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EXECUTIVE INDEX

INVOLVING FATHERS IN COMMUNITY CHILD HEALTH SERVICES

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Men in my antenatal classes give three common reasons why they intend to father differently than they were fathered: community expectations, partner pressure, and their own wish for connection with their child.

1. **Community expectations:** highlight the fact that fathers are expected to be involved in the day-to-day care of their baby, not simply to be a provider and protector.
2. **Partner pressure:** "She'll kill me (if I don't)": the second reason is offered with some humour by the fathers-to-be. The wives or partners of these men will insist on their taking a different, more hands-on approach than fathers of previous generations.
3. **Their own wish to connect with their child:** "Because I want to have a good relationship with my kid, that's why I am doing this," is usually expressed by one of the men, and the others nod in affirmation, and this captures perhaps the most profound change in our understanding of a father's role.

Not that fathers of previous generations did not have good relationships with their children; the men in these groups are frequently adamant that their own fathers were 'good fathers' (after all, they turned out OK) and enjoyed positive relationships with their children. However, there is a recently developed awareness that the pathway to having good relationships with children and teenagers starts early, and these men want to be involved in caring activities when their children are infants.

From the perspective of professionals working with families, there has also been a fundamental shift in how we view the role of fathers. Where once the inclusion of a father in the discussion of infant care may have been seen as irrelevant to good practice, it is now more likely to be considered desirable – not only for the father, but for the family too.

At the national Father-Inclusive Practice Forum held in 2005, examples of service delivery that included fathers were presented from around Australia. These programs illustrated the various models of service delivery where work had been conducted to *actively* include fathers, not simply 'run a program for fathers'. Government and non-government services reported changing their referral processes, staffing, publicity, program design, hours of operation and service location to encourage fathers' participation; not simply

An initiative of the Centre for Community Child Health, The Royal Children's Hospital, Melbourne

The Royal Children's Hospital Melbourne
Centre for Community Child Health

participation in a separate, men-only service, but in a father-inclusive service that regarded fathers and mothers as a team raising their children.

There is a remarkable parallel in the progression of these two groups – fathers and professionals – toward the goal of father-inclusion. Both fathers and professionals working with families agree that in principle, fathers should be as involved as mothers in the care of children and infants. However both groups also drastically underestimate how difficult it will be to put the ideal into practice, and both groups face discouragement or criticism for not achieving equality. In spite of the rhetoric of equal parenting, the reality is that fathers return to work, on average, within two weeks of the birth of their baby. For mothers, the average is closer to six months.

Regardless of the intentions of the couple, as the father returns to full-time work and the mother remains at home to provide full-time care of the newborn, inevitably it will be the mother who does the lion's share of the work and who gains a deeper understanding of the moods and personality of their baby. The reality of time available to be shared in the first months, added to the reality of breastfeeding, pushes most fathers toward the role of 'helper' to the mother and away from taking joint responsibility for the full care of their infant.

For professionals, the story is remarkably similar. In working with family-related services over the last decade, from antenatal settings to schools, I have been struck by how warmly professionals endorse the ideal of fathers' participation. In workshops and informal discussions with nurses, midwives, early childhood staff and teachers (almost all females and mostly mothers), the support for fathers to be more engaged in the services' support for families is often unanimous. However, when we look at the progress in refashioning maternity services and community-based family services toward family-centred care that is inclusive of fathers, it is difficult to see signs of significant change. Systemic issues such as the unrealistic time demands in service provision, mother-focused service designs and professional training that have largely ignored the role of fathers, have resulted in service delivery models where it is difficult to even notice fathers.

In an informal conversation, an experienced nurse was describing the benefits of support groups for mothers who were struggling with postnatal depression. The

nurse described a situation that occurred as part of the group work process. One of the mothers told her story, her eldest child had suffered a serious accidental injury. The nurse explained how effective the mothers' group was rallying in support of the woman. The strength of the other women in the group and their ability to support the distressed mother clearly gave the nurse enormous encouragement in her daily work in a difficult area. Her face reflected her excitement as she recalled the healing taking place and her satisfaction regarding her role in initiating and assisting the success of the group. After a pause I asked, "And the father? What was happening for him?" She looked surprised and answered "Oh I am not sure. I don't know anything about him".

It is important to appreciate that the nurse concerned had approached me to discuss how to get fathers more involved. She was an advocate of fathers' participation and was sure that fathers could significantly improve the outcomes for their children through their involvement with the service.

Awareness of fathers is important, but without a more coherent understanding of *why* and *how* to involve fathers, we are unlikely to see the institutional change required to include fathers in what would be truly family-centred practice. The 'why' has been answered through the last decade of research on child development; while many study results are qualified or preliminary, sufficient evidence of the potential positive effect of fathering on their children's development exists to justify the inclusion of fathers in all parenting services.

Attachment theory, for example, is the basis of much of our support for families with infants. The earliest formulations emphasised the mother-infant dyad as the site of primary attachment and as the place where the template for subsequent attachment figures was established. There is now widespread acceptance that a secure father-infant attachment is formed independently of the mother-infant relationship and that both have consequences for the child's development.

Children with two depressed parents, for example, are at greater risk of social, psychological and cognitive deficits while fathers' depression at eight weeks postpartum has been found to double the risk of behavioural and emotional problems in children at 3.5 years of age, independently of mothers' depression status. This recent evidence strongly suggests that the father's emotional health should be assessed with the mother's.

An effective screening for new fathers, however, will require a keen appreciation of the context for fathers' help-seeking behaviour with professionals. A recent description of the 'usual' arrangements leading up to the birth, highlights how fathers might not establish any meaningful relationships with health practitioners and they may miss out on important knowledge regarding infant development.

CASE STUDY

When Michelle and Anthony visit Michelle's general practitioner after a positive pregnancy test, Anthony expresses his support but asks few questions. When asked about the couple's intentions for pregnancy care, Anthony's quick glance towards Michelle flags his uncertainty. For the following visits, Michelle attends the clinic alone. Anthony does participate in the ultrasound consultation and he joins in when prompted during the antenatal classes, but he accepts that the emphasis throughout is appropriately on the mother and ensuring a successful birth. During the birth, he wonders if he is in the way and is grateful that the mother and baby are healthy at the end. After the birth, when the home-visiting nurse arrives, Anthony goes to make coffee and misses most of the discussion. His return to work precludes him attending the doctor's checkups for mother and baby
(Fletcher et al, 2006).

The new father's lack of professional contact, reinforced by his early return to work, the centrality of breastfeeding and social conventions which mean that fathers don't expect to know much about infants, all contribute to a strong polarity within the mother-father team. While new fathers may be willing or even eager to be involved, they generally rely on the mother to 'know' about the baby and what should be done. The trust in mothers to know what to do has a major influence on two aspects of help-seeking by fathers. Although there is discussion in the literature of mothers as gatekeepers to fathers' participation (keeping the fathers at a distance to preserve the mothers' control of infant care) the more common occurrence is that fathers look to mothers to know what they (the fathers) need to do.

In my own research following new fathers through the birth of their first child, I noticed how often the fathers' survey, which asked about the fathers' perceptions of events, was completed in discussion with their wife or partner.

More importantly, the trust between new mothers and fathers which is built into his reliance on the mother to 'know', creates a serious dilemma for the father in the case of any serious difficulty with the infant or child. If the problem is not resolved quickly, the mother is likely to be frustrated and unsure as to the best course of action. Problems such as mastitis or postnatal depression in the mother, irritability or illness in the infant, or chronic illness or disability in the child are relatively common and in each case create a dilemma for the father. In these situations, where treatments are often not efficacious and social factors play an important part, the father can continue to trust her (the mother's) judgement and cope with her distress as well as the effects of the problem, or he can branch out on his own to seek advice from professionals and form his own opinion as to the causes of the problem and optimum treatment regimes.

In the case of maternal postnatal depression, the situation of the father is exacerbated by the common wish of mothers not to discuss their difficulties with others outside of the immediate family. In these cases, the father may have been specifically told by the depressed mother not to discuss 'her' business with others.

HOW TO INVOLVE FATHERS IN YOUR SERVICE

- **Be actively inclusive**
  Make it clear that you expect his involvement from the beginning. At the first meeting or phone call, convey the expectation that his opinion counts and that his involvement will be needed to ensure successful outcomes for the infant or child.
- **Sharing best practice**
  Ask colleagues how they manage to engage with fathers in their clinics or sessions; sharing strategies can help make everyone's job easier.
- **Leave information**
  When conducting home visits, assume that some fathers will notice information (pamphlets, stickers for the fridge, coasters, placemats) after you have left.
- **Father-specific resources**
  Seek out material to give him or leave for him. There are several resources available free or at low cost which convey important information about fathers' roles.
- **Explain the importance of father-infant relationships**
  Expect to assist him to clarify the importance of father-infant relationships – he may be unaware of recent research about the impact of father-infant interaction on child development.
- **Identify referral pathways for fathers**
  Many generic services do not have father-inclusive procedures or practices but they may respond to your inquiry by reviewing their offerings.
- **Professional development**
  Look for professional development in the competencies of father-engagement. Both male and female practitioners can improve their skills and help build a father-inclusive workforce.

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REFERENCE

Fletcher R, Matthey S, Marley C G, 2006 'Addressing depression and anxiety among new fathers', *Medical Journal of Australia,* 185, 461-463.

Useful websites

http://raisingchildren.net.au/articles/work_and_family_dads_finding_a_balance.html

http://www.goodbeginnings.net.au

http://www.fatherhoodinstitute.org/index.php

http://www.aifs.gov.au/afrc/links/menfathers.html

REFLECTION QUESTIONS

1. *Working with families of newborn babies is often mother/child focused. We also know that secure father-infant attachment, like mother-infant attachment, has consequences for a child's development. How do ensure that the role of the father is well supported through your work?*
2. *What measures can you take within your service to learn more about the needs and preferences of fathers within your local community? Has your service considered consulting with fathers in regard to the design and development of new programs?*
3. *In your daily practice, how do you endeavour to meet the needs of fathers, taking into consideration such elements as age, cultural background or particular socioeconomic circumstance?*
4. *How do your service's policies and procedures reflect 'father-inclusive practice'?*
5. *How does your service information or advertising include specific reference to fathers and actively seek to engage fathers into programs?*

INFANT FEEDING: AN UPDATE

'To achieve optimal growth, development and health, the World Health Organization (WHO) recommends that infants should be exclusively breastfed for the first six months of life. Thereafter, to meet their nutritional requirements, infants should receive adequate and safe complementary foods while breastfeeding continues up to two years of age and beyond.'

The WHO recommendations about infant feeding are clear:

- Babies should receive only human milk for the first six months of life
- Babies should continue to be breastfed following the introduction of complimentary or family foods
- Breastfeeding can continue until the baby's second birthday, or even beyond.

ADVANTAGES OF BREAST MILK

According to the breastfeeding policy (2007) of the Royal Australian College of Physicians (RACP), *'Breast milk is superior to formula. The nutritional composition of breast milk is unique with narrow ranges for most nutrients, and many additional factors which are not in formula.'*

Compared to formula-fed infants, breastfed infants have:

- improved neurodevelopmental outcomes
- a lower incidence of infections, obesity and diabetes
- better feed tolerance
- less physiological gastroesophageal reflux
- a lower incidence of necrotising enterocolitis.

Child and family nurses have an important role in supporting and encouraging mothers to breastfeed, and also to support those mothers who choose not to or who are unable to breastfeed their babies.

EARLY INTRODUCTION OF FORMULA

A mother's decision to stop breastfeeding is often the result of a complex decision-making process for both parents that is not always obvious to professionals. According to a study by Anderson et al (2002), the well-being of the baby is the prime concern of all mothers, irrespective of her social background.

However, other factors in the decision-making process include the reality of the family's lifestyle as well as the mother wanting a 'contented and settled baby'. For babies under 12 months of age that are no longer breastfed, the only safe alternative is an infant formula.

When working with mothers who use infant formula, the key message is to ensure the manufacturers' guidelines are followed, unless otherwise instructed by a health professional. In Australia, infant formulae are heavily regulated and all standard products contain prescribed amounts of protein, fats, carbohydrates, vitamins, minerals and other nutrients necessary to meet babies' nutritional needs. The introduction of special products such as low lactose, anti-reflux (AR) or soy formulae require professional consultation, e.g. with a dietician or paediatrician.

SUPPORTING MOTHERS TO BREASTFEED

Supporting new mothers through the common difficulties that may arise in the early days of establishing breastfeeding, such as poor attachment, poor milk supply or mastitis, is a vital role for child and family health nurses. Research has demonstrated that early support to establish breastfeeding has positive outcomes for mothers choosing to breastfeed (Chung et al, 2008). Lactation consultants – community based or private – are also available to provide support to both mothers and health care professionals. There are also numerous resources (see websites listed) which provide professionals with up-to-date and relevant breastfeeding information for mothers.

For child and family health nurses, two other important ways to provide support for breastfeeding mothers are:

- Assisting mothers to continue to breastfeed when they return to work, and
- Supporting mothers in the weaning process.

CONTINUING TO BREASTFEED UPON RETURN TO WORK

Many mothers do not even consider continuing to provide breast milk for their babies when they return to work as this does not occur to them as a viable option. However, by expressing and storing milk at

work, continuing to provide breast milk for their infants is a *very* viable option for mothers returning to work.

Here are some ideas to discuss with mothers returning to work.

Planning the return to work

- Discuss with the mother the practical arrangements at her place of work, including a suitable place to express and store her breast milk during work hours. Should facilities for expressing be unavailable at her place of work, discuss how she could approach her manager to support expressing at work.
- Discuss expressing options.
- Discuss safe storage and transportation of expressed breast milk.
- Suggest practicing expressing a few weeks before returning to work and if possible, build up a reserve of breast milk.
- A few weeks before returning to work, the baby can be introduced to breast milk from a cup or bottle; a baby can feed from a cup from about seven months of age. Perhaps this is best given by the father or a friend for the first few times.

Starting work

- If the baby is in childcare, suggest that the mother label her expressed milk with her baby's name, time and date expressed.
- Assuming the mother has a good milk supply, she need only express at times when her baby would normally feed.
- If the mother is having difficulty keeping up with her baby's demand, she may need to express more frequently.

SUPPORTING MOTHERS IN THE WEANING PROCESS

Weaning is a very personal decision for mothers who must take into consideration the needs of her child, her own needs, as well as the home and family situation. Gradual and mutual weaning when both the baby and the mother are ready is ideal, but sometimes weaning needs to happen earlier or more quickly than planned. This can happen if the mother becomes unwell, when a baby refuses the breast, or if a mother chooses to wean from the breast.

Different support strategies are required depending on when and why weaning is taking place. Again, there are numerous resources available for health professionals and parents – both on-line and printed.

FINAL WORD...

Whether feeding the baby from the breast or the bottle, it is important to remind mothers that feeding is a primary method for her to initiate a secure attachment relationship with her baby. If using a bottle, encourage mothers to hold her baby and if possible, give her baby her undivided attention. Feeding provides mothers another excellent opportunity to comfort and nurture her baby, and also herself.

A complete list of references for this article is available from www.rch.org.au/ccch

Useful websites

www.breastfeeding.asn.au
www.betterhealthchannel.vic.gov.au

REFLECTION QUESTIONS

1. *Within your local area, how do you work to ensure new mothers receive consistent and practical breastfeeding support?*
2. *Does a network of representatives (child and family health nurses and midwives) from your local maternity hospital, community health centre and lactation clinics meet regularly to discuss breastfeeding support? If not, how can you work to facilitate the development of a network in your local area?*

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