Supporting mothers to breastfeed: the development and process evaluation of a father inclusive perinatal education support program in Perth, Western Australia

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SUMMARY
Entry into fatherhood is a challenging period with new responsibilities and changes in family dynamics. Hegemonic imagery of men portray them as capable, confident and able which can disadvantage expectant fathers who often struggle to make sense of the changes occurring around and within their own parenting journey. Although fathers historically have not been included in breastfeeding classes, antenatal education programs can be an opportunity to inform and support them in their new role. Forty-five antenatal sessions for fathers (n = 342) of 1 h duration were conducted by five male educators between May 2008 and June 2009 in Perth, Western Australia. A theoretical framework from health promotion literature was used as a guide in the program's development. Fathers in the intervention group gained information about their role, the importance of communication and the benefits of breastfeeding to both mother and baby. An evaluation was obtained from fathers immediately after the session and again at 6 week post-birth, whilst mothers reported on the perception of their partners’ support for breastfeeding in the 6 week survey. The aim of this paper is to describe the development and process evaluation of a perinatal education and support program for fathers to assist their partners to breastfeed.

Key words: breastfeeding; fathers; perinatal education

INTRODUCTION
Breastfeeding is the most natural, efficient and cost-effective method of providing infants the best start in life. Breastfeeding benefits include optimal infant nutrition (Allen, 2005), psychological, developmental and physical health benefits for both mother and infant (McFadden and Toole, 2006), economic benefits for the family (Cattaneo and Quintero-Romero, 2006) and environmental benefits for the community (Leon-Cava et al., 2002; Mettner, 2006; Oddy et al., 2006). The protective effect of breastfeeding against obesity is consistent and appears to increase with the duration of breastfeeding (Arenz et al., 2004). The World Health Organization (WHO) (World Health Organisation, 2001) and the American Academy of Paediatrics (AAP) (American Academy of Pediatrics, 1997) recommend exclusive breastfeeding for 6 months, plus the continuation of offering breast milk until age two, with appropriate complementary foods. Although most developed countries maintain high initiation rates, prevalence rates fail to meet these recommendations.
Fathers are recognized as providing support which can influence breastfeeding duration (Scott and Binns, 1999; Tohotoa et al., 2009); therefore efforts to support fathers assume this parenting role is strongly advocated (Wolfberg et al., 2004). Antenatal education programs have been recommended as an ideal opportunity to also improve fathers’ knowledge of breastfeeding (Giugliani et al., 1994), although historically fathers have not been included in breastfeeding education programs. Antenatal education has traditionally targeted women to provide childbirth information with the goal of increasing confidence (Hibbard et al., 1979) and reducing maternal and infant morbidity and mortality (Gagnon and Sandall, 2000). Such education has traditionally used didactic presentations to deliver information deemed important by health professionals (Myors and Mabbutt, 1997). Whilst the majority of mothers are provided with some form of breastfeeding information in Australian hospitals, in antenatal classes and breastfeeding clinics, the content and delivery is not uniform (Zareai et al., 2007). More recently, antenatal education focus has changed from women only, to include partners and family members (Schmied et al., 2002).

Previous studies have reported that fathers often perceive that current information provided is not always appropriate to their needs (Barclay et al., 1996; Tohotoa et al., 2009), is maternally biased (Singh and Newburn, 2001; Tohotoa et al., 2009) and reinforces a feeling of being on the sideline rather than central to the pregnancy and birth experience (Moriaty, 2002). Boyce et al (Boyce et al., 2007) in a survey of 312 Australian men found that fathers who had insufficient information about pregnancy and childbirth were (18.6%) more at risk of increased psychological stress both before and after the birth of their baby (Boyce et al., 2007). A literature review of 33 programs from a range of countries examining fathers’ experiences of parenthood in the first year found that two of the main concerns for fathers were being confident as a father and as a partner and living up to the new demands (Nystöm and Ohrling, 2004).

Findings from Australian and US studies suggest focusing on men’s needs can reduce paternal stress, improve maternal and paternal satisfaction, enhance interpersonal skills and paternal involvement with household tasks (Diemer, 1997; Dellmann, 2004), whilst a study from the UK found that fathers wanted more information given in the antenatal period on parenting, baby care and relationships (Deave and Johnson, 2008). Men wanted reassurance that everything in their relationship would return to normal once the baby was born; however, this topic was seldom discussed because men’s needs were rarely acknowledged or supported (Donovan, 1995; Pastore et al., 2007).

Evidence about the impact of antenatal education on fathers is mixed. Some research found that antenatal education for fathers increases their knowledge about pregnancy, the birth process and also enhances parenting skills (Barclay et al., 1996; Schott and Priest, 2002). However, others found that antenatal classes did not meet the needs of the male partner in relation to the emotional and psychological aspects of parenthood (Donovan, 1995). Australian researchers reported that participants in a men’s only discussion group felt more comfortable making contact with other fathers than in a mixed gender group (Schmied et al., 2002). Mc Elligott’s (McElligott, 2001) Scottish study (n = 54) found fathers wanted information about their role and the care of their baby following delivery whilst Fletcher et al. (Fletcher et al., 2004) in an Australian study of 212 fathers, suggested that fathers were prepared for childbirth, but not for lifestyle and relationship changes (Fletcher et al., 2004). Fletcher et al. (Fletcher et al., 2004) proposed that health services could support new fathers by providing information on parenting from a father’s perspective, or running father-specific sessions as part of routine antenatal care programs.

Fathers plus and Fatherhood Institute in the UK along with Father Involvement Research Alliance in Canada provide resources to increase father inclusive practice for health professionals working with fathers.

This paper describes the development and process evaluation of a perinatal education and support program for fathers to support their partners to breastfeed. The program was developed as part of a randomized controlled trial with the aim of increasing breastfeeding prevalence up to 6 months post-birth. The results of this paper are describing the baseline and 6 week data only, the 6 month data will be presented elsewhere.

**Theoretical frameworks**

Social Cognitive Theory (Bandura, 1986), the Health Belief Model (Strecher and Rosenstock, 1987), Social Learning Theory (Bandura, 1986), and Social Cognitive Theory (Bandura, 1986) are theoretical frameworks that can be applied to understanding paternal involvement in the perinatal period. The Health Belief Model suggests that individuals are more likely to adopt healthy behaviors if they perceive the health behavior is important and if they believe they have the ability to adopt and maintain the behavior. Social Learning Theory posits that individuals learn behaviors by observing and imitating others, and that cues such as norms and feedback can influence behavior. Social Cognitive Theory suggests that individuals are more likely to adopt healthy behaviors if they perceive the behavior is important and if they believe they have the ability to adopt and maintain the behavior.
1997) and Gender theory (Connell and Messerschmidt, 2005) were used to inform the development and implementation of the perinatal education and support program. The Health Belief Model guided the formative research and supported information delivery, while Social Cognitive Theory was predominately used in shaping the intervention and in facilitating understanding of the potential interaction between overestimation of new parents capacity to cope and underestimation of potential problems. Emergent data from formative research (Tohotoa et al., 2009) identified the utility of Gender theory to inform the content and the program delivery process (Connell and Messerschmidt, 2005). The social construction of masculinity, role expectations and elements of hegemonic masculinity were both challenged and utilized as motivational elements by the male facilitators during the antenatal session. The formative data from the fathers identified the themes of protector, provider and planner as being male roles that could be used as motivators to enhance support for mothers and that the theme of stoicism could be challenged to increase support. Masculinities change over time and the changing role of men within gender relationships was included in the discussion around perceived father roles.

METHODS

The perinatal education and support program consisted of two elements: an antenatal education session in addition to postnatal education and support. This section will outline how the formative research was conducted and informed development of a perinatal education and support program. It will focus on the recruitment, training and delivery of the antenatal package and the sequencing of postnatal support package.

The objectives of the perinatal program were:

(i) To promote the unique role of being a father and the associated implications on lifestyle and relationships;
(ii) discuss ways to support partners to breastfeed;
(iii) to provide information about resources available to parents; and
(iv) to provide relevant ongoing postnatal education and social support.

Formative research

To understand the needs of expectant Western Australian fathers, a qualitative design was employed using focus groups, interviews and an on-line questionnaire with fathers of breastfed babies between May 2007 and October 2007 in Perth, Western Australia. Each data collection approach included the same questions to ensure consistency. In addition, focus groups were held with mothers who were breastfeeding to gain their perceptions about how fathers could best support their breastfeeding partner. Findings from this formative phase have been reported elsewhere (Tohotoa et al., 2009).

Information from the formative phase was used to develop the content for the antenatal education session. Additional data were obtained from reviewing the current antenatal class format and curriculum at each of the participating hospitals in addition to meeting with a total of 12 antenatal educators from the study hospitals. Feedback from other health professionals (an obstetrician who was conducting parent education in a private capacity and an educator with a non-government agency) was also included. Data from the focus groups interviews, questionnaires and all feedback were then incorporated into the development of an antenatal education session. Both the Health Belief Model and Social Cognitive Theory were used to provide a theoretical foundation and process support for the design of the intervention material. Three major content areas were identified as the most important issues to be discussed; ‘the role of the father’, ‘the benefits and importance of breastfeeding to both mother and baby’ and ‘what to expect in the first 4 weeks at home’. The antenatal session was then piloted with a group of six fathers. All participants offered constructive feedback in relation to the session content that resulted in changes to the timing and flow of information. The 6 week support package was showcased and minor changes made to the sequencing of products sent. A second pilot session was then conducted with five different fathers 1 month later, with no further changes required.

A logo was created to reflect the philosophy of the project, ‘Smarter stronger, breastfeed longer’ and was used on all education materials and correspondence with participants and stakeholders. Handouts for the intervention were developed to complement the education session and contained general information about parenting and the role of the father, the
importance and benefits of breastfeeding for both mother and baby, and activities on how to bond with your baby.

**Recruitment and training of facilitators for the antenatal session**

During the formative research men indicated preference for a male facilitator who understood the parenting role and was able to communicate effectively. Three criteria were essential to be a facilitator: (i) have been a father of a breastfed baby; (ii) have an understanding of adult learning principles; and (iii) have a commitment to promoting the importance of the father’s role in early parenting. Seven male facilitators were initially recruited from hospital, education and community backgrounds; three were registered midwives and four were teachers. Two facilitators subsequently withdrew due to time constraints. The remaining five male facilitators were given standardized training that provided an overview of the research project, the content of the antenatal class and delivery processes. Each facilitator was given a compendium containing a USB and CD with the PowerPoint presentation of the antenatal session. As a backup and for use in those hospitals without PowerPoint facilities, a set of overhead transparencies of the PowerPoint presentation was included. Stationery was provided along with work sheets, evaluation sheets, pens, a marble and a golf ball (for visual representation of baby’s stomach) and name labels. The facilitators were given the opportunity to personalize the PowerPoint material by including pictures of their own children. Findings from the formative phase indicated this strategy was important for credibility.

The recruitment of fathers for the antenatal session

An information sheet which explained the aim of the project was posted to all expectant parents who registered for antenatal education prior to their first class. Inclusion criteria required the participants to understand written English in order to complete the questionnaires, to be over 18 years of age (unless accompanied by an adult who could give consent for the minor to participate) and intention to attend the antenatal program. At the time of recruitment, all participants were invited to complete a baseline questionnaire that contained demographic information that included age, marital status, occupation, educational level and nationality. Data were also collected on breastfeeding knowledge and attitudes, well-being over the past week and intention to breastfeed. Consent forms were completed on that first night by all expectant parents who chose to participate, prior to administration and completion of the baseline questionnaire.

The antenatal session for intervention fathers was delivered as a supplement to the existing antenatal sessions offered by the hospitals and was normally delivered on the third or fourth week of their antenatal programs (total program = 4 weekly sessions). This was to benefit from the prior opportunity for social networking within the group.

**Delivery of the antenatal package**

During the delivery of the intervention antenatal education session, all male participants were given materials developed to support and complement the session. These included; a ‘new father’s guide’ identifying the potential problems for parents and infant in the first 4 weeks at home and a pamphlet/brochure ‘how to be a breastfeeding champion’ that described strategies to support their partner to breastfeed. The brochures offered helpful tips, a list of essential resources and websites and telephone numbers to assist with problems associated with breastfeeding difficulties or infant health. Their purpose was to enhance the provision of support the fathers offered their partners, to improve their problem-solving abilities in relation to breastfeeding and associated issues and to assist them to identify possible signs of postnatal anxiety and depression. Roles of the father were the explored, for example, the protector role was used in discussions around restricting visitors
post-birth to enable the mother adequate rest and breastfeeding time: the planner role was used in problem-solving activities in small groups, and the role of provider was acknowledged and ways to continue support following a return to work were explored. Participants were able to articulate problems that they might encounter and through completion of a worksheet and via group questions and discussion, identify potential solutions.

Each pregnant partner was given a ‘mother’s information’ booklet that incorporated similar information to the men’s resources to maintain transparency of information. Men were invited to complete an evaluation sheet at the end of the antenatal education session with questions on the content of the class, the facilitator and presentation strategies. Process evaluation of the education package included feedback from the evaluation sheet as well as a second post or online survey 6 weeks post-birth seeking feedback about the usefulness/relevance of the antenatal session and the information contained in the postnatal support package.

**Postnatal education and support**

After the successful birth of the baby the second component of the intervention was initiated. This involved sending a sequence of information, resources and motivational material to the parents via the father. The scientific literature provided the evidence for the sequencing of this support (Schwartz *et al.*, 2002; DiGirolamo *et al.*, 2005). It coincided with the known stressors (sleeplessness, fatigue and lack of self confidence) and inhibitors (breastfeeding difficulties including sore nipples and perceived insufficient milk supply) to breastfeeding. The material complemented the information received during the antenatal session, acknowledged the stressors affecting new parents and sought to provide information and social support to assist them gain confidence in their parenting role.

Complementary products and educational materials relevant to their baby’s developmental needs were posted according to the timeline outlined in Figure 1. A congratulatory birth card was sent to the parents acknowledging

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**Fig. 1:** Outline of support resources offered over the 6 week period.
their new baby and commencing the postnatal support package. At Week 1, a sample size of nipple cream was included for mothers to help reduce sore nipples, a known inhibitor to breastfeeding at this stage (Schwartz et al., 2002) and the developmental milestones pamphlet was presented as a way for fathers to track their baby’s progress and growth to increase their self-confidence and understanding of normal infant behaviour and development. The recognition of good nutrition for breastfeeding mothers and the importance of a healthy diet were reinforced in the dietary guidelines posted during the second week for both the fathers and the breastfeeding mothers. Week 3 is often the time of a growth spurt for baby with an accompanying increase in feeding leading to increased stress and fatigue (Schwartz et al., 2002). A ‘how to relax’ relaxation exercise brochure combined with two individually packed herbal teabags at Week 3 acknowledged the need for ‘time out’ and encouraged parents to practice the simple, easy exercises to reduce stress and fatigue. At Week 4, a logo printed beer can holder was posted as a motivator and conversation starter with peers, and was timed to assist the response to the 6 week survey.

A recognized risk period for postnatal depression is between 4 and 6 weeks post-birth (Matthey et al., 2000), and a postcard highlighting the signs and symptoms of postnatal depression along with a comprehensive brochure about postnatal depression with associated help resources were sent at Week 5 as part of an anticipatory guidance approach. All participants had identified on their baseline questionnaire responses, their preferred method of responding to future questionnaires with the choices of phone, email or post. At 6 weeks post-birth, a questionnaire was administered by telephone, email or post to all participants, according to their preference of responding. Data were collected on type of birth, birth or breastfeeding complications and perceptions of support received for breastfeeding.

Ethics approval for the study was granted by the Human Research Ethics Committee of Curtin University and from the North Metropolitan Area Health Service, South Metropolitan Area Health Service and the Joondalup Health Campus.

RESULTS

The results include data from the intervention antenatal session evaluation surveys, and the 6 week postpartum survey.

Intervention antenatal sessions and evaluation

A total of 45 education sessions were conducted by five male educators in eight maternity hospitals. Each session had an average of six participants with a range of 2–14 attendees. Of the 385 men in the intervention group who confirmed their desire to participate in the program, 342 (89%) attended the antenatal sessions and 295 (86%) responded to the 6 week survey. Work commitments including working away was the main reason cited for not attending the class. Table 1 describes participant demographic variables.

The use of adult learning principles incorporated small group work and offered the opportunity for the men to interact and share their apprehensions about the new parenting experience (Knowles et al., 2005). The importance of prioritizing information was essential to the men gaining confidence in problem-solving regarding lifestyle and relationship changes. Men talked about ‘being informed by a father and sharing with other men’ as being the most important aspect of the class, and the ‘relaxed feel without the partners’. Another participant said ‘issues I thought were silly are actually common and that’s a relief’.

Table 1: Demographics male participants attending intervention antenatal session (n = 342)

<table>
<thead>
<tr>
<th>Education</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;Year 10</td>
<td>71 (21%)</td>
</tr>
<tr>
<td>Year 12</td>
<td>78 (23%)</td>
</tr>
<tr>
<td>Trade/diploma</td>
<td>129 (38%)</td>
</tr>
<tr>
<td>Tertiary</td>
<td>64 (19%)</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>191 (56%)</td>
</tr>
<tr>
<td>De facto</td>
<td>109 (32%)</td>
</tr>
<tr>
<td>Single</td>
<td>30 (9%)</td>
</tr>
<tr>
<td>Age</td>
<td>29 years (average) (range 16–51)</td>
</tr>
<tr>
<td>Nationality</td>
<td></td>
</tr>
<tr>
<td>Australian born</td>
<td>222 (65%)</td>
</tr>
<tr>
<td>Income</td>
<td></td>
</tr>
<tr>
<td>In Australian dollars</td>
<td>$86 000 (average) (range &gt;$15 000–$120 000+)</td>
</tr>
</tbody>
</table>
One activity that was particularly useful involved a visual representation of a baby’s stomach capacity at birth and 1 month compared with a marble and a golf ball, respectively. The men shared how this activity assisted their appreciation of two to three hourly feeding in the first few weeks and the intensity of the mother-baby bond. As one dad explained ‘It makes so much sense when you see it like that’. The benefits of exclusive breastfeeding for the first 6 months for both the mother and the baby was new information to most men and led to interactive discussions to develop supportive strategies. Men talked about ‘learning details for breastfeeding’ and getting ‘information on helping mothers to breastfeed’. Misunderstandings and myths were addressed by the facilitators and lifestyle changes explored. One of the myths dispelled by the facilitators was around the belief that breastfeeding is a natural phenomenon and that all women can breastfeed without major difficulties. The facilitators talked about the difficulties many women experience with engorgement, painful nipples from poor attachment technique and stressed the importance of initial and ongoing help if difficulties arose with breastfeeding. The misunderstanding that ‘Baby will just fit into our lives’ was addressed with a simple activity to identify the 5 ‘S’ words that would be affected by bringing a new baby/babies home. This proved to be very popular (identified in the evaluation sheet comments section) and enabled discussion around sleep difficulties, sex and when to resume intimate relations, the stress and social life changes and self-identity issues in becoming a father. As one man wrote in the evaluation sheet ‘it’s ok to think of myself without guilt’, and another commented that the importance of the activity for him was ‘other men’s questions and opinions’.

Feedback from the facilitators indicated that most of the participants actively engaged in the sessions and informally reported that ‘everything was relevant’. The evaluation sheet completed at the end of the session by the fathers in the intervention group, concurred and revealed that most men had a positive, informative experience; 99% felt the presentation was relevant and the presenters appropriate. Over 90% responded that the role of father, the importance of breastfeeding to both mother and baby and the facilitators to successful breastfeeding were adequately addressed (Table 2). Feedback regarding improving the session included ‘more time, more handouts, role playing and videos’. The overall tenor of the comments can be summed up by one participant’s comment: ‘I’m glad I’m here, the talk was informative, I learned things I didn’t know, particularly about breastfeeding and it was well presented’.

### Father’s 6 week follow-up

All participants were sent a questionnaire at 6 weeks post-birth to provide feedback regarding the antenatal education session and postnatal support package. The questionnaire asked fathers ‘how helpful were the educational materials sent to you?’ and their responses were recorded on a Likert scale. Whilst the most interest was with the new fathers guide 69% \((n = 205)\) and reflected the relevance of an anticipatory guide, the information in the PowerPoint handouts was scored at 63% \((n = 187)\) and few men found it unhelpful 2% \((n = 7)\). The information about postnatal depression 66% \((n = 196)\) was the next most helpful, followed by information and exercises on ‘how to relax’. The total results from returned responses 86% \((n = 295)\) are described in Table 3. The fathers were also asked ‘what other information or materials might have been helpful for you?’ The majority of fathers responded with ‘don’t know, or got enough’.

### Table 2: Men’s feedback following the ‘fathers only’ antenatal education session \((n = 342)\)

<table>
<thead>
<tr>
<th>Variable item</th>
<th>Agree, (n) (%)</th>
<th>Neither, (n) (%)</th>
<th>Disagree, (n) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helped with my expectations</td>
<td>328 (96%)</td>
<td>14 (4%)</td>
<td></td>
</tr>
<tr>
<td>Promoted the unique role of father</td>
<td>321 (94%)</td>
<td>21 (6%)</td>
<td></td>
</tr>
<tr>
<td>Increased awareness and importance of breastfeeding</td>
<td>307 (90%)</td>
<td>31 (9%)</td>
<td>4 (1%)</td>
</tr>
<tr>
<td>Identified facilitators to breastfeeding</td>
<td>318 (93%)</td>
<td>21 (6%)</td>
<td>4 (1%)</td>
</tr>
<tr>
<td>Identified lifestyle changes</td>
<td>314 (92%)</td>
<td>28 (8%)</td>
<td></td>
</tr>
<tr>
<td>Provided resource materials</td>
<td>321 (94%)</td>
<td>21 (6%)</td>
<td></td>
</tr>
<tr>
<td>Educator effective and appropriate</td>
<td>338 (99%)</td>
<td>4 (1%)</td>
<td></td>
</tr>
<tr>
<td>Presentation allowed for open discussion</td>
<td>324 (95%)</td>
<td>18 (5%)</td>
<td></td>
</tr>
<tr>
<td>Presentation was relevant</td>
<td>338 (99%)</td>
<td>4 (1%)</td>
<td></td>
</tr>
</tbody>
</table>

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Downloaded from http://heapro.oxfordjournals.org/ at Pennsylvania State University on September 17, 2016
The responses from those fathers who did comment varied from wanting a booklet rather than pamphlets or brochures to a DVD of breastfeeding with problem-solving solutions to common breastfeeding problems. More internet websites and email contact were also requested.

Mothers in the intervention group (77%) reported enjoying breastfeeding more than mothers in the control group (69%) whose partner did not receive the antenatal education session intervention. Both the control (78%) and intervention (84%) group mothers identified their partner as the one who gave them most support for their breastfeeding efforts and both groups experienced similar attachment and engorgement difficulties and sought help from their child health nurse, midwife or lactation consultant for these problems.

DISCUSSION

The results of the perinatal intervention gave fathers timely, relevant information and resources to help reduce anxiety and increase their problem-solving abilities. It helped them develop awareness of potential breastfeeding difficulties, infant developmental milestones and postnatal depression, identified in the evaluation sheets. Feedback from fathers in this study confirms the desirability and value of a father inclusive support package during the perinatal period. The use of a gender-specific group was seen as a positive strategy for the men as highlighted in the evaluation. This outcome is consistent with other studies using adult learning principles and gender-specific group facilitators to increase the positive parenting experience for both mothers and fathers (Diemer, 1997). Supporting the feedback from our study, Friedewald et al. (Friedewald et al., 2005) in a review of 91 all male discussion forums that included 670 expectant fathers, found participants valued a male facilitator, felt the importance of their role as a father was acknowledged, and were able to discuss their fears and concerns without shame or embarrassment.

Although our study aimed to assist fathers to support their breastfeeding partner, topics around lifestyle changes and intimacy issues also featured in discussions where participants were able to reflect upon how they might manage these changes and the expected gender role changes inherent in the transition to fatherhood. The positive use of problem-solving strategies was supported by Petch and Halford who found the changes in relationships post-birth and expectations of new parenthood could compromise relationships (Petch and Halford, 2008).

Study participants expressed interest in information about postnatal depression (n = 66%) and found the resources helpful for identifying and recognizing the signs and symptoms. This contrasts with an Australian study by Fletcher et al. (2008), who offered men a series of educational modules in the antenatal period and found that only 29% took up the postnatal depression module (Fletcher et al., 2008). Given the seriousness of this issue and the fact that postnatal depression affects 13% of women and 3–10% of fathers (Matthey et al., 2000), the value of fathers having this information cannot be underestimated. Providing participants with information on reducing stress and anxiety was not regarded as useful by some men which could reflect the hegemonic masculinity culture of ‘strong and capable’ (Connell and Messerschmidt, 2005). Likewise in this study, the importance of good nutrition for breastfeeding and for adults in general was not as high a priority for fathers compared with topics such as ‘what to expect in the first 4 weeks’. Fatigue and sleeplessness adjustments may have contributed to the lack of enthusiasm for both the relaxation exercises and the dietary guidelines.
This was supported by Elek et al. (Elek et al., 2002) in a longitudinal study with 44 couples, who found that both mothers and fathers suffered with fatigue and sleep disturbances in the first 4 weeks postpartum.

Breastfeeding education is different to breastfeeding support. This study found informing men about potential problems (like engorgement and mastitis) and giving them strategies to problem solve, increased the level of support their breastfeeding partner perceived they received at 6 weeks post-birth. Support for a perinatal education and support package was found in a study undertaken in Canada by (Semenic et al., 2008) with 189 mothers. It highlighted the need for establishing exclusive breastfeeding in the early postnatal weeks and suggested the need for a continuum of pre-and postnatal strategies to encourage exclusive breastfeeding (Semenic et al., 2008). Likewise, incorporating an ongoing postnatal support package increased the information and resources available to the new parents over time and were consistent with Hannula et al.’s review (Hannula et al., 2008) that found intervention packages using various methods of education and support were more effective for breastfeeding support than interventions concentrating on a single method.

Fathers in this study wanted more internet and email communication and this reflects the increasing use of internet technology. Further research with breastfeeding support internet education interventions is needed and recommended. Development of a DVD for postpartum use was suggested by several fathers and warrants further research. A review of antenatal education programs could identify current deficiencies and lead to standardization of antenatal programs that incorporated adult learning principles and have gender-specific class options. Further research to explore the efficacy of antenatal education versus postnatal education and support is required to determine the most cost-effective way of enhancing fathers’ support.

Limitations
This research has several limitations that need to be considered when reviewing our findings. The participants only included parents enrolled in antenatal education and hence may not be representative of all parents. They represent parents who sought antenatal education from the public sector which may not reflect parents attending comparable education offerings within the private sector. Demographic data revealed participants in both the control and intervention groups came from diverse ethnic backgrounds and geographical localities within the Perth metropolitan area. The 6 week questionnaire gave a brief overview of the fathers’ response to the intervention, and the subsequent results were an indication of fathers’ feedback rather than a definitive answer. This paper nevertheless adds to the findings of other studies and supports the use of adult learning strategies and gender-specific options for antenatal education programs.

CONCLUSION
This paper reported on a program that was successful in developing father-specific intervention material that was well received and successfully met its objectives. The intervention targeted fathers and incorporated men from a wide cross section of socioeconomic settings with the majority of participants in low socioeconomic locations. Elements of hegemonic masculinity were utilized to enhance the relevance and acceptability of the interventions material. Utilizing key role expectations expressed by our fathers (planning, protection, provision) we were able secure their engagement by presenting expectations that fit within a culturally appropriate framework. When we challenged some of the male characteristics such as stoicism we were able to demonstrate how it conflicted with the positive expectations (planning, protection, provision). Utilizing hegemonic theory while controversial has provided a positive utility in the context of this intervention. It is likely it could also be used by researchers in other cultures to enhance fatherhood practices.

There are very few gender-specific groups for fathers currently in any public maternity hospital in Western Australia and this study demonstrates their perceived importance to new fathers. Support for breastfeeding requires a commitment by both parents and fathers are instrumental in the decision-making and support of breastfeeding. In order to fulfil this essential role, fathers need to be supported with timely information and problem-solving skills to best support their partner’s breastfeeding.
efforts. Health services need to be responsive to assist fathers prepare for this essential role. Specific consideration needs to be given to recruiting and retaining fathers from lower socioeconomic settings. This research was successful as it used a range of data collection methods to gather the formative data. Further exploration of the potential of the internet to provide both antenatal and postnatal education is needed and could be the future of health promotion campaigns when engaging with fathers. Video and DVD technology was actively supported by the fathers and maybe a better way of information transfer in a time poor society. There is a need for further research into postnatal support for fathers if they are to become a breastfeeding advocate and champion the right of their baby to the best nutritional start in life.

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