

ashamed to attend ANC appointments with their partners. They may be seen as needing to fulfil their traditional role as the protector and provider.

Also, cultural beliefs about pregnancy and childbirth affect men's engagement in ANC. For example, traditional beliefs in some African communities dictate that men should not be present during childbirth, which is a women's issue. This leads to men feeling excluded from the process and not actively involved in pregnancy and childbirth. Another study conducted in Zanzibar by Shuwena (2016) reported that community perception was a key driver of low husband participation in mothers' reproductive health. The study established that the community's perception of masculinity and femininity affected the understanding of who is responsible for childcare and pregnancy. In this case, women were considered the only ones responsible for mothers' duties, and men would, in a few instances, play passive roles Shuwena (2016).

In terms of culture, a study in Malawi documented that women in the country could not openly discuss issues around intimacy as this is considered a precursor to having extra-marital affairs (Kalembo et al., 2013). Women would not disclose or talk about contraceptives, such as the use of condoms or share with people their HIV status since such would be considered acts of women involved in extra affairs (Kalembo et al., 2013).

Another research conducted in Uganda by Debra et al. (2014) established that the level of men's engagement of male spouses in seeking health care associated with reproduction was defined by gender roles and responsibilities. These Gender norms dictate that the 'major role for men is to provide for the family while that of women is to give birth and care for the child/children. The resultant effect is that men have been restrained or very low. Much of men's support was in terms of finances, while the services offered in the antenatal clinics were considered useful to women

only. This led to a high presence of pregnant women who come to seek services alone (WHO, 2019).

Studies (Kululanga et al., 2011; Masaba & Mmusi-Phetoe, 2020; Gathuto, 2014; Nkuoh et al., 2010) have identified social and cultural practices as big drivers of the observed limited numbers of men involved in issues of pregnancy care. Findings from these studies further show that communities have negative beliefs and perceptions about the participation of male partners in the mothers'wellbeing of the mother and in taking care of children's health - rephrase. Masaba and Mmusi-Phetoe (2020) contend that in cases where men who accompanied or escorted their spouses to the Antenatal clinic were viewed as weaklings by their peers. The duo found that men who took their pregnant women to receive care from the antenatal clinics would be termed as less masculine and having been dominated by their wives. This community perception strongly impacts men, limiting their involvement in ANC beyond their decision-making powers.

Audet et al. (2016) findings on the involvement of male spouses in reproductive behaviour observed that men that went with their wives to health facilities during ANC visits were perceived as not good enough men, and they would be embarrassed by their fellow men. The study further documented that ANC services were considered by men as specifically designed for women. Thus, men did not want to find themselves engaging in spaces of women and on issues of women. In addition, Ganle et al. (2016) reported that men in their study perceived ANC services as exclusively for women and that men's engagement is considered an intrusion into the domain of women. Interfere with women's roles. Men in the study revealed that they consider it not useful for men to go to clinics and labour wards as that would amount to competition with women in their reproductive roles (Ampin et al., 2021).

Another study looking at the factors leading to the low male interest in supporting their wives in mothers' health-related matters in the remote parts of Malawi by Kalulanga et al. (2012) revealed that women and men looked at pregnancy as an area predominantly for women. The study further revealed that the socialization processes for men and women were responsible for allocating reproductive other responsibilities. Boys and girls in this context are culturally socialized to believe that mothers'roles, including health-seeking, are the duties of women. The study also showed that even during childbirth, men and boys were not allowed to be present near the women giving birth as that was viewed as a taboo and an abomination. Men are often not allowed anywhere near the labour room during delivery. This was the case for the community members, whether a woman delivered in a formal or informal facility (Ampin et al., 2021). Men would be excluded from engaging in the processes, and sometimes instructions would be given to pregnant mothers not to tolerate their men coming closer to the area where they are giving birth. These beliefs were reported to be held and perpetuated by older women who believed that men's involvement in ANC was shameful and embarrassing. Sometimes, it is considered a traditional foreign belief.

Jealousy also prevents men from actively engaging in ANC clinic visits and activities during childbirth (Ampin et al., 2021; Kululanga et al., 2012; Auvinen et al., 2013). This is because men who accompany their spouses will likely feel bad when other men tenderly touch their pregnant spouses. This was reported among men aged 30 years and above, and they noted that the tender care would be worse, especially during childbirth. Further, in their study, Auvinen et al. (2013) found that some men would not be comfortable when midwives who are of the male gender dealt with their wives with much kindness, and sometimes others would to further rub the backs of the pregnant women. This was noted as one of the reasons men avoided going to the facilities with their partners, and others would prevent their wives from attending ANC services if such acts of

kindness were rendered to them. An obvious impact of such behaviour from men is the limitation of women's access to quality health care on mothers 'needs.

2.4 Socioeconomic Barriers to Men's Participation in ANC

Studies provide that understanding the socioeconomic status of married men and how it is related to their level and nature of participation in ANC is necessary for the drive for the comprehensive health of children and mothers. As key players in the reproductive arena, men must be active participants in the pregnancy of their spouses regardless of their social and economic status. This acknowledgement means socioeconomic issues such as financial challenges and income sources may pose a hindrance and affect participants of men in ANC. In many instances, men are the key breadwinners. They would most likely be engaged in income-generating activities resulting in needing more time to escort their wives to ANC clinics, a good point but poorly articulated. The nature of work that men engage in, such as casual jobs, may present a challenge to their availability for clinic attendance during their spouse's pregnancy. The nature of work in such a setting may not allow an employer to allow absenteeism. As a result, absenteeism may mean that there would be no pay, or sometimes it may result in loss of employment. Loss of pay and employment are deterrents considered to have more devastating effects on the household and thus may not be traded with ANC clinic attendance or childbirth.

Recce et al. (2010), in their study in Western Kenya, found that distance from the health facility was one of the barriers for make involvement in ANC in the regions, including the distance to clinics for them to participate in health education, blood testing and counselling, the time taken during one appointment and the financial costs involved to travel to the clinics. The study findings indicated that men acknowledged that their low or lack of participation in ANC was due to the

challenges related to access and movement. It was construed that clinic visits presented logistical challenges to men.

Reece et al. (2013) in another study established that men were perceived to have a principal responsibility of providing. Thus, trading off between clinic visits and their time in income-generating activities takes time and effort. Such a tradeoff would mean that income for that specific day or time away from work is compromised, thus presenting a barrier to participation in the pregnancy of their spouses and even during childbirth. While some men would attend ANC clinics, the study found that they had challenges with the hours the clinic – clinics operate during work hours making – sometimes men are not able to secure permission from work or work commitments cannot allow them to accompany their spouses' operation as well as transport costs which have an impact on their nature of participation in antenatal clinic visits as men are generally expected to cater for the logistics of attending ANC. Their low-income levels predisposed them to compare putting food on the table and incurring costs considered extra to attend to the education, tests, and counselling in ANC (Reece et al., 2010).

AMREF observed that a hindrance to the level of male engagement in matters related to the antenatal caring domain in the continent of Africa was due to economic and social factors such as sources of livelihood and social status. The overrepresentation of men as casual labourers and other income-generating activities means they have limited time to participate in programs and initiatives that require their time away from their livelihood activities (AMREF, 2013). Among nomadic pastoralists, men are key participants in livestock herding and spend most of their time away from home with livestock in search of pasture and water. Men in informal settlements of Africa are engaged in Juakali and casual labour, characterized as daily wage employment. The study concluded that the sources of livelihood for the majority of men in Africa present a conflict

between securing their household economy and attending to mothers'health and child wellbeing programs (AMREF, 2013). Thus, men have challenges engaging in ANC since they must support their wives logistically to access health facilities while simultaneously providing for their household needs. Because of the low income generated or daily wage, the resources can hardly support the husband and the wife to attend the many ANC clinics.

Similarly, in Malawi, a study by Golden (2011) established that economic variables were considered essential in determining men's involvement in health-related programs, including attending ANC clinics. While the study found that almost all the respondents acknowledged that men had extensive awareness of the need and usefulness of getting involved in the pregnancy of their female partners or spouses, their economic status became a major setback. The study noted that men could not afford to meet the cost of transporting their wives and themselves to the clinic. As a result, many opted to struggle to secure the transport money or means needed for their wives alone to attend the antenatal clinics (Golden, 2011). The little income thus does not allow the household to secure transport for two people for the clinic visits while simultaneously managing to put food on the table or meet other demanding expenses. Thus, the provision and availability of transport is a key economic issue that limits the participation of men in their spouses' pregnancies through ANC clinic visits.

A study in Zanzibar also recorded socioeconomic barriers that prevent male spouses from supporting health-seeking concerning ANC because of other types of care associated with childcare and job commitments, as they were the sole breadwinners for their families. The study also noted that male spouses would be left at home with the other children to care for them as their spouses would visit the ANC clinic alone during pregnancy (Godlove et al., 2010). Another barrier to men's engagement in ANC is the nature of partner communication (WHO, 2019). The study

reports that poor communication between spouses is a key driver of lack of involvement. On the other hand, good communication was highlighted as a contributor to partner positive disclosure resulting in an understanding that breeds support in many matters, including child and mothers' health (AMREF, 2013; WHO, 2019).

Besides the finances required to support spouses and their partners to attend ANC clinics, the cost of services charged for care was highlighted as a major drawback to men's participation and attendance of ANC clinics. The amount of money required to receive services is out of reach for some people resulting in a consensus where the spouses agree that only the wives attend, or sometimes it results in a lack of attendance. This scenario influences the general perception and uptake of services related to ANC and other mothers' and SRH services, including family planning.

2.6 Theoretical Framework

The Social Relations Approach (SRA) is a framework for understanding and analyzing the social dimensions of gender inequality. It was developed by Naila Kabeer, a development economist, in the early 1990s. The SRA argues that gender inequality is not simply a matter of individual differences between men and women, but is also a product of the social relationships that structure society. These social relationships include rules, resources, people, activities, and power. The SRA identifies five key dimensions of social relationships:

- Rules: These are the norms, values, and expectations that govern social interactions. They can be formal (e.g., laws and regulations) or informal (e.g., social norms).
- Resources: These are the material and non-material assets that people have access to. They include things like income, education, land, and social networks.

- People: These are the individuals who participate in social relationships. They have different social positions, which are defined by their gender, class, race, ethnicity, and other factors.
- Activities: These are the things that people do in their everyday lives. They include things like work, childcare, and household chores.
- Power: This is the ability of individuals or groups to influence the behaviour of others. It can be exercised in formal or informal ways.

The SRA argues that these five dimensions of social relationships are interconnected. They work together to create and reproduce gender inequality. For example, rules about gender roles can limit women's access to resources, such as education and employment. This can lead to women having less power than men, which can then limit their ability to participate in activities that are important to them. The SRA has been used to analyze gender inequality in a wide range of contexts, including the workplace, the household, and the community. It has also been used to develop policies and programs to address gender inequality.

The SRA is a powerful tool for understanding and analyzing gender inequality. It can help us to identify the root causes of gender inequality and to develop effective policies and programs to address it.

In addition to the five dimensions of social relationships listed above, the SRA also emphasizes the importance of context. The way that social relationships work to create and reproduce gender inequality can vary depending on the specific context. For example, the rules about gender roles may be different in a rural community than in an urban community. Similarly, the resources that are available to women may be different in a developed country than in a developing country.

The SRA is a dynamic framework that can be used to analyze gender inequality in a variety of contexts. It is a valuable tool for those who are working to promote gender equality.

2.6.1 Relevance of the Theory to Study

The social relations approach provides a comprehensive framework for examining the complexities of male involvement in antenatal care (ANC) within a specific sociocultural context. In the case of Kanduyi Sub-county in Bungoma, this conceptual framework is particularly relevant for investigating the socioeconomic and sociocultural barriers that hinder male participation in ANC. This approach recognizes that social relationships and interactions shape individuals' behaviours, attitudes, and decision-making processes within a given community (Fisher, 2011). By adopting the social relations approach, this study acknowledges that male involvement in ANC is influenced by multifaceted social dynamics, including gender norms, power dynamics, and cultural beliefs.

The social relations approach emphasizes the significance of examining the roles and expectations assigned to men within the community, as well as how these roles intersect with healthcare practices and beliefs (Fisher, 2011). In Kanduyi Sub-county, traditional gender norms may restrict men from actively engaging in ANC due to the perception that reproductive health is primarily a women's domain. This approach allows for an exploration of the social construction of masculinity and its implications on male involvement in ANC. It recognizes that societal expectations and the division of labour based on gender influence men's decisions and behaviours related to healthcare-seeking.

Furthermore, the social relations approach acknowledges the power dynamics within social relationships and how they impact male involvement in ANC. It recognizes that gendered power

dynamics can create barriers for men to actively participate in ANC. These power imbalances might stem from traditional patriarchal systems that prioritize male authority and decision-making within the family unit. In Kanduyi Sub-county, the social relations approach would enable an examination of how power dynamics influence men's ability to make decisions regarding ANC and how they navigate potential conflicts within the family and community.

Lastly, the social relations approach highlights the significance of cultural beliefs and practices within a specific community. It recognizes that cultural values, norms, and beliefs shape individuals' perceptions and behaviours concerning healthcare-seeking practices. In the case of male involvement in ANC in Kanduyi Sub-county, cultural beliefs about masculinity, fatherhood, and the role of men in reproductive health play a crucial role. This approach would allow for an exploration of how cultural beliefs and practices influence men's attitudes, beliefs, and behaviours regarding ANC.

In conclusion, the social relations approach provides a robust conceptual framework for investigating the socioeconomic and sociocultural barriers to male involvement in ANC in Kanduyi Sub-county, Bungoma. By adopting this approach, the study acknowledges the importance of examining social relationships, gender norms, power dynamics, and cultural beliefs within the community. This framework facilitates a comprehensive analysis of the multifaceted factors that influence male participation in ANC, ultimately contributing to a deeper understanding of the barriers and potential strategies for promoting male involvement in maternal healthcare.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter discusses the research approach that was applied to address the study objectives. The discussion includes information on the study's research settings, research design, target population, method of sampling, sample size, and unit of analysis, as well as the methods used for data collection, processing, and analysis. It also includes a discussion of the study's key ethical considerations.

3.2 Research site

According to Figure 3.1 below, the study was carried out in Kanduyi Sub-County, Bungoma County in Western Kenya (see the map below for the locations of the study sites). Bungoma County is roughly 3,032 square kilometers in size and borders Uganda to the northwest, Kakamega County to the east and southeast, Busia County to the west and southwest, and Trans-Nzoia County to the north-east (County ADP, 2020). Bungoma County is divided into nine administrative sub-counties: Bumula, Kandui, Sirisia, Kabuchai, Kimilili, Webuye West, Webuye East, Mt Elgon, and Tongaren. The county seat is located in the Kanduyi Sub-County of the main Bungoma town, which is where the sub-counties end. The aforementioned sub-counties are further divided up into smaller -45-county assembly wards.

According to the 2 019 population census, the county has a population of 1,670.570 people (812, 146 men and 858,389 women) who primarily speak Bukusu, Teso, and Tachoni (KNBS, 2019). According to the 2014 Kenya Demographic Health Survey (KDHS) (KNBS & ICF Macro, 2015)

, the county has a high Neonatal Mortality Rate (NMR) of 32% per 1000 live births, which is hig her than the national average and indicates an increase of 22%.

The traditions that define ties and kinship relations of the communities of Bungoma are patriarchal, where roles are culturally defined along gender lines. From the socialization processes, their communities culturally expect men, women, boys, and girls to act or behave in a particular manner. In this regard, men are not supposed to take part in chores assigned to women. For example, on issues related to pregnancy and childbirth, men are not keen on participation, and as such, they are considered the duties of women. While this is the case, few men or male partners actively participate in all the activities in the process of pregnancy with their spouses (GOK, 2013). Even with the limited involvement of men, many of those who participate are involved during delivery but are generally absent during ANC clinic visits when their spouses are pregnant (GOK,2013).

Bungoma County has 184 health facilities that offer healthcare services to the residents. The facilities include 12 major hospitals, including Bungoma County Hospital, the county's oldest health facility. There are also 17 health centers spread across the county. The county has invested in the level 2 health facilities, which currently stand at 102 dispensaries and over 50 clinics conveniently situated within the county, to support the major hospitals in offering services to residents, including ANC, delivery, and postnatal care, among other services. Furthermore, hospitals in Kanduyi Sub-County also feature the County and Sub-County hospitals that offer basic and comprehensive health services. At the same time, numerous health centers, and dispensaries offer basic services to community members (County ADP, 2020). From level 2, two facilities to level 5, they are all equipped to handle ANC and SRH services.

In the current dispensation, health policy formulation and regulation are the responsibility of the national government through its line ministry. However, in terms of health service planning and delivery, county governments such as Bungoma have the mandate to design and tailor their service delivery approach to meet the needs of their people (MOH, 2019). The county government selected about eight public health hospitals spread across the county to support the initiatives to reduce maternal and neonatal deaths. The selected hospitals have been equipped with facilities to deal with inpatient newborn incidences. The healthcare workers in the facilities have been trained in caring for newborns and mothers' health complications. The facilities have been renovated and equipped with modern facilities, such as diagnostic machines in the newborn units. Some of these facilities include two county-level hospitals in Webuye and Bungoma and six other sub-county hospitals in Chwele, Bumula, Kimilili, Mt Elgon, Sirisia and Naitiri (MoH, 2019). In 2013, maternity services, through the Free Maternity Service (FMS) policy, abolished all fees charged for maternity services in public health facilities.

Figure 3. 1: Map showing the study site

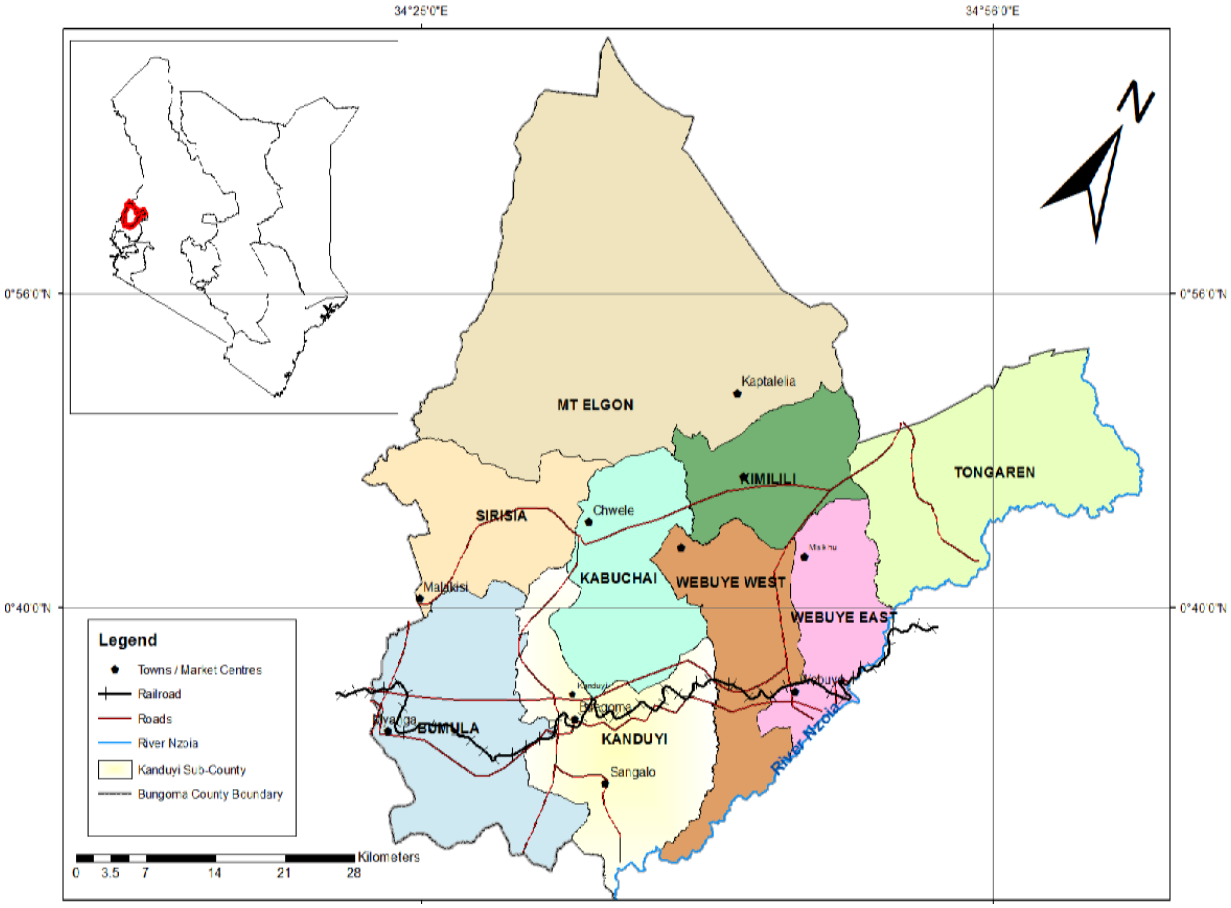

Figure 1: Map of Bungoma County. Source: Obiri (2013)

3.3 Research design

The study used a cross-sectional descriptive research design. The study's design made it possible to comprehend the obstacles preventing male engagement in antenatal care. The focus group discussions and in-depth interviews with married men who had fathered at least one kid and were residing in the study area were done in accordance with the research objectives and used qualitative data collection approaches, such as open-ended questions. Key informant interviews with experts in the field were used to gather complementary qualitative data.

KIIs are necessary for qualitative research because they provide rich and detailed data that can help researchers gain a deeper understanding of the phenomenon under study. According to Patton (2015), KIIs can be particularly useful when the topic of interest is complex, and when the perspectives of different stakeholders need to be taken into account.

KIIs are also valuable because they allow researchers to access information that may not be available through other sources, such as documents or surveys. As Creswell (2014) notes, KIIs can provide insights into the experiences, beliefs, and attitudes of individuals, as well as the context in which they operate. Furthermore, KIIs can help researchers identify themes or patterns in the data that may not have been apparent otherwise. According to Morse (2015), KIIs can be used to generate hypotheses or theories about a phenomenon, which can then be tested through further research.

3.4 Sample Population and Unit of Analysis

In this study, the sample population or sampling universe comprised all married men or men in cohabitation relationships who had sired at least one child. The targeted men were aged 18 years and above and living in the Bukembe Ward of Kanduyi Sub-County as residents. The unit of analysis was an individual married or cohabiting man who had sired at least one child and was living in Bukembe Ward in Kanduyi Sub-County in Bungoma County.

3.5 Sample Size and Sampling Procedure

A sample of 20 married or cohabiting men who had at least one child was used in the study. The participants in the study were purposefully chosen from among the responses. With the aid of community health volunteers and village elders in the research region, the married or cohabiting men who had fathered a child were located. The researcher believed that with 20 respondents, no

new information was likely to be revealed by the additional respondents based on the saturation principle. Potential participants were informed about the research endeavour and their rights during participation before being included in the sample. The sample only contained those who gave their permission. As convenient sampling was used in the study, the researcher stopped recruiting when she had attracted 20 participants. The sample size was settled on based the principle of saturation. The researcher believed that no new information would be produced even if more interviews were done.

3.6 Data collection methods

3.6.1 In-depth Interviews

This study's primary data collection method was in-depth interviews (IDIs). Creswell (2009) explains that in-depth interviews can generate more insights from the study participants as they allow room for participants to provide information in their voices and words more freely. With the aid of an in-depth interview guide, the data collected under or through this method included socioeconomic and sociocultural barriers to male engagement in ANC in Bukembe Ward in Kanduyi Sub-County. The guide was divided into three sections: The first section captured the demographic profiles of the study respondents. The second documented information on socioeconomic barriers to men's involvement in ANC, while the third part documented the sociocultural barriers to men’s involvement in ANC.

The interviews were conducted with individual married men who had sired at least one child. The respondents were reached in their homes, and interviews were conducted outside their houses but away from other family members in cases where family members were present during the study. The interviews were conducted in the language the respondents were most comfortable with, such

as Kiswahili and Lubukusu. Those who did not speak Lubukusu were interviewed in Swahili (4). Since the researcher needed to improve in the local language, local research assistants supported her in conducting the interviews in the local language. Overall, one research assistant was engaged in this study. He was trained on both ethical standards of research and study tools. Whom she trained in qualitative research and data collection. With permission from the study respondents, the interviews were audio-recorded for later transcription.

Further, detailed notes were also taken by the research assistants and the researcher after gaining permission from the study respondents. On average, the interviews lasted 30 minutes each. The interviews took place between June and July of 2022.

3.6.2 Focus Group Discussion

A focus group discussion (FGD) is a group of people gathered from similar backgrounds or experiences to discuss an area of interest to them. FGDs are moderated by a facilitator who guides the discussion and a note-taker who takes detailed notes of the proceedings. FGDs are essential in qualitative research because they provide a platform for participants to share their experiences, perceptions, and attitudes towards a particular topic. According to Krueger and Casey (2015), FGDs are a useful data collection technique because they allow researchers to explore participants' beliefs, values, and attitudes in a group setting.

Additionally, FGDs provide a rich source of data that can be used to generate new hypotheses or theories. As noted by Morgan (2018), FGDs can help researchers identify themes, patterns, and relationships within a particular population. Moreover, FGDs offer an opportunity to collect data from a diverse group of participants, which can enhance the validity and reliability of the findings.

According to Kitzinger (2014), FGDs can provide insights into the cultural, social, and historical context of a particular phenomenon.

For this study, four (4) FGDs were conducted with married men purposively selected from the target population. Each group consisted of 10 married men who had sired or not sired, and every effort was taken to ensure that these men were in marriages or cohabiting relationships and had sired at least one child. The discussions took an average of one hour. The FGDs focus captured as much detail as possible on the sociocultural and socioeconomic barriers to supplement data obtained from the in-depth interviews. A few who participated in the IDIs were also asked to participate in the FGDs. These discussions helped gain consensus on sociocultural and socioeconomic barriers to men's participation in ANC in the study area. The FGD had a different guide with some questions similar to those asked in the IDIs for triangulation.

The researcher facilitated the group discussions while the research assistants took notes. The discussions were conducted in Kiswahili. In cases where discussions were held in the local language (Bukusu), this was facilitated by a note-taker who was well-trained by the researcher in conducting group interviews and translations during qualitative research. The researcher ensured that before recording the discussions using audio tape recorders and note-taking, the discussants had given their consent.

3.6.3 Key Informant Interviews (KIIs)

Key informants who had in-depth information and experience about the nature of men's engagement in ANC, namely the societal and socioeconomic hurdles limiting men's participation, were interviewed. Six key informants in total, including a community health worker, a social worker, a nurse, a doctor from the ANC clinic, a traditional birth attendant, a representative from

the county department of health, and an officer from a local NGO/CBO working on maternal reproductive health issues, were interviewed for this study.

Since the informants were selected based on their knowledgeability, they shared their views on critical barriers to men's involvement in ANC in the study area through a social, cultural, and economic lens. Data collection was facilitated using a key informant interview guide in the annex. The purpose of the KIIs was to help triangulate the information.

3.6.4. Secondary Sources

Key secondary materials such as books, journal publications, websites, and reports on barriers to men's engagement in ANC have been consulted in conceptualizing this research and developing a research proposal. These sources have been used continuously to strengthen the research paper enriching the research findings and filling some gaps in areas that primary qualitative data could not capture.

3.7 Data Processing and Analysis

Given that the majority of the interviews were conducted in Lubukusu and Kiswahili, the information from the IDIs, FGDs, and KIIs was translated into English after the fieldwork. Interviews that were recorded on tape were verbatim transcribed in the original tongue before being translated into English. The clarity and coherence of the transcripts were then examined. Before writing the write-up, the transcripts were meticulously analyzed to identify themes. Contextual and thematic analysis were used for data analysis. This strategy was also used to display the results of the study during reporting.

In the presentation of the findings, the emerging themes from the research have been presented, interpreted, and discussed concerning other earlier similar studies to provide an understanding of the participants' social world and how they construct meaning. The transcripts were managed in NVivo software, where coding and preliminary analysis were conducted. To ensure the data was comprehensively analyzed, necessary narrative descriptions and explanations were employed. In addition, verbatim quotations have been used to present the findings as evidence and to bring the live voices of the study participants into the report.

3.8 Ethical Considerations

As a requirement, the researcher presented the research project proposal to the Department of Anthropology, Gender, and African Studies (DAGAS) of the University of Nairobi through a proposal defense seminar attended by staff and students. Upon approval, a research permit from the National Commission for Science, Technology, and Innovation (NACOSTI) was sought for the researcher (refer to appendix **NACOSTI/P/22/16607**). Once granted, the study also sought additional permission and approvals from the Ministry of Education and Health in the County of Bungoma and the Office of the County Commissioner to be cleared before beginning fieldwork. While in the field, the researcher paid courtesy calls to the local administration to notify them of her presence in the areas and the purpose of the research as part of the community entry strategy.

The study observed key ethical considerations during and after data collection, such as informed consent, confidentiality, and anonymity. This was done by ensuring that no personally identifiable information was collected, and in cases where it was unavoidable, the names were removed from the transcripts and replaced by pseudonyms. On informed consent, the researcher provided full information to the potential study participants on the purpose of the study, the benefits and risks

of their participation, and how the data collected would be used. The information provided under consent included their voluntary participation and their right to withdraw from the study at any time without consequences. The researcher gave potential participants time to seek clarification on some of the unclear issues. As required, the researcher addressed all the concerns of the potential study participants. After this detailed provision of information, only those who gave consent verbally were recruited to participate in the study. Informed consent forms were also shared with the study participants, where they could read the information contained and sign.

Regarding confidentiality, the researcher was well-trained in research ethics, including full disclosure to reduce harm to the study respondents. The data was recorded using notebooks and audio recorders, which were transferred and stored in a password-protected folder on the researcher's computer. This limited access to the information by other people other than the researcher. The results of this study have only been used for academic purposes and not for any other purpose. Further, the researcher ensured that all interviews were held in private and secluded places away from intruders or non-participants.

To ensure the potential participants' anonymity, the researcher removed all personal identifying information, such as names and addresses, from the data sets. The researcher used non-identifiers in reporting the findings in a general way that ensured the participants would never be identifiable. Findings generated from this study will be availed at the University of Nairobi Library in the form of a master's thesis and the county government Department of Education and health services. The researcher will also try to disseminate the findings to the study respondents in adhering to the dissemination and participation consideration. The researcher will also try to share the results of this study with the scientific community through a journal publication.

CHAPTER FOUR

BARRIERS TO MEN'S PARTICIPATION IN ANC

4.1. Introduction

The findings of this study, whose major objective was to investigate the obstacles to male ANC participation in the Kanduyi Sub-County in Bungoma County in Western Kenya, are presented in this chapter. A) to investigate sociocultural and b) socioeconomic impediments to male engagement in ANC were the study's specific aims. The demographic information about the study participants is presented in the first section. The sociocultural and socioeconomic factors that prevent men from engaging in ANC are discussed in the second section. The socioeconomic factors are discussed last.

4.2. Socio-demographic Characteristics of the Respondents

This section presents the socio-demographic characteristics of the participants. These characteristics are important as they help show the wider social context in which the phenomenon under observation operates. The socio-demographic variables investigated in this study were age, source of livelihood, type of marriage, and religion of the participants.

Age was measured based on the respondent's last birthday. This standard approach was taken to ensure uniformity in the reporting of the current age.

Table 1 below gives a summary of the age distribution among the respondents.

Age-Group (n=20)	Count	Percentage
18-25	3	15.8%
26-35	9	47.4%
36-45	4	21.1%
46-55	3	15.8%
56+	1	5.3%

Table 1: Age distribution of the respondents.

In this study, the age of the respondents was critical in understanding the age group at which men are likely or provide the most support to their wives during pregnancy. Studies (Guspianto et al., 2022) have shown that men of a certain age are more likely to accompany their spouses to ANC than younger age groups. The age of the men was a key determinant of participation and mediated the way other social, cultural, and economic factors influenced men's involvement in their wives' pregnancies. Some studies conducted before also present a similar scenario where younger men or male partners were seen to be more likely to attend the ANC clinics with their wives (Guspianto et al., 2022). Others also present mixed and contrary findings on the age of the male partners and their level of participation in maternal and child's health. Similarly, a study in Malawi found that older married men rarely discussed reproductive health issues with their wives. In contrast, married men under 25 years were more open to discussing issues around reproduction with their wives, hence actively getting involved in ANC and other mother and child's health activities/ services (Nchimunya, 2015).

Type of marriage	Count	Percentage
Monogamous	14	70%
Polygamous	6	30%

Table 2: Type of Marriage of the respondents.

The study investigated the type of marriage the respondents were involved in. Table 2 above the distributions by type of marriage of the respondents. This was intended to answer the question of whether being in a monogamous or polygamous marriage in any way influenced men's perception towards ANC. The views of men in monogamous and polygamous marriages varied on the needs and level of support offered to their spouses during pregnancy and perceptions about the sociocultural barriers preventing their participation. Almost all men/ respondents in polygamous marriages viewed pregnancy as a responsibility of women and noted that husband participation was not very important. The type of marriage was an important factor to investigate as polygamous men may face obstacles such as jealousy among the co-wives and absence from the homestead during ANC.

Type of religion	Count		Percentage
Christian	Pentecostal	12	60%
	Non-Pentecostal	4	20%
	Others	2	10%
Muslim		2	10%

Table 3: Respondent' Distribution by Religion

According to the study's findings, the respondents practice a variety of religions, with Christianity being the one that predominates in the region. As a result, the majority (18) of respondents said they were Christians, while only two (2) said they were Muslims. Further investigation into

religion revealed that there were other Christian religions, including Catholicism and Pentecostalism. This distribution is summarized in Table 3 above.

Studies have also shown that one's level of education has a bearing on how one views ANC and pregnancy in general, as it is correlated with the level of knowledge. Generally, studies (Guspianto et al., 2022) show that men with high knowledge about ANC and pregnancy, in general, are more likely to partake in ANC. Table 4 below shows this distribution.

Level of Education	Count	Percentage
Primary	7	35%
Secondary	10	50%
Tertiary	3	15%

Table 4: Respondents' distribution by the level of education

Livelihood activity is an economic variable that has a bearing on the men's participation in the pregnancy of their spouses. Livelihood activities shape the time available for men to participate in ANC. This was used as a socioeconomic indicator. Sources of livelihood also define the household or husband's socioeconomic status with ramifications on their level of involvement in ANC, as discussed in the next section. The demand for labour and time from the different sources of livelihood acts as a barrier to men’s engagement in ANC. From the findings, respondents involved in casual labour and businesses as their livelihood activity may need more time to support their wives on mothers’ health issues and, more specifically, on ANC.

Type of livelihood	Count	Percentage
Farming	11	55%
Business	3	15%

Casual labour	4	20%
Wage employment	2	10%

Table 5: Livelihood distribution among the respondents.

In addition, working places act as meeting places where some values are reinforced, and members who do not conform to this line face the risk of negative sanctions such as being dis-communicated from the social groups

4.3. Sociocultural Barriers to Men's Engagement in ANC

This section attempts to answer the first research question, "What are the sociocultural barriers to male engagement in ante-natal care in Kanduyi Sub-County." Sociocultural dynamics shape and define how people behave, what they believe in, and what they do or not do. In this study, sociocultural factors have a significant bearing on the practices that involve women's pregnancy and childcare. While some men are receptive to men's engagement in ANC, some are reluctant. These sociocultural barriers are discussed in detail and presented under the themes below.

4.3.1. Social and peer networks

Data from the IDIs indicate that men in similar social groups share world worldviews that may influence them to think similarly. These groups range from age groups based on rites of passage to livelihood groups where men converge to generate a source of income. These groups normally act as places of discussion on all family matters, including ANC. Peer and social networks strongly influence men's participation level in mothers'health, specifically during their wives' pregnancies. The married men must conform to the ideals and values of the social networks, which influence shaping the belief system of these group men on matters associated with mothers'health.

"We are men and pregnancy is a women's issue. We don't have to involve ourselves in that process…... As circumcised men, when your fellow men see you taking your wife to the clinic during pregnancy, they will laugh at you."

(FGD#1 Husband 34 years old).

"The fact that some men participate in those clinics can't be the reason why I would start attending them with my wife. do such. How will I face my peers telling them how I usually take my wife to the antenatal clinic… many other people in the family can give her that support" ***(IDI#11 Husband 41 years old).***

"How will my age mates or even those who are young see me…they may think that I am not man enough because that is not what is culturally expected of me. some may even refuse to associate with me because of the thinking that my wife controls me or has become more powerful than me at home..." ***(FGD#1 Husband 29 years old).***

Therefore, men escorting or accompanying their spouses to ANC may be influenced by how members of the groups, normally age-mates or workmates. The respondents stated that their lack of participation in ANC was because they needed to conform with what their peers and age mates in their social networks approved of how to conduct themselves. The group's code of conduct is deemed masculine behaviour and shapes the level of involvement of men in mothers'health, who, in turn, also socialize their sons to this code of conduct. Therefore, with the fear of being ridiculed by their peers, these men would rather save themselves the shame by not attending the ANC with their spouses.

These sentiments were shared across both IDIs and KIIs.

"It's the men themselves who tell each other or lie to each other not to be involved in ANC even when they have been asked to be accompanied by their spouses to the health facilities. Men discourage each other arguing that accompanying their partners to an ANC facility is a sign of weakness. If they attend ANC, they will be considered weak by their peers. This scenario has made men by large shy away from the clinics in addition to other factors" ***(KII#3 Health Worker).***

Thus, the study shows that the opinions of peers or other men in the social groups greatly influence the male partners' perspectives and decisions about supporting and attending ANC services with their wives. The group peers ridicule and demean or look down upon those engaging in antenatal

clinics. This demonstrates how peer groups and a circle of friends shape the behaviour and attitudes about mothers'health. These findings illustrated the real-life experiences of men as informed by their social world. Men who escort/accompany their wives to clinics for ANC services are considered not men enough. The risk of losing one's social capital and network because of clinic visits concerns married men.

Therefore, when invited to engage in ANC, male partners who have been influenced by their peers try to uphold their manly roles by staying away from mothers'health care in general and, more specifically, ANC, which they traditionally thought belonged to women. Men's masculine power and control would be tacitly given up if they agreed to accompany their spouses to the maternity clinics in response to the demands of their female companions.

> *"wee, me staki kupoteza mabeshte juu ya bibi. Wataniona ka nimekaliwa na unajua mwanaume lazima angurume kwa nyumba. (I do not want to lose friends because of my wife. They will see me as someone manipulated by the wife, and as you know, a man must roar in the house.)* ***[IDI 10- husband, 38 years]***

Such men are perceived as being dominated by their wives and hence have no say among their peers.

These findings are not unique to this study but have been recorded in previous studies. Ampin et al. (2021) found that the opinions of male partners' friends about ANC were key aspects that shaped their attitudes and decision-making regarding ANC attendance. Similarly, Brown et al. (2008) recorded that the male network was a key sociocultural barrier to their participation in ANC and PNC in Malawi. They recorded that male and female study participants noted that the influence of male social groups prescribed the desired behaviour and attitude that shaped how men responded to issues associated with ANC and PNC attendance. Fear of negative sanctions plays an integral role in men's engagement in ANC.

4.3.2. Gender norms

Gender norms shape and define a man and a woman and their identities in the community (Ampt et al., 2015). The sociocultural norms have a long-standing and strong rooting in many communities in Kenya, with significant influence on the community members' social and cultural beliefs and practices. The norms serve as pillars that maintain and sustain the social and cultural undertakings of the community members (Mekonen et al., 2022). Gender norms dictate the allocation of roles and responsibilities of men and women, including roles and responsibilities associated with mothers'health, sexuality, and reproduction. Gender norms shape the beliefs, behaviours and practices around mothers'health and reproductive health (Kaye et al., 2014). These gender norms manifesting in gender roles and responsibilities influence the level of male partners' participation in their wives' pregnancies.

The men who participated in this study stated that ANC was traditionally a space restricted to women. Married men in this context believe that roles and duties associated with pregnancies and childcare are purely roles of women.

> *"Here we know that issues around mothers'health care for women and that is how our culture here has been. We can't change it now…. we are men and therefore we don't get involved in activities such as taking our women to clinics"* ***(IDI# 7 Husband 42 years old).***
>
> *"as a man I cannot be involved in ANC matters because my wife has other women who are suited to support her during that period of pregnancy"* ***(FGD#2 Husband 34 years old).***
>
> *"You know we all have our roles and duties that we dispense. Childcare and visits to the clinics are all responsivities designated for women because men have other responsibilities like food provision that we get involved in"* ***(IDI# 16 Husband 50 years old).***

Male engagement in mothers' health issues and supporting their wives during antenatal clinic attendance is often viewed as deviant or out of the norm. In the study setting, activities associated

with mothers' health, such as antenatal and postnatal clinic visits, are perceived as women's roles. Thus, the participation of men is viewed as unusual, limiting men's involvement.

The study respondents noted that their participation in ANC is defined and shaped by their community gender roles. These norms relegated duties on mothers' health as a responsibility of women. However, some respondents noted that they would sometimes, under very difficult conditions, go against these norms and escort their wives to the clinics.

> *"I have tried my best not to be involved in such matters but sometimes I have no choice but to take her to the clinic when the date of visit is due, and the health facility wants us to be present for them to receive services"* ***(IDI#1 Husband 27 years).***
>
> *"……sometimes when she is unwell or when my mother and other in-laws are not around to escort her to the clinic then I am forced to attend or accompany her to the health facility….and even when you go there is nothing that you will do there as a man"* ***(FGD#2 Husband 45 years old).***

These include circumstances when their pregnant wives are unwell and cannot take themselves to the hospitals, when there is no female member in the household to escort their pregnant wife to the clinic and when the clinic or health facilities insist that the women can only be given services when they attend the clinic with their spouses.

The findings were confirmed by some key informants who noted that gender norms strongly influenced the participation level of the married in their spouses' ANC clinic attendance. One of the key informants had this to say.

> *"The gender norms have a strong influence on the level of participation of men in the pregnancy of their wives because men believe that roles related to mothers'health such as ANC and PNC are duties of women…they are the ones who make their wives pregnant but when they are required to support these women during the period of the pregnancy they distance themselves because they see that as a role of woman…."* ***(KII# NGO Official).***

Thus, gender norms reveal that ANC is considered a space for women, in which case men are considered trespassers (Guspianto et al., 2022). The gender norms present the belief that only

women should attend ANC. The sociocultural norms perceive ANC as a highly gendered field where men are considered brad winners. At the same time, women, on the other hand, are assigned the responsibility of pregnancy and childbearing.

The findings of this study are similar to or confirm those of Kelvin et al. (2013), who established that cultures prescribe mothers' health and reproductive roles are purely duties of women and men are shamed from engaging, and even women themselves act as agents of supporting men not to participate. In the same vein, Shiyagaya (2016), in his study in Namibia, found that cultural dynamics present challenges to male engagement in ANC. Shuwena's (2016) study in Zanzibar also reported that community perception was a key driver of low husband participation in mothers' reproductive health. The current study established that the community's perception amount masculinity and femininity affected the understanding of who is responsible for childcare and pregnancy. Hence. Women have been considered the only ones responsible for mothers' duties, and men would play passive roles in a few instances.

4.3.3. Socialization process

Socialization in the African culture presents the channel through which people internalize the community norms, beliefs, and practices. These practices have an overall effect on how men, women, boys, and girls participate in various activities within the community. The socialization process can be termed the engine that drives belief systems into boys and girls, who exhibit the learned beliefs when they become men and women in the community. As such, in this study, married men exhibited the outcome of their socialization process as a factor limiting their participation in ANC and mothers'health in general. Men are taught about allocating responsibilities, including mothers'and reproductive responsibilities.

Findings show that men were socialized to believe that maternity and reproductive health are solely for women. This has greatly impacted married men as they dispense the knowledge learned at an early age in life. Men in the study setting consider issues associated with ANC clinic visits and childcare as women's duties, exemplified in the following quotes.

> *"…and it is not us refusing to participate in mothers'health issues, but it is a result of our processes of socialization. We were taught as young boys that our place and duties are in physical work of fending for the family and duties associated with childcare and mothers'health are responsibilities of women and girls"* ***(FGD#1 Husband 43 years old).***
>
> *"That is the way we were trained. We are men and we must behave like men. Women and girls have their roles, and we have our roles too. The role of taking children to clinics and going to the clinic during pregnancy and childbirth are all activities assigned to women by our culture. I believe this is the case in many other cultures in the country"* ***(IDI#20 Husband 37 years old).***
>
> *"Here we are not allowed even to participate in activities related to childcare and childbirth. When my wife is giving birth, my mother will even chase me away be it in the hospital or at home…our culture of socialization considers the roles associated with ANC as duties of women. Men's appearance and involvement in such roles are considered an abomination and many participants are shamed for that kind of act"* ***(FGD#2 Husband 40 years old).***
>
> *"During initiation into adulthood, we are taught as young boys that mothers'and reproductive health roles are roles of women and our participation in those roles would only mean that we are weak men"* ***(IDI# 14 Husband 30 years old).***

The study revealed that the socialization process where boys and girls were taught how to become men and women, respectively, provided an opportunity for understanding and internalizing roles associated with SRH or reproduction. The effect is the low participation of men in ANC. One key informant supported these sentiments by saying:

> *"Socialization process in this community is a key factor that influences the level of participation of men in ANC. When boys in the community are socialized to believe that the roles and duties of mothers'health are duties of women supported by girls, they grow to understand that and even when they are married, they also don't participate based on what they were taught. They also teach their children the same thing as far as mothers'roles are concerned"* ***(KII#2 Health Worker).***

Thus, the study results show that in the study area socialization process serves as a factor limiting the involvement of married men in the pregnancy of their wives and other mothers'health-related matters. It can be deduced that boys and girls are culturally socialized to understand that roles associated with childbirth, pregnancy and other mothers'health duties are responsibilities of women. In this manner, men are socially segregated from engaging in clinic visits during their wives' pregnancies. In cases where men support their women during pregnancy and even childbirth, such men are considered to have adopted foreign or abnormal/obnoxious behaviour. They are shamed for that kind of act by their peers. The status quo remains that roles around mothers'health are allocated to women.

In agreeing with the results of this study, Kalulanga et al. (2012), conducting a study in Malawi, revealed that there was low male interest and participation in ANC because of the socialization process that trained men that roles in mothers'and reproductive health are duties of women. The study further revealed that the socialization processes for men and women were responsible for allocating or defining reproductive and mothers'responsibilities. According to Kalulanga et al. (2012), during childbirth, men and boys were not allowed to be present near the women giving birth as that was viewed as a taboo and an abomination. Men would not be allowed anywhere near the labour room during delivery.

Another study by Ampin et al. (2021) also provided similar findings. The study recorded that in cases where a woman delivers in a formal or informal facility, men would be excluded from engaging in the process, and sometimes instructions would be given to pregnant mothers not to tolerate their men coming closer to the area where they are giving birth. These beliefs were reported to be held and perpetuated by older women who believed that men's involvement in ANC was shameful and embarrassing.

4.3.4. Stigmatization

Stigmatization of men threatens their masculinity. Most of the time, they will try to dissociate themselves from activities that will put them in a situation where their masculinity is questioned by their fellow men and other community members. To overcome this ridicule and mockery, these men try their best to avoid it. This is because communities have negative beliefs and perceptions about the participation of male partners in the mothers'well-being of the mother as well as in taking care of the health of children. In many communities, men who actively get involved in roles associated with mothers' reproductive health, such as accompanying women to the clinic during pregnancy, childbirth and postnatal clinic, are shamed and considered to be good enough men leading to low levels of male engagement, as witnessed in the study area.

The study shows that married men avoided accompanying their spouses to clinics during pregnancy because of the stigma associated with it. When men are seen accompanying their wives to ANC clinics, carrying children and sitting with other women in the clinics as they await to be attended to, is perceived negatively by the community members? In such cases, the men who take part in pregnancy-related clinic visits are considered to have taken up women's roles and are perceived as women. The following voices present the situation as perceived.

> *"….the way people will look at and talk badly about you will make you hate why you got involved in the visit to the clinic with your wife"* ***(IDI#7 Husband 28 years old).***
>
> *"We have made it a habit or practice here that when we see other men taking their wives to clinics they become the talk of the town. the people who will start talking and shaming you as a man are the women whom we are supporting during this critical period"* ***(FGD#2 Husband 34 years old).***

The results indicate that the fear of being perceived as a weak man and his masculinity questioned is a key factor limiting men from taking their wives to health facilities for ANC clinic visits. The

key informants also corroborated the findings from the individual and group discussions that stigma was one of the drivers of low men's engagement in ANC. One key informant asserted as follows:

> *"The fear that you will be ridiculed and shamed by both men and women in the community on why you are competing with women in their spaces is what led us to this kind of scenario. Some men would wish to be involved in the visits to the clinic, but the risk involved is what deters them When a husband and a pregnant wife visit the clinic, he may find it difficult to interact with the crowd of women that he may find at the facility. When such as man is seen by other men they will associate him with femininity and women's behaviours…. thus men fear these kinds of the stigma that tests their masculinity and status as strong men in the community"* ***(KII# 1 Community leader).***

Thus, this study shows that men would rather not participate in ANC activities to protect their masculinity or to evade stigma. Activities around ANC services, such as sitting in groups of women, enhance the risk of stigma and their status as fellow men and other community members are questioning me. Men avoid taking their spouses to ANC clinics because they do not want to face the embarrassment of their involvement. These results agree with the Health Belief Model on self-efficacy and dwell on beliefs that the married men held about their ability and capacity to adopt new health behaviour models in their community and risk stigmatization (Rosenstock et al., 1988; Champion & Skinner, 2008). This means that the men had the confidence and the ability to act on new health behaviours suggested to them but could not successfully practice them because of the risk it presented to their status and masculinity.

From the findings, the married men realized or manifested self-efficacy when their perceived barriers or threats were more and outweighed the perceived benefits of adopting new health-related behaviour (Champion & Skinner, 2008). As such, self-efficacy presents that married men in this study can and will only adopt or decide to take up new health behaviours only with the belief that they would successfully do so. Earlier studies on the barriers to male engagement in ANC also

recorded similar findings. A study by Masaba and Mmusi-Phetoe (2020) reported that men who supported and escorted their spouses to health facilities to receive ANC were viewed as weak by their peers, leading to stigmatization. The results showed that men who took their pregnant women to receive care from the antenatal clinics would be termed as less masculine and dominated by their wives. This community perception strongly impacts men, limiting their involvement in ANC.

Another study by Audet et al. (2016) also recorded the same results. The study indicated that men who went with their wives to health facilities during ANC visits were perceived as not good enough men, and they would be embarrassed by their fellow men. The study further documented that ANC services were considered by men as specifically designed for women, and thus, men wanted to avoid finding themselves engaging in spaces of women and on issues of women.

The study shows that sociocultural barriers are key in defining how people and communities perceive and how a response is initiated. The social and cultural norms define what is considered illness and disease; pregnancy and childbirth are not by any chance illness, including care for the unborn that may require similar visits to health facilities as well as their causes and provide the approach that members take in seeking medication (Brown et al., 2008). The perceptions and response mechanisms overall affect individuals' health and well-being within the community. Equally, the sociocultural factors provide an avenue for understanding the different population and demographic dynamics extant within the societies, such as the varying rates and range of mortality, morbidity, infant and survival (Davis et al., 2020; Ongolly & Bukachi, 2019).

4.4. Socioeconomic Barriers to Men's Engagement in ANC

This section answers the second research question, "What are the socioeconomic barriers to male engagement in ante-natal care in Kanduyi Sub-County." Socioeconomic factors occur mostly at the household level and pose a great threat to the participation of men in ANC and other mothers' health-related activities. Socioeconomic barriers are both direct and indirect, where direct costs as associated with out-of-pocket costs such as those incurred to receive ANC services, while indirect costs are associated with the time or opportunity cost involved in the attendance of ANC clinics. These barriers influence men's involvement in different dimensions, as discussed in the sub-themes below, and they include costs associated with ANC services, livelihood/economic activities, and knowledgeability.

4.4.1. Livelihood activities

In this study, findings indicate that married men were engaged in different sources of livelihood and income generation that required their maximum participation daily to secure an income or food for the family. Respondents noted that they engaged in income-generating activities such as farming, businesses, casual labour, informal economy jobs and wage employment, all of which required their presence at work. These jobs are casual, meaning that if one is absent, they would not be paid on that day. Thus, many men leave their wives to attend ANC clinics while seeking to secure income for the household. Some of the respondents projected their views in the following quotations.

> *"…then we must agree that she goes alone to the clinic as I got to look for work and get money for our children to have food. If I decide to go with her, then that day we may have to go without food"* ***(IDI#11 Husband 26 years old).***

> *"I am a Boda Boda rider and I am supposed to give my boss some money from the business every day so I have to work up very early in the morning to ensure that I get enough for my family and what I will even pay my boss…so there is no time to go and sit in the lines*

in the clinic because you are taking your wife for ANC services" ***(IDI#17 Husband 43 years old).***

"Our income comes from working for people on their farms and other casual jobs that are available from time to time. So, during the times when she is pregnant, she can't be doing this job anymore, so I am left to do it alone. Where will I get the time to again take her to the clinic when getting food itself is a problem.... for me to get better income I must start the work early and come back late" ***(FGD#1 Husband 48 years old).***

The nature of the income-generating and livelihood activities provided daily income for family sustenance where the men had no time for healthcare seeking. Those who worked in the informal settlement noted that their absence from work meant that there would be no pay for that day. In contrast, others employed on monthly salaries indicated that when they missed going to work, their salaries would be deducted at the end of the month. Consider the voices below.

"In my place of work, you only have one day off which is a Sunday and you see on such days there are no ANC clinics. If I miss going to work on any of the other days, then my salary will be deducted at the end of the month" ***(IDI#9 Husband 35 years old).***

"I am a Juakali person so If I don't go to work there will be no pay for that day…. we are paid daily but if you miss work then you can't claim any money….but also if you miss work you may lose the opportunity to work there because they will for someone who will be doing the job that I was doing. So, we have no option but to go to work and just let the women go to the hospital by themselves" ***(FGD#2 38 Husband years old).***

This idea was supported by key informants who noted that the nature of sources of livelihood in the study area played a key role in dissuading men from accompanying their wives to the ANC clinic. The demand for their time securing income for the households and attending ANC clinics are provided in the sentiments below.

"One of the great challenges that married deal with here is the balance between going to look for work and going to the hospital. The sources of income in this area are demanding since most of them are working as casuals, some in the factory and others in town. These jobs require the presence of these men daily. Absence is such cases are treated as disciplinary issues where some get fired or see a reduction in their remuneration……so it is a difficult situation, and they rarely find time to go to the clinics with their partners" ***(KII#3 NGO Official).***

> *"The time they spend in the clinic is what discourages many of them from going there. Their job is demanding and time-consuming so taking more time in the hospitals as they wait to receive the services makes them choose to go to work"* ***(KII#4 County Official).***

Thus, the results show that livelihood activities were a barrier that hindered the decision of married men to escort their wives to receive ANC services. Livelihood activities are time demanding, requiring the men's daily participation, hence lacking time to participate in ANC clinics. The time spent to generate income to sustain the household is considered important compared to the time required to take their wives to the ANC clinics. The nature of work that men engage in, such as casual jobs, may present a challenge to their availability for clinic attendance during their spouse's pregnancy. The nature of work in such a setting may not allow an employer to compromise or allow absenteeism. As a result, absenteeism may mean that there would be no pay, or sometimes it may result in loss of employment. Lack of pay and loss of employment are considered to have more devastating effects on the household, which the study participants noted could not be traded with attending an ANC clinic.

In addition, the study shows that time spent in the ANC clinic is considered non-productive or waste as it can be used to generate income for families.

> *"…if we both go to the hospital, what will we eat in the evening? Our traditions dictate that women accompany other women to health facilities while men look for food."* **IDI 9, Husband-35years**

Hence, the need to earn income to support their livelihood was a key barrier to male engagement in ANC. These findings have been echoed in other studies. For instance, a study by Byamugisha et al. (2012) in Uganda established that men are the key economic pillars or breadwinners. As such, the entire household depended on them, and therefore, they would not afford the time to accompany their spouses to antenatal clinics. Another study by Recce et al. (2010) in Western

Kenya among men engaged in various livelihood sources also recorded similar results. The study recorded that with huge household economic dependence on men, those men who were engaged in businesses reported that they would attend to their businesses. In contrast, their wives would attend the clinics alone during pregnancy. As such, male partners were responsible for footing all the expenses incurred in the transportation when accompanying their partners to clinics to seek ANC services.

> *"We participate but not by going to the clinics. I cannot close my business when there is someone else who can accompany her. But I always pay her bills whenever she goes to the hospital."* **IDI 1, Husband-29 years.**

4.4.2. Costs associated with ANC

Out-of-pocket expenses provide a significant barrier for men to accompany their spouses to ANC clinic appointments as one of the primary socioeconomic obstacles. A man's decision to accompany his spouse to antenatal clinics is influenced by the prices because it's one of the factors they have to take into account. The costs borne directly by the families for women to receive ANC services during pregnancy include transportation fees to and from the health facilities, meals for the day when the pregnant lady is away from home, and the expenditures associated with services. Although cost is not a gender issue, it can be viewed through the lens of social expectations where men have been brought up as providers and women as caregivers. In this case, it is easier for men to cater for the cost of ANC for their spouses than for both.

According to study results, respondents were prevented from accompanying their wives to antenatal appointments because they couldn't afford the cost of transportation. The results demonstrate the necessity for transportation because it was impossible for the respondents to walk

to the health facilities where pregnant women in the study area got mothers' and SRH services. In this region, it typically takes 3 km or hours to get to a medical centre.

The transport cost from the homestead to the health facility was noted as higher, and sometimes it is challenging for the families to raise such amounts for their wives. For the husband to attend ANC clinics with their spouses requires that they also have transport to and back from the health facility. The transport for two people to attend the ANC clinic was considered a great burden that men as key breadwinners could not afford. They instead struggled to ensure they had transport for their pregnant wives to attend the clinics.

The excerpts below illustrate this point.

> *"……even when you calculate the distance from here to the hospital is about KSh 300 for one person. That alone is a lot of money that we don't get very easily here and so you can imagine when you want to raise KSh 600 for two people. And like now even the cost of transport has gone up because of fuel which means more money…."* ***(FGD#2 Husband 39 years old).***
>
> *"We always struggle to put food on our table, we have children to take to school and yet the hospital wants us as men to go to the hospital with our wives…. that is not possible because we don't have that kind of luxury with money around here"* ***(IDI#19 Husband 48 years old).***
>
> *"Many times, we don't even have enough money to take care of transport for our wives to the health facility. This means that sometimes they must cover some distance on food and then use the little money for the rest of the journey. This situation is bad, and we can't afford to get transport for two of us at the same time to the facility"* ***(FGD#1 Husband 35 years old).***

The study results show that the burden brought about by the cost of transportation for the men and their wives to the health facility influenced the decision of men to leave their women to attend antenatal clinics alone. Based on their sources of income discussed in the earlier section, men in the study area need more income. Hence, the need to foot transportation costs for their wives is already a burden to them in addition to providing transportation for themselves.

Besides financial costs incurred for transportation of the pregnant wife and her spouse to attend the antenatal clinic, the cost of food that the pregnant woman or couple may eat and the cost of services, as indicated by the study respondents, as one of the financial drawbacks that make the involvement of men in ANC clinic scarce. Three study participants presented the situation as experienced in the following voices.

> *"….and it is not just about the transport alone, there are other costs such as food and the money required for the pregnant women to receive services in the clinic"* ***(IDI#14 Husband 41 years old).***
>
> *"The money needed for ANC service is a lot which sometimes we can't afford. You have to pay for the transport for two people and since you will take longer there it will mean that you will have to buy something to eat and also the cost of some of the services they charge…. yet in all this we have very little roles to play in the clinic. There are no proper places for us to even sit in the clinics because they just put you together with other pregnant women…."* ***(FGD#2 Husband 52 years old).***
>
> *"The reason we don't appear in these ANC clinics is that the financial costs involved are too high to bear so we must choose whom to go and it's automatic that is her who will go. The transportation cost alone is very high from here to the facility and you have not paid for services and yet you need to cater for the usual household needs"* ***(IDI#5 Husband 50 years old).***

The key informants corroborated the above findings from the study participants by noting that the financial costs associated with seeking antenatal services were a key factor preventing male engagement.

One key informant had this to say.

> *"This community is not well-off and hence small financial costs such as those needed for transportation would be a challenge to many men. The sources of income also provide very little income…men don't have the financial muscle to pay for themselves and their wives to attend ANC clinics while at the same time providing food and paying school fees. This is a big challenge and therefore you know that it's only women who must use the little money available to receive the services during pregnancy. But also, in some instances those who can't afford the money required to pay for transportation and services, even the pregnant wives sometimes would miss the ANC services"* ***(KII#3 NGO Official).***

The findings demonstrate that the costs associated with seeking ANC services present an extra financial burden on the shoulder of married men who, in addition to other roles, provide for the family's needs. This situation makes the married decide to support their spouses with the money needed to receive ANC services without escorting them, as the costs for two people are not affordable to them. The cost of seeking ANC services for wives escorted by their male partners is out of reach for the men. While the male partners would agree that only the pregnant wives attend the clinics, sometimes the high costs of transportation and services may lead to a lack of attendance for the pregnant wife. The financial costs present one of the major drawbacks of the economic influence on male partner involvement in ANC services. This situation influences men's general beliefs and perceptions and, eventually, the update of mothers 'and SRH services such as ANC and contraceptives.

Golden (2011), in his study in Ghana, reported the same results. Investigating the barriers to men's engagement in ANC and PNC, the study found that men could not afford the cost of transport for two people – (their wives and themselves) for them to attend ANC and PNC clinics with their spouses. As a result, many men opted to struggle to secure the transport money or means needed for their wives alone to attend the antenatal clinics (Golden, 2011). In the same vein, another study by Ongolly and Bukachi (2019) conducted in Western Kenya also recorded that low-income levels did not allow the household to afford the cost of transport for two people – this was a major reason men let women go alone. Secure transport for two people for the clinic visits while simultaneously managing to put food on the table or meet other demanding expenses. From the discussion, the provision and availability of transport or cost of transport is a key socio-economic issue that limits the participation of men in their spouses' pregnancies through ANC clinic visits.

The household's income level plays a critical role in influencing the update of mothers'and SRH services. As influenced by sources of income, social status presents a unidimensional factor that affects how male partners of different social statuses get involved in visits to clinics during the pregnancy of their wives. A study by Reece et al. (2010) also established that men were perceived to have a principal responsibility of providing. Thus, trading off between clinic visits and their time in income-generating activities takes time and effort. Such a tradeoff would mean that income for that specific day or time away from work is compromised Reece et al., (2010).

Thus, while some men would wish to accompany their wives to ANC clinics, the study found that they noted challenges with the clinic's hours and transport costs that impact their nature of participation in antenatal clinic visits. Their low levels of income predisposed them to compare putting food on the table and incurring costs considered extra to attend to the education, tests and counselling in ANC, leading to the non-involvement of male spouses and sometimes absenteeism of the pregnant women.

4.4.3. Knowledgeability of the Importance of ANC

The knowledge level of male partners of mothers'and child-related health is considered a driver of their participation in ANC initiatives. Men with elaborate and more knowledge about mothers'health, including ANC, would likely be more inclined towards accompanying their pregnant wives to the ANC clinics. Source This is likely to be in reverse for male partners with less knowledge and information about mothers'health.

The study findings show that most participants needed a greater understanding of the mother and child's health components and the importance of male partners' participation. Compounded by their low levels of education, as discussed earlier. The study respondents needed proper knowledge

of the services associated with ANC clinic visits. They needed to understand their roles and value in getting involved in mothers'health matters. This is what some of the respondents had to say.

> *"As a man, why should I be in the clinic where it's only women who are being given services…. the place is designed for women and mothers health care issues of women so my participation in the clinics is not necessary. I guess if she is asked about my name, what I do when we got pregnant she can comfortably explain without me being there"* ***(IDI#18 Husband 33 years old).***

> *"In the pregnancy of wife my role is to get her pregnant and I wait to see my child when she is born……all these other activities they want us to participate in are just meant to embarrass men"* ***(FGD#1 Husband 51 years old).***

Still, on age, a small proportion of the respondents thought that old age comes with experience. Hence, relatively older men may participate in ANC, unlike young men with limited experience. The excerpts below amplify this notion.

> *"We try our best as men to support them. Even going to the clinics, we would want to go although other challenges may prevent us. But I can say that these young couples have problems because they don't understand marriage and its challenges and the young probably does not know what he needs to do to support her wife besides providing money"* ***(FGD#1 Husband 58 years old).***

> *"As men, we have limited knowledge about mother and child's health. You know even the way we are raised we are not associated with such things so when you get married you are not supporting like taking her to the clinics for ANC services intentionally but it's because we are informed on its value"* ***(IDI#10 Husband 29 years old).***

The male partners' limited knowledge about the mother and child's health limited to lack of participation was also supported by two key informants whose voices are projected below.

> *"Another barrier that I would say preventing the involvement of married men is ANC is about their understanding of the role they should play in the whole process. Based on our culture, many men understand that the mothers'issues are for women and the sole responsibility of women"* ***(KII#1 Community Leader).***

> *"……some also have not gone to school and thus their understanding of their role as mothers health is poor. They don't know they are equal participants in ANC and PNC just the same way they participated when getting pregnant…so it is an area that we most of the time ignore but it is hurting the country because, with their ignorance, men will continue avoiding and shying away from supporting women during the pregnancy period"* ***(KII#6 Health Worker).***

The findings, as demonstrated by the quotes, indicate that the level of knowledge of the male partner influences their involvement in ANC clinic visits and other mother and child's health matters

The male partners in the study saw their attendance in the clinics as a waste of time and unneeded, which is a manifestation of a lack of understanding of the significance of male partner participation in ANC. This demonstrates the need for greater comprehension of the value of both partners' involvement in mother and child health services. The married men in the study area are unaware of the benefits that men's engagement in mothers' health has on women's access to and uptake of reproductive health care services during pregnancy, delivery, and the postpartum period. These benefits include improved mothers' access to antenatal and postnatal services, increased uptake of antenatal services, and ANC during the first trimester.

Male partners who accompany their expectant wives to clinics provide an opportunity for them to learn information and gain knowledge about mothers' health issues that will improve their reproductive behaviour, despite their lack of mothers' health experience. The findings of the study are consistent with previous research. A man's degree of support for his wife during pregnancy, delivery, and after delivery is directly connected with his understanding of mothers' health issues, according to a study by Ampin et al. (2021). This shows that males who are less knowledgeable about mothers' health are less likely to accompany their wives to ANC and PNC clinics.

Ongolly and Bukachi (2019) observed the unawareness of ANCrelated services among male spo uses in a recent study carried out in Busia, Kenya.

The results of the study demonstrate that several male participants confused mother and child's health services with family planning and contraceptive facilities, which suggests that they were

unaware of these resources and their connection to mothers' health. Marriage-related services are not well known to married men, which points to the need for community-level education programs for men of all ages.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1. Introduction

This chapter presents the project's conclusion, summary, and recommendation. The first section presents the study's summary while the second section presents the study's conclusion while the last section presents the recommendations. The study sought to achieve two objectives: to explore socioeconomic barriers to men's involvement in ANC in Kanduyi Sub-County of Bungoma and to determine sociocultural barriers to men's involvement in ANC in Kanduyi Sub-County in Bungoma County. Married or cohabiting men who have sired at least one child in the Kanduyi sub-county provided ground from the barriers to men's engagement in ANC have been analyzed.

5.2. Summary

This study looked into the hurdles to male ANC participation, specifically the social and economic hindrance to men's ANC involvement in Kanduyi Sub-County. The data was gathered through 20 in-depth interviews and two focus group talks with married men who had sired at least one kid, as well as six key informants. Most of the study respondents were between the ages of 26 and 35, while the remaining respondents were between the ages of 18 and 58. The majority (14) of the 20 respondents were in monogamous relationships, with the remainder (6) in polygamous marriages.

Only two (2) of the study participants identified as Muslims, whereas the majority (18) of respondents said they were Christians. Additionally, out of the 20 respondents, ten (10) said they had completed secondary education, and eleven (11) said they were engaged in agriculture as a means of subsistence.

Findings show that the sociocultural barriers had the most impact on men's involvement in the women's ANC. Men in the study context perceive mothers and childcare differently, whereas

some see such practices as a province of the women in the community. The findings demonstrated that peer and social networks, gender norms, the socialization process and stigmatization had the most impact on men's engagement in ANC in the study area. From the findings, peer and social networks strongly influence the level of participation of men in the pregnancy of their wives because of the group's ideals and values, which influence the belief system of the members on matters associated with mothers'health. As such, the study shows that most of the study respondents are not involved in their partners' pregnancy because of the need to conform with what their peers and age mates in their social networks approve of how to conduct themselves. The group's code of conduct is deemed as masculine behaviour and shapes the level of involvement of men in mothers'health, who, in turn, also socialize their sons with this code of conduct (Guspianto et al., 2022).

From the study, the opinions of peers or other men in the social groups greatly influence the male partners' perspectives and decisions about attending ANC services with their wives. The peers in the group ridicule and demean or look down upon those who participate in antenatal clinics, which demonstrates that the groups shape men's behaviour and attitudes about mothers' health. Male partners influenced by their peers attempt to invoke their masculine roles by avoiding being involved or associated with mothers' health care, specifically ANC, which they culturally consider a woman's domain.

Gender norms dictate the allocation of roles and responsibilities of men and women, including roles and responsibilities associated with mothers' health, sexuality, and reproduction. Gender norms shape mothers' reproductive health beliefs, behaviours, and practices. These norms relegated duties on mothers' health as a responsibility of women. However, some respondents noted that they would sometimes, under very difficult conditions, go against these norms and

escort their wives to the clinics. The norms perceive ANC as a highly gendered field where men are designated as breadwinners while women, on the other hand, are assigned the responsibility of pregnancy and childbearing. While the roles are defined for many other activities, mothers health roles and responsibilities are culturally ingrained duties that women are expected to bear, an important feature of a sociocultural setup.

These findings also show that through the socialization process, belief systems on mothers' health are learned in this study, and married men exhibited the outcome of that process. Men are socialized to become men, and this precludes involvement in mothers' and childbirth activities about allocating responsibilities, including mothers' reproductive responsibilities. Through socialization, boys and girls are taught how to become men and women, respectively, providing an opportunity for understanding and internalizing roles associated with mothers' health. From the study, boys and girls are culturally socialized to understand that roles associated with childbirth, pregnancy and other mothers' health duties are women's and men's responsibilities are segregated socially from engaging in mothers' health activities.

The study findings show that the stigmatization of men threatens their masculinity. As a result, men will try to dissociate themselves from activities that will put them in a situation where their masculinity is questioned by their fellow men, including being mocked because of participation in certain roles and activities in the community. The results of this study show that married men, in a bid to protect their masculinity through stigmatization, may avoid participating in ANC. Activities around ANC services, such as sitting in groups of women, enhance the risk of stigma and their status as me being questioned by fellow men and other community members. Therefore, men avoid taking their spouses to ANC clinics because they do not want to face the embarrassment of their involvement.

From the study, socioeconomic barriers are both direct and indirect. Direct costs are associated with out-of-pocket costs, such as those incurred to receive ANC services. In contrast, indirect costs are associated with the time or opportunity cost of attending ANC clinics. The socioeconomic barriers identified in this study were livelihood or economic activities, the husband's knowledge level of mothers' health and costs associated with seeking ANC services. On livelihoods, men engage in activities to generate income for the household resulting in them having very little or no time for other activities that would benefit the family, including seeking mothers' reproductive health. The livelihood activities influence or discourage them from escorting their wives to receive ANC clinics since many are time-demanding, requiring the daily participation of the men hence needing more time to participate in ANC clinics. As a result, absenteeism may mean that there would be no pay, or sometimes it may result in loss of employment. The time spent to generate income to sustain the household is considered important compared to the time required to take their wives to the ANC clinics.

The costs associated with attending ANC clinics present a great challenge for men, which is an aspect of consideration before deciding to escort their partners to antenatal clinics. The location of health facilities where pregnant women received mothers' SRH services required transportation, which was noted as very costly. Men in the study area have little income, and hence the need to foot transportation costs for their wives is already a burden to them in addition to providing transportation for themselves. Besides the transportation cost, the cost of services posed a financial challenge for married men preventing their clinic attendance. The costs associated with seeking ANC services present an extra financial burden on the shoulder of married men who, in addition to other roles, provide for the family's needs. Consequently, married people decide to support their

spouses alone with the money needed to receive ANC services without escorting them, as the costs for two people are not affordable.

From the study, Men with elaborate and more knowledge about mothers health, including ANC, were likely to be more inclined towards accompanying their pregnant wives to the ANC clinics. This shows their limited understanding of the significance of the participation of both partners in the mother and child's health care services. The married men in the study do not understand the positive impact of men engaging in mothers' health on women's access and use of reproductive health care services during pregnancy, including improved mothers access to antenatal services and increased uptake of antenatal services ANC during the first trimester. While they may have limited knowledge of maternal, male spouses attending the clinics with their pregnant spouses present an opportunity for them to access information and get knowledge of mothers'health issues that would improve their reproductive behaviour.

5.3. Conclusion

The study findings highlight the importance of addressing both sociocultural and socioeconomic barriers to men's participation in ANC. By working to change these attitudes and beliefs, we can encourage more men to get involved in this important healthcare activity. This will ultimately benefit both women and their babies, as well as the entire community.

In addition to the specific barriers identified in this study, there are likely other factors that prevent men from participating in ANC. For example, some men may simply be unaware of the importance of ANC or may not know how to access these services. It is important to continue to research and identify these barriers so that we can develop effective interventions to address them.

The study findings also suggest that there are some promising strategies for increasing men's participation in ANC. For example, the study found that men who had positive experiences with ANC were more likely to recommend it to other men. This suggests that peer education and social marketing campaigns could be effective in promoting men's participation in ANC.

Overall, the study findings provide valuable insights into the barriers to men's participation in ANC. By addressing these barriers, we can help to ensure that all women and their babies have access to the quality health care they need.

5.4. Recommendation

Based on the findings on sociocultural and socioeconomic barriers to male engagement in ANC, the study makes the following recommendations.

1. Challenge traditional views of masculinity. Men should be encouraged to see themselves as partners in their wives' health care, not just as providers. This can be done through education and awareness-raising campaigns that challenge traditional views of masculinity.

2. Address sociocultural barriers. The social and peer networks that men belong to can play a significant role in shaping their attitudes towards ANC. These networks should be targeted with interventions that challenge the belief that pregnancy is a woman's issue and that men do not need to be involved.

3. Make ANC services more accessible to men. Men who live in rural areas or who work long hours may have difficulty accessing ANC services. These services should be made more accessible to men, such as by providing transportation to and from appointments.

4. Use peer education and social marketing campaigns. Peer education and social marketing campaigns can be effective in promoting men's participation in ANC. These campaigns should focus on the benefits of ANC for both women and their babies, as well as the importance of men's involvement.

5. Provide training for health care providers. Healthcare providers should be trained to understand the barriers that men face in participating in ANC. They should also be able to provide information and support to men who are interested in getting involved.

6. Collect data on men's participation in ANC. It is important to collect data on men's participation in ANC so that we can track progress and identify areas where further interventions are needed. This data can also be used to inform the development of new policies and programs.

5.5. Suggested areas for further research

1. A future study on barriers to male engagement in postnatal care (PNC) is proposed in the study area and other similar contexts because this study was limited to the barriers preventing men from engaging in ANC (ANC).
2. There is a need for a qualitative study that investigates social, economic, and cultural factors that motivates men to participate in ANC and PNC since the study found few instances of male getting involved in mothers health care.
3. A study on the perceptions of women and service providers on the barriers and motivators to male engagement in ANC and PNC in the study area and other similar contexts.
4. A mixed-method study investigating the Knowledge, Attitudes and Beliefs (KAPs) of men and women on the importance of male partner involvement in mothers'health as a contribution to understanding the challenges of realizing comprehensive mothers' health care in the country.

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APPENDICES

Appendix I: Consent Form

Introduction

My name is _____, and I am a master's student from the Department of Anthropology, Gender, and African Studies at the University of Nairobi. I will discuss the socioeconomic and sociocultural barriers that prevent male engagement in ANC (ANC) in your community. This interview is for research purposes only, and all the information obtained will be kept safe in our files. You will not be identified in any presentation of the study reports. Participation in this study is voluntary, and you may leave the discussion anytime. Also, you are free to refuse to answer any questions that you feel are not appropriate or that make you feel uncomfortable. Please ask me any questions about the study at any point during the discussion. Although you may not directly benefit from engaging in this study, your information may lead to improved community mothers'health programs and services.

If you have any concerns about this study, please contact me at 0722777260.

Do you have any questions?

Do you agree to participate in this study and confirm that you are at least 18 years old? Yes □, No□

With your permission, we would like to audio-record the interview.

Do you agree to be audio recorded? Yes □, No □

Your participation in the study will be highly appreciated.

I_____ hereby voluntarily consent to participate in the study. I acknowledge that a thorough explanation of the nature of the study has been given to me by Master. /Miss._____. I clearly understand that my participation is completely voluntary.

Signature_____Date_____

Signature of Researcher/Assistant_____Date_____

Appendix II: In-Depth Interview Guide

Socio-demographic characteristics

1. What is your age?
2. What is your type of marriage?
3. What is your highest education level?
4. What is your occupation?
5. What is your level of income?
6. How many years have you lived in this area?
7. What is your religion?

Questions

i. Please tell me a little bit more about your community. What types of marriages exist in this community?

ii. How are men and women involved in issues around the health of their families? How about children? How about the wife?

iii. What major issues do men discuss with their wives/partners concerning their number of children? How about the well-being of the families (children specifically)?

iv. What social factors within this community prevent men from engaging in issues on mothers'health? Explain to me their influence on male spouse participation in ANC. What would happen if they participated?

v. What are the economic factors that prevent men from engaging and supporting their wives during pregnancy? Why is this the case? Explain to me more of the economic challenges leading to men not engaging in ANC.

vi. How is the participation of men in mothers'health perceived in this community? What are the traditional/cultural issues that prevent men from engaging in ANC? How is participation different for different groups of men?

We have come to the end of our discussion; thank you so much for engaging

Appendix III: Focus Group Discussion Guide

Demographic characteristics			
Gender of the group		Level of education	
Type of marriage		Age	
Level of education		Occupation	

The following sections will guide the discussion, and probing will be based on the participant's responses. However, discussion points have been highlighted to guide research in digging deeper.

Section one

As we start, I would like you to explain to me how the men/ in this community support their wives in issues related to mothers'health. Are there factors that prevent women from engaging in the mothers'health of their wives? Explain to me more about the societal issues that prevent men from engaging in ANC. *[probe for factors within the households, community, social factors, economic factors, influence on different groups of men, influence on types of marriages]*.

Section two

Now I want us to talk about the influence sociocultural factors have on the participation of men in ANC. Let's think of cultural issues that are part of our lives and the community and societal structures and how they influence men's participation in their wives' pregnancies. What are the cultural factors that prevent men from engaging in ANC? How have these factors prevented men from engaging in the pregnancy of their wives or spouses? *[Discussion points: social norms, gender norms, gender relations, cultural perceptions, and community norms]*

Do you have any additional thoughts or questions?

Thank you for your participation.

Appendix IV: Key Informant Interview

Background information

Affiliation

Gender

Position

Years of service

Questions

1. Paint for me a picture of how men get involved in mothers'health issues in this community.
2. What are the existing community structures that leverage men to support their wives on matters related to mothers'health in this community?
3. What are the existing barriers to men's participation in ANC and other mothers'health-related support?
4. What are the social factors that prevent men from supporting their wives from the start of pregnancy until the end? Are there stages where they get involved during the pregnancy, and why?
5. From your experience, what are the economic factors existing in this community that act as barriers to men's participation in ANC?
6. How do the economic factors vary for different groups of men/, age of men, economic status, and types of marriages?
7. What are the cultural issues extant in this community that prevent men from engaging in ANC?
8. How would you describe the impact of the socioeconomic and cultural factors on men's participation in ANC?
9. Do you have anything else to add?

We have come to the end of our short discussion. Thank you for engaging.

Appendix IV: Workplan

Activity/Period	2021		2022				
	March to Oct	**Dec**	**Jan to March**	**April to May**	**June to July**	**Aug**	**Sept**
Proposal Development and Defence							
Correction, research permit							
Data collection							
Data Analysis and write-up.							
Submission of the first draft of the project paper							
Submission of final project paper							
Graduation							