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Socio-Cultural Determinants of Fathers' Involvement in Child Health and Nutrition in Northern Ghana: A Mixed-Methods Study

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Abstract

Despite the growing recognition of the benefits of fathers' involvement in health and nutrition, getting fathers to participate actively is hindered by varied socio-cultural practices and beliefs especially in northern Ghana. This study aimed at assessing the socio-cultural barriers and enablers of fathers' participation in child health and nutrition. The design of the study was a convergent parallel mixed cross-sectional study. The quantitative aspect of the study included 250 mothers who were randomly selected. For the qualitative component, four (4) focus group discussions (FGDS) and twelve (12) key informant interviews were conducted. The involvement of fathers was measured under three dimensions: child nutrition decision-making, physical assistance for lactating mothers and provision of financial assistance. The study shows that the overall level of father's involvement in childcare was very low at a prevalence of 2.8%. However, out of the 250 fathers, only 0.4% were involved in final decision making on EBF, 1.2% were involved in decision making in CF, 23.2% were involved in physical support to mothers and 33.2% were involved in financial support to mothers. Cultural beliefs, occupation of fathers, stigmatization and poverty were barriers to fathers' involvement in childcare. Father's recognition of perceived advantages of involvement in childcare and advocacy were the main enablers of men's involvement in childcare. Paternal involvement in childcare was very low. Nutrition and health authorities in the district may have to design SBC strategies to demystify cultural beliefs that may hinder paternal involvement in childcare.

Keywords: Child Health, Child Nutrition, Paternal Involvement, Sociocultural Barriers, Sociocultural Enablers.

Introduction

Interventions to improve child nutrition and health need to be deliberate because malnutrition in all its forms continues to be a global public health issue (1) and the impact is great in Sub–Saharan African families (2). According to recent data, undernutrition may be the cause of nearly half of all deaths in children under the age of five years (3, 4). Undernutrition increases the frequency and severity of common infections, increases the risk of death from such infections, and prolongs convalescence (5–7). Globally, only about one-third of all nations are on the right trajectory to half the proportion of stunted children by 2030, and roughly 25% of nations are unable to evaluate their current level of progress (8). Moreover, only one in six countries may meet the 2030 target of 3% prevalence for overweight people. To meet the 2030 global target of 89 million fewer children suffering from stunting, more concerted efforts are needed by nations. However, if the current trends continue, 39.6 million children will fall short of the 2030 target, with over 80% of these affected children living in Africa (8). Optimal child feeding practices during infancy, and particularly in the first 1000 days of life are crucial and determine the overall health status of the child and the development of non-communicable diseases later in life (9–11). However, only a small proportion of children benefit from these optimal practices in sub-

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Saharan Africa (12).

In Ghana, especially the northern regions, child feeding practices remain suboptimal. For instance, in the Kpandai District, 89.5% of children fail to meet the minimum dietary diversity (MDD), 60.5% do not achieve the minimum meal frequency, and 91.5% do not receive acceptable diet (13).

The involvement of men in child health and nutrition presents an opportunity for improved nutrition outcomes because men often play key roles in final decision making (14), particularly regarding access to food and spending on health care (15). This is particularly very important in sub-Saharan Africa including Ghana where men are key decision influencers in households (16). While numerous interventions have focused predominantly on maternal roles in childcare (17), emerging research underscores the pivotal yet often overlooked role of fathers in promoting child health and well-being (18). In many sub-Saharan African contexts, including Ghana, socio-cultural norms and gendered expectations significantly shape the extent and nature of paternal involvement in childcaring practices (19–21).

The aim of this study is to assess the socio-cultural barriers and enablers of fathers' participation in child health and nutrition. In this study, the authors hypothesis that, sociocultural factors influence the participation of fathers in childcare and nutrition. Despite the growing recognition of the importance of fathers' involvement in child health and nutrition (22, 23), there is limited research on the socio-cultural factors that influence this involvement in Ghana. Most public health interventions in Ghana focus predominantly on mothers, often overlooking the potential contributions of fathers (24). The Kpandai District, located in Ghana's Northern Region, presents a compelling case for examining the influence of socio-cultural factors on fatherhood roles, given its diverse ethnic composition and deeply rooted traditional values (25). Understanding the specific cultural and social determinants that either facilitate or hinder fathers' engagement in child health and nutrition is crucial for designing more inclusive, gender-sensitive health interventions. This will also inform policy and programmatic strategies that promote shared responsibility in childcare and foster improved health outcomes for children in similar rural and culturally complex settings.

Ultimately, the findings of this study will support efforts to create more inclusive and effective health interventions that recognize the vital contributions of both parents in raising healthy and thriving children. The findings of this study will also guide the development of culturally sensitive policies and programs that promote equitable parenting practices and improve health outcomes for children and families.

Methodology

Study Area

The research was carried out in the Kpandai district. The district is located in Ghana's Northern Region, between latitudes 8 and 9.29 degrees north, and longitudes 0.29 degrees east and 1.26 degrees west. Nanumba South district borders it on the north, East Gonja on the west, Krachi West district on the south-west, and Nkwanta North district on the east (26).

With a population of 126,213, the district has a total land surface area of 1,132.9 km^2. The district of Kpandai is blessed with three major rivers: the Oti, the Dakar, and the White Volta. During the rainy season, there are low-lying and swampy places that become flooded. Large expanses of river banks are created by the water bodies, which are ideal for rice farming.

The district is situated at the crossroads of the Northern Savannah and the moist semi-deciduous forest. The Guinea Savannah Woodland is the district's natural vegetation, which evolved from natural climatic circumstances and has been significantly influenced by human activity. Semi-deciduous trees such as oil palms, raffia palms, acacia, shea-nut trees, and dawadawa trees make up the tree cover. Agriculture is the primary source of income in the district. Crop growers, fishers, and animal farmers make up this industry (26). Figure 1 is the map of Ghana, indicating the Kpandai district where the study was conducted.

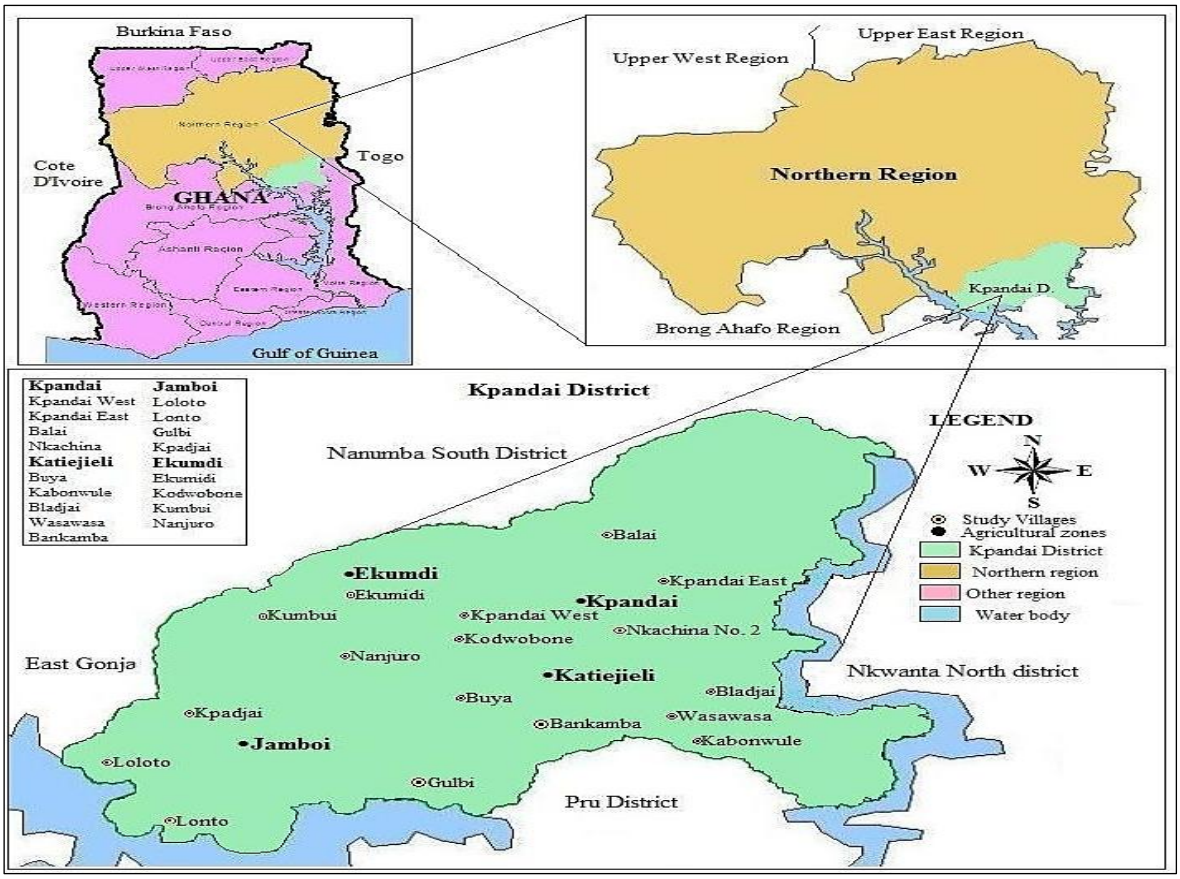

Figure 1: Map of Kpandai based on GSS (26)

Study Design and Participants

The study is a convergent parallel mixed cross-sectional study that involved both qualitative and quantitative approaches. Mothers of children 6-23 months were the main participants for the quantitative component of the study. Fathers, mothers, and community health volunteers also constituted the focus group discussions (FGDS) and key informant interviews (KII). The study is guided by the Bronfenbrenner's social ecological framework.

Sample Size Determination and Sampling Procedure

A multi-stage simple random sampling procedure was used to select the mothers. The first stage was the selection of two sub-districts from five in the Kpandai district. Names of the five sub-districts were written on pieces of papers and put in a box. From the box, two papers were randomly drawn out, one at a time without replacement. The sub-districts which had their names on the sampled papers were used as the study sub-districts.

The second stage was the selection of two communities from each of the selected sub-districts. The sample frames were two lists of communities with a health center in each of the sub-districts. From each sample frame, two communities were then randomly selected. A total of four communities were finally considered for the study.

The third stage of the sampling was done at the health centers during child welfare clinic (CWC) sessions. By probability proportional to size sampling, a representative number of randomly selected mothers with 6-23 months old child were recruited for the study. Thus, the number of mother-child pairs selected from each health center in the four communities, was proportional to the community population size. During CWC sessions at each health center, each mother with child 6 – 23 months was made to select from two pieces of papers on which 'Yes' or 'No' was written. Only mothers who picked 'Yes' and agreed to take part in the study were recruited. In all, a total of 250 mothers were considered for the study. This sample size was determined in reference to a published protocol (27).

Purposive sampling was used to select participants for FGDS and KII. Four FGDS were conducted after saturation was reached. Each FGD consisted of 8-

12 members involving fathers only, mothers only, and fathers and mothers at different times.

A total of twelve key informant interviews (3 from each community) were also conducted, involving men, women and community health volunteers. The women who were recruited for the KII were leaders of mother-to-mother support groups in the communities.

Data Collection

The participants' quantitative data were collected using a pre-tested structured questionnaire. This was done using a mobile based platform - KoBoCollect version 2021.2.4. The data collected comprised the sociodemographic characteristics of the mothers and fathers, and the mothers' perspectives of the level of fathers' involvement in childcare.

The qualitative data was collected using FGD and KII guides. The data comprised the personal and community experiences of the respondents regarding fathers' involvement in childcare including the socio-cultural enablers and barriers to their involvement.

Inclusion and Exclusion Criteria

Mothers with children 6 - 23 months and living with their spouse, key informants who are natives of the study communities, and health professionals residing in the study communities were qualified to be included in the study. Participants that did not satisfy these criteria were excluded.

Data Analysis Plan

Qualitative Data Analysis: The qualitative component of the data was analyzed using thematic analysis approach. It involved systematically identifying, organizing and offering insights into the pattern of meaning of data. It helped to observe and make sense of collective meanings and experiences. It also focused on identifying and explaining the common way of understanding an issue (28).

Data collected was summarized into meaningful texts. The texts were then organized into manageable and meaningful segments through coding. Abstract themes were then extracted from the coded texts and later refined into specific texts that are discrete but broad enough to cover a set of idea. The refined themes were then reorganized, presented and interpreted.

Quantitative Data Analysis: The data was analyzed using IBM SPSS Statistics version 26.0 software. Descriptive statistics were used to summarize the data. Fathers' engagement in childcare and feeding, including decision making in child nutrition, physical assistance for nursing mothers, and financial support, were also summarized.

Data Quality: The questionnaires were developed in English but were conducted in the local languages the participants understood. The few participants who could grant the interview in the English language did so.

All the recordings were also done in the language the participants could freely express themselves. The recordings were then transcribed verbatim in English language before analysis. After the interview, all questionnaires were reviewed in the field to ensure their completeness.

The focus group discussions and KII were conducted in environments devoid of human destruction where the participants were comfortable and relax to participate in the study. Multiple participant groups were used to increase the study's credibility by triangulating viewpoints and perspectives, as well as to gain a better understanding of fathers in childcare.

Measurement of Paternal Involvement

Child Nutrition Decision Making: Fathers who made or agreed to the final decision for the child to be exclusively breastfed were said to be involved in EBF decision making. For CF, fathers' involvement was determined by their involvement in 2 or all of the explainable variable: final decision on complementary feeding, final decision on what food to start with as a complementary food, and final decision on meal-time serving order.

Physical Support: In the study, the physical support variables were defined to include: father feeding the child at mealtimes, father assisting the child's mother with domestic tasks and farming activities, father accompanying the child's mother to child welfare clinics, and father enlisting the help of other family members to support the woman. Fathers who were involved in more than 50.0% of the explainable variables were said to be involved in the provision of physical support to the child's mother.

Financial Support: The financial support was defined to encompass four variables thus, father purchased food for the child, father purchased/provided egg(s) for the child, father purchased food for the breastfeeding mother, father purchased/provided meat or fish for the

home, and father provided transportation or support with money for transportation for the mother and child to clinics. Here, fathers' who were involved in 3 or more of the criteria were said to be involved in the provision of financial support.

To obtain the overall level of men's involvement in childcare by using the above-mentioned dimensions, each dimension scored one [1] if involved in, and zero [0] if not involved in. A total score was calculated by adding the scores of all the dimensions. The level of involvement was classified as follows: a score of zero to two [0-2] was regarded as a low level of involvement, and a score of three to four [3-4] as high level of involvement. This approach of categorization has been applied in a previous study (29).

Ethical Considerations

The study protocol was approved by University for Development Studies' Institutional Review Board with reference, UDS/RB/043/22. Approval from the district health directorate was also sort before the study. Before any information was collected, participants' informed consent was acquired. Participants were given codes and pseudonyms, and they were also guaranteed the privacy of their answers. Additionally, all study participants were made aware that no aspect of the data collection process would be unethically or physically intrusive. The only use of the data was to provide answers to the study questions. All participants were made aware that the exercise was optional and that they had the option to stop participating at any time during the research period.

Results

Demographic Characteristics of Mothers and Children

The ages of children in the study range from 6 to 23 months [mean age, M= 14.17; standard deviation, SD= 5.446]. One hundred and seventeen [117] children, constituting 46.8% were in the age bracket of 6 -11 months and 133(52.2%) children were in the age bracket of 12-23 months. One hundred and forty-three [143 (57.2%)] of the children were females and 107 (42.8%) were males.

The mean age of the mothers was 26.26 years [SD= 4.827]. Most of the mothers were Christians constituting about 81%. Few of them [21(8.3%)] practiced African Traditional Religion (ATR) and 25(9.9%) practiced Islam. Also, majority of the mothers [177 (70.8%)] belong to the Konkomba ethnic group and just about 0.8% of them belong to other ethnic groups.

Assessment of the formal education level of the mothers showed that 101(40%) did not have any form of formal education. About 70 (28%) had primary education and just 5 (2%) had tertiary education (Table 1).

Table 1: Socio-demographic Characteristics of Mothers and Children

Variable	Category	Frequency	Percentage (%)
Sex of child	Female	143	57.20
	Male	107	42.80
Age group of children	6-11 months	117	46.80
	12-23 months	133	53.20
Religion of mother	ATR	21	8.40
	Christianity	204	81.60
	Islam	25	10.00
Ethnicity of mother	Basari	23	9.20
	Gonja	16	6.40
	Konkomba	177	70.80
	Nawuri	32	12.80
	Others*	2	0.80
Occupation of mother	Agric	171	68.40
	Civil servant	7	2.80
	Trader	72	28.80
Education of mother	None	101	40.40
	Primary	70	28.00
	JHS	61	24.40

	SHS/Vocational	13	5.20
	Tertiary	5	2.00

JHS=Junior high school; SHS=senior high school; ATR=African traditional religion, Others*= Kotokoli and Nchumuru

Socio-demographic Characteristics of Fathers

Majority of the fathers in this study (72%) belong to the Konkomba ethnic group and 1.2% belong to other minority ethnic groups which include the Kotokoli and Nchumuru ethnic groups. Most of the fathers were within the age bracket of 30-34 (31.6%). Few of them were below 25 years (20-23) and constitute 2% of the total men who took part in the study (Table 2).

Also, majority [204(81.6%)] of the fathers were predominantly into agriculture. The remaining few fathers were either civil servants or were involved in trading activities. Predominantly, the fathers who participated in the study were Christians. The other fathers were either practicing the ATR or Islam. The family type of the fathers was either monogamy or polygamy. However, the predominant family type was monogamy. And assessment of the educational level of fathers showed that about 51% of the fathers involved in the study had no form of formal education whilst about 49% of them had some form of either primary, JHS, SHS/Vocational or tertiary education (Table 2).

Table 2: Socio-demographic Characteristics of Fathers

Variable	Category	Frequency	Percentage (%)
Age of fathers (Years)	20-24	5	2
	25-29	40	16
	30-34	79	31.6
	35-39	72	28.8
	≥40	54	21.6
Educational level of fathers	None	127	50.8
	Primary	26	10.4
	JHS	51	20.4
	SHS/Vocational	25	10
	Tertiary	21	8.4
Ethnicity of fathers	Basari	21	8.4
	Gonja	14	5.6
	Konkomba	180	72
	Nawuri	32	12.8
	Others	3	1.2
Occupation fathers	Agric	204	1.6
	Civil servant	24	9.6
	Trader	22	8.8
Religion of fathers	ATR	27	10.8
	Christianity	196	78.4
	Islam	27	10.8
Family type	Monogamy	210	84
	Polygamy	40	16

Others= Kotokoli and Nchumuru; ATR=African Traditional Religion

Table 3: Prevalence of Paternal Involvement in Child Care and Nutrition

Variable	Category	Frequency	Percentage (%)
Fathers' involvement in exclusive breastfeeding	Involved	1	0.4
	Uninvolved	249	99.6
Fathers' involvement in complementary feeding	Involved	3	1.2
	Uninvolved	247	98.8
Fathers' involvement in Physical support to mothers	Involved	58	23.2
	Uninvolved	192	76.8
Fathers' involvement in financial support to mothers	Involved	83	33.2
	Uninvolved	167	66.8
Overall involvement of fathers in child care and nutrition	Involved	7	2.8
	Uninvolved	243	97.2

Prevalence of Fathers' Involvement in Child Care and Nutrition

In this study, the involvement of fathers in childcare was assessed under three dimensions including: involvement in child nutrition (exclusive breastfeeding and complementary feeding), involvement in physical support and involvement in financial support to the mothers. The study revealed that fathers had varied level of involvement in childcare. Majority of the fathers (97.2%) were not involved in the care processes of their children. However, about 33% of them were involved in financial support, 23.2% were involved in physical support to the women, 0.4% were involved in EBF whilst 1.2% were involved in CF (Table 3).

Socio-Cultural Barriers to Paternal Involvement in Child Care and Nutrition

Almost all the women and majority of the male participants in the study expressed that, men were not involved in decisions on the feeding of their children. Their responses corroborate what was revealed by mothers from the quantitative survey. Through focus group discussions and key informant interviews, the participants outlined varied reasons why men were constrained to participate in childcare. The common themes that immerged from all the FGDS and corroborated by key informants included; socio-cultural beliefs, stigmatization of men involved in childcare, poverty and occupation.

Socio-Cultural Beliefs

Even though efforts are being made by the Ghana health service and its partners to get men to support childcare and feeding process, some socio-cultural beliefs were noted as barriers to these efforts. Female participants said that some men were unable to see the significance of men's involvement in childcare and continued to view childcare as a woman's responsibility. The majority of respondents claimed that conventional ideas are still having an impact on males who are unable to recognize the value of being involved in childcare. According to informants, socio-cultural ideas have an impact on women as well, preventing them from allowing men to carry out duties that are normally associated with women. For example, these were what some participants said regarding exclusive breast feeding:

*"*When it comes to when to start feeding a baby, it's the role of the mother. They know when the child needs to eat. But this time we hear them say that the doctors say they should give the baby food when they are up to 6 months" [Male FGD].

"The women are those who take care the children, so you the father cannot tell when they should feed the child. Sometimes you don't even see when they start to give the children food or water" [Male FGD].

"The man has no business with how the mother should breast feed the child. The child is always with the mother and she has the breast to feed the child. The man is supposed to provide food staff for the entire household" [Female FGD].

"It's surprising to believe that most women do not feel comfortable when their husbands are helping them with house hold chores like washing dishes or cooking. According to them, it's not the role of men to do such activities. The community believes that any husband who is seen actively participating and supporting the wife is under a spell of the wife" [Female KI].

Stigmatization of Men Involved in Child Care and Nutrition

Stigmatization is another barrier but was noted to be related to sociocultural beliefs of the participants. According to the female participants, stigmatization of men who engaged in what they perceived as mostly "feminine pursuits" is prevalent. The women expressed that, partners who got involved in activities like cooking or fetching water were often being made fun of or derided for doing "women's work". This was strongly affirmed by men during FGDS and KIIs.

These are some excerpts from the FGDS and KIIs

"Another challenge is that the men feel child feeding is the work of the women. If a man is seen to be actively involved in activities like cooking food or going to fetch water, other men laugh at him. Even women in the community begin to think that you the woman whose husband is helping you is lazy, or you have charmed your husband to be a woman" [A mother in Female FGD].

"Sometimes men who are seen to be involved in childcare, like bathing the child, cooking food, sweeping the home or fetching water are given names. They are not regarded as true men by their colleagues and sometimes given secret female names. This is why most of the men will not want to support" [A father in Male FGD].

"As a man, when you try to help your wife with cooking or taking care of the children, people start calling you names. They say you are weak or that your wife controls you. Some even joke that you are no longer a man. So many men avoid doing these things just to keep their respect" [Male KI, Health Volunteer].

"Men who help with childcare or household chores are often mocked. People say they are doing 'a woman's job' and question their masculinity. Even other women sometimes laugh at them, which makes it hard for men to support us openly" [Female KI, Health Volunteer].

"In our community, when a man is seen cooking or helping with the children, people laugh at him or say he has been bewitched by his wife. They say such things are not for real men. This kind of talk discourages many men from helping, even if they want to" [Male KI, Community Leader].

Poverty

One other emergent theme that came up through the FGDS and informant interviews was poverty. Both male and female participants expressed that sometimes the men are not able to support the women financially because they just don't have the money. This is what a father said during a FGDS which was agreed by all other members in different FGDS and corroborated by the key informants:

"We wish we could always give the women money to go to market to by fish and meat or to travel to the clinics but we are poor. They only thing we do to survive is the farming. Sometimes it can take you more than one month and you don't have even GHC 1.00 in your pocket as a man. So, what do you give the woman? You have nothing to give" [A father in Male FGD].

Another man expressed that:

"Most of the people here struggle a lot. The people are too poor. You need to come back here around June-July to see things for yourself. During this period of the year, even food to eat becomes a problem and we are helpless. That makes it difficult for us to support the women how we wish to" [A father in Male FGD].

A key informant also said:

"Sometimes I don't blame the men. If you talk to the few men who normally follow their wives for CWC or antenatal, you will realize that the men wish they could support their wives and children to feed well, but the 'there is not there'. The people are poor. If you recommend foods like eggs or meat for the child or pregnant wife the man is unable to provide" [Female KI].

Occupation

As noted, to be the predominant occupation of the participants in the study, it was strongly expressed during the FGDS that most of the men were farmers and usually spend almost all their time in the day on their farms. Hence the men did not have enough time to offer any none-agricultural support to the breastfeeding mother. The men and women explained that that was the reason the men left the feeding and care for the children to the women. A man said:

"As a man you are supposed to work on your farm to feed your family. Farming is the only work we do. So how can you leave the farm work and follow the woman to the hospital or be helping to take care of the child? Your farm will spoil" [Male FGD].
Other excerpts include:
"The men are so particular about their farm work. Before day will break, they are already on their farms. They don't even see the children before leaving. So, when the child is sick how will they know? No man will agree not to go to his farm to be thinking about the child. That is the work of the woman" [Female FGD].
"From morning until evening, we are on the farm. By the time we return, we are too tired to do anything else. It's not that we don't want to help our wives, but farming is demanding, and it takes all our time. That's why most men just leave the childcare to the women" [Male KI, Farmer].
"Our husbands go to the farm very early and come back late, sometimes after sunset. They are hardly around during the day, so everything to do with the baby—feeding, bathing, even when the child is sick—falls on us. They say they are busy with farm work, so we have no choice." [Female KI, Mother and Small-Scale Trader].

Socio-Cultural Enablers to Paternal Involvement in Child Care and Nutrition

Enablers of men's involvement refers to the different elements that support men's participation in childcare. The enablers of men's involvement that were identified include: men's recognition of the advantages of involvement and advocacy.

Recognition of Advantages of Men's Involvement in Child Care and Nutrition

Men's appreciation of the advantages of their involvement in childcare was one of the key factors that enabled it. Men themselves expressed that they only got involved actively in the care of their children because they knew how important that was. Community health volunteers who were key informants expressed that even though there have been lot of sensitizations to bring men on board to improve IYCF practices, most fathers will still not get involved because they did not see the need to. This is what some informants said:

"I don't blame the men who do not want to get involved in taking good care of their children. They still don't know the essence even though we have been speaking to them. Most of them still hold on the old belief that childcare is the work of the women. Some even say that its God that protects children and if a child will do well, it's not what the father will do. Men who have seen the importance of supporting their wives are those who you see supporting them always" [Male KI, Health Volunteer].
"Our husbands don't know that we suffer with the children. All they do is to just provide you with the yam or maize. You the woman has to provide the rest before you can cook. When the child is sick it's you the woman that will have to carry him/her to the clinic before if you are lucky your husband will follow up. But some men are doing well. I think they know the importance of supporting" [female KI, MTMSG leader].
"I make time to help with feeding and bathing my child because I now understand how important it is. When I'm involved, I feel more connected to my child, and I also see that it reduces the burden on my wife. It's not just her responsibility—it's ours" [Male KI, Father and Farmer].
"We've done a lot of sensitizations, and some men now understand why they should support their wives in feeding and caring for the child. But the truth is, many still don't see it as their role. They say, 'That is a woman's duty.' Until they see the benefit for themselves, change will be slow" [Female KI, Health Volunteer].

Advocacy

Advocacy was another factor that encouraged men to take on childcare responsibilities. Community members and informants both said that NGO advocacy and messaging has helped to encourage men to support the women in child health. Women mentioned that radio and video messages made men understand that they need to play more active roles in the home and help their spouses with childcare, cleaning, and cooking. A participant in a focus group said:
"Some NGO came to us some time ago. They gave the women some 'susu box' to be contributing money. They even supported them to farm the yellow sweet potato which they said is good for the children. They encouraged we the men to always help our wives to take care of the children. Through that some men even now carry their

wives and children for weighing" [A father, Male FGD].

A woman also said:

"Some of the men now support their women because of the 'susu box' people (USAID RING Project). They put some men together (Father-to-father support groups) and they were discussion how to properly feed the children. That thing has helped to change some men. Some of them now bath the children, feed them, buy good food for them and some even take them to the clinic when they are sick" [A mother, Female FGD].

"Before, I used to think taking care of children was only for women. But after hearing messages on the radio and from the NGO people, I began to see that it's also my duty. Now, I help my wife with feeding and sometimes even bathe the baby. It has brought more peace to our home" [Male KI, Community Leader].

"The advocacy has really helped. After those radio programs and videos, some men changed. They started helping more at home, even with things like cooking or cleaning after the children. It's not all men, but at least now they understand it's not shameful to support their wives" [Female KI, MTMSG Leader].

Discussion

Fathers' Involvement in Child Care and Nutrition

In the present study, very few fathers (2.8%) were observed to be involved in the care processes of children. Of the 250 fathers, only 0.4% were involved in final decision making on EBF, 1.2% were involved in decision making in CF, 23.2% were involved in Physical support to mothers and 33.2% were involved in financial support to mothers.

Relative to a study in Uganda, only 9% of males were involved in some physical support and about 47% were involved in some financial support to mothers (30). This is consistent with previous studies that suggested that there was minimal involvement of men in child caring and feeding processes in Asia (31, 32), in South Africa (14) and Ethiopia (33).

Conversely, another study in Ethiopia, showed high prevalence (72.4%) of paternal involvement in IYCF particularly in BF practices (34). Meanwhile in South India, 40.9% of fathers were involved in IYCF (35).

The low prevalence of fathers' involvement in childcare in this present study and the variation of involvement from studies in different areas could be due to cultural differences and culture-specific norms related to gender roles (36, 37). This is justified by the results from the FGDS and KII in this study that revealed that cultural beliefs, occupation, poverty and stigmatization were barriers to the involvement of fathers in childcare. Studies have shown that child feeding and care practices is perceived to be the reserve of mothers (30, 38–40). The role of the fathers is usually restricted to income generating activities. Fathers might be urged to adopt particular steps that support better feeding practices, such as encouraging exclusive breastfeeding and giving young children nutrient-dense complementary foods (41).

Because most households view men as providers and resource managers, that could account for the appreciable involvement of men in providing physical and financial supports. Therefore, their positions in the household will have an impact on how they participate in feeding the children. These findings are in line with studies conducted in Kenya (40) and Uganda (30) according to which men play a crucial role in providing food for the family.

Making decisions about infant and young child feeding was the activity in which men participated the least. In particular, they did not take part in decisions about when to exclusively breastfeed, when to introduce complementary foods, what to introduce as a complementary food, or how to serve food at meals. This conclusion can be linked to the cultural norm that young children spend most of their time with their mothers and that it is the mother's job to feed the child (42). The study also discovered that some males claim that working away from home limits their ability to help with child-rearing duties. A study evaluating men's participation in infant and young child feeding in Kenya agree that men participate less in decision-making for child feeding (40, 43).

Socio-Cultural Barriers and Enablers of Paternal Involvement in Child Care and Nutrition

Through focus group discussions and key informant interviews the following barriers to paternal involvement in childcare were identified: socio-cultural beliefs, stigmatization, poverty and

occupation. This is consistent with the findings of similar studies in Nigeria (42), Kenya (44), Malawi (45) and Burkina Faso (46). The barriers to paternal involvement in childcare are mainly behavioral (47) which are hinged on socio-cultural beliefs. As such, efforts to get men involved in childcare should target behavior change in the context of cultures.

Again, themes that emerged from the FGDS show that men's recognition of the advantages of involvement in childcare and advocacy were the main enablers of men's involvement in childcare. This agrees with prior studies in different cultural settings (48, 49). When a man realizes the benefits of support in childcare against the cost, he is more likely to participate in the childcare process (47). One key identifiable way to get men to buy into the idea of support in childcare is a continuous advocacy and sensitization which is in line with a recommendation by a previous study (31).

Conclusion

The prevalence of paternal involvement in childcare was generally low. Decisions on exclusive breastfeeding and complementary feeding were singular decisions of mothers. Socio-cultural factors including beliefs, occupation of fathers and poverty predict fathers' involvement in childcare and feeding practices. These socio-cultural practices fit into the Bronfenbrenner's social ecological framework.

Stake holders who matter in promoting maternal and child nutrition should consciously target social behavior change communication (SBCC) efforts at men, taking cognizance of their culture and beliefs, to enable them adopt positive attitudes towards childcare. There should also be intense advocacy and education on the benefits of male involvement in child health and nutrition.

Recommendation for Future Research

This study is limited by the indicators used in determining father's involvement in child health and nutrition. Future research should explore broader dimensions beyond what is discussed in this study.

Abbreviations

CWC: Child Welfare Clinic, FGDS: Focus Group Discussions, KII: Key Informant Interviews, MDD: Minimum Dietary Diversity, NGO: Non-Governmental Organization, SBCC: Social and Behaviour Change Communication, UDS: University for Development Studies.

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Author contributions

All individuals listed as co-authors significantly contributed to the work, and their inclusion is based on mutual agreement.

Conflict of Interest

All authors declare no conflict or potential conflict of interest.

Declaration of Artificial Intelligence (AI) Assistance

We declare that we employed generative AI and AI-assisted tools to aid in the refinement of language, structure, and grammar. However, all content, ideas, and academic analysis presented in this work remain the result of our own intellectual effort and original thought.

Ethics Approval

As part of a larger project, the study received ethics approval from the University for Development Studies' Institutional Review Board with reference, UDS/RB/043/22.

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