

Title: Rhetoric or reality? Father support in promoting breastfeeding

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Summary (150 words)

Fathers have an important but overlooked role in supporting their breastfeeding partner given that their support can have a considerable impact on rates of breastfeeding initiation and continuance. Fathers remain a valuable yet ‘untapped’ resource for breastfeeding mothers, as well as for health professionals (and lay people) whom may be supporting breastfeeding in both clinical and community settings. In this article we summarise the research regarding insights into *why* fathers should be included in public services intended for the family including maternity services. We also summarise some of the main issues regarding *what* excludes fathers from these services (such as gender-based discourses about men and fathers). Finally, we then propose *how* fathers can be included more meaningfully by health professionals particularly in relation to supporting breastfeeding.

Rhetoric or reality? Father support in promoting breastfeeding

Increasing rates of breastfeeding is a key public health and health promotion issue given the range of positive health benefits for infants and mothers both in the short and longer term (Sherriff et al., in press a). The need to improve initiation and continuance breastfeeding is reflected in various national, European, and international policies and strategies. In the UK examples include the Healthy Child Programme (DH, 2009); NICE guidance on maternal and child nutrition (NICE, 2008); ‘Giving all Children a Healthy Start in Life’ policy (DH, 2013); ‘Call to Action’ for the health visitor implementation plan (DH, 2011), and; the Public Health Outcomes Framework for England (DH, 2012). Unfortunately however, the UK has among the lowest rates of breastfeeding continuance compared to many other European countries (see Cattano, et al., 2009). The latest Infant Feeding Survey reveals that although UK mothers are breastfeeding for longer than in 2005, only 34% are breastfeeding at six months and of these only 1% are exclusively breastfeeding (McAndrew et al., 2012). To put this in context, the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) state that infants should be ‘exclusively breastfed for the first six months of life in order to achieve optimal growth, development and health’ (WHO/UNICEF, 2003). Clearly, in the UK as well as other countries, there is a long way to go in order to meet this aspiration.

In previous articles, we have argued strongly that fathers have an important but overlooked role in supporting their breastfeeding partner and express concern that the practice of providing effective support to fathers in their parenting role continues to lag behind policy

aspirations (Sherriff et al., in press a; Sherriff et al., in press b; Sherriff and Hall, 2011; Sherriff et al., 2009). We propose that fathers remain a valuable yet ‘untapped’ resource for breastfeeding mothers, as well as for health professionals (and lay people) whom may be supporting breastfeeding (e.g. health visitors, midwives, breastfeeding advocates, Children’s Centre staff). However, in making this argument we raise three key questions which we will address in turn:

Three key questions to consider:

- *Why* should fathers be included in public services related to child-bearing such as maternity services?
- *What* excludes fathers from accessing public services?
- *How* can fathers be engaged more meaningfully by health (and social care) professionals particularly in relation to supporting breastfeeding?

Why should fathers be included in public services?

Over the past 10 years or so there has been a steady rise in interest from the UK Government in terms of supporting parents, and more recently, supporting fathers specifically. Nationally there are currently over 30 policy and legislative documents which explicitly refer to fathers and/or engagement with fathers in family support as well as health and education services (Olley and Potter, 2012). Relevant examples include the updated Healthy Child Programme (DH, 2009); ‘Giving all Children a Healthy Start in Life’ policy (DH, 2013); the Children’s Plan (DCSF, 2007); Sure Start Children’s Centres Practice Guidance (2006), and Supporting Families in the Foundation Years (DE, 2011). In some instances, this relatively recent intensified policy interest has stemmed from a desire to reduce rates of teenage pregnancy, address social exclusion, and reduce potentially poor outcomes for children. In other cases, the impetus has instead stemmed from a growing research evidence base which demonstrates that positive father involvement (whether resident or not) can have significant role to play in the long-term development and well-being of their children (Sarkadi et al., 2008).

However, whilst for some this increased policy focus on engaging with fathers has been cause to celebrate, for others it remains nothing more than political rhetoric evidenced by a lack of consistent, coordinated, and meaningful engagement with fathers across many public, private, and voluntary services. But why should fathers be included in public and other services such as maternity, midwifery, and health visiting services?

The case for involving fathers in both universal and targeted services has never been clearer; empirical evidence demonstrates that active, early, and regular engagement by the father can predict a range of positive social, psychological, and behavioural outcomes for the child. For example, research shows that positive influences of father engagement can include better cognitive development, improved mental health, higher educational attainment, reduction in frequency of behavioural problems, better relationships with peers, and less involvement in crime and substance misuse. Moreover, the converse is also true with low levels of involvement being associated with a range of negative outcomes (Flouri, 2005; Lamb, 2004; Lamb and Lewis, 2004; Sarkadi et al., 2008).

In relation to breastfeeding, the notion that fathers can have a significant impact on breastfeeding initiation and continuance is also clearly evidenced in the research literature in this area. For instance, a range of studies demonstrate that the father of the baby is a primary source of support to the breastfeeding mother and can influence and/or contribute to decision-making regarding initiation, continuance, maternal breastfeeding confidence, and weaning (e.g. Piscane et al., 2005). Moreover, intervention studies which train and/or educate fathers explicitly to understand the value of breastfeeding and how to help their breastfeeding partner show positive indications that they are better able to support their partners. In a small randomized controlled trial (RCT) of a two-hour prenatal intervention, breastfeeding initiation among women whose partners had attended the class in comparison with the controls, was significantly higher (74% vs. 41%; Wolfberg et al, 2004). More recently, Maycock and his colleagues' (2013) conducted a much larger RCT to investigate the effects of an antenatal breastfeeding education session and postnatal support targeted to fathers. The authors found that any breastfeeding rate for the intervention group was significantly greater at 6 weeks than the control (81.6% vs 75.2% respectively).

What excludes fathers?

Given the strong policy focus on the need to engage with fathers in mainstream services (and particularly in relation to supporting breastfeeding, maternity services), why has engagement with fathers in relation to supporting breastfeeding mothers remained sparse, short-term, and patchy in terms of both span and quality?

It is likely that there are a number of explanations for a lack of father engagement that conspire to prevent this 'untapped' resource for breastfeeding mothers from being fully

realised. One reason is that a central focus on mothers is understandably deeply embedded within universal services for children and families and therefore tends to be the ‘default position’ for many practitioners and service delivery models (Page et al. 2008, Sherriff, 2007). In maternity services this is unsurprisingly prominent with the mother clearly defined as the ‘patient’ and thus ‘priority’. However, this narrow and automatic focusing does mean that fathers can become excluded and essentially rendered ‘invisible’ in a somewhat routine way rather than through deliberate conscious action. For example in our recent study involving interviews with mothers and fathers on breastfeeding, one father reported his experiences of such routine exclusion (Sherriff et al., 2014):

“When little un was born we had this woman come into the delivery suite to show my wife how to latch on she didn't speak to me at all!”

It is of course also important to recognise that health practitioners who are used to only working with mothers may not be clear about the relevance of working with fathers particularly when resources are limited, or they may be unclear how best to do this (Sherriff, 2007). Indeed, antenatal and midwifery services have tended not to routinely identify and engage with fathers and fathers-to-be during the important initial stages of pregnancy and birth, and where this does occur, it tends to result from individual staff taking the initiative, rather than from plans at the heart of the local service delivery model (Sherriff et al., 2012).

There are also a number of dominant gender and professional-based discourses that relate to fathers (and men) as services users that are likely to impact on service delivery models and how mothers and fathers are perceived by, and engaged with, those services. Three dominant discourses are relevant here including: fathers as a ‘risk vs resource’; men and fathers as being of ‘no-use’, and; the ‘homogeny of fathers’. In terms ‘risk vs resource’, many practitioners struggle to manage their concerns about engaging with fathers because of personal and professional beliefs and fears around domestic violence and the potential impact on women and children. With regards men and fathers as being of ‘no-use’, this discourse has led to ‘deficit’ beliefs with men and fathers perceived as being unable to cope, childlike, difficult to cope with, unable to take responsibility, and lacking either practical or emotional commitment to family life. Finally, in terms of ‘homogeny of fathers’, fathers are seen as a single, uncomplicated, non-diverse entity with mostly the same needs that can somehow be met by simply setting up a ‘fathers group’ and (unrealistically) hoping men will attend.

However, it is important to also note briefly the existence of gender-based discourses where men and fathers *exclude themselves* from universal services. For example, hegemonic masculinity discourses define social understandings of what constitutes ‘ideal’ masculinity or in other words, what it means to be a ‘real’ man or boy. Consequently, such discourses can lead some men and fathers to perceive ‘services for the family’ as being ‘services for women and children’ and thus present a potential threat to their hegemonic status and thus masculinity. Other discourses include ‘feminisation’ discourses where some men and fathers perceive see Children’s Centres, maternity settings, etc. as places for women or ‘female centres’ and thus not for them effectively excluding themselves from service provisions.

Regardless of the specific discourse(s) at play, evidence demonstrates overwhelmingly the positive impact that fathers can make to the long-term health and well-being of the child. Therefore these gender and professional based discourses and beliefs (personal and professional) need to be challenged.

Key Questions:

- How might your organisation or service unintentionally exclude fathers?
- If you are attempting to engage with fathers, what might their needs be in relation to helping them support their family?
- How can you make your service more ‘father-friendly’?
- What changes might be needed? Think about time, place, approach and other practicalities.

How can fathers be engaged?

Engaging meaningfully with fathers in public services including maternity and midwifery provision, requires health practitioners to re-think, de-construct, and re-construct their perceptions and ways of working with men and fathers. However, whilst this is no easy task due partly to the dominance of the gender discourses mentioned previously, it is a task that is essential in order to promote the development of more father-inclusive public services, and better support for breastfeeding women.

One important consideration for practitioners is to think carefully about how they ‘reach’ or access their target group. Practitioners providing services in Children’s Centres (e.g. health visitors, breastfeeding advocates), commonly invite fathers to attend and/or participate in

fathers' groups, a 'dads' breakfast' (fry-up), or five-a-side dads (football) as tactics to entice them to attend. However, this can be problematic on two fronts: first, such activities often fail to recognise the diversity of fatherhood (e.g. teenage fathers, older fathers, lower-socio-economic fathers, disabled fathers, gay fathers) as well as the existence of diverse needs; this means that service delivery models around father engagement are likely to only appeal to a certain demographic of fathers (e.g. those who like football) and in doing so, alienate and exclude others.

Second, this model of inviting fathers 'in from the cold' to events, activities, or groups is arguably a form of recruitment strategy which relies on encouraging fathers into a service. In contrast, with other public services such as maternity services, fathers and fathers-to-be are likely to be already present alongside their partner without the need for specific recruitment tactics. This means that how health practitioners approach father engagement is thus likely to require quite different approaches depending on the particular setting in question. The challenge for maternity and midwifery settings therefore is to consider how health practitioners can respond meaningfully to such a diverse range of fathers from different backgrounds with different needs, who attend with their partner.

The way maternity care is commonly organised in the UK can generate feelings of exclusion and uncertainty for fathers. For instance, in our recent research on supporting breastfeeding (Sherriff et al., in press b), both mothers and fathers raised a range of issues relating to service provision including the negative attitudes and behaviours of practitioners towards fathers, fathers being ignored, provision to fathers being inadequate or conflicting, and delivery models that simply don't 'fit' with working fathers (e.g. appointment times and antenatal classes during the day). Indeed, we have argued previously that health practitioners, particularly those in maternity settings, need to interrogate their own attitudes and beliefs towards fathers to promote the development of more father-inclusive services (e.g. Sherriff and Hall 2011). Recent guidance from a collaboration between the Royal College of Midwives, the Department of Health, the Royal College of Obstetricians and Gynaecologists, and the Fatherhood Institute (*Reaching Out: Involving Fathers in Maternity Care*), provides some useful suggestions regarding 'top tips' for involving fathers in antenatal care, intrapartum care, and postpartum care which may go some way to challenging some of the discourses we have discussed. Similarly, *Engaging Fathers in the Early Years* (Potter and Olley, 2012) also provide various useful suggestions for engaging and working with fathers in various settings including maternity. In our recent study to define the concept of 'father

support’ in relation to breastfeeding, we developed a new model of father support to promote breastfeeding which draws out some key practical implications specifically for health practitioners in engaging fathers to support their breastfeeding partner (Sherriff et al., in press b). In the box below, we draw on these publications to provide concrete ways of engaging with fathers in public services more generally, as well as some specific ideas for engaging with fathers around supporting breastfeeding specifically.

Ideas for engaging fathers

Engaging fathers in public services	Example/explanation
Encourage a cultural shift in thinking to normalise father involvement in public services	<ul style="list-style-type: none"> Recognition that father involvement should be the norm not the exception - and a statutory requirement in many cases.
Develop indicators to monitor father engagement	<ul style="list-style-type: none"> If targeting fathers is truly a meaningful aim, indicators to monitor engagement should be used to identify effectiveness and gaps in provision.
Whole-systems thinking	<ul style="list-style-type: none"> Investigate all aspects of service delivery for ‘parents’ (the whole-system). How are mothers and fathers treated at every level? E.g. When fathers walk in the door are they made welcome, ignored, or even made to feel like a hindrance? How can the system operate better to ensure fathers are not routinely excluded (deliberately or otherwise)?
A gender differentiated approach	<ul style="list-style-type: none"> Adoption of a service delivery model that explicitly considers mothers and fathers as having different needs which need to be addressed differently.
Assess settings for gender bias	<ul style="list-style-type: none"> Many waiting rooms, maternity units, community settings etc. focus on imagery around mothers and children. Ensure positive images of fathers and their children are also visible, as well as information specifically for both mothers <i>and</i> fathers.
Marketing services to fathers specifically	<ul style="list-style-type: none"> Rather than use ‘parent’ which is often a euphemism for ‘mother’, ensure the term ‘mother and father’ is used. Alternatively, if information is of direct relevance for fathers, say so!
Staff training	<ul style="list-style-type: none"> Involving fathers is everyone’s responsibility. Training could include sessions for staff to explore their experiences of working and including fathers, including issues around father diversity, and that fathers needs cannot be met by simply holding a ‘dads group’.
A father’s new role	<ul style="list-style-type: none"> Being a new father is a large transition for men just as new motherhood is for women. Recognition of this and the lack of confidence that may ensue need to be addressed.
Engaging fathers to support breastfeeding	Example/explanation
Knowledge and information	<ul style="list-style-type: none"> Ensure communications and information about breastfeeding support is targeted to fathers. Consider the timings of participative information sessions (e.g. antenatal classes) to be ‘father sensitive’ including avoiding working hours. Assist fathers in ‘learning the support role’ regarding breastfeeding and challenge misconceptions and myths in a supportive environment. Conduct activities to help parents manage their expectations of breastfeeding more realistically, and reduce (father) anxieties in relation to concerns about the mother’s welfare (e.g. nipple pain, mastitis, confidence, guilt, and stress) and the baby’s weight gain.
Practitioner attitudes	<ul style="list-style-type: none"> Recognition of the influence the father can have with regards breastfeeding, and that he can be a valuable ‘untapped’ resource for the mother. Encouragement of father to access support when needed, not perceiving him as a ‘controlling partner’ but one who wants to best support his partner and child.
Decision-making	<ul style="list-style-type: none"> Fathers are an important gatherer of second opinions and filter of information in supporting the decisions ultimately reached by the mother. Involve the father in discussions relevant to both his parenting and supporting role. Fathers worries concerning the welfare of the mother and baby mean they can be instrumental in the decision to move to formula. Practitioners can supportively challenge myths and misconceptions, and recognising the influence of the father in the decision regarding mode of feeding.
Practical support	<ul style="list-style-type: none"> Clarifying (to the father) the scope of his practical role in supporting breastfeeding which can include <i>all</i> other aspects of childcare and domestic tasks including opportunities to bond that <i>do not</i> involve breastfeeding (e.g. bathing, playing, clothing, storytelling, changing, taking for walk, fetching water for the mother).
Emotional support	<ul style="list-style-type: none"> Assist fathers to understand how they can support their breastfeeding partner e.g. ‘being there’ (helping to reduce a mother’s feelings of isolation), offering affection and encouragement, and being an advocate (e.g. to ‘standing up’ to negative interference in public, or liaising with health professionals).

Conclusion

The case for engaging with fathers in universal and targeted services is evident. In terms of breastfeeding, the evidence regarding the positive influence and support of the father in relation to initiation and continuance is well established and growing. In the UK and many other countries, this influence is reflected in a range of governmental policy documents regarding health and the early years. However, although there has been some progress on the ground, it is clear that there is still much to be done in terms of practitioners ‘for the family’ routinely and meaningfully engaging with fathers in public services such as maternity services. Consequently, although we believe that current policy drivers to increase father engagement (including breastfeeding) are currently more rhetoric than reality, they are nevertheless essential. Such policy drivers help to raise awareness of the need to embrace the positive contribution fathers can make to the family and a range of long-term child outcomes.

In this article, we have attempted to raise awareness of the fact that fathers remain a valuable yet mostly ‘untapped’ resource for breastfeeding mothers, as well as for health professionals (and lay people) whom may be supporting breastfeeding in both clinical and community settings. We hope that in exploring *why* fathers should be included in public services, *what* excludes fathers from these services, and *how* fathers can be included more meaningfully, that we have gone some way in helping health professionals to turn political rhetoric into a reality.

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