The transitioning role of Botswana fathers in breastfeeding

Lynn Rempel[1], Motshedisi Sabone[2], John Rempel[3], N. Swart[4], Kenalepe Molefi[5]

Abstract

Although infant care has traditionally been perceived as women's work, especially when the mother was breastfeeding, fathers are becoming increasingly involved in parenting and breastfeeding support. However, there is little research regarding this transition in an African context. The purpose of this study was to explore the role of the fathers in the breastfeeding family in Botswana. The study used a descriptive qualitative design informed by grounded theory. Twenty-one breastfeeding couples from rural and urban localities were interviewed over a period of 4 months in 2010. An interview guide was used to collect data from mothers and fathers who were interviewed separately. Audio-recorded interviews were transcribed, translated and coded to describe fathers' experiences and their roles as well as factors influencing such roles. Ethical clearance was made with relevant authorities and participants provided written consent. Father acted as provider, protector, loving and caring partner to the mother, breastfeeding supporter and direct loving baby care provider. Although all fathers valued playing a role in breastfeeding, they were sometimes constrained by traditional norms related to the care of the mother and the newborn. However, the study showed that cultural traditions were changing, and fathers were providing both physical care and emotional support to both the mother and the breastfeeding baby. Thus father's roles in the care of their new born infants can be characterised as being in transition, as today's parenting abandon traditional norms and values to accommodate the needs of the modern family. This study can inform health care providers about the dynamics of fathers' participation in breastfeeding, and help them to tailor support programmes to suit the needs of breastfeeding couples in Botswana.

Keywords: Breastfeeding, cultural transition, culture, father-infant relations, father's role

[1] Department of Nursing, Brock University, Canada, E-mail: lrempel@brocku.ca
[2] School of Nursing, University of Botswana, E-mail: sabonebm@mopipi.ub.bw (corresponding author)
[3] Department of Psychology, St Jerome University, Canada, E-mail: jrempel@uwaterloo.ca
[4] School of Nursing, University of Botswana, E-mail: ncs35@case.edu
[5] Ministry of Health, Botswana E-mail: kmolefi@gov.bw

Introduction

Although infant care has traditionally been perceived as women's work, especially when the mother was breastfeeding (Pontes, Osorio, & Alexander, 2009), fathers are becoming increasingly involved in the lives of their children (Lamb, 2010). Research on father's involvement during breastfeeding is limited, especially in African contexts (Nsamesang, 2010). However, a few studies have explored father-infant involvement in selected African cultures. In Ivory Coast, husbands encouraged their HIV positive wives to feed the baby on artificial formula and actively participated in baby feeding (Traoré, Querre, Brou, Leroy, Desclaux, & Desgrées-du-Loû, 2009). In Tanzania and Ghana, young fathers enjoyed participating in baby care but were constrained by their culture (Dumbaugh, Tawiah-Agyemang, Manu, Ten Asbroek, Kirkwood, & Hill, 2014; Mbekanga, Lugina, Christensson, & Olsson, 2013) and inadequate support from the health care system (Mbekanga, Lugina, Christensson, & Olsson, 2013). This paper presents findings of a study that investigated the perspectives of both mothers and fathers on the role of the father in breastfeeding in Botswana.

Although fathers' participation in child care and breastfeeding has been reported to be evolving (Lamb, 2010; Rempel & Rempel, 2011) little is known about what happens in Botswana. The purpose the study was to explore the role of fathers in the breastfeeding family in Botswana from the perspectives of both breastfeeding mothers and the infants' fathers. The goal of the research was to broaden the understanding fathers' roles in their partners' breastfeeding decision making. Results from the study could inform interventions and strengthen the positive impact of fathers on the health and development of babies, as well as guide nurses and midwives in fostering strong supportive families.

Methods

Design

The study employed a descriptive qualitative design informed by grounded theory (Sandelowski, 2000). The aim of descriptive qualitative studies is to gain first-hand knowledge on the participants' experience of a phenomenon, and the findings reported in language that is close to participants' everyday language so that the data can directly inform interventions (Neergard, Olessen, Andersen, & Sondergaard, 2009). Sandelowski (2000) argued that any qualitative approach may use techniques, words or phrases of other qualitative approaches and become toned to the direction of such other approaches without making claim to their methodological integrity. The study therefore used techniques of the grounded theory method such as the grand tour question (Martin, & Gynnild, 2011) and constant comparison analysis.

Study participants

Twenty-one (21) couples participated in the study; 47.6% and 52.4% were from an urban and a rural area of Botswana respectively, and had a baby who had been breastfed during the previous two months. The classification of rural versus urban area was based on Botswana's population census. Three couples lived separately because they worked in different areas. The mean ages for mothers and fathers were 28.7 and 34.3 years respectively, while the breastfeeding babies had a mean age of 6.4 months. Full-time employment was at 47.6% for fathers and 23.8% for mothers. All employed mothers had three months of leave time following the birth of their breastfeeding babies. Participants' socio-economic status ranged from low to middle income. Low, medium and high monthly income levels were estimated at less than $200 (P2000), $200-1000 (P2000-

P10,000), and above $1000 (over P10, 000), respectively.

Ethical considerations

The study protocol was approved by the research ethics boards of the three researchers' employing universities, the ethical review boards of Botswana's Ministry of Health and the District Health Management Tteams at the participating sites. All participants provided written informed consent.

Data collection and analysis

Interviews were arranged with both mothers and fathers in a location of their choice, most commonly at their homes. Fathers and mothers were usually interviewed concurrently in separate areas of their house or yard. Most of them chose to be interviewed in Setswana, although some used English or both. Each participant was interviewed by a team of two researchers matching his or her gender. Interviews were audio-recorded and transcribed. An undergraduate research assistant fluent in both English and Setswana translated Setswana transcripts into English. The translated scripts were reviewed by one of the authors who is bilingual (Setswana/English speaker).

The fathers' interviews began with the following grand tour question: *'We would like to take this opportunity to find out from you what role you play in breastfeeding. Please feel free to tell us about your experiences as the father of a breastfeeding baby and the partner of a breastfeeding mother as best as you can.'* Follow-up, probing questions explored specific aspects of the fathers' roles such as: '*What are the decisions that you have made, or the activities that you have carried out to support breastfeeding for your baby?'* Mothers' interviews followed the same pattern but asked about fathers' roles. Researchers used statements such as: *'What I hear you saying is …'* to validate their emerging interpretations of participants' responses. Field notes were taken and cross-checked following each interview. The research team met between sets of interviews, and used constant comparative analysis to identify emerging themes. Using theoretical sampling for emerging concepts ((Martin & Gynnild, 2011), interviews later included probes regarding traditional postpartum practices and their perceived impact on the couples' sex lives.

Following transcription and translation, the research team reviewed and coded the transcripts and identified substantive codes (Hernandez, 2010) associated with words, phrases and sentences that described fathers' experiences and their roles. In order to accurately capture the meaning in Setswana and English responses, three researchers who were fluent in both Setswana and English compared codes and resolved inconsistencies. Selective coding generated several axial codes that identified fathers' roles in the breastfeeding family and factors influencing such roles.

Findings

Two main themes emerged from the data and these were 1) a parenting culture in transition, and 2) role variation for fathers. The first theme emerged as a core theme that connected five sub-categories describing the different roles of fathers in the care of their new babies.

Parenting culture in transition

The ways in which parenting culture in Botswana is changing emerged as the core theme in our analysis. Participants indicated that the roles of breastfeeding couples were changing from

traditional ones, and that the change may have been prompted by factors such as urbanization and women's increasing participation in formal employment. The main features of the change were increased father's participation in breastfeeding support and care of the mother and baby, and reduced support of the extended family to couples with new babies. In order to understand the nature and implications of the change in parenting culture, we first describe the five categories of roles currently played by fathers in Botswana. After describing the roles, the core theme of parenting culture in transition is re-visited in order to determine how each role fits within a transitioning parenting culture.

Role variation for fathers

Five categories emerged from the participants' description of fathers' role during the breastfeeding period; these were father as provider, protector, loving and caring partner to the new mother or *motsetse* (Setswana for confined mother) breastfeeding supporter, and loving caregiver to the baby.

Provider: Participants perceived fathers' roles in breastfeeding as that of ensuring that the mother has access to material resources such as food, shelter, clothing, diapers, and the health care that she requires to care for the baby. The provider role was particularly pronounced for fathers who had restricted access to direct contact with the mother and infant. A rural father said: 'I give the money to the mother because she knows what the baby needs'. Low-income couples talked about fathers' efforts to come up with new income generating strategies in order to ensure that they had enough money to fulfil the provider role. It was important for fathers to make sure that mothers had a nourishing diet for milk production. One low-income rural father living separately from the mother said: 'I buy ...vegetables and fruits for the mom to pass to the baby through breast milk …. I have to feed the mom so as to feed the baby with the nutrients'.

Protector: Participants reported that fathers had a responsibility to protect the health and wellbeing of the infant and its mother. It was important that fathers provide a healthy and hygienic physical environment. Many fathers also took time off work to take the infant to the health clinic for regular growth monitoring or to see a doctor when the baby was ill. One father was actively researching on baby care because he had realized that the science keeps on changing.

The fathers' way of protecting the health of their infants was by encouraging breastfeeding and ensuring that it was successful. One of them said that breastfeeding was so important that he considered fathers who discourage breastfeeding to be abusive and denying the children their rights to good health. One consideration for several fathers, especially those of low income, was the economic benefits of breastfeeding.

A critically important protective role fathers play in breast feeding in Botswana, given the high prevalence of HIV infection among adults of childbearing age (Avert, 2015), was HIV testing and responsible sexual behaviour. Almost all fathers considered couple testing for HIV to be one of the most important actions for ensuring that their baby would breastfeed. Most couples tested together and a few planned to test every three months for the duration of breastfeeding. Failure to breastfeed could suggest irresponsible behaviour. One father explained:

> Breastfeeding has become a marker for HIV status. If the extended family members realize that a baby is not breastfed, they make conclusions that mom is HIV positive. As such, it is a challenge if your baby is not breastfed because you do not know how you will face elders.

Responsible sexual behaviour, including a period of sexual abstinence, is a traditional

cultural expectation. One mother captured this when she said: '*You are expected to abstain from sex. If you stop breastfeeding prematurely, people may conclude that you have poor morals and want to get back to sex'.* The period of sexual abstinence could range from six weeks to as long as the mother continues to breastfeed, depending on the couples' understanding and acceptance of the culture. Delaying sex was perceived as a way of protecting mother and baby from diseases. Some reasoned that raw areas such as the mother's uterus and episiotomy and the baby's umbilicus needed to be given time to heal. Abstinence would also reduce the risk of pregnancy that might deprive the baby of breast milk and parental attention. Some couples resumed sexual activity fairly soon after the baby's birth; the reason was that the use of a condom was consistent with the traditional goals of protecting the baby by protecting the mother from diseases or getting pregnant soon after giving birth. Others did this by abstaining from sexual intercourse during the first few months following the baby's birth. An urban mother reported that the desire to resume sex after some months of abstinence had led the couple to consult with the elders of the church who advised that it was safe to resume sexual intercourse.

Fathers' protective role was also included providing a healthy emotional environment for both mother and baby to thrive. Several couples reported that it was important that fathers cultivate a good relationship with the mother for the emotional health of both the mother and the baby. The mother's physical and emotional relaxation was considered important for both the production of milk and the baby's healthy growth and development.

Partners were also expected to resist extra-dyadic sexual relations as sexual fidelity was perceived as important for the physical and emotional health of the family. However, a few partners expressed concern that the long a period of culturally sanctioned sexual abstinence for men could lead to extra-marital sex and strain mother-father relationship.

Loving and caring partner to the new mother (or motsetse)

Several couples reported that fathers had made the necessary arrangement for *botsetse* (a period of mother and baby confinement following the birth of a baby), even if this meant that they would be excluded from direct contact with mother and baby for several weeks. In most Tswana cultures *Botsetse* involves the presence of an older female who cares for the newborn and supports the new mother (*motsetse*) to heal and rest during the first weeks or months of the baby's life. The baby's maternal grandmother is usually expected to take care of *motsetse* in the case of the first baby. For subsequent babies of a married couple, the baby's paternal grandmother is expected to take charge. Mother and baby are either moved to the grandmother's home or the grandmother comes to stay with the new parents. Sometimes this means that the father has to move out of the bedroom or the house to give way to the grandmother.

For one father, having his wife stay with her family and him visiting gave him an opportunity to get to know his in-laws more closely. However, in urban areas or in the case where the grandmother is working, husband and wife had to manage on their own. This then meant that the father of the baby participated more in the care of mother and baby than he would under the traditional set up.

Couple teamwork brought mother and father closer together. Some couples shared information and ideas on child development. One father reported that he would buy two parent-craft magazines and give one to the wife to read while he was reading the other. Afterwards, they would exchange the magazines and after reading, discuss what they had learned. Appreciating her husband's active support, a low-income urban mother used the expression '*keeps me going*' to describe her husband's love for her and the baby. A middle-income mother said that the

effects of the father's help and involvement were intangible – *'it is something you feel.'* Some participants talked about the idea of the father *'being there'* for the mother and baby. A rural mother said:

> One needs a supportive partner; and I believe I had successful pregnancy and birth because I have a very supportive husband ….a husband gives you assurance that you will get long-term help, that you will rest, and that you will be fed.

*Breastfeeding supporter***:** Most participants saw breastfeeding support or doing everything possible to ensure that breastfeeding is successful as a major responsibility for the father. Supportive behaviors included encouraging the mother to breastfeed, encouraging a lactation enhancing diet, discouraging the mother's use of alcohol, relieving the mother of some household chores, or simply being a breastfeeding team player. Some fathers helped with breast pumping, positioning the baby for breastfeeding or assisting the baby to grasp the nipple. One middle income urban father said that he engaged the mother in *'positive conversations'* during breast feeding: *'It is important that she is physically and emotionally relaxed as I have read that when she is emotionally stressed, the milk may be scanty….'*

Breastfeeding decisions were often seen as the mother's prerogative as they concerned her body. Some mothers spoke of personally considering whether or not they wanted to breastfeed, then approaching the fathers for their opinion, and the two discussing and reaching a consensus. Some fathers had been quite direct, and insisted that the mother should breastfeed. Mothers in such situations had experienced mixed emotions; they appreciated the fathers' supportive intentions, but preferred to make their own decisions as mothers. However, for many, breastfeeding was simply expected, as one father stated: '*There was really no question about it; ….as there were no limitations to breastfeeding on our part, we had to consider ourselves blessed and we needed not waste time discussing whether or not to breastfeed'.*

A direct, loving caregiver to the baby: All fathers in this study were committed to caring for their babies. Many articulated the importance of loving and being there so that the babies could know and bond with them. Some were very involved in direct baby care while others were only a little involved but desired more involvement. The direct baby care role included bathing, changing diapers, and baby-sitting when mothers were doing other errands, or just sitting with mother and baby to admire the latter. Fathers also cuddled or played with the baby or enjoyed seeing the baby smile or go to sleep.

Some fathers took time off from work or farm to take care of their babies. One of them planned his annual leave to coincide with when his wife's maternity leave would end so that he could take care of the baby when she went back to work. An urban father had taken time off work to care for the baby so that the mother could pursue further studies. Because Botswana has no explicit paternity leave policy, fathers' time off work was generally unpaid. Some fathers also noted that they were sometimes restricted from socialising with other men in bars or participating in political party meetings and church activities. Reflecting on his initial concern about such restriction, one father said: *'Now I am quite comfortable about it as I have admitted that I have passed the stage of being just a married man to that of being a dad as well.'*

Fathers who had been actively involved with their infants from birth (usually those whose wives give birth at private hospitals) appreciated the experience. One such father proudly noted that he had been present at the birth of the baby and that he had cut the umbilical cord. Another was still excited that he had given his baby the first bath at home and reported that he would always keep that as a memory of his experience with his baby. He reported that his motivation came from the fact that he never bonded with his own father and did not want his children to

have a similar experience.

Although fathers' role in providing direct infant care was pleasurable, it could also be frustrating. Some fathers felt a little left out when they could not be as close to their babies as the mothers were. One of them said: *'Sometimes I even wish she was bottle-fed so that like her mom, ….because the one thing with breastfeeding, only mom enjoys that closeness with the baby'.* However, other fathers argued that the diverse ways the father participated in child care were as valuable as direct breastfeeding. One said:

> As a dad, I do not feel jealous about the closeness that develops between mom and the breastfeeding baby, and I cannot expect to have the same degree of bonding that is between mom and baby. I believe that as my daughter grows and appreciates the roles of mom and dad, she will appreciate me for the part that I play towards her welfare.

Interestingly, some participants suggested that fathers' involvement was better with breastfed babies. One mother said:

> With our previous bottle-fed babies, he would just leave the baby as long as milk and bottles were there; but with our current baby who is breastfeeding, he enjoys seeing it happen. So, I see breastfeeding bringing us together. He gets concerned if I go out and get delayed and he calls to remind me to come home to breastfeed.

An urban dad said:

> As a dad, you are looking at this other gentleman who is sucking and feeding from your wife; and you ensure that your wife gets nourishing food to be able to feed this other gentleman; all that is fun and it brings the three of you together.

Parenting culture in transition re-visited

The variation in the reported fathers' roles in child care indicates that the culture of parenting in Botswana is in transition. A mother stated: '*Nowadays, life has changed such that mom and dad have to co-participate in the baby's welfare'.* Participants described a variety of ways of responding to the continuum of possible roles that fathers can play in their babies' lives. Some couples lived up to all traditional expectations without question; others conformed to some expected practices, but modified others to suit their current situations. Still others rejected cultural norms that denied them the right to participate in the birth and care of their babies. This means that although some fathers accepted traditional limitations imposed by cultural norms, several expressed dissatisfaction with the practices. For example, Some felt powerless as the female relatives took full charge of the mother and baby, sometimes not even allowing the father to cuddle the baby. One father made reference to what he described as '*pain in my heart'* because of the separation from his child. Another said:

> You feel like you are left out in the upbringing of your little one and this often causes men to abandon their babies because they are denied an opportunity to bond with them. However, because some people believe in such things, one tends to go with them because doing otherwise would be labelled disrespectful. I really love my baby and would like to be present in his life.

Some participants spoke of negative attitudes towards a man who takes an active part in his baby's care, even among health care workers. This is because the traditional postpartum practice of *botsetse* is a woman's affair, and men are supposed to keep a respectful distance and know as little as possible about what goes on during the *botsetse* period. But this father also noted that the attitudes were changing as the society was also changing. One highly involved father said:

> At the clinic, nurses and moms who are there with their babies stare at me. They watch

> every move that I take with the baby as if they doubt if I know what I am doing. I hate that kind of attitude….

A mother said:

> Because Setswana culture sort of shuns a man who carries out chores that should be done by a woman, I was not comfortable about dad washing nappies and was embarrassed about it. However, he was very comfortable with it and it made him feel proud about being a caring dad.

The power of culture is so strong that even health care professionals were not fully accepting of fathers playing roles traditionally considered feminine as the father quoted above reported. However, it seems that a number of factors influence fathers' readiness to challenge traditional norms and practices. First, the socioeconomic status of fathers appeared to play a role in the transition, with more affluent couples being most likely to challenge traditional practices than low economic status ones. Similarly, mothers' employment and geographical distance between the nuclear and extended families were associated with greater deviation from traditional norms. Also, urban fathers more readily adopted new attitudes towards fathers' direct child care than rural ones. In rural areas, females in the extended family played a larger part in supporting the *motsetse* with chores while several urban fathers were doing that. Finally, fathers who were living with mother and baby were more involved in direct baby care than those who were living apart from them.

Discussion of the study findings

The interviews in this study revealed that Botswana's parenting culture is evolving. All of the fathers interviewed wanted to be involved in the lives of their babies. However, couples found themselves at different levels on a continuum of fathers' involvement in breastfeeding. In each own unique way, each couple was acting as a team to meet the needs of the baby. The following discussion highlights the experiences that breastfeeding couples encounter as they navigate a culture in transition.

In their description of the fathers' role in the breastfeeding family both mothers and fathers noted that the fathers must be providers and protectors so that the physical and social environment within which the child grows will support healthy development. Couples reported that breastfeeding is good for the growth and health of babies. A primary responsibility of the mother is to breast feed (provided she is HIV negative) while that of the father is to be a loving and caring partner to the *motsetse* and to support the mother's breastfeeding in order to ensure that the baby eats and grows well. These fathers were as much a part of the breastfeeding team as the most involved fathers in a Canadian study (Rempel & Rempel 2011)

Fathers' roles were commonly informed by the couples' understanding of and comfort with Botswana traditional post-partum practices, particularly traditions related to *botsetse*. As the study was limited to two locations in the south-eastern part of Botswana, there may be some local variations in how *botsetse* is treated elsewhere in the country. However, in general, *botsetse* is considered an older women's affair because older women are believed to be more knowledgeable than young parents on the needs of an expectant woman, a newborn baby, and an early post-partum mother. The father's access to the mother and the infant is restricted and the couple is expected to abstain from sexual intercourse throughout the confinement period.

However, in a changing Botswana society, grandmothers and other female relatives are no longer available, especially to young urban and working couples; the traditional support

network has thus weakened. This can be partly attributed to factors such as increased women's participation in higher education and formal employment as well as increased urbanisation. In this context, fathers are discovering the value of developing strong bonds with their children right from infancy as they work together with the mothers as parenting teams.

In addition, contemporary pressures compel fathers to be present in the lives of their babies from the onset. Fortunately, many of the fathers in the study have embraced this new requirement and are showing change in their expectations about women and child care (Dobson, 2011). The findings of the study differ from those of earlier studies in Botswana which reported low male involvement in child care (Mogobe, Leburu, & Motshwane, 2006; Sabone, 2009). This further reinforces our argument that the culture of parenting in Botswana is changing.

Fathers' participation as breastfeeding and parenting teams was not without challenges though, as overt co-participation was not widely accepted as normal. Couples were experiencing cultural pressures such as expectations that all mothers should breastfeed, that fathers should avoid direct contact with the mother and baby during the first few weeks of the post-partum period, and that couples should have a pre-determined period of abstinence from sexual contact following the baby's birth. However, it was clear that there was a shift towards shared parenting. The findings of this study are congruent with those in Ghana ((Dumbaugh, Tawiah-Agyemang, Manu, ten Asbroek, Kirkwood, & Hill, 2014) which revealed similar cultural practices such as having older female family members dictate the terms of how to care for new mothers and their babies. Like participants in this study, most Ghananian fathers wanted to be more involved in the care of their newborns.

Although the *botsetse* tradition requires that fathers to be sexually responsible, many participants were not pleased with long periods of sexual abstinence. However, all fathers felt that it was important for the father be sexually responsible and test for HIV. As the study did not include questions on HIV, interviewers did not inquire about the participants' HIV status. However, all participants talked about HIV testing. Botswana has one of the highest HIV prevalence rates in the world (16), but it also has a one of the most successful prevention of mother-to child transmission of HIV (PMTCT) programmes. It is likely that the mothers in this had participated in the PMTCT programme and were sero-negative because, at the time, only those testing negative would be allowed to breastfeed. The success of the PMTCT programme may have influenced fathers' involvement in breastfeeding because couples are expected to test and decide whether or not to breastfeed.

Both urban and rural couples valued breastfeeding and the fathers' full participation in breastfeeding and baby care. Although both fathers and mothers supported the cultural practices related to breastfeeding and baby care, the transition from indirect to direct participation in breastfeeding and baby care was faster for fathers in urban areas. This was likely due to the weaker extended family support systems in urban areas, which necessitated the participation of fathers in caring for their babies. Secondly, the demands of employment in urban areas meant that the duration of breastfeeding and the mothers' time with the baby were reduced, and this ironically created an opportunity for fathers to be involved in their children's care.

Study limitations

Findings of the study may not provide a generalised picture of the transitioning role of fathers in breastfeeding as the study was limited to the capital city and a rural village approximately 100 km from the city. A study that covers a wider geographical area and a sample that includes participants from the diverse ethnic groups in the country could enhance the generalisabilty of

the findings.

Recommendations

Nursing and midwifery curricula and continuing professional development could be enhanced by a greater consideration of the influence of practitioners' values on the decisions that couples make about breastfeeding and parenting. Such curricula could enhance the health practitioners' responsiveness to changing societal values and practices. Nurses and midwives need to encourage conversations between mothers and fathers to allow fathers to provide the kind and level of involvement in breastfeeding that best works for them.

Through such strategies as family centered maternity care and paternity leave for fathers of breastfeeding babies, the health care policy needs to provide an opportunity for fathers to ensure that their infants have the best start in life by getting involved in their care from the outset. Future studies must address frustrations that fathers experience as they transition from their traditional roles as observer fathers to more contemporary roles as hands-on fathers. There is need for programmes that can prepare young men and women for their emerging roles as breastfeeding partners.

Conclusion

The study has shown that fathers participating in their babies' care did not only desire to be actively involved during the breastfeeding, but that they also played a number of important roles. However, it was apparent that the fathers were transitioning from traditional, culture determined roles to those that take into account the needs of contemporary families. Professional education for nurses and midwives and public policy should respond to the changing roles of fathers, and assist them to transition smoothly into their new roles. The findings of the study can thus inform health care providers to tailor support programmes that can assist fathers to better participate in breastfeeding.

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