UNIVERSITY OF THE WESTERN CAPE

Faculty of Community and Health Sciences

AN EXPLORATION OF THE KNOWLEDGE OF AND INVOLVEMENT OF FATHERS IN THE PRACTICE OF COMPLEMENTARY FEEDING OF INFANTS AND YOUNG CHILDREN IN TSHOLOTSHO DISTRICT, ZIMBABWE

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A mini-thesis submitted in partial fulfilment of the requirements for the degree of Master of Public Health in the School of Public Health, Faculty of Community and Health Sciences, University of the Western Cape.

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Declaration

I declare that "An exploration of the knowledge and involvement of fathers in the practice of complementary feeding of infants and young children in Tsholotsho district, Zimbabwe." is my own work. It has not been submitted for any degree or examination at any university. All the sources that I have used or quoted have been indicated and acknowledged by complete references.

Name: Shamiso Moyo

Signed: 

Date: 7 March 2019

Abstract

The first 1000 days of life represents the period from conception right up to a child's second birthday. Over the years, there has been a growing body of evidence focusing on the importance of nutrition during this period; also referred to as the 'window of life'. It is during this period that most incidents of stunting occur. Age appropriate nutrition can provide a child with positive health benefits for the rest of their life. During these first two years infant and young child feeding practices are ideally made up of optimal breastfeeding practices (i.e. exclusive breastfeeding from birth up to six months and continued breastfeeding up to or beyond two years), along with age appropriate complementary feeding practices from six months up to two years.

To date, local research studies that have explored the role of parents in infant and young child feeding have tended to focus, firstly, more on the mothers than the fathers, and secondly, have tended to focus more on breastfeeding than complementary feeding and practices. By conducting this research study, it was anticipated that rich information would be accessed from fathers in the district that could then be used to assist the local health workers and district health management team to improve the current infant and young child feeding interventions being implemented at district and community level specifically for children 6 to 23 months.

This explorative study used a qualitative research approach mainly due to its flexible nature where greater spontaneity was allowed in the interaction between researcher and study participants. Information collected from fathers using in-depth interviews was triangulated with that from key informants. The interviews were audio-tape recorded and transcribed

verbatim in isiNdebele followed by translation into English. Thematic analysis was used to identify main themes and sub-themes of the study.

The study found that the fathers did not have consistently accurate and detailed knowledge of complementary feeding. Furthermore, the little knowledge they had was obtained mostly from their wives.

The study also found that the fathers did support their wives with household activities such as playing with the child, fetching water and firewood in bulk and cooking simple meals for their children, though the latter was generally reported as being done during the mothers' absence. Specifically mentioned by key informants is that there has been a notable change in behaviour among the fathers in comparison to what they did 10 years ago: fathers nowadays seem to be more involved in complementary feeding. Some of the fathers are still however, mindful of what the predominant culture defines as a father's role in child feeding and thus only do selective activities. Decision making seems to be shared when it comes to the purchase of food in the household according to this study. It was however, a different scenario when it came to take the child to the health centre for routine monitoring.

From their perspective, the fathers were not immune to facing challenges in relation to their involvement in complementary feeding. They mentioned facing financial challenges as their main obstacle affecting their involvement in complementary feeding.

Overall, the study recommends that further research be done in other parts of the country on the same subject matter to consider the different cultural dynamics that may affect the understanding, experiences, and perceptions of the role fathers can play during the complementary feeding period of children 6 to 23 months.

Key words: perceptions, knowledge, involvement, fathers, complementary feeding, infants, Zimbabwe, qualitative research, key informants, challenges.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CF	complementary feeding
CBF	community-based facilitator
ENSURE	Enhancing Nutrition, Stepping Up Resilience and Enterprize
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IYCF	infant and young child feeding
MOHCC	Ministry of Health and Child Care
MTCT	Mother-to-child-transmission
SSA	Sub-Saharan Africa
UNICEF	United Nations Children's Emergency Fund
USAID	United States Agency for International Development
VHW	Village Health Worker
WFP	World Food Programme
WHO	World Health Organisation
ZimVac	Zimbabwe Vulnerability Assessment Committee

Chapter 1: Description of the study

1.1 Introduction

Stunting, characterised by a low height-for-age, reflects poor linear growth from conception up to when a child reaches two years of age (Milman, 2005). Stunting is a result of chronic malnutrition (i.e. malnutrition over a long period of time). In early childhood, it has a detrimental effect on intelligence, psychomotor development and fine motor skills (UNICEF, 1998). This can then lead to a reduction in the child's mental capacity which, in turn, has a negative effect on their school performance and can even reduce their work capacity in their adulthood (Jukes et al.., 2002).

1.2 Study rationale

1.2.1 The prevalence of stunting in Zimbabwe

Globally, stunting affects over 155 million children under five years, of these 30.3% live in Africa (FAO, IFAD, UNICEF, WFP and WHO. 2018). The stunting rates in Southern Africa are at 28.1% with at least 1.8 million children under five years being stunted. (UNICEF, WHO & World Bank Group, 2017). In Zimbabwe, stunting is at 26.6% (ZimVAC, 2016). In the Tsholotsho district, a district in the south-western part of Zimbabwe and the site where this proposed study took place, the prevalence of stunting is slightly higher than the national average at 30% (ZimVAC, 2016). The severity of stunting in the district would be classified as 'high' according to the World Health Organisation (WHO) classification for assessing the severity of malnutrition by prevalence ranges among children under five years of age, where anything from a prevalence of 30% to 39% falls within this range (WHO, 2018b).

1.2.2 The first 1000 days of life

The first 1000 days of life represents the period from conception right up to a child's second birthday (Black et al., 2008). Over the years, there has been a growing body of evidence focusing on the importance of nutrition during this period; also referred to as the 'window of life' (Bhutta et al., 2008; Dewy & Huffman, 2009; Victoria et al., 2008). According to Black et al (2008) most incidents of stunting occur within the first two years of life. This is when children have a high demand for nutrients, while a limitation in the quality and quantity of their diets takes place after the period of exclusive breastfeeding. The right nutrition during the first 1000 days of a child's life can save more than a million lives annually, while also boosting a country's Gross Domestic Product (GDP) by as much as 12% (UNICEF, WHO & World Bank Group, 2016).

1.2.3 The importance of infant and young child feeding

In relation to nutrition, the first two years of a child's life are extremely important, as this early phase provides a child with positive health benefits for the rest of their life (WHO, 2018a). During these first two years, infants' and young children's feeding practices (IYCF) *ideally* are made up of optimal breastfeeding practices (i.e. exclusive breastfeeding from birth up to six months and continued breastfeeding up to or over two years), along with age appropriate complementary feeding practices from six months up to two years (WHO, 2002).

Two feeding practices that are important to define in relation to the above and at the start of this document are:

- Exclusive breastfeeding, which is defined as the practice of giving an infant breast-milk only for the first six months of life and no other food or drink except for medicines prescribed by a doctor (WHO, 2014), and
- Complementary feeding is a recommended child feeding practice that starts from six months and typically continues up to two years. It covers this 18-month period during which breast-milk alone is no longer enough to meet the nutritional needs of an infant, thus making it necessary to introduce other foods (WHO, 2018a).

Related to this, complementary foods are defined as foods other than breast milk or infant formula, which are introduced to provide the required nutrients. The WHO (2003) recommends that complementary foods be added to an infant's diet at the beginning of six months of age, whilst the mother continues to breastfeed (WHO, 2003).

1.2.4 The determinants of chronic malnutrition.

According to the well-known UNICEF conceptual framework of undernutrition (Pelletier, 2002), stunting is a manifestation of immediate, underlying and basic causes of malnutrition over a long period of time. The immediate causes of malnutrition are inadequate dietary intake and infectious diseases which occur at individual level. This is due to underlying causes such as household food insecurity, inadequate maternal and child care, inadequate health services, and an unhealthy household environment and lack of health services; all of which impact on the household and/or at community level. Further 'upstream' are the basic causes such as the country's economic structure and its formal and non-formal institutions and the related political and ideological superstructure (Pelletier, 2002).

The Food and Agriculture Organisation (FAO) have also noted that:

> *"Among the key determinants of stunting are: compromised maternal health and nutrition before and during pregnancy and lactation, inadequate breastfeeding, poor feeding practices for infants and young children, and unhealthy environments for children, including poor hygiene and sanitation"* (FAO, IFAD, UNICEF, WFP and WHO, 2017:17).

Thus, taking preventive action to address all these layers of determinants will ultimately assist in reducing stunting in children. Examples of such preventative action include, advocating for the adequate nourishment of pregnant and lactating mothers, promoting exclusive breastfeeding during the first six months of life, and advocating that complementary foods provided to children aged between 6 to 23 months be of an adequate quantity, quality, and variety (FAO, IFAD, UNICEF, WFP and WHO, 2017).

In Zimbabwe, the Ministry of Health and Child Care (MOHCC), through the *Zimbabwe National Health Strategy 2016-2020* (MOHCC, 2016), has a set of objectives by which the country can act to reduce stunting. One such objective (Objective 13.3) focuses on the promotion of complementary feeding that is age appropriate (MOHCC, 2016). Another objective focuses on the "promotion of family-focused behaviour change communication on appropriate adolescent, maternal and child care practices" (MOHCC, 2016: 44). Important to highlight here is the emphasis that the Ministry is placing on the family unit, and with that comes the idea of actively trying to encourage men to consider themselves as an equally important element in supporting appropriate child care practices. Their involvement is encouraged despite the fact that it is commonly acknowledged that Zimbabwe is a patriarchal

society with many of the men being the key decision makers at home (Enhancing Nutrition, Stepping Up Resilience and Enterprise, 2014).

The national *Food and Nutrition Security Policy for Zimbabwe* (Food and Nutrition Council, 2011) similarly promotes the reduction of stunting through its recognition that malnutrition leads to a reduced ability to work and relatively higher morbidity with associated higher medical and health care costs to the country.

1.2 Problem analysis and statement

Despite there being such national policy documents in place such as *the Zimbabwe National Health Strategy 2016-2020* (MOHCC, 2016), the actual complementary feeding practices of children 6 to 23 months in Zimbabwe is poor. For children receiving complementary foods, one of the aspects in which the adequacy of their diets is measured, is through dietary diversity[1]. The proportion of children aged 6 to 23 months who receive food from at least four out of the seven recommended food groups is known as minimum dietary diversity and this is one of the core infant and young child feeding (IYCF) indicators (WHO, 2008a).

According to the ZimVac (2016) in an annual assessment done by the government and humanitarian agencies in 2016, only 9% of children in Zimbabwe aged 6 to 23 months are consuming foods from the recommended four food groups.[2] At a provincial level, in Matabeleland North Province, in which the district of Tsholotsho lies and this study is based, only 7% of the children between 6 to 23 months are consuming food from the recommended four food groups (ZimVac, 2016). The lack of diversity in the diet of young children in the

[1] Dietary diversity is the qualitative measurement of food consumption that reflects the households' access to a variety of foods (FAO, 2013)
[2] The four food groups are: Grains, legumes, fruits and vegetables and Animal source foods

Province is understandably intertwined with the power, choices and decisions (or lack thereof) that various members of the household have and make in relation to infant and child feeding practices.

To date, international and local research studies that have explored the role of parents in IYCF have tended to focus, firstly, more on the mothers than the fathers, and secondly, have tended to focus more on breastfeeding than complementary feeding (Pryer et al., 2003). The rationale for this female focus has been the fact that mothers spend significantly more time with children, especially during feeding times (McHale et al., 1995).

Interestingly, a recent study conducted in Ethiopia by Gebremedhin et al. (2017) found that the direct involvement of the husband in IYCF practice increased the dietary diversity of the children aged 6 to 23 months in the household by 13.7%. This led the authors to conclude that there was an important need to promote and increase the involvement of husbands in IYCF in the study districts. Such conclusions echo earlier recommendations by authors such as Sheriff et al. (2009) who advocated that any intervention designed to increase the rate of breastfeeding should consider a father's role in supporting this feeding practice.

However, having had several meetings with health staff from Tsholotsho district and staff from the provincial office of Matabeleland North, it has been acknowledged that there has been no locally-relevant research and/or guideline development that provides information on the involvement of fathers in complementary feeding. At present local health workers[3] appear to rely on anecdotal evidence and their general impressions as to the extent (and possibility) of male involvement in IYCF in the research setting. Research in this area would provide the

[3] District nutritionist, nurses

district team with the necessary evidence-based information to develop more appropriate and efficacious health education and counselling programmes.

In Zimbabwe, the prevention of mother-to-child-transmission (MTCT) programme has recognised the importance of involving men in related interventions with the establishment of male mobilisers in the fight against HIV and AIDS as one example of this (MOHCC, 2011). According to a Ministry of Health and Child Care manual *"Male Mobilisers Manual"*, men usually have little information to make informed decisions about health promoting behaviours and this in turn results in them not adopting some of those behaviours being promoted (MOHCC, 2011). Just as men are now recognised as key partners in the prevention of MTCT programmes, more so men ought to be acknowledged as critical partners in supporting the nutritional health of their infant and/or young child.

1.3 Study purpose

Against the background of the problem described above, this study sought to explore the knowledge and the extent of the involvement of fathers in the practice of complementary feeding of infants and young children in the district of Tsholotsho, Zimbabwe. By using a qualitative research approach, the researcher sought an in-depth understanding of the perceptions and beliefs, the knowledge and the personal experiences of local fathers around the issue of IYCF. By conducting this research study, it was anticipated that rich information would be accessed from fathers in the district that could then be used to assist the local health workers and district health management team to improve the current IYCF interventions being implemented at district and community level. Ultimately, it was envisioned that information gathered through this study, would not only contribute to more efficacious IYCF

programming but also contribute towards the district's efforts to reduce stunting in Tsholotsho district.

1.4 Study setting

Zimbabwe is a low-income country situated in southern Africa. It is bordered by five countries, namely Botswana, Mozambique, Namibia, South Africa, and Zambia. There are 59 districts in Zimbabwe, with Tsholotsho being one of them. The population in Zimbabwe is approximately 13 million (ZimStat, 2012), with 113,895 of these people residing in rural Tsholotsho. In the district of Tsholotsho, there are 22 wards, which are all rural. The average household size is 4.7 members, while 65% of the households are male-headed households. Due to the proximity of the Tsholotsho district to both Botswana and South Africa, a significant number of the young population have migrated to these neighbouring countries in search of work. Families in the district thus rely heavily on remittances from South Africa, though some subsistence farming is still practised.

The district has one main referral hospital, namely Tsholotsho district hospital as well as a mission hospital called Phumula Mission Hospital. There are currently 20 clinics throughout the district, the Government or the Rural District Council are responsible for the administration of these institutions. All clinics have at least one primary care nurse whilst doctors are only found at the hospitals. At clinic level, nutrition support in the form of trainings to village health workers, growth monitoring, counselling and support is provided by the nurses, while in the villages the village health workers provide nutrition education and counselling, as well as mobilisation for immunisation days.

1.5 Outline of the report

The study is presented in six chapters. The first chapter has introduced the study, while Chapter 2 presents a review of the relevant literature relating to complementary feeding practices along with the role of fathers, their knowledge, perceptions and experiences regarding complementary feeding of children aged 6 to 23 months in Tsholotsho district and beyond. The chapter also addresses the dynamics of gender, regarding roles of fathers and also delves a little into the local culture as it pertains to infant and young child feeding. In Chapter 3, the research aim and objectives are outlined, alongside the research design and methodology that is used in this study. The research results are presented in Chapter 4. Thereafter, Chapter 5 discusses these research findings with reference to varying sources of literature reviewed. Chapter 6 then concludes the study and provides recommendations towards improving complementary feeding of children aged 6 to 23 months in Tsholotsho district and beyond with an aim of ultimately reducing stunting.

Chapter 2: Literature review

2.1 Introduction

Infant and young child feeding (IYCF) practices that are optimal, greatly contribute to child health and nutrition (Mukuria et al., 2016). UNICEF, WHO and World Bank Group (2016) go on to specifically mention that IYCF practices are a major determinant of child nutritional status outcomes. Being a recommended child feeding practice, complementary feeding starts from six months and continues up to two years. It is from six months when breast-milk alone is no longer sufficient to meet the nutritional needs of an infant, hence the introduction of other foods becomes necessary (WHO, 2018a). In countries with poor resources the complementary feeding period is often associated with growth faltering (Victoria et al., 2010). However, regardless of whether infants are being optimally breastfed or not, they will become stunted if they do not receive the required quality and quantity of complementary foods from six months of age (Bhutta et al., 2008). There is currently a dearth of research that has been conducted in Sub Saharan Africa (SSA) on the complementary feeding period, particularly in relation to what role men can play in this period. This, along with the high rate of stunting in Zimbabwe (which is currently 26.6% according to the 2016 ZimVac assessment (ZimVac, 2016)) has been one of the key motivators for proposing this explorative study.

This chapter reviews the literature on the engagement and involvement of fathers in the complementary feeding of children between the ages of 6 to 23 months as it relates to the study objectives. It outlines the commonly understood definition of complementary feeding and then goes on to consider the socio-economic and contextual factors influencing IYCF practices along with the knowledge and perceptions of fathers regarding IYCF practices. There is also a review of literature relating to men and women's role with respect to

complementary feeding at the household level along with recommendations for future interventions from other studies done.

2.2 Defining complimentary feeding

Exclusive breastfeeding, which is defined as feeding an infant with breast milk *only* except for prescribed medicines, immunisations and vitamin and mineral supplements from birth up to six months, has long been considered best practice (WHO, 2017). From the age of six months however, the high nutrients required for children cannot be met by breast milk alone and the initiation of age appropriate, complementary feeding is thus recommended (WHO, 2001). Complementary feeding is important to help each child achieve their full growth potential (WHO, 2013). Due to the fact that most stunting incidences occur within the first two years, this period is considered as a crucial child development period in which the quality of children's diets should be monitored (Black et al., 2008).

Mukuria et al. (2016) indicate that appropriate complementary feeding includes the timely introduction of semi-solid foods from six months of age, increasing the quantity, density, and variety of foods, increasing frequency of feeds as the child gets older, responsively feeding the child, and ensuring hygienic preparation and feeding of foods. This is done whilst maintaining breastfeeding. This period is not easy for caregivers as many factors come into play such as the child's preferences, their appetite, and caregivers' feeding behaviours (Dewey & Brown, 2003). The researchers Becquet et al. (2006) have even brought to our attention that it is also not easy for researchers to assess the nutritional adequacy of complementary feeding because aspects such as qualitative dimensions (i.e. food diversity and food frequency) as well as the quantitative dimensions (i.e. number of meals, exact amount of each food group nutrient intakes, total energy intake, vitamin coverage) need to be

considered. For example, where it is recommended by WHO, (2006;185) that children aged 12 to 23 months should eat 3 to 4 meals a day plus breastfeeds (meal frequency), many caregivers do not necessarily abide by this due to circumstances such as unavailability of food in the house. What this ascertains is that there are numerous factors that need to be considered in relation to complementary feeding.

2.3 The importance of complementary feeding

Complementary feeding from 6 to 23 months is important in order to help each child achieve their full growth potential (WHO, 2013). When an infant reaches six months of age, their energy and nutrient needs start to exceed that of what is being provided by breast milk and complementary feeding becomes necessary to fill the energy and nutrient deficit (Dewey & Adu, 2008). Infants need complementary foods that are higher in nutrient density than what is required for an adult diet. As an example, an infant aged between 6 to 8 months and is breastfed requires nine times as much iron and four times as much zinc as an adult male (FAO/WHO, 2005). This goes on to support the notion that infants should essentially receive the most nutrient-rich foods that are available in the household, yet more often than not, the opposite is the case in low-income countries. Furthermore, Dewey and Brown (2003) highlight that infants have high nutritional requirements relative to the size of their bodies and yet consume small amounts of food and as a result they require nutrient-dense foods. Despite this, complementary foods that are being given to infants in many developing countries are nutritionally inadequate. For example, in many African countries, a thin porridge made with maize meal, which is a bulky food with a low nutrient density, is used as complementary food (Faber, 2005). Sadly, this does not meet the nutrient needs of infants during this period of complementary feeding.

As breastfeeding continues throughout the period of complementary feeding i.e. up to the age of two years or older, the amount of nutrients that are required from complementary foods depends on the quantity that is provided by human milk and varies considerably by nutrient. The only complication is that some micronutrients are highly variable in human milk, depending on the woman's nutritional status, and the intake of the milk (Rivera & Lutter, 2003). In a study conducted in Allahabad, India, the researchers concluded that delayed initiation of breast feeding, deprivation from colostrum and improper complementary feeding come out to be significant risk factors for under-nutrition among children under five years of age (Kumar et al., 2006). According to Bhutta et al. (2008), sub-optimum complementary feeding is a clear determinant of stunting and for any improvements to occur there needs to be a focus on the frequency and the energy density along with an adequate quality diet.

2.4 Consequences of malnutrition

The immediate consequences of malnutrition are morbidity, mortality and disability (Black et al., 2008), while some of the longer-term consequences in later years are decreased adult stature, reduced intellectual ability and decreased economic productivity (Milman, 2005). The researchers Black et al. (2008) expanded on the UNICEF conceptual framework for malnutrition and elaborated more on the consequences of malnutrition (short-term and long-term). As can be seen from Figure 1, one of the consequences of childhood malnutrition i.e. morbidity, arises from undernourished children having weak immune systems and are thus more susceptible to infections and illnesses. In the long-term, insufficient nutrient intake and infections that occur frequently can cause stunting, leading to largely irreversible effects such as delayed motor and cognitive development (Black et al., 2008).

Scott et al. (2002), have also elaborated on how malnutrition can result in micronutrient deficiencies, such as vitamin A deficiency. Deficiencies in vitamin A have been associated with the increased severity of diseases such as measles. An outbreak in a community immediately puts a strain on the health system as more resources (human, immunisations, time) would be needed to contain such an outbreak.

Bearing these consequences in mind and as illustrated in Figure 1, this study will contribute to the body of knowledge on one of the underlying causes (i.e. inadequate care) through the exploration of the knowledge and involvement of fathers in the practice of complementary feeding of infants and young children and the ways in which they can reduce the burden of care by women.

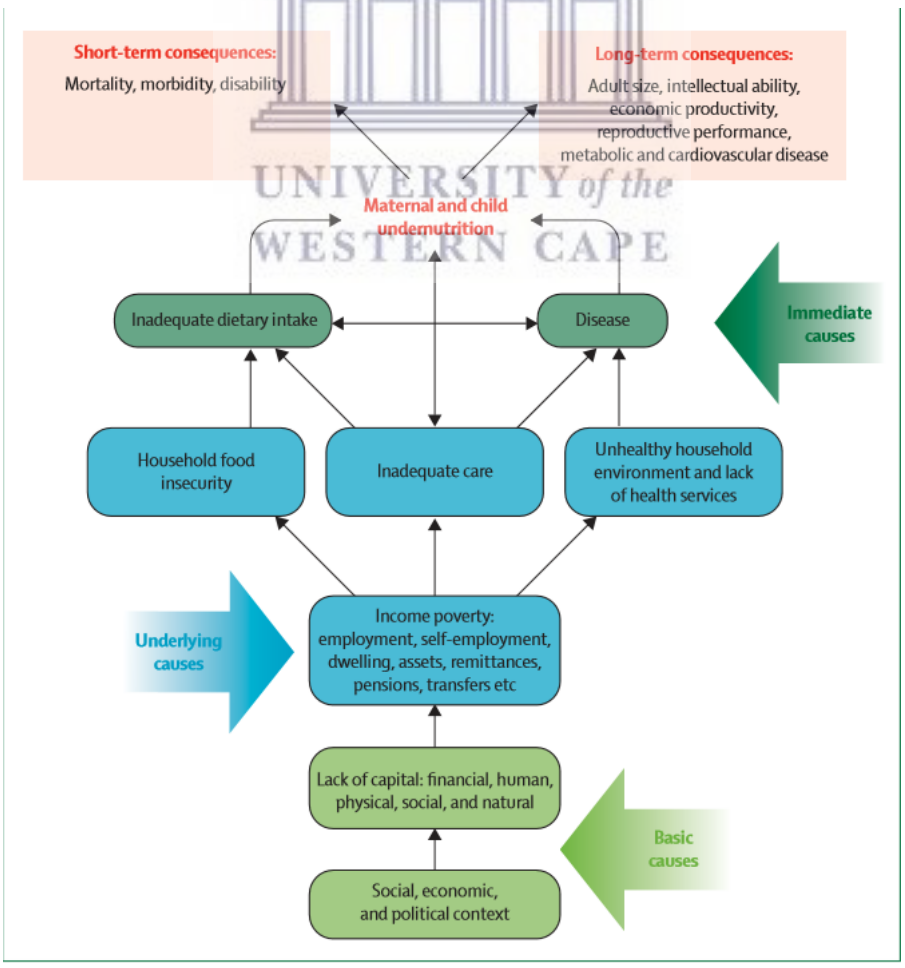


Figure 1 Framework of the relations between poverty, food insecurity, and other underlying and immediate causes to maternal and child under-nutrition and its short-term and long-term consequences. (Source: Black et al., 2008:244).

2.5 Fathers and complementary feeding

To my knowledge, little scientific knowledge exists on fathers' involvement in child feeding specifically in Zimbabwe. The importance of the involvement of fathers during the complementary feeding period cannot be over emphasised. They are an important component of the 'family unit' and moreover, to ensure optimal complementary feeding, there needs to be the involvement of both parents, fathers included.

A recent research paper by Sanghvi et al. (2017), compared four case studies of complementary feeding programmes that were implemented in Bangladesh, Malawi, Peru and Zambia. They acknowledged that the improvement of complementary feeding required an understanding of what was driving the feeding behaviours along with how to facilitate the adoption of improved practices in a variety of both cultural and economic settings (PAHO, 2003; WHO, 2008b). From their analysis, one of their recommendations was the targeting of fathers with nutrition messaging for improved complementary feeding behaviour change (Sanghvi et al., 2017).

Furthermore, an earlier study done in Sub-Saharan Africa (Nigeria, Cameroon and DRC Congo) found there to be higher odds of stunting among children of single mothers than compared to children whose mothers were in a union (Ntoimo & Odimegwu, 2014). All these studies validate the importance of the involvement of fathers during the complementary feeding period.

2.6 Socio-economical and contextual factors influencing IYCF practices

As illustrated by the conceptual framework for malnutrition (Figure 1), there are a range of contextual factors operating at varying levels from individual, household, community and national that influence IYCF practices. They influence IYCF practices in multiple ways. As Acharya et al. (2004) notes, the adoption of optimal IYCF practices that are specifically related to complementary feeding depends primarily on factors such as decision making and behaviours at family or household level. In most African cultures, the family unit constitutes a central social institution and support mechanism for some family members such as women and children (Aubel, 2012). Similarly, White and Klein (2002) identified varying parameters that have provided an insight into the dynamics at household level and the influences related to child nutrition such as the roles of the different family members, the hierarchical relationships between household members and the associated decision-making power. This study specifically focuses on the extent of involvement of fathers in complementary feeding, and it is for this reason that literature focusing on the involvement of fathers in IYCF has been explored in some depth.

2.7 Fathers' perceptions towards IYCF

It is important to consider the fathers' perceptions towards IYCF, as a person's perceptions are an integral part of the human decision-making process. Parke (2008) notes that a father's own perception of the role that he believes he ought to play in his child's life might influence his behaviour (Parke, 2008). An example being that if a father believes that it is the mother's job to feed the children, he may not participate in any child feeding during meal times (Vollmer et al., 2015). For example, in a study by Muraya et al. (2017) which looked at gendered decision-making in community-based child nutrition interventions in rural Kenya, it was observed that during household visits, fathers were generally uninterested in "engaging

in the discussions, as they described child nutrition as '*women's business*' (Muraya et al., 2017:36).

In contrast, McBride et al., (2005) suggest that the maternal perceptions of a father's role in the family and in child care is also a powerful predictor of how involved the father will be, regardless of a father's own perception of his role. In other words, if the father is not perceived as important by the mother, the mother may adopt certain behaviours or attitudes that discourage the father from increasing his involvement in child care and feeding.

On the other hand, the father's perception of the mothers' opinions, can also affect a fathers' involvement in IYCF (Pasley et al., 2002). This in itself highlights the importance of father's perceptions towards IYCF as it somewhat affects, positively or negatively how they participate in matters regarding IYCF. Nevertheless, mothers are said to be more likely to initiate as well as continue breastfeeding when they believe that their husbands have positive attitudes toward breastfeeding (Giugliani et al., 1994). Similarly, the researchers Anderson et al. (2010), who set out to 'explore how fathers perceive the role in feeding and caring for their infants', reported that the perceptions of fathers with regard to infant-feeding was influenced by the experience they had with their previous children as well as the form of advice from other fathers. Such studies show the significance of the perception of fathers towards IYCF.

2.8 Decision-making roles within the household: the position of men

Men are often given the title of 'household head', which then inevitably leads to the assumption that they make all the decisions regarding household matters (Matinga, 2002). This finding is similar to another study by Njai and Dixey (2013), where the wives have also

labelled their husbands as ‘decision makers’ in the community. From both studies, it is clear that the men are significant decision makers in the household and community at large.

In many contexts, men have greater social and economic power along with significant control over their partners; especially in developing countries. They are often able to decide on the timing and size of family as well as whether their wives will utilise the available health care services or not (Illiyasu et al., 2010). One study that was conducted in Nepal from a randomised control study of 442 women showed that the exclusion of fathers can essentially lower breastfeeding rates (Mullany et al., 2007). In Kenya, assessments and surveys on IYCF have demonstrated that engaging key influencers, for example fathers, at the household and community level, improves IYCF practices (Dinga, Kiage & Kyallo, 2018). This shows just how much influence fathers have on IYCF practices.

Burns et al. (2016) noted in their study in the DRC that with men controlling the household finances they also made many of the decisions on how money should be spent, including some decisions regarding health and nutrition practices. The lack of purchasing power of the mothers in this study was identified as one of the key barriers to complementary feeding (Burns et al., 2016). This is clearly reflective of the gender dynamics within the society and the greater social and economic power men generally have over women.

In a northern Nigerian community, Illiyasu et al. (2010) had earlier found that in relation to health, men also decide on the timing and size of family as well as whether their wives will utilise health care services available to them. This is against a background that men themselves view attending child health-related education and taking the child for immunisations as insignificant activities (Bilal et al., 2016). In a qualitative study with a

sample size similar to that of this study of ten fathers in Ethiopia, Bilal et al. (2016) noted that it was a real problem for the fathers to go to the health centres. Even more recently, the same was noted by Dougherty et al., (2017), in a study in Niger, where it was noted from discussing with the fathers that they did not perceive it their responsibility to take children to health centres. It was only upon watching specifically designed community videos related to IYCF and health care that the men began to appreciate their role or importance in this regard (Dougherty et al., 2017).

2.9 Partners' lack of social and financial support for mothers

It is important to look at the role played by social support in the acquisition of food. A study in Western Kenya by Pelto et al. (2015) found that infant and young child diets were affected both directly and indirectly by the extent to which caregiver's partners participate in providing food from agricultural activities, provide money to buy food and help with IYCF. Other researchers such as Engebretsen et al., (2010), Israel-Ballard et al., (2014), and Jones et al., (2012), have shown that the fathers' lack of support for child feeding is negatively associated with practices such as exclusive breastfeeding, diet diversity, and meal frequency among many other IYCF practices. For example, the qualitative study by Engebretsen et al. (2010) was aimed at gaining a deeper understanding of some of the complex patterns in decision making with regards to infant feeding amongst men and women in Mbale District, Eastern Uganda. The study results showed that men were generally seen as providers by the women and community at large and because of this, women tended to hold the men responsible for the lack of food in the household and subsequent low breast-milk supply. Furthermore, these views were to some extent held by the men who also saw this as their obligation in providing extra food for the breastfeeding woman. The authors concluded by

recommending that fathers should be included in infant feeding training sessions for increased acceptance of infant feeding practices.

In a quantitative study by Jones et al. (2012), conducted in the rural Bolivian Andes, women revealed that the lack of support from their spouses was experienced as a key barrier to appropriate child feeding and negatively affected any improvements to children's diets and feeding practices. These studies reflect the traditional demarcation of males and females' roles within the household and as such should not be neglected when developing community-based interventions to strengthen complementary feeding.

As was highlighted in studies in Uganda and Bolivia, the gendering of roles and related domains of gender-specific activity is a wide-spread phenomenon (Aubel, 2005). With men traditionally being seen as responsible for the provision of financial resources (including the provision of food) to support the family's survival. As Aubel (2012) later suggests, due to the nature of their traditional role, men may not possess extensive experience and knowledge in issues of child nutrition. Similarly, Jones et al. (2012) note that culturally ingrained attitudes towards women and the gendered division of labour might also be preventing men from supporting women when it comes to reducing the burden of care on the women. Important to note is that this may or may not be accurate with reference to the fathers in Tsholotsho district, and through this study, the nature of their experience and knowledge with regards IYCF practices will be established.

It is evident from all the cited literature that fathers have some form of influence, whether positive or negative during the period of complementary feeding. How they either support or

do not support their partners (the mothers) have some bearing on the decisions mothers make regarding some IYCF practices.

2.10 The involvement of men in child nutrition and IYCF practices

Evidence from a number of studies in Sub-Saharan Africa (SSA) has shown that the knowledge and involvement of men in child nutrition is generally limited. Evidence of this comes from other Africa countries such as Malawi (Waltensperger, 2001; Matinga, 2002), Congo (Fouts & Brookshire, 2009) and Ghana (McGadney-Douglas & Douglass, 2008). For example, in the latter study it was found that most of the fathers were not involved in the care of their malnourished children as this was left as a responsibility of female family members. Similarly, in rural Mexico, Perez-Gil-Romo et al. (1993) concluded that men were never involved in infant care and feeding. It is against such a background that Aubel (2011) in her literature review of IYCF interventions recommended that programme planners should take on a more family-focused approach by involving men and other influential household actors. Some recommendations have been put forward on improving male involvement in the infant feeding decision-making process. Specific examples of such recommendations are the 'understanding of household roles and relationships' so as to better understand the role played by men instead of just side-lining them and the 'viewing of men as resources and not as obstacles' so as to actively engage them in strategies that promote optimal IYCF practices (Aubel, 2011).

2.11 Fathers' knowledge of IYCF practices

A formative research by Mukuria et al. (2016) in rural Western Kenya, found that caregivers such, as fathers, typically lack up-to-date knowledge of optimal IYCF practices, particularly during the complementary feeding period. The research went on to confirm the importance of

fathers with regards to key decision making related to child nutrition and their willingness to be more informed in nutrition-related activities at household level. In another study conducted in rural Zimbabwe by Jenkins et al. (2012), it was revealed that because the key decision makers (fathers and/or male partners) are often poorly informed about the importance of exclusive breastfeeding, this was one of the constraints on attempts to increase the rate of exclusive breastfeeding in Zimbabwe. For example, a qualitative assessment by Fjeld et al. (2008), conducted in Southern Zambia whose purpose was to assess the potentials and barriers in the promotion of exclusive breastfeeding found that many of the fathers were not well informed about exclusive breastfeeding and were not even aware of the existence and importance of the practice. Some, it was suggested, would even go to the extent of preventing their wives from practising exclusive breastfeeding (Fjeld et al., 2008).

2.12 Some of the implications of inappropriate infant and young child feeding practices

While numerous challenges exist during the complementary feeding period, this literature review has narrowed it down to two which are directly related to this particular study. **Inappropriate infant and young child feeding practices** are the biggest contributing factor to the high morbidity among infants and young children in developing countries (Faber, 2005). They also result in growth faltering during this crucial period of growth. Some studies have shown that faltering in weight begins at around three months of age and continue to about 12 months. Thereafter, it declines at a slower pace until about 18 to 19 months. The pattern for faltering in length is different, suggesting that various physiologic mechanisms, dietary deficiencies or other environmental factors underlie these two manifestations of growth faltering (Rivera & Lutter, 2003).

Early introduction of complementary foods before an infant is six months, increases the risk of an infants' exposure to microbial contaminated foods, thereby increasing risk of diarrhoeal diseases (Lamberti, 2011). This can lead to dehydration and death, as illustrated in the conceptual framework depicted in Figure 1. Population based studies in developing countries have shown that the greatest risk of nutritional deficiencies and growth retardation occurs in children aged between 3 to 15 months (Quinn et al., 2005). However, from the age of six months, there is a gap between nutritional requirement and the amount that is obtained from breast milk. This is also against the background of the high nutrient demand of children that cannot be met by breast milk only. Despite this, this period is considered as a crucial period in which the quality of children's diets should be monitored and unless complementary foods are introduced at six months an infant's growth is likely to falter (Black et al., 2008). As in the qualitative study in the western region of Gambia by Njai and Dixey (2013), it was found that husbands can have a major influence on the infant feeding practices including the timing for initiating complementary foods. One of the aspects the study looked at was the factors responsible for early introduction[4] of solid or complementary foods before the recommended age. Two of the study groups (community health nurses and mothers) indicated one of the factors as being the husbands. A mother was even quoted saying, "…you know husbands are also responsible for the early introduction of complementary foods to the child…" (Njai & Dixey, 2013:76). It is acknowledgements like these by mothers, that continue to show one the reality of some of these existing challenges and how fathers play a crucial role during the complementary feeding period.

[4] Before six months of age

2.13 Summary

This literature review has considered a variety of sources from peer-reviewed journal articles to programme reports and assessments on IYCF and fathers. While data has been limited for the Zimbabwean context, some countries such as Kenya and Ethiopia have done numerous studies which have provided a wealth of knowledge concerning the topic of exploration. As such, it is my hope that the readers' minds have been introduced to the aspects of focus under this study and that whatever information arises from this study contributes to the scientific body of knowledge that can be used in future.

Chapter 3: Research design and methodology

3.1 Introduction

This chapter introduces the methodology used for this study. The chapter begins by outlining the aim and objectives of the study. The study design is described along with the sampling procedures, data collection and analysis methods and the considerations that are made in relation to rigor. The limitations of the study and the ethical considerations employed are also discussed.

3.2 Aims and objectives

The aim of the study was to explore the understanding, experiences, and perceptions of the role fathers can play in the complementary feeding period of children (between 6 to 23 months) in Tsholotsho district, Zimbabwe.

The objectives of this study were to:

1. Explore fathers' understanding of the importance of age appropriate, complementary feeding in children (6 to 23 months).
2. Explore the perceptions and personal experiences fathers have had in relation to age appropriate, complementary feeding of children (6 to 23 months) in their household.
3. Explore with fathers what they perceive to be some of the significant challenges inhibiting their greater involvement in the complementary feeding of children within their household.

3.3 Methodology

Study Design

This explorative study used a qualitative research approach mainly due to its flexible nature where greater spontaneity is allowed in the interaction between researcher and study participants. Participants were free to respond in greater detail and more openly to the questions asked (Mack et al., 2005). Against this background, the study aimed to explore the understanding, experiences and perceptions of the role that can be played by fathers in the complementary feeding period of children (between 6 to 23 months). Furthermore, this is an area where little research has been done hence, using a qualitative approach for this study according to Malterud (2001) enables the exploration of meanings of social phenomena as experienced by individuals themselves, in their natural context. In this study, the rural fathers were investigated within their natural environments (homesteads). The qualitative research method of using open ended questions enabled participants to answer in their own words and evoke responses that were meaningful to the participants, unbiased and unanticipated by the researcher, and rich in its nature (Mack et al., 2005).

Study Population

The study population comprised all adult married fathers whose ages ranged between 26 to 42 years with at least one child aged between 6 to 23 months, who were residing in Nkunzi ward, Tsholotsho district at the time of the study. All ten fathers were recruited from the villages within the catchment areas of Nkunzi clinic. In relation to the key informants the population comprised three community health volunteers (such as village health workers and community-based facilitators) who, in support of Ministry of Health and Child Care (MOHCC), were volunteering in the district at the time of the study.

Sampling

The sample was purposefully selected. Ritchie, Lewis and Elam (2003) define purposive sampling as the selection of study units that are chosen because of having certain characteristics which enable detailed exploration and understanding of the themes under study by the researcher. For the purposes of this study, married fathers with at least one child aged 6 to 23months at the time of the study were purposefully selected.

In terms of the sampling process, the researcher reviewed the current registers of all children under five years of age that are kept by community volunteers from three different villages in Nkunzi ward of Tsholotsho district. Nkunzi ward was selected as it was the nearest ward (~100·km from Bulawayo) in Tsholotsho district with a clinic. With the assistance of a Village Health Worker (VHW), who is the custodian of health and nutrition issues in the village, the researcher purposively selected married fathers associated with ten of the registered children (aged 6 to 23 months) living in the catchment area of Nkunzi clinic. The selection of the fathers was based on those who had been present in their households in the past 3 months or more months preceding the study. The VHW first contacted the fathers by virtue of them having children aged between 6 to 23 months and explained the purpose of the study and whether they would be willing to be interviewed. This was done until there were at least 10 fathers willing to participate in the study. All the fathers were from villages surrounding the clinic. The VHW visited all the fathers and informed them of the study. After they indicated that they were willing to participate, appointments were set up with them with regards the date and time most suitable for the researcher to visit them.

The VHWs and community-based facilitators (CBFs) were also purposively selected as key informants in the study. VHWs are Ministry of Health and Child Care (MOHCC) volunteers[5] who live and work within their communities. They are trained in community IYCF, counselling, and in some cases act as the intermediary between the clinic and the households. CBFs are also MOHCC volunteers whose specific mandate is to provide training to the communities on water, sanitation and hygiene. Given their embeddedness within the community, the researcher believed that both cadres would be able to provide deeper insight into the research issue, given their first-hand knowledge and understanding of the issue, as well as being able to strengthen the validity of the research findings, which is, as Shenton (2004) suggests, the value of key informants.

In terms of selecting the three key informants, the researcher requested that the nurses[6] at Nkunzi health centre (who are familiar with all the local volunteers that support and report to them), advise on whom they thought would be suitable key informants based on their activity and experience in IYCF.

Sample size

A total of ten semi-structured, in-depth interviews with married fathers were conducted. Ritchie, Lewis, and Elam (2003) indicate that samples in qualitative research are usually small. They support this notion by stating that if the data is properly analysed, a saturation point will be arrived at where little new evidence will be obtained from the discussions. It is at this point that a larger sample size ceases to contribute to new evidence. Data saturation was reached before the tenth father and hence there was no need to interview any additional fathers beyond the initial ten that had been planned for.

[5] They receive a quarterly allowance
[6] Those who were present at the time of the study

Three key informant interviews were conducted: two with VHWs and one with a CBF from three different villages with differing norms (Nemarundwe, 2006).

Data Collection

The research data was collected through semi-structured, in-depth interviews with fathers, as well as key informant interviews with both VHWs and CBF from the catchment villages surrounding Nkunzi clinic. In-depth interviews allowed the researcher to gain deeper insight into the individual roles and perceptions of men, regarding complementary feeding (Mack et al., 2005). Moreover, according to Mack and Woodsong et al. (2005:30) "they are an effective method for getting people to talk about their personal feelings, opinions and experiences".

Key informant interviews also provide an opportunity for detailed investigation to take place, exploring people's personal perspectives for an in-depth understanding of the personal context within the research phenomena (Ritchie, Lewis & Elam, 2003). The key informant interviews allowed for the researcher to gain a deeper understanding as to some of the responses that were given by the fathers as well as some of the community norms around household gender dynamics and their observations of the fathers with regards to some IYCF practices. The interview guides for both the fathers and the key informants are found in Appendix 5 and Appendix 6 respectively. The interview guides were developed by the researcher and reviewed by her mini thesis supervisor. The pre-testing of the interview guide was then done with one married father in order to test for language and content suitability, to make any corrections or adjustments to the tool and to take note of the duration of the interview.

Ethical approval to conduct the study was obtained from the Senate Research Committee of the UWC in South Africa on the 9th of November 2017, while local authority to collect data was obtained from the Tsholotsho Rural District Council on the 5th of February 2018. Data collection took place from 30 May 2018 up to the 8th of June 2018. The interviews took place at the homesteads where the fathers lived and this was made possible by arrangements made by the VHW.

As this was a home set-up, the researcher was initially greeted by both husband and wife at the prior agreed upon times. In all instances, the wives went on to excuse themselves after the researcher shared information about the study as they understood that the interviewees were meant to be the fathers. The interviewer shared information from the participant information sheet (Appendix 8), then the fathers went on to sign the consent forms signifying their consent to participate and understanding that they were not given anything for their participation in this study. An electronic recording device was used to record the interviews. The recording of the interviews allowed the researcher to devote her full attention to listening and asking in-depth questions. The researcher was also able to provide an accurate account of the interview, capturing the participants' language and tone through field notes and recording device (Legard et al., 2003). Throughout the interviews the researcher also took field notes in a diary. Interviews, on average, lasted 50 minutes. They were conducted in the local language of isiNdebele as the tools had also been translated to isiNdebele. The researcher was fluent in the local language. At the end of each interview the researcher asked the interviewees if they had anything to add or ask. Some of the fathers emphasised their earlier points, while others had nothing more to say. The researcher thanked the interviewees and informed them that she would share the study findings with them.

The digital recording of each interview was transcribed by the researcher into a notebook. It was then translated into English and thereafter typed into a Microsoft word document.

Pesser (2005) notes that the researcher's gender and other social statuses could have an influence on the esteem, trust and rapport of an interview and this can either facilitate or thwart access to data. Given the researcher, a 38-year-old woman, was interviewing fathers, the researcher remained mindful of the gender dynamics that were likely present in conducting the interviews.

Rigour

In this study, rigour was achieved by (i) the initial thorough discussion of reflexivity, (ii) keeping an audit trail, (iii) verifying with each interviewee (during the course of the interview) that the researcher's interpretation of the information that they had shared with her was accurate, and (iv) ensuring triangulation using different information sources.

Reflexivity is defined as a process in which the researcher will make known their values, beliefs and biases that may influence the study (Creswell & Miller, 2000). Before embarking on the data collection process, the researcher documented her initial opinions and beliefs on the father's roles and their perception of complementary feeding. The researcher's perception was that fathers do not know much about IYCF and hence assumed that their participation would likely be very minimal. Furthermore, the researcher thought that culture still played a key role/is a challenge/barrier to the involvement of fathers in IYCF. This practice of sharing one's own perceptions and assumptions about the issue being studied enables both the researcher and reader to be mindful of the researcher's position and thus be more mindful in

ensuring that the researcher's bias will not overly influence the results of the study (Creswell & Miller, 2000). In this regard, the researcher took down notes by the fathers and ensured that the researcher presented the information just as it was said by the fathers. The researcher also recorded her reflections of each interview in her fieldwork journal.

An *audit trail* was maintained by the researcher through a reflexive fieldwork journal together with all digital recordings field notes and data analysis notes. Through the keeping of such an audit trail, this ensured that the research process was well documented and clear, while also ensuring accuracy in research findings (Cutcliffe & Mckenna, 2004).

The researcher had frequent debriefing sessions with her mini-thesis supervisor so as to bring out any flaws in the research as well as receive guidance from the supervisor based on her experiences and perceptions (Shenton, 2004).

Data verification was also done in this study. This involved discussing data as well as the interpretations with the fathers, VHWs and CBF at the end of their interviews so that they could confirm the credibility of the information captured by the researcher (Creswell & Miller, 2000). In this regard, the interviewees agreed with the data/information collected. This according to Creswell and Miller (2000), in terms of establishing credibility, is a crucial technique.

The information from the in-depth interviews with the fathers was *triangulated* with information from the key informant interviews with the VHWs and CBF. This allowed the verification of the role and perception of fathers from their view to be verified with what the VHWs and CBF see in the community or know from experience, hence providing detailed

and accurate description of the research question (Shenton, 2004). Babbie and Mouton (2010) go on to support this strategy when they indicate that the best method in obtaining the various divergent constructions of reality that exist within a study is to obtain data on the different events and relationships from different viewpoints. Information obtained from the VHWs and CBF aided in confirming or disputing what the fathers mentioned in their interviews. This form of triangulation is known as *data source triangulation*. Triangulation is being used because it relies on multiple forms of evidence/sources instead of just a single incident or data point in the study (Creswell & Miller, 2000).

Data Analysis

Thematic analysis was used to analyse the qualitative data. The researcher and supervisor read through the transcripts several times so as to be familiar with the data. The researcher then came up with a list of categories and sub-categories which were reviewed by the supervisor. Thereafter, a few changes were made and the final list of categories and sub-categories was agreed upon by both the researcher and supervisor. The researcher went on to look at common sub-themes that related to the study objectives. The main themes that came out were: (i) fathers' understanding of complementary feeding, (ii) view of fathers towards complementary feeding, (iii) the extent to and the manner in which fathers reported to help with CF, (iv) decision making and division of roles between males/females in the household, (v) perceived challenges, and (vi) reflection on gender issues. These themes and sub-themes are the ones that will appear as major findings of the study (Braun & Clarke, 2006).

3.4 Limitations

The study only focused on a rural area setting, hence the knowledge and involvement of fathers regarding complementary feeding in the urban area was not considered, despite their

differing dynamics and challenges found in urban areas. Thus, concerning IYCF and more specifically complementary feeding, rural men cannot speak on behalf of urban men as their settings, dynamics etc. are different.

Furthermore, the study was conducted in Matabeleland Province, which is mainly a Ndebele speaking area with Ndebele culture and tradition. This will thus limit the transferability to other regions of the country that are for example predominantly of Shona culture and tradition.

Another limitation to the study was that, this research, being a mini-thesis, is limited in terms of time, budget and resources. As such, only the nearest ward in Tsholotsho district could be accessed – given it was geographically accessible and convenient in terms of its proximity to the researcher's place of work

3.5 Ethics considerations

Ethics approval was obtained from the University of the Western Cape (UWC) Ethics Committee on the 9th of November 2017, reference number BMI7/9/8 (Appendix 11). Local authority permission to conduct the research was sought from the Rural District Council of Tsholotsho on the 5th of February 2018 (Appendix 12).

In order to ensure that all participants voluntarily and in an informed manner consented to participate in the study, they were provided with a participant information letter (Appendix 1 and Appendix 2) that explained the objective of the research. It also clearly explained that they have the right not to participate in the research and should not in any way feel threatened by not participating in the study (Mouton, 2001). Those who decided to participate in the study were asked to sign the informed consent form (Appendix 3). Each participant was

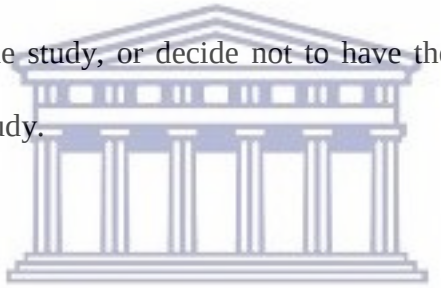
given the opportunity to refuse to participate, although none did. Participants were also given an opportunity to consent to having the interview recorded. The researcher explained to the participants that they can choose to have their interview recorded or not. In order to avoid bias created by respondents, the key informant interviews and in-depth interviews involved only those participants genuinely willing to take part and share their information in a free manner with the researcher (Shenton, 2004).

The issue of *confidentiality* was upheld in this research. The researcher explained to the participants that all the information that was recorded from the interviews was for the sole use of this particular research and nothing else and would be kept securely locked away. According to Mouton (2001), confidential information that is provided by the research participants must be treated as such by researchers. By participating in the research, the participants would have entrusted the researcher with a lot of private information and it is mandatory of the researcher to respect and be honourable in keeping to such principles. Furthermore, with regards to *anonymity*, it was also explained to the respondents that no respondent identification particulars were to be captured on field notes and that pseudonyms would be created which will only be known by the researcher. The pseudonyms that were used were Father 1, Father 2, up to Father 10 and for the KIIs it was VHW1, VHW2 and CBF.

The researcher ensured that no harm would befall the research participants as a direct or indirect consequence of the research (Wassenaar, 2007). The researcher took the utmost care in protecting them during the process of data collection. This was protection from either physical or psychological harm, or otherwise.

All data collected is being kept in a locked cabinet which can only be accessed by the researcher. All typed data is being kept on a password protected computer. The list of pseudonyms that link each participant to their identifier (and in turn the participant to their interview transcript) is securely kept by the researcher in a password protected file and computer. The participant's anonymity will also be protected when the results of the study are written up into a research report, journal article and presented to stakeholders. This will be ensured by continuing to use pseudonyms (and removing any identifying information) when presenting quotes and/or recounting the experiences of the participants.

Participants were assured that there would be no adverse consequences to them should they decide not to participate in the study, or decide not to have the interview recorded if they consent to participate in the study.



Whilst no harmful impact was anticipated, should there have arisen any participant requiring counselling, the researcher would have discontinued the interview and referred the participant to a local counsellor who is based at their local health centre.

3.6 Summary

The chapter provided a detailed description of the methodology used in the study. The sample was described along with how it was selected. Data was collected using semi-structured in-depth interview guides and analysed using a thematic analysis approach. Ethical considerations and rigour were both maintained all through the study. The results will be discussed in the next chapter.

Chapter 4: Results

4.1 Introduction

The key findings of the research project are presented in this chapter. The demographic characteristics of the fathers will be shared. Thereafter, the results will be presented under the major themes and sub-themes that emerged from the analysis. Some of the results were summarised in tables while some were narrated through. In total, 13 respondents were interviewed by the researcher: 10 fathers, 2 Village Health Workers (VHWs) and 1 Community Based Facilitator (CBF).

4.2 Demographic characteristics of the fathers interviewed

The 10 fathers who were interviewed were all living in a village in Nkunzi ward, rural Tsholotsho district, in the south-western part of Zimbabwe. This is a rural district and is approximately 100 km southwest of the second capital of Zimbabwe, Bulawayo. The population mainly survives on subsistence farming as well as remittances from South Africa. This has resulted in varying income levels across the households and this is depicted in the varying structures that one will see across the district. Some houses are made from bricks (some foreign as well), while other houses are made from traditional clay mud. Most homesteads have a small vegetable garden for green vegetables. With regards to the particular village with the 'fathers', some homesteads were within a radius of 2 km from the nearest clinic as well as the local grocery shops. They were also near a main road with easy access to public transport.

The fathers that were interviewed ranged in age from 26 to 42 years with an average age of 32 years. They have all been present at their home all or most of the year round. Of the 10

fathers interviewed, none were formally employed, they were all doing small, part-time jobs for income such as building, painting or herding of their cattle, while others were subsistence farmers, selling their surplus. Whilst some of the fathers occasionally sought for temporary employment across neighbouring countries of South Africa and Botswana, others looked for part-time menial jobs in their community.

The age of the father's last-born child (which ranged from 7 to 19 months), and their feeding was the focus of this study. There were five boys and five girls.

Table 4.1 Sociodemographic characteristics of fathers and their household

Characteristics	Number (n=10)
Age range (years) of fathers	
26 to 30	*5*
31 to 35	*3*
36 to 40	*1*
41 to 45	*1*
Age range of father's last-born child (months)	
6 to 8	*1*
9 to 12	*4*
13 to 23	*5*
Other children i.e. below 18 years) in the household:	
no other children	*2*
1 child	*2*

2 children	*5*
3 children	*1*
Lives with wife and children only	*2*
In addition to wife and children, lives with his parents (a mother or father or both)	*5*
In addition to wife and children, lives with a sibling	*1*
In addition to wife and children, lives with a herd boy or nephews or nieces	*2*

Table 4.2 shows the sociodemographic characteristics of the fathers and their households. What is clear is that the extended family circle still exists as evidenced by the number of households who were living with a mother or father or both, sibling or nephews, nieces or herd boys. Traditionally, this extended family provides some form of support during complementary feeding.

4.3 Fathers' familiarity and understanding of the concept of complementary feeding

The interviews with the fathers commenced by exploring their knowledge about complementary feeding, their understanding of the required food types that should be consumed by children aged 6 to 23 months, and where they get their information on complementary feeding.

4.3.1 Importance of age appropriate complementary feeding

The interviews with the 10 fathers revealed that they all had some idea of what complementary feeding (CF) referred to. Seven of them specifically noting that

complementary feeding referred to the baby being fed solid foods in addition to breastmilk from six months and older. Some fathers suggested they were confident of this information as they "got it from their wives".

In fact, their wives seemed to be the main source of information for the fathers about complementary feeding; something which is elaborated on in the next section.

On being asked why age appropriate complementary feeding in children (6 to 23 months) is important, all but one of the fathers seemed to have an accurate understanding of its value, and expressed it in the following way:

> *I have been told that it is important for the child to grow well. As the child grows from six months, they need more food in their diet* - Father 9

> *A child should be given nutritious foods that help them to grow well. If a child does not get fed sufficient foods to grow, they may become malnourished* - Father 7

There was only one father (*Father 2*) who indicated that "am not very sure about this". i.e. he was not very sure about why age appropriate CF in children (6 to 23 months) is important and seemed slightly embarrassed by this as *he said this looking down*. Although he had heard from his wife that it was *"...about child feeding. About the foods that the baby eats*."

4.3.2 Source of information about complementary feeding

Most of the fathers indicated their primary source of information about complementary feeding was their wife, though a secondary source seemed to be from the local village health

worker. When asked if they had heard about the term, many of the respondents noted how they had found out about it from their wives:

> *Yes, I have heard my wife talking about this, she has discussed this with me and my mother. Normally she does this on a day she comes from the clinic and has learnt/discussed something with the nurses, she shares the information with me* - Father 4

> *Yes, I have heard about CF. my wife has mentioned this to me before as well as the local VHW. It's about feeding of young children from six months onwards* - Father 1

> *Yes, a VHW comes to visit us and talk about such issues with my wife* - Father 3

When asked who they would speak to if they wanted to learn more about complementary feeding, most of the fathers confidently mentioned their wives. Responses such as the following were given:

> *I would actually ask my wife because she is very knowledgeable in these matters* - Father 5

> *I would ask my wife as she is the one who takes the baby to the clinic and is in constant communication/interaction with the nurses at the clinic* - Father 4

There were only two fathers who indicated that they would ask the local VHW as they reside near the VHWs, as one these fathers shared:

If I wanted more information, I would ask the local VHW as she also resides within our village. Or I could also go to the clinic and ask the nurses. They are quite friendly - Father 1

Only one of the key informants mentioned 'talking' to fathers about complementary feeding when asked on the sort of activities they do as community volunteers, though they were probably included under the term 'community' as per below:

I basically talk to mothers and the community at large about infant and young child feeding…- VHW1

It was only one father (*Father 6*) who was not sure of who he would ask if he wanted to learn more about complementary feeding.

4.3.3 Father's understanding of the required food types

The Ministry of Health and Child Care (MOHCC) initiated community nutrition education awareness raising focus on teaching mothers and caregivers of children from 6 to 59 months about the "4 Star Diet". One of the key messages of this campaign is the promotion that children, from the age of six months should consume foods from at least four food groups i.e. legumes, fruits and vegetables, grains, and animal source foods (ASFs). Given that this is the national message; the fathers were asked to see whether they were familiar with the variety of foods that were being consumed by the children from six months and older.

Depending on the age of the child, varying foods were mentioned by the fathers. All the children were reported to be eating foods from the four food groups. Most of the foods

mentioned by the fathers were also those mentioned by the key informants as indicated in Table 4.2. This showed that the fathers were indeed aware of the sort of foods eaten by their young children. Important to note as stated by one key informant is that:

> *In this community, the children eat varied foods. This is mainly dependent on the family income and also mothers' knowledge* - VHW1

The children also ate from their own plates. It is encouraged that children eat from their own plates so as to be able to provide the right quantity of food per age group. Most of the meals mentioned were from the family pot, while some were cooked specifically for the young children (see Table 4.2). For example, mealie meal porridge was cooked in the morning specifically for the children vis-à-vis a lunch meal that is made for the whole family, including these young children.

Table 4.2 Foods from family pot versus foods cooked specifically for the children

Foods from family pot	Sadza or rice with: Soup Meat (chicken, beef, goat, kapenta, amacimbi) Vegetables Eggs Lentils Beans
Foods cooked specifically for the children	Mealie-meal porridge enriched with various ingredients: peanut butter, milk, eggs,

	crushed dried vegetables

The foods consumed from at least four food groups are shown in Table 4.3 and illustrate that the children were being fed foods from the four food groups according to their father's knowledge.

Table 4.3 Foods eaten by the children as expressed under the four food groups

Legumes	Fruits and vegetables	Grains	ASF
Cooked beans	Green vegetables	Maize	Beef
Cooked lentils	(different types)	Sorghum	Chicken
Groundnuts	Bananas	Millet	Goat
Cowpeas	Sweet potatoes	Rice	Kapenta
Round nuts	Chunks		Eggs
Green beans	Potatoes		Amacimbi
	Cabbage		
	Oranges		
	Mangoes		
	Local wild fruits		

Along with understanding the type of foods eaten by their children, the fathers had some knowledge on the number of meals that should be eaten by their babies in a day. Most of the fathers understood the number of meals that should be eaten by their children as being at least three or more and up to five meals/day. For example, as one father shared:

> *I believe that he should eat three main meals a day and perhaps, depending on appetite, pick on snacks/fruits in-between his meals* - Father 1

This was also confirmed by one key informant as:

> *Most people feed their children three or four times a day depending on the age of the baby* - CBF

There were two fathers who were not entirely correct in their understanding of the number of meals required: one father (*Father 2*) suggested that the number of meals eaten should be according to the baby's appetite and ought to "*Eat when hungry"* which he noted was *"usually five times a day".*

Another, (*Father 6*) could not quantify the number of meals exactly and said "*I am not sure what is recommended, but I think she should eat many times/many meals."*

The other aspect of complementary feeding is continued breast feeding, for which the MOHCC recommends it up to the age of two years or older. This is looked at in the section below.

4.3.4 Fathers' knowledge of continued breastfeeding for children up to two years or older

MOHCC in Zimbabwe promotes continued breast feeding from six months up to two years or older. The fathers were asked if their babies were still breastfeeding and if yes or no, up to what age they stopped. Most of the babies were still being breastfed with the exception of three. The following reasons were given by those fathers:

My wife stopped breastfeeding when our son reached one year and four months. My wife was no longer producing a lot of breastmilk - Father 1

She stopped at 11 months as she no longer wanted to breastfeed. She said her nipples were very painful - Father 10

My son just started refusing breast milk and we ended up not forcing him - Father 7

4.3.5 Support to mothers

Generally, most of the fathers said that they support the mothers of their children in some form or another so that they get enough time to prepare meals. This is when they are present at home. From those who indicated that they help out, varying motivating factors were pointed out.

It is good but cannot be done every day. Here I am only able to support my wife if I am not busy herding our cattle or working on a building project. I think what motivates me to do this is my understanding of how important it is for her to get sufficient time to look after the children/tend to their needs. I also see how hard she works around the home- plus we have a lot of children (he says giggling). The sort of activities I help with are fetching water and firewood and also cooking when my wife is not at home – Father 1

During meal preparation at times I help with minding the baby to enable the mother to prepare meals without interruption (if the child's grandmother is not around). As a man I cannot be seen to do this all the time. The way you are judged as a man is

tricky in the sense that some would still view a husband who helps out as foolish or under some spell/love potion, while others are now more receptive of this new trend - Father 4

Other fathers were of the opinion:

I think that there is nothing wrong with men supporting mothers with young children. I know that in this community some men will disagree with me on this viewpoint. In this household I do this though not too frequently as there are a lot of people who help out in this regard - Father 5

Traditionally I know that it is not very acceptable but times are changing and we need to move with the changing times. But some men like myself I have no challenges in helping my wife. After all, I am around and not away in Botswana as before or other times - Father 2

Fathers should be supportive and should do other house chores that can be done by men as well as fetching water, firewood etc. if you don't help your wife, by night time she will be so tired such that behind closed doors no action will take place[he said with a giggle] - Father 9

There was only one father who expressed his reservations:

Mmmm. I think that men should just stick to fending/providing for their families and leave the child care issues for their wives as the women spend their time at home,

whilst us men go in search of food and money. Here my wife does all the cooking as mother of the household. I can play with the baby whilst she is cooking - Father 6

Interestingly, the key informants had varying opinions, which included influence from the wives and had this to say:

...Some men support whatever their wives come up with especially with regards child feeding-feeding the baby, playing with the baby… - VHW 1

Men are not that informed but they seem to adapt what they are told by their wives. Men still very much follow tradition/culture-where child care is considered as women's role. However-due to wider community leadership requests, Ministry of health and community health workers at large, they are now a bit more open to assisting their wives a bit. This is with things like collecting firewood and water in bulk. I guess when quantities are big-the task is seen as a masculine one rather than feminine… - VHW 2

4.4 Perceptions and experiences of the father's role in relation to complementary feeding

4.4.1 The perception of the fathers regarding their role in providing food for the family

The fathers were asked the question on their role regarding complementary feeding. For most of the fathers, the reported practices were providing food and money to buy food while other additional responses were assisting with the feeding and provision of moral support to their wives and working in the garden.

I provide food through working in the garden along with money to buy food - Father 8

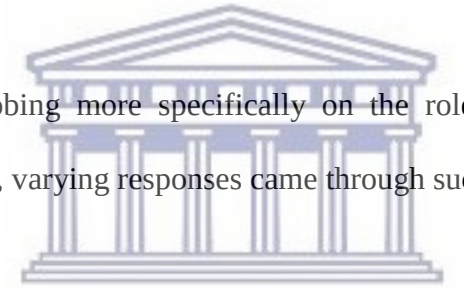
I provide the income to buy the food needed at home - Father 2

I ensure that my family eats. How? - I do this by providing either food – in- kind or give money to my wife to buy food - Father 5

Generally, the fathers were said to play the role of provision of both food and money by all the key informants who indicated as illustrated by one quote:

They provide financial resources, food and labour for farming - CBF

As a follow-up through probing more specifically on the role played by the fathers in providing food for the family, varying responses came through such as:



I get piece jobs every month and I use some of the money to buy food such as kapenta fish, cooking oil and sugar. I also have a small garden in the yard where my wife and I grow vegetables - Father 10

I buy the food. I have a taxi that is hired out and this brings us income into the home. Providing for the family is how a man can help support his wife - Father 2

I play a financial role-provide money to buy food. I also keep cattle and we get milk. I do farming as well - Father 5

4.4.2 What the fathers cook for their children

Most of the fathers mentioned that they were able to cook foods like porridge, boil eggs and '*isitshwala*', though mostly in the wife's absence.

> *I can cook porridge, sadza and relish. I can confidently prepare these. What if my wife travels away-does this mean that the children should starve? As long as she gives me permission to use her pots, am able to cook* [he said this with a smile] - Father 9

> *I can cook porridge with peanut butter. I grew up eating this sort of porridge and learnt how to prepare it from my mother. I make this for my children during my wife's absence-say she woke up early and went to a ladies meeting etc* - Father 1

About this aspect, one key informant had the following to say:

> *...some fathers cook for their children when mum is away-have been told this by a few mothers* – VHW 2

One therefore sees that some of the fathers do cook at home and are cooking for their children, though they prefer to do this in the wife's absence as indicated earlier.

Some of the common recipes that were mentioned by the fathers include enriched porridge and sadza. Porridge is a thin mixture of water and mealie meal which is left to simmer for a few minutes. Thereafter, various ingredients can be added to it whilst still simmering, such as peanut butter (most commonly mentioned), eggs, pounded kapenta, and some salt and sugar to taste. On the other hand, sadza is made from an initial mixture of mealie meal and water

and left to simmer for a few minutes. Thereafter, mealie meal is added to it bit by bit, stirring in the pot as it thickens. This is then served with any relish.

4.5 The role played by fathers in complementary feeding

All the fathers acknowledged that the period of complementary feeding was an important one for the health of their children. Some even went on to explain how they are practically involved with complementary feeding of their children. With regards to the extent they practically feed the child, most fathers said they fed their babies, with some preferring to do so when the wife is away while others doing so even in their wife's presence.

> *I feed my child when the mother prepares the food for the baby. I have no problem in doing this. I realise that at times as men we tend to worry a lot about what other men think of us instead of worrying more about what is best for our young children. I understand the importance of CF and feel happy when I see my child eating their food* - Father 5

> *I feed him quite frequently. We have a strong bond and he is happy when I feed him, unlike when his mother feeds him* - Father 3

> *A lot of times actually. I feed her when my wife is busy, though when she is not well she only wants to be fed by her mother* - Father 8

On being asked 'who normally feeds the child', a lot of the fathers admitted that it is mostly done by their wives; with them feeding the children here and there.

> *My wife, sister, nephews. Me a few times* - Father 5

Both of us, though my wife feeds the baby during sickness - Father 9

Mother of the child and myself at times - Father 8

4.6 Decision making and division of roles between male/female in the household

4.6.1 Decision making in the household around food issues. Who buys what?

Generally, all the fathers indicated that they play a providing role towards complementary feeding. This is in providing money to buy food for the family, or working in the fields and gardens to produce food for the family, or doing part-time income generating jobs. Some of the fathers have even acknowledged that society has placed certain expectations on them regarding the 'roles of men' and women in the household. Reflecting on what was said by one of the fathers earlier:

As a man I cannot be seen to do this all the time. The way you are judged as a man is tricky… - Father 4

In terms of decision making in the household based on who decides on what food should be bought in the household, half of the fathers indicated that both husband and wife decide, whilst the other half said that their wives decide. Varying reasons were given in support of either response. Amongst those who indicated that they both decide, one father indicated below:

My wife and I both decide. My wife consults me and we agree on what to buy - Father 2

Among those who indicated that it was the wife who decided, one father also said:

> *My wife decides. She knows what the family like to eat* - Father 4

It was interesting to note that most of the fathers said that both husband and wife generally decide on the use of money in the household. One of the fathers had this to say:

> *We both discuss and see how much is available versus the family needs such as school fees, clothing, food etc.* - Father 2

There were two fathers that indicated otherwise in that:

> *I have the final say but we discuss with my wife* - Father 10

And,

> *I generally decide and allocate to my wife money for different things that are needed by the family* - Father 6

4.6.2 Who takes the child to the clinic

Positive health seeking behaviours are an essential component during the complementary feeding period of a child as they support the health and well-being of a child. According to the MOHCC, a child has to receive a supplementary dose of vitamin A twice a year from the age of six months up to five years, while growth monitoring is encouraged on a monthly basis.

All the fathers happily mentioned that it is the mothers who take the children to the clinic for things like vitamin A supplementation and growth monitoring. Similarly, regarding the actual decision making around this activity, all the fathers but one said that it was their wives who decide. The one father indicated that decision making around this activity was done by both of them.

Both of us. My wife consults with me - Father 8

4.7 Perceived challenges

For the past decade, the Zimbabwean economy has been on a downward spiral and thus it is not surprising that most fathers mentioned that their greatest challenge was a financial one. Most fathers mentioned that they faced a lack of adequate income to purchase foods. Other fathers also talked about the unavailability of certain foodstuffs on the local markets in the villages, few part-time jobs to earn income along with the inability to keep up with the child's appetite.

…. we also face a challenge of food affordability. We cannot afford to buy some food such as meat for relish - Father 1

Unavailability of some foods locally and financial constraints (shortage of money to purchase some of the required foods) - Father 4

Child eats a lot. 'Ukudla akumaneli' (food he eats is not enough). We want to try to give him more food in-between meals - Father 2

4.8 Reflections on gender

4.8.1 Views on women's roles and the contributions of fathers to complementary feeding

It was important to discuss gender roles and responsibilities as it relates to complementary feeding within their households with the fathers. The element of culture appears to play a role, though perhaps no longer as strong, in influencing what men and women do within their homesteads and community at large. The fathers themselves seem to have a more open attitude/no hard and fast rules regarding what should be done by their wives versus what they should do. However, some of them openly pointed out that despite this 'modern way' of thinking, they acknowledge the existence of what society or culture defines/deems as traditional norms regarding the roles of men and women in the home. Others were still of the opinion that the mothers' role is child care (holistically from cooking, cleaning house, and taking care of the children), while the fathers' role is just provision of finances in the home.

> *Yah. There are differing perceptions by men on this aspect. Some are like myself and they have no problem in taking on some roles such as feeding the baby and cooking some porridge. But there are other men who are not comfortable with this and do not assist in any way* - Father 5

> *It's not easy to change traditional norms and culture. There are things that I have no problem doing. Things such as fetching firewood and even cooking (depending on what is being cooked). Am not the best cook in that department*]he said laughing] - Father 8

Though my wife cooks mostly, I am happy to help sometimes. Yes, it is a fact that traditionally/culturally the woman does the cooking within the homestead, but I am ok with helping my wife as and when I can. Look-I am happy to feed my son - Father 3

Our culture is such that there are pre-defined roles within the homestead- roles for women and roles for men. If as a man you are seen to be cooking too much other men will laugh at you - Father 4

The issue of culture was also brought up by the key informants. One key informant expressed the following:

The culture is such that looking after the young children is viewed as women's work. Though this is now changing especially among some of the younger couples…. Could be a result of acculturation or change in cultural norms. The young are susceptible to the change in cultural norms because they learn from tv, radio etc. so even when it comes to shared decision making, shared roles and workloads, its usually the young couples rather than the old guard – VHW 1

4.9 Summary

This chapter provided a general description of the fathers who were interviewed. A description of how the fathers understand complementary feeding was made and this showed that the fathers do have some form of understanding when it comes to complementary feeding, foods eaten by their young children and its importance. The results also showed that most of the fathers got their information on complementary feeding from their wives with the exception of two who consulted VHWs. They generally provide support to their wives such

as playing with the child and fetching water and firewood in bulk, with activities such as cooking being preferred to be done in the wife's absence. They are aware of what culture dictates regarding men and women's roles and most choose to do what they want with regards their involvement in complementary feeding.

Decision making on matters of finances was mostly done by both parents, while the mother was left to decide on matters of health seeking for the child. The challenges faced by the fathers were mainly to do with a lack of money to buy food along with food shortages in some of the rural shops.

Chapter 5: Discussion

5.1 Introduction

The aim of this study was to explore the understanding, experiences, and perceptions of the role that fathers can play in the complementary feeding period of children aged 6 to 23 months in Tsholotsho district, Zimbabwe. This chapter includes a discussion of findings of this research initiative and is guided by the study objectives which were to:

1. Explore fathers' understanding of the importance of age appropriate complementary feeding in children aged 6 to 23 months,
2. Explore the perceptions and personal experiences fathers have had in relation to age appropriate complementary feeding in children aged 6 to 23 months, and
3. Explore with fathers what they perceive to be some of the significant challenges inhibiting their greater involvement in complementary feeding of children within their household.

Given the above, the chapter will also reflect on how these findings relate, or not, to the existing literature by considering the similarities and/or differences in their findings. The chapter concludes with a discussion on the limitations of this study and possible topics for future research.

5.2 Reflections of the researcher: initial assumptions and new discoveries

At the time of conceptualising this study the researcher's thoughts on the topic were that local fathers were unlikely to have much understanding of complementary feeding. The researcher imagined that this was the case since the local cultural norms in Zimbabwe make childcare a priority for mothers. It was also the researcher's assumption that, because of this patriarchal norm, that they would also unlikely to have had any practical, hands-on experience with

complementary feeding. Interestingly, the researcher's assumptions and pre-conceptions about fathers being disengaged from the practice of complementary feeding was unfounded. The researcher came to learn that local fathers were in fact much more engaged in the issue than was initially imagined. The researcher realised that whilst others are still very much influenced by what culture dictates, some fathers are in some form of transition where they are now open to directly participating in child feeding.

5.3 Fathers' understanding of age appropriate complementary feeding

5.3.1 Knowledge of complementary feeding

Whilst many of the fathers did not have consistently accurate and detailed knowledge of CF (for example, the age it is meant to begin and number of meals that should be eaten in a day depending on the child's age), it is safe to say that most of the fathers had a basic idea of what CF entailed i.e. the addition of solid foods to breastmilk; which can either be prepared specifically for the baby or from the pot. This finding is consistent with the findings from a research study that was done in Western Kenya by Mukuria et al. (2016) where it was found that the fathers lacked up-to-date knowledge of optimal IYCF practices, especially during the CF period.

From the interviews it was evident that the fathers could identify and name the required food types that should be consumed by their children aged between 6 to 23 months, based on what their wives would have prepared for the children. The children have foods such as enriched mealie-meal porridge cooked specifically for them (with varying additions such as peanut butter or dried and pounded kapenta), while during family meal times they are fed from the

family pot[7]. In line with what MOHCC is advocating for the 4 Star Diet, the foods being consumed by the children are at least from the four food groups (legumes, fruits and vegetables, grains, animal source foods) and is varied in nature. This is noted by Abeshu (2016) who indicated that from the sixth month onward, complementary foods should be of a variety and of balanced mixtures of foods containing cereals, tubers, and foods of animal and vegetable origin.

While this study was not looking at fathers' in-depth knowledge on exclusive breast feeding, it assessed their awareness of continued breastfeeding among their children. Most of the fathers, were aware that their last born was still on the breast or not. One of the responses, such as noting that one mother stopped breastfeeding due to painful nipples was also similar to those given by fathers from a study done in southern Zambia by Fjeld et al. (2008), where they indicated 'sore nipples' as one of the causes of stopping breastfeeding after six months.

5.3.2 Source of complementary feeding information

The results from this study showed that most (with the exception of two) fathers confirmed their primary source of information on CF as their wives, with only two also stating their local VHW as a secondary source. This is similar to what other studies have shown. For example, in the formative research by Infant and Young Child Nutrition (IYCN), which was done in eastern and western Kenya in 2011, the men indicated that their sources of information on child care were the women who would have, in turn, received information from the clinic. Other trusted sources of information for the men included nurses and trained community health workers (IYCN, 2011; Thuita et al., 2015). Similar results were found by Bilal et al. (2016) in their study done in Ethiopia, where parental discussions seem to be the

[7] Which included sadza (this is a thick meal made from pounded maize), meat (animal source foods), vegetables, soup from tomatoes and onions or at times from any meat stew

source of information for fathers, with most fathers relying on second hand information from their wives. This is also in line with what a few of the fathers said as additional sources of information on complementary feeding: namely, that their wives provide them with information on complementary feeding and what this shows is that the fathers do receive information on CF, but the source of this information is limited to certain groups of people: their wives and local community health volunteers[8].

From an angle of practically feeding the child, in this study, those fathers whose source of information was the wives, and seemed to have some knowledge of CF alluded to participating and supporting their wives through varying activities such as feeding the child etc. Through the IYCN research (2011) it was learnt that husbands who learnt this information through their wives also appreciated the maternal infant and young child feeding (MIYCN) behaviours and furthermore reported that the practice of these behaviours brought happiness to their lives. This came out in this study through *Father 9* who giggled and said that "…*if you don't help your wife, by night time she will be so tired such that behind closed doors no action will take place*".

5.4 Perceptions and personal experiences of age appropriate complementary feeding

5.4.1 Support to mothers

In this study, it was interesting to note that most of the fathers indicated that they support the mothers of their children in some form or another so that the mothers get enough time to prepare meals for both the family and the young child. This is perhaps similar to what Bilal *et al.* (2016) and Thuita et al. (2015) found in their studies when they noted that the fathers

[8] VHWs, CBFs

selected some childcare activities and responsibilities and reported helping their wives with chores and childcare respectively.

In this particular study, though not routinely expressed across all interviews, all of the fathers in Tsholotsho acknowledged that they engage in one or more activities such as playing with the child, chopping and fetching firewood and water in bulk and cooking simple meals. Some activities such as fetching firewood and water in bulk were done so as to support their wives, whilst cooking simple meals was done mainly in the absence of the wives and they were left alone with the children. The latter type of assistance is similar to the findings from an Ethiopian study by Bilal et al. (2016) where the fathers shared that they would do these activities only if the mother was busy with other household activities or if the mother was not around. In another study by Kansiime et al. (2017) done in rural south-western Uganda, it was found that some men mentioned how working away from home made them less available to participate in child feeding activities. In relation to the current study done in Tsholotsho, there could be some truth in this as one of the fathers (Father 2) clearly indicated the opposite to this as aiding him to participate in child feeding activities. This was when he said, *"…but some men like myself have no challenges in helping my wife. After all, I am around and not away in Botswana as before or other time"*.

Whereas this study was not observing the actual IYCF practices and evaluating their outcomes, a study by Dinga, Kiage and Kyallo (2018) which was looking at IYCF practices as practiced by fathers in the Kisumu region of Kenya, noted a positive correlation between paternal support, better infant feeding practices[9], and nutrition outcomes. Similarly, the results of a study by Jones et al. (2012) showed that the lack of support from spouses was

[9] Dinga, Kiage and Kyallo (2018) measured this by minimum dietary diversity, minimum meal frequency, minimum acceptable diet.

cited as being a key barrier which was also negatively associated with improvements in child diets and feeding practices.

Based on these studies it is thus important to appreciate the level of support provided by the fathers in Tsholotsho to their wives. It would thus be prudent to reflect on the following as noted by Bilal et al. (2016), that the full involvement by the fathers might be difficult given their socialisation. Their average age was 40 years. The researchers Bilal et al., (2016) identified that in the past, all the household chores were considered as the responsibility of the mother; however, now almost half of the husbands in the community they sampled were now helping the mothers of their children. This may or may not be true regarding all the fathers in Tsholotsho district, but in a small town called Epworth in Northern Zimbabwe, the Newsday newspaper of 28 July 2018 had an article titled, ***'I don't mind sharing household chores: Epworth man'***. The article had a picture of the father riding his bicycle while strapping his baby on his back. He even went on to say "*I even take turns to do household chores with my wife. I cook sadza, while she is seated. People talk a lot in the community, but I don't mind*". This is a similar approach taken by some of the fathers in this study who indicated that they cook for their children. Though they acknowledged the existence of the issue of 'community perception' and how at times it possibly influences the sort of activities the fathers become involved in. Some fathers still consider how other community members (old and young) may view them and in this regard end up not doing as much as they would possibly want to. However, perhaps this is a sign that with time and shifting social norms, Zimbabwean fathers might increasingly be supporting their wives with IYCF.

5.4.2 Fathers' role in complementary feeding

Regarding their role in complementary feeding, all of the fathers reported bringing home purchased food and money to buy food. This was achieved through some of the fathers doing part-time jobs. Both the VHWs and the CBF confirmed that through part-time jobs fathers provided food as well as money to purchase the food. Similar to this study, Dougherty et al. (2017) initially found, in five rural villages in the Maradi region of Niger, that men generally take an indirect and supportive role by providing food and financial resource. It was only after an intervention on community videos about infant and young child feeding that was specifically targeting men, did they report to participate in household chores and buying more varied food. It was good to note that the fathers in Tsholotsho are providing financially for their children. In a study that was conducted in the rural sub-district of Agincourt, Limpopo province in South Africa (Madhavan & Townsend, 2007) the authors reported that children whose fathers did not provide financial support to their family were found to be at higher risk of malnutrition. They concluded among many other aspects that parental financial support was important in facilitating access to nutrition.

In support of what the fathers in Tsholotsho indicated Aubel et al. (2003), in their study exploring the role of grandmothers and other household actors such as fathers in child health and nutrition, mention that in daily situations fathers tend to play a secondary supportive role in relation to child caring practices; in contrast to the primary role that the mother plays. These authors go on to say that it is in crisis situations (such as when emergency health treatment is needed), when special logistical and financial support is required that men's involvement generally increases.

Generally, the fathers in Tsholotsho see themselves as playing a somewhat 'provider' or 'supplier' role when it comes to complementary feeding and this is similar to what other researchers such as Bilal et al. (2016) and Thuita et al. (2015) have found in their studies.

5.4.3 Perceptions of fathers regarding complementary feeding

According to two key informants, village health workers working in the Tsholotsho community, the fathers' perceptions and practices of child care and feeding seem to have improved from the past decade. They indicated that this has been evident especially among some of the younger fathers i.e. those aged 40 years and younger. They suggested that to have fathers talk of cooking for their children and assisting with household chores like fetching firewood and water in bulk shows that there is a positive change in their perception of their role regarding child care and household chores.

In their study, Bilal et al. (2016:335) aimed at 'investigating the extent of perceptions, practices and challenges of fathers from low-income settings in routine child care in Ethiopia'. During the course of their study they came up with 3 models of fathers which are outlined in the box below:

Model to describe fathers' perception, beliefs, practice, and challenges towards routine child care and feeding

Model 1: traditional fathers

- Fully perceive that child care is only mother's responsibility,
- Only feel responsible for making money/farming,
- Difficult to change attitudes and behaviours.

Model 2: fathers in transition

- Perceive childcare as being the mothers' and fathers' responsibility,
- Do not feel completely responsible for child care,
- Set preconditions and are selected on the activities,
- Changing behaviour and practice will not be difficult.

Model 3: modern fathers

- Perceive child care and child feeding as a shared responsibility between the mother and father,
- Totally involved in child's life,
- Know their responsibility in the house,
- Very ready for changes.

Source: Bilal et al. (2016:335)

Based on the accounts and perceptions of the fathers in Tsholotsho towards complementary feeding, they can be placed in two of the three models, namely: the traditional fathers (Model 1) and fathers in transition (Model 2).

Based on the results, this study could not confidently classify any fathers under the category of modern father (Model 3). Looking at how Bilal et al. (2016) described this group, one can interpret that in as much as the Tsholotsho fathers occasionally helped with some activities such as cooking, most indicated that they would only do this in the absence of the child's mother. While one or two interviewees could be categorised as 'traditional fathers' (Father 6 and Father 4), the rest could be said to be 'fathers in transition'.

5.4.4 Role of fathers in complementary feeding

Some of the fathers mentioned their willingness to cook specific meals for their children albeit during the wives' absence. They reported to be able to cook mealie-meal porridge enriched with peanut butter and also sadza with relish (meat, vegetables, soup). As noted in the beginning of this chapter this was an unexpected finding for myself as the researcher. What struck the researcher was that those who reported doing this talked confidently and positively about their practice, with smiles on their faces, expressing their willingness to assist in this way. This is contrary to what was found by IYCN (2011) in eastern and western Kenya. In this particular Kenyan context, it was reported that the men had no input in any food preparation as they considered it not to be their work as men. For the Kenyan men, what they considered as feasible was bringing food or money to purchase food for the family.

It is thus important to bring to light what was said by Parke (2008) and cited by Vollmer et al. (2015:3735), "…*because the role of the father is more loosely defined by societal norms than the role of the mother, a fathers' own* ***perceptions*** *of his role in his child's life may drive his behaviour*". This indeed may explain the perceptions of some of the fathers in Tsholotsho, such as shared by one interviewee (Father 5) when he said:

> *"I feed my child… I have no problem in doing this…I realise that at times as men we tend to worry a lot about what other men think… I understand the importance of complementary feeding…".*

Bearing all this in mind, this study adds new insight into the current literature about the Zimbabwean norms and the extent to which the fathers engage in certain activities at the household level related to complementary feeding.

5.4.5 Decision making at the household level regarding complementary feeding

i. Purchase of food

In this study, it was found that half of the fathers indicated that they decide together with their wife on what foods to buy, while the other half said it was their wife's decision entirely about what food to purchase. This is quite contrary to the findings from a baseline survey done in Bangladesh in 2011 by Saha et al. where they found that fathers had a strong control over the foods that were purchased in the household. Similarly, in another study by Bilal et al. (2014) in Ethiopia, it was found that if the father is responsible for making the financial decision within the household the decision to purchase nutrient-rich foods for the baby also depends on him. When one considers the dynamics of power and decision making between men and women in general (and within the context of a household specifically) issues like culture, religion and the dominant gender norms obviously come into play. Whilst the latter two examples stand in contrast to the level of engagement reported by the fathers in Tsholotsho, it is useful to be aware of what happens elsewhere and how context-specific a father's involvement in child-feeding practices are.

ii. Health centre visits

From the study, all the fathers mentioned how it was the mothers who took the children to the clinic for routine check-ups i.e. for growth monitoring, vitamin A supplementation and that it was also their wives who made the decision about when to take the child to the clinic. This is similar to findings by Muraya et al. (2017) in Kenya and Tolhurst and Nyonator (2006) in Ghana which showed similar dynamics as with this study where the mothers decided on when to take as well as actually taking the children to the clinic. In Ethiopia, Bilal et al. (2016) found that the father's perceived taking the child for immunisations and attending any other

health-related visit for their child was considered an insignificant activity. However, what this study did not investigate was if there was any change in the father's attitude if the nature of ailment became more serious.

Findings from this study in Tsholotsho are also consistent with what was found by Molyneux et al. (2002) in Kenya which explored decision-making dynamics and treatment-seeking patterns of parents in relation to fever and malaria. Their findings showed that generally while men were the main decision makers in relation to the child being taken for treatment for childhood illness, mothers were less likely to consult or seek permission from anyone for symptoms such as fever.

5.4.6 Gender considerations regarding fathers and complementary feeding

It was important to discuss with the fathers with regards gender roles and responsibilities as they relate to complementary feeding within their households. Some of the fathers, regardless of their 'modern' way of thinking, acknowledge the existence of what culture defines as traditional norms regarding the roles of men and women in the home. They further acknowledged that it was not easy to change traditional norms and culture. Between 2010 and 2011, UNICEF and London School of Tropical Medicine conducted an extensive literature review about gender influences on child survival. They drew on findings from academic and 'grey' literature along with a systematic search of the Discover database[10]. From this review, it was noted that generally, the gender division of labour among men and women dictates that women provide most of the childcare whilst the men fulfil some sort of income generating role. This generally reflects the dominant division of labour that was reported by the fathers in this study.

[10] Which comprises 33 of the leading health and Social Sciences databases

There has been an increasing recognition in the field of international health and nutrition that gender inequalities and/or dynamics are a major social determinant of child health (Commission on the Social Determinants of Health, 2008). While culture plays a role in influencing what men do or not do in child feeding, Barker et al. (2003) brings in a different dimension through their analysis of men's roles. They suggest that the lack of men's involvement with their children should not be viewed as 'irresponsibility'. Instead, the complexity of men's experiences should be recognised. They also go on to state that the father's life stage may influence the degree of their involvement and provision for their children.

From her literature review on young child nutrition and HIV, Aubel (2011) concluded that intervention strategies should adopt a more family focused approach i.e. involving the men more. However, any efforts to involve those with greater decision-making authority must challenge rather than reinforce gender norms that maintain power hierarchies within households, which are ultimately damaging to the health of children. What Barker et al. (2003) and Aubel (2011) are essentially saying to us is that fathers should be included more despite how society perceives their actions when it comes to IYCF.

The diagram below (Figure 2) shows how gender divisions of labour among men and women are influenced by cultural, social and economic determinants and this ultimately results in inappropriate childcare practices which impact on child survival.

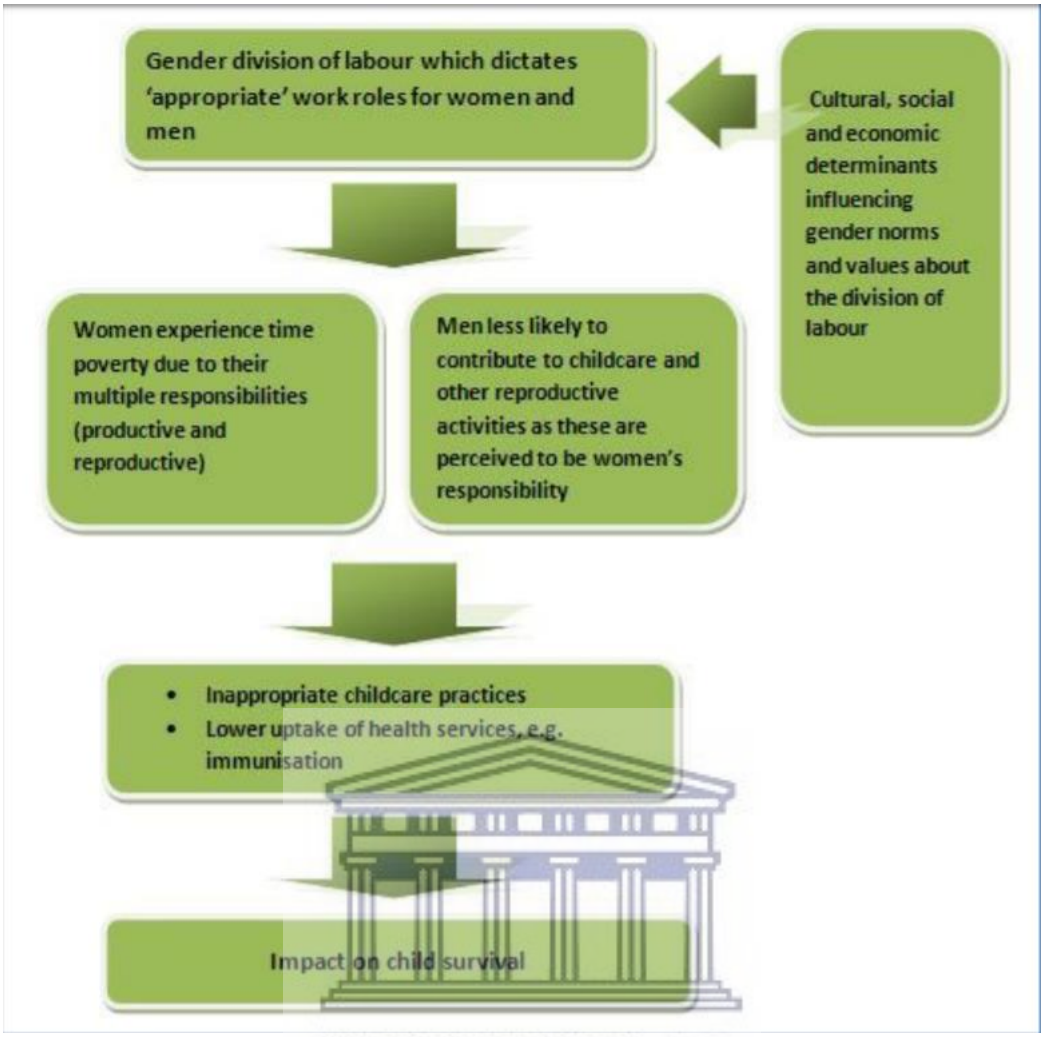


Figure 2 Diagram depicting the relationship between elements of the gender divisions of labour and child survival, adapted from UNICEF & London School of Tropical Medicine. (2011). Gender Influences on Child Survival, Health & Nutrition: A Narrative Review, pg34.

Using the above diagram (Figure 2) and its depiction of how gender relations ultimately impact child survival, it can be seen that the element of 'culture' that was mentioned by the fathers is still in existence ultimately affects the level and type of support they may render to their wives. This in turn maintains the traditional norms of certain roles being solely women's, as indicated by a few of the fathers in this study. This in-turn can lead to inappropriate child care practices along with a lower uptake of health services which ultimately impacts child survival or more specifically-stunting.

This further highlight how complex issues of child care are at the household level and how possibly, by engaging fathers, some of these 'gender norms' can be changed for the better of young children.

5.3 Challenges faced during complementary feeding

The Zimbabwean economy has been on a downward spiral, losing 52% of its gross domestic product (GDP) between 1999 and 2008. Since then, industries have shrunk, unemployment skyrocketing, while the country has been left importing most of its basic commodities (Kanyenze, Chitambara & Tyson, 2017). With the economic downturn that has befallen the country, it was not surprising that most fathers cited a lack of adequate finances as their major challenge with regards to complementary feeding, along with shortages of certain food (such as cooking oil and rice) from the rural shops. The shortages of certain foods were also confirmed by two of the key informants. This resonates with findings from other studies where, for example, Bilal et al. (2016) found that financial problems were mentioned as a major factor that was hindering the fathers from purchasing adequate food along with the shortage of food. In the study by Dougherty et al. (2017:19), it was noted that, "factors such as money" posed a barrier for families in relation to the purchase of adequate food for the family. Furthermore, a husband even went on to indicate that the lack of money limited him in the frequency and amount of nutritious food that he could bring the family.

Based on the responses from a few of the fathers, additional challenges faced are a poor understanding of the importance of complementary feeding, and the consideration of child feeding activities as women-only responsibilities as indicated by the 'traditional fathers'-model 1. This was also noted by Bilal et al. (2016) among the fathers in Ethiopia. What this

shows is that these challenges are not just unique to the fathers in Zimbabwe, but are also faced by fathers elsewhere in Africa.

5.4 Study Limitations

The study did not interview mothers of children aged 6 to 23 months as a way of triangulating what the fathers had said. This is one limitation as a study in Bolivia by Jones et al. (2012) reported women as not receiving support from their spouses. With regards to the fathers in Tsholotsho, apart from the key informants, there is no one else at household level to confirm or deny the information given by the fathers.

The study having been done in Tsholotsho thus only considers how 'Ndebele' fathers understand, perceive, and experience complementary feeding. Zimbabwe is a nation of many cultures and this then limits the conclusiveness of the results as there would need to be similar studies in other parts of the country so as to explore how fathers from other cultures perceive the subject matter as well.

5.5 Summary

This chapter discussed findings from the study. Similarities and contrasts were shown between the study findings and literature mostly from other countries as there is a paucity of literature on this study topic in relation to Zimbabwe. The study explored fathers' understanding of the importance of complementary feeding along with their perceptions and personal experiences of complementary feeding in children aged 6 to 23 months. The challenges they faced were highlighted. The study also looked broadly at the gender dynamics in that community along with the cultural norms in existence.

What has been clear from this study is that fathers have some knowledge about complementary feeding and mostly get this information from their wives. This aspect was similar to a number of studies involving fathers from other African countries. Despite the element of culture which has traditionally dictated what men and women do, some of the fathers look beyond this and do what they think is best for their children. With regards the fathers in Tsholotsho, there seems to be a shift towards them being more involved in activities such as cooking for their children etc. as compared to long ago. This was shown by key informants who mentioned acculturation as playing a key role in this 'shift', though this was noted more among the younger generation.

Chapter 6: Conclusion and recommendations

6.1 Introduction

The study set out to explore the understanding, experience, and perceptions of the role that fathers can play in the complementary feeding period of children aged 6 to 23 months in Tsholotsho district, Zimbabwe. The study also explored what the fathers perceived to be some of the significant challenges inhibiting their greater involvement in complementary feeding of children in their households. Against this background, the findings from this study were presented and discussed and this chapter will now conclude the study and provide both general recommendations and recommendations for further research.

6.2 Conclusion

This study found that the fathers did not have consistently accurate and detailed knowledge of complementary feeding. Furthermore, the little knowledge they had was obtained mostly from their wives. This finding is consistent with findings from others studies done elsewhere such as the Ethiopia study by Bilal et al. (2016) and Kenya study by Thuita et al. (2015).

The study also found that the fathers did support their wives with household activities such as playing with the child, fetching water and firewood in bulk and cooking simple meals for their children, though the latter was generally reported as being done during the mothers' absence. These activities are also consistent with what was found in studies done in Kenya by Thuita et al. (2015) and IYCN (2011). Interesting to note, and specifically mentioned by key informants, is that there has been a notable change in behaviour among the fathers in comparison to what they did 10 years ago: fathers these days seem to be more involved in complementary feeding. This increased involvement can be illustrated through the Model by Bilal et al. (2016) to describe fathers' perception, beliefs, practice and challenges towards routine child care and feeding, which shows that most of the fathers interviewed (eight of ten)

could be classified as 'fathers in transition' who perceive child care as being the mothers' *and* fathers' responsibility. These fathers are still however mindful of what the predominant culture defines as a father's role in child feeding and thus are selective about the activities they do. On the other hand, the two fathers who were classified as being 'traditional fathers' perceived that child care was the responsibility of mothers only and their responsibility was to provide money.

Decision making seems to be shared when it comes to the purchase of food in the household according to this study. It was however, a different scenario when it came to taking the child to the health centre for routine monitoring. None of the fathers were involved in this activity as they all indicated that their wives did this. This was similar to other findings in literature from countries such as Kenya (Molyneux et al. 2002; Muraya et al. 2017), Ghana (Tolhurst & Nyonator, 2006) and Ethiopia (Bilal et al, 2016).

From their perspective, the fathers were not immune to facing challenges in relation to their involvement in complementary feeding as they mentioned facing financial challenges as their main obstacle affecting their involvement in complementary feeding in that they could not provide adequate nutrition for the child. It was also noted that these challenges faced by the fathers were not just unique to this study, but in other countries as well.

Through the use of a diagram (Figure 2), it was shown how gender divisions of labour between men and women are influenced by cultural, social and economic determinants and this ultimately results in inappropriate childcare practices which impact on child survival.

Thus, showing the complexities of child care at household level and how important it is for fathers to be involved in the child care practices of their children is still- and will be in the future an important research endeavour.

As well noted, many of the findings from this study resonate with what has been found in literature in many other African countries. The findings from this study bear significance in that there is no other known study in Zimbabwe that has explored the understanding, experiences and perceptions of the role that fathers can play in the complementary feeding period of children aged 6 to 23 months in Zimbabwe. Rich exploratory insights into the subject matter have been provided and can thus be expanded upon in future research. Bearing all this in mind, the following recommendations are made.

6.3 Recommendations

I. Taking into account one of the limitations of this study i.e. of it focusing on one cultural domain (Ndebele), it is recommended that similar studies be done in other cultural domains within Zimbabwe so as to reflect the multicultural nature of the varying traditions and culture. By knowing the perceptions, practices and challenges regarding complementary feeding, this will then help the Ministry of Health and Child Care in crafting interventions to involve and/engage fathers more in their children's lives. This being done with the ultimate aim of improving child feeding and possibly reducing stunting.

II. The role of fathers in complementary feeding needs further research. Apart from the angle looked at by this study i.e. 'what the fathers perceive as their role', it is still

unclear how father's perception of how his wife perceives his role within the family set-up may influence his child feeding practices.

III. In order to reach those fathers who, obtain their information from community volunteers, it may be important for clinics to host 'fathers' days so that fathers may be specifically provided with information by the community volunteers regarding child feeding so as to increase their understanding.

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Appendix 1: Information sheet for fathers

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809 Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

INFORMATION SHEET

Project Title: An exploration of the knowledge and involvement of fathers in the practice of complementary feeding of infants and young children in Tsholotsho district, Zimbabwe.

What is this study about?

This is a research project being conducted by Shamiso Alice Moyo, a student at the University of the Western Cape, Cape Town, South Africa. We are inviting you to participate in this research project by taking part in an interview. We would like to interview fathers who have children between the ages of 6 - 23 months. We would like to discuss with them their understanding, experiences and opinions about the role fathers can play in the feeding of their children between the ages of 6 - 23 months. The purpose of this research project is to obtain first-hand information from fathers about this topic so that we can use this information to assist the nutritionists to come up with their future planning around their health promotion and nutrition programmes in the district.

What will I be asked to do if I agree to participate?

You will be asked to participate in an interview with the researcher for approximately one hour. The researcher will have a set of questions that she will be asking you to respond to. The questions that will be asked will be those that will explore the understanding, experiences and perceptions of the role fathers can play in the complementary feeding of children 6 to 23 months. During the interview, the researcher will be taking down notes in a note-book, while also recording the whole interview on a voice tape recorder.

Would my participation in this study be kept confidential?

The researcher undertakes to protect your identity and the nature of your contribution. To ensure your anonymity, a pseudonym will be used and only the researcher will be aware of your true identity. To ensure your confidentiality, only the researcher will have access to the collected data. The collected data will be stored in locked filing cabinet and transcribed notes typed and kept in a password-protected computer file only known by the researcher.

If we write a report or article about this research project, your identity will be protected through the use of a pseudonym that will ensure your anonymity.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others. In this event, we will inform you that we have to break confidentiality to fulfil our legal responsibility to report to the designated authorities.

What are the risks of this research?

All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator explore the understanding, experiences and perceptions of the role fathers can play in the complementary feeding of children 6 to 23 months. We hope that, in the future, other people might benefit from this study through improved understanding of what fathers know, understand, experience and perceive about complementary feeding. This would help to add onto the body of knowledge with regards complementary feeding.

Do I have to be in this research and may I stop participating at any time?
Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised or lose any benefits to which you otherwise qualify.

What if I have questions?
This research is being conducted by **Shamiso Alice Moyo and School of Public Health** at the University of the Western Cape. If you have any questions about the research study itself, please contact Shamiso Alice Moyo at: 0773507044 and shamyalice@yahoo.com**.**
Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof Uta Lehmann
School of Public Health
Head of Department
University of the Western Cape
Private Bag X17
Bellville 7535
soph-comm@uwc.ac.za

Prof Anthea Rhoda
Acting Dean of the Faculty of Community and Health Sciences

University of the Western Cape
Private Bag X17
Bellville 7535
chs-deansoffice@uwc.ac.za

This research has been approved by the University of the Western Cape's Research Ethics Committee. (REFERENCE NUMBER: *BM17/9/9*)

Appendix 2: Key Informant information sheet - VHWs and CBFs

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E-mail: soph-comm@uwc.ac.za

INFORMATION SHEET

Project Title: An exploration of the knowledge and involvement of fathers in the practice of complementary feeding of infants and young children in Tsholotsho district, Zimbabwe.

What is this study about?

This is a research project being conducted by Shamiso Alice Moyo, a student at the University of the Western Cape, Cape Town, South Africa. We are inviting you to participate in this research project by taking part in an interview. We would like to interview VHWs/CBFs who have volunteer in the selected wards. We would like to discuss with you your, experiences and opinions about the role fathers can play in the feeding of their children between the ages of 6 - 23 months. The purpose of this research project is to obtain first-hand information from fathers about this topic so that we can use this information to assist the Nutritionists to come up with their future planning around their health promotion and nutrition programmes in the district. Your in-put as VHWs/CBFs is very valuable as you live and work within these communities.

What will I be asked to do if I agree to participate?

You will be asked to participate in an interview for approximately one hour. The researcher will have a set of questions that she will be asking you to respond to as an individual. The questions that will be asked will be those that will explore your understanding with regards the, experiences and perceptions of the role fathers can play in the complementary feeding of children 6 to 23 months. During the interview, the researcher will be taking down notes in a note-book, while also recording the whole interview on a voice tape recorder.

Would my participation in this study be kept confidential?

The researcher undertakes to protect your identity and the nature of your contribution. To ensure your anonymity, a pseudonym will be used and only the researcher will be aware of your true identity. To ensure your confidentiality, only the researcher will have access to the collected data. The collected data will be stored in locked filing cabinet and transcribed notes typed and kept in a password-protected computer file only known by the researcher.

If we write a report or article about this research project your identity will be protected

through the use of pseudonyms.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others. In this event, we will inform you that we have to break confidentiality to fulfill our legal responsibility to report to the designated authorities.

What are the risks of this research?

All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator explore the understanding, experiences and perceptions of the role fathers can play in the complementary feeding of children 6 to 23 months. We hope that, in the future, other people might benefit from this study through improved understanding of what fathers know, understand, experience and perceive about complementary feeding. This would help to add onto the body of knowledge with regards complementary feeding.

Do I have to be in this research and may I stop participating at any time?
Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised or lose any benefits to which you otherwise qualify.

What if I have questions?
This research is being conducted by **Shamiso Alice Moyo and School of Public Health** at the University of the Western Cape. If you have any questions about the research study itself, please contact Shamiso Alice Moyo at: 0773507044 and shamyalice@yahoo.com**.**
Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

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BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
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Bellville

Appendix 3: Consent form for all interviewees (fathers, VHWs, CBFs)

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CONSENT FORM

Title of Research Project: An exploration of the knowledge and involvement of fathers in the practice of complementary feeding of infants and young children in Tsholotsho district, Zimbabwe.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

___ I agree to be audiotaped during my participation in this study.

___ I do not agree to be audiotaped during my participation in this study.

Participant's name……..

Participant's signature…….

Date……

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

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Private Bag X17
Bellville 7535

Appendix 4 : Local authority permission request

43 Aberdeen Road
Matsheumhlope
Bulawayo, Zimbabwe

1 September 2017

The Provincial Medical Directorate
Matabeleland North Province
Bulawayo, Zimbabwe

Dear Sir/Madam

RE: Request for permission to carry out a Masters research by Shamiso Alice Moyo

My name is Shamiso Alice Moyo and I am a Masters student currently in the process of completing my MPH with the University of the Western Cape, Cape Town South Africa.

As part of the requirements of the MPH we are required to conduct a small research project. My research project aims to explore the understanding, experiences and perceptions of the role fathers can play in the complementary feeding period of children (between 6 to 23 months) in Tsholotsho district, Zimbabwe.

Please find the protocol attached with this request that describes the background and motivation for the study and what is proposed in terms of process.

I would like to request permission to conduct my research *"An exploration of the knowledge and involvement of fathers in the practice of complementary feeding of infants and young children in Tsholotsho district, Zimbabwe."*

Ethical approval for this research has been approved by the University of the Western Cape's Research Ethics Committee. (REFERENCE NUMBER: BM17/9/8).

I would welcome any questions or concerns you have about this research and can be reached on my mobile (0773 507044) or through email (shamyalice@yahoo.com).

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof Uta Lehmann
School of Public Health

Head of Department
University of the Western Cape
Private Bag X17
Bellville 7535
soph-comm@uwc.ac.za

Prof Anthea Rhoda
Acting Dean of the Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
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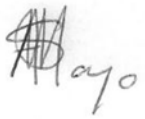
chs-deansoffice@uwc.ac.za

Sincerely



Shamiso Alice Moyo
0773 507 044
Email: shamyalice@yahoo.com

Appendix 5: In-depth Interview Guide for use with Fathers

General background questions about the father and his presence in the household

- What is the age of your child/your youngest child?
  (Probe: is the youngest a girl or a boy)?
- How many other children live in this household? What are their ages?
  (Probe which are girls and which are boys)
- How many other adults (apart from yourself) live in this household currently?
  (Probe what their relationship is to the participant)
- Since your last child was born, have you lived all / for most of the year in this household - or only some of the year in this household?
  (Probe economic migrancy and the potential number of days / months or over the period of a year the father is away from home for)

Father's Understanding of complementary feeding

- Please tell me about complementary feeding in your own understanding.
  (*Probe who provided them with this information and what information they were given*)
- What sort of foods should/does your child eat?
  (*Probe if child consumed foods from the four food groups*)
- What do you understand with regards the number of meals that should be eaten by your child in a day?
- Where does your child eat from?
  (Probe if child eats from their own plate or from an adult's plate)
- What is your understanding with regards supporting the baby's mother to get enough time to prepare meals?
  (Probe to what extent this is happening in his household or prepared to help)
- *(Probe on the sort of activities he does or is willing to do)*What recipes do you know for young children?
  Probe if he is willing or able to prepare such recipes
  Probe if he would prepare such recipes in either the presence or absence of the mother

Perceptions and personal experience

- Can you tell me about your experience with complementary feeding?
- To what extent do you practically feed the child?
  (Probe if he feeds child, at what times does he feed the child and number of times)
- Who normally feeds the child
  (Probe who feeds the child during sickness)
- How do you feel about complementary feeding?
- What is your role regarding complementary feeding?
- What is your role in your family's access to food?
  (Probe what sort of support he provides in this regard?)
- Who decides on what food should be bought in the household?
- Who decides on how money should be used in the household?
- Who decides on utilisation of health services for the child such as growth monitoring and vitamin A supplementation?

Perceived Challenges

- Are there any challenges that you face regarding complementary feeding?
  (*Probe if any challenges and specifically what they are and how they are overcome*)

Appendix 6: Interview Guide: Key Informant (VHWs)

- What sort of activities do you do as a VHW with regards to complementary feeding?
- What is the average number of meals consumed by children 6 to 23 months in your community?
- From your perspective and based on your day-to-day interactions, describe the local culture with regards men and complementary feeding in this community?
- What sort of activities do the men do with regards complementary feeding?
- What do the men understand/know what complementary feeding is?
- From your observations, how are fathers involved in the complementary feeding of their children?
- What sort of support if any do fathers provide to their families regarding complementary feeding?

Appendix 7: Interview Guide: Key Informant (CBF)

- What sort of activities do you do as a CBF that is linked to complementary feeding?
- To what extent are the fathers involved in supporting their family's access to clean and safe water?
- From your perspective and based on your day-to-day interactions, describe the local culture with regards men and complementary feeding in this community?
- What sort of activities do the men do with regards complementary feeding?
- What do the men understand/know what complementary feeding is?
- From your observations, how are fathers involved in the complementary feeding of their children?
- What sort of support if any do fathers provide to their families regarding complementary feeding?

Appendix 8: Information sheet for fathers - TRANSLATION

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E-mail: soph-comm@uwc.ac.za

Isihloko salesi sifundo sithi:

Ukuchwayisisa ngolwazi kanye lokuphatheka kwabo baba ekunikeni abantwana abancane ukudla esigabeni seTsholotsho, Zimbabwe.

Ukuchwayisisa lokhu kumayelana ngani?

Lokhu kuchwayisisa kweziwa ngu Shamiso Alice Moyo, ongumfundi e University yase Western Cape, eCape Town kwelase South Africa. Siyakunxusa ukuba uphatheke kulesi sifundo ngokuxoxisana lathi. Sithanda ukuxoxisana labo baba abalantwana abale nyanga eziyisithupha kusiya kulabo abala matshumi amabili lantathu. Sifisa ukuxoxisana lani ngokuzwisisa kwenu, ngemibono yenu, ngeselakubonayo njalo lesandla elingaba laso ekunikeni umntwana olenyanga eziyisithupha kusiya kumatshumi amabili lantathu ukudla. Ulwazi esizalithola ekuchwayisiseni lokhu kuzasisiza ukuba siphathisane labakhangelane lezokudla ekubumbeni inhlelo zempilakahle lezokudla esigabeni.

Nxa ngivuma ukuphatheka kulokhukuhlolisisa, kuyini engikhangelelwe ukuthi ngikwenze?

Sizacela ukuxoxisana lawe phose okwe hola elilodwa.Lo ochwayisisayo uzaba lemibuzo azakubuza yona.Imbuzo le izabe imayelana lokuzwisisa, esalake lahlangana lakho njalo langemibono yenu ngesandla obaba abangaba laso ekunikeni ekunikeni umntwana olenyanga eziyisithupha kusiya kumatshumi amabili lantwathu ukudla. Ochwayisisayo uzabe bhala phansi, njalo lomtshinyana ogcina amazwi uzasetshenziswa ngesikhathi lixoxa.

Ukuphatheka kwami kulokhu kuchwayisisa kuzaba yimfihlo na?

Ibizo lakho, lapho ohlala khona, lazo nje zonke impendulo ozazipha kulesisifundo kuza gcinwa kuyimfihlo.Kuzakwaziwa yimi kunye lalowo ongiholayo kulokhu kuchwayisisa. Njalo ibizo lakho kalisoze lilotshwe ndawo kungwalo zalesifundo njalo konke ozakutsho akusoze kwaziwe ukuba kwakhulunywa nguwe loba ngubani ozaba lengxenye kulesisifundo. Zonke izingwalo eziphathelene lalokhu kuhlolisisa (kumbe lesi sifundo) zizagcinwa endaweni efihlakeleyo zifinyelelwa yimi lalowo ongiholayo kulesi sifundo.

Singavele sibhale amaphepha ngaloko esikufundileyo kulololu uhlelo asisoze siveze ibizo lako. Sizafihla ibizo lakho ngokusebenzisa elinye elingasilo lakho

Ngenje zimiso lezivumelwano ezihlelwe ngabomthetho kumbe ababona ngokuziphatha kwabaqeqeshileyo, sizaveza labo abahlukuluza kumbe abangaphathi kuhle abantwana.

Inhlupho ongahlangana lazo ngokuxoxisana lathi?

Zonke inxoxo zokuchwayisisa zingaletha ukungahlaliseki, ngakho ke sizenza konke okusemandleni ethu ukubasikuvikele kulokho kungahlaliseki. Thanda utholakele usukuleso simo, sizaku xhumanisa lenhlanganiso eziphathelane lalokho.

Nzuzo bani ozayithola nxa uthe wakhethe ukuba kulesifundo?

Akulanzuzo oyitholayo ngokubayingxenye kulesisifundo, kodwa impumela izasiza ochwayisisayo ukuzwisisa ngemibono yenu ,ngeselakubonayo njalo lesandla elingaba laso ekunikeni umntwana olenyanga eziyisithupha kusiya kumatshumi amabili lantwathu ukudla. Silethemba ukuthu ukuchwayisisa lokhu kuzaphathisa abanye kwelakusasa, ekuzwisiseni indlela obaba abazwisisa ngayo, lembono yabo mayelana lokunika abantwana abancane ukudla. Lokhu kuzakwengeza ulwazi abalalo mayelana lokudla kwabantwana abancane.

Kungumlando na ukuba ube yingxenye kulesisifundo?

Ukuphatheka kwakho kulokhu kuchwayisisa kukuwe. Ukhululekile ukwala kumbe ukuvuma. Nxa ungakhetha ukuba uphatheke kulokhu kuchwayisisa ulemvumo yokwekela loba kusiphi isigaba. Nxa uthe wekela kumbe wala ukuphatheka, akusoke kwabalo kwethuselwa, kumbe ukubekwe icala.

Nxa ungaba lemibuzo.

Lokhu kuchwayisisa kwenziwa ngu **Shamiso Alice Moyo le School of Public Health e University yase Western Cape.** Nxa ungaba lemibuzo mayelana lalokhu kuchwayisisa, xhumana lo Shamiso Alice Moyo ku 0773507044 loba ku **shamyalice@yahoo.com**

Nxa ungaba lemibuzo mayelana lokuchwayisisa kanye lama lungelo akho ngokuphatheka kwakho kumbe uhlupho ongabe uhlangane lalo, xhumana lo:

Prof Uta Lehmann
School of Public Health
Head of Department
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Prof Anthea Rhoda
Acting Dean of the Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535
chs-deansoffice@uwc.ac.za

Loku ukuchwayisisa kuvumiwe leUniversity yase Western Cape's Research Ethics Committee. (REFERENCE NUMBER: BM17/9/8)

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
Research Office

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University of the Western Cape
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Appendix 9: Information sheet for VHWs and CBFs - TRANSLATION

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809 Fax: 27 21-959 2872

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Isihloko salesi sifundo sithi:

Ukuchwayisisa ngolwazi kanye lokuphatheka kwabo baba ekunikeni abantwana abancane ukudla esigabeni seTsholotsho, Zimbabwe.

Ukuchwayisisa lokhu kumayelana ngani?

Lokhu kuchwayisisa kweziwa ngu Shamiso Alice Moyo, ongumfundi e University yase Western Cape, eCape Town kwelase South Africa. Siyakunxusa ukuba uphatheke kulesi sifundo ngokuxoxisana lathi. Sithanda ukuxoxisana lamaVHW kumbe amaCBF. Sifisa ukuxoxisana lani ngokuzwisisa kwenu, ngemibono yenu, ngeselakubonayo njalo lesandla elingaba laso kwabobaba ekunikeni umntwana olenyanga eziyisithupha kusiya kumatshumi amabili lantathu ukudla. Ulwazi esizalithola ekuchwayisiseni lokhu kuzasisiza ukuba siphathisane labakhangelane lezokudla ekubumbeni inhlelo zempilakahle lezokudla esigabeni.

Nxa ngivuma ukuphatheka kulokhukuhlolisisa, kuyini engikhangelelwe ukuthi ngikwenze?

Sizacela ukuxoxisana lawe phose okwe hola elilodwa.Lo ochwayisisayo uzaba lemibuzo azakubuza yona.Imbuzo le izabe imayelana lokuzwisisa, esalake lahlangana lakho njalo langemibono yenu ngesandla obaba abangaba laso ekunikeni umntwana olenyanga eziyisithupha kusiya kumatshumi amabili lanthathu ukudla. Ochwayisisayo uzabe bhala phansi, njalo lomtshinyana ogcina amazwi uzasetshenziswa ngesikhathi lixoxa.

Ukuphatheka kwami kulokhu kuchwayisisa kuzaba yimfihlo na?

Ibizo lakho, lapho ohlala khona, lazo nje zonke impendulo ozazipha kulesisifundo kuza gcinwa kuyimfihlo.Kuzakwaziwa yimi kunye lalowo ongiholayo kulokhu kuchwayisisa. Njalo ibizo lakho kalisoze lilotshwe ndawo kungwalo zalesifundo njalo konke ozakutsho akusoze kwaziwe ukuba kwakhulunywa nguwe loba ngubani ozaba lengxenye kulesisifundo. Zonke izingwalo eziphathelene lalokhu kuhlolisisa (kumbe lesi sifundo) zizagcinwa endaweni efihlakeleyo zifinyelelwa yimi lalowo ongiholayo kulesi sifundo.

Singavele sibhale amaphepha ngaloko esikufundileyo kulololu uhlelo asisoze siveze ibizo lako. Sizafihla ibizo lakho ngokusebenzisa elinye elingasilo lakho.

Ngenje zimiso lezivumelwano ezihlelwe ngabomthetho kumbe ababona ngokuziphatha kwabaqeqeshileyo, sizaveza labo abahlukuluza kumbe abangaphathi kuhle abantwana.

Inhlupho ongahlangana lazo ngokuxoxisana lathi?

Zonke inxoxo zokuchwayisisa zingaletha ukungahlaliseki, ngakho ke sizenza konke okusemandleni ethu ukubasikuvikele kulokho kungahlaliseki. Thanda utholakele usukuleso simo, sizaku xhumanisa lenhlanganiso eziphathelane lalokho.

Nzuzo bani ozayithola nxa uthe wakhethe ukuba kulesifundo?

Akulanzuzo oyitholayo ngokubayingxenye kulesisifundo, kodwa impumela izasiza ochwayisisayo ukuzwisisa ngemibono yenu ,ngeselakubonayo njalo lesandla elingaba laso ekunikeni umntwana olenyanga eziyisithupha kusiya kumatshumi amabili lantwathu ukudla. Silethemba ukuthu ukuchwayisisa lokhu kuzaphathisa abanye kwelakusasa, ekuzwisiseni indlela obaba abazwisisa ngayo, lembono yabo mayelana lokunika abantwana abancane ukudla. Lokhu kuzakwengeza ulwazi abalalo mayelana lokudla kwabantwana abancane.

Kungumlando na ukuba ube yingxenye kulesisifundo?

Ukuphatheka kwakho kulokhu kuchwayisisa kukuwe. Ukhululekile ukwala kumbe ukuvuma. Nxa ungakhetha ukuba uphatheke kulokhu kuchwayisisa ulemvumo yokwekela loba kusiphi isigaba. Nxa uthe wekela kumbe wala ukuphatheka, akusoke kwabalo kwethuselwa, kumbe ukubekwe icala.

Nxa ungaba lemibuzo.

Lokhu kuchwayisisa kwenziwa ngu **Shamiso Alice Moyo le School of Public Health e University yase Western Cape.** Nxa ungaba lemibuzo mayelana lalokhu kuchwayisisa, xhumana lo Shamiso Alice Moyo ku 0773507044 loba ku **shamyalice@yahoo.com**

Nxa ungaba lemibuzo mayelana lokuchwayisisa kanye lama lungelo akho ngokuphatheka kwakho kumbe uhlupho ongabe uhlangane lalo, xhumana lo:

Prof Uta Lehmann
School of Public Health
Head of Department
University of the Western Cape
Private Bag X17
Bellville 7535
soph-comm@uwc.ac.za

Prof Anthea Rhoda
Acting Dean of the Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535
chs-deansoffice@uwc.ac.za

Loku ukuchwayisisa kuvumiwe leUniversity yase Western Cape's Research Ethics Committee. (REFERENCE NUMBER: BM17/9/8)

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
Research Office
New Arts Building,

C-Block, Top Floor, Room 28
University of the Western Cape
Private Bag X17
Bellville

Appendix 10: Consent form for all interviewees – Translation

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809 Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

CONSENT FORM
(Invumo evela kophendula imibuzo)

Isihloko salesi sifundo: Ukuchwayisisa ngolwazi kanye lokuphatheka kwabo baba ekunikeni abantwana abancane ukudla esigabeni seTsholotsho, Zimbabwe.

Ngithole ingcazelo engcweleyo ngalesi sifundo njalo sichasiswe ngolimi engiluzwisisayo. Ngalokho ke ngikhethe ukuba yingxenye kulesi sifundo. Imibuzo yonke engibe layo iphenduliwe. Kusobala kimi lokuba ibizo lami kunye lakho konke okuphathelene lami kuza ngcinwa kuyimfihlo kulesi sifundo. Ngiyazwisisa njalo ukuba uma ngingasathandi ukuba lengxenye kulesi sifundo ngilakho ukutshiya loba kusiphi isigaba ngingaphanga zizatho zokuba kungani sengiguqule umcabango.

___ Ngiyavuma ukuba amazwi ami athathwe ngomtshina wamazwi.

___ Angivumi ukuthi amazwi ami athathwe ngomtshina wamazwi.

Ibizo lalowo opha imvumo (name)…….
Ibizo elixhakaxhakiweyo (signature)…….
Kumhlaka
(date)…….

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office
New Arts Building,
C-Block, Top Floor, Room 28
University of the Western Cape
Private Bag X17
Bellville 7535

Appendix 11: Ethics approval from the University of the Western Cape

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

Private Bag X17, Bellville 7535
South Africa
T: +27 21 959 2988/2948
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09 November 2017

Ms SA Moyo
School of Public Health
Faculty of Community and Health Sciences

Ethics Reference Number: BM17/9/8

Project Title: An exploration of the knowledge and involvement of fathers in the practice of complementary feeding of infants and young children in Tsholotsho district, Zimbabwe.

Approval Period: 27 October 2017 – 27 October 2018

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

PROVISIONAL REC NUMBER -130416-050

Appendix 12: Local authority permission from Tsholotsho Rural District Council

43 Aberdeen Road

Matsheumhlope

Bulawayo

5th February 2018

The District Administrator

Tsholotsho District

RE: Request for Permission to conduct research in Tsholotsho District as part of Masters in Public Health fulfilment

Dear Madam

I hereby request for permission to conduct research in Tsholotsho District as part of a Master's in Public Health fulfilment. My name is Shamiso Moyo and I am currently enrolled by the University of the Western Cape, South Africa. I am in my final year and proposing to conduct a research titled- *'An exploration of the knowledge and involvement of fathers in the practice of complementary feeding of infants and young children in Tsholotsho district, Zimbabwe'*.

The research participants will be fathers who have children between the ages of 6 - 23 months. I would like to discuss with them their understanding, experiences and opinions about the role fathers can play in the feeding of their children between the ages of 6 - 23 months. The purpose of this research is to obtain first-hand information from fathers about this topic so that this information can be used to assist the nutritionists to come up with appropriately informed health promotion strategies and nutrition programmes in the district.

Please do not hesitate to request for further information.

Sincerely

Shamiso Moyo

05/02/2018

PP