Fathers’ Narratives and Perspectives on Exclusive Breastfeeding for 6 Months in Kiambu County, Kenya

by

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Thesis submitted in partial fulfillment of
the requirements for the degree of
Master of Science in the Duke Global Health Institute
in the Graduate School of Duke University

2020

ABSTRACT

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Abstract

Background: Exclusive breastfeeding (EBF) in Kenya is on the rise, but there is still room for improvement. Current literature demonstrates that fathers have a positive influence on breastfeeding initiation, duration, and exclusivity. Yet there is a lack of information on paternal support in Kiambu County and Kenya, as a whole. This study aimed to explore fathers' experiences with fatherhood, their perspectives and narratives on EBF, and the ways they support their partners through EBF for 6 months.

Methods: The study took place in three public, government hospitals in Kiambu County, Kenya. Two qualitative research methods were used to address the study aims: in-depth interviews and qualitative story completion. Data was analyzed using a rigorous process of applied thematic analysis.

Results: Fathers in this study described fatherhood as a challenging, but rewarding experience. Participants articulated positive sentiments towards EBF and had varying levels of knowledge on its benefits. Fathers described that they supported their partners by providing a nutritious diet and financial resources, helping with household chores, and facilitating childcare. Finally, the findings also illuminated evident gaps in paternal knowledge on EBF and the lack of father-centered information at public health facilities.

Conclusions: This research established a baseline understanding of paternal support for a specific subgroup of fathers in Kiambu County, Kenya. Future research can further these findings by building a more representative, holistic picture of paternal support in Kenya. This will provide the necessary insights for designing context-specific educational interventions and programs targeting fathers in Kenya.

Dedication

I dedicate this thesis to my grandmothers, Joyce Kennerly and Edith Phillips. To the two matriarchs in my life, thank you for your love and your prayers. I hope to become your wildest dream.

I dedicate this work to my parents, Christopher Phillips and Patresse Phillips. I am because of you. No amount of gratitude will ever be enough.

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Lastly, I would like to acknowledge all of the fathers who agreed to participate in this study. Thank you for being brave enough to share your story.

1. Introduction

Exclusive breastfeeding is the feeding method where an infant is solely given breast milk and no other foods or liquids (WHO, 2019) (UNICEF, 2019). Breast milk is known to be the best food for infants as it provides all the essential nutrients and energy for the initial months (WHO, 2019). Apart from being a rich source of food for infants, exclusive breastfeeding also promotes sensory and cognitive development, protects against infectious and chronic diseases, and is a useful tool for combatting infant mortality (WHO, 2019). The World Health Organization (WHO) recommends that all mothers exclusively breastfeed their infants for the first six months of their lives (WHO, 2019).

Globally, it is estimated that only 41% of infants are exclusively breastfed which is indicative of suboptimal infant nutrition practices (WHO, 2019) (UNICEF, 2019). Further, breastfeeding trends vary significantly depending on income status and geographic region. Exclusive breastfeeding rates from low-income, lower-middle income, and upper-middle income countries are 47.0, 39.0, and 37.0, respectively (Victora et al., 2016). While data from high-income countries is limited, the general trend suggests that breastfeeding rates decrease with increasing national wealth (Victora et al., 2016). Data from the DHS Program suggest that the duration of exclusive breastfeeding (months) is highest in South America and East Africa. East African countries report higher durations of exclusive breastfeeding (months) with Ethiopia (3.6), Uganda (4.0), Rwanda (5.4), Burundi (5.1), Tanzania (3.5), and Kenya (3.3) (Ethiopia and ICF et al., 2017) (Uganda Bureau of Statistics, 2018) (Kenya National Bureau of Statistics et al.,

2015) (National Institute of Statistics of Rwanda et al., 2016) (Burundi Institute of Statistics and Economic Studies et al., 2018) (Ministry of Health et al., 2016).

As a lower-middle income country in East Africa, Kenya is amongst the leading nations in initiation and practice of exclusive breastfeeding (UNICEF, 2019). Yet, there is still considerable room for improvement. According to the Kenya Demographic & Health Survey (KDHS), 84.1% of mothers breastfed their infants for the first month, but this number decreased to 42% by the fourth month (Kenya National Bureau of Statistics et al., 2015). Additionally, there is variability regarding the median duration (months) of exclusive breastfeeding across the regions of Kenya. The KDHS reports the highest median duration in the central region (4.3), followed by the coast (3.8), western and nyanza (3.4), and finally rift valley (3.1) (Kenya National Bureau of Statistics et al., 2015). Kiambu County, the study site, is located in the central region of Kenya. While its reported duration of exclusive breastfeeding is the highest, it is still under the WHO's recommended standard of six months (WHO, 2019). The significant decline in breastfeeding mothers and substandard duration of breastfeeding in Kenya warrants further investigation into what factors influence exclusive breastfeeding.

Wainaina et al.'s study in Nairobi, Kenya provides useful insights into Kenyan mothers' experiences with exclusive breastfeeding (Wainaina et al., 2018). Researchers mentioned insufficient production of milk, pain, and inadequate breastfeeding competencies and skills as reasons for discontinuing exclusive breastfeeding. Study participants acknowledged that support from spouses, relatives, health professionals, and community members was integral to successful breastfeeding (Wainaina et al., 2018).

Further, the lack of this support lead to breastfeeding challenges (Wainaina et al., 2018) (Kimani-Murage et al., 2015). In their article, Rollins et al. urge readers to move away from societal notions of breastfeeding being "an individual's decision and the sole responsibility of a woman to succeed" (Rollins et al., 2016, p. 500). Rather, society should accept its role in breastfeeding support as exclusive breastfeeding is determined by family, community level factors, cultural perceptions, and societal factors (Rollins et al., 2016) (Bich et al., 2019). Therefore, it is of interest to explore sources of external social support in breastfeeding research, particularly that of the father (Rempel & Rempel, 2011).

In 1997, Bar-Yam and Darby set a strong precedent and priority for partner research when they released an international literature review on the relationship between fathers and breastfeeding (Bar-Yam & Darby, 1997). Their review demonstrated that fathers had the greatest influence on the mother's decision to initiate breastfeeding, more than doctors, lactation consultants, or nurses (Bar-Yam & Darby, 1997). Additionally, they confirmed that fathers are a promising research tool for improving the initiation, duration, and exclusivity of breastfeeding (Meedya et al., 2010) (Abbass-Dick et al., 2019) (Bar-Yam & Darby, 1997). Within the literature, there is clear indication that fathers have considerable influence on mothers' decision to breastfeed and positively influence breastfeeding outcomes (Al Namir et al., 2017) (Bar-Yam & Darby, 1997).

Other studies have delved into the specific mechanisms through which fathers support breastfeeding practices. Current literature states that there are three main pathways fathers exert influence: 1) knowledge about breastfeeding, 2) positive attitudes around breastfeeding, and 3) involvement or practices in supporting breastfeeding (Freed

et al., 1992) (Alvarado et al., 2006) (Laanterä et al., 2010) (Sherriff et al., 2014) (Bich & Cuong, 2017). A quasi-experimental study in Vietnam designed a community based education intervention targeting fathers' knowledge, attitudes and involvement in breastfeeding (Bich et al., 2019). The study demonstrated successful results where men in the intervention group had partners with significantly higher practices of initiation and exclusive breastfeeding with a range of time intervals (Bich et al., 2019). Although research and interventions targeting male involvement show significant promise, these results do not capture and represent the experiences of Kenyan fathers.

The majority of existing research on male involvement or their perspectives on breastfeeding has been collected on fathers from North America, Europe, or Asia. Of the existing studies addressing this topic in Kenya, most information on paternal involvement is collected indirectly from mothers, rather than from the fathers themselves (Wainaina et al., 2018) (Kimani-Murage et al., 2015). Thus, it is necessary to acknowledge that there is an existing gap regarding the knowledge, attitudes, and practices associated with exclusive breastfeeding from fathers in Kenya. This gap has implications on a researcher's ability to design educational interventions targeting Kenyan fathers. The study in Vietnam concluded that interventions involving men must fully understand and consider their socioeconomic, cultural, and political context during their design and implementation phases (Bich et al., 2019). Prior to the development of toolkits and programs to equip Kenyan fathers to support mothers through exclusive breastfeeding, it is necessary to build a foundational understanding of their current perspectives on, and involvement in, breastfeeding support.

This study aims to inform this gap and investigate how Kenyan fathers engage in

breastfeeding support. The research objectives include exploring Kenyan fathers' lived experiences with fatherhood, exploring perspectives and narratives on exclusive breastfeeding, and identifying specific ways Kenyan fathers support their partners through exclusive breastfeeding for 6 months. This information will be integral to designing context-specific interventions for fathers in Kenya that aim to improve social support for breastfeeding mothers.

2. Methods

2.1 Overview

This study employed qualitative methods to understand the narratives and perspectives of men whose children were currently exclusively breastfed. It took place in three public, governmental hospitals in Kiambu County, Kenya. The sample consisted of Kenyan fathers of infants 0-4 months old who were exclusively breastfed. A total of 13 research participants completed three data collection procedures: a baseline demographic survey, an in-depth interview, and a written story completion prompt. This study was done in partnership with Jacaranda Health, a non-profit organization in Nairobi dedicated to improving maternal healthcare in the public and private sector. Finally, it received ethical approvals from the Duke University Campus IRB and the AMREF Ethics & Scientific Review Committee in Kenya.

2.2 Setting

The study took place in Kiambu County, Kenya, which is one of 47 counties in Kenya. Kiambu has a population of 1.6 million people and is located just north of the country's capital city, Nairobi. The study took place in government hospitals in Kiambu, where basic healthcare services are offered free of charge. Working in public facilities allowed the research team to capture participants from a wide range of economic standings. Prior to the start of the study, the research team visited five public hospitals in Kiambu County to discuss the study with hospital administration staff. After the visit, three facilities were selected for study participation: Nyathuna Level 4 Hospital, Kihara Level 4 Hospital, and Ruiru Sub District Hospital. The locations were selected because

they were amenable to the research team working in their facility and could offer a private room for data collection activities.

2.3 Participants

The population for this study was Kenyan fathers who had infants aged 0 to 4 months. The inclusion criteria were that they were a biological father of an infant born in the past 120 days, had a domestic partnership or marital relationship with the mother (between the ages 18-49) of the child, and had a partner currently exclusively breastfeeding (EBF) their infant. Finally, individuals were excluded if they were raising their infants without a partner, if they had health conditions that inhibited their ability to interact with their partner or infant, or if they could not read or write.

The target sample size for this study was between 10 to 20 participants, with the ultimate goal to reach thematic saturation in the data (Guest et al., 2006) (Guest et al., 2012). The final study sample size was 13 participants; each participant completed an in-depth interview and a qualitative story completion prompt. While the research team did not meet its maximum sample size requirements, they reached saturation after 8 rounds of data collection. The first author determined saturation based on the stability of the codebook and the absence of new content codes after 8 interviews (Guest et al., 2006).

2.4 Procedures

2.4.1 Recruitment

Study participants were recruited using three primary methods. The first method was through the use of approved research nurses. Prior to recruitment, one nurse from each hospital was briefed on the study and provided with a script for recruiting potential

participants as mothers entered the postnatal clinic throughout the week. First, the nurse presented the study opportunity to the female patient. If the patient had a male partner and he was interested in participating in the study, the nurse collected the male partner's number from the female patient and presented it to the first author. The first author then called the father and asked preliminary screening questions to determine eligibility. If the participant was eligible and interested in participating, the research team organized a time to meet. In some cases, the nurses became overwhelmed with their work at the hospital and struggled to assist with participant recruitment. For this reason, the research team employed two additional recruitment methods.

The second method of recruitment was led by the first author and the research assistant. When the research team was present at the public health facility, they would go to the postnatal care ward, and present the research opportunity to female patients waiting for their appointments. If a woman expressed interest, the research team asked the woman to provide the contact information of the father. The first author then called the father and asked preliminary screening questions to determine eligibility. If the participant was eligible and interested in participating, the research team organized a time to meet. Finally, the research team would also approach any men who were present in the postnatal care ward. They introduced themselves, provided a description of the study, and asked preliminary screening questions. If the man was eligible and interested, the research team collected his contact information. The research team followed up later to organize a time to meet.

2.4.2 Training Local Research Assistant and Data Collection

A Kenyan research assistant led all data collection procedures under the supervision of the first author. She had extensive experience conducting in-depth interviews as well as focus group discussions. The first author had CITI certified research ethics training, whereas the research assistant took a research ethics course during her undergraduate studies. Prior to the beginning of this study, the first author also explained the study and how each instrument was to be administered to the research assistant. When the participants arrived at the hospital for their study appointment, they were directed to a quiet, private room. The research assistant described the study and confirmed their interest in participating. The research assistant then read aloud the consent form and gave the participant an opportunity to ask questions. Once the participant provided written informed consent, the research assistant proceeded with data collection. The majority of data collection was conducted in Kiswahili, and participants always had the choice of communicating in English or Kiswahili. First, the participant was presented with a baseline demographic survey, and they were instructed to answer the questions on paper. Next, the research team presented the qualitative story completion prompt, explained the instructions, and answered any questions. The participant usually took 15-20 minutes to write their response to the prompt. Finally, the research assistant conducted a recorded in-depth interview with the research participant using a semi-structured interview guide. Each interview ranged from 27-45 minutes in length. The first author was present for all of the data collection procedures. Further, they were responsible for answering questions, taking notes during the in-depth interview, and handling the data paperwork or recordings.

After the data collection procedures, participants were offered tea and snack (approx. $2.50 USD) and received transportation compensation (approx. $5 USD). The survey, story prompt, and interview notes were labelled with participants' unique study ID, transported back to Jacaranda Health's office, and electronically uploaded to the first author's encrypted computer. All research data were stored in an encrypted folder in the first author's Dropbox. The next day, the audio recordings folder was shared with a translator. The translator's native language is Kiswahili and she had done previous work with Jacaranda Health. Interview and story completion data were translated and transcribed into English simultaneously.

2.5 Measures

The baseline demographic survey captured participant's education level, female partner's education level, area of residence, household size, and marital status.

The in-depth interview guide followed a semi-structured format, with open ended questions followed by possible probes. The guide was drafted by the first author and shared with members of the research team for iterative feedback. This resulted in the rearrangement of the structure of the guide and the inclusion of two new questions. The guide was piloted prior to use, which resulted in the rewording of one question and the inclusion of one more question. The topics included the transition to fatherhood, challenges with fatherhood, exclusive breastfeeding knowledge, opinions on exclusive breastfeeding, and exclusive breastfeeding support.

The qualitative story completion prompt was developed following Virginia Braun et al., "Qualitative Story Completion: A Method with Exciting Promise" (Braun et al., 2017). This article provided guidance on designing the story stem and the instructions for

the data collection procedure. After the design, the prompt was shared with the research team and piloted. This feedback was incorporated into the final prompt.

2.6 Analysis

Analysis of the in-depth interview data was conducted using a rigorous applied thematic analysis process (Guest et al., 2012). Thematic analysis applies a wide breadth of scope to the data set and allows themes to emerge from the data content (Guest et al., 2012). Given that the research aims sought to explore paternal exclusive breastfeeding support in Kiambu County, applied thematic analysis was deemed the most appropriate method for studying this cultural phenomenon (Guest et al., 2012).

In order to gain a deep familiarity of the data, the first author read all transcripts twice. During the second pass reading, the first author wrote memos on themes emerging from the data. These thematic memos were used to create a first draft codebook, which included clear definitions of the codes as well as examples of how they were applied to interview data. Transcripts were uploaded into NVivo 12, and half of the transcripts were coded. The first author then wrote memos on coded data, as a way to check the quality and consistency of the coding. Based on this reflection, revisions were made to the final codebook. The final codebook was used to code all 13 in-depth interview transcripts. The first author ran coding queries for the structural and content codes. A review of the structural and content codes led to the identification of three primary themes (Being a Father, Perspectives on Exclusive Breastfeeding, and Mechanisms of Support). Analytic memos were written to synthesize data under each of these themes. Representative quotes were selected to provide evidence for each of the themes.

More specifically, the data referring to ways father enact breastfeeding support was analyzed using House's four domains of social support. These include: "informational (information provided to another during a time of stress), instrumental (the provision of tangible goods and services or tangible aid), appraisal (the communication of information which is relevant to self-evaluation rather than problem solving), and emotional support (the provision of caring, empathy, love, and trust)" (House, 1981). The content provided in the participants' responses was represented in three of the four House domains: 1) instrumental support, 2) emotional support, and 3) informational support.

All of the story completion prompts underwent a process of horizontal patterning (Braun et al., 2017). Braun et al. describe horizontal patterning as "the identification of patterns in specific elements of the story" (Braun et al., 2017, p.1491). In this case, the responses after each "cue" undergo comparative analysis (Braun et al., 2017). After taking full stock of the narrative data, the content was analyzed and the first author identified emerging themes. Finally, the data was grouped by themes, further specified into subthemes, and presented in data visualizations.

3. Results

Results include data from the baseline demographic survey (n=13), the qualitative story completion prompt (n=13), and in-depth interviews (n=13). The following will describe the study sample and how Kenyan fathers describe their lived experiences as fathers. Then, it will discuss the narratives they constructed about paternal engagement with exclusive breastfeeding. The last two sections will discuss the perspectives Kenyan fathers have on exclusive breastfeeding and, subsequently, the mechanisms through which fathers demonstrate exclusive breastfeeding support.

3.1 Description of the Sample

The 13 participants ranged in age from 22 to 41, with an average age of 28 years. Even though sampling was limited to Kiambu County, the catchment area included participants from 3 different counties in Kenya: Nyeri, Kiambu, and Nairobi. The highest level of education attainment ranged from primary school to post-secondary education. Only one of the fathers included in the study was not married and was in a domestic partnership with the mother of their child. Finally, two fathers had a child or children prior to the birth of their youngest. While descriptive data was not collected on mothers, only one father specifically stated that his wife used to work and was taking time off to care for their child. Therefore, we assume that the majority of study participants are the primary breadwinners, while their partners stay home and care for their infant. Additional demographic data on the fathers can be found in Table 1.

Table 1. Demographic Information on Study Participants.

Participant	Age	Education Level	Relationship Status	Residence	No. of Children	Infant's Age (months)
01	23	Secondary + Informal Training	Married	Kiambu	01	4.0
02	25	Secondary	Married	Kiambu	01	3.0
03	31	Secondary	Married	Kiambu	01	4.0
04	31	Secondary + Informal Training	Married	Nairobi	02	1.5
05	23	Primary	Married	Kiambu	01	1.5
06	25	Primary	Married	Kiambu	02	2.5
07	22	Secondary	Married	Nyeri	01	1.5
08	29	Post-Secondary	Married	Kiambu	01	1.0
09	31	Secondary	Partnered	Kiambu	01	2.5
10	41	Primary	Married	Kiambu	05	2.0
11	25	Secondary	Married	Kiambu	01	1.5
12	40	Secondary	Married	Kiambu	01	1.5
13	24	Post-Secondary	Married	Kiambu	01	1.5

3.2 Being a Father

Prior to assuming status as fathers, participants discussed that they had more agency over their lives and the choices they made. Among these included the ability to "go back home late", "socialize with friends, play some pool, and play darts", and "buying whatever [they] wanted without planning". This freedom of choice was a result of previously feeling solely responsible for themselves. In comparison to their current lives, they stated that the bachelor life had less challenges, less expenses, and "no stress".

Participants were asked about their transition into fatherhood and described it as a rewarding, yet difficult experience. The majority of participants expressed that having a child is "a blessing" and brings them joy. Many fathers also discussed how their infant is a source of motivation and self-improvement in their professional, social, and personal lives. Some fathers articulated that their child gives them "a reason to work harder because there is someone that is depending on you." Others discussed how this has prompted them to communicate more with their partners about "sharing out responsibilities" or limit fighting to maintain a healthy environment for their baby. Additionally, the majority of fathers discussed how this has made them reduce the amount of time they spend outside of the home socializing with friends. This is largely driven by their desire to spend more time supporting their partner and caring for their child. Finally, some fathers express that having a baby encouraged them to face their challenges.

> *"I can't complain the life is good, because it's a blessing and I accept it but we have to conquer and we continue. Even if the challenges are there we cannot complain. So the life is good actually it is not that hard."* –RUI-0813003

While participants described fatherhood as a positive experience, they also stated that it comes with an increased amount of responsibility. Among these include "providing for the family", being "financially prepared", budgeting, living in harmony with their partners, and helping care for their baby. Yet, fathers describe that fulfilling their responsibilities has been challenging.

The most prevalent challenges fathers in the study faced were financial instability and unstable employment. The majority of employed participants worked in the informal sector as masons, drivers, and casual day laborers. This work is extremely flexible and often operates on a "first come, first served" basis, which makes it an unreliable source of income. Participants shared experiences where they had to repeatedly hunt for open positions so they could secure money for their family for the week. Other participants claimed that they were jobless and struggled to find employment. Given that expenses increase after having an infant, lack of income or unemployment was a major source of stress.

> "*You are just wondering what will happen if you don't succeed that day, because you can get work or not get. And if you don't get then you will panic and so you are forced to let the partner handle the household chores while I go outside and look for money.*" – RUI-0802001

This father has not solely struggled with finding employment, but his stress from financial instability also inhibited his ability to support his partner care for their baby. Other employed participants described dealing with a similar situation. They discussed their decision to take time off work to help their partner recover from their pregnancies or care for the baby. In some cases, participants reported that they lost their jobs due to their

decision to take time off work. This places fathers in a contradictory position where they need to prioritize either being physically present for their family or securing income.

Participants also mentioned other challenges including disagreements with their partner, lack of sleep, their partner's medical issues, and inexperience with caring for a small infant. One father stated that he feels stressed when his baby cries because he is unsure of what to do to help. Another father expressed worry when his child does not "pass stool" or makes "funny movements" as he is concerned with the welfare of his child. Only two out of thirteen participants have experience with raising a small infant, thus fathers' descriptions of their preparedness for fatherhood varied.

Many fathers discussed that storing their money in a savings account was an integral part of preparing for fatherhood. Others discussed that their prior experience with fatherhood has prepared them to recognize signs of illness or danger in their infants. For new fathers, it has been more difficult to understand basics regarding the wellbeing of their infant. Participants did articulate that they "wished to receive more information" from doctors, but are adequately supported by their friends and families.

> "*Some of my friends tell me these things do happen and so you have to be strong, you are man. You are the head of the family, you need to be strong to encourage your wife and in such situations and so I get information."* – NYA-0717001

The majority of fathers stated that their family and friends gave them advice about saving and maintaining good relations with their partner. Further, when participants are discouraged, their families and friends provide encouragement and guidance.

3.3 Narratives on Exclusive Breastfeeding

The story completion data provided insight into fathers' narratives on exclusive breastfeeding. This methodology placed the research participants in a hypothetical situation where they return home to their partner who is struggling to breastfeed their infant. As the research participant, their role was to determine how the story progresses. Consequently, the data derived from the story completion exercise is not necessarily representative of lived experiences. Rather, this data explores common discourse and understandings on exclusive breastfeeding (Gravett, 2019). The sample size for the story completion data was 13 participants, but in many cases a single response was coded more than once across different themes.

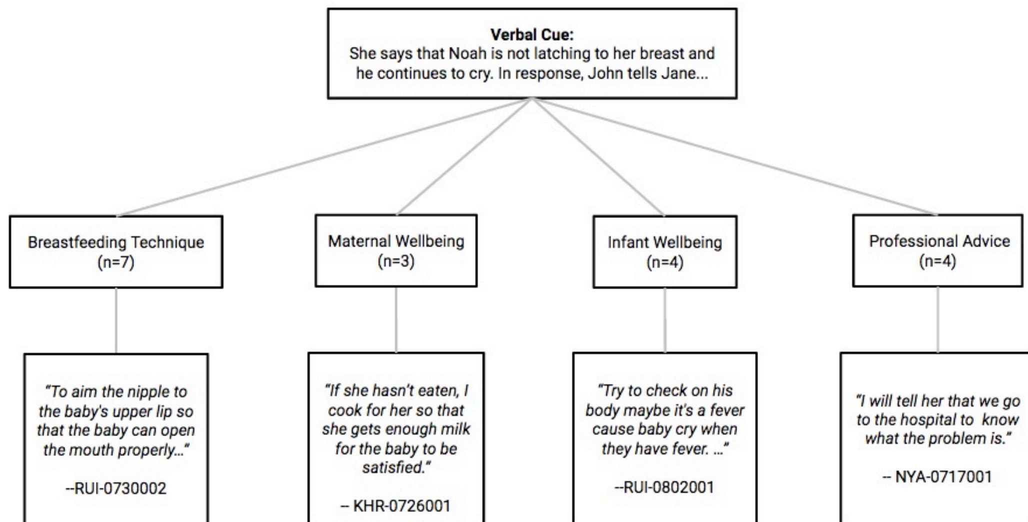

Figure 1: Summary of Story Completion Results from the "Verbal" Cue. The sample size was thirteen participants (n=13), and some responses are represented under more than one theme.

The story completion began with a verbal cue that was designed to place participants in a situation where their partner is struggling with exclusive breastfeeding (Figure 1). It prompted participants to create a verbal response that would potentially address their partner's breastfeeding dilemma. The 13 written responses fell under four themes: breastfeeding techniques, maternal well-being, infant well-being, and professional advice. The first, "breastfeeding technique" refers to content that provides detailed and specific language about breastfeeding practices. Seven of the thirteen participants completed the prompt with technical language in response to Jane's struggle with latching. More specifically, participants mentioned breastfeeding position, holding the baby, and "aiming the nipple to the upper lip" as examples of technical language.

The second theme, "maternal wellbeing", refers to content about the mother's health and present ability to breastfeed. Three out of thirteen participants responded with content regarding maternal wellbeing. For example, participants mentioned ensuring that Jane had eaten so she has the energy or nutrition to feed the baby. The third theme, "infant wellbeing" referred to content about the infant's health or ability to breastfeed. Four out of thirteen participants wrote content about the welfare of the infant. For example, participants recommended checking if the infant was sick or consoling the infant in response to struggling with latching.

The fourth theme, "professional advice", refers to content that mentioned outsourcing breastfeeding information to an individual with professional medical experience. Four out of thirteen participants mentioned seeking professional advice in response to Jane struggling with latching. More specifically, the research participants

stated that they would tell their partner to go to the doctor or the hospital to figure out the root of the problem.

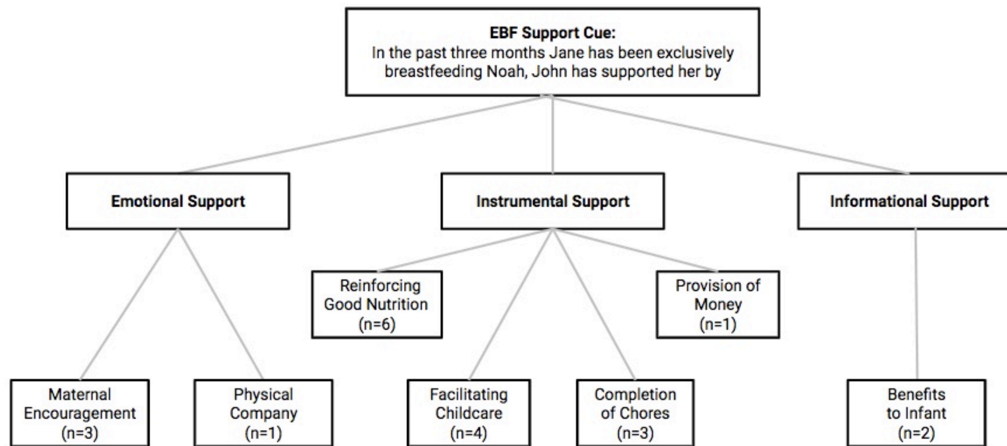

Figure 2: Summary of Story Completion Results from the "EBF Support" Cue. The sample size was thirteen participants (n=13), and some responses are represented under more than one theme.

The next cue in the story completion prompted participants to think of ways fathers support their partners through exclusive breastfeeding (Figure 2). Instrumental support was cited the most by research participants. This was exemplified in a range of ways: through the provision of nutritious food, helping care for the infant, facilitating with chores, and providing money for the household. Reinforcing good nutrition was the most widely cited by research participants as a way for John to support Jane while she is exclusively breastfeeding.

Emotional support was the second most popular domain. Research participants wrote that John reduced Jane's stress or "gave her morale" to support her. Additionally,

one research participant wrote that John gives Jane company. Finally, informational support was the least cited domain. Only two participants cited informational content as a mechanism of exclusive breastfeeding support. In these cases, the participants stated content reminding Jane that "it is not good to give the baby food" and the benefits of exclusive breastfeeding to the infant.

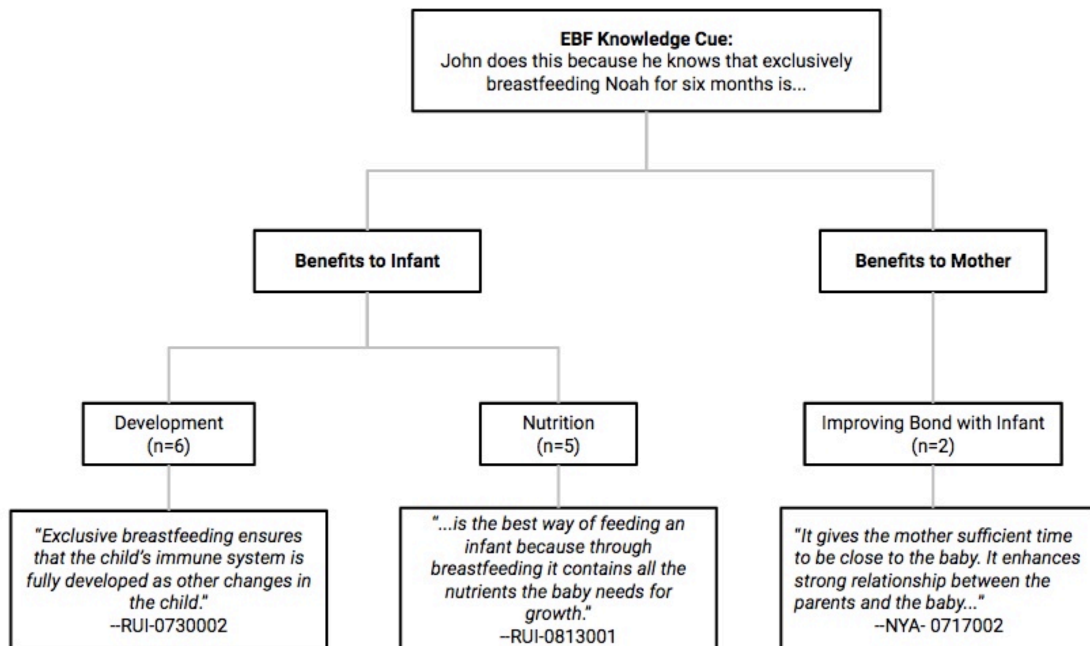

Figure 3: Summary of Story Completion Results from the "EBF Knowledge" Cue. The sample size was thirteen participants (n=13), and some responses are represented under more than one theme.

The final cue presented was designed to capture paternal perceptions of breastfeeding knowledge (Figure 3). The data from this cue was categorized under two major themes: benefits to infant and benefits to mother. Benefits to infant was the most cited theme with a total eleven participants writing content about how exclusive

breastfeeding has positive impacts on the infant. Within this theme, two sub-themes emerged: development and nutrition. Development refers to content addressing the infant's growth and medical progression. Six participants cited this stating that exclusive breastfeeding contributes to the immune system, weight gain, protection from illnesses, and generally good health. The other sub-theme, nutrition, refers to the infant's diet. Five participants mentioned that exclusive breastfeeding is beneficial to the child's nutrition. More specifically, they stated that "it contains all nutrients needed for growth" and warned against giving food before six months.

Lastly, the remaining content fell under the second theme, "benefits to mother." Content under this theme was limited to two participants. Further, they both stated that exclusive breastfeeding benefits the mother by allowing her and the infant to bond.

3.4 Perspectives on Exclusive Breastfeeding

When discussing the benefits of exclusive breastfeeding to their infants within the interviews, the majority of fathers mentioned that it "prevents some diseases", "makes the baby healthy", and helps with "growth". A few fathers went into more depth discussing how it "boosts immunity" and improves the bond between the infant and its mother. Another recited specific information he received from a health provider stating that it will prevent the infant from contracting HIV, if the parents were HIV positive. Finally, a small minority admitted that they had no idea and they "will get that experience later."

When asked about the benefits of exclusive breastfeeding to the mother, however, nearly all fathers struggled to respond. The majority of participants admitted to not knowing anything about the benefits of exclusive breastfeeding to the mother. Similar to the benefits to the child, some participants discussed that it fosters a bond

between the mother and her child. Other participants stated that breastfeeding improves the mother's milk flow, prevents mastitis and engorgement of the breasts, and that it is a requirement if the mother loves her infant.

Additionally, participants were asked to provide their source of information on exclusive breastfeeding. Most fathers stated that they received information about breastfeeding from doctors/nurses when they took time off for work. The education they received was often limited to telling them that "the baby should be introduced to other foods after 6 months." As a result, many participants stated that they knew the mother should exclusively breastfeed for 6 months, but they did not know why. Further, a few participants also mentioned that they received information from family members, coworkers, friends, antenatal care (ANC) booklets, hospital talks, or primary school.

With regards to recognizing exclusive breastfeeding challenges, many participants initially claimed that their partner had no struggles with exclusive breastfeeding. After further probing, a few participants identified a range of challenges including having "(in)sufficient breast milk", "abdominal and back pains", and "sickness". Still, the majority of fathers were not able to state the benefits of exclusive breastfeeding to their partners.

Finally, participants expressed varying attitudes towards exclusive breastfeeding. Many expressed positive sentiments in support of exclusive breastfeeding due to the benefits for the infant. Other fathers discussed how they perceived breastfeeding to be emotional, intimate, and a time for the mother and the infant to bond. One participant explicitly stated that watching his wife and his infant "made him feel love and want to help." Others expressed that they supported exclusive breastfeeding solely because it

was "according to doctor's advice." Conversely, a few fathers understood the benefits of exclusive breastfeeding, but desired that their partners discontinue the practice. The reasons for this included concerns that their infants were not getting enough milk and breastfeeding was too challenging. A few men discussed that the fear of their child being unsatisfied tempted them to try "nan" (infant formula) or cow's milk.

3.5 Mechanisms of Support

Similar to the qualitative story completion prompt, paternal social support was analyzed using House's four domains of social support (House, 1981). Within the in-depth interviews, there was evidence of paternal social support in the instrumental, informational, and emotional domains.

Instrumental support was the most frequently cited domain through which participants exemplified support for exclusive breastfeeding. Participants mentioned helping with latching, providing money and food, and doing household chores as ways to support their breastfeeding partners. In a few cases, participants also stated that they invited family or outside help to assist their partners when they could not be present. Some fathers also stated that they accompanied their partner to the clinic if they did not have work or were granted time off. However, they also admitted that it is not common for fathers to accompany their partners to the clinic because they need to go to work. This creates conflict for fathers of young infants as attending clinic with their partner is difficult. Simultaneously, they claim that they do not receive enough information about childcare and exclusive breastfeeding. As a result, when their infant is in distress some feel "stressed because the baby keeps crying" and they do not know what to do to help.

Emotional support was the second most cited domain. The majority of participants noted that they provided emotional support by reducing their partner's stress and encouraging them to continue breastfeeding when their partner encountered issues.

> "*While she is breastfeeding and I am in the house I encourage her. I chat with her and try to encourage her to breastfeed so that she doesn't develop low self-esteem. So, I am normally boosting her."* – NYA-0717001

Additionally, some fathers discussed how emotional support has manifested largely in their transition to parenthood. More specifically, for fathers who struggled to find employment or secure a sufficient income, their partners also felt the stress of financial instability. Consequently, fathers have to employ words of encouragement to their partners and assure them that they will prevail.

> "*Yes, talking and telling her that we are not the first ones to go through what we are currently undergoing. And there have been other people in the same place and more will continue being in the same space. It is only a temporary struggle."* – RUI-0802001

Finally, informational support was referenced the least. This primarily manifested as participants recognizing medical or health issues and recommending their partner to see a doctor. In more seldom cases, some fathers were able to provide more information on latch technique, breastfeeding positions, and mastitis.

4. Discussion

This study presents novel, context-specific information on the nature of paternal support for breastfeeding in Kiambu County, Kenya. More specifically, it explores fathers' perceptions and perspectives on exclusive breastfeeding, illuminates ways they support breastfeeding mothers, and situates this information within narratives of fatherhood. The participants in this study constitute a distinct group in Kiambu County: fathers already engaging with maternal and child healthcare. As such, their contributions are different than the standard Kenyan father. This is the first study that recognizes engaged fathers in Kiambu County and employs qualitative story completion as a data collection method. Thus, it has exciting new insights to contribute to the growing body of literature on paternal involvement with breastfeeding.

The results in this study align with findings from previous studies. Participants described that the birth of their child marked a significant transition in their lives where becoming more responsible and providing for their families was a necessity (Holland, 1994) (Gage & Kirk, 2002). The need to provide for their infant was a strong source of motivation, but fathers in the study also grappled with securing employment, providing enough money for their family's needs, and knowing how to console their infant when it was crying. While they state receiving advice from families and friends, fathers also articulated a desire to get more information from doctors to help prepare for fatherhood. This interest in breastfeeding education is supported by results found from other studies on paternal support (Brown & Davies, 2014) (Sherriff N et al., 2009) (Sherriff & Hall, 2011) (Tohotoa et al., 2009).

Similar to a study in South Africa, fathers enacted breastfeeding support through seeking healthcare services, and providing finances and emotional counsel (Mgolozeli et al., 2018). Moreover, these Kenyan fathers also facilitated household chores and child care which are pre-established modes of breastfeeding support (Rempel & Rempel, 2011) (deMontigny et al., 2018) (Smith et al., 2006). Many fathers admitted that they knew their partners and infants should practice exclusive breastfeeding for 6 months, but could not give concrete reasons why. Throughout the data there is evidence of gaps regarding benefits of exclusive breastfeeding to the mother, recognizing challenges their partners face, and providing informational support to their partners. This could be a function of conflicts with work, and a lack of father-centered information at public health facilities. More broadly, it could also be a reflection of mass media campaigns on breastfeeding that tend to emphasize the benefits to infants only (General (US) et al., 2011).

The study participants' stories are recognized as a valuable source of data within the larger field of narrative research (Gravett, 2019). O'Toole explicitly states "people are storied beings and to generate a more in-depth understanding of people and their experiences, researchers need to begin with their stories" (O'Toole, 2018, p.175) (Gravett, 2019). As a new and upcoming method, qualitative story completion presents ample opportunity. Designing a story stem gives researchers the ability to curate a stimulus and target specific narrative data. Additionally, it provides a reliable platform to access sensitive or undesirable responses and sheds light on sociocultural discourses (Braun et al., 2018) (Gravett, 2019). Finally, it allows participants to preserve their own personal views or experiences and share narratives in a context devoid of researcher-participant hierarchies (Gravett, 2019).

Within this study, the story completion data demonstrated how the participants perceive and understand their role in exclusive breastfeeding. In all of the prompts, participants portrayed the protagonist as engaging, having a positive attitude towards exclusive breastfeeding, and being able to articulate some benefits of exclusive breastfeeding. Levels of engagement varied, but there were no narratives depicting the protagonist deflect the responsibility of childcare and breastfeeding solely upon the mother. These results speak to the presence of paternal support within sociocultural discourses and tropes among engaged fathers in Kiambu County.

4.1 Implications for further research

These findings suggest that there are windows of opportunity for strengthening paternal support. If educational and informational gaps are present among involved fathers, we are confronted with the question of what the nature of paternal support is for the standard father in Kenya. This warrants more paternal support research with larger, more representative, and geographically diverse sample sizes in Kenya. Once the national foundation is set, the following priority is to identify the most efficacious interventions for improving paternal breastfeeding support. When discussing potential interventions to implement in Kenya, it is necessary to ensure that they are appropriate and suitable to the country's cultural context (Abbass-Dick et al., 2019) (Bich et al., 2019).

Previous studies have found that effective breastfeeding interventions share three components. Those include taking place during the antenatal or postnatal period, occurring in a face-to-face format, and being administered by trained professionals or peer supporters (McFadden et al., 2017) (Abbass-Dick et al., 2019). While these components have been incorporated into interventions across the world, we must still

tailor interventions to the needs, challenges, and cultural climate in Kenya. Even though fathers in this study articulated the desire to engage with healthcare professionals, doing so in a face-to-face format could be difficult to navigate due to work responsibilities. Given this study's results, interventions for engaged fathers in Kiambu country need to mediate access to professional health counsel and limited time availability. Additionally, they should also provide credible information on the benefits of exclusive breastfeeding, detailed breastfeeding technique (latching, positioning, etc.), and solutions to common problems or concerns (inadequate milk supply, mastitis, etc.). Potential recommendations which have demonstrated success in past studies include in-home counselling from community health workers or the development of electronic health platforms (Haider et al., 2000) (Lau et al., 2016). Further, more research is warranted to identify fathers' preferences regarding how to receive breastfeeding information in Kenya (Abbass-Dick et al., 2019).

Finally, since the ultimate goal of fortifying paternal support is to aid mothers practicing exclusive breastfeeding, it is important to consider their needs and preferences as well. First and foremost, further breastfeeding research in Kenya should target insights from mothers regarding the support they want to receive, if any at all. Another recommendation is to design interventions for couples where they are both educated simultaneously (Abbass-Dick et al., 2019). This will provide a platform for educational consistency, communication, teamwork, and practice with problem-solving (Abbass-Dick & Dennis, 2017) (Panter-Brick et al., 2014). Yet these interventions must also be wary of excluding mothers in toxic or abusive relationships or whose partners are absent. Thus breastfeeding interventions engaging groups should prioritize the mother's needs at the

center of their design, and be accessible to other sources of external support outside of father.

4.2 Study Limitations

This study has several limitations. First, it included a total sample size of thirteen fathers in Kiambu County. This makes the results highly specific and limits generalizability to Kiambu County and the greater Kenyan population. Secondly, the recruitment method was limited to men who were present at clinic or whose partners attend clinic. This presents a host of issues that compromised the strength of the data.

Regular engagement at health facilities already exemplifies engagement with the health and welfare of the mother and child. It is likely that the study's results were skewed to represent more involved fathers rather than the standard experience of fathers in Kiambu County. Many potentially eligible participants were excluded, thus limiting the ability to capture diverse opinions and experiences. Finally, recruitment at public hospitals was likely a suboptimal catchment area for fathers. After data collection sessions, the first author and research assistant asked the participants the best places to recruit fathers and many did not mention public hospitals. Rather, they discussed the workplace and church as possible recruitment areas.

The qualitative story completion prompt's instructions were not adequately detailed. Initially, the instructions were intentionally made to not specify a minimum or maximum amount of words. The reason for this was to permit responses that depict disengaged or uninterested fathers. While none of the participants failed to complete their stories, there was variability in the richness of the data. This lack of specification, therefore, led to the production of shorter, less detailed stories. Additionally, fathers were

excluded from data collection if they could not read or write. This criterion was intended to ensure that participants could complete the data collection instruments and fully engage with the story completion exercise. Yet, it also limited the scope of the data to educated and literate fathers.

5. Conclusion

This study has successfully built and established an understanding of paternal involvement and support for exclusive breastfeeding for a subgroup of fathers in Kiambu County, Kenya. Its findings suggest that this group of fathers engage in breastfeeding support and have basic, limited knowledge on exclusive breastfeeding. Additionally, it experimented with a novel arts-based research method, qualitative story completion, and delves into the strengths and weaknesses of this method. Given these results, we recommend that more research regarding paternal support be executed in Kenya. It is important to include a larger, more representative sample of fathers to be better informed on the nature of support and the current needs of all fathers in Kenya. This information is crucial for designing relevant and effective educational programs and interventions for Kenyan fathers.

Appendix A

In-Depth Interview Guide

1. Tell me a little bit about yourself.
2. Where did you meet your partner?
    -Probe: Tell me about her.
3. How old is your infant?
4. Describe your experience being a father.
    -Probe: How does it compare to your life before your child was born?
5. What are some of the greatest challenges you've faced with fatherhood?
6. What are some challenges your partner has faced with motherhood?
    -Probe: Describe your partner's experience with exclusive breastfeeding.
    - Probe: How long has your partner been exclusively breastfeeding your infant?
7. Describe your opinions associated with exclusive breastfeeding.
    - Probe: Do you think this is beneficial for your partner?
    - Probe: Do you think this is beneficial for your baby?
    - Probe: What influences your opinions on exclusive breastfeeding?
8. When and from who/where did you learn about exclusive breastfeeding?
9. In what ways do you support your partner through exclusive breastfeeding?
    - Probe: Do you support her financially? Describe.
    - Probe: Do you support her emotionally? Describe.
    - Probe: What do you do when your partner has challenges with breastfeeding?
10. Has your experience supporting your partner through exclusive breastfeeding been what you expected?
    - Probe: What were your initial expectations?
    - Probe: How is your current experience different from that?
    - Probe: Tell me more.
11. Do you have anything else to add?

Qualitative Story Completion Prompt

Instructions:
Before you begin this activity, please read these instructions carefully. Below is the prompt for the qualitative story completion exercise, please read it completely. Throughout the story, there are multiple blanks or missing lines. The objective of this activity is for you, the research participant, to fill in these blanks with words or phrases to complete the story. There is no correct answer, so please fill in the blanks to the best of your ability. Additionally, there is no minimum or maximum on the amount of words you may use to fill in the blanks and there is no time limit for the activity. During the entirety of the activity, a research assistant will be present to answer any questions you may have. Thank you for your participation.

Story Completion Prompt:
After a day at work, John returns home to his partner, Jane, and infant child, Noah. Jane gave birth to Noah three months ago and she spends the majority of her time taking care of him. When John comes home, he sees Jane in the bedroom attempting to breastfeed their son, Noah. Jane has struggled with breastfeeding for a long time. Noah wakes up in the middle of the night and often seems unsatisfied with Jane's breast milk. Today, like most days, John walks into the bedroom and sees that Jane is frustrated. She says that Noah is not latching to her breast and he continues to cry. In response, John tells Jane, "____
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______________________________."

In the past three months Jane has been exclusively breastfeeding Noah, John has supported her by

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____.

John does this because he knows that exclusively breastfeeding Noah for six months is

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