Father Links Baby Shed Project Report
April 2011
Acknowledgements

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This project was partially funded by a seeding grant through the Families NSW South East Sydney Parenting Coordination Project under the auspice of the Benevolent Society in 2008. The project was facilitated by the Women’s Health and Community Partnerships unit of South Eastern Sydney Illawarra Health Service (SESIH) now known as South Eastern Sydney Local Health District.

This report was written by the Women’s Health and Community Partnerships unit

Cover photograph: Father and Daughter used with permission

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Executive Summary

This report outlines the development, implementation and outcomes of the Baby Shed Project, which was initiated and implemented by the Women’s Health and Community Partnerships unit of South Eastern Sydney Illawarra Health Service. A seeding grant to enable a pilot project was received from the Families NSW South East Sydney Parenting Coordination Project under the auspice of the Benevolent Society.

The Baby Shed Project is a health promotion project offering early intervention to increase fathers' engagement with their baby and enhance their confidence in parenting. A series of three Baby Shed groups were facilitated over a twelve-month period from March 2009 to March 2010.

This project was developed by the Women’s Health and Community Partnerships unit to address the limited availability of postnatal early parenting education programs for fathers. Early parenting education programs conducted through the Child and Family Health Services indirectly exclude fathers as the service generally targets new mothers. Child and Family Health Services have traditionally delivered a service to new mothers and babies as opposed to new parents and babies. As these programs are offered exclusively during working hours they may be unavailable to the majority of working fathers, thereby indirectly excluding them.

The intention of the Baby Shed groups was to provide a forum for men to talk about their experiences on transitioning to fatherhood; discuss the social and emotional changes for themselves, their partner, and their relationship while concurrently establishing a pattern of practical care-giving and emotional engagement between a father and his newborn baby. A health and peer support education model was utilised to normalise experiences and emotions as well as providing opportunity to increase fathers’ confidence engaging with their new baby. Developing the fathers’ skills and confidence with baby care activities also aimed to increase support for the mother through sharing the childcare responsibilities more equally between both parents.

The main objectives were to:

- provide and evaluate a postnatal group program designed specifically for fathers
- enhance emotional engagement between the father and their infant
- increase the capacity of fathers to take responsibility for the care of their infant

Attendance at the Baby Shed groups intended to increase the fathers’ confidence in caring for their baby. Increased emotional engagement and development of strong father-baby attachment
would be achieved through the promotion of father involvement and increased knowledge and understanding of normal infant communication and behaviour.

The effectiveness of the Baby Shed Project in engaging new fathers was measured by:

- attendance and retention rates over the duration of the group
- the fathers’ self assessment questionnaire of their perceived feelings of confidence and ability in their parenting skills before and after the group

These measures were seen as a useful in ascertaining the effectiveness of the group in changing fathers’ attitudes towards adopting the role of caregiver. All participants reported a positive change in their overall sense of confidence as caregiver to their baby over the course of the group. The presence of an experienced Child and Family Health Nurse, who was committed to involving fathers, was particularly well received by the father’s attending the group, and felt to be one of the most crucial factors in reaching the objectives of the program.

The pilot groups were free of charge, however, in order for the program to be sustainable, sources of funding would need to be identified and a fee for service structure may be required. The local Neighbourhood Centre where the initial groups were held has expressed interest in offering groups free of charge to fathers who are identified to have a high risk demographic.

The timing of the group on for three hours on Saturday mornings was approved of by the fathers’, however the ideal duration of the program remains uncertain. The Project Officer considered a consecutive six-week program was perhaps too great a commitment to expect from fathers’ adjusting to the life of their new family.

For many new fathers the time commitment may be a barrier in attending fathers groups. It would appear that fathers are highly focused on the immediate needs of adjusting to their new family situation and the usual strategies of engaging the community, such as the media, are ineffective at reaching fathers of newborn babies. A valuable lesson learned from the pilot groups was the need to change the promotional strategy in order to meet the widespread need for this group.

There has been a great deal of interest in this pilot program, which has served as a useful learning experience for the coordination of future programs. It is believed that this style of group program can easily be adapted to other health settings to improve the health outcomes for families through enriching relationships and sharing experiences and responsibilities.
Introduction

In 2009 the Families NSW South East Sydney Parenting Coordination Project under the auspice of the Benevolent Society was awarded a seeding grant to pilot an innovative postnatal service for new fathers. Families NSW were supportive of the Baby Shed Project as it contributed to their aim to establish a network of strategies and services that respond to the needs of children and parents. The main strategy comprised of linking families with appropriate sources of support and early intervention strategies during pregnancy and for the first eight years of the child’s life.

*A Head Start for Australia: An early year’s framework* (2004), NSW Commission for Children and Young People and Queensland Commission for Young People 2004, identified several national and international literature reviews which provide strong evidence to support investment in the early years.

Overview of the project

Three series of Baby Shed groups were funded as a pilot project and coordinated by the Women’s Health and Community Partnerships unit of South East Sydney and Illawarra Area Health Service. The Baby Shed is an early intervention, health promotion project with the aim to provide a forum for men to talk about their experiences on transitioning to fatherhood; discuss the social and emotional changes for themselves, their partner and their relationship while concurrently establishing a pattern of practical care-giving and emotional engagement between a father and his newborn baby. It aimed to enhance fathers’ confidence in parenting and improve family functioning by sharing the responsibilities and demands of newborn care between both parents and provide support for mothers.

A series of three groups were conducted in the period March 2009 to March 2010. The first two groups were conducted at the local Neighbourhood Centre. The final group was run in collaboration with Health Education Coordinator of the Royal Hospital for Women and facilitated in March 2010 at the hospital. There was a perception amongst the group co facilitators that holding the group at the hospital would give it more credibility and make it accessible to a wider socially and culturally diverse population of fathers.

Background

The need for postnatal fathers’ programs such as the Baby Shed reflects a broad change in social attitudes towards the role of fathers in childrearing. Lamb (1998) noted a major shift in the literature with respect to the influence of fathers on child development. He stated that in the 1970s, developmental psychologists considered the involvement of fathers in active parenting
unimportant to developmental outcomes in children. However, since then there has been a near complete reversal of this attitude with acknowledgment of the important developmental influence of fathers for long term social, emotional and developmental outcomes for children. Recent research highlights the crucial importance of the quality of father-child bonding to the development of children’s emotional resilience and long-term psychosocial developmental outcomes (Huppert et al 2010, Lamb and Lewis 2004, Lamb and Tarnis-LeMonda 2004). In addition, McCain and Mustard (1999) noted this particularly where a close emotional bond is established early in the child’s life.

In a parallel trend, Berlyn et al (2008) acknowledge “a strong sense in the literature that the experience and practice of fatherhood in modern industrialised societies like Australia has undergone major transformations in recent decades”. A trend towards women’s greater workforce participation has resulted in an expectation of greater parental sharing of childrearing activities. However, recent evidence suggests that changes in parenting practices have been limited, and there are still large differences between mothers and fathers in the time given to childcare and the type of childcare provided (Craig 2003).

Attachment theorists note that a long term close emotional bond emerges from the pattern of emotional communication that accompanies the numerous daily instances of attention to infants’ basic physical needs such as hunger, tiredness and temperature regulation by the primary carer/s (Schore 1994). Time spent providing physical care is an important factor in establishing close parent-child bonds. Russel et al (1999) state that fathers’ report minimal involvement in infant care as a barrier to the establishment of close long term bonds between fathers and their children. New fathers’ reported lack of confidence in infant care, as well as the perception that infant care, by virtue of its strong association with breastfeeding, as ‘women’s business’. In addition mens’ focus on their work and career may limit new fathers’ participation in infant care.

Attachment theory argues that a strong and enduring emotional bond emerges from repeated experiences of basic care given by adult caregivers to infant children. Attachment theory, is based on the work of Bowlby (1984), describes the affective bond that develops between an infant and a primary caregiver. Attachment is defined as a pattern of interaction that develops over time as the infant and caregiver interact, particularly in the context of the infant’s needs and bids for attention and comfort.

Bowlby (1984) described the infant as biologically predisposed to form an attachment to the caregiver and to use the caregiver as a haven of safety or a secure base while exploring the environment, when the infant feels threatened he/she will turn to the caregiver for protection and comfort. The caregiver’s responses to such bids help mould the attachment relationship into a pattern of interaction that develops over the first year of life.
Sroufe (1996) has described the attachment relationship in terms of the dyadic regulation of the infant’s emotions and arousal. Since infants are not capable of regulating their own emotions they require the assistance of a primary caregiver in modulating their fluctuating emotions. The infant is equipped to express distress through crying and other means that are signals for the caregiver to respond. Responding to the infant’s signals keeps the distress and arousal within reasonable limits for both infants and caregivers and represents the beginning stages of coordination in the regulation process. In the first few months of the infant’s life the caregiver is solely responsible for regulating the infant’s emotions, which requires sensitivity to the infant’s signals.

Whilst much of health service delivery focuses on the caregiver role of mothers, recent literature indicates that a long-term, close emotional father-child bond emerges when fathers have a high level of involvement in the provision of care to their children. A close father-child bond is associated with improved outcomes in mental health, education, and general psychosocial functioning across the child's lifespan (McCain and Mustard, 2002). In addition, McCain and Mustard state that this close father-child bond plays a preventative role in that a high level of father-child interactions during infancy is understood to be a protective factor in areas such as child protection and postnatal depression.

The literature indicates that Child and Family Health Services have a very poor record of engaging fathers (Fletcher et al 2001, Fletcher 2003). This finding is supported at local level by informal verbal reports from Child and Family Health Nurses involved in the Baby Shed Project, noting that fathers’ currently constitute an extremely small proportion of parents accessing their services.

Child and Family Health Services have traditionally been seen as delivering a service to new mothers and babies as opposed to new parents and babies. Fletcher et al (2001) argue that if service delivery is to reflect changes in social attitudes towards more equitable parental sharing of childrearing, then the needs of fathers’ must cease being dismissed as unimportant. Fletcher et al (2001) identified the following thirteen impediments to effective service delivery to fathers by Child and Family Health Services:

1. Attitudes of health professionals and educators
2. Lack of skills of engagement among staff
3. Lack of appropriate models of male service delivery
4. Mothers as gatekeepers
5. Lack of information and resource materials
6. Lack of knowledge about men
7. Medical education versus fathering education
8. Fathers attitudes to services
9. Timing of child care and parenting classes
10. The format and staffing of child care and parenting classes
11. Failure to recognise fathers in family service settings
12. Perception of men as a threat to children
13. Socio-cultural attitudes

Fletcher et al (2001) suggest services acknowledge these barriers in order to design and implement specific ‘father friendly’ programs that account for gendered differences in engaging with health services.

Postnatal early parenting education programs conducted through the Child and Family Health Services indirectly exclude fathers, generally target new mothers and are presented in women’s cultural idioms. These programs are offered exclusively during working hours making them unavailable to most working fathers. Antenatal education programs have found the components of men-only sessions to be an effective way of promoting father’s interest in parenting (Galloway et al 1997).

Project Aims

The Baby Shed Project was seen as an extension of the success of the introduction of Father Links (SESIAHS 2007), the antenatal men-only discussion groups by providing a similar service for fathers in a hospital setting. The project targeted fathers attending birthing classes with their partners.

The format of the Baby Shed involved the provision of a male facilitated forum for men to discuss emotional, social and relationship changes associated with transitioning to fatherhood while simultaneously providing an opportunity to engage in the ‘hands-on’ experience of caring for their infant. The group structure was divided into two sections:

- Initially the whole family was included in the group process of introduction, outline of group aims and clarification of uncertainties
- Once the mothers’ were familiarised with the facilitators and venue they left the group.

This format was designed to ensure that the mothers’ were comfortable to leave their babies and for them to have some time for self care or to network with the other mothers. The project was developed to overcome an existing gap in Child and Family Health Services, which traditionally target new mothers.

The original plan for the program was to provide a series of three Baby Shed groups over a twelve month period. Each series would run over six consecutive-weeks held on a Saturday morning for fathers and their babies. The key objectives of the group design were to make it appealing and accessible to fathers. This included a Saturday morning timeslot, male focused
context, co-facilitation by a male health worker and a male community worker and delivered free of charge. In addition it was felt that the presence of a Child and Family Health Nurse would provide reassurance for the fathers once their partners left the group this nurse was female as there were no male Child and Family Health Nurses employed in the service during the time of the project implementation. The Nurse was available to model the practicalities of infant care such as nappy changing, wrapping, soothing and settling a crying baby and guide the fathers where necessary through the practice of new baby care skills. She was also available to provide information and advice on other aspects of infant development and care as needed.

The aims of the Baby Shed groups were to:

- deliver key health messages about early childhood development and bonding to increase men’s understanding of their baby’s needs
- assist and encourage fathers to provide support to their partner
- assist fathers to develop confidence in their interactions with their new baby through peer support
- encourage fathers to develop an independent supported play group structure to continue after the six-week facilitated phase of the program

The planned promotional strategy was to target a specific local geographical area to establish a local community group, which was thought to lead to an increased commitment to maintaining an ongoing, unsupervised phase of the group,

Health and peer support education models were utilised in order to increase the fathers’ confidence in engaging with their new baby. The intention was to establish an early pattern of practical care-giving and emotional engagement between fathers and their baby. Teaching baby care skills to fathers also aimed to increase support for mothers by sharing the childcare role between parents.

**Project Objectives**

The objectives of the Baby Shed Project were to:

- provide and evaluate a postnatal group program designed specifically for fathers
- enhance emotional engagement between the father and their infant
- increase the capacity of fathers to take responsibility for the care of their infant

**Health Indicators**

The effectiveness of the Baby Shed Project in engaging new fathers was measured by attendance and retention rates over the duration of the group, and self reported shifts in confidence, attitudes and ability to provide care to their baby. As the project approach was
holistic with a preventative, intergenerational and psychosocial focus, many anticipated health outcomes are long term, multi dimensional, and consequently difficult to measure. However, the fathers’ self assessment of their level of confidence and ability in the skills of early parenting before and after the group were seen as a useful measure of the effectiveness of the group in changing attitudes towards the father and caregiver role.

**Key Activities**

The following section outlines the key activities undertaken and the progress made towards achieving the project objectives:

**Objective 1**

**Provide and evaluate a postnatal group program designed specifically for fathers**

Over the term of the project, the Project Officer attended meetings with government and non-government services to develop a plan for a time limited small group for new fathers. Two co facilitators were identified, a case worker from the local Neighbourhood Centre and a Child and Family Health Nurse from the Child and Family Health Service.

A delivery plan for the group was developed in consultation with the co facilitators. It was agreed that the group would have a process-oriented format, thus the group would be largely unstructured allowing group participants and facilitators to identify relevant issues for discussion. An informal session plan was developed with an outline of topics to include normal infant behaviour, infant communication, infant development, practicalities of settling and sleeping, infant massage and play. Other topics discussed in the groups included adjustment to parenthood, managing stress associated with changed patterns of sleep, postnatal depression, changes in the parents’ relationship and the participants’ own experience of being fathered. Models of fatherhood and the various social constructs of fatherhood, including father as provider, protector, disciplinarian, emotional support for mother and the absent father were also included in discussions.

**Objective 2**

**Enhance emotional engagement between the father and their infant**

The Baby Shed groups’ objective to enhance the emotional engagement of the father with his infant was through the promotion of healthy, realistic attitudes by the father towards child rearing. There are many aspects to this objective, including assisting the father to understand
that ambivalence is a normal part of the parenting experience, and that relationships do not occur in a vacuum but are influenced in complex ways by present and past life circumstances.

The series of groups highlighted the importance of caregiver recognition of infant communication signals; including crying, smiling, posturing, gaze aversion and the importance of responding to these signals. The facilitators of the Baby Shed groups aimed to promote bonding, nurturance and emotionally responsive care which are essential for normal, healthy development of the infant. Attachment theory and research has led to a deeper understanding of the early care giving relationship, how it supports the infant’s early development, and how defining characteristics of a particular relationship are incorporated into the infant’s sense of self and carried forward into subsequent relationships.

**Objective 3**

**Increase the capacity of the father to take responsibility for the care of their infant**

It was intended that fathers would develop increased confidence in caring for their baby specifically in the areas of soothing, settling and handling the baby. This increased involvement would provide opportunities for the father to communicate with his baby resulting in increased emotional engagement and development of a strong father-infant attachment.

In order to plan an evaluation tool to assess the effectiveness of objectives 2 and 3 the project officer met with the Associate Professor of Maternal, Infant and Family Health, at the School of Nursing and Midwifery University of Western Sydney. Pre and post group questionnaires were prepared and distributed during the series of Baby Shed groups.

**Results**

**March and November 2009 Pilot Baby Shed Groups**

The program was promoted through local media, health and community networks and through the distribution of an advertising flyer. A feature article was published in the Southern Courier newspaper and the group was listed on the Resourcing Parents Strengthening Families website [www.resourcingparents.com](http://www.resourcingparents.com). In addition, presentations were made to Child and Family Health nurses and the Inner and Eastern Sydney Child and Family Interagency. Strong community interest in the group was anticipated as no similar service was currently being offered to fathers in the local community.

There was an unexpected limited response to the promotion of the first group held in March 2009. There were seven respondents; four indicated they were interested in attending the group. Two fathers’ did not attend as they thought it was a playgroup, and one didn’t provide
comment as to his reason for not attending. Consequently, the group was reduced from the planned six-week to a two-week program, with the two sessions being held a fortnight apart due to Easter holidays occurring between the two sessions.

Four fathers attended the first session along with their babies and partners. The whole family was included in the group process of introduction, outline of group aims and clarification of uncertainties. Once the mothers' were familiarised with the facilitators and venue they left the group. This format was designed to ensure that the mothers' were comfortable to leave their babies and for them to have some time for self care or to network with the other mothers. The mothers' stayed approximately forty five minutes then left the session for some free time, whilst the fathers stayed with their babies. The group, following the departure of the mothers’ focused on practical aspects of parenting such as baby care and settling. A DVD, *Hello Dad: Infant Communication for Fathers* (Good Beginnings Australia and The NSW Institute of Psychiatry 2007) was shown and discussed.

The mood of the group was relaxed and informal, with participants freely interacting and attending to their baby's needs as necessary. The age of the babies ranged between one to six months. All babies slept for the majority of the session.

Following a two-week break the second session was held. There were two fathers present at this session. One absent father had stated at the outset that he had a prior commitment and was unable to attend; another father advised the facilitators he was sick that morning. One mother came to the session and departed after thirty minutes. The group mood was of a relaxed conversational tone, which focused on settling and the Child and Family Health Nurse was available to demonstrate various settling techniques.

The sessions focused on fathers’ sharing their experiences of the pregnancy, birth, and care of their baby. In addition there was comparison of developmental stages experienced to date, demonstration of various care techniques by the nurse, and some disclosure of the challenges encountered. The majority of fathers’ were very positive about their experiences and seemed to be reasonably well resourced. One of the fathers’ reported considerable stress associated with baby health issues and prolonged hospitalisation. One of the fathers disclosed some tensions in the marital relationship resulting from changes associated with the arrival of a new baby.

Babies were fed and changed throughout the group and were integral to the group process. There was a willingness of the group to prioritise the needs of the baby where necessary. Upon conclusion, the men were very positive in their responses to the session.

Only one father returned a completed evaluation form (Appendix 1) from the March 2009 group. This evaluation and additional verbal feedback indicated a moderate increase in confidence and emotional engagement experienced by the participating father. The feedback provided from this group was used to direct the evaluation methods for the following two groups in the series.
The November 2009 program was also held in the local Neighbourhood Centre and conducted by the same team of co facilitators. Three fathers' attended the program over three consecutive Saturday's. Program content and group process was similar to the March 2009 group allowing for the normal variation which occurs between groups in a peer education model that is process-oriented rather than content-oriented.

March 2010 Group

The third series of groups were held at The Royal Hospital for Women. Nine fathers enrolled before intake was closed, confirming the co facilitator's assumption that the hospital setting would increase access to all fathers, potentially add credibility to the program and fathers’ feeling more secure in the hospital environment with availability of services. A further three men expressed interest in the program, but were unable to attend due to work commitments, physical health, and an unknown reason. All enrolled fathers attended all of the group sessions. Program content was similar to the previous two groups focusing on normal infant development, demonstration and modelling of infant care techniques, parental relationship, social and emotional impact of parenting transition and the importance of self care.

Fathers were asked to complete a questionnaire (Appendix 1) which included a self assessment scale for confidence in providing infant care and eleven infant care competencies pre and post group. Seven of the nine participating fathers completed both pre and post group questionnaires. The post group questionnaire was completed without reference to their initial set of responses, the Project Officer and Associate Professor considered this as an accurate method to identify changes in subjective sense of confidence and competence of the fathers.

Fathers’ were asked to rate on a scale of 1 – 10 their responses to questions regarding a range of care-giving activities and ability to assess their baby’s needs. The results showed changes in the father’s self-rated sense of confidence as measured in the pre and post questionnaire. All fathers’ showed a positive change in their overall sense of confidence as caregiver for their baby over the course of the group. This global sense of confidence-as-caregiver was the biggest quantitative change in any of the domains tested. Three of the fathers reported an increase in confidence across all domains. When the seven completed questionnaire responses were averaged there were increases in confidence across all domains.

The fathers were also asked qualitative questions that included what they found most and least useful in the group and how they felt the group had changed their parenting. The responses to qualitative questions gave a more general sense of how the group was perceived by the fathers. The father’s responded positively to the input of the Child and Family Health Nurse and they identified her as ‘the expert’ in childcare. The majority of the father’s indicated that they would
have preferred the group to have been more ‘structured’ and information focused in style rather than the interactive, process-oriented approach.

**Discussion**

The most valuable lesson learned from the two pilot groups in 2009 was the need to change the promotion and recruitment strategy. Initial response to group promotion was very limited. It would appear that fathers are highly focused on the immediate needs of adjusting to their new family situation and the usual strategies of engaging the community, such as media, are ineffective at reaching the fathers of newborn babies. A more comprehensive needs analysis of the target group may have provided greater scope for strategies to use when engaging with fathers’. Increased attendance at the final group indicated that focusing on networking with maternal and infant health practitioners, including but not limited to Midwives and Child and Family Health Nurses, resulted in more effective promotion, which may also have been enhanced by the hospital venue as opposed to a local Neighbourhood Centre. There was a perception amongst the group co facilitators that holding the group at the hospital would give it more credibility and make it accessible to a wider socially and culturally diverse population of fathers.

It is recommended that future promotional strategies focus on building collaborative partnerships with health professionals working directly with families. These include Antenatal Educators, Midwives, especially during the antenatal period, and Child and Family Health Nurses. Whilst health professionals were informed about the Baby Shed groups, it is believed that more education and information would lead to them actively promoting this model of postnatal parent education to new families. Perhaps for future groups additional information regarding appropriate promotional strategies and perspectives of the group could have been obtained from the participating fathers’ via telephone interview or questionnaires at a suitable timeframe post attendance at the groups, for example two to six weeks post participation.

The responses to the qualitative questions indicate a perceived need to slightly alter the content and format of the group, although the retention rate indicates the style of the group was similar to what new fathers find acceptable and did not result in withdrawal from the group prematurely. As the content and structure of the group resulted in achievement of the objectives it is recommended that any changes to the style are minimal.

The evaluations of the series were not comparable as each series was significantly different as the project developed. In hindsight a telephone survey performed two to six weeks after completion of the series may have optimised the evaluation. The evaluations did not confirm the preferred duration of the groups, and the preference for closed or open group formats.
The Baby Shed groups were designed to be delivered in a closed as opposed to an open group format. The Earlybird Facilitators Manual (SESIAHS 2005) defines a closed group as one in which the participants who attend the first session remain together for the duration of the group, in addition it further explains that closed groups have a definite time structure. Alternatively, open groups are continuous and ongoing; participants join and exit to meet their individual needs. Consideration needs to be given to the advantages and disadvantages of each structure, and what is considered the most appropriate format. In addition, the needs of the participants will determine the facilitation style as either a structured versus unstructured format.

There appears to be benefits in facilitating a postnatal group where both parents attend, and after initially sharing a group they are then separated by sex and gendered specific groups may be facilitated by same sexed facilitators. Additionally, the baby could be alternated between parents throughout the group to reduce a mothers’ anxiety when separated from her baby, and the fathers anxiety if his breast fed baby becomes hungry. The gendered groups could be brought together again to close the session.

The Royal Hospital for Women’s Health Education Coordinator has expressed strong interest in offering the groups on a fee for service basis to the general community. The local Neighbourhood Centre, where the initial groups were held, has sourced funding to facilitate the Baby Shed groups free of charge to populations in a high risk demographic. Male group facilitators from the Royal Hospital for Women antenatal program are to be trained to deliver this postnatal model of service provision. Two child and family health nurses have also expressed interest in co facilitating future groups, providing for a sustainable team in the longer term.

**Conclusion**

The three Baby Shed groups were partially funded as a pilot study by Families NSW South East Sydney Parenting Coordination Project under the auspice of the Benevolent Society and coordinated by the Women’s Health and Community Partnerships unit of South East Sydney Illawarra Area Health Service.

The Baby Shed groups were delivered free of charge, however, if the groups are to continue and be sustainable the program will need to identify sources of funding on an ongoing basis.

As the resources required for the Baby Shed program are minimal the program can easily be adapted to other health settings in community and hospital facilities. The establishment of a wide referral network including local Child and Family Health and Midwives is essential, as is the early engagement and support from these health professionals to assist in the recruitment of fathers.
The need for this group has been identified and there is interest from both local government and non government organisations in the area and the Health Education Coordinator of the Royal Hospital for Women. The Baby Shed Project has been an invaluable learning experience for the services directly involved and for services who are interested in facilitating similar projects in the future.

**Recommendations**

The Baby Shed Project report recommends Health, community and non government services:

- Commit to training and providing male group facilitators to develop and implement “father friendly” programs that account for gendered differences and are appropriate to fathers' needs and that minimise parental anxiety
- Provide or access an experienced Child and Family Health Nurse committed to involving fathers in childcare in the delivery of Baby shed groups
- Strive to develop sustainable groups by identifying sources of funding, providing the service during evenings and weekends to ensure ease of access, and providing Baby Shed groups free of charge for the high risk demographic
- Support Baby Shed facilitators to establish early engagement with and support from health professionals establish a wide referral network with maternal and infant health services who are essential for promotion of groups
Appendix 1: Pre and Post Group Questionnaire

Date:
Name:
Address:
Phone:
Age:
Ethnicity:
Partner’s Name:
Your Child’s Name:
Date of Birth:
Gender:

What do you want from this group?

How was the pregnancy and birth?

How are you and your partner coping with the baby?

Are there any health/developmental problems with the baby?

If you were left alone with your baby for the day, how confident would you feel?

Not confident
at all

Completely confident

1 2 3 4 5 6 7 8 9

With regards to the group, are there any issues we need to know about before we start?

How did you find out about the group?
The following statements describe what some parents believe about their abilities to take care of
their infants. After reading each statement, please circle which number that you feel most
closely describes how you feel about yourself in relation to parenting. There are no right or
wrong answers.

I have good judgment in deciding how to care for the baby.

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I am able to tell what my baby likes and dislikes.

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I am able to sense my baby’s moods.

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I am able to show my love for my baby.

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I am able to calm my baby when he/she is upset.

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I am able to stimulate my baby by playing with him/her.

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I am able to give my baby a bath without him/her getting cold or upset.

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<tr>
<th>Cannot do</th>
<th>Moderately certain can do</th>
<th>Certain can do</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I am able to manage the feeding of my baby.

<table>
<thead>
<tr>
<th>Cannot do</th>
<th>Moderately certain can do</th>
<th>Certain can do</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
How much of the time can you tell what your baby needs?

<table>
<thead>
<tr>
<th>Hardly ever</th>
<th>Almost all the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2 3 4 5 6 7 8 9</td>
</tr>
</tbody>
</table>

How well do you think you understand your baby’s needs?

<table>
<thead>
<tr>
<th>Hardly at all</th>
<th>Very well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
</tbody>
</table>

How much have the tasks of taking care of a new baby been satisfying?

<table>
<thead>
<tr>
<th>Not at all satisfying</th>
<th>Completely satisfying</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
</tbody>
</table>

Thank you for your cooperation with this questionnaire
Appendix 2: Immediate post group verbal comments from fathers

- Very positive environment
- Liked the interaction
- Liked the tips
- Having the early childhood nurse was a reassurance
- Would like more specifics
- 5 – 6 would be the optimum number
- Could focus workshops on specific issues e.g. settling
- I think I would have found it more difficult if it was in the first 4 weeks. I wouldn’t have come
- It was good really practical information
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