

**THE ROLE OF MEN IN HINDERING OR PROMOTING  
BREASTFEEDING IN OSHAKATI, NAMIBIA**

OTILIE VAFEENDJOVO KAVELA

STUDENT NO: 2232666

A MINI-THESIS SUBMITTED TO THE FACULTY OF COMMUNITY AND  
HEALTH SCIENCES, UNIVERSITY OF THE WESTERN CAPE.  
IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF  
MASTERS IN PUBLIC HEALTH IN THE SCHOOL OF PUBLIC HEALTH



UNIVERSITY *of the*  
WESTERN CAPE

SUPERVISOR: DR. DEBRA JACKSON

MAY 2007

## ABSTRACT

### THE ROLE OF MEN IN HINDERING OR PROMOTING BREASTFEEDING IN OSHAKATI, NAMIBIA

Otilie Vafeendjovo Kavela

Mini-Thesis, Faculty of Community and Health Science, University of the Western Cape.

Breastfeeding is important for the health and well being of infants. WHO recommends globally, exclusive breastfeeding for the first 6 months and thereafter, adequate and safe complementary foods to be introduced and baby to be breastfed for up to 2 years of age or beyond. WHO Global Data Bank (1996), reported that only 35% children exclusively breastfed, and only 19% in Africa. Exclusive breastfeeding in Namibia is very low, at 26%. A Household Survey conducted in peri-urban area of Oshakati and Ondangwa in North West Region Namibia in 1991, found breastfeeding practices to be very poor. Men as fathers being less supportive were among the factors seen contributing to poor breastfeeding practice. In order to explore the role of married and single men whether in hindering or promoting breastfeeding patterns, I conducted an explorative, qualitative study. The study was designed to assess the group perception and view to appropriate breastfeeding patterns, explore the cultural beliefs of men on breastfeeding, attitudes of men towards breastfeeding and roles and actions of men that support or hinder breastfeeding.

The study population included men who were recent fathers in Oshakati District, aged 20- 40, admitted in Oshakati Intermediate Hospital, recovering from illness, and speaking vernacular language - Oshiwambo.

Non-probability sampling method was used, participants consisted of 32 men. Four focus group interviews were conducted. Each group comprised of 8 men. 16 participants were drawn from the surgical ward and other other 16 from the orthopedic ward. The study concluded that men had negative cultural attitudes towards breastfeeding, knowledge on breastfeeding was limited, had no access to breastfeeding information, are not involved in decision making of infant feeding, do not attend antenatal clinics but they said they were willing to change from present practices. Programme implications suggest health workers to identify harmful and beneficial local beliefs and adopt them in health education programmes. Health care systems to include men in breastfeeding and prenatal programmes should be developed.

May 2007

## DECLARATION

I declare that this mini-thesis is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree or examination at any other University.

---

Otilie V.Kavela

---

Date



## ACKNOWLEDGEMENTS

Firstly, I give glory to my Lord, for protecting, giving me strength and the knowledge through the course.

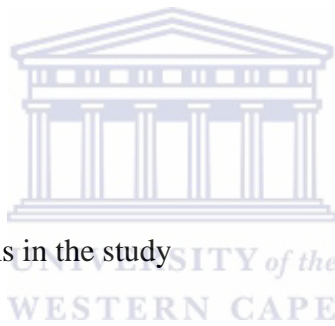
Words cannot describe the support, dedication and encouragement my supervisor Debra Jackson she provided. Not any part of this mini-thesis is ever accomplished without her assistance.

I wish to thank my husband, for his incredibly patience and understanding. He provided much needed support and encouragement to continue with my study especially when I was nearly overwhelmed by the thoughts of giving up studying. Special thanks also go to my Sister-in law Elizabeth for her willingness to take over for domestic duties and responsibilities on my behalf, especially in assisting my husband to look after children when I was busy with the study.

I would like to extend my warmest appreciation and he artful thanks to the PMTCT Sister Helena Hidengwa and nurses at male orthopedic and surgical wards, Sister Toini Aluvilu and Mr. Philip Shilongo, for their assistance. Patients, for their willingness to participate in the study are also appreciated.

To friends and colleagues, who provided sympathetic ear when frustrations and anxiety about deadlines nearly overpowered me.

CONTENTS	PAGES
Abstract	ii
Declaration	iv
Acknowledgement	v
<b>CHAPTER 1 INTRODUCTION&amp;BACKGROUND</b>	<b>1</b>
1.1 Introduction	1
1.2 Formulation of the problem	1
1.2.1 Background to the problem	1
1.2.2 Research problem	5
1.3 Aims and Objectives	5
1.3.1 Aim	5
1.3.2 Objectives	6
1.4 Definition of used Terms in the study	6
1.5 Outline of the study	7
1.6 Conclusion	7
<b>CHAPTER 2 LITERATURE REVIEW</b>	<b>8</b>
2.1 Introduction	89
2.2 Breastfeeding general	9
2.3 Roles of father in supporting breastfeeding	14
2.4 Previous studies	16
2.4.1 Knowledge and attitudes	16
2.4.2 Involvement in decision making	18
2.5 Conclusion	19



CHAPTER 3 RESEARCH METHODOLOGY	21
3.1 Introduction	21
3.2 Research design	21
3.3 Study setting	22
3.4 Study population and sample	24
3.5 Sampling design	24
3.6 Data collection	25
3.6.1 Procedure	26
3.6.2 Instrument	27
3.7 Data analysis	28
3.8 Validity/Rigour of the study	29
3.8.1 Credibility	30
3.8.2 Transferability	30
3.8.3 Dependability	30
3.8.4 Confirmability	31
3.9 Ethical consideration	31
3.9.1 Permission to conduct the study	31
3.9.2 Right to full disclosure	31
3.9.3 Freedom from exploitation	32
3.9.4 Right to confidentiality	32
3.10 Limitation of the study	32
3.11 Conclusion	32



CHAPTER 4 DATA PRESENTATION	33
4.1 Introduction	33
4.2 Understanding of Breastfeeding	35
4.2.1 Men's knowledge on breastfeeding	35
4.2.2 Exclusive breastfeeding	35
4.2.3 Good things about breastfeeding	37
4.2.4 Bad things about breastfeeding	37
4.3 Practice of breastfeeding	38
4.3.1 Duration of breastfeeding	38
4.3.2 Practice for exclusive breastfeeding	40
4.3.3 Involvement in decision-making	41
4.3.4 Attitudes and cultural practices	43
4.4 Reason for support/Non support by men to breastfeeding	44
4.4.1 Parenting	44
4.4.2 Fear to be cheated	44
4.4.3 Lack of access to information	45
4.5 Roles and actions of fathers	45
4.5.1 Roles of fathers to infant care	45
4.5.2 Roles of fathers to infant feeding	46
4.5.3 Prenatal support	47
4.5.4 Support after delivery	48
4.5.5 Support during pueriperium	49
4.6 Desire for more involvement	49



CHAPTER 5 SUMMARY AND INTERPRETATION OF FINDINGS, CONCLUSION,

IMPLICATION AND RECOMMENDATIONS	52
5.1 Summary of findings	52
5.1.1 Participant understanding of breastfeeding	52
5.1.1.1 Knowledge of breast-feeding	52
5.1.2 Practices of breast-feeding	53
5.1.2.1 Duration of breastfeeding	53
5.1.2.2 Practice of exclusive breast-feeding	54
5.1.2.3 Involvement in decision making about feeding option	55
5.1.2.4 Attitudes and cultural practices	56
5.1.3 Reason for support /non –support by men to breastfeeding	58
5.1.3.1 Reason for support by men to breastfeeding	58
5.1.3.2 Lack of access to information	59
5.1.4 Roles and actions of men as fathers	59
5.1.4.1 Roles of men as fathers in care of infants	59
5.1.4.2 Role of fathers to infant feedings	60
5.1.4.3 Prenatal support	61
5.1.4.4 Support after delivery	62
5.1.4.5 Support during pueriperium	62
5.1.5 Desired Practices for men to be involved in caring of children during infancy	63
5.2 Conclusion	65
5.3 Programme Implication	67
5.4 Research Recommendations	68

BIBLIOGRAPHY	70
ANNEXURE A	76
ANNEXURE B	78
ANNEXURE C	79



## CHAPTER 1. INTRODUCTION & BACKGROUND

### 1.1 INTRODUCTION

This chapter involves the orientation to the study with the description of the research problem, purpose and significance of the study, research methodology, ethical considerations and limitation of the study. Also, definitions used in the study and an outline of the study is given.

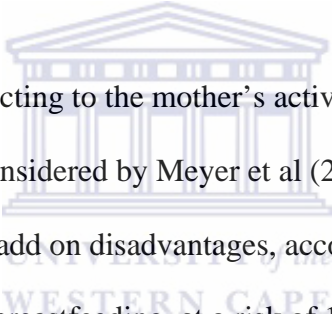
### 1.2 FORMULATION OF THE PROBLEM

#### 1.2.1 Background to The problem

Breastfeeding is important for the health and well being of infants. Harrison, Keet & Shore (1987) refer to breast milk as the specific food of the human infant and note it provides the infant with optimum growth and survival. For optimal growth, development and health of the infant to be achieved and to ensure that infants are provided with ideal food, WHO recommends globally, exclusive breastfeeding for the first 6 months and thereafter, adequate and safe complementary foods to be introduced and baby to be breastfed for up to 2 years of age or beyond (WHO, 2003). According to WHO, over 1.5 million babies' lives are saved every year through breastfeeding.

Research has shown exclusive breastfeeding to be beneficial to infant, mother, family and society. Breast milk provides first immunization via colostrum, and thereafter through breastmilk, especially in first six months. Breast milk is clean and safe, so infants are protected against diarrhoeal diseases usually resulting from dirty water, food, teats and

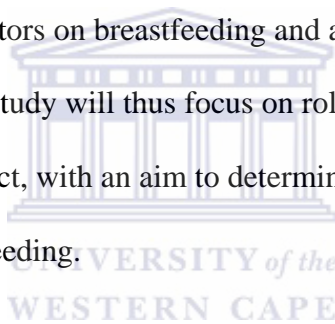
bottles (MOHSS, 1994). According to Meyer et.al, (2002 p. 20.13) malnutrition is not common in a breastfed child since mother's milk contains balanced nutrients such as carbohydrates, protein, fat, mineral and vitamin. In addition, incidence of breast and ovary cancer, as well as postnatal hemorrhage is reduced to the mother. Ovulation is inhibited and serves as a contraceptive method, thus increasing chance for child spacing (MOHSS, 1994). As stated by MOHSS (1994), mother's milk is undoubtedly economical since the family and society save financial costs in buying formula and bottles and babies have fewer health problems resulting in less medical expenses. Lastly, contact between baby, mother, father and nearest family members is enhanced (MOHSS, 1994).



However, breastfeeding is restricting to the mother's activities, as she is the only one who can breastfeed the baby, thus considered by Meyer et al (2002) as its greatest disadvantage. More recently to add on disadvantages, according to WHO, HIV virus can be transmitted to baby through breastfeeding, at a risk of 15 –30 %. Risks are increased due to viral load, problems such as mastitis, bleeding nipples, infant's immature gut, sores in mouth, etc. (WHO 2003). Studies have shown the risk to be higher with mixed feeding (WHO, 2003). For HIV infected mothers, WHO (2006) recommends exclusive breastfeeding for the first 6 months of life. Replacement feeding is recommended as long as it is safe, acceptable, feasible, affordable and suitable. HIV is not the focus of this study but only discussed here since exclusive breastfeeding remains important and the safest option to feed infants in the majority of African contexts.

Despite the benefits, exclusive breastfeeding is rarely practiced. Semega-Jennet (1998) notes global estimates indicate that 85% of mothers do not conform to optimal breastfeeding practices as according to WHO Global Data Bank (1996), only 35% exclusively breastfed, with a rate of only 19% in Africa. Exclusive breastfeeding in Namibia is very low, as according to Ministry of Health and Social Services (20003), the Namibia Demographic Health Survey in 2000 indicated it to be only 26%, and these figures are undefined as to timing of exclusive breastfeeding..

Castello (1990) states that social factors such as women's perception, lack of support by employers, disunity among doctors on breastfeeding and attitudes of men, all act as barriers to breastfeeding. This study will thus focus on roles men are playing on breastfeeding in Oshakati district, with an aim to determine whether they are hindering or promoting exclusive breastfeeding.



Global Initiatives aimed at protection, promotion and support of breastfeeding have recognized the need of inclusion of men in breastfeeding programmes. During a meeting in Florence in 2000 celebrating the 10<sup>th</sup> anniversary of the Innocenti Declaration meeting in 1990, Dr. Ted Greiner suggested the formulation of norms pertaining to father's role during infancy, how he can support the mother in various ways, before the formula companies establishes theirs (Baby Friendly Hospital Initiative Newsletter 2000).

Similarly, WHO (2003) sees that if infant feedings practices are to be improved, besides women and caregivers, fathers must also be reached with information regarding exclusive breastfeeding.

Men in Tanzania have taken a positive move, by forming the Father's Organization in 1988, through The Mwenje Christian Fathers Fellowship (MCFF) under leadership of local pastor O N Msaki. Child rearing by both parents was a main issue of the organization, with the role of men in promotion of breastfeeding being among the main programmes. Involvement of men in breastfeeding was realized to enhance family life (Msaki, 2002).

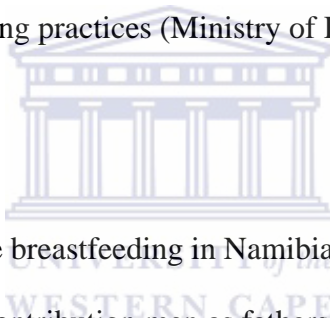
Namibia launched the global Baby Friendly Hospital Initiative in 1992. Certificates of commitment were presented to 9 hospitals, including Oshakati Intermediate Hospital (Ministry of Health and Social Services, 1992). To achieve the objectives of the BFHI, it was seen that men as fathers also have a role to play. Even that, little has been done to involve men in breastfeeding in Namibia.

A lot has been said and done about breastfeeding and mothers. Breastfeeding advice is given during prenatal, immediately after birth then throughout pueriperium. Most pictures on breastfeeding show mothers and babies but not men. Practically at Oshakati hospital, pregnant women are seen coming alone at antenatal clinics. When labor commences, some men do not accompany their wives/partners at maternity wards. Some do accompany them and leave them there, experiencing labor pains alone. Some do not visit them post delivery.

Given the situation above, the researcher feels it is appropriate to conduct a study in order to establish the contribution men as fathers do make, whether they are in hindering or promoting breastfeeding patterns in Oshakati district, Namibia.

### 1.2.2 Research Problem

The Household Health and Nutritional Survey conducted in peri-urban area of Oshakati and Ondangwa in North West Region Namibia in 1991, found breastfeeding practices to be very poor. Men as fathers being less supportive were among the factors seen contributing to poor breastfeeding practices (Ministry of Health and Social Services, 1992).



Due to the low rate of exclusive breastfeeding in Namibia, it is appropriate to conduct a study in order to establish the contribution men as fathers make, and whether they are hindering or promoting breastfeeding patterns in Oshakati district, Namibia. No previous study has been done in the district about the involvement of men in breastfeeding in the Oshakati district.

## 1.3. AIMS AND OBJECTIVES

### 1.3.1 AIM

The study aimed to explore the role of men who are fathers, aged 20-40, in hindering or promoting breastfeeding patterns in Oshakati district, Namibia.

### 1.3.2 OBJECTIVES:


In regards to men and nature of breastfeeding, the study attempted to:

1. Assess the group perception and view to appropriate breastfeeding patterns.
2. Explore the cultural beliefs of men on breastfeeding.
3. Assess the attitudes of men towards breastfeeding.
4. Assess roles and actions of men that support or hinder breastfeeding.

### 1.4 DEFINITIONS USED TERMS IN THE STUDY

#### ABBREVIATIONS

WHO	World Health Organization
BMFI	Baby and Mother Friendly Initiative
BFHI	Baby Friendly Hospital Initiative
MOHSS	Ministry of Health and Social Services
PI	Principal investigator



#### KEY WORDS

- **Breastfeeding:** It is process that the child has received breast milk direct from the breast or expressed (WHO, 1996).
- **Exclusive breastfeeding:** Infant has received only breast milk from mother or a wet nurse, or expressed breast milk, and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines (WHO, 1996).
- **Involvement:** The state of being involved (Searle&Brink,1984).
- **Barrier:** That which hinder an approach (Searle&Brink,1984).



- Support: To give assistance (Kozier et al, 2000).

## 1.5 OUTLINE OF THE STUDY

CHAPTER 1. Introduction to the study, formulation of the problem, purpose and significance of the study, aims and objectives of the study, research methodology, data analysis, ethical considerations, limitations of the study and definitions of terms.

CHAPTER 2. Review of literature.

CHAPTER 3 The research methodology – design of the study, study setting, sampling, data collection procedure and data analysis procedure, ethical considerations and limitations of the study.

CHAPTER 4 Method used for data analysis, presentation of findings.

CHAPTER 5 Summary and interpretation of findings, implications, conclusion and recommendations.



## 1.6 CONCLUSION

This chapter has given the description of the problem for the study, aim and objectives, introduction to the literature review, methodology and definitions of terms. The chapter ends with an outline of the study. The next chapter is about the literature review.

## CHAPTER 2: LITERATURE REVIEW

### 2.1 INTRODUCTION

Chapter 1 provides the orientation of the study by discussing the background and statement of the problem, aim and objectives, introduction to the literature review, methodology, definitions of terms and an outline of the study. This chapter will deal with literature review related to the study.

Relevant literature reviewed is based on:

- Presentations and findings of other researchers on same research topic
- What is already known and about the problem and what needs to be researched

After the principal researcher identified the research topic, libraries were accessed to identify and critically review literature sources. Sources were identified using computerized searches, bibliographies, indexing journals and catalogues. The researcher got assistance from the supervisor about what to include in the study and were to find the information. Literature related breastfeeding in general and breastfeeding with men were obtained.

Reviewed literature topics for this study-included: breastfeeding in general, role of father in supporting breastfeeding, previous studies to determine knowledge and attitudes on breastfeeding and involvement in decision-making

It should be noted that the majority of studies found during the review were conducted in developed countries outside Africa. There is limited literature from Africa, and Namibia,

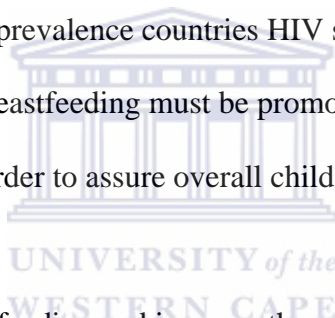
on men involvement in breastfeeding. Some relevant literature in Africa was obtained from Tanzania, Gambia and Namibia. This is an indication how men involvement in breastfeeding is neglected.

## 2.2 BREASTFEEDING GENERAL

Breastfeeding has various benefits, which were outlined in the introduction (Ministry of Health and Social Services, 1994 and Meyer et al, 2002). Socio-cultural factors including lack of belief in exclusive breastfeeding by locals, employers including government not providing adequate maternity leave or crèches at workplace, lack of social support at household and community level to workload of pregnant and lactating women and lack of political commitment are all potential threats to sustainability of exclusive breastfeeding (Semega-Jennet, 1998). As documented in Murray (1996), Myanmar, a country in South-East Asia only 4,5% of babies were exclusive breastfed by the age of 5 months, according to the study by Oo in 1993 conducted in peri-urban area of Yangon Division. Murray (1996) notes a low rate of exclusive breastfeeding was reported in Botswana, by the International Planned Parenthood Report (1990) whereby at age of 4 months, only 37% mothers exclusive breastfed their children. According to Namibia Demographic Health Survey in 2000, exclusive breastfeeding remains low in Namibia, at only 26% (Ministry of Health and Social Services, 2003).

The decline in breastfeeding practices can be attributed to the dilemma of HIV/AIDS and transmission of HIV through breastfeeding (Ministry of Health and Social Services, 2003). Despite the pandemic of HIV infection, the World Health Organization still

recommends breastfeeding to be protected, promoted and supported for both HIV negative and positive mothers to exclusively breastfeed. This is because exclusive breastfeeding is the safest infant feeding option in many living conditions prevalent in Africa. These were acknowledged during the International African Regional Workshop on Infant Feeding and HIV held in Pretoria, South Africa 23-27 August 1999 (IBFAN AFRICA, 1999). Participants in the workshop pointed out that research has shown that benefits of exclusive breastfeeding outweigh the risk of not breastfeeding as infants who are not breastfed are up to 14 times more likely to die from diarrhea, and 3 times more likely to die from acute respiratory infection, compared to exclusive breastfed. It should also be noted that even in high prevalence countries HIV still only affects a minority of pregnant women. Exclusive breastfeeding must be promoted and protected in disadvantaged populations in order to assure overall child survival.



To reverse the decline in breastfeeding and increase the rate of exclusive breastfeeding, WHO and UNICEF adopted various global strategies for implementation by different national governments. These include The International Code of Marketing of Breast milk Substitutes (1981), adopted by the 34<sup>th</sup> World Health Assembly and passed 10 resolutions. These included the Innocent Declaration on the promotion of exclusive breastfeeding for six months, (1990) with a major goal to empower all women to breastfeed exclusively for six months and continue with adequate complementary foods for two years or beyond. Lastly the Global Baby Friendly Hospital Initiative (1989) with the implementation of Ten Steps to Successful Breastfeeding in all maternity units (Ministry of Health and Social Services,2003).

To restore the low exclusive rates, the MOHSS in Namibia launched the Baby and Mother Friendly Initiative in 1992, to be extended to women, work places and whole community. One of objectives was to achieve 75% of exclusive breastfeeding rates for 4-6 months (Ministry of Health and Social Services, 2003). On the other hand, Namibia also adopted the National Health Bill, which regulates the marketing of artificial feeding products to protect health workers, and mothers from baby milk industry propaganda. In addition, the Ministry of Health developed the Namibia Food and Nutrition Policy of 1995 and draft the HIV/AIDS Policy in 2001 and they are all in supportive of breastfeeding. Furthermore, the National Policy on Infant and Young Child Feeding was developed in 2003 to ensure the protection of breastfeeding, children born to HIV mothers to have best nutrition and assure artificial feeding does not to spill over breastfeeding in HIV-negative populations (Ministry of Health and Social Services, 2003).

### *Barriers to Exclusive Breastfeeding*

Studies have shown how health workers in many maternity hospitals carry out negative routine practices, which are not favorable to exclusive breastfeeding. According to King (1992), health workers do either issue glucose water, infant formula because milk has not established, scheduled feeds and separate mother and baby after delivery. These negative practices are due to limited knowledge on breastfeeding issues that needed to support mothers and families. The Ministry of Health/UNICEF/WHO (1990) reported on the Expanded Programme of Immunization knowledge, attitude and practices survey

conducted in Botswana among health workers (Murray, 1996:26). The results showed that of 84% knew the benefits of breastfeeding; however, health workers still lacked knowledge of physiology and lactation management. Only 37% knew what stimulate milk supply and only 8% associated breastfeeding with child spacing. To improve the situation in Botswana, where unsupportive routines were also prevalent in maternity hospitals, the Baby and Mother Friendly Hospital Initiative in was also implemented in 1992. The training of health workers was one of the activities.

Culture was earlier mentioned as one factor that poses a threat to the maintenance of exclusive breastfeeding. Anthropologists Williams, Baumslag & Jellife (1989) establishes that children are born into two external worlds, the physical/geographical and that one of culture. It is through culture people learning the values, norms and beliefs of their communities, from generation to generation and it is shared among all members. Williams, Baumslag & Jellife (1989) continues to explain that members have to behave according to the culture and there is sanction prescribed for any disobedience. These include food to be eaten and the way of preparation, approved methods of rearing children and roles of parents.

Le Beau (1997a: 2) pointed out that each culture has a set of ideas, that is an ideology, how to stay healthy, how to prevent diseases and how to treat people, that is ethno medicine.

In Mozambique, an ethno medical research was conducted by Green, Jurge & Dgedge in Manica in 1991 among traditional healers to determine traditional beliefs and practices in relation to diarrhoea disease. From the results it can be observed how the baby can be deprived from exclusive breastfeeding since the mother has to give up breastfeeding due to cultural beliefs. The child was seen to develop diarrhea from the mother's milk, which is contaminated through wrongful behavior as from committing adultery (Green, 1996).

Culture is not static but changing, new practices and beliefs are absorbed as people are coming into contact with new world. According to Williams, Baumslag & Jellife (1989), in Lesotho, sexual intercourse is a taboo while mother is breastfeeding. That is why in order to have sex; migrant male workers bring along home formula cans to their wives to replace breastfeeding with bottle-feeding. van du Toit & van Staden (2005) note where the society is rapidly changing, in material culture like condoms, injections, tablets etc. are introduced for birth control, it will affect the non-material culture that are men's system of norms and value, although it will lag behind. This phase will be experienced by confusion since according to van du Toit & van Staden (2005:35), people do not know how they should act or what is right or wrong, whether their culture or the new discovered inventions. As with further explanation, the introduction of contraceptive measures to limit the family, because of their norms and value, people now doubt about the permissibility of it or not premarital and extramarital sexual intercourse to be practiced that may not been allowed before. This is because there is even a doubt for using a condom in marriages.

To improve exclusive breastfeeding in a cultural context, Murray (1996) cited the example in Myanmar, where breastfeeding was promoted beyond the hospital through the Baby Friendly Home Delivery project. It was observed that 60% of deliveries in non-urban areas were attended by midwives, 10-20% by auxiliary midwives and 5-10% by traditional birth attendants. The project was conceived based on Ten Steps to successful breastfeeding, in order to reach rural women and to train all delivery attendants to be familiar with baby friendly practices.

### 2.3 ROLES OF FATHER IN SUPPORTING BREASTFEEDING

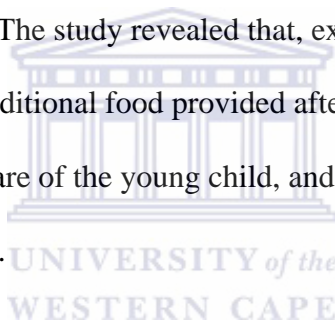
The Father is one of the best people to provide support to women who are breastfeeding (Breastfeeding Promotion Network of India, 2003). The article states that he can support by encouraging and praising his partner that by exclusively breastfeeding her baby will serve a good example to other mothers in the community. Fathers need to learn and be familiar with all aspects related to breastfeeding. He can also tell his wife and other relatives that his baby is only to be breastfed because he knows that mother's milk is the best food for his baby. He can help mother during weaning period to give emotional nourishment to the child through playing, cuddling and giving a cup, and can be understanding and good listener to accommodate breastfeeding at home or even away from home (National Women's Health Information Center, 2004).

However, some cultural attitudes by fathers are not supportive to breastfeeding and can force mothers not breastfeed successfully. Renfrew, Fisher and Arms (1990) note that many men in Western cultures do not accept their partners to breastfeed in public. They



also note that some feel jealous by the closeness of mother and baby and feel excluded and thus advise the women to bottle-feed so that he can also form bonding. Some men have the attitude that the breast is only a sexual object (Castello, 1990).

Men in Namibia may also contribute cultural attitudes towards breastfeeding. Zimba and Otaala (1991) conducted a relevant study in Uukwaluudhi Northern Namibia, using quantitative and qualitative methods by structured interviews and observations. The study was to understand traditional practices and beliefs in relation to child rearing practices and beliefs during prenatal, perinatal, 0-3 year and 3-6 years period in the life of a child among 136-sample household. The study revealed that, exclusive breastfeeding lasts not longer than six months, with additional food provided after the third month. Also, men are seldom involved in direct care of the young child, and men are essentially absent until the child is older (Evans, 1994).



Various methods can be instituted to break barriers pertaining to men. In Brazil, a well-known singer and male role model was included in an advertisement campaign asking other fathers to support breastfeeding (Castello, 1990).

Gambia intervened through the Baby Friendly Community Initiative project. Men were included in the project since it is realized that they are actors in decision making of infant feeding and usually not targeted with breastfeeding intervention programmes and mothers alone may find it difficult to take a decision on exclusive breastfeeding without the support of their husbands. Exclusive breastfeeding increased from 1,3% (n=324) to

99,5% (n=413). Both mother and father became concerned with breastfeeding and nutrition of pregnant women (Semega-Jennet, 1998).

Men in Tanzania are expected to be involved during antenatal, labor/delivery and postnatal, to decide with partner/wife on appropriate feeding option for coming baby and many others, as were outlined by Dr Charles Sagoe Moses, addressing the WABA forum in Arusha Tanzania in 2002 (Msaki, 2002).

Roles of men are also documented in the BMFI, manual (Ministry of Health and Social Services, 1992). It includes creation of friendly environment at home, accompany mother and child to health facilities for immunization, family planning etc., provide enough food, ensure rest for mother during pregnancy and lactating mother and taking care of older siblings, etc.



## 2.4 PREVIOUS STUDIES

### 2.4.1 KNOWLEDGE AND ATTITUDES

Fathers have poor knowledge about breastfeeding, especially those who do not attend prenatal classes to receive information on the subject by health personnel. Giugliani, Bronner, Caiffa, Vogelhut, Witter and Perman (1994) undertook a comparative study in the UK among 92 breastfeeding and 89 non-breastfeeding newborns to determine father's knowledge of breastfeeding, and to see whether they are prepared to encourage their partners to breastfeed. Researchers looked into paternal factors such as previous breastfed children, attendance of antenatal classes and information received about breastfeeding

from medical personnel, use of reading material and interest to learn more on breastfeeding. Results indicated that fathers with previous breastfed children had attended antenatal classes and received information on the topic and had better knowledge than their counterparts. The study suggested the need for fathers to be prepared during prenatal to assume their new role as breastfeeding supporters and to improve their knowledge of breastfeeding.

Freed, Fraley and Schanler (1992) conducted a survey among 268 men at five private hospitals in Houston, Texas to examine expectant father's attitudes and knowledge regarding breastfeeding. Unlike the previous study, these studies showed that the majority of fathers had good knowledge and attitudes on breastfeeding and do even participate in decision-making in feeding option of the child. The study was dominated by white (81%) and married participants (97%), while black and Hispanic participants were only 8% and 6%, respectively. Results revealed that compared to fathers in the formula feeding group, the fathers in the breastfeeding group knew that breastfeeding is better for the baby (92% vs. 62%), helps with infant bonding (92% vs. 53%), protects infant from disease (79% vs. 47%), reported that they want their partner to breastfeed (90% vs. 13%), and expressed respect for breastfeeding women (57% vs. 16%). Attitudes of the formula feeding group towards breastfeeding are that it is bad for breast (52% vs. 22%) makes a woman ugly (44% vs. 23%), and interferes with sex (72% vs. 24%). Notable, both groups in majority did not support breastfeeding in public (71%), which is not good at all as the baby needs to be breastfed on demand, with no exception of the place.

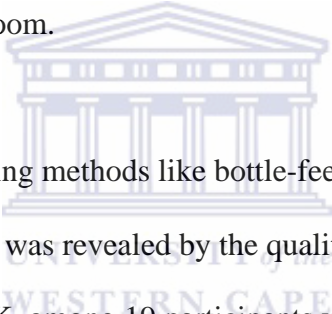
Mothers may not exclusively breastfeed assuming that the father is having negative attitudes towards breastfeeding. A survey conducted again by Freed, Fraley and Schanler (1993) at five private hospitals in Houston, Texas among 268 pairs of expectant mothers and fathers was looking into accuracy of expectant mothers' predictions of fathers' attitudes regarding breastfeeding. 69% of mothers preferred exclusive breastfeeding unlike 58% of fathers, but their attitudes were not worse as mothers were predicting although they still harbored misconceptions on breastfeeding.

#### 2.4.2 INVOLVEMENT IN DECISION MAKING

Studies have indicated that unless fathers are included in breastfeeding education programmes and breastfeeding campaigns, to be made aware of benefits of breastfeeding, then they will remain barriers to exclusive breastfeeding.

Voss and Manners (1993), to investigate the involvement of fathers with infant feeding and their attitudes to the method of feeding adopted, conducted a pilot observational survey using a questionnaire, among 113 fathers. 30% did not discuss method of infant feeding with anyone, 60% did with partner, 64% of fathers helped sometimes with child feeding and 17% always do. The majority did not mind partners feeding in front of friends and relatives, 42% did not like it and over half did not support breastfeeding in public. Based on the findings, fathers felt left out in making decision about infant feeding. The study recommended the involvement of fathers in decision making of infant feeding, at least from early stage.

The need to involve fathers in breastfeeding was also supported by the study surveyed 245 women in a Pennsylvania medical center (Arora et al, 2000). The purpose was to determine breastfeeding and bottle-feeding initiation rates, duration of breastfeeding and factors associated with feeding decision. On exclusive breastfeeding, about 44.3% who started breastfeeding, only 13% were breastfeeding when their babies were six months old. Mothers reported not exclusively breastfeeding due to perceptions of the father's attitudes towards breastfeeding. Again, the study stressed the need of involvement of fathers and educates them on benefits of breastfeeding, to be done at doctor's office, prenatal classes or in delivery room.



Fathers are choosing other feeding methods like bottle-feeding because they want to be involved in child feedings. This was revealed by the qualitative study, prospectively designed done in Coventry, UK, among 19 participants via 12 clinics (Earle, 2000).

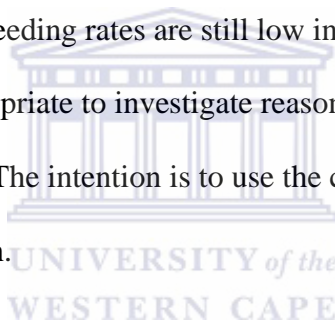
## 2.5 CONCLUSION

There is limited work done about men involvement in breastfeeding and the majority of available studies were conducted in developed countries outside Africa. These previous studies mainly focused on knowledge and attitudes and also involvement in decision making with feeding options. Results show that knowledge of breastfeeding is better and poor with different studies, and there is high tendency of negative attitudes, especially towards breastfeeding in public. Men are generally not involved in decision-making.

There is limited literature from Africa, and Namibia, on men involvement in breastfeeding. Some relevant literature in Africa obtained was from Tanzania, Gambia and focuses on interventions to curb barriers to breastfeeding, pertaining to men. One study from Namibia mainly looked into traditional practices and beliefs in relation to child rearing practices and beliefs during prenatal, prenatal, 0-3 year and 3-6 years period in the life of a child then. The gap from available literature is the lack of information regarding men's nonsupport reasons to breastfeeding.

Even though the Baby Friendly Initiative was implemented in Namibia, with roles of men documented, exclusive breastfeeding rates are still low in Namibia.

As a reason, it was found appropriate to investigate reasons for low rate, by obtaining information from men's view. The intention is to use the collected information in rectification of present situation.



This chapter was about reviewing literature for this study, which included breastfeeding in general, role of father in supporting breastfeeding, previous studies to determine knowledge and attitudes in breastfeeding and involvement in decision-making

The next chapter focuses on research methodology that was used to conduct the study. It includes the description of research design, study setting, study population, sampling design, data collection and analysis, validity/rigour of the study, ethical consideration and limitation of the study.

## CHAPTER 3: RESEARCH METHODOLOGY

### 3.1 INTRODUCTION

The last chapter presented literature reviewed related to men and breastfeeding. This included breastfeeding in general, role of father in supporting breastfeeding, previous studies to determine knowledge and attitudes in breastfeeding and involvement in decision-making.

This chapter introduces the methodology. Research methodology includes study design, study setting, study population, sampling, data collection, data analysis, validity/rigour of the study, ethical considerations and limitations of the study.

### 3.2 RESEARCH DESIGN

An exploratory approach was utilized to conduct the study. This method is “conducted in attempt to gain insight into a particular area of problem” (Bless & Higson- Smith 1995:41). It is considered relevant since the study attempted to get more insight into how men are playing their roles in breastfeeding in relation to their attitudes, knowledge and cultural beliefs.

The study was qualitative in nature. “Qualitative data are those pieces of information which are nonstatistical in nature, which are generally observational data analyzed in a non-statistical manner” (Bailey 1987:495). It takes place in the real life of participants. According to Gilbert, Selikow & Walker et al (1996), the method is aimed at drawing out,

what the people are thinking, where they derive their ideas and beliefs, the structuring and organization of their ideas, the meaning they give to their actions and behaviors in their natural setting.

Qualitative methods suit the study, as it was aiming to gain in-depth information on opinions and why the men carry certain tasks out and others not in support to women who are exclusively breastfeed. So, their understanding, cultural beliefs and attitudes, meaning and experience could more easily be understood through qualitative, rather than quantitative methods.

### 3.3 STUDY SETTING

As reported by Namibia Demographic and Health Survey of 2000, Namibia is situated in South-Western Africa, bordered by Atlantic Ocean in the west, Botswana and Zimbabwe in the east, South Africa in south and Angola in the north and is ranked as middle-income country (Ministry of Health and Social Services, 2003). The total population is 1,826,854, of which 936,718 are female, 890,136 are male, with a total fertility rate of 4.2 (Government of the Republic of Namibia, 2002).

Namibia consists of 13 regions. This study was conducted in Oshana region, which has the area of 5290 square km at the Northwestern part of Namibia, in the peri-urban area of Oshakati. Oshana is the smallest region, with 161916 population, whereby 73957 are men within age group 15-59 years of 53% and of 93% of the population is Oshiwambo speaking, black people (Government of the Republic of Namibia, 2001).



Oshakati Intermediate Hospital is a referral hospital for 4-four other regions which are Omusati, Oshana, Oshana, Oshana and Kunene. Oshakati Intermediate hospital maternity unit has the bed occupancy of 60.10%, with yearly deliveries between 3441- 4525 for years 2001-2005 (Oshakati Intermediate Hospital Maternity Statistic Book). According to the Namibia Demographic and Health Survey (2000), Oshana region recorded 90% immunization coverage, 14/100 000 live births maternal mortality, 44/1000 live births infant mortality and 64/1000 live births child mortality rates. About 64/100 000 live births of perinatal deaths were reported in the region in 2005 (Oshakati Intermediate Hospital Management Information System). Due to the pandemic of HIV/AIDS in whole world, with Namibia no exception, the MOHSS launched prevention of mother - to - child transmission (PMTCT) services in March 2002 in Oshakati Intermediate Hospital (MOHSS, 2005). Health professionals provide routine counseling and voluntarily testing at first antenatal visit. Single - dose Nevirapine 1tablet (200mg) is given to HIV positive women in labour and syrup to baby post partum. (MOHSS, 2005). In 2002 - 2004, 790 women were voluntary counseled and tested antenatal. Only 66 fathers, were counseled and tested together with their partners and received counseling on baby infant feeding. Statistics showed that 62% of mothers chose to exclusively breastfed, 19% replacement, 15% mixed and 4% were not known (Oshakati Intermediate Hospital PMTCT register, 2002 - 2004). No free formula is provided.

### 3.4 STUDY POPULATIONS AND SAMPLE

According to Brink (1999), a population is the entire group of people or object the researcher wishes to study provided that they meet the criteria of the study. The study population of this project included men who are recent fathers in Oshakati District aged 20- 40 who are recovering from illness.

The sample comprised of 4 focus group discussions, each with eight men who have been admitted in the surgical or orthopedic wards at Oshakati Intermediate Hospital at time of the study. Men in the recuperative phase of their hospital stay were approached for participation. Those who are either physically or mentally unable to participate based on current medical status were excluded from this convenience sample.

Representative bias of the sample is possible as it includes only men admitted in the hospital. While a household survey would likely be more representative of the general community, the hospital setting was chosen, as it was the easiest way to get men and suits the limited resources of a mini-thesis.

### 3.5 SAMPLING DESIGN

A non-probability, purposive sampling method was used to select the study sample. Fathered men (i.e. men who have children) were purposively selected since they have rich information in bringing up children, unlike men who do not have children.

According to Brink (1999), the method is advantageous as it allows the researcher to

select the sample based on their knowledge of the study topic. Criteria for the sample included:

- Men aged 20-40
- Have children
- Speaking vernacular language - Oshiwambo
- Admitted to the surgical or orthopedic wards at Oshakati Intermediate Hospital at time of the study.
- Able to physically and mentally participate in a focus group discussion.

### 3.6 DATA COLLECTION METHOD

Data were collected on the 10th and 13th October 2006. Data were collected using focus group interviews. Four focus groups were conducted. Using that method would be advantageous since the study was expecting fathers to explore their attitudes, opinions, and knowledge on breastfeeding. Brink (1999) also commented on the method that: The researcher collects information on opinions and experiences simultaneously in a short time period. Also, participants were allowed to share thoughts among each other, new ideas initiated from different participants created discussion, arguing and reaching consensus. Different opinions give rich information rather than collecting information from an individual interview. During group interaction, it would be possible to hear how respondents are discussing the topic among themselves. Information that cannot be recorded such as non-verbal cues like facial expressions could be observed and noted. The interviewer has a chance to observe participants who are not interested, exaggerating

or who seem not to understand, and action taken, e.g. rephrase the question if not understood like the question on exclusive breastfeeding.

However problems with the method could be expected, as it may be hard to get a group of 6-8 men with inclusion criteria characteristics at the same time. Also, if the group is not well mixed, e.g. if there are one or more assertive men in the group, they can dominate the discussion and submissive men's view will be excluded. "Some people are uncomfortable talking in groups" (Brink 1999:159).

### 3.6.1 PROCEDURE

The researcher visited the units after doctor's ward rounds and ward routine procedure were done to avoid disturbances among health workers and patients. Appointments were made with respondents at the selected wards. The unit's sisters in charge assisted the researcher to identify the participants. A conducive place, i.e. private rooms, in the wards were arranged for discussion. Before each interview, the purpose of the study was explained and written consent obtained (ANNEXURE B). The principal researcher conducted the focus group sessions. During the interview, data were captured by means of a tape recorder while at same time notes were taken. A registered nurse (T. Aluvilu), who was trained as a trainer in 1993 in promotion of BMFI, assisted in taking notes and organizing the tape recording while principal investigator conducted the focus group discussion. The discussion did not last more than an hour. For each group, a 2Litre container of traditional non-alcoholic drink (Oshikundu) was prepared to share among themselves.

### 3.6.2 INSTRUMENT

An open-ended interview guide was developed to allow respondents to answer focusing on the study topics. “Open-ended questions allow participants more flexibility to express all what they know, richer information can be provided and more probing can be done to get more deeply what respondents think” (Giddens 1993:687). It provides more diverse data than close-ended questions (Brink 1999:155). However, Brink (1999) again notes open-ended questions are time consuming, and the diversity of answers may also be difficult for coding and analysis. It should be noted that the instrument did not contain specific questions about HIV and infant feeding. The reason to that is that even in highest prevalence countries HIV is an issue for approximately 25% of the mothers, while exclusive breastfeeding and infant practices are an issue for 100% families. Discussing HIV could threaten to divert attention away from main study objectives and introduce an emotionally charged issue. The researcher however was prepared to guide the discussion as some of the fathers brought it up and try to keep the focus on the topic of infant feeding and fathers’ roles, not a general discussion of HIV and infant feeding. Sensitivity was also maintained to avoid inadvertent disclosure of HIV status based on feeding method chosen for the infants of the participating fathers.

Questions covered include: Description of breastfeeding and exclusive breastfeeding, duration of breastfeeding, good and bad things on breastfeeding, involvement in decision making of children feedings, attitudes and beliefs towards breastfeeding, role of fathers and men to infant care and feeding, support of woman pre-natal, after delivery and during

puerperium and lastly whether participants liked to be involved in care of their children or not. (ANNEXURE C)

### 3.7. DATA ANALYSIS

As stated by Brink (1999:179) data analysis entails categorizing, ordering, manipulating and summarizing data and describing them in meaningful terms.

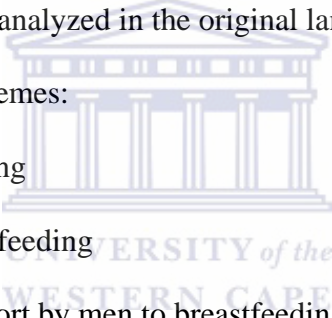
Data was analyzed using both thematic and content analysis approaches. In thematic analysis, the aim was to understand common stories and concepts that emerged as men tell their stories and discuss the questions will be grasped and arranged in a meaningful data set (Gifford, Undated). In the present study, the researcher already had selected key predetermined themes of interest from the available literature review and these guided the collection of data. Predetermined themes were: Understanding of breastfeeding, Practices of exclusive breastfeeding, and Reason for support/non-support by men to breastfeeding. Gifford (Undated) notes that content analysis looks for meaning given to phrases within the context the interview that is taking place, rather than just the words, phrases, action or events itself. Analysis in qualitative studies is an ongoing process during data collection (Johnson et al, 1993). Thus, after daily interview session, the audio taped interview was listened to, and transcripts regularly reviewed so that the results inform the subsequent focus groups. The data analysis process entailed repetitive listening to the audio taped, transcribed verbatim and noted emerging topics from the interviews. Transcripts of the focus group were read and re-read, and then noted down emerged themes and highlighted them with a color pen in order to identify them easily, identified and categorized themes and assigned codes to each category (Gifford, Undated).

Phrases and statements of participants were grouped into units for categorization. Then, coding was done according to the list of category headings. Highlighted data were cut off with a scissor and pasted them on paper given headings and subheadings. During analysis, data obtained from client's responses were linked together. Pre determined themes and emerged themes from present data were examined their relationship and thereafter combined together and grouped together according to their meaning. After that, a list of categories and subcategories of themes was compiled.

The researcher started to write the report with findings based on the themes.

The interview transcripts were analyzed in the original language.

Below are the predetermined themes:

- 
1. Understanding of breastfeeding
  2. Practices of Exclusive Breastfeeding
  3. Reason for support/non-support by men to breastfeeding

Additional themes originating from the data will be presented in results.

### 3.8 VALIDITY/ RIGOUR OF THE STUDY

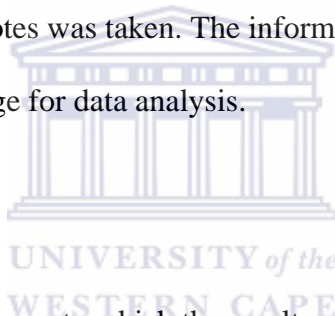
Le Compted et al, (1982:32) cited in Brink (1999: 124), argues, "Validity in qualitative research is concerned with the accuracy and truthfulness of scientific findings." If the soundness of the qualitative research is to be measured, Gifford (Undated) is suggesting that judgments should be made based on credibility, transferability, dependability and conformability.

### 3.8.1 Credibility

Providing a thick description rich in information related to the study enhanced credibility of the study. Suitable participants (men) were identified and their descriptions given.

Before the interview session the researcher, introduced the topic to participants and asked permission to participate in the study. This was done to build up a good trustful relationship, which could increase the willingness to participate and give information.

Also, the interview was tape recorded to ensure that provided information not to be missed and at the same time, notes was taken. The information was later transcribed verbatim in the original language for data analysis.



### 3.8.2 Transferability

Transferability refers to “the degree to which the results of a study can be generalized to settings or sample other than he ones studied” (Brink, 1999:124). In present study, the researcher ensured transferability by describing the study setting and participants. This will make it possible for the results to be applied to other similar context.

### 3.8.3 Dependability

Dependability was achieved by maintaining reflexivity. Daily events were recorded by making brief field notes at the end of each group discussion. Changes that were made whether in the questions, in the research design and problems that occurred during time



of the study all were noted. Non-verbal cues of respondents and how the researcher responded and managed the interview was noted.

#### 3.8.4 Confirmability

According to Gifford (Undated), confirmability has to do with the collected data, whether they are real and not produced by the researcher being biased. Double coding was done during data analysis. Mr. Phillip Shilongo, who has worked at the Multi Disciplinary Research Center and Consultancy at University of Namibia 1997-2000 and holds a Master Degree from University of Stellenbosch in 2004, assisted as a second coder. Relevant literature was viewed in conjunction with collected data, during analysis.

### 3.9 ETHICAL CONSIDERATIONS

#### 3.9.1 Permission to conduct the study

First the researcher obtained ethical clearance from the University of the Western Cape. Written permission to conduct the study in the district was sought from the Ministry of Health in Namibia and granted as requested (ANNEXURE A).

#### 3.9.2 Right to full disclosure

The aim and benefits of the study was explained to participants. Prior to the start of the focus group, signed informed consent was obtained from each participant. APPENDIX

### 3.9.3 Freedom from Exploitation

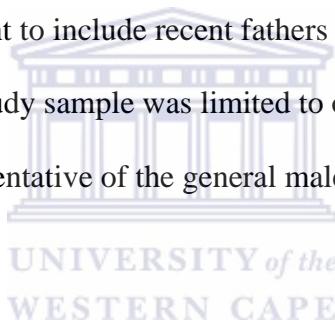
Participants were informed that participation is voluntarily. Participants could also withdraw from the study any time with risk to further health care. APPENDIX B

### 3.9.4 Right to confidentiality

Confidentially was assured to participants. Identifying participants by using the word “Group” ensures anonymity.

## 3.10 LIMITATIONS OF THE STUDY

The study population was meant to include recent fathers in Oshakati 20-40 who were recovering from illness. The study sample was limited to orthopedic and surgical wards. These men might not be representative of the general male population of Oshakati region.



## 3.11 CONCLUSION

This chapter covered the research methodology. An exploratory approach was utilized to conduct the study and the study was qualitative in nature. Open-ended interview guide was used to collect data. The next chapter will deal with presentation of data.

## CHAPTER 4: DATA PRESENTATION

In this chapter, data will be presented, using a narrative report writing style.

### 4.1 INTRODUCTION

The interviews were conducted within a period of a week in October 2006. All participants met inclusion criteria: Criteria for the sample included:

Men aged 20-40, have children, speaking vernacular language – Oshiwambo, admitted to the surgical or orthopedic wards at Oshakati Intermediate Hospital at time of the study and able to physically and mentally participate in a focus group discussion. Referring to their group's presentation identifies participants.

Participants consisted of 32 men. Four focus group interviews each comprised 8 men. Sixteen participants were drawn from the surgical ward and the other 16 from orthopedic ward. However as stated that problems with the chosen data collection method could be expected, it was hard to get fathers 20-25 years old, for the last focus group. As a result, researcher waited till late afternoon when fortunately a right person was admitted and luckily he was willing to participate and his condition was also fit.

Table 4.1- Age of participants:

Age	Number of participants	Percentage of participants
20-25	4	13%
26-35	13	40%
36-40	15	47%

Interviews were conducted in orthopedic and surgical wards. Despite being male wards, documents of Ten Steps of Breastfeeding are displayed on walls of rooms where patients are sleeping, one in English and other in Oshiwambo, which is a local language of participants. The hospital wards provided places which were quiet and conducive for the discussion.

An open-ended interview guide was used to collect data. Probing was done to get more clarity on certain issues. Participation in the discussion from participants in all groups was overwhelmingly high. The researcher used the opportunity to give clarification and explanations as requested, after each session. Information requested from the participants were about advantages of breastfeeding, and the role of father prenatal, after delivery and during puerperium. Clarification was made how the child can get diarrhea.

The results of the interviews will be reported using the following 5 main identified themes:

1. Understanding of breastfeeding
2. Practices of breastfeeding
3. Reason for support/Non-support by men to breastfeeding
4. Roles of fathers
5. Desired practices for men to involvement in childcare

## 4.2 UNDERSTANDING OF BREASTFEEDING

### ***4.2.1 Men's Knowledge On Breastfeeding***

To determine their level of understanding, study participants were questioned to describe breastfeeding, exclusive breastfeeding, goodness and badness of breastfeeding.

When asked to describe breastfeeding, participants in all 4 groups described it as:

*“Breastfeeding is the process that the child sucking breast milk directly from the mother's breasts.”* While noted that participants only mentioned direct sucking from breasts, this necessitated the further probing to ascertain their knowledge on expressed milk, which can be given per cup or spoon whether it is also part of breastfeeding.

Participants in Group 1 consider it to be part of breastfeeding, *“Yes..., since the milk is expressed from the mother, it must also considered to be part of breastfeeding”*. This was not the case with other groups as participants in Group 2, with wonders -, *“The mother to be milked...? Like an animal? Three of participants were even laughing. Participants in Group 3 had just put it that “Maybe it is also but...expressing of milk we just heard for animals”*. Responses of participants in Group 4 already indicated how men lack information on process of breastfeeding: *“Yes, since the milk is from mother... Yes. But by the way, why should women express milk. If the purpose is because of going to work, babies should just fed with formula as usual”*.

### ***4.2.2 Exclusive Breastfeeding***

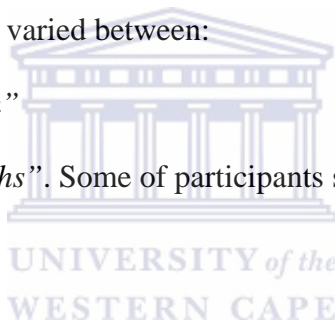
Participants were also asked to determine their understanding on exclusive breastfeeding. It was noticed with the first group that the question could not be

understood in local language if translated like “breastfeeding only”. The researcher found it necessary to rephrase the question as following “For how many months, the child is expected to be breastfed only and not receiving any other drinks or solid, not even water then breast milk unless receiving drops or syrups such as vitamins, mineral supplements or medicines? It was only 2 men out of all from different focus groups were able to give a correct answer on exclusive breastfeeding. Even correct, he was on the other hand unsure. *“I am speaking under correction... Hmm, it is from birth up to 6 months”*, said participant in Group 2. Similarly to a participant in Group 4, *“I think, but not sure...it is from birth up to 6 months”*.

Answers given by rest of group varied between:

*“ It is from birth up to 1 month”*

*“It is from birth up to 2-3 months”*. Some of participants said either they do not know or have no idea.



It was interesting with the 3<sup>rd</sup> group who could not hide their opinion, and started with discussion among them by arguing that

*“ It is impossible to believe that the child can stay from birth up to 6months without receiving anything like water, she can die from thirsty”*

*“Just say... were have you see a child grown up to 3 months without receiving a soft porridge, traditional drink (oshikundu), a soup or even water? It is just impossible.*

#### **4.2.3 Good Things about breastfeeding**

When asked about goodness of breastfeeding, although they did not mention all the advantages and benefits of it, participants were able to mention the following positive benefits: *“Breast milk is natural, it cannot make the child sick”*

*“Breast milk is full of nutrients”*

*“Breast milk contains vitamins”*

*“Breast milk can make a child strong”.*

Overall, all points were mentioned in all groups, none could give a different point and participants were not able to elaborate on what they mentioned.

#### **4.2.4 Bad things about breastfeeding**

Statements made by the majority of participants revealed how they perceived breastfeeding could be risky for transmitting different sickness and infections from mother to child.

As Group 1 put it *“ Breastfeeding is only bad if the mother is sick, like having stress, then the milk will be also not healthy and stress to be transmitted to the baby”.*

According to Group 2, *“ If the mother is not tidy, if she is not keeping her environment and belongings clean, then the dirtiness can affect the breast milk and the baby can get diarrhea”.*

Participants in Groups 3 and 4 have raised concerns that breastfeeding can transmit HIV virus to the baby if the mother is infected.

Group 3 participants agreed that, “ *Sometimes breast milk is not good especially if the mother is infected with the new disease, she can pass the disease to the child.* The fact that the topic is not about HIV/AIDS and the researcher knew already that the community is referring HIV to as a new disease; no further probe was made. Participants were requested to end there if there is no other different bad point on breastfeeding.

Group 4 “ *Nowadays breastfeeding is very risky and dangerous, especially if the mother is infected with HIV/AIDS, then she can pass the virus to the baby through breastfeeding*”.

Participants requested more clarification about this issue from the researcher: “*Sister, maybe you can give us more information about this since we are seeing babies dying everyday because it is just of this deadly virus.*” The researcher intervened to reassure participants that their question is respected and today the discussion is not about HIV but about roles of men in breastfeeding and it was appropriate to focus on breastfeeding.

Participants accepted the request with no problem.

However, there were 2 participants in both Group 1 and 2 who felt that there is nothing bad with breastfeeding.

#### 4.3 PRACTICE OF BREASTFEEDING

##### ***4.3.1 Duration of Breastfeeding***

When asked whether their children were breastfed, all the participants children had been breastfed. When asked whether they are aware if a child should be breastfed for a certain

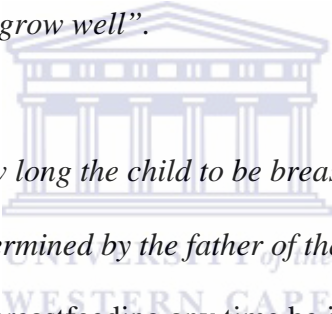


period, in Groups 1,2, and 3 agreed that it should be for 2 up to 3 years. Participants in Group 4 had a different opinion:

First they said: *“There is no any limitation of time with breastfeeding”*. Later on they come to agree, *“It must be for 1 year”*.

Participants were further questioned to give their views on how they feel about recommendations for length of breastfeeding. Some do support it while others not, due to various reasons.

For Groups 1 and 3, *“ It is good, there must be put a period for how long the mother to breastfeed so that the baby can grow well”*.



Group 2 felt, *“ The time for how long the child to be breastfed must not be a must because in our culture, it is determined by the father of the child”*. Probing revealed that culturally, the mother can stop breastfeeding any time be it within six months, a year or as long the father sees that the child has grown up or wishes it to stop for other reasons. *“If a woman missed a day without breastfeeding, as from next day, she will stop”*. After further probe, *“You see it is done because sometimes she may have sexual relationship with other men. In this manner, milk can be made dirty and make the baby sick or even die”*. They discussed that in their culture, a father’s child has the mandate for mother to wean. According to participants, *“The woman must report to the father of child before ceasing breastfeeding, to get a consent”*. Asked what will happen if she does it on her own: *“No, nobody knows but maybe older parents knows better. It is just a practice we found.”*

Group 4 also based their arguments on culture “ *No, it is not good. Different families are having their own beliefs whereby the child must just breastfed up to even 1 year. Maybe the baby will die if breastfeeding goes beyond a year.*” Some participants said they even witnessed that in their families.

#### ***4.3.2 Practice for Exclusive Breastfeeding***

As participants did not possess knowledge on exclusive breastfeeding, neither could they say whether their children were exclusively breastfed, including the two participants who were able to mention the duration of exclusive breastfeeding. It could be that their partners exclusively breastfed but they did not notice. Whether there is any benefit with exclusive breastfeeding, some felt it was the responsibility of the mother to practice that and they may have a right answer to this question. Overall, all groups have same idea and putting it in their own words:

Group 1, “*No, this is very difficult for us to know since we are not the one who breastfeed the baby, it is the women.*”

Group 2, “ *The thing is, women will be in good position to answer that. When probed why women, “Possibly woman are receiving information on that, including its benefit, maybe they are practicing what they are taught”.*

Group 3 argued that, “*This point we told you earlier that children can suffer from thirsty and hunger that is why it cannot practiced”.*

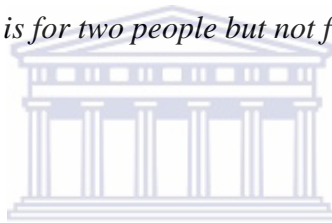
Group 4 participants also, *“Maybe the women exclusively breastfed”*.

#### **4.3.3 Involvement in decision about feeding**

None of men in all groups reported that he was involved in the decision about the feeding of their children, during infancy.

When asked about who should be involved in the decision of infant feeding in a household, men did not appear to ignorant of their parenting responsibility.

As 1st Group put it *“ The child is for two people but not for one, so they both need to make a decision”*.



Group 2 argued differently, *“Decision making in the household is the responsibility of men, he is the head of the house even feedings suppose to be done by him”*.

According to participants in Group 3, women should deal with child feedings issues, and men do not need to decide.

*“ It is their natural responsibility gifted by God... She is the one who carry the pregnancy, starting prenatal visits, give birth to child and taught and shown how to feed that child, not the men”*. Two men in these group differed from others claiming that *“Both men and women should be involved so that they can assist each other when needed”*. But the rest of the group continued to defend their argument, *“Just listen to the*

*radio one day how health workers are educating women about breastfeeding and other feedings but not men, so they must decide”.*

Group 4, all participants were also agreed that both men and women must be involved but only one man argued differently that, “ *Culturally, the child is for the women family side, that is why the men cannot decide but the woman self. Men will see to the child’s need when he has grown up”.*

All participants reported that they were not involved in the decision of feedings of their children, even though there were still those who considered men decision makers in the household. Based on these statements, the researcher felt that it was necessary to find out why they were not involved.

Some men quoted separation as one factor, as Group 1 said “*Sometimes you are not living together as you are not married. It is not easy to make a decision if you are living from different houses, you do not have the right, only the family of the women”.*

Group 2, “*Women are having their women offices with their rights, they can report you if you are interfering with their decisions, even with feedings”.*

Participants in group 3, for their non-involvement they felt “ *Women is the nearest person to the child, she is even the one who receives information on children care, including feedings, so she need to be more involved, not men”.* They continue to defend their arguments by saying, “*Men don’t know problems of children when it comes to*

*feedings, he don't have breasts to produce milk and some do not even know how to cook... That is why maybe we are not involved".*

Men in Group 4 also quoted separation as the reason.

#### ***4.3.4 Attitudes and cultural practices***

When asked to tell more about attitudes and cultural beliefs in their community, participant's statements bring to surface, the myths that are commonly held against breastfeeding in the public. According to men in groups 1,3, and 4, if the women is at any gathering, like church, public meetings and so on, she is not allowed to breastfeed among people. She must go out, get an isolated place to breastfeed. Probing let participants to discuss why breastfeeding is not allowed in the crowd.

Group 1, "*People are naughty they can bewitch the breast milk and if the baby suck that dirty milk, he can die*".

Group 3, "*Where there are many people they can pollute the air and if the breast is taken out the milk there inside can be contaminated and the baby can die or become retarded.*"

Group 4, "*I won't feel comfortable to see my partner taking out the breast in presence of people. No...the breast is a very important and private organ, if possible, it must be only seen by the partner or family members*".

Participants continue suggesting that it is better for the women always to have a tin of formulae at hand to prepare bottle feedings in case she maybe at any gathering. To them, it will help her not to miss anything because of going outside to breastfeed and other way; she saves the baby from death.

#### 4.4 REASONS FOR SUPPORT /NON SUPPORT BY MEN TO BREASTFEEDING

##### **4.4.1 Parenting**

Some men valued the importance of men to support breastfeeding. Participants when asked to explain why is it important for men to support breastfeeding, men in-Group 1 agreed that *“The child is for two parents, women and men, therefore where needed and possible, men should support their partners while breastfeeding”*.

##### **4.4.2 Fear to be cheated**

Also in favor of supporting breastfeeding participants in Group 3 explained that: *“ If men does not support breastfeeding, then they can be cheated or abused by women to buy formulae from the shops if she do not want to breastfeed. They continued to say, “Some women does not want to breast feed telling apparently her milk is not good for the baby or she does not have enough milk. We heard that they are in fear of their breasts to be spoiled and become ugly if sucked and men will no longer likes them”*.

##### **4.4.3 Lack of access to information**

They also cited lack of information as problem:

*“What is needed is just information, we cannot support by giving a breast but assist with something else as long as we are educated on breastfeeding like women”.*

Participants’ in-group 2 has a different opinion. To them, *“There is no need to support breastfeeding since men does not produce milk, they do not have breasts”.* After laughter, *“You can even see that men are not given information on breastfeeding. The more support must be from women side who is getting information”.*

Similarly, men in Group 4 felt *“ There is no really need for men to support breastfeeding”.* To them, *“That is the natural responsibility of the woman, men need less or no support on it since he is not even given education about it”.*

#### 4.5 ROLES AND ACTIONS OF FATHERS

##### **4.5.1 Roles of fathers to infant care**

Participants were asked to tell about role of fathers and men in the care of infants in their community. Overall, their opinions are described below:

*“As a men and father, you have to buy food, clothes and all belongings needed by the infant”*, was the view of group 1,3 and 4.

*“If the women is not around or if she is not feeling well and the baby is ill, the father can take the baby to the clinic or hospital”.* This was the view for participants in-group 2.

When asked if the woman is around and not sick, *“We can go together if she feels like or if the baby is seriously ill”.*

An attempt was made to find out to both groups if there is no other caring activities men can carry out. The simple answer from groups was that was all they can mention.

#### ***4.5.2 Roles of fathers to infant feeding***

Participants were questioned further to determine the role of fathers in their community, in relation to infant feeding. It was interestingly to note that men in the groups did not feel the necessity of being associated with infant feedings.

Group 1, agreed that *“There is no specific responsibility but...Men can give milk with the bottle if it is prepared, if the child started with solid foods, he can feed the child even with a spoon”*.



Group 2 shifted it to women again, *“ Maybe women will know better since it is their responsibilities”*.

For Group 3 again, *“There is no specific responsibility of men to infant feedings, if it is there then we do not know”*.

Participants in-Group 4 *“ Infant feedings are responsibility of women”*.



### **4.5.3 Prenatal support**

On the question about prenatal support by men, participants in all 4 Group, either men give money or food.

*“ A man give his partner money for hospital purposes like when she is going for antenatal services”* Group 1.

*“ As a man, buy food for women any kind like fruits, vegetables and so on, everything she asks”*. Group 2.

*“Give the women money to buy what she needs like food, clothes and to pay hospital fees and transport when she is sick”* Group 3 and 4.

The researcher found it necessary to ask about support in terms of accompanying their partners to antenatal clinics; only three men in-Group 1 who felt it is needed.

Some participants felt it is waste of time for men to go to prenatal clinics when they do not have evidence of what they are going to do there. As stated by participants in Group I, *“Why should men go there if the purpose of women to go there is for palpation?”*.

Three participants who saw the need to accompany stated that, *“Sometimes the women is sick and unable to walk, just take her there, give her in hands of nurses or doctors”*.

They continued to complain that *“Is only that ooh... you will wait for hours there outside, you can sleep and wake up and they are not yet finished”*.

Participants in Group 2 even find it funny, *“It is so funny, just imagine men also standing among the group of pregnant women, what are they doing there?”*

Group 3 questioned, “ *For what good reason men must go there if he does not carry the pregnancy? Women must go, she is going to be palpated*”.

Group 4 also agreed that, “*It is not a practice here to accompany women to prenatal clinics. It is not needed since we hear that women are going there for palpation, to see if she s having problems related to her pregnancy, so why men there?*”

These sentiments were an indication that men who either felt the necessity to support in terms accompanying women to prenatal, and those who did not, somehow felt that palpation is the only services provided there. This necessitated the researcher to create awareness among participants as per group, about services provided at prenatal clinics including health education on breastfeeding. Most men did not bother with these and just said women must just listen carefully and to tell the partner where necessary.

#### ***4.5.4 Support after delivery***

The participants noted that men are not present during delivery and neither can they be able to render support after delivery. They just accompany the women to labour room if she wants, and leave her in hands of midwives or doctors. They do not go there because: “*What business does men have there in delivery room? He is not a midwife neither a women have to give birth*”. Group 1.

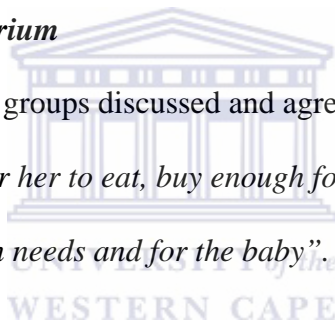
Group 2, Uncomfortably, *“Ugh, men cannot render any assistance after delivery since we cannot be there. It is difficult, it frighten us, we will die, no...”*

Group 3 indicated that, *“Historically and traditionally, men cannot be there at birth that is why it is difficult to say how women can be assisted at that time.”*

Similarly to Group 4 *“No, men are not there during delivery, it is not done... Yes, no support that time after delivery, our culture does not allow that”*.

#### ***4.5.5 Support during pueriperium***

Overall, all participants in both groups discussed and agreed that: *“When the women is discharged, slaughter a goat for her to eat, buy enough food to be well fed and healthy, give money to cater for her own needs and for the baby”*.



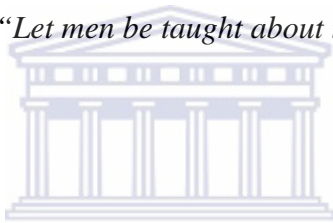
#### **4.6. DESIRES FOR MORE INVOLVEMENT**

It was so interesting to note that, participants in majority, indicated that they wanted to be involved in the care of their children during infancy. Some have blamed the health system for not creating conducive environment for enabling men to participate. That is why, when they explained how they would have take care of their children, they also made some suggestions for improvements.

As participants tells: *“Men could have support his partner with breastfeeding, to give correct information were she is wrong”*. After probe, *“Like, if she don’t want to*

*breastfeed, then men tell her why is it important to*". According to participants, *"Unfortunately men are not targeted with education about breastfeeding. Without proper information, then forget about proper support"*. This was the view of men in Group 1. They suggested information to be given through media, especially radio. To them, information must not only target women, but men also. Also, pamphlets about breastfeeding, men must also appear there.

Men in Group 2 felt: *"Men can feed their children use formula and bottles so that they can also be with their children and to know each other well"*. In order to share the responsibility, men demanded, *"Let men be taught about types of formula, preparation and how to feed the child"*



*"The world of today is not of yesterday, we don't want to live like our fore fathers"*, said the men in Group 3. They want to accompany partners to antenatal clinic and also at labor. *"Let us be included in such programmes please so that we can see and hear by ourselves what is being done there instead of being told by women"*.

Women are more close and like their children than men, this is because they are taught how to take care of them, alluded men in Group 4. Men want also to be more caring. *"Health workers must also teach us about good practices of caring and feeding of children, which type of food and when and how to give it."*

Even that, there were men in minority who felt the care they are offering is enough.

*“No, it is just okay, men does not need more involvement because the women is there”.*

This chapter was designed to present data. The next chapter is about the summary of the findings, conclusion, implication and recommendation.



## **CHAPTER 5: SUMMARY OF FINDINGS, INTERPRETATION, CONCLUSION, IMPLICATION AND RECOMMENDATIONS**

The previous chapter covered the method used for data analysis, presentation of findings of results. This chapter will present the summary of findings, interpretation, conclusion, implications and recommendations of the study.

### **5.1 SUMMARY AND INTERPRETATION OF FINDINGS**

#### **5.1.1 PARTICIPANTS UNDERSTANDING OF BREASTFEEDING**

##### ***5.1.1.1 Knowledge of Breastfeeding***

Breastfeeding being natural process, participants in all groups seemed to be able to describe it. On the other hand, the study revealed that the majority of men are not aware that human beings too can express milk, which can be given to the child to drink, which is also a process of breastfeeding.

The study revealed that generally, men's knowledge on breastfeeding was limited. This was demonstrated by their lack of understanding about exclusive breastfeeding. It can be assumed that participants do not know the importance of exclusive breastfeeding and that is why they found it impossible for the child to stay up to 3 months without being given anything like soup, soft porridge and so on. Lack of belief in exclusive breastfeeding was seen as posing a threat to the sustainability of exclusive breastfeeding, as documented by Semega Jennet, (1998).

With regards to goodness of breastfeeding, men were able to mention some positive benefits. Generally, their opinions on its benefit related to the child's health only. This is another indication of the insufficient knowledge men possess. Breastfeeding is said to be both beneficial to infant, mother, family and society as stated in Ministry of Health and Social Services (1994) and Meyer et. al, (2002). They were not able to elaborate on the points they mentioned, just said it is good. The poor knowledge about breast-feeding by men as fathers has been also reported in the study by Giugliani, Bronner, Caiffa, Vogelhut, Witter and Perman, (1994).

The lack of full understanding of breast-feeding by men was also demonstrated when they described breastfeeding to be bad. The points raised include stress from mother to baby through breast milk, diarrhea facilitated by dirtiness through breast milk. Some participants were aware that HIV virus could be transmitted from mother to baby through breastfeeding (WHO, 2003). The question remains whether men are aware of risk factors that are facilitating the transmission during breastfeeding, so that they can be able to support their partners accordingly or be more sensitive to HIV-positive family or community members.

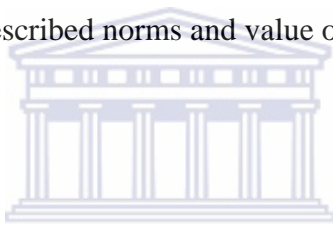
## 5.1.2 PRACTICES OF BREAST FEEDING

### *5.1.2.1 Duration of Breastfeeding*

All men in the present study reported that their children were breastfed, which is a good practice. It is even good that participants in minority knew that children must be breastfed

for at least up to 2 years or beyond, as recommended by the WHO. They supported these durations of breastfeeding as it is beneficial to the child. Even that, it may raise concern since men could not elaborate more on how it is good for the baby.

Some participants, who said that the child should be breastfed for up to 1 year, based their arguments on culture. To them, it is not good to put a limitation as for how long the child should be breast-fed. Different families have their cultural beliefs, so they need to decide according to their culture. Participants showed respect to their culture. They are in line with what Williams, Baumslag & Jelliffe (1989) said that members of any community have to behave according to prescribed norms and value otherwise they will be sanctioned if they disobey.



#### ***5.1.2.2. Practice of Exclusive Breastfeeding***

It was evident from the study that many of the men did not know whether their children were exclusively breastfed or not. Fathers who do not understand exclusive breastfeeding and do not know how their infants are being fed cannot therefore be supportive to the mother to practice exclusive breastfeeding. Similar problems were documented in Ministry of Health and Social Services (1992).

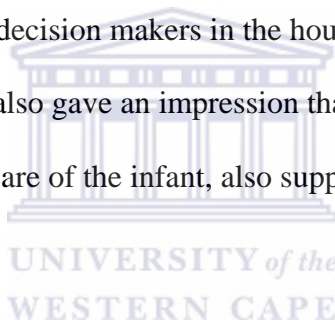
It was interestingly to note that men stated lack of information as one reason why they are not in position of knowing issues related to exclusive breastfeeding.



### ***5.1.2.3 Involvement in Decision making about feeding option***

Results from the present study indicated that none of the participants were involved in the decision about infant feedings. This supports the results from Voss and Manners (1993) study, whereby 30% of 113 fathers did not discuss method of infant feeding with anyone.

The study indicated a variation in men's reasoning about who should be involved in decision about feeding in a household. Some felt both father and mother should be involved. Participants recognized that the child is for two people that is why no one should be excluded in decision-making. Others were not involved because of separation. Other participants felt men are decision makers in the household, including infant feeding. Expressed sentiments also gave an impression that men in the present study feel left out in decision making on care of the infant, also supporting the study by Voss and Manners (1993).



Another reason given why men do not involve in decision-making, is because of culture. There appears to be a cultural belief that it is the woman's responsibility to make decisions regarding the child, although a minority of men did express that both parents should be involved or that decision making regarding all things should belong to the men.. Similarly, the study by Evans (1994) in Namibia, whereby men were reported to be seldom involved in direct care of young children and essentially were absent until the child is older. Being the case, one can say mothers alone may find it difficult to take a decision on exclusive breastfeeding without the support of their husbands.

Some participants felt women must make the decision since it is their natural responsibility. Beside the natural responsibility, men once more claimed that women are getting information on infant care and feeding from pre natal clinics and over the radio, but men still are excluded. The assumption here is that men as fathers will not really feel the importance of their involvement if they are not targeted with information.

#### ***5.1.2.4 Attitudes and Cultural practices***

Some cultural attitudes are not supportive to breastfeeding and can force mothers not breastfeed successfully.

The present study has revealed cultural attitudes that are held against breastfeeding in public. Various reasons were explored. One of the reasons advanced is witching. If there is a witch among the group where the breastfeeding women are, he can do something on the milk and the baby can die. Besides witching, many people can pollute the air.

Contaminated air can affect breast milk if the breast is taken out right among people.

There is a need for further investigation into these beliefs to establish the effect it has on breastfeeding practices.

From responses obtained, men do not feel comfortable for his partner's breast to be seen by others, unless they are family members. The breast is considered as very important, private organ. Castello (1990) also noted that some men have the attitude that the breast is only a sexual object.

Studies by Voss and Manners (1993), Freed, Fraley and Schanler (1992) also found that men do not support breastfeeding in public.

It has also emerged that, cultural beliefs determine weaning. Interestingly, sometimes women have to stop breastfeeding, when it is found that she engaged in sexual relationship with a man not a father of the baby. As men tell, the reason is that other men can contaminate the milk. So, they think it is better to save the baby not to suck dirty milk as he can die. Green, Jurge&Dgedge in Manica in 1991, also observed similar belief in Mozambique. Results showed that diarrhea in children were because of contaminated milk if the mother committed adultery. On the basis of this belief, it can be assumed that women in Mozambique maybe also instructed to stop breastfeeding. The child will no longer exclusively breastfed especially if the child get diarrhea at the age below 4months. Also in Lesotho, Williams , Baumslag & Jellife (1989) noted that sexual intercourse is a taboo while mother is breastfeeding. In order to have sex, men have to buy formula tins, for bottle-feeding to replace breastfeeding. All these beliefs can be linked to what Le beau (1997a) said that every culture has a set of ideas how to prevent diseases and how to treat people who are sick. However, such practices do need further investigation. Particularly in the current environment to see how it can be related to the knowledge that HIV virus can be transmitted to the baby through breastfeeding and couples are expected to practice safe sex after delivery.

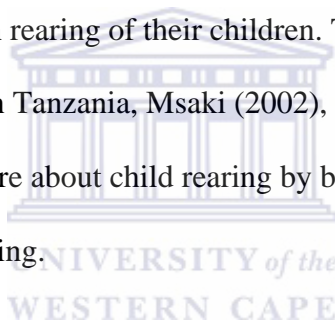
### 5.1.3 REASON FOR SUPPORT/NON-SUPPORT BY MEN TO BREASTFEEDING

#### *5.1.3.1 Reason for support by men to breastfeeding*

It is encouraging that although men are having poor knowledge on breastfeeding, and are not involved in decision making around child feeding, the majority are in favor of men being supportive of breast-feeding. Reasons advanced include parenting and men's fear to be cheated by women.

#### *Parenting*

Some men were aware of their responsibilities as parents. They supported that both parents should play their role in rearing of their children. This is in fact a positive idea, which was also taken by men in Tanzania, Msaki (2002), whereby one of their main issues for their organization were about child rearing by both parents and men was expected to promote breastfeeding.



#### *Men's perceptions of why women don't breastfeed*

Men alluded that they are in support of breastfeeding because they fear to be abused and cheated by women who do not want to breastfeed. Men mentioned that there are some women who don't want to breastfeed, as they fear their breasts to become ugly. If the breasts become ugly, apparently men won't like them. In fact, women may judge men wrong. Men in this study want to support breastfeeding and are aware of the benefits of breastfeeding and they do not want to buy formula. This finding is supported by findings from the study by Freed, Fraley and Schauler (1993), who found that mother may not exclusively breastfeed assuming that the father is having negative attitude towards

breastfeeding. The findings show that man's attitudes were not worse as women were predicting.

### ***5.1.3.2 Lack of access to information***

The findings from the present study revealed that men as fathers have limited or sometimes no access to information on breastfeeding issues. Men reported throughout the study that they are not receiving information on breastfeeding. The sentiments expressed were similar whether by the group who are in favor of support or non-supporters to breastfeeding. One can assume that inaccessibility to information is probably the reason for the limited knowledge on breastfeeding by these men.

Denying men information pertaining to breastfeeding will make them remain barriers to exclusive breastfeeding. Even the WHO, (2003) has stated that if infant feeding practices are to be improved, then men must also be reached with information regarding exclusive breastfeeding. Men need to acquire knowledge to enable them to learn various ways how they can support breastfeeding. He can support by help mother during weaning period just to play with the child, cuddle and give a cup, as stated in National Women's Health Center, (2004).

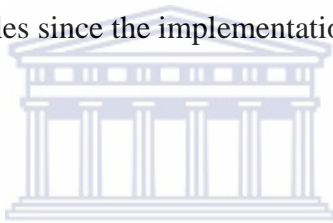
## **5.1.4 ROLES AND ACTIONS OF MEN AS FATHERS**

### ***5.1.4.1 Roles of men as fathers in care of infants***

All men in the study were in agreement that their role in infants care includes buying food, clothes and all belongings needed by the infant.

Another caring activity mentioned was that men could take the child to the clinic or hospital if sick but only if the mother is sick or not around.

Men are expected to accompany children to health facilities, etc. as documented in Ministry of Health and Social Services (1992) irrespective whether the mother is around, not sick or if she is willing. Cultural beliefs can have an influence on taking care of children that can be also a case with present participants. According to Williams (1989), in each society, there are approved methods of rearing children, differentiating roles each parent has to play. There is a need for further investigation to establish to which extend men are made aware of their roles since the implementation of the BMFI, in relation to their culture.



#### ***5.1.4.2 Role of fathers to infant feedings***

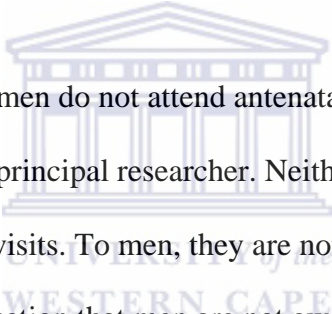
It was evident from the findings of the present study that men do not participate much when it comes to infant feeding. Some participants partially acknowledge that they can assist with bottle feedings and feed the child with solid foods but only if already prepared. They do not seem to be aware of possible roles as outlined by the National Womens Health Information Center, (2004), e.g. that fathers can help the mother especially during weaning period to give emotional nourishment to the child with many activities including feeding with a cup.

A possible explanation could be that since the majority of participants are not aware of expressed breast milk, one can assume that they cannot fully participate in feedings of

children. Once more, men considered women to be better placed to comment on children feedings.

#### ***5.1.4.3 Prenatal Support***

Statement from participants revealed that men as fathers do support their partners prenatally. They provide food. This is one of their roles as documented in BMFI manual (1992). They do also provide money since without money you won't be able to buy food, clothes, paying hospital fees if she is sick and to pay transport if going to antenatal clinic as they stated it.



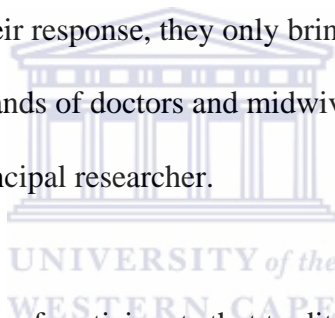
An interesting finding was that men do not attend antenatal clinics. This is in support of the practical observation of the principal researcher. Neither did men see the need to be involved with antenatal clinic visits. To men, they are not palpated and it is a waste of time to go there. This is an indication that men are not aware of services rendered at antenatal clinics from palpation. There were a minority who were in support of accompanying women to prenatal clinics, but only when she is sick or unable to drive. Even that, they will not go inside the clinics self to see what is happening but they wait outside, since it is not a practice their community.

There is a need for involving men in prenatal care services. This will be beneficial since men will also receive information on breastfeeding. In the present study, men have poor knowledge about breastfeeding. This is supported by the study by Giugliani, Bronner, Caiffa, Vogelhut, Witter and Perman (1994) who also found that fathers, especially those

who do not attend prenatal classes to receive information had poor knowledge of breastfeeding. To be involved at prenatal clinic will allow them to decide with their partner on appropriate feeding options for the coming baby and other activities. Dr Charles Sagoe Mose also highlighted that when he was addressing the WABA forum in Arusha Tanzania in 2002. Men need to understand that prenatal care is more than just palpation.

#### ***5.1.4.4 Support after delivery***

The study revealed that men are not present during delivery; so they are unable to render support after delivery. From their response, they only bring women to labor rooms and leave them there alone in the hands of doctors and midwives. This is again supporting the practical observation of the principal researcher.



It has emerged in the expression of participants that traditional norms can be seen as a barrier to the attendance of the father during delivery,

#### ***5.1.4.5 Support during puerperium***

Support during the postnatal period generally takes the form of buying enough food for the women to be well fed and healthy. The men also mentioned slaughtering of a goat, which can be assumed that it is traditionally done since each group mentioned that.

Culture does determine food to be eaten and its way of preparation, Williams, Baumslag & Jelliffe (1989).




### 5.1.5 DESIRED PRACTICES FOR MEN TO BE INVOLVED IN CARING OF CHILDREN DURING INFANCY

An additional theme generated by the data indicated a dichotomy or tension among the participants between traditional versus modern beliefs and cultural practices. Participants in majority indicated that they very much wanted to be involved in taking care of their children during infancy. Men complained that the current situation is not conducive to enable them to participate fully but that they are just kept aside. Even though they seemed to hold traditional beliefs, the men deemed it necessary to change from what their forefathers had been doing. Culture is not static but does change because people do learn new practices and beliefs as they are exposed to new environment (Williams, Baumslag & Jelliffe, 1989). That is why; the main concern was about access to information about breastfeeding. If they were empowered with knowledge and information about breastfeeding, then they could support their partners and take care of their children fully and make correct decisions in terms of feeding. As they want to know more about types of food, it enables them together with mothers to provide safe and appropriate complementary foods. They want information to be given through media, especially the radio. It is evident from the comment made, that information material on breastfeeding rarely contains pictures of fathers. The principal researcher made a similar observation.

Participants also revealed that they could have done more if they were included in prenatal clinics and attend partners while in labor. In present practice, women are reporting to men what they were told by midwives. This can either be about diet to be

taken or feedings options. Men felt if they could hear by themselves then they could be able to assist their partners and children from early stage. What fathers are requesting was also recommended by researchers such as Giugliani, Bronner, Caiffa, Vogelhut, Witter and Perman (1994) & Arora et al, (20000). Involving men in prenatal programmes will ensure that fathers will be prepared to assume their new role as breastfeeding supporters and improve their knowledge of breastfeeding.

The involvement of men during antenatal, labor/delivery and postnatal was also realized being important by men in Tanzania, as outlined by The WABA forum in Arusha Tanzania in 2002.



The study by Earle (2000) conducted in Coventry, UK, revealed that fathers are choosing other feeding methods like bottle-feeding because they want to be involved in child feedings. Also according to Renfrew, Fisher and Arms (1990) this is also a practice in Western culture. In the present study, men also incorrectly thought bonding could only be built through bottle-feeding with formula. They felt men could participate in feeding if they know the types of formula, the preparation and how to feed the baby. They would have done that and are demanding education from health providers, about that. Dr. Ted Greiner while addressing the Tenth Innocenti Declaration 10<sup>th</sup> anniversary meeting in 2000 in Florence (Italy), made a warning remark on this that if norms pertaining to fathers role during infancy are not to be formulated, clearly indicating how he can support mother in various ways, then formula companies will take over.

If the mother breastfeeds and the father formula feeds, one can call this as mixed feeding. This can be dangerous since according to WHO, (2003) mixed feeding poses a high risk in transmitting HIV virus to the baby during, for the infected mother. Thus, health education among men needs to be increased, to provide accurate information and to create more awareness on this issue.

Some participants felt the caring they are currently providing is enough. du Toit & van Staden (2005) indicated that changing from traditional to modern practices could be characterized by a state of doubt. People do not know how they should act, what is wrong and right whether their culture the new discovered inventions. That is why it will be also not easy for men to change from their current caring roles.

There is a need for awareness to be created in order men to develop positive changes towards breastfeeding and care of children in general.

## 5.2 CONCLUSION

Breastfeeding is important for the health and well being of infants. For optimal growth, development and health of the infant to be achieved and to ensure that infants are provided with ideal food, WHO recommends globally, exclusive breastfeeding for the first 6 months and thereafter, adequate and safe complementary foods to be introduced and baby to be breastfed for up to 2 years of age or beyond (WHO, 2003). Breastfeeding is advantageous and beneficial to child, mother, family and society at large. Exclusive

breastfeeding is rarely practiced, with 26% in Namibia. Mothers alone may find it difficult to take a decision on exclusive breastfeeding without the support of their husbands Semega Jenet (1998).

The study revealed that men have negative cultural attitudes towards breastfeeding. This was indicated by the fact that they do not support breastfeeding in public, are seldom involved in direct care of young child and absent till the child is older. While some consider themselves decision makers in household, the child to be weaned by his order, most men were not involved in decision making regarding infant feeding. Their knowledge about breastfeeding is limited. This was evident how participants described breastfeeding to be good or bad. Goodness was limited to the child, no elaboration on facts mentioned. Participants have little idea about exclusive breastfeeding.

This negative trend could be attributed to the fact that men are not attending prenatal clinic, neither are they present at delivery. Breastfeeding advice is given during prenatal, immediately after birth then throughout pueripuerium.

Positive findings is that men are willing to be involved in the care of children, to carry out their roles as father to support women when breastfeeding. Men find present breastfeeding programmes not inclusive of men and recommended changes emphasis was put on access to information.

To conclude, the present study met the objectives of the study. So, to protect, promote and support breastfeeding, let men, as fathers be included in breastfeeding programmes. Norms pertaining to fathers role during infancy, how he can support mother in various ways, must be formulated (Baby Friendly Hospital Initiative Newsletter, 2000). Fathers reached with information regarding with exclusive breastfeeding practices can be improved (WHO, 2003). Otherwise, men will remain barriers to exclusive breastfeeding.

### 5.3 PROGRAMME IMPLICATIONS

It was evident from the study that men hold cultural beliefs, which can negatively affect the practice of exclusive breastfeeding. Therefore, there is a need for health workers to learn about local beliefs and practices, to identify those to be beneficial and the harmful ones. These will then be adopted in the health education approaches on breastfeeding.

The study results revealed that men have limited knowledge about breastfeeding. Also, men are not involved in decision making of feedings option of children and have no access to information about breastfeeding. Men need to be more involved and supportive by telling his female family members especially his mother, that he wants his child to be exclusively breastfed.

There is a need within the healthcare system to include men in prenatal programmes. In order for men to use these services, healthcare providers need to ensure that Mother and Child Health care services are “father friendly”. The environment must be made conducive, were men have to be welcomed more into the “women’s world”. Men should

be made aware of their parenting role to child care and to be more supportive of breastfeeding extended during delivery and pueriperium. In order for the message to be welcomed, information must be coming from male health workers.

Education about infant and young child feeding needs to be increased, targeting both men and women. Education can be started as early as from schools and through media.

Correct information will help to remove cultural and other negative attitudes, towards breastfeeding harbored by men. Lack of involving men, as fathers will just make them barriers to breastfeeding.

#### 5.4 RESEARCH RECOMMENDATIONS

Breastfeeding is important, as it is the only way that provides ideal food for the healthy growth and development of infants. As per WHO recommendation, infants should be exclusively breastfed for the first 6 months of life, including babies borne from HIV infected mothers. Ability of mothers to exclusively successfully breastfeed will be enhanced provided that there is a support from men as fathers. From the issues and results of the present study, future research about breastfeeding in relation to men is recommended:

1. A study to obtain views of women on relevance to breastfeeding support by men.
2. A follow up study to the current study, on wider scale using Focus Group discussion, covering all regions, to determine variations in community views on men's role about breastfeeding.

3. An observational study to be conducted at Prenatal clinics and Maternity units to determine the involvement of men.
4. An analytical study to assess how roles of men were explained in breastfeeding policies.
5. An intervention study to include men in prenatal, delivery and postpartum services.



## BIBLIOGRAPHY

Arola, S., McJunkin, C., Wehrer, J., Kuhn, P.(2000). Major factors influencing breastfeeding rates: Mother's perception of father's attitude and milk supply. *Pediatrics* Electronic Pages 106(5): e67. Available:

<http://pediatrics.aappublications.org/cgi/content/full/106/5/e67> [24/08/2004 09:00 AM]

Bailey, K.D. (1987). *Methods of Social Research. 2<sup>nd</sup> Edition*. The Fees Press: New York

Bless, C & Higson-Smith, C. (1995). *Fundamentals of social Research methods: An African perspective. 2<sup>nd</sup> Edition*. Juta & Co, Ltd: South Africa.

Brink, H.I. (1999). *Fundamentals of Research methodology for Health Care professionals. 2<sup>nd</sup> Edition*. Juta & Co, Ltd: South Africa.



*Breastfeeding Promotion Network of India*. (1998-2003). Fathers can help.

[www.bpni.org/cgi1/fathers.asp](http://www.bpni.org/cgi1/fathers.asp)

Castello, B.H. (1990). Breastfeeding on prime time in Brazil. *Dev Commun Rep*. Volume 71: 4,7, [Online], Available:

<http://.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstra...> [05/24/2005 05:10 AM].

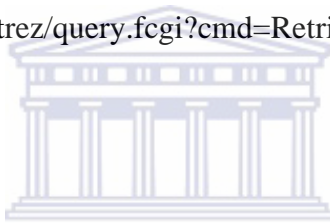


du Toit, D. & van Staden, J. (2005). *Nursing Sociology*. Van Schaik Publishers: Pretoria, South Africa.

Evans, J. L. 1994, 'Child rearing practices and beliefs in Sub-Saharan Africa': Workshop proceedings, Windhoek, Namibia, 26-29 October 1993.

Freed, G.L., Fraley, J.K., and Schanler, R.J. (August 1992). 'Attitudes of expectant fathers regarding breastfeeding'. *Pediatrics*. Volume 90, (2 Pt 1): 224-7,[Online], Available:

<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstra...> [08/24/2004 10:10 AM].



Gifford, S. (Undated). Analysis of Non-numerical Research. In Kerr, C., Taylor, R & Heard, G. *Handbook of Public Health Methods*. McGraw Hill: Sydney. pp. 543-554.

Giugliani, E.R., Bronner, Y., Caiaffa, W.T., Vogelhut, J., Witter, F.R., Perman, J.A. (November 1994) 'Are fathers prepared to encourage their partners to breastfeed? A study about father's knowledge of breastfeeding'. *Acta Paediatr*. Volume 83, (11): 1127-31, [Online], Available:

<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstra...> [08/24/2004 10:15 AM].

Giddens, A. 1993. *Sociology*. Polity Press: Oxford,UK.

Government of the Republic of Namibia. (2002). *The 2001 Census Preliminary Results*. National Planning Commission. Namprint: Windhoek. Namibia.

Green, E.C. (1996). *Indigenous Knowledge System and Health Care promotion in Mozambique*. In *Indigenous Knowledge and its uses in Southern Africa*, H. Normann, I. Snyman and M.Cohen, (eds). Institute for Indigenous Theory and Practice, Human Sciences Research Council: Cape Town. pp.51-65.

Harrison, V.C., Keet, M.P. & Shore, S.C.L. (1987). 2<sup>nd</sup> Edition. *The Newborn Baby*. Juta & Co: Cape Town.

IBFAN Africa statement on HIV and Infant Feedings. The IBFAN Africa Regional Workshop on Policy Guideline for Infant feeding and HIV, 23-27 August 1999, Pretoria, South Africa.

Kozier, B., Erb, G., Berman, A.J.&Burke, K.(2000). *Fundamentals of Nursing. Concepts, Process and Practice*. Precentice Hall Health: Upper Saddle River, New Jersey.

King, F.S. (1995). *Helping Mothers to Breastfeed*. AMREF: Kenya, Nairobi.

LeBeau, D. (1997a). Traditional Medicine and functions of Witchcraft Accusation. Paper presented at the Namibian Colloquium on 20 March 1997.

Ministry of Health and Social Services. (1992). Towards a Baby and Mother Friendly Nation: Guideline for the implementation of the Baby and Mother Friendly Initiative. Namprint: Windhoek, Namibia.

Ministry of Health and Social Services (2003). Namibia Demographic and Health Survey 2000. Namprint: Windhoek, Namibia.

Ministry of Health and Social Services. (1994). Breastfeeding Is Best for the Baby- The advantages of Exclusive Breastfeeding for 4-6 months: A Resource Book for Mothers in Namibia. Namprint: Windhoek, Namibia.

Ministry of Health and Social Services (2005). Rollout Plan for Prevention of Mother- to -Child Transmission of HIV, Voluntary counseling and testing, antiretroviral therapy. Namprint: Windhoek, Namibia.

Meyer, B. J., Papendorp, D.H., Meij, H.S.&Viljoen, M. (2002). *Human Physiology: Chemical, physical and physiological principles*. Juta & Co: South Africa.

Msaki, O.N. 2002, World Alliance For Breastfeeding Action Global Forum II: Personal Experience on commitment to fathering and Breastfeeding through a Church fathering group: “The Mwenge Christian Fathers Fellowship, paper presented to the First Men Only Forum, Arusha International Conference Centre (AICC) Arusha- Tanzania, 26 September.

Morse J.M. (1994). *Designing funded qualitative research*, N.K. Denzin and Y.S.

Lincoln, (eds) Sage Publications: Thousand Oaks. pp. 220-235.

Murray, S.F. (1996). *Baby Friendly Mother Friendly*. Mosby: England.

National Women's Health Information Center. Breastfeeding: Breastfeeding made easier at home and work. [Online], Available: <http://www.4woman.gov/> [04/08/04 10:39 AM]

Oshakati Intermediate Hospital PMTCT register (2002-2004). Oshakati district.

Namibia.Oshakati Intermediate Hospital Maternity Statistic Book (2001-2005). Oshakati District. Namibia.

Semega-Jennet I.S. (1998). The Second Abraham Horwitz Lecture, Breastfeeding: From Biology to Policy. [Online], Available: <http://unsystem.org/scn/archives/npp17/ch11.htm>. [06/07/2004 09:30AM]

Searle, C. &Brink, H.I.L. (1984). *Aspect of Community Health*. King Edward The Seventh Trust:Cape Town.

The Baby –Friendly Hospital Initiative Newsletter. Sept/Oct. 2000.

Voss, S., Finnis, L, Manners,J. (August, 1993). 'Fathers and breastfeeding: a pilot observational study'. *JRSoc Health, Volume 113 (4): 176-80*,[Online], Available:

<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract>  
...[08/24/2004 10:30 AM].

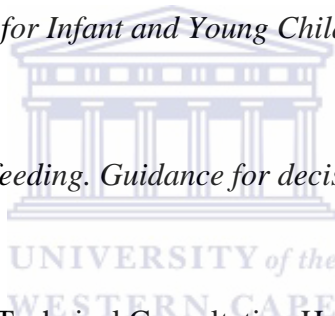
Willms, D.G&Johnson, N (1993). *Analysis and Interpretation*. In *Essential in Qualitative Research: a notebook for the field*. (Unpublished), pp.69-82.

Williams, C.D., Baumslag, N. & Jellife, D.B. (1989). *Mother and child Health. Delivery the Services*. Oxford: Newyork, Toronto.

WHO, (2003). *Global Strategy for Infant and Young Child Feeding*. WHO: Geneva.

WHO, (2003). *HIV and infant feeding. Guidance for decision-makers*. WHO: Geneva.

WHO HIV and Infant Feeding Technical Consultation Held on behalf of the Inter-agency Task Team Consultation (IATT) on Prevention of HIV Infections in Pregnant Woman, Mothers and their Infants Geneva, October 25-27, 2006.



ANNEXURES

---

ANNEXURE A: A LETTER OF PERMISSION

RE: APPLICATION FOR PERMISSION TO CONDUCT A RESEARCH STUDY IN  
OSHAKATI DISTRICT.

Enquiries: O.V.Kavela

P.O.Box 954

Tel. 065-2233136

Oshakati

19.May 2006

The Permanent Secretary

Ministry of Health and Social Services

Private Bag 13198

Windhoek

Namibia



Dear Dr. K. Shangula

I am a distance Master Degree student at the University of the Western Cape. As a requirement for the study, I am expected to do a research study. The site is Oshakati Intermediate Hospital. The title of the study is, “The role of men in hindering or promoting breastfeeding in Oshakati, Namibia.”

The study population will be recent fathers in Oshakati aged between 20 and 40 years who are recovering from illness, those admitted in orthopedic and surgical wards.

Therefore, I humbly request your good office to grant me permission to conduct my study. Included is a copy of research proposal, which has been approved by the Higher Degrees Research Committee at the University of the Western Cape.

Your kind response will be highly appreciated.

Your sincerely

O.V. Kavela



ANNEXURE B: CONSENT FORM

*The role of men in Hindering or Promoting Breastfeeding in Oshakati-Namibia*

PURPOSE.

Permission for you to participate in a research study is required. The research study will required you to explore your roles in breastfeeding in relation to your attitudes, knowledge and cultural beliefs. The reason for conducting this study is to explore the role of men hindering or promoting breastfeeding patterns.

PROCEDURE.

The study will consist of 4focus group discussion last not more than an hour .you will be asked to respond to questions pertaining to breastfeeding. The discussion will be tape – recorded and tape recording will be erased after information from tapes has been obtained.

RISKS

There are no physical risks involved by participating in this study. If you feel that the content of the interview is causing you feeling of emotional discomfort; you are free to end the interview.

BENEFIT

There is no direct benefit to you for participating in this study. The results of –the study will help health care providers in programmers related to men role in breastfeeding.

CONFIDENTIALY

Anonymity will be ensured to information you will provide and the results of this study will be reported as group results. Information will be kept.

PARTIICIPATING.

Your participation in this study is voluntary. You can withdraw from the study and time as you feel without victimization.

CONSENT.

I have read the information contained in this consent from and give my consent to participate in the study.

Signature of Investigator	Date.....
Signature of participant	Date.....
Signature of witness	Date.....

THANK YOU FOR PARTICIPATING IN THIS STUDY.



## ANNEXURE C:QUESTIONS GUIDELINE

How would you describe breast-feeding?

Were your children breastfed? Why or Why not?

It has been argued that a child should breastfed for a certain period. What is your opinion on this?

What are good things about breastfeeding?

What are the bad things about breastfeeding?

How do you understand exclusive breastfeeding?

Were any of your children exclusively breastfed? If yes, how long?

Were you involved in the decision about feeding of your children when they were infants?

Who should be involved in the decisions about infant feeding in a household?

Do you think it is important for men to support breastfeeding? Why or why not?

Tell me more about the attitudes and beliefs in your culture when a woman should breast-fed and when she must not.

What is the role of fathers and men in the care of infants in your community?

What is the role of fathers and men in relation to infant feeding in your community?

Tell me more how the woman can be supported pre-natal, after delivery and during pueripuerium. (Probe by father of baby, if only mention other family members role)

Would you like to have been more involved in taking care of your children, especially when they were infants? Why or why not? If yes, what would you like to have done differently?