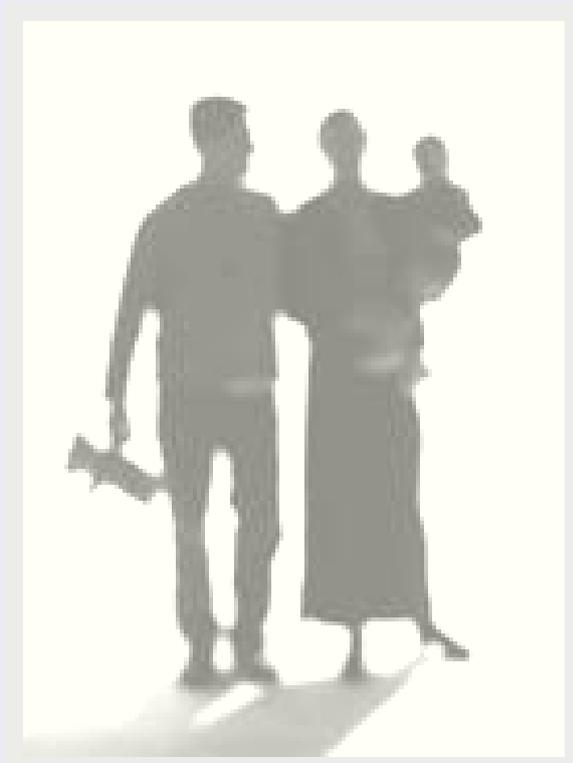




Whitehorse Community
Health Service

Baby Makes 3

promoting safety and wellbeing
among new families



Final Report - Phase 1

Baby Makes 3



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Report prepared by David Flynn

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PART I - BACKGROUND

1. Introduction

As the name suggests, *Baby Makes 3*, is concerned with that stage of life when the arrival of a new born baby signals the end of a 'couple' and the beginning of a family.

For most couples, the birth of their first child is a major turning point. It is a time of major lifestyle changes when many practical adjustments need to be made. A time of major relationship changes, as couples increasingly focus their attention and energy on their baby.

It is a time when couples expect to grow closer together, yet a significant number find it moves them further apart. It is a time that families often expect to be filled with great happiness and joy, but unfortunately, it is also a time when male family violence can escalate.

Baby Makes 3 is a family violence prevention project targeting first time fathers that seeks to promote safety and wellbeing among new families. Funded by the *Victorian Health Promotion Foundation*, it is a project that aims to identify the means by which first time fathers can be supported in acting respectfully, responsibly and in non-violent ways through the various phases of starting a family, and ultimately, to develop and implement these strategies.

Baby Makes 3 is a collaborative project, building on existing partnerships between health and family violence services in the eastern metropolitan region of Melbourne. Together, the organisations possess considerable experience in providing targeted health promotion and early intervention services to new families.

The partnership includes:

- Whitehorse Community Health Service
- City of Whitehorse, Maternal and Child Health Service
- Birralee Maternity Service, Box Hill Hospital (Eastern Health)
- Eastern Domestic Violence Service

This paper reports on phase one of the *Baby Makes 3* project:

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- *Part I* outlines the partnership's shared understanding of family violence and explores the theoretical basis underlying approaches to family violence prevention targeting first time fathers.
- *Part II* reports on the activities undertaken during phase one of the project – a family violence awareness workshop for health professionals, and research with first time fathers.
- *Part III* discusses the research findings and identifies a number of recommendations for improving service delivery from a family violence prevention, and health promotion perspective.
- *Part IV* provides a summary of those recommendations and develops a proposal for phase two of the project – the implementation of strategies to promote equal and respectful relationships among first time families.

2. Nature and Scale of Family Violence

Baby Makes 3 is a collaborative project between partner organisations involved in antenatal and postnatal family services, and family violence services. The effectiveness of a family violence prevention project of this kind requires a shared understanding of family violence and a willingness to acknowledge family violence as a widespread and serious problem.

A thorough discussion of these issues is beyond the scope of this paper, however, the following chapter is designed to present the shared understanding that partner organisation possess about the nature and scale of family violence as it relates to the current project.

Definitions of family violence

One of the difficulties in discussions about family violence is that people have very different understandings of the meanings of different terms. The term 'domestic violence' is widely used within the community, but some people associate this term with the expression 'it was just a domestic (dispute)', and the way this is used to deny, minimise and justify a lack of response to violence.

The term 'violence against women' is another useful term as this emphasises the fact that it is predominantly men who are the perpetrators of violence. In addition, 'intimate partner violence' is useful to highlight the particular types of violence against women which occur within an intimate relationship.

For the purposes of this paper, the term 'family violence' has been preferred because it serves as a broader term that includes the effects of male violence on women, children and babies. However, it is used without any intention to limit the discussion or exclude any particular behaviour. In this paper, family violence is defined as:

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'...violent male behaviour that is repeated, controlling, threatening and coercive, and that occurs between men and women (and their children) who have had, or are having an intimate relationship.'

The term 'violence' should not be understood as limited to physical behaviours. 'Violence' is used to cover all behaviour people would regard as either violent or abusive, or violating the right of another person to safety and wellbeing.

Types of family violence

Family violence can assume a number of forms (NTV, 2007):

- Emotional violence:* Involves behaviour which does not accord equal importance and respect to another person's feelings and experiences. It is often the most difficult to pinpoint or identify. It can also be seen to underlie all of the other forms of violent and controlling behaviour. It includes the refusal to listen to or denial of another's feelings, telling people what they do or do not feel and ridicule or shaming another person's feelings. It also includes making the other responsible for one's own feelings, blaming or punishing them for how one feels, and manipulation by appealing to their feelings such as guilt, shame and worthlessness.
- Physical violence:* Involves attacks, or threats of attack, on one's physical safety and integrity. These range from hitting, kicking, punching and assault with weapons, through to murder. It can involve harming or threatening to harm children, relatives, pets or possessions.
- Verbal violence:* Includes verbal putdowns, yelling, swearing and ridicule of any aspect of a woman's being, such as her body, her beliefs, occupation, cultural background, skills, friends or family.
- Sexual violence:* Includes all sexual behaviour without consent (or threats of such behaviour), such as unwanted touching, rape, and making a partner view pornography. It also includes a man expecting a woman to have sex as a form of reconciliation after he has just beaten her; in these circumstances she is unable to withhold consent for fear of further violence.
- Social violence:* Includes all behaviour which limits, controls or interferes with a woman's social activities or relationships with others, such as controlling her movements and denying her access to her family and friends.

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Financial violence: Includes not giving a woman access to her share of the shared resources, or expecting her to manage the household on an impossibly low amount of money.

Spiritual violence: Includes all behaviour which denigrates a woman's religious or spiritual beliefs and preventing her from attending religious gatherings or practising her faith.

Prevalence of family violence

The prevalence of family violence is notoriously difficult to determine (VicHealth, 2004). Compared with victims of other forms of violence, women affected are less likely to disclose incidents of violence, report it to police, seek support, or even name the act as violence (Mulroney, 2003). The Women's Safety Survey (ABS, 1996) – widely regarded as providing the most reliable source of information – found that 1 in 5 women are subjected to *physical* violence in their adult lives. In addition 42% of these women were pregnant at the time of the violence (VicHealth, 2004). These statistics should be understood as reflecting *minimum* levels of violence.

Effects of family violence on women

The effects of family violence on women's physical and mental health are wide-ranging and persistent. The range of health problems experienced by women are indicated in *table 1*.

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Table 1: Summary of known health outcomes of intimate partner violence (VicHealth, 2004)

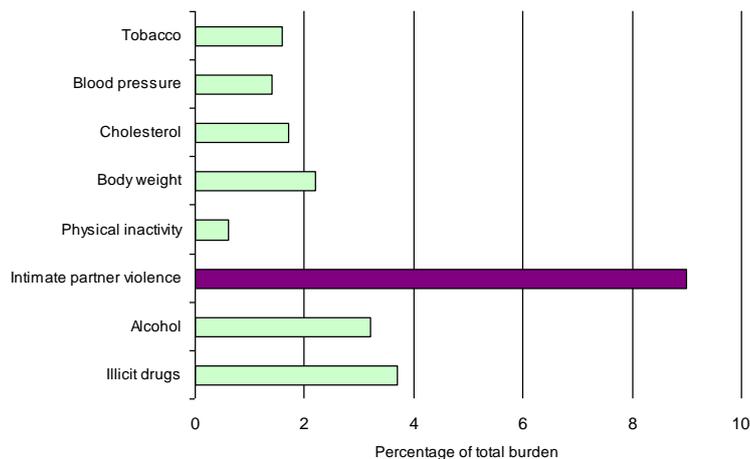
<i>Fatal impacts</i>	
	<ul style="list-style-type: none"> • Femicide • Suicide • Life-threatening sexually transmitted infections (eg HIV) • Death of mother or infant during or following childbirth
<i>Non-fatal impacts</i>	
Physical injuries	<ul style="list-style-type: none"> • Bruising • Lacerations or tears • Fractures
Reproductive health	<ul style="list-style-type: none"> • Sexually transmitted diseases • Urinary tract infections • Human papilloma (wart) virus • Abnormal Pap tests • Termination of pregnancy • Complications of pregnancy (eg inadequate weight gain, infections during pregnancy, miscarriage, haemorrhage, low birth weight)
Mental health	<ul style="list-style-type: none"> • Attempted suicide • Self-harming behaviours • Depression • Anxiety • Eating disorders • Traumatic and post-traumatic stress symptoms • Other psychiatric disorders such as phobias and dissociative and somatisation disorder (involving the physical expression of psychological symptoms)
Behaviours and practices affecting health	<ul style="list-style-type: none"> • Harmful tobacco and alcohol use • Illicit and licit drug use (eg tranquillisers and sleeping pills)
Other	<ul style="list-style-type: none"> • Chronic pain disorders (eg headaches, neck pain) • Gastrointestinal and digestive disorders • Sleep problems

A recent study of the health costs of violence was undertaken by VicHealth (2004). The study found that family violence is the leading contributor to death, disability and illness in Victorian women aged 15-44, being responsible for more of the disease burden than many well-known risk factors such as high blood pressure, smoking and obesity (see *figure 1*). An important point, however, is that this study only referred to the effects of physical and sexual violence. The inclusion of the non-physical forms of violence would mean that the health costs are far greater.

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Figure 1: The top eight risk factors contributing to the disease burden in Victorian women aged 15-44 years (VicHealth, 2004)



Effects of family violence on babies

Many women are subject to domestic violence while they are pregnant and this can result in numerous impacts on the unborn child, including poor fetal growth and effects on brain development (Quinlivan, 2000). Some adverse outcomes of pregnancy and labour such as miscarriage, low birth weight, still birth and the birth of a disabled child may also be attributable to traumatic experiences of family violence (DOCS, 2002).

During infancy, babies can be directly involved in family violence. Even when they are apparently lying passively in their cots, infants are extremely sensitive to their surroundings and especially to the emotional signals given out by their caregivers, including the caregiver's depressed, anxious, fearful or angry mood (DOCS, 2002).

Exposure to family violence can severely impact on a baby's developing brain. At birth, a baby's brain is 25% of its adult weight, increasing to 66% by the end of the first year – the developing brain is most vulnerable to the impact of traumatic experiences during this time (DOCS, 2002). New research on brain development suggests that exposure to trauma will change the organisation of the brain, resulting in difficulties dealing with stresses later in life (NSCDC, 2005).

The other major impact of family violence on babies is the significant disruption in their attachment to their primary caregiver. The importance of secure attachment

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in positive developmental outcomes has been well established and negative consequences have often been found where infant-parent attachments have been classified as insecure (DOCS, 2002). Research on attachment in infancy has shown that the more serious the level of partner violence, the higher the likelihood of insecure (specifically, disorganised) attachment (DOCS, 2002). Therefore, babies are more likely to be deprived of quality parenting where family violence is present.

3. A Framework for Family Violence Prevention

Family violence is both prevalent and serious, but at the same time, it is wholly preventable. Yet there is a critical lack of evidence with regard to 'what works' in preventing family violence.

Prevention strategies targeting men have largely centred on raising awareness of the impact of family violence and its criminal nature, with the aim of changing male attitudes to violence against women. Whilst this is a worthwhile approach, the *Baby Makes 3* project has sought to move beyond the limitations of simple awareness raising by targeting the additional and underlying causal factors associated with family violence.

Explanations of family violence

Whilst it is debateable to speak of a 'cause' of family violence – there is nothing that can 'cause' a man to choose violence – identifying the causal factors is essential for prevention. It is only when these causal factors are known and understood, that successful primary prevention strategies can be formulated.

It is important, then, to have a working knowledge of the two main approaches to explaining family violence, through the understandings offered by socialisation and role theories, and through a feminist analysis of gendered power relations.

Socialisation and role theory

Socialisation and role theory are concerned with the processes by which individuals acquire attitudes, beliefs and values through a lifetime of social interactions. In theory, violent behaviours are learned through observation of role models in the family, peer group and community.

Socialisation is particularly relevant to notions of masculinity and the shaping of attitudes and values that men associate with 'being a man'. From an early age, males are socialised into a particular form of masculinity. They are recruited into a masculine life by role models from all areas of life including childhood toys, myths

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and stories about male 'heroes', male characters in film and television, sports stars and importantly, their own fathers (McGregor, 2003).

Society presents men with many different forms of masculinity. However, there is one form that is considered dominant or superior to others (Connell & Messerschmidt, 2005). This dominant form of masculinity has well defined characteristics that include success, power, status, strength and aggressiveness. Yet, it can also be defined by what it is *not* – anything that even remotely hints of femininity is portrayed as a weakness, and strictly prohibited.

Constructions of masculinity play a crucial role in men's violence. The pervasive influence of the dominant form of masculinity can result in men feeling that they need to 'prove' their masculinity, lest they be perceived as weak or feminine. Too often, this results in a constant competition between self and others, an inability to maintain relationships based on equality, a need to demonstrate various forms of power and control, and importantly, the use of violence and abuse as a means of maintaining power and control.

Dominant constructions of masculinity, then, predispose men towards violence, and in turn, violence becomes a means by which men construct their masculinity (Pease, 2004). There is, therefore, no choice but to address men and masculinities if we want to stop violence against women.

However, as a theory of causation, socialisation and role theory, whilst helping to explain certain male attitudes and beliefs, ultimately provides an inadequate model for explaining actual male behaviours. Certainly, it can explain the greater acceptance of violence among men (by linking violent behaviours with the dominant form of masculinity); however, it portrays men as passive victims of their upbringing and ignores the fact that individual men make a *choice* to be violent (Pease, 2004). After all, men are socialised into a diverse society and presented with multiple and varied role models. As such, theories of socialisation and gender roles are limited in explaining why men choose a particular behaviour in a particular circumstance. For a more comprehensive explanation of violence against women we need to examine the issue of gendered power.

Gendered power relations

An important contribution to explaining male violence against women comes from feminist theories of gendered power relations. A feminist analysis recognises family violence as a direct result of the underlying inequality of men and women, characterised by male dominance and female subordination (Connell, 2003).

There is a long history of male dominance and the subordination of women, and despite the fact that today's society operates much more on the principles of 'gender equality', this equality remains more in principle, than in actuality. Throughout most of history, in comparison to women, men have had a very privileged existence, and as a group, men continue to inherit a culture of male privilege.

Male privilege is an important contributing factor in the socialisation process for most men. It is closely aligned with what we refer to as 'traditional' gender roles, the attitudes and beliefs that position men as the 'head of the household' with a

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moral 'right' to discipline and control family members (Howard, 2003). Male privilege establishes expectations that men as a group will always have more power than women and this creates a sense of *entitlement* among some men – a belief that men are 'entitled' to be more powerful. This is particularly true for men whose attitudes and beliefs support traditional gender roles.

The relationship between traditional gender roles and violence against women is well established. Traditional notions of gender role have consistently been associated with greater acceptance of violence (Flood & Pease, 2006). The strongest and most consistent predictors of holding violence supportive attitudes are being male, and having weak support for gender equality (VicHealth, 2006). Traditional gender roles form the structural bedrock from which men develop a sense of their own entitlement in relation to female partners (James, Seddon & Brown, 2002).

However, gendered power relations are more than significant socialising factors shaping men's attitudes to gender roles. The existence of gender inequalities can also explain the *choice* that men make to use violent behaviours against women (Pease, 2004). Male violence – both physical and non-physical – should be understood, then, as the means by which men exercise power and control, out of a sense of entitlement, as a means of maintaining the privileges associated with gender inequality.

Themes for action

Although the causes of family violence are complex, there is emerging consensus that the significant causal factor in relation to family violence is the unequal distribution of power and resources among men and women (VicHealth, 2006). Undoubtedly, factors in our social and cultural environment – notions of masculinity, traditional gender roles and gendered power imbalances – play a significant part in this inequality. Addressing these factors, therefore, can help to prevent the occurrence and consequences of intimate partner violence.

To date, most of the family violence prevention strategies targeting men have sought merely to counter violence supportive attitudes (Keleher & Armstrong, 2005). The problem with this limited approach, however, is that attitude change does not guarantee behaviour change (Flood, 2005). For prevention strategies to be effective, they must meet the challenge of producing lasting changes in attitudes, values *and* behaviours associated with violence against women (Flood, 2006).

In developing the framework to guide primary prevention of violence against women, the Victorian Health Promotion Foundation (VicHealth, 2007) has identified the underlying determinants of violence against women, identifying three broad themes for action:

- Promoting equal and respectful relationships between men and women
- Promoting non-violent social norms and reducing the effects of prior exposure to violence
- Improving access to resources and systems of support

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The *Baby Makes 3* project sits primarily within the first of these themes, however some project activities are located within the other themes as indicated below:

Promoting equal and respectful relations

This theme for action is concerned with the way gender roles, identities and relationships are constructed and defined within society, and with the distribution of power and material resources between men and women.

Prevention strategies, then, must focus on the principles of gender equality and social justice, and must challenge the patriarchal power relations that sustain violence (Flood, 2006). Men must be encouraged to develop respectful, trusting and egalitarian relationships with women, and promote positive, non-oppressive constructions of gender and selfhood (Flood, 2005).

This is the main aim of the *Baby Makes 3* project, which seeks to address this theme for action by providing education about gender and gender equality, and translating this into positive ways in which men can relate to the women in their lives. By targeting first time fathers, the project undertakes this task at a time when gender roles and gender equity are directly relevant and meaningful to men and the changes they are experiencing.

Promoting non-violent social norms

This theme for action concerns the relationship between violence against women, and the broader social norms and cultural support for violence in general, and violence against women in particular. Prevention strategies must confront the beliefs, values and discourses that support violence (Flood, 2006).

For *Baby Makes 3*, the notion of a 'culture of masculinity' is relevant. The task is to challenge the dominant discourses about fatherhood and masculinity, to redefine masculinity and develop alternate masculinities that promote new understandings of the attitudes, values and beliefs associated with male behaviour (McGregor, 2003; Pease, 2004).

Improving access to resources and support

This theme for action relates to the social and material resources available to individuals, communities and organisations.

The relevance for *Baby Makes 3* is that prevention strategies should be complemented by the attitudes and approaches of service providers and professionals. The development of a shared understanding of the nature of family violence is paramount. Furthermore, professionals must possess a critical understanding of the social determinants of family violence and how these can be effectively addressed.

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Intermediate outcomes

In connection to the framework to guide primary prevention of violence against women (VicHealth, 2007), there are a number of intermediate outcomes that can be expected from the *Baby Makes 3* project. These include:

At an individual/relationship level

1. Improved connections to resources and support
2. Respectful and equitable gender relations
3. Improved attitudes toward gender equity, gender roles and violence against women
4. Improved skills in non-violent means of resolving interpersonal conflict

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At the organisational level

1. Modelling, promotion and facilitation of equal, respectful and non-violent gender relations
2. Establishing partnerships across sectors to address violence

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Long-term benefits

The *Baby Makes 3* project also contributes to a number of long term benefits. These include:

At an individual/relationship level

- Reduction in violence-related mental health problems
- Improved interpersonal skills and family relations
- Reduced intergenerational transmission of violence and its impacts

At the organisational level

- Violence prevention resources and activities integrated across settings
- Valuing and promotion of respectful gender relations
- Improved access to resources and systems of support

At the community level

- Communities that value gender equity and respectful relationships between men and women

At the society level

- Reduced gender inequality
- Improved quality of life for men and women
- Reduced levels of violence



PART II - PROJECT ACTIVITIES

4. Objectives

The goal of *Baby Makes 3* is stated as:

To identify the means by which partner organisations can support first time fathers in acting respectfully, responsibly and in non-violent ways through the various phases of starting a family.

Project objectives

Four objectives were developed in order to achieve the project goal. These are:

Objective 1: By the end of the project, key workers in the partner organisations (including midwives, maternal child health nurses and community health workers) will possess a shared understanding of the nature and scale of family violence as it relates to first time parents.

Objective 2: By the end of the project, a comprehensive and critical assessment of the way current services engage first time fathers around the issues of respect, responsibility and equality will be completed.

Objective 3: By the end of the project, partner organisations will have developed a capacity building plan to equip them to respond on a sustainable basis to the needs of first time fathers.

Objective 4: By the end of the project, potential strategies to assist first time fathers in relating to their partners with respect, responsibility and equality will be identified.

Project strategies

A number of strategies were implemented to ensure the project objectives were achieved.

- A family violence awareness workshop was conducted for workers in the partner organisations. Topics included the different types of family violence, the prevalence and effects of family violence on women and babies, and understanding family violence in terms of gender roles and relations, particularly as it relates to new families.

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- A review of current services was conducted by means of interviews with service providers, and the completion of questionnaires by new fathers in relation to antenatal and postnatal services.
- Literature reviews were conducted in relation to the theory underlying family violence prevention work with men, the challenges of working with men in family violence prevention and the previous and current programs targeting first time fathers.
- Interviews were conducted to research the needs of first time fathers in relation to gender roles and gender relations during the transition to parenthood. Approximately half of the fathers interviewed for the project were men who had previously attended, or were currently attending a men's behaviour change program.

5. Family Violence Awareness Workshop

The Family Violence Awareness Workshop was conducted on Friday the 16th of November. The workshop was designed as a means of building a shared understanding of family violence among the partner agencies.

Workshop participants

Participants included:

- 21 Maternal and Child Health Nurses from the City of Whitehorse
- 6 Midwives from Birralee Maternity Service, Box Hill Hospital
- 7 Child and Family Workers from Whitehorse Community Health Service.

Workshop objectives

To enable participants to:

- Identify the different types of family violence
- Understand the prevalence of family violence
- Understand the effects of violence on women, babies and young children
- Understand the social determinants of family violence
- Feel confident in addressing family violence with female clients

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- Understand the transition to parenthood in relation to family violence

Workshop content

The workshop utilised a combination of small and large group discussions, whiteboard presentations, videos and role-plays to cover the following topics:

- Defining family violence
- Understanding the various types of violence – especially the non-physical forms of violence
- Effects of violence on women and children
- Debunking myths associated with family violence – beliefs about family violence, beliefs about relationships, beliefs about power and control
- Attitudes to speaking about family violence with clients
- Skill development – the ways professionals can ask their client's about family violence and how to respond to a disclosure
- Where to refer clients for further assistance

Workshop evaluation

The workshop was evaluated using pre and post questionnaires (see *appendix A*). Of the 34 participants at the workshop, 32 completed questionnaires were received (the evaluation results are presented in *appendix B*). The questionnaires assessed the change in participant's understanding of the following four areas:

1. Knowledge of family violence

By the end of the workshop, participants indicated that family violence was more common and more serious than they had previously thought and indicated a significant improvement in their understanding of the different types of violence (questions 1, 2 & 4). Participants were also more likely to acknowledge the gendered nature of family violence, although some participants maintained agreement with the statement that "family violence is committed equally by men and women" (question 3). This is an issue that should be further addressed at a later stage.

2. Causes of family violence

By the end of the workshop, participants were less likely to see family violence as resulting from a temporary 'loss of control', or as a result of being 'provoked' (questions 5 & 8). Family violence was less likely to be understood as resulting

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from poor communication between parties, although some participants maintained their position that a woman's experience of violence was related to her inability to communicate effectively (question 9).

3. Effects of family violence

Participants indicated increased awareness of the impact that experiencing family violence has on women, babies and young children (questions 11 & 12).

4. Responding to family violence

Participants indicated they felt more confident to ask clients about their experience of family violence, to respond appropriately to any disclosure, and to refer clients to any appropriate service (questions 13, 14 & 15).

In summary, the evaluation strongly indicated that the workshop had achieved its objectives. It was noted, however, that sustained change would be more likely if additional, follow-up workshops could be provided, as a means of reinforcing the understandings generated in this workshop.

One possibility for future workshops would be to focus on the knowledge and skills required for professionals to engage with male clients around the issue of family violence. Potential topics could include engaging with men in ways that do not collude with their potential use of violence, encouraging men to take responsibility for their behaviours, and the need to maintaining a focus on the safety of women and children.

6. Research with First Time Fathers

There were two research activities undertaken for *Baby Makes 3*. The first involved a survey of first time fathers attending Birralee Maternity Service's childbirth education program and the second involved in-depth qualitative interviews with first time fathers attending the Maternal and Child Health Service and Whitehorse Community Health Service. An overview of the results for these research activities are presented in this chapter.

New fathers questionnaires

Questionnaires were completed by 35 first time fathers at the completion of childbirth education classes at Birralee Maternity Service during the period September to November, 2007. 30 of those men were again surveyed during the subsequent reunion class, held in the initial weeks following the birth.

The questionnaires aimed to generate data on new fathers' experiences of childbirth education classes. The men were asked how well childbirth education prepared them for:

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- the birth of their baby
- the lifestyle and relationship changes that follow the birth
- becoming a father

In addition, the men were asked if they would prefer:

- more opportunity for males to discuss issues related to becoming a father
- a male facilitator to work in collaboration with the midwives

The questionnaire is presented in *appendix C*, and the results presented in *appendix D*. The differences between the antenatal and postnatal surveys were not dramatic, but nonetheless, there was an observable divergence between the two data sets. An outline of the results is presented below.

Confidence about the impending birth

All men surveyed either agreed or strongly agreed that childbirth education helped them to feel more confident about the impending birth of their baby. There was no difference between the antenatal and postnatal questionnaires in relation to this question.

Preparation for lifestyle changes

Whilst the antenatal survey indicated that men largely agreed that antenatal classes had prepared them well for the lifestyle changes they could expect following the birth, the postnatal survey indicated that men were less likely to agree that they were well prepared.

Preparation for relationship changes

The degree of preparation for any relationship changes was an additional question asked during the postnatal survey. At this time, almost half of the men surveyed did not agree that antenatal classes had prepared them for the relationship changes that would most likely occur as a result of the birth.

Preparation for their role as a first time father

Whilst the antenatal survey indicated that men mostly agreed that antenatal classes had prepared them well for becoming a father, during the postnatal survey men were less likely to agree that they were well prepared for being a first time father.

Inclusion of more male-specific content

The antenatal survey indicated that most men either agreed or were neutral as to whether having more father-oriented discussion would be beneficial. In the postnatal survey however, there was a clearer indication that more male-specific content would be valuable.

Presence of a male facilitator

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Most men during the antenatal survey did not agree that having a male facilitator would be beneficial, yet during the postnatal survey, there had been a clear shift towards greater preference for a male facilitator.

The small sample size does not allow for any concrete conclusions to be drawn from the questionnaires, however, the survey of first time fathers did indicate that whilst men felt that antenatal classes prepared them well for childbirth, they felt less prepared for the relationship and lifestyle changes that followed the birth. They also recognised that greater focus on preparation for fatherhood during the antenatal stage would have been beneficial.

It should also be noted that the postnatal survey was conducted quite soon after the birth, during the time when men are still adjusting to their new role. Had the surveys been conducted some months after the birth, it is possible that the results from the antenatal and postnatal questionnaires would have revealed an even greater divergence. This was one of the topics covered during the in-depth interviews with first time fathers.

Interviews with first time fathers

Interviews were conducted with first time fathers to examine the relationship between men and women during the transition to parenthood. The interview format (see *appendix E*) was designed to generate data on:

- Relationship changes during the transition to parenthood
- The influence of gender roles during early parenthood
- Perceptions of gender inequalities in new families
- Experiences of current services and how service delivery could be improved to meet the needs of first time fathers

Fifteen first time fathers were recruited to participate in one-hour, tape recorded, interviews. Seven of these men were recruited from Maternal and Child Health 'fathers nights'. The other eight men were recruited from the 'Men Making Change Program' – a men's behaviour change program at Whitehorse Community Health Service. The rationale for balancing the participants in this way was to ensure a mix of those fathers who were actively engaged in parenthood alongside fathers who would be able to speak about their use of violence.

Key themes from the research

Relationship and lifestyle changes

All men in the research group were able to identify a number of often unforeseen relationship and lifestyle changes that occurred during their transition to fatherhood. These most often included an absence of free time, greater demands on their time and energy, less time available to spend together as a couple, and increased stress or financial pressure.

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Some men clearly adapt well to the changes that occur during the transition to fatherhood, reporting improvements to their relationship with their partner following the birth of a child. In the words of one father:

"It brought us closer together... we had a common focus on the baby"

Interview #1

These men see their new role as a father as providing them with an opportunity to improve their relationships with their family. As one father remarked:

"You get out what you put in... it's important to form a bond (with your child) and build a relationship"

Interview #3

Yet some men express difficulty in adapting to the lifestyle changes that fatherhood undoubtedly brings. These men speak of *'the constant demands on your time and energy'* and the *'financial pressure'* that comes with the birth of a baby, and their difficulty in dealing with these changes.

A key issue during this time is that men experience difficulty in occupying the dual roles of 'provider' and 'carer'. Both of these roles loom large in the lives of first time fathers and some men indicate a real difficulty in balancing what they invariably perceive as 'competing' tasks. This is illustrated by one father who described:

"There was an expectation I would be more involved (with caring for my child) but (my partner) has stopped work and there is more pressure on me to be the breadwinner"

Interview #4

And most commonly it seems the 'provider' role, whether by economic necessity or social expectation, takes precedence over the role of 'carer'. One father simply explained:

"I would like to be more involved but I have work commitments"

Interview #10

It should also be noted however that some men, when faced with these dual roles, make an active choice to pursue the 'provider' role as a means of avoiding family responsibilities. As this former participant in a men's behaviour change program noted

"I was spending more time at work so I could avoid the stress at home. I wasn't coping well... avoiding responsibility... and it wasn't fair on (my partner)"

Interview #6

For the men who experience difficulty in adapting to the lifestyle changes following the birth of a child, adverse relationship changes inevitably follow. These relationship changes were described by a number of men as *'increasing tension'* in their relationship, or as *'less time together and more fighting'*. For one participant these changes culminated in separation, three months after the birth – a fact that indicates the significance of this life-cycle stage in terms of promoting safety and wellbeing.

Preparation for fatherhood

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The difficulty that men report in adjusting to lifestyle and relationship changes needs to be understood in the context of how men are prepared for fatherhood. Universally, participants in the research reported they felt unprepared for the lifestyle and relationship changes that occurred when they became a father.

Quite simply, men do not talk to other men about the significance of the changes that occur at this time. Indeed, in the months leading up to the birth of their baby, only one member of the research group had engaged in conversation with another man about becoming a father, reporting that this conversation was merely at a superficial level. A further two men within the research group reported reading books about fatherhood but on looking back, saw these books as focussed on the relationship between fathers and babies, rather than on lifestyle and relationship changes.

In contrast, 14 of the 15 men interviewed during this project had attended childbirth education classes. This highlights the significance of childbirth education as the major source of information for men about the transition to fatherhood. Unfortunately, reports indicate that these antenatal classes are failing to meet the needs of fathers.

The men interviewed for this project found that attending antenatal classes did little to prepare them for the transition to fatherhood. This was clearly stated by a number of men and summarised by this man who stated, in relation to his experience of antenatal classes:

"It wasn't really helpful... it was mostly focussed on the birth"

Interview #11

The research participants clearly stated that antenatal classes failed to prepare them for relationship and lifestyle changes. In the words of one man:

"I was prepared for the birth but not the relationship"

Interview #6

Or according to another:

"I wasn't prepared for how much they (babies) restrict your movement, ... restrict your freedom"

Interview #13

Many men pointed to the lack of male-specific content, or discussion of the male experience. In the words of two fathers:

"Antenatal classes were a good experience – I learnt a lot, but not much about fathers"

Interview #10

and

"It (antenatal class) just focussed on being a good support for (my partner)"

Interview #14

Yet despite the perceived lack of preparation for fatherhood, many of the men pointed out that it would have been virtually impossible to be fully prepared. As one man pointed out:

"The changes are so big and so sudden... nothing could prepare you for that"

Interview #12

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There was also the recognition that during this period, the couple is so focussed on the birth of the baby they simply are not ready to assimilate the information that is presented about the lifestyle and relationship changes they could expect after the birth. One man explained:

"It probably wouldn't sink in anyway... you're too worried about the birth... It's not until it hits you that you understand"

Interview #14

It should also be noted that, universally, the men interviewed for this research reported that there was no mention or discussion of family violence during childbirth education classes. This is despite the fact that other risk factors (alcohol, smoking, etc...) were discussed. The men – perhaps not surprisingly - also indicated that this was not a topic that they would have expected to be included within the childbirth education curriculum.

Gender roles

One of the key themes to emerge from this research was the presence of traditional attitudes towards gender roles in new families. This is despite the dramatic changes that have occurred in society in relation to this issue over the past generation. The *Baby Makes 3* research, at least, indicates that traditional gender roles continue to maintain a powerful influence over the contemporary family.

Attitudes supporting traditional gender roles are common among first time fathers. As indicated by this man who clearly states:

"Your main role is to help the mother... to be the breadwinner"

Interview #4

In some cases, the suggestion that men should be moving away from their traditional role as a 'provider' was actively resisted, as described by this father:

"I thought the woman should do everything. I resented the fact I had to do more"

Interview #6

Even among those men who described themselves as actively involved fathers, the influence of traditional gender roles was clearly evident. This point is illustrated in the following quotes, both from self-described 'involved fathers':

"There is an expectation I will be more involved (with caring for my child)... I want to be more involved... I just try and give (my partner) as much support as I can"

Interview #1

and

"(My partner) does most of the work, but that's because I'm at work most of the time... But after work, and weekends, I try to support her and help out as much as possible"

Interview #10

Despite seeing themselves as having stepped outside the confines of traditional gender roles, these men maintain attitudes to parenting that still bear the

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hallmarks of the traditional model – seeing their own role as offering ‘support’ and ‘helping out’, with ultimate responsibility for childcare resting with the mother.

Of course men are not the only parties responsible for maintaining traditional attitudes to gender roles. The portrayal of men as ‘support persons’ in antenatal education (above) and the postnatal focus on ‘maternal and child health’ also can be seen as reinforcing the traditional model of family.

Indeed, gender roles are also maintained by mothers’ attitudes, with ‘maternal gatekeeping’ being a key factor in preventing fathers from being more actively involved with their babies. As one first time father indicated:

“I wanted to do more but (my partner) wouldn’t allow me”

Interview #5

In addition, there are cultural attitudes that also maintain the dominance of traditional gender roles. As one participant stated in relation to his Asian heritage:

“Males are not involved with babies. Culturally, there is no expectation I should be involved”

Interview #7

Finally, it should also be noted that men are likely to be resistant to moving away from traditional gender roles, simply because to do so, requires them to contribute more time and energy to non-traditional and low-status tasks such as housework and childcare. This attitude to gender roles was encapsulated in the following quote from a first time father who, when asked whether he was the type of dad who changes nappies, replied:

“I did change nappies when (my partner) was in the hospital (after the birth), but I stopped when she came home... It’s like this: when I had to do it, I did it, but now I don’t have to do it, I don’t”

Interview #12

For this man, and most likely many others, traditional gender roles grant the permission to behave in ways that are simply easier for them, although perhaps not in the best interests of their families.

Gender inequality

Another key theme to emerge from the research was the general lack of awareness of the concept of gender equality and how it might relate to new families.

Most often, for the men in the research group, equality was understood purely in financial terms. When asked ‘how has having a baby changed the level of equality in your relationship?’ a typical answer was:

“I guess the level of equality changed in some ways... mainly because we lacked a second income... we needed to balance the finances”

Interview #1

Or,

“Before the birth we had our own finances but there’s only one income now... we lost that second income”

Interview #14

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Only in three cases did the men interviewed, identify housework or caring as an area of inequality. One man was able to clearly state that following the birth:

"It's probably less equal because she does more now"

Interview #10

In another interview, however, the inequality was seen differently. The following man lamented the fact that the birth of his baby had resulted in him having to contribute more to the housekeeping. When asked if he had 'made any changes to the way he did things to foster greater equality?' he replied:

"I was having to do more... allowing (my partner) to look after her own health – but that was not fair on me!"

Interview #4

Clearly, maintaining equality was a challenge for this man.

In some cases, however, the challenge to maintain equality was adopted more by women than by men. In a number of interviews, men talked about their partner feeling they needed to do more to compensate for no longer having an income. This is evident in the following quote:

"Now that I am back at work she needs to feel like she's contributing more... she does more cooking (than before the birth)"

Interview #12

This quote also illustrates how men's understandings of the level of equality in their relationship are clouded by their attitudes to gender roles. Men are less likely to identify inequalities that are hidden within traditional gender roles. Housework, for example, is not seen as an area of inequality because traditional gender roles promote a lack of responsibility for housework among men. This is revealed by the number of research participants who understood their contribution to housework in terms of 'helping out'.

For example:

"(having a baby) doesn't really change (the level of) equality – if anything (my partner) has to do more... I do the housework when I get home from work and 'help out' as much as I can"

Interview #2

Or:

"I try to 'help out' as much as I can"

Interview #1

The implication is that ultimately, responsibility for housework rests with the female partner, and even when that female partner is performing more of the housework tasks, this situation is not identified as a form of inequality.

There were also some men in the research group who not only failed to recognise unequal responsibility for housework as a form of inequality, but also failed to make any attempt to 'help out'.

For example:

"I am expected to do more housework but mostly I don't"

Interview #6

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Or:

"It's a bit of a sticking point – I just refuse to clean up! I'm at work all day, it's part of her job"

Interview #13

It should also be noted that, whilst many of the men interviewed for the project were unable to articulate exactly how having a baby had changed the degree of equality in their relationship with their partner, most of the men (9 of 15) agreed that their relationship was more equal prior to the birth of their baby.

Presence of violent behaviours

The identification of disputes over housework as a 'sticking point' (in the above quote) also illustrates what was another key theme to emerge from the research – the presence, throughout the research group, of what should be described, to various degrees, as violent behaviours. When this particular man was asked what he meant by a 'sticking point', he proceeded to describe arguments during which his behaviour including yelling, insults, put-downs and even physical intimidation. Although not identified by the man himself as violent acts, or in anyway problematic, these behaviours clearly fall within the range of abusive and controlling behaviours outlined in Part I of this report.

The participants were asked if they found themselves becoming frustrated or angry and whether their behaviour was ever a problem. Most men answered yes to these questions. This was perhaps more evident for those fathers who had attended a behaviour change group, but was also true of those fathers who described themselves as having made a successful transition to fatherhood.

For most men, anger and aggressive behaviours were present to various degrees as indicated by the following quotes:

"Yes, anger and frustration were there – but not to the extent it was a problem"

Interview #1

"Yes, it was more of a problem – but I try to walk away"

Interview #2

"Yes, it was a big problem"

Interview #8

"Yes, it had a big impact on (my partner) "

Interview #11

When asked whether their levels of anger and frustration increased following the birth of their babies, some fathers reported that their situation hadn't really changed as a result of becoming a father, saying:

"It had been a problem for a long time"

Interview #6

Or:

"(It was) more ongoing rather than as a result of the baby"

Interview #10

Whereas other fathers indicated that levels of anger and frustration had increased sometime after the birth:

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"Yes, not immediately after the birth, but definitely after 3 months"
Interview #7

Or:

"Initially I was a great dad but 6 months after the birth things changed"
Interview #5

Or as this father of a sixteen month old child indicated, the escalation occurred:

"More so in the last 2 months" Interview #13

Those men who indicated their anger levels increased following the birth offered a number of reasons to explain this, including:

"no free time" Interview #1

"constant demands on your life and energy" Interview #2

"not (being) prepared for difficulty settling child" Interview #3

"feeling trapped" Interview #4

"(a) lack of patience" Interview #5

"due to lack of communication" Interview #8

Most of the reasons given for explaining their behaviours were directly relevant to their experience of becoming a father and the lifestyle and relationship changes they had encountered.

The increased levels of anger and frustration and the presence of problematic behaviours reported by the research group, does however, raise the question of whether engaging first time fathers around issues of violence and behaviour change is necessarily a family violence *prevention* project. It could be argued that given the presence, and in some cases escalation, of anger and violent behaviours during the transition to fatherhood, a project of this type would be best conceptualised as an *early intervention* project, rather than a *prevention* project. This could have important implications for the development of relevant strategies for engaging men at this life stage.

Services for first time fathers

Further key points from the research relate to the men's experiences of the services offered to first time fathers.

Fourteen of the fifteen men interviewed during the research indicated that they would be interested in more postnatal services for fathers. There was a positive perception of the 'fathers nights' conducted by the City of Whitehorse Maternal and Child Health Service – a point that is also supported by fathers nights evaluations conducted by MCH. The first time fathers indicated that they were interested in hearing from other males about their experience of fatherhood, and would be keen to learn strategies to assist them during their transition to

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fatherhood. The men also clearly indicated (14 of the 15 men interviewed) a preference for a male facilitator, specifically a father, to conduct the father nights.

However, the desire for more services for first time fathers is complicated by the fact that many men report a lack of available time to participate in such activities. Whilst the research group indicated clear support for the provision of more services for first time fathers, they also suggested that they would not necessarily attend those services. The primary reason given for this was the men's work commitments.

These sentiments represent an ongoing challenge to the provision of services for this target group.

Summary of research findings

The research undertaken for the *Baby Makes 3* project included questionnaires and interviews with new fathers and a workshop and discussion with health professionals. A number of key themes have emerged.

There are 5 key findings about the transition to fatherhood:

- **Lack of preparation for fatherhood**

New fathers are generally unprepared for the relationship and lifestyle changes they experience during the transition to fatherhood.

They report difficulty in balancing dual work and family roles.
- **Dominance of traditional gender roles**

Despite changes to the way men perceive their contribution to their families; traditional attitudes to gender roles continue to have considerable bearing on how new families view the roles of mothers and fathers.

Even in families where fathers are actively involved, ultimate responsibility for childcare and housework rests with mothers.

There are significant cultural expectations and pressures on men to be primary breadwinners.
- **Lack of awareness of gender equality**

Equality is most often viewed in terms of financial or economic terms.

A lack of equality in other areas, such as housework and caring, is often obscured by gender roles
- **Presence of violent behaviours**

Men report an increase in levels of anger and frustration, and violent behaviours can escalate following the birth of a child.

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- **Interest in more services for fathers**

Men are interested in more male-specific content and services.

There is a strong belief that the presence of a male worker would be beneficial to new fathers.

The research has also identified a number of *clear relationships between these 5 key findings and the delivery of these services*:

- **Services currently fail to prepare men adequately for fatherhood**

Services primarily target mothers and the needs of fathers are not being met. There is an absence of male-specific content and a lack of education about relationship and lifestyle changes that inevitably follow the birth of a child.

- **Services reinforce traditional gender roles**

Both before and after the birth the focus of services is overwhelmingly (and understandably) on the wellbeing of women and children. Males are often engaged as a 'support' person, which unfortunately grants men the permission to avoid responsibility for childcare, thereby entrenching traditional gender roles.

- **Gender equality is not addressed by services**

Services understandably and rightly focus on the mother and child relationship, with the couple relationship not considered relevant to core business. In addition, the level of equality between the mother and father in the family system is not considered important to family well being.

- **A lack of focus on holding men accountable for their behaviours**

Among health professionals there is a lack of knowledge about the gendered nature of family violence. There is a reluctance to speak openly about violent male behaviours and minimal early intervention to prevent violence. This lack of response serves to maintain secrecy about family violence and fails to hold men accountable for their behaviours.

- **Services need to be more inclusive of fathers**

The provision of fathers nights in Maternal and Child Health settings has been a success and has been received positively by men. However men also identify a general lack of services for fathers. There is a lack of male workers and a lack of male-specific content. In addition, current workers lack confidence and skills in engaging men.

The summary of the research findings is presented in *Figure 2*.

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Figure 2: The relationship between key themes from the research and service delivery

Research Findings	Relationship to Service Delivery
<p>Lack of preparation for fatherhood</p> <ul style="list-style-type: none"> Fathers unprepared for relationship and lifestyle changes Difficulty balancing work and family 	<p>Lack of focus on fatherhood</p> <ul style="list-style-type: none"> Services primarily target mothers Absence of male-specific content Absence of relationship education Lack of education about lifestyle changes
<p>Dominance of traditional gender roles</p> <ul style="list-style-type: none"> Presence of traditional attitudes to gender roles Ultimate responsibility for childcare rests with mothers Cultural expectations and pressures on men to be primary breadwinners 	<p>Services reinforce traditional gender roles</p> <ul style="list-style-type: none"> Males engaged as a 'support person' Maternal and Child Health focus is on women and children Men given permission to avoid responsibility for childcare
<p>Lack of awareness of gender equality</p> <ul style="list-style-type: none"> Equality viewed primarily in financial terms Lack of equality in 'housework' and 'caring' often obscured by gender roles 	<p>Gender equality not addressed by services</p> <ul style="list-style-type: none"> Focus on the mother/child relationship Couple relationship not considered relevant to service delivery Level of equality not considered important to family wellbeing
<p>Presence of violent behaviours</p> <ul style="list-style-type: none"> Men report an increase in anger and frustration following birth Violent behaviours can escalate following the birth 	<p>Lack of focus on male behaviours</p> <ul style="list-style-type: none"> Lack of knowledge about family violence Reluctance to speak openly about violent behaviours Lack of early intervention Lack of response maintains secrecy and fails to hold men accountable for their behaviours
<p>Interest in more services for fathers</p> <ul style="list-style-type: none"> Interest in more male-specific content 	<p>Need for greater targeting of fathers</p> <ul style="list-style-type: none"> Success of fathers nights

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-
- Interest in having a male facilitator

↳ Lack of male workers and male-specific content

↳ Lack of confidence/skills in engaging men

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Limitations of the Research

One of the limitations of this research project was related to the difficulty in obtaining participants. It was initially envisaged that many more first time fathers would be able to be interviewed (>30) however this turned out not to be the case, with first time fathers seemingly reluctant to participate. The final number of participants (15) did nonetheless provide enough useful material for the purposes of the research. What is indicated by the poor response, however, is the difficulty of engaging men at this time in life, and this will undoubtedly be an ongoing issue for phase 2 of the project.

Another limitation of the research relates to the timing of the interviews. Some members of the research group were men who were very early on in their transition to fatherhood. Three men had babies who were less than 3 months old. What became clear as the research progressed is that many of the men with older children reported that they did not experience real difficulty – in terms of their behaviour – until much later on in their journey through fatherhood. For two men, it was not until one year after the birth that anger and problematic behaviours became a real issue for them. It is possible then, that seeing as how the research group contained a number of relatively 'new' fathers, the research did not fully capture the difficulties experienced by men during the transition to fatherhood.

Another issue encountered during the interview process was the reluctance of the men to discuss their behaviours in terms of family violence. There was clearly a degree of resistance to naming certain behaviours as 'violent', even though the men themselves described yelling, throwing objects, etc... (although the men who came to the project via a men's behaviour change program were more likely to do so). The research participants did not see questions about family violence as relevant to their experience of fatherhood which they clearly saw as more to do with their relationship with their child, rather than their relationship with their partner. This is perhaps not surprising given the ideology that surrounds the formation of a new family. It is likely, however, that the research did not capture the men's (or their partner's) private, 'hidden' experience of their potential violent or otherwise controlling behaviours. This, of course, is also likely to be an ongoing issue for phase 2 of the project.

Furthermore, if the men were resistant to talking about their levels of anger and the accompanying violent and abusive behaviours, they were even more resistant to discussing their sexual behaviours. The interviews had hoped to capture data on how men had dealt with changes to their sex life, however, midway through the research it became apparent to the researcher that the answers given by the men were likely to be unreliable and consequently the results for this part of the interviews has not been included in the final report. The sexual behaviour of first time fathers has the potential to be highly abusive, with some men expressing resentment to being 'deprived' sex. However, this research project was unable to shed any light on how men experience the transition to fatherhood and the birth of their baby in terms of their sexual behaviour.



PART III - DISCUSSION

7. Family Violence Prevention Targeting First Time Fathers

There are a number of reasons why it is important to target first time fathers with strategies to prevent family violence. Men not only are the main perpetrators of violence, but they are more likely to hold violence supportive attitudes (VicHealth 2006).

Targeting first time fathers acknowledges that men have a positive role to play in helping to end men's violence against women (Flood, 2006), and also play an important role in shaping the attitudes and behaviours of children (as parents) and of other boys and young men (VicHealth, 2007).

Increased risk during family formation

It has long been recognised that the transition to fatherhood is a time when there is an increased risk of violence. Family violence often intensifies during pregnancy and in the period following the birth of a child (Dept. of Victorian Communities, 2007; Taft, 2002) and the findings from the *Baby Makes 3* research seems to confirm this. Certainly, a significant number of the men involved in the research acknowledged an increase in their levels of anger and frustration following the birth of their babies and indicated that this was directly related to the unexpected relationship and lifestyle changes that followed the birth.

Clearly, a key factor contributing to the increasing risk of violence is the difficulty that some men encounter in adapting to the changes relating to this stage of life. Therefore, prevention strategies at his time can play a key role in reducing the degree of harm to women and their babies (Walsh & Weeks, 2004).

Window period

The transition to fatherhood is a specific time in men's lives when they are in contact with health services and are most open to receiving information and skills development (O'Brien & Rich, 2002). It represents a 'window period' where men are accessing support and focussing on family relationships (King, 2001 & 2005). There is, therefore, a real opportunity to engage men because they are receptive to intervention, which may not be the case during other life stages. Indeed, the men involved in the research clearly indicated that they actually *want* to access services that speak to them directly about their experiences as first time fathers.

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The window period for intervention becomes increasingly relevant when we consider that the transition to fatherhood is a time when gender roles and relations are changing. For most men, the transition to fatherhood represents a time when their beliefs about gender roles invariably influence the choices they make about how they live their lives, and we know there is a strong relationship between an individual man's perpetration of violence and his attitudes about gender roles and relationships (VicHealth, 2006).

Consequently, during the transition to fatherhood, there exists a major opportunity to challenge men's attitudes to traditional gender roles, to promote alternate masculinities based on caring and nurturing, rather than dominance and oppression and to promote equality in their changing relationships with their partners. This is of particular importance given the profound shifts in gender relations over the past generation, with the role of fathers, in particular, having undergone major change.

A focus on relationships

It is becoming increasingly recognised that fathers have a significant impact on child development outcomes. There is now substantial literature that establishes a number of important ways in which positive father involvement can produce favourable cognitive, emotional and social development outcomes for children (Allen & Daly, 2002; Flood, 2003). This is not because of any 'unique' contribution that men make to parenting, but rather because of the increased capacity for caring and nurturing that father involvement brings to families (Flood, 2003). Fathers' (and mothers') positive involvement in parenting can produce positive effects on children. This fact can serve as an important motivator in determining a father's level of involvement in the family (Hatten, Vinter, Williams, 2002).

Men identify fathering as something which is a central part of their life (King, 2005). It has been observed that men have increased motivation and interest in engaging with services, when service provision is linked with the father's underlying desire to have closer relationships with his children (King, 2001). There is therefore an opportunity to engage first time fathers in the prevention of family violence by capitalising on their beliefs about the important contribution that men make to families.

Recommendation Focus on the Father/Child Relationship

A successful strategy for engaging men is to focus on their relationship with their children and the significant impact of positive father involvement on child development.

This should be the starting point for any strategies that seek to engage with first time fathers. Intervention aimed at promoting safety and wellbeing among new families is more likely to be successful if it begins with acknowledging the centrality and importance of a father's relationship with his children.

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The challenge however is to extend any intervention with first time fathers beyond the father/child relationship, to include the couple relationship and the family system as a whole. The father/child relationship is of major significance and it is also the relationship that men are most willing to focus on. Men have rated being accessible when children need them, and guiding and teaching them, as the most important things fathers do (Russell, *et.al.*, 1999). Men are clearly interested in their children's wellbeing. However, this narrow construction of fatherhood overlooks the important and positive contribution that parental harmony has on a child's development.

Men's healthy relationships with women are crucial to the wellbeing of children and families (Flood, 2003). When it comes to children's wellbeing, the family context is far more influential than the individual father/child relationship. Research has shown that the absence of family hostility is the most consistent correlate of childhood adjustment, and correspondingly, the presence of marital conflict is the most consistent and reliable indicator of child maladjustment (Russell, *et.al.*, 1999). The challenge in family violence prevention work is to broaden men's understandings of fatherhood so that men understand the father/mother relationship to be just as important as the father-child relationship.

Recommendation **Place Increased Focus on the Couple Relationship**

The transition to fatherhood involves not only the creation of new relationships between parents and their children, but dramatic shifts in the relationships between men and women.

A narrow construction of fatherhood concentrates overly on the father/child relationship, at the expense of the couple relationship.

Interventions with first time fathers should be extended to incorporate a more holistic understanding of fatherhood that acknowledges the importance of the father/mother relationship.

Addressing male violence

To work cooperatively with men in a project of gender equality we need to balance the positive contribution that men can make to families with the fact that men *do* perpetrate family violence (Featherstone, 2005). This is particularly relevant when programs are actively supporting father's involvement with children and other family members. The key to achieving this balance is to ensure that men are held accountable for their behaviours.

Yet addressing violent and controlling behaviours is problematic for a number of reasons. Workers often lack sufficient knowledge about the effects and dynamics of family violence and may lack sufficient confidence and skills in addressing male behaviours, particularly in working directly with men (these facts were borne out in the family violence awareness workshop conducted for *Baby Makes 3*). Furthermore, men are frequently resistant to acknowledging their behaviours as harmful or violent. The temptation is to simply avoid the topic of male behaviours.

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Recommendation **Focus on Male Behaviours**

Greater attention needs to be paid to addressing male behaviours during the transition to fatherhood.

Family violence is promoted within an atmosphere of secrecy, and failure to address the issue of male violence serves only to assist men in avoiding taking responsibility for their behaviours.

The problem is that family violence is promoted within an environment of secrecy. Failure to address male behaviours only assists men in avoiding taking responsibility for their behaviours. The risk is that by avoiding the topic of male violence, workers may actually collude with any violent or controlling behaviour that may be present, with significant implications for the safety of women and children.

Recommendation **Avoid Collusion**

Workers need to develop greater awareness of the principle of collusion and the ways they can potentially collude with male violence. Workers require improved skills in interacting with men in ways that avoid collusion.

In working with first time fathers, there is a temptation to focus on the positive contribution made by fathers, and to ignore the potential for male violence. In so doing, workers run the risk of feeding into the sense of entitlement that is a result of male privilege. There is a danger that working with fathers in this way could merely empower men to maintain a *status quo* in regards to the power imbalance between men and women. Whilst it is necessary to engage men by focusing on the positive contribution they can make to their family's wellbeing, it is also essential that men be held accountable for their behaviour. Families must be served in holistic ways that include addressing violence.

8. Gender Roles and Gender Equality

Gender roles and gender equality are central to family violence prevention. Gender roles and relations is one of the key underlying determinants of violence against women (VicHealth, 2007). Understanding the influence of gender roles and the distribution of power and material resources between men and women is fundamental to any strategies for promoting safety and wellbeing among new families.

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Changing family models

A generation ago, constructions of fatherhood were heavily influenced by what has come to be known as the 'traditional' model of family. Under this model, a father's main function was to be a good economic provider for his family – a 'breadwinner' – and to work outside the home. It was expected that men would not undertake more than a minimal role in the care and nurturing of their children, which was considered to be the natural domain of women. The traditional model was characterised by a polarisation of gender roles where women performed the vast majority of domestic tasks and men occupied what was considered their rightful place as 'head of the house'.

However, the polarisation of roles in the traditional family, with labour divided heavily along gender lines, was not without problems. Foremost of these was the gender inequality associated with men performing paid work outside the home and women performing vastly undervalued housework inside the home. Add to this the time spent performing each type of work, the status accorded to the work, and the lack of flexibility and career opportunities for women and it is easy to understand the effect of the traditional model of family in establishing a significant power imbalance between men and women.

The traditional model also has major implications for the relationship between fathers and their children. The lack of involvement of fathers in the care and nurturing of children inevitably resulted in fathers being seen as 'distant' from their children, a fact that is still lamented today by men who were raised in traditional families (Russell, *et.al.*, 1999). This lack of connection between fathers and their children has been identified as having major implications for child development (Fletcher, 2005).

In contemporary Australia, however, the traditional family is becoming far less common. The decrease in permanent fulltime work and the rise of part-time and casual work, particularly among women, has meant that many fathers are no longer the sole 'breadwinner' in the family (HREOC, 2005). In recent times we have seen the rise of 'dual income' families as more women are entering the workforce, and in addition to this change outside the home, we are witnessing a change inside the home as well.

The past generation has seen the emergence of a new, 'shared-parenting' model of family, characterised by an increasing level of father involvement in childcare and household tasks, and greater equality between men and women. In today's family, new accounts of an alternate masculine identity – exemplified by the nurturing father – are appearing and men and women are expressing strong egalitarian attitudes to parenting (Flood, 2003; Craig, 2006). The *Baby Makes 3* research, however, has identified that even within the more contemporary models of family – those families where fathers are actively involved in the care of infants – traditional gender roles continue to influence the organisation of day to day tasks.

Nonetheless, given the relationship between traditional views about gender roles and lower levels of support for gender equality, particularly among men (Flood & Pease, 2006), the promotion of alternative forms of masculinity that reflect malleable gender roles is an important means of promoting equal and respectful

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relationships. Working with first time fathers provides a unique opportunity to promote alternative masculinities based on the nurturing and caring of infants to counter the influence of traditional gender roles.

Recommendation **Promote Alternative Masculinities**

Traditional masculinity is culturally defined in terms of dominance, toughness and male honour. Traditional masculinity reflects a belief in rigid gender roles

Working with first time fathers provides an opportunity to promote alternative masculinities by focussing on a father's capacity to care for and nurture infants.

Gender inequality

Attitudes to parenting and housework among Australian men and women have changed significantly and now reflect strong acceptance of egalitarian roles (HEROC, 2005). Today, there is a cultural expectation that fathers will be more involved with their children. Yet despite the decreasing influence of the traditional model of family, and the emergence of a new model, it is clear that the ideal of shared parenting is still a long way off.

Recent studies indicate widespread approval for the idea of shared parenting, but they also reveal that it simply has not been adopted in practice (Craig, 2006). Despite the mutual belief among men and women that housework and parenting *should* be shared, there is a marked difference between attitudes and actual behaviours.

Perceptions of fatherhood have clearly shifted and the image of a nurturant and involved father now exerts a powerful influence. However the culture of fatherhood has changed much faster than the reality. It is estimated that fathers are highly involved in the day-to-day care of their children in only 5-10% of families (Flood, 2003). What is more, the childcare tasks in which men *do* engage are arguably the most fun ones, and men have far more discretion over *when* they perform childcare. Fathers are rarely alone with their children and are more likely to see their role as 'helping out' rather than relieving women of the responsibility of childcare (Craig, 2006).

In contrast, mothers continue to provide more absolute child care than fathers, even when they are equally engaged in full-time participation in the work force (Craig, 2006). Furthermore, the *experience* of providing care is different, in kind and quality, for mothers in comparison to fathers. Mothering involves more double activity, more physical labour, a more rigid timetable and more overall responsibility than fathering – and this applies even when women are working full time (Craig, 2006). This is reflected in the *Baby Makes 3* research which found that, even among those families where men described themselves as highly involved fathers, ultimate responsibility for childcare and household tasks rested with the female partner.

Even in the sphere of employment, change has been slow. Despite the increasing participation of women in the workforce, only a minority of fathers make a significant change to their working lives following the birth of a child (Hatten,

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Vinter & Williams, 2002). A key contributing factor here is the gender pay gap (HREOC, 2005) where women, on average, receive less income than their partners, thereby adding financial incentive for men to remain in the workforce. Yet, irrespective of pay differentials, there is a noticeable expectation that mothers will make changes in *their* work patterns, whilst men will not.

Although it is apparent that attitudes towards gender roles are changing, the demise of the traditional family has been exaggerated (Scott, 2006). The traditional model still has considerable bearing in many families in defining how parents think about the father role (Hatten, Vinter, & Williams, 2002). The definitions of parenthood are changing, but the role of parents and of fathers in particular, remains stereotypically gendered (Russell, *et.al.*, 1999).

These themes were also common to the *Baby Makes 3* research which identified the dominance of traditional gender roles and a general lack of awareness among men of the concept of gender equality. Among the research group, equality was viewed primarily in economic terms. Men found it difficult to assess the level of equality in their relationship beyond strict financial terms, illustrating how a lack of equality in housework and caring is often obscured by attitudes to gender roles.

Recommendation **Provide Education about Gender Roles**

Men are more likely than women to hold traditional attitudes towards gender roles, and those men who hold such views are more likely to perpetrate violence.

Men are frequently unaware of how their own attitudes to gender roles may be affecting the quality of their relationship and their family's wellbeing.

At a stage of life when gender roles become increasingly significant and influential, the provision of education to first time fathers (and mothers) about gender roles – the limitations of traditional gender roles and the benefits of shared parenting roles – would be beneficial.

The widespread acceptance of traditional gender roles in parenting is a key factor in explaining why expectations of gender equality are not being realised (HREOC, 2007).

Fatherhood and gendered power

The transition to fatherhood is a key time for men. For some men – those who are more trustful of egalitarian relationships and involved fatherhood – it can be a smooth transition, but for those men struggling with the uncertainties of contemporary gender roles, it can be fraught with difficulty (Flood, 2003).

The competing ideals of the traditional and shared-parenting models of family polarise beliefs and create conflict for men. These competing models are powerful influences on men that inevitably cause tension between the demands of being a good 'breadwinner' on one hand, and needing to 'be there' for the children on the other (Hatten, Vinter & Williams, 2002). Although men invest strongly in being available for their children, the discourse surrounding the role of economic

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provider is very strong (Featherstone, 2005). Some men can become trapped within narrow gender roles emphasising work, money making, public status and success.

These themes emerged strongly from the *Baby Makes 3* research. All men involved in the interviews perceived cultural expectations and pressures on men to be primary breadwinners and highlighted the difficulty of trying to balance work and family commitments. More commonly however, it was the 'provider' role which took preference over the role of 'carer', and in some cases, men made an active choice to pursue the 'provider' role as a means of avoiding family responsibility.

From a family violence perspective, the tension that comes with the transition to fatherhood can be understood through an analysis of power. The dominance of gender stereotypes in relation to fatherhood has tended to obscure dominant constructions of masculinity and how these interact with fathering practices, but paying attention to gendered power relations is essential (Featherstone, 2005). Research has repeatedly shown that patterns of gender inequality are interwoven with social definitions of masculinities and men's gender identities (Connell, 2003)

Gender role orientation and egalitarian beliefs are critical for the process of adjustment for new fathers. But if gender equality is to be realised and family violence is to be prevented, men are required to relinquish certain aspects of power and privilege they have enjoyed in the context of the traditional nuclear family (Flood, 2003). The task for family violence prevention is to assist men in relinquishing this power.

Recommendation **Provide Education about Balancing Work and Family**

The balancing of work and family is a major issue for first time fathers.

Finding the right balance involves relinquishing the power and privileges that men have typically received from traditional gender roles.

Educating men about the dual role that fathers are expected to fulfil would assist men in finding a working balance between the roles of 'provider' and 'carer'.

During the transition to fatherhood, there is a tendency for men (and women) to accept gendered work and family roles by default. However, the entrenched 'male breadwinner – female carer' model does little to promote equality between men and women (HREOC, 2005). By targeting first time fathers, family violence prevention strategies can capitalise on the window period where men are open to receiving advice and information, and first time fathers can be guided towards new models of fatherhood characterised by a sharing of economic power, and increased responsibility for childcare and household tasks. In this way, the underlying inequalities between men and women can be minimised and the social determinants of family violence can be addressed.



9. Promoting Equal and Respectful Relationships

During the transition to parenthood, relationships between men and women receive little attention. The couple relationship is rarely addressed by services and is seen as extraneous to service delivery. The concept of equality in relationships is not considered important to family wellbeing, and is rarely addressed, if at all.

Yet, promoting equal and respectful relationships between men and women has been identified as a key theme for action in preventing violence against women (VicHealth, 2007). An issue for consideration then, is what are the best ways of promoting equal and respectful relationships?

Essentialist definition of fatherhood

As mentioned in the previous chapter, the competition between traditional and shared-parenting models of family is a source of tension for men. In response to this uncertainty, some men have attempted to reassert traditional values (and male power) by claiming that traditional gender roles are biologically determined (Flood, 2003). This is the biological essentialist approach to fatherhood – adopted and popularised by a number of authors, for example: Biddulph (1994) and Fletcher (2005) – which argues that, as men, fathers make a 'unique' contribution to parenting.

This essentialist definition of fatherhood suggests that fathers do not have the natural ability that mothers have to care for and nurture children. It is an approach that, whilst not denying that fathers make an important contribution to the upbringing of children, argues that a father's contribution is fundamentally and inherently different to that made by mothers.

Unfortunately, this view of fatherhood is common. There is a widespread belief in society that traditional gender roles are rooted in the natural abilities of men and women (Hatten, Vinter & Williams, 2002). A product of this belief is the fact that only a very small number of men feel that a father's involvement in, and responsibility for, his children's wellbeing should be equal to that of mothers (Hatten, Vinter & Williams, 2002). These gendered patterns of parenting can be a major constraint on fathers' interactions with children (Flood, 2003).

This understanding of fatherhood is reflected in the approach of services that engage fathers as a 'support' person, rather than as an actively involved parent. Engaging fathers as a 'support' for mothers, only reinforces traditional expectations and can give permission for men to avoid responsibility for childcare and by extension housework.

The main problem with an essentialist approach of this kind is that it is simply not supported by the evidence. Yes, it is true that we can observe different parenting styles between men and women, but these gender differences in parenting emerge in response to societal pressures and expectations – they are not based

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on biology (Flood, 2003). Fathers *do* tend to exhibit more traditionally masculine qualities in their caring, but men and women are *equally capable* of caring for children (Flood, 2003; Doucet, 2004). Fathers' contribution to parenting is distinctive, but not unique (Flood, 2003).

In the attempt to engage men in the prevention of family violence, we must withstand the temptation to adopt a biological essentialist definition of fatherhood – that fatherhood is inherently different from motherhood – even though the idea of fathers making a unique contribution to their children is a popular belief that many men support and are likely to respond positively to. But in order to argue that the distinctive contribution of fathers is desirable and valuable, we do not have to make the further claim that this contribution is unique and exclusive to men. This serves only to ensnare families in traditional gendered patterns of relating. We must instead focus on the reality that gender does not play a part in an individual's capacity to care for children, and that men can be caring, loving and nurturing, to the same degree as can women.

Maternal gatekeeping

The same biological argument can be mounted with respect to mothers. The belief that women are naturally and instinctively better carers than men has played a major role in the delineation of parenting roles between mothers and fathers. Proponents of mothers as natural carers speak of a bond that is created between mother and child through childbirth, of a 'maternal instinct' and of a capacity for patience and sympathy. These widely held beliefs inevitably place mothers in the position of gatekeepers with regard to the tasks of parenting and caring within families (HREOC, 2005).

The existence of Maternal and Child Health Services is evidence of how society places significant importance on the mother and child relationship. Whilst it is only right that after the birth of a child, the wellbeing of women and children is of paramount importance, it is worth considering how the structure of these services may reinforce traditional gender roles and have unintended consequences for the level of equality between mothers and fathers.

Recommendation **Provide Education about the Equal Capacity of Fathers and Mothers to Care for Infants**

The popular belief that mothers are naturally more adept at caring and nurturing infants is widespread, despite mounting evidence to the contrary.

Promoting equality requires a focus on the equal capacity of men and women to care for children. This could be achieved by educating parents about the equal capacity of men to care for and nurture infants.

Maternal gatekeeping is deeply rooted in women's profoundly felt obligation to care for their children (Doucet, 2004). Indeed, the vast majority of mothers say they are comfortable taking on the bulk of childcare responsibility while their husband is the main provider (Hatten, Vinter & Williams, 2002). Similarly, mothers are major contributors to the decision for some families to adopt a pattern in which

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fathers are significant caregivers (Russell, *et.al.*, 1999). Indeed, if mothers are not supportive of increasing paternal involvement, new fathers can experience difficulty in finding the time and space to interact with their babies. In this scenario, the default position is polarised gender roles. Addressing maternal gatekeeping then is a key challenge in establishing parenting equality.

The difference paradigm

Cultural conceptions of gender and parenting tend to assume – against mounting counter evidence – that women and men are naturally, fundamentally and inalterably different from one another, and that mothers and fathers must do different things and fulfil different parenting roles. We attach different perceptions to the terms ‘mothering’ and ‘fathering’ with a strong inference that a parents gender might offer something unique and special (Howard, 2003). We believe that mothers and fathers are different at nurturing (Doucet, 2004). These differences – based on biological essentialist definitions of fatherhood and motherhood – result in a ‘difference paradigm’, where notions of equality and shared-parenting become highly contested ideas. However, in reality, the differences between mothers and fathers, and indeed, between women and men are much less important than the similarities (Hyde, 2005).

Nonetheless, the difference paradigm remains a powerful influence on the way we envisage the roles of men and women within the family, and it represents a major challenge to the prevention of family violence. It has important implications if our aim is to promote gender equality. A key question is: how can we have *equality* between men and women in the family when fatherhood and motherhood are so heavily imbued with *difference*?

There are two answers to this question and consequently two ways in which we can move towards equality. The first answer is that we can’t. We can’t have equality while the paradigm of gender difference remains. Our objectives therefore should be to assist men and women to shift their family model from the traditional model towards the shared-parenting model as much as possible; as shared parenting is only way that true equality can be achieved. The problem here, of course, is that circumstances do not always allow families to share work and childcare equally. Nonetheless, moving as far as the circumstances will allow towards a shared parenting model (by fathers taking on more responsibility for childcare and domestic chores) will undoubtedly result in increasing gender equality. This is one of the key rationales in relation to the framework for father-inclusive practice in early intervention and family related services developed by the Family Action Centre (2005).

The second answer is that ‘difference’ and ‘equality’ are not mutually exclusive, and that we can have gender equality in the presence of gender difference. This approach acknowledges that inequality is not a direct result of difference. It is not the presence of differences that results in inequalities, but the disadvantages that flow from these differences. The important issue is not difference, but the difference difference makes (Doucet, 2004). The reason why the traditional model of family can produce gender inequality is not because men and women are performing different roles; it is because traditionally, women’s work (the nurturing,

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caring and domestic work) has been undervalued, and it is this undervaluing of a woman's contribution to the family that results in a power imbalance.

Recommendation **Provide Education about Relationship Equality**

The concept of equality is poorly understood, particularly when following the birth of a child, men and women adopt different familial roles. Yet the fact that fathers and mothers are occupying different roles does not mean they cannot have an equal relationship.

There is a clear need for education about the nature and importance of equality in relationships, including areas such as housework and caring, and how to achieve equality even when mothers and fathers are performing different roles.

There are therefore two ways to overcome the difference paradigm that wants us to believe that men and women are essentially different. We can focus, not on the differences, but on the similarities, which for first time fathers means the capacity to care for and nurture children, and the ability to perform household tasks. This approach is completely compatible with the aim of promoting alternative notions of masculinity (i.e. the nurturant father) which is another key strategy in family violence prevention. We can also create equality in the presence of gender difference by valuing, equally, the contributions of both genders. Yet to accomplish this, there is still another challenge to overcome, namely, men's resistance to gender equality.

Resistance to gender equality

There are a number of reasons why men are resistant to gender equality. These are, more often than not, related to dominant constructions of masculinity and may involve a deeply embedded psychological fear of being seen as 'not masculine' or even a reversion to an ideological defence of male supremacy (Connell, 2003; Pease, 2006). However, the main reason why men are resistant to gender equality is because men are, to a large degree, the recipients of many formal and informal benefits that flow from gender inequalities in what is known as the 'patriarchal dividend' (Connell, 2003).

The patriarchal dividend that men receive comes in the form of male privilege. It includes material benefits such as higher income and the increased freedoms that flow from minimal involvement in caring and housework (HREOC, 2005). There are also many benefits that men receive in the form of interpersonal power. These include the social status associated with paid work, and the authority associated with being the 'head of the house'. In comparison to paid work, unpaid caring and housework (predominantly performed by women) is undervalued and does not have the same status as paid work, despite its significant economic and social contribution (HREOC, 2005).

The defence of male privilege and the patriarchal dividend is the key reason why many men will actively resist gender equality (Flood 2005). It is the same resistance that women encounter when they ask men to do more housework or become more involved in the care of children (HREOC, 2005). It goes some way

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to explaining why many new fathers, when faced with the choice between work and family, invariably express a commitment to paid work, under the pretext of needing to be a good 'provider' (HREOC, 2005; Hatten, Vinter & Williams, 2002).

Men's resistance to gender equality represents a major challenge for family violence prevention, as men are often motivated to *maintain* inequalities. The risk is that men will either overtly or covertly avoid participating in a project that requires them to sacrifice their traditional source of power. In response to this resistance, it may be prudent to seek ways of engaging men in gender equality through methods that are perceived as more beneficial to the men themselves. In relation to first time fathers, the opportunity exists to motivate men by focusing on the benefits, not just for themselves and their partners, but also for their child's wellbeing and development.

Recommendation **Promote the Benefits of Equality**

Gender equality has significant benefits for fathers, mothers and children's wellbeing, particularly in terms of relationship quality.

Focussing on the benefits of equality is an important means of overcoming any resistance to gender equality among first time fathers.

Involving both men and women

The key target group for *Baby Makes 3* is first time fathers. However, it is important to acknowledge that strategies to promote equal and respectful relationships must involve both men and women.

Educating women can help increase women's critical understanding of the significance of gender roles and relations during family formation and can assist in overcoming maternal gatekeeping. It can also develop and build on existing skills in recognising, resisting and rejecting violent or controlling behaviours.

Most importantly, educating women about gender roles, gender equality and male violence can change men. Shifting women's expectations of partners and intimate relations can increase the pressure on and incentives for men to behave in equal and respectful ways (VicHealth, 2007).

Recommendation **Target Men and Women**

Both men and women should be included in education and awareness raising about gender roles and equality.

Including women not only builds their own knowledge of these issues, but can shift their expectations of how their partners should behave, and this can have a significant bearing on changing male behaviours.

Targeting both men and women is also likely to overcome any male resistance to participation as the men involved will not feel they have been 'singled out'. Ideally,

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women's and men's education programs should complement each other as this is likely to accelerate shifts in social norms and gender relations.

10. Implications for Service Delivery

It is worth remembering that the pressures and forces acting on new families are not limited to the domain of individuals and relationships. There are undoubtedly a number of social and structural factors impacting on men and women leading up to and following the birth of a child. These include a mix of pressures arising within the workplace, government policy and community attitudes (for a deeper discussion of these issues see Squire and Tilly, 2007).

The *Baby Makes 3* project, however, has focussed on the individual and relationship dynamics within new families and their connection to relevant organisations and service delivery. In particular, *Baby Makes 3* has sought to identify correlations between the experiences and perceptions of new fathers and the services with which they come into contact during the transition to fatherhood.

There are a number of implications for service delivery.

Challenges for services

The targeting of first time fathers in the prevention of family violence involves overcoming a number of challenges.

One of the key challenges is the need for services to be more inclusive of men. The undeniable fact is that currently, services primarily target mothers, and first and foremost are concerned with the mother and child relationship. The widespread belief is that services are the domain of women and children, rather than men. The relationship between services and new families needs to evolve to become father inclusive.

However, becoming father inclusive does not mean that a focus on mother and child wellbeing necessarily needs to be compromised. Indeed, being father inclusive is consistent with improving the health of women and children, by acknowledging the potential for gendered violence and the need to hold men accountable for their behaviours.

It is well recognised, however, that men are a difficult group to engage, and this is even more pronounced in prevention and early intervention services because men usually seek help *during* a crisis, rather than before it occurs (King, 2001).

In addition, child and family health professionals often have under-developed skills in relation to engaging fathers (Fletcher, Silberberg & Baxter, 2001). This is most often simply a result of having limited contact with fathers and therefore

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limited opportunities to develop skill levels, however, a lack of confidence in engaging fathers can play a part in perpetuating the exclusion of fathers.

The design of programs can also be a barrier to increasing fathers' access to services. The timing of services is often restricted to business hours, and with a large proportion of men in full-time employment fathers are simply unable to attend. The gender of the practitioner is another aspect of service design that can influence the willingness of fathers to engage (Fletcher, Silberberg & Baxter, 2001). An absence of male practitioners in child and family services can reinforce traditional views about fathers' participation.

Recommendation **Be Father Inclusive**

There is a need to make services more family oriented rather than mother and child oriented.

Greater attention must be paid to the ways men experience the transition to fatherhood, including their perceptions of relationship and lifestyle changes.

There is an opportunity for services to capitalise on the significant window period – when men are focusing on family relations – to provide information, education and support that will benefit not just men, but women and children too.

However, arguably the greatest barrier to engaging fathers in the prevention of family violence is the attitudes of child and family health professionals in relation to the *role* of fathers in families. Health professionals must become aware of the degree to which their own attitudes on the role of fathers have been shaped by traditional models of the family. The pervasive influence of traditional family values cannot help but influence the way workers engage with families. Whilst to some extent this is unavoidable, workers must remain mindful that by reinforcing traditional gender roles, they may be contributing to, and sustaining, gendered power imbalances within families, and that these power inequalities are a key determinant of family violence.

Antenatal services

The first time that new fathers come into contact with the service system is likely to be when they attend childbirth education classes. At Birralee Maternity Service, 60% of first time fathers attend childbirth education, in one form or another, with their partners. This may vary from a six-week program to a weekend workshop. Childbirth education classes, therefore, are a means of reaching a significant proportion of first time fathers.

However, the results from the *Baby Makes 3* research indicate that antenatal classes are failing to meet the needs of first time fathers. Men clearly indicate that whilst these classes helped them to prepare for the birth of their baby, they did little to prepare them for the lifestyle and relationship changes that followed the birth. This is consistent with the findings of Fletcher, Silberberg and Baxter (2001) from their study of 200 new fathers in New South Wales.

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The male perception of childbirth education is that it prepares them for the birth of their baby, and their role as a support person, but fails to prepare them adequately for fatherhood. Many men in the current study identified how antenatal classes focussed wholly on the women's experience, with very little content about their own experience beyond how they could support their partner. This focus on the mother's experience during childbirth education is, of course, as it should be. But given that antenatal classes are, for many men, their only source of information about parenthood, and given that a significant number of men *do* attend these classes, the lack of male-specific content is regrettable. As discussed previously, the absence of male-specific content can reinforce traditional gender roles.

Over recent years however, there has been a move to focus greater attention on the transition to fatherhood, with the emergence of a number of programs aimed at preparing men for fatherhood. The Fatherhood Support Program at the Adelaide Women's and Children's Hospital, and the Dad's Connect program developed by Good Beginnings and the University of Technology Sydney, are examples of programs that have incorporated a male-specific session (run by male facilitators) into a traditional antenatal education program. Similar programs are appearing at the Royal Women's and Mercy Hospitals in Melbourne.

The objectives of these various programs vary but it is generally considered that the value of these all-male sessions is that they provide an opportunity to discuss aspects of the fathering role that would not typically be addressed during conventional childbirth education (Friedewald, Fletcher & Fairbairn, 2005).

The problem with these all-male sessions however, from a family violence prevention perspective, is the risk that these forums may only serve to reinforce traditional gender roles and will not challenge men's understandings and attitudes to gender equality. The issues of gender roles and gender equality are not addressed by any of the programs mentioned above. Unfortunately these programs, whilst meeting an expressed need for more male-specific content during antenatal education are likely to be of little value in terms of promoting equal and respectful relationships between men and women.

Recommendation **Greater Focus on Relationship and Lifestyle Changes During Antenatal Education**

There is a clear need for greater focus on relationship and lifestyle changes during antenatal childbirth education.

The inclusion of all-male discussions led by male facilitators would serve as an important means for preparing men for the transition to fatherhood. However, these forums must address issues of gender roles and relations.

The relationship and lifestyle changes that follow the birth of a child are important topics for both men and women and should be addressed within a framework of gender roles and relationship equality,

This issue of male violence should also be addressed during antenatal education.

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The relationship changes that follow the birth of a baby are an issue not generally addressed by conventional childbirth education. When the changes *are* addressed, they are usually discussed in terms of 'improving communication' between partners. The topics of gender roles and gender equality are largely, if not wholly, absent from curriculum.

The other major omission from the childbirth education curriculum is the topic of male violence. This is of interest given that other risk factors such as drugs, alcohol, smoking, physical inactivity, and poor nutrition are prominent components of antenatal education. Yet the major risk factor contributing to the disease burden in Victorian women (VicHealth, 2004) is not addressed in any capacity. Addressing male violence at this stage is an important means of holding men accountable for their behaviours and is integral to family violence prevention.

Birralee Maternity Service has recently developed a new model for childbirth education. The Ready Set Baby program is an expanded antenatal program developed to address the emotional, mental and physical transition to first time parenting (Eastern Health, 2005). Whilst the Ready Set Baby program, in its current incarnation does not address issues of gender roles, gender equality and male violence, the expanded program does provide room for developing the program to include these topics. The Ready Set Baby program has the additional benefits of increasing linkages between Birralee Maternity Service and Maternal Child Health Services.

Recommendation Further Development of the Ready Set Baby Program

Ready Set Baby is an expanded antenatal education that has been run previously by Birralee Maternity Services and Maternal and Child Health Services, although it is not currently being run due to financial constraints.

The expanded program provides an ideal opportunity to trial the inclusion of additional education focussing on relationship and lifestyle changes, gender roles and relations, and male violence.

The success of addressing gender roles and relations at the antenatal stage is, however, likely to be limited due to the fact that couples are simply unable to fully assimilate information about changes they are yet to experience. Nonetheless, addressing these issues during the antenatal stage forms an integral part of a holistic and comprehensive approach to family violence prevention that also includes important contributions from postnatal services, particularly Maternal and Child Health Services.

Maternal and Child Health Service

The Maternal and Child Health Service plays an important role in engaging all families with children from birth to school age, providing on-going primary health care to improve their health, development and wellbeing.

Every baby born in the City of Whitehorse receives a home visit from a Maternal and Child Health nurse in the first two weeks following the birth. Of all the babies

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born in a given year, approximately 900 are born to first time parents. That is to say, there are approximately 1800 women and men per year in the city of Whitehorse for whom the phrase *Baby Makes 3* reflects their changing family.

All first time parents are invited to attend a 'new parents group' when their baby is 4 to 6 weeks old. These groups are facilitated by Maternal and Child Health nurses at each of six locations (family centres) throughout the City of Whitehorse.

The First-Time Parent Group Resource and Facilitation Guide for Maternal and Child Health Nurses (Edgecombe, *et.al.*, 2001) states that the purpose of these groups is to:

- Enhance parental and emotional wellbeing
- Enhance parent-child interaction
- Provide an opportunity to establish informal networks and social supports
- Increase parental confidence and independence in child rearing

The content of the groups vary, as it is the task of participants to select from a range of possible topics (Edgecombe, *et.al.*, 2001). These include:

- Being a parent: changes and challenges
- Getting to know your baby
- Looking after yourself: exploring mothers' health
- Baby's ages and stages: what to expect
- Managing childhood illnesses
- What to do in an emergency: first aid and resuscitation
- Keeping your child safe: preventing accidents
- A settled baby: what does it mean?
- Food: your baby and the family
- Teething and looking after baby's teeth for life
- Returning to paid work

Whilst the new parents groups are aimed at both mothers and fathers, in reality it is mostly mothers who attend, and informally the groups are known as 'new mums' groups. It is rare for fathers to attend. This is, in part, due to the timing of the groups – usually during the day – when many men are at work and unable to attend. In addition, gender roles and expectations are almost certainly instrumental in a new father's reluctance to attend.

The group programs in the City of Whitehorse are unique, however, in that one of the seven group sessions is held after hours – as a special 'Fathers Night' – where men are invited to attend (with their partners) and to participate in a structured discussion of 'fatherhood'.

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To date, the Maternal and Child Health Service has been highly successful in conducting these fathers nights, in that many men *do* attend (between 75% to 100% attendance), and the evaluations undertaken indicate that the men are happy with content of the evening. The results of the *Baby Makes 3* research support these evaluations in that those men interviewed for the project who had attended a Fathers Night indicated it was a positive experience. Although, many men indicated that having only one night was problematic in that it was difficult to discuss personal issues among men they had only just met. Some men also expressed that a male facilitator would have been beneficial. Men in the research group also commented that the Fathers Nights focussed on the fathers' connection with his baby and not on his relationship with his partner. Indeed the relationship between men and women is not a topic recommended in the resource and facilitation manual.

Of course, the MCH Fathers Nights are not the only source of support for fathers. Other fathers programs do exist, but most are open to all fathers, rather than 'first time' fathers, and tend not to address issues connected with the transition to fatherhood. In fact there are very few programs in existence that do target first time fathers. The 'Wow! I'm a Dad' program developed by the Men's Health and Information Resource Centre, University of Western Sydney. (Ozgul & Grochulski, 2005) was the only program identified during this project that targets first time fathers during the weeks after the birth (other programs either target men leading up to the birth, or target all fathers regardless of the age of their child). Yet this program also fails to address issues of gender role and equality, and when relationship issues are discussed, it is in terms of improving communication between partners, rather than addressing the presence of power imbalances.

Whilst the feedback from male (and female) participants suggests that the Maternal and Child Health Fathers Nights have been a success, there are, nonetheless, a number of issues that could be considered problematic, particularly from a family violence prevention perspective. These are:

- There is only one fathers' session. Consequently the evening focuses mostly on engaging the men present and making them feel comfortable in a group situation. Most time is taken up allowing them to get to know each other, and there is little time to for any structured content.
- The focus is on the father/child relationship, whilst little attention is paid to father/mother relationship.
- When relationships issues are discussed it is usually in terms of improving communication, rather than addressing gender roles and gender equality.
- The one-off sessions may actually reinforce traditional gender roles.
- Many Maternal and Child Health Nurses have expressed that they do not feel confident to engage and facilitate group sessions with fathers, let alone address relationship issues.

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The issue, then, is how can new parents groups function more effectively to meet the needs of first time fathers, to promote healthy relationships and to prevent family violence?

Recommendation **Development of New Parents Groups**

The content of new parents groups should place greater emphasis on promoting equal and respectful relationships between men and women.

The structure of the new parents groups should be altered to include more evening sessions (3-4) allowing fathers to attend.

These sessions should take advantage of the opportunity to educate new parents in relation to gender roles and relationship equality, whilst promoting the capacity of fathers to care and nurture infants.

There are a number of changes that could be made including:

- placing greater emphasis on promoting equal and respectful relationships by providing relationship education to both men and women.
- Altering the structure of the groups to include a greater number of 'fathers' session. Either by increasing the overall of number of sessions (perhaps by holding some sessions at alternate venues or at alternate times, e.g. a weekend)
- The inclusion of structured discussions of topics such as gender roles, relationship equality, or the capacity for fathers to nurture infants with equal ability as mothers.
- Addressing staffing issues so that male facilitators and specialist relationship educators deliver some of the sessions
- To provide professional development for MCH nurses to increase skills related to engaging fathers.

Professional Development

The professional development of staff is a key area whereby all services could improve their prevention of and response to family violence.

The two key areas where workers' skills require improvement: are in relation to their ability to provide early intervention in family violence cases, and their ability to engage men without collusion.

To provide adequate early intervention in family violence situations, workers require increased knowledge about family violence, particularly the ability to recognise and respond to clients experience family violence, and increased confidence in their ability to speak openly to clients about family violence. These topics were covered during the family violence awareness workshop conducted for phase one of the *Baby Makes 3* project. It is, nonetheless, necessary for follow-up workshops to be conducted so that the learning in this area becomes

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consolidated and to ensure that workers appreciate that the early intervention in family violence is a fundamental aspect of the work they undertake with new families.

Recommendation **Professional Development**

Services offered to new families can be enhanced by improving worker's skills in two areas.

Improved early intervention in family violence scenarios is crucial. This requires knowledge of risks and effects of violence, the ability to speak openly about violence, recognising the signs of violence and responding to disclosures of violence.

The largely female workforce also would benefit from professional development to improve skills and confidence in engaging men. This would also require awareness of the concept of collusion, and the ways that workers can avoid colluding with male violence.

The other area where professional development is required is to provide the skills necessary to engage men without colluding in a man's potential to use violence. Workers need to develop greater awareness of the principle of collusion and the ways they can potentially collude with male violence. Workers require improved skills in interacting with men in ways that avoid collusion. (See *chapter 7* for additional discussion of this topic).

Capacity Building

The *Baby Makes 3* partner organisations have a powerful role in promoting equal and respectful relationships between men and women, but there remains enormous potential to build the capacity of the system.

Developing a shared understanding of the influence that gender roles and gender equality have on the wellbeing of first time families is crucial to building capacity, yet this is a challenging assignment given the myths and assumptions that pervade popular beliefs about the role of men and women in the family. Delivering education and professional development in this area is a specialist task.

Recommendation **Employment of Specialised Relationship Educators**

The provision of information and education about relationships, particularly to new parents, is a specialised task.

Promoting equal and respectful relationships with new parents groups requires a comprehensive understanding of gender roles, gender equality and the dynamics of family violence.

The employment of specialised male and female relationship educators would be a necessary means of promoting equal and respectful relationships in both antenatal and postnatal settings.

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It is recommended that specialist relationship educators and facilitators be employed to complete this task. The employment of a team of specialists would acknowledge the importance of promoting equal and respectful relationships among new families.

These specialists would:

- be able to deliver group work in antenatal settings such as childbirth education classes and postnatal settings such as the new parents groups
- be male and female workers able to co-facilitate interventions targeting both males and females, or similarly to facilitate same gender group work
- be able to provide professional development workshops to health workers
- work in partnership across settings

Ultimately, the employment of a team of specialist relationship educators to promote healthy relationships among first time families will serve to provide a means of meeting the needs of first time families in a new and innovative way that serves to build the capacity of the service delivery system. This is the aim of *Baby Makes 3 – phase two* and is outlined in greater detail in *chapter 12*.



PART IV – FUTURE DIRECTIONS

11. Project Summary & Recommendations

Summary of phase one

The *Baby Makes 3* project began with recognising the seriousness and prevalence of family violence, particularly as it relates to new families (chapter 2).

A framework for family violence prevention was adopted to guide the project (chapter 3). A key theme for action was identified as *promoting equal and respectful relationships between men and women*, especially in relation to attitudes and beliefs about gender roles and gender equality.

A number of research and promotion activities were conducted across the partner organisations (chapter's 4 & 5) including a critical assessment of the way current services engage first time fathers around issues of respect, responsibility and equality (chapter 6). The key findings identified a number significant opportunities for services to engage with new families (especially fathers) around these issues.

The formation of a family is a critical life stage that brings with it a significant window period for engaging first time fathers (chapter 7). It is a time when issues of gender roles and gender equality become increasingly relevant to the decisions that men and women make about how they interrelate (chapter 8). It provides an enormous opportunity to promote equal and respectful relationships between men and women (chapter 9). Yet the promotion of equal and respectful relationship is not something that services currently undertake, despite its enormous contribution to the safety and wellbeing of new families (chapter 10).

Recommendations from phase one

The *Baby Makes 3* project has generated a number of recommendations that will assist partner organisations to support first time fathers in acting respectfully, responsibly and in non-violent ways, through the various phases of starting a family.

There are four groups of recommendations:

1. *General recommendations for current services*
2. *Specific recommendations for improving antenatal services*
3. *Specific recommendations for improving Maternal and Child Health services*
4. *Recommendations for new and innovative programs targeting new families*

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These recommendations are summarised in the following tables.

General recommendations for current services

<p>Be father inclusive</p>	<ul style="list-style-type: none"> ☐ Make services more family oriented rather than mother and child oriented. ☐ Pay greater attention to the ways men experience the transition to fatherhood, including their perceptions of relationship and lifestyle changes. ☐ Capitalise on the significant window period – when men are focusing on family relations – to provide information, education and support that will benefit not just men, but women and children too. 	<p>Formatted: Bullets and Numbering</p>
<p>Focus on the father/child relationship</p>	<ul style="list-style-type: none"> ☐ Promote the significant impact of positive father involvement on child development. ☐ Promote the importance of a father's relationship with his children. 	<p>Formatted: Bullets and Numbering</p>
<p>Promote alternative masculinities</p>	<ul style="list-style-type: none"> ☐ Emphasise a father's capacity to care for and nurture infants. 	<p>Formatted: Bullets and Numbering</p>
<p>Place increased focus on the couple relationship</p>	<ul style="list-style-type: none"> ☐ The transition to parenthood can involve dramatic shifts in the relationships between men and women. ☐ Promote a more holistic understanding of parenthood that acknowledges the importance of the father/mother relationship. 	<p>Formatted: Bullets and Numbering</p>
<p>Focus on male behaviours</p>	<ul style="list-style-type: none"> ☐ Pay greater attention to addressing male behaviours during the transition to fatherhood. ☐ Family violence is promoted within an atmosphere of secrecy, and failure to address the issue of male violence serves only to assist men in avoiding taking responsibility for their behaviours. 	<p>Formatted: Bullets and Numbering</p>
<p>Avoid collusion</p>	<ul style="list-style-type: none"> ☐ Develop greater awareness of the principle of collusion and the ways workers can potentially collude with male violence. ☐ Improved skills in interacting with men in ways that avoid collusion. 	<p>Formatted: Bullets and Numbering</p>
<p>Professional development</p>	<ul style="list-style-type: none"> ☐ Improving worker's skills in each of the above areas. ☐ Improve skills for early intervention to family 	<p>Formatted: Bullets and Numbering</p>

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	<p>violence scenarios.</p> <ul style="list-style-type: none"> ☐ Improve skills and confidence in engaging men
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Specific recommendations for improving antenatal services

<p>Greater focus on relationship and lifestyle changes</p>	<ul style="list-style-type: none"> ☐ Place greater emphasis on relationship and lifestyle changes during antenatal childbirth education. ☐ Involve men and women in discussion of gender roles and relationship equality. ☐ Include all-male discussions led by male facilitators to prepare men for the transition to fatherhood. ☐ Address male violence as a key risk factor during pregnancy. 	Formatted: Bullets and Numbering
<p>Further development of the Ready Set Baby program</p>	<ul style="list-style-type: none"> ☐ Ready Set Baby is an expanded antenatal education that has been run previously by Birralee Maternity Services and Maternal and Child Health Services. ☐ The expanded antenatal program provides an ideal opportunity to trial the inclusion of additional education focussing on relationship and lifestyle changes, gender roles and relations, and male violence. 	Formatted: Bullets and Numbering

Specific recommendations for improving Maternal and Child Health services

<p>Development of New Parents Groups</p>	<ul style="list-style-type: none"> ☐ The content of new parents groups should place greater emphasis on promoting equal and respectful relationships between men and women. ☐ The structure of the new parents groups should be altered to include more evening sessions (3-4) thereby allowing both parents to attend. ☐ Group sessions should take advantage of the opportunity to educate new parents in relation to gender roles and relationship equality, whilst 	Formatted: Bullets and Numbering
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	promoting the capacity of fathers to care and nurture infants.
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Recommendations for new and innovative programs targeting new families

Employment of specialist Relationship Educators	<ul style="list-style-type: none"> ☐ The provision of information and education about relationships, particularly to new parents, is a specialised task. ☐ Promoting equal and respectful relationships with new parents groups requires a comprehensive understanding of gender roles, gender equality and the dynamics of family violence. ☐ The employment of specialised male and female relationship educators would be a necessary means of promoting equal and respectful relationships in both antenatal and postnatal settings. 	Formatted: Bullets and Numbering
Provide education about gender roles	<ul style="list-style-type: none"> ☐ Men are more likely than women to hold traditional attitudes towards gender roles, and those men who hold such views are more likely to perpetrate violence. ☐ Men are frequently unaware of how their own attitudes to gender roles may be affecting the quality of their relationships and their family's wellbeing. ☐ At a stage of life when gender roles become increasingly significant and influential, the provision of education to first time fathers (and mothers) about gender roles – the limitations of traditional gender roles and the benefits of shared parenting roles – would be beneficial. 	Formatted: Bullets and Numbering
Provide education about balancing work and family	<ul style="list-style-type: none"> ☐ The balancing of work and family is a major issue for first time fathers. ☐ Educating men about the dual role that fathers are expected to fulfil would assist men in finding a working balance between the roles of 'provider' and 'carer'. 	Formatted: Bullets and Numbering
Provide education about the equal capacity of fathers and mothers to	<ul style="list-style-type: none"> ☐ The popular belief that mothers are naturally more adept at caring and nurturing infants is widespread, despite mounting evidence to the contrary. 	Formatted: Bullets and Numbering

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<p>care for infants</p>	<ul style="list-style-type: none"> ☐ Educating parents about the equal capacity of men to care for and nurture infants is central to promoting equality.
<p>Provide education about relationship equality</p>	<ul style="list-style-type: none"> ☐ The concept of equality is poorly understood, particularly when following the birth of a child, men and women adopt different familial roles. ☐ There is a clear need for education about the nature and importance of equality in relationships, including areas such as housework and caring, and how to achieve equality even when mothers and fathers are performing different roles.
<p>Promote the benefits of equality</p>	<ul style="list-style-type: none"> ☐ Gender equality has significant benefits for fathers, mothers and their children's wellbeing. ☐ Focussing on the benefits of equality is an important means of overcoming any resistance to gender equality among first time fathers.
<p>Target men and women</p>	<ul style="list-style-type: none"> ☐ Both men and women should be included in education and awareness raising about gender roles and equality. ☐ Including women not only builds their own knowledge of these issues, but can shift their expectations of how their partners should behave, and this can have a significant bearing on changing male behaviours. ☐ Including both partners goes some way to overcoming male resistance

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The next step for the *Baby Makes 3* project is to operationalise the above recommendations. This process involves the progression to a new phase for the project involving direct service delivery to men and women and the professional development of the workforce.

The recommendations outlined above are encapsulated in the project proposal for phase 2 of *Baby Makes 3* outlined in chapter 12.

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12. Proposal for phase two

The following chapter outlines the proposal for phase two of the *Baby Makes 3* project. During phase two, the strategies for promoting safety and wellbeing among new families – identified in phase one – will be implemented.

Project summary

As the name suggests, *Baby Makes 3* is concerned with that stage of life when men and women are negotiating their transition to parenthood. For most couples, the birth of their first child is a major turning point in their lives when they must adjust to major lifestyle and relationship changes. Many couples (particularly men) experience difficulty in adjusting to their new roles. This is especially relevant when we consider the major social changes that have occurred over the past generation in relation to gender roles and family responsibilities.

In previous generations, families were characterized by a polarisation of gender roles, where women performed the majority of domestic tasks and men occupied what was considered their rightful place as 'head of the house'. However, in contemporary Australia, the dominance of the 'traditional family' and its inherent power imbalance is declining. Attitudes to parenting and housework among men and women have changed significantly and now reflect strong acceptance of egalitarian roles. There is now a cultural expectation that fathers will be more actively involved in the care and nurturing of children. Yet despite the mutual belief among men and women that housework and parenting *should* be shared, there is a marked difference between attitudes and actual behaviours. This fact is clearly evident among new families, in particular. Couples are often unprepared for the relationship and lifestyle changes that follow the birth of their first child, and there is a tendency to adopt gendered work and family roles by default. This is of concern given the identifiable links between traditional gender roles, the distribution of power within relationships and the perpetration of violence against women.

Society has changed dramatically over the past generation, but unfortunately, services for first time families have failed to keep pace. Antenatal and postnatal services continue to be based on the traditional model of family – with the focus placed on the mother/child relationship whilst fathers are engaged as the 'support' person. The unintended consequence is that traditional gender roles are reinforced among new families, and men are given permission to avoid responsibility for childcare. These are the conditions in which family violence can proliferate.

For antenatal and postnatal services, the relationship between mothers and babies is core business, and increasingly, services are focusing on the

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relationship between fathers and babies, but the missing link is the relationship between fathers and mothers. Men and women are educated and supported in all aspects of caring for their baby, but they are given no guidance when it comes to negotiating gender roles or in creating an equal and respectful relationship throughout the changes that accompany the birth of their baby.

The *Baby Makes 3* project seeks to fill the gap in current services by addressing the relationship between men and women throughout the transition to parenthood. *Baby Makes 3* seeks to prevent family violence before it occurs by establishing a team of Relationship Support Workers to promote equal and respectful relationships among first time families. The *Baby Makes 3* team will work across the partner organisations, in antenatal, postnatal and community health settings to challenge the cultural norms associated with traditional gender roles in new families, and to give first time families the information and skills they need to create equal relationships. Importantly, *Baby Makes 3* will also conduct professional development activities for health professionals to raise awareness of the importance of gender equality in new families and to increase skill levels in the promotion of equal and respectful relationships.

Project rationale

The stage of family formation is a key time for intervention to prevent violence against women. It is a time of increased risk, as violence often intensifies during pregnancy and in the period following the birth of a child. It also offers a 'window period' during which men (and women) are open to receiving information and skill development. It is a time when men are accessing support and are focusing on family relationships, and a time when attitudes to gender roles and gender equality become increasingly important to the choices they make about how they live their lives.

The *Baby Makes 3* project closely adheres to the VicHealth (2007) framework guiding the primary prevention of violence against women, and responds to *Action Theme One: Promoting equal and respectful relationships between men and women*. The project seeks to prevent violence before it occurs by:

- supporting men and women through the transition to parenthood,
- altering traditional attitudes to gender roles,
- raising awareness of the importance of maintaining gender equality during family formation, and
- providing practical skills and strategies for maintaining equal and respectful relationships.

To prevent violence against women it is crucial to target men, and targeting first time fathers not only acknowledges that men have a positive role to play in helping to end men's violence against women, but they also play an important role in shaping the attitudes and behaviours of children. As a collaboration

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between antenatal and postnatal health services, *Baby Makes 3* presents a significant opportunity to work with men (and women) during their transition to parenthood – a time when issues of gender roles, gender equality and family relationships are relevant and likely to be given proper consideration.

Relationship between phase one and phase two

The rationale for the *Baby Makes 3* project was developed during phase 1 – a research project aimed at identifying ways that Organizations can support first time fathers in acting respectfully, responsibly and in non-violent ways. Key themes to emerge from the research undertaken in phase 1 included:

- ☐ The dominance of traditional gender roles during family formation, and
- ☐ The lack of awareness and understanding in relation to gender equality
- ☐ Lack of awareness of the strategies by which new families can maintain equality in their relationships

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The research also identified that current services targeting first time families:

- ☐ Fail to address the mother/father relationship in terms of promoting gender equality,
- ☐ Reinforce traditional gender roles, and
- ☐ Fail to address male family violence

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A significant achievement of phase one was the development of a shared understanding among partner Organisations of the nature and scale of family violence as it relates to first time families, and an acknowledgement that organisations could (and should) be doing more to serve new families in a holistic way by promoting equal and respectful relationships.

Phase 1 identified a number of potential strategies for assisting first time fathers to relate to their partners with respect, responsibility and equality. The principles underlying these strategies include:

- ☐ Engaging men and women throughout the transition to parenthood – including before and after the birth – with a shared and consistent approach across organisations and settings.
- ☐ Enhancing first time mothers' and fathers' ability to cope with relationship and lifestyle changes by addressing gender roles and gender equality.
- ☐ Assisting first time mothers and fathers in the transition to parenthood by promoting the importance of equal and respectful relationships, and developing strategies for achieving this.
- ☐ Placing greater emphasis on male behaviours and early intervention in family violence situations.

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Phase 2 of *Baby Makes 3* involves the implementation of these strategies. Phase 2 is likely to succeed for a number of reasons:

- By involving both antenatal and postnatal services, the project promotes a consistent message throughout the transition to parenthood.
- The Maternal Child Health Service is already engaging male partners as part of its New Parents Groups, thereby overcoming the barrier of engaging men in health promotion.
- The inclusion of a professional development component of the project means that outcomes are likely at both the individual/family level and at the Organisational level.

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Phase 2 is an innovative approach to working with first time families. It acknowledges the societal changes that have occurred over the past generation and the need for a more developed approach to supporting men and women in their transition to parenthood. It aims to serve new families holistically by promoting equal and respectful relationships. The scale-up of the project allows the identified strategies to be implemented and evaluated.

Target population

Baby Makes 3 is a collaborative project building on existing partnerships between health and family violence services in the City of Whitehorse, in the eastern metropolitan region of Melbourne. The project targets first time families in the Whitehorse community, typically, men and women aged 15-44yrs.

The Whitehorse community is diverse with almost one-third (31.8%) of residents born overseas in a wide range of countries. Of those born overseas, the largest numbers are from the United Kingdom [4.3%], China [excluding Taiwan Province] [2.4%], Greece [1.5%], Italy [1.5%], Malaysia [1.4%], Viet Nam [1.4%], New Zealand [1.3%], Hong Kong [1.0%], India [0.9%] and Sri Lanka [0.8%].

There is the potential to reach a large number of men and women throughout the duration of the project. At Birralee Maternity Service (Box Hill Hospital) there are approximately 2000 births per year. Of these, 800 births are a couple's first baby; with 500 couples attending mainstream childbirth education classes.

The Whitehorse Maternal and Child Health Service has direct contact with 900 first time families per year, with a significant proportion of these attending new parents groups, and many first time fathers attending special 'fathers nights'.

Baby Makes 3 is conceptualised as a universal service, targeting all first time families attending the partner organizations. However, depending on the availability of funding from other sources, the size of the project may limit its capacity to reach all first time parents. Nonetheless, it is estimated that *Baby Makes 3* will have contact with at least 400 and potentially up to 2000 couples in each year of the project.

Project management

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Phase 2 will maintain the existing partnership between:

- Whitehorse Community Health Service
- City of Whitehorse, Maternal and Child Health Service
- Birralee Maternity Service, Box Hill Hospital (Eastern Health)
- Eastern Domestic Violence Service

The *Baby Makes 3* team will be established within the Primary Health Care Program at Whitehorse Community Health Service. A *Baby Makes 3* team leader will be employed to plan and organise project activities with line management from the Manager of the Primary Health Care Program.

A reference group made up of representatives from the partner organisations and other key stakeholders was established during phase 1 and this reference group will continue during phase 2 to provide direction for the running of the program.

Project objectives and strategies

Objective 1: To engage men and women attending antenatal clinics, or childbirth education classes at Birralee Maternity Service in individual, couple or group work that increases their awareness of how attitudes to gender roles and gender equality can influence the health of their relationships and their family's wellbeing.

Strategies:

- ☐ Development of a group work curriculum focusing on gender roles and gender equality designed to prepare men and women for the lifestyle and relationship changes that accompany the birth of their first child
- ☐ The *Baby Makes 3* team will be present during antenatal clinics to offer support and education to individuals & couples interested in preparing for lifestyle and relationship changes following the birth of their babies
- ☐ The *Baby Makes 3* team will facilitate group discussions and deliver presentations during childbirth education classes, addressing issues of gender roles and gender equality, to assist in preparing couples for the lifestyle and relationship changes that will follow the birth of their babies
- ☐ The *Baby Makes 3* team will deliver additional antenatal groups according to demand

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Objective 2: To engage men and women attending 'new parents groups' at Maternal and Child Health Centres in the City of Whitehorse, in at

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least two group sessions aimed at promoting equal and respectful relationships during early parenthood.

Strategies:

- ▢ Design and development of a group work curriculum to provide education to first time parents addressing:
 - gender roles: balancing work and family
 - promoting father involvement in caring and nurturing of infants
 - developing an awareness of gender equality
 - maintaining equal and respectful relationships
- ▢ The *Baby Makes 3* team will deliver the group program to 'New Parents Groups' over 2 to 3 sessions
- ▢ The *Baby Makes 3* team will be available to offer support and education to individuals & couples identified by Maternal and Child Health Nurses as requiring additional support

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Objective 3: To engage midwives and Maternal Child Health nurses in partner organisations in professional development workshops that increase their skills and understanding of preventing family violence by promoting equal and respectful relationships between men and women during the transition to parenthood.

Strategies:

- ▢ Conduct workshops with antenatal and postnatal health professionals to develop a shared understanding of family violence as it relates to first time parents, and to improve skills in recognising and responding to family violence
- ▢ Conduct workshops with antenatal and postnatal health professionals to develop skills in engaging with men in ways that avoid collusion with male family violence
- ▢ Conduct workshops with antenatal and postnatal health professionals to develop a shared understanding of the ways workers can promote equal and respectful relationships
- ▢ To work with Birralee Midwives and Maternal and Child Health Nurses to develop skills in conducting group work programs

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Expected outcomes

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The Baby Makes 3 project closely follows the VicHealth (2007) framework to guide primary prevention of violence against women. As such, the expected outcomes are closely aligned to those outlined in the framework. Intermediate outcomes are expected at individual/relationship, organisational and community levels.

Outcomes at the Individual/Relationship Level:

- | ☐ Enhanced ability of families to cope with relationship and lifestyle changes, and greater awareness among new parents of how attitudes to traditional gender roles can affect relationship equality
- | ☐ Increased capacity of families to manage the stresses that arise during family formation
- | ☐ Respectful and equitable gender relations
- | ☐ Men behaving responsibly, respectfully and in non-violent ways towards their partner
- | ☐ Improved skills in non-violent conflict resolution
- | ☐ Improved connections to resources and support

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Outcomes at the Organisational Level:

- | ☐ Greater awareness among health professionals of how attitudes to traditional gender roles can affect relationship equality
- | ☐ Increased capacity of services to respond holistically to first time families
- | ☐ Greater collaboration across sectors to address family violence
- | ☐ Expanded knowledge as to the effectiveness of family violence prevention programs
- | ☐ Promotion and facilitation of equal respectful and non-violent gender relations

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Outcomes at the Community Level:

- | ☐ Improved connections between community members and sources of formal and informal support
- | ☐ Communities that model and promote respectful and equitable gender relations

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Concluding remarks

The proposed *Baby Makes 3* is an innovative project that responds to a gap in service delivery. Currently there is no service that promotes healthy relationships among men and women during their transition to parenthood. This is despite the fact that the quality of a couple's relationship is a key factor in determining their children's health and wellbeing.

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It is also despite the fact that intimate partner violence is a key risk factor contributing to the burden of disease in Victorian women of childrearing age. It is remarkable that for women preparing for childbirth, all other major risk factors (illicit drugs, alcohol, exercise, body weight, cholesterol, blood pressure, tobacco) are comprehensively addressed, but the major risk factor – intimate partner violence – is not.

The only relationship services in existence are 'downstream' services that provide late intervention to relationship problems. In contrast, *Baby Makes 3* seeks to implement a health promotion approach to relationships and fill what is a gaping hole in current services. The escalation of intimate partner violence during pregnancy and following childbirth is evidence enough that the service is necessary.

Not only does *Baby Makes 3* fill a gap in current service delivery, but the capacity building component of the project will contribute to sustained changes in service delivery, increasing the ability of the partner organisations to serve families holistically and increasing opportunities for preventing violence against women. The production of group program curriculums and the professional development aspects of the project will ensure the sustainability of the project.

There is also enormous potential for the program to be extended to other local government areas thereby providing state-wide access to the program.

Baby Makes 3 is an exciting and innovative project that endeavours to break new ground in working with men and women around issues of gender equality. With a firm foundation in theory, a strong focus on the social determinants of family violence, and a working partnership of existing services committed to the development of strategies to promote safety and wellbeing among new families, the project promises to be highly influential in changing male behaviours, and to deliver positive results in the prevention of family violence.

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Appendices

Appendix A - Workshop Evaluation Questionnaires

Appendix B - Workshop Evaluation Results

Appendix C - Questionnaire for First Time Fathers

Appendix D - Results of First Time Fathers Questionnaires

Appendix E - Format for interviews with First Time Fathers

Appendix F - Position Description – *Baby Makes 3* Team Leader

Appendix G - Position Description – *Baby Makes 3* Relationship Support Worker

Baby Makes 3

Promoting safety and wellbeing among new families



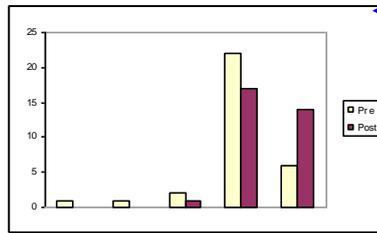
WORKSHOP EVALUATION QUESTIONNAIRE

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
<i>Your knowledge of family violence</i>					
Family violence is common in our community	<input type="radio"/>				
Family violence is a serious issue for child and family services	<input type="radio"/>				
Family violence is committed equally by men and women	<input type="radio"/>				
I have a good awareness of the different types of family violence	<input type="radio"/>				
<i>Causes of family violence</i>					
Family violence results from people getting so angry that they temporarily lose control	<input type="radio"/>				
Family violence can be partly excused if, afterwards, the violent person genuinely regrets what they have done	<input type="radio"/>				
Family violence can be partly excused if the violent person is genuinely suffering from emotional stress or strain	<input type="radio"/>				
In many cases, family violence occurs because the violent person has been provoked	<input type="radio"/>				
Family violence occurs due to a lack of effective communication between partners	<input type="radio"/>				
<i>Effects of family violence</i>					
It is hard to understand why women stay in violent relationships	<input type="radio"/>				
I have a good awareness of the effects that family violence has on women	<input type="radio"/>				
I have a good awareness of the impact that exposure to family violence has on babies and young children	<input type="radio"/>				
<i>Responding to family violence</i>					
I would feel confident to ask clients about their possible experience of family violence	<input type="radio"/>				
I am confident I would respond appropriately if a client disclosed an experience of family violence	<input type="radio"/>				
I know where to refer a client who has experienced family violence	<input type="radio"/>				

Evaluation Results

1. Family violence is common in our community

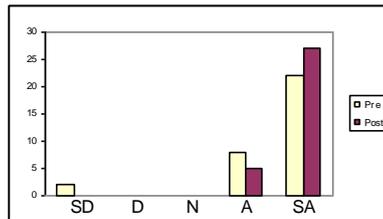
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre	1	1	2	22	6
Post	0	0	1	17	14



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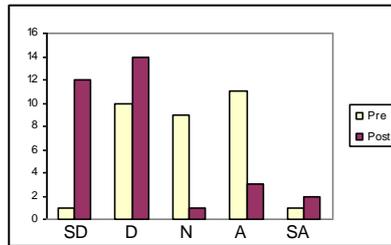
2. Family violence is a serious issue for child and family services

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre	2	0	0	8	22
Post	0	0	0	5	27



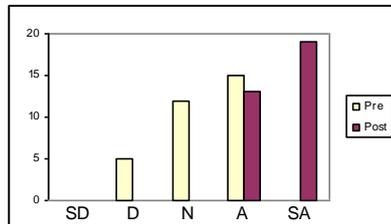
3. Family violence is committed equally by men and women

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre	1	10	9	11	1
Post	12	14	1	3	2



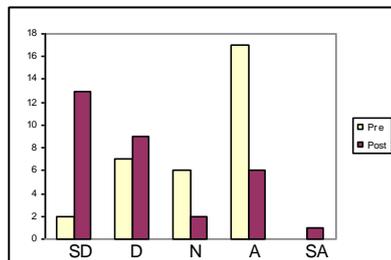
4. I have a good awareness of the different types of family violence

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre	0	5	12	15	0
Post	0	0	0	13	19



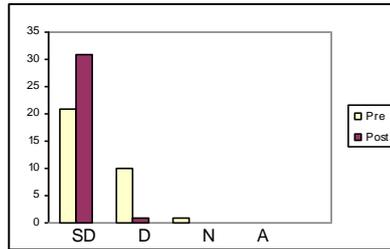
5. Family violence results from people getting so angry that they temporarily lose control

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre	2	7	6	17	0
Post	13	9	2	6	1



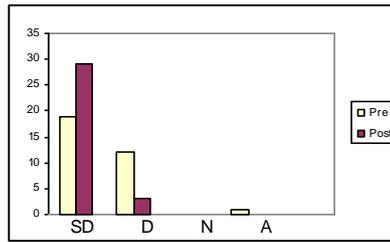
6. Family violence can be partly excused if, afterwards, the violent person genuinely regrets what they have done

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre	21	10	1	0	0
Post	31	1	0	0	0



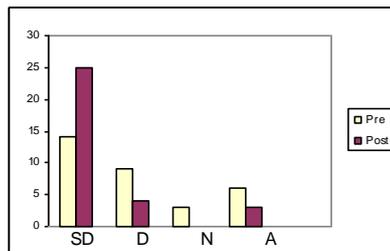
7. Family violence can be partly excused if the violent person is genuinely suffering from emotional stress or strain

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre	19	12	0	1	0
Post	29	3	0	0	0



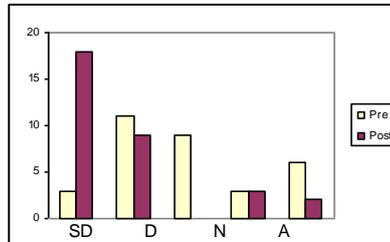
8. In many cases, family violence occurs because the violent person has been provoked

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre	14	9	3	6	0
Post	25	4	0	3	0



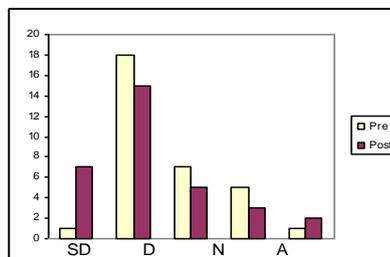
9. Family violence occurs due to a lack of effective communication between partners

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre	3	11	9	3	6
Post	18	9	0	3	2



10. It is hard to understand why women stay in violent relationships

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre	1	18	7	5	1
Post	7	15	5	3	2

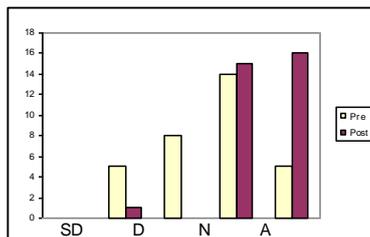


Appendix B

Workshop Evaluation Results

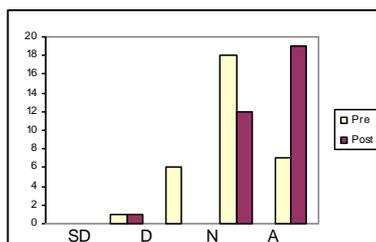
11. I have a good awareness of the effects that family violence has on women

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre	0	5	8	14	5
Post	0	1	0	15	16



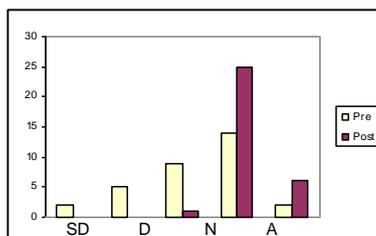
12. I have a good awareness of the impact that exposure to family violence has on babies and young children

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre	0	1	6	18	7
Post	0	1	0	12	19



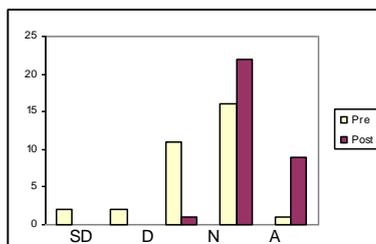
13. I would feel confident to ask clients about their possible experience of family violence

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre	2	5	9	14	2
Post	0	0	1	25	6



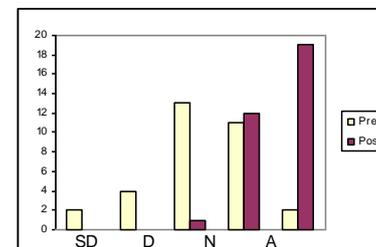
14. I am confident I would respond appropriately if a client disclosed an experience of family violence

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre	2	2	11	16	1
Post	0	0	1	22	9



15. I know where to refer a client who has experienced family violence

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre	2	4	13	11	2
Post	0	0	1	12	19



And Baby Makes 3

researching the needs of first time fathers



Questionnaire for First Time Fathers

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Attending antenatal classes helped me to feel more <i>confident</i> during the birth of our baby					
The antenatal classes prepared me well for the changes in <i>lifestyle</i> after our baby was born					
The antenatal classes prepared me well for the <i>relationship</i> changes after the birth of our baby					
The antenatal classes prepared me well for my role as a <i>father</i>					
It would be good to have time in the antenatal sessions for men to discuss issues related to men and <i>becoming a father</i>					
It would be good to have a <i>male facilitator</i> to work with expectant dads					

Do you have any suggestions about how we could improve the way antenatal classes meet the needs of first time fathers?

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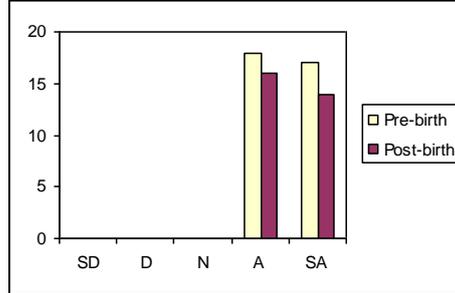
.....

Thankyou for your time!



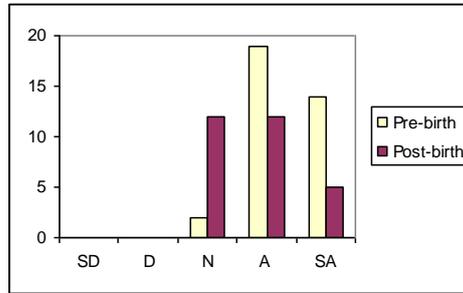
Q1. Attending the antenatal workshops helped me to feel more *confident* about the impending birth of our baby

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre - birth	0	0	0	18	17
Post - birth	0	0	0	16	14



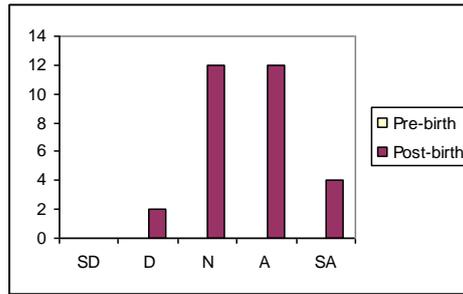
Q2. I feel better prepared for the changes that will happen to our *lifestyle* after the birth of our baby

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre - birth	0	0	2	19	14
Post - birth	0	0	12	12	5



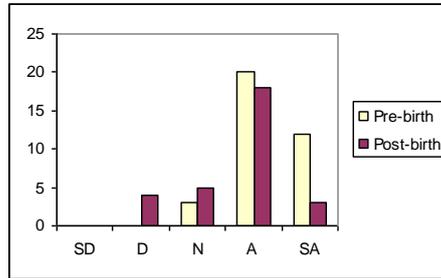
Q3. The antenatal classes prepared me well for the *relationship* changes after the birth of our baby

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre - birth	-	-	-	-	-
Post - birth	0	2	12	12	4



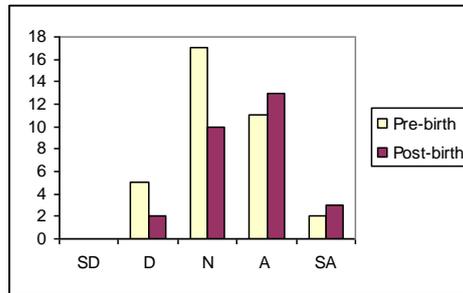
Q4. I feel better prepared for my role as a *first time father*

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre - birth	0	4	3	20	12
Post - birth	0	0	5	18	3



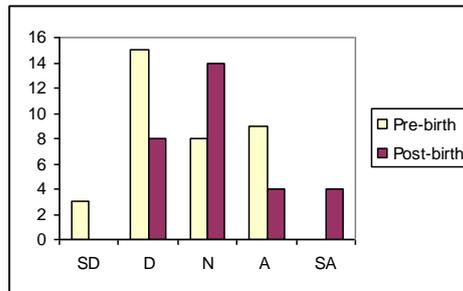
Q5. It would have been good to have had time in the workshop for men to discuss issues related to becoming a father

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre - birth	0	5	17	11	2
Post - birth	0	2	10	13	5



Q6. It would have been good to have had a male facilitator to work with expectant dads

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Pre - birth	3	15	8	9	0
Post - birth	0	8	14	4	4



Interview Format

1. Introduction

- ☐ Introduce project aims:
 - conducting research into the needs of first time fathers
 - to develop strategies for promoting wellbeing among new families
- ☐ Outline purpose of interview:
 - obtain information about the relationships between men and women during the transition to parenthood
 - obtain input into the design of services for first time fathers
- ☐ Obtain permission to tape record the session

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2. Relationship Changes

Intro: Most discussions around fatherhood revolve around adjusting to life with a new baby, but during the transition to fatherhood, there are also many changes that occur in your relationship with your partner.

- ☐ What changes have arisen in your relationship with your partner as a result of becoming a parent?
- ☐ What effect has these changes had? Have they been positive or negative?
- ☐ Looking back, how well prepared were you for these changes?
- ☐ Did you have any discussions with other males about what you might expect?
- ☐ What did these discussions involve and were they useful?

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3. Gender Roles

Intro: One of the issues that first time fathers are facing these days is the changing role of fathers in the family. The traditional model was that men were primarily 'breadwinners' and it was the woman's role to raise the children. Nowadays however, a new model is emerging where fathers are expected to be much more involved in the care of children.

- ☐ How would you describe your level of involvement and do you feel there is an expectation that you should be more involved?
- ☐ What is it that stops you from becoming more involved?
- ☐ To what extent should fathers be involved in the care of young babies?
- ☐ Thinking about your own family model – the extent to which it is a 'traditional' model or a 'new' model – How did you come to this arrangement?
- ☐ Did you discuss it with your partner prior to birth?
- ☐ To what extent was it a contested issue?
- ☐ Did you discuss it with other males?
- ☐ To what extent was it just assumed that you and your partner would operate in this way?

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4. Gender Relations

Intro: Another issue that is relevant in contemporary society is that of equality in relationships. The changes that occur at the birth of a child can also have impacts on couples perceive the degree of equality within a relationship.

- ☐ How has having a baby changed the level of equality in your relationship?
- ☐ Would you consider that your relationship was more equal before the birth?
- ☐ What answer would your partner give?
- ☐ How can you have a truly equal relationship when mothers and fathers generally do different things?
- ☐ Have you made any changes to the way you do things in order to foster greater equality?
- ☐ How would you know if perceived inequality was becoming a problem in your relationship?

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5. Service Delivery

Intro: I am also interested in your experiences of the services that are current available to first time fathers

Antenatal Classes

- ☐ How well did antenatal classes prepare you for the relationship changes that followed the birth?
- ☐ What was your experience of antenatal class?
- ☐ Would having a male facilitator made a difference?
- ☐ Would having a male-specific session have been beneficial?

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Postnatal Classes

- ☐ If you attended any parenting classes after the birth, what was your experience of these?
- ☐ Did the class contain information about relationship changes
- ☐ If you didn't attend, why not?
- ☐ Do you think parenting classes after the birth of a child are a good idea?
- ☐ Would you attend if there was more father specific content?
- ☐ Would the presence of a male facilitator make a difference?
- ☐ Would a workday or weekend be best?

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Other Services

- ☐ If you have accessed any other services for either parenting or relationship issues, were these useful?

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6. Additional

Sex

- ☐ What was your experience of changes to your sex life?
- ☐ How did you as a couple deal with this?
- ☐ What would you say to another first time father who was asking for your advice on this matter?

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Anger and frustration

- ☐ Following the birth, did you find that anger and frustration were an issue for you?
- ☐ What was the source of this do you think?
- ☐ What would you say to another first time father who was asking for your advice on this matter?

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Other

What other advice would you give a first time father?

7. Summing Up

- ☐ Thank participants for their involvement
- ☐ Obtain contact details if interested in receiving the findings of the research
- ☐ Invite further comments if participants are interested (provide contact details)
- ☐ Thank participants again for their involvement

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Position Description

Baby Makes 3 -Team Leader

POSITION:	<i>Baby Makes 3</i> – Team Leader
REPORTS TO:	Primary Health Care Manager
CLASSIFICATION:	Social and Community Service Award
TIME FRACTION:	0.4 EFT, fixed term – August 2008 to June 2011 After hours work required
APPROVED:	CEO and Date
REVIEWED:	Date

PRIMARY OBJECTIVE:

Whitehorse Community Health Service works within a Social Model of Health framework in delivering a range of services, programs and health promotion initiatives in response to identified population health needs within the Whitehorse community.

The position is responsible for the provision and development of services in accordance with a new and innovative family violence prevention project titled *Baby Makes 3*.

The *Baby Makes 3* project seeks to fill a gap in current service delivery by promoting healthy relationships between men and women throughout their transition to parenthood. *Baby Makes 3* is a collaborative project between 4 partner organisations: Whitehorse Community Health Service, Birralee Maternity Service (Box Hill Hospital), Maternal and Child Health Service (City of Whitehorse) and Eastern Domestic Violence Service. The three year project aims to work across partner organisations, in antenatal, postnatal and community health settings to challenge cultural norms associated with traditional gender roles in new families, and to give first time parents the information and skills they need to create equal and respectful relationships.

Aspects of the role include:

- ▣ Project management
- ▣ Provision of relationship support and education to new parents
- ▣ Development of a group work curriculum
- ▣ Facilitation of group work with new parents
- ▣ Facilitation of professional development workshops

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KEY DUTIES:**Project Management**

- | ☐ Coordinate the implementation of the *Baby Makes 3* project in accordance with project aims and objectives as specified in funding documentation
- | ☐ Work with the project reference group to develop, monitor and refine systems, policies and procedures that support the effective implementation of *Baby Makes 3*.
- | ☐ Provide feedback to the reference group by facilitating regular reference group meetings
- | ☐ Ensure the establishment and sustainability of the project by maintaining linkages between partner organisations
- | ☐ Work collaboratively with external evaluators

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Staff Management

- | ☐ Lead and supervise team members to ensure achievement of project aims and objectives
- | ☐ Provide formal supervision and support to team members
- | ☐ Assist staff in developing and accessing resources to support the project

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Human Resources

- | ☐ Participate in recruitment, selection and orientation of staff to the team
- | ☐ Check and authorise staff timesheets, leave applications etc...
- | ☐ Receive notification and respond appropriately when staff are unable to attend work

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Health Promotion

- | ☐ Lead the development of a group work curriculum focussing on gender roles and gender equality, designed to prepare men and women for the lifestyle and relationship changes that accompany the birth of their first child
- | ☐ Provision of relationship support and education for individuals and couples
- | ☐ Co-facilitation of group work addressing gender roles and gender equality with first time parents
- | ☐ Be instrumental in the design and facilitation of professional development workshops for health professionals aimed at: developing a shared understanding of family violence, developing skills in engaging with men in ways that avoid collusion with male family violence, and developing a shared understanding of ways workers can promote equal and respectful relationships
- | ☐ Work alongside midwives and MCH nurses to develop their skills in conducting group work programs
- | ☐ Facilitate and support community action to promote healthy and respectful relationships

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Service Development and Networking

- | ☐ Identify further opportunities for ongoing development and sustainability of project activities
- | ☐ Work closely with the Project Reference Group, WCHS staff, and partner agencies to develop strong links with broader health & welfare service system
- | ☐ Participate in capacity building projects with partner organisations

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Organisational

Position Description:

Baby Makes 3 – Team Leader

- ▣ Participate in programs, meetings and activities that contribute to the ongoing improvement of the WCHS as negotiated with line manager
- ▣ Participate in the organisational continuous quality improvement program
- ▣ Participate in the performance management system including the development and monitoring of an individual work plan and annual performance review.
- ▣ Implement WCHS procedures and protocols in the planning, delivery and evaluation of health promotion activities

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Record Keeping

- ▣ Collect and report statistics and other associated information in relation to the project objectives as relevant
- ▣ Undertake evaluation activities in conjunction with external evaluator
- ▣ Prepare and submit reports as required, as per the project funding agreement
- ▣ Create and maintain files and records of interagency interactions

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Occupational Health and Safety

- ▣ Follow and promote safe work practices, procedures and instructions as per WCHS policies and procedures
- ▣ Perform all duties in a manner, which ensures personal health and safety and that of others in the workplace
- ▣ Report all hazards or incidents that cause or may cause harm
- ▣ Undertake training in fire and emergency procedures required by WCHS
- ▣ Ensure a safe and clean work environment according to quality standard

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POSITION DIMENSIONS:

Direct Reports: Nil

Internal Liaisons: Men's Health Team
Primary
Other WCHS service providers in the broader multi disciplinary team

External Liaisons: Project Reference Group
Other relevant health, welfare and community agencies
Relevant community groups

QUALIFICATIONS AND EXPERIENCE:

Mandatory Qualifications

- ▣ Relevant tertiary qualification in Health/Social Sciences such as Social Work, Psychology or Counselling.
- ▣ Minimum of five years experience working in the primary health care or welfare sector

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- ☐ Current drivers licence

Desirable Qualifications

- ☐ Post graduate qualifications in a related and relevant area
- ☐ Work experience in the family violence service system

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Experience and Skills

- ☐ Experience in working with families (especially men) with particular reference to early childhood and parenting and relationship issues including family violence
- ☐ Excellent interpersonal skills, ability to establish relationships with clients peers and stakeholders
- ☐ Capacity to work with minimal supervision and engage in the planning, implementation and evaluation of services and programs
- ☐ High level communication skills, including public speaking skills, ability to engage and encourage effective group communication
- ☐ Demonstrated experience in facilitating groups and workshops
- ☐ Ability to work closely with, and take direction from, a reference group
- ☐ Ability to work autonomously within community based environments
- ☐ Well developed interpersonal skills and the ability to liaise and develop effective working partnerships with diverse interest groups
- ☐ Good oral and written communication skills
- ☐ Computer literacy
- ☐ Good problem solving skills, initiative and the ability to be flexible and responsive to issues and new developments
- ☐ Commitment to organisational values, the Social Model of Health and Primary Health Care
- ☐ Capacity to take initiative and engage in the planning, implementation and evaluation of health promotion initiatives
- ☐ Awareness of and willingness to respond to the needs of clients from culturally and/or linguistically diverse backgrounds.
- ☐ Demonstrated knowledge and experience working within a health promotion framework
- ☐ Commitment to the principles of continuous quality improvement.

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KEY PERFORMANCE OBJECTIVES

Key performance objectives as negotiated through work plan development.

I understand the role, duties and responsibilities as outlined above.

Date: _____

Position Description:

Baby Makes 3 – Team Leader

Manager _____

Date: _____

KEY SELECTION CRITERIA

Please ensure you address the key selection criteria in your application

- KSC1** Relevant qualifications and work experience
- KSC2** Project management skills and experience in the design and implementation of systems and programs
- KSC3** Effective leadership skills and ability to support a team of workers
- KSC4** Experience in working with families (especially men) with particular reference to early parenting and relationship issues including family violence
- KSC5** High level communication skills, including public speaking skills, ability to facilitate effective group communication
- KSC6** Ability to design and deliver professional development workshops
- KSC7** Experience in developing collaborative links with health and welfare workers and other service providers
- KSC8** Demonstrated skills and experience in engaging with the target group using a health promotion framework
- KSC9** Well developed problem solving skills and the ability to work autonomously within a community based environment



Position Description

Relationship Support Worker

POSITION:	<i>Baby Makes 3</i> – Relationship Support Worker
REPORTS TO:	Primary Health Care Manager
CLASSIFICATION:	Social and Community Service Award
TIME FRACTION:	0.4 EFT, fixed term – August 2008 to June 2011 After hours work required
APPROVED:	CEO and Date
REVIEWED:	Date

PRIMARY OBJECTIVE:

Whitehorse Community Health Service works within a Social Model of Health framework in delivering a range of services, programs and health promotion initiatives in response to identified population health needs within the Whitehorse community.

The position is responsible for the provision and development of services in accordance with a new and innovative family violence prevention project titled *Baby Makes 3*.

The *Baby Makes 3* project seeks to fill a gap in current service delivery by promoting healthy relationships between men and women throughout their transition to parenthood. *Baby Makes 3* is a collaborative project between 4 partner organisations: Whitehorse Community Health Service, Birralee Maternity Service (Box Hill Hospital), Maternal and Child Health Service (City of Whitehorse) and Eastern Domestic Violence Service. The three year project aims to work across partner organisations, in antenatal, postnatal and community health settings to challenge cultural norms associated with traditional gender roles in new families, and to give first time parents the information and skills they need to create equal and respectful relationships.

Aspects of the role include:

- ☐ Provision of relationship support and education to new parents
- ☐ Development of a group work curriculum
- ☐ Facilitation of group work with new parents
- ☐ Facilitation of professional development workshops

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KEY DUTIES:

Health Promotion

- ▣ Development of a group work curriculum focussing on gender roles and gender equality, designed to prepare men and women for the lifestyle and relationship changes that accompany the birth of their first child
- ▣ Provision of relationship support and education for individuals and couples
- ▣ Co-facilitation of group work addressing gender roles and gender equality with first time parents
- ▣ Conduct professional development workshops for health professionals aimed at: developing a shared understanding of family violence, developing skills in engaging with men in ways that avoid collusion with male family violence, and developing a shared understanding of ways workers can promote equal and respectful relationships
- ▣ Work alongside midwives and MCH nurses to develop their skills in conducting group work programs
- ▣ Facilitate and support community action to promote healthy and respectful relationships

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Service Development and Networking

- ▣ Identify further opportunities for ongoing development and sustainability of project activities
- ▣ Work closely with the Project Reference Group, WCHS staff, and partner agencies to develop strong links with broader health & welfare service system

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Organisational

- ▣ Participate in programs, meetings and activities that contribute to the ongoing improvement of the WCHS as negotiated with line manager
- ▣ Participate in the organisational continuous quality improvement program
- ▣ Participate in the performance management system including the development and monitoring of an individual work plan and annual performance review.
- ▣ Implement WCHS procedures and protocols in the planning, delivery and evaluation of health promotion activities

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Record Keeping

- ▣ Collect and report statistics and other associated information in relation to the project objectives as relevant
- ▣ Undertake evaluation activities in conjunction with external evaluator
- ▣ Prepare and submit reports as required, per the project funding agreement

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Occupational Health and Safety

- ▣ Follow and promote safe work practices, procedures and instructions as per WCHS policies and procedures
- ▣ Perform all duties in a manner, which ensures personal health and safety and that of others in the workplace
- ▣ Report all hazards or incidents that cause or may cause harm
- ▣ Undertake training in fire and emergency procedures required by WCHS
- ▣ Ensure a safe and clean work environment according to quality standard

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POSITION DIMENSIONS:

Direct Reports: Nil

Internal Liaisons: Men's Health Team
Primary
Other WCHS service providers in the broader multi disciplinary team

External Liaisons: Project Reference Group
Other relevant health, welfare and community agencies
Relevant community groups

QUALIFICATIONS AND EXPERIENCE:

Mandatory Qualifications

- | ☐ Relevant tertiary qualification in Health/Social Sciences such as Social Work, Psychology or Counselling.
- | ☐ Minimum of three years experience working in the primary health care or welfare sector
- | ☐ Current drivers licence

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Desirable Qualifications

- | ☐ Post graduate qualifications in a related and relevant area
- | ☐ Work experience in the family violence service system

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Experience and Skills

- | ☐ Experience in working with families (especially men) with particular reference to early childhood and parenting and relationship issues including family violence
- | ☐ High level communication skills, including public speaking skills, ability to engage and encourage effective group communication
- | ☐ Demonstrated experience in facilitating groups and workshops
- | ☐ Ability to work closely with, and take direction from, a reference group
- | ☐ Ability to work autonomously within community based environments
- | ☐ Well developed interpersonal skills and the ability to liaise and develop effective working partnerships with diverse interest groups
- | ☐ Good oral and written communication skills
- | ☐ Computer literacy
- | ☐ Good problem solving skills, initiative and the ability to be flexible and responsive to issues and new developments
 - | ☐ Commitment to organisational values, the Social Model of Health and Primary Health Care
 - | ☐ Capacity to take initiative and engage in the planning, implementation and evaluation of health promotion initiatives
- | ☐ Awareness of and willingness to respond to the needs of clients from culturally and/or linguistically diverse backgrounds.
- | ☐ Demonstrated knowledge and experience working within a health promotion framework
 - | ☐ Commitment to the principles of continuous quality improvement.

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KEY PERFORMANCE OBJECTIVES

Key performance objectives as negotiated through work plan development.

Position Description: Baby Makes 3 – Relationship Support Worker

I understand the role, duties and responsibilities as outlined above.

_____ Date: _____

Manager _____ Date: _____

KEY SELECTION CRITERIA

Please ensure you address the key selection criteria in your application

- KSC1** Relevant qualifications and work experience

- KSC2** Experience in working with families (especially men) with particular reference to early parenting and relationship issues including family violence

- KSC3** High level communication skills, including public speaking skills, ability to facilitate effective group communication

- KSC4** Ability to design and deliver professional development workshops

- KSC5** Experience in developing collaborative links with health and welfare workers and other service providers

- KSC6** Demonstrated skills and experience in engaging with the target group using a health promotion framework

- KSC7** Well developed problem solving skills and the ability to work autonomously within a community based environment