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Preventing violence
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Respect, Responsibility and Equality

Baby Makes 3

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I kept telling the guys at work,

'Guys, you should be doing this course'.

And they said, 'why?'

And I said, 'just flipping do it because it will open your eyes'.

Baby Makes 3: Project Report

Author: David Flynn

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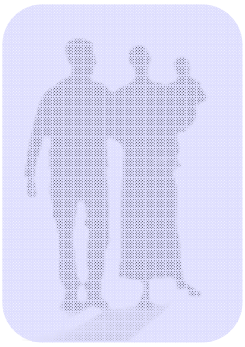
CITY OF WHITEHORSE

Baby Makes 3



Acknowledgements

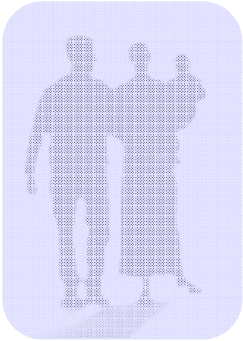
The *Baby Makes 3* project could not have succeeded without the enthusiasm of members of the Project Reference Group each of whom dedicated much of their precious time to support project activities. They include:

Pam Heselev	Maternal Child Health Coordinator in the City of Whitehorse
Christine Haddrick	Maternal Child Health Nurse, City of Whitehorse
Lea Fitcher	Coordinator of Specialist Women's Clinics, Birralee Maternity Centre
Tricia Kunek	Childbirth Education Coordinator, Birralee Maternity Centre
Diane Johnson	Just Families Project Counsellor, Drummond Street Services
Olive Aumann	Health Development Manager, Whitehorse Community Health Service
Chris Grace	Men's Health Team Leader, Whitehorse Community Health Service
David Flynn	Baby Makes 3 Project Coordinator, Whitehorse Community Health Service

Special mention needs to go to the following people who each made a significant contribution to the project:

- The Maternal Child Health nurses and staff in the City of Whitehorse, who recognised the value of the project and whose support and efforts were often above and beyond the call of duty
- Pam Heselev, whose leadership was key to the project's implementation and achievements
- Christine Haddrick for her pioneering work in developing fathers nights in the City of Whitehorse
- Chris Grace, for his decades long work with the Men Making Change program, who recognised the need and opportunity for a primary prevention program of this kind
- The *Baby Makes 3* Group facilitators – Christine Haddrick, Marelle Wolfkamp, Rodney Vlais, Mark Bennetts and, most importantly, Denise Roberts – who contributed thoughts and ideas to the evolution of the group program
- Jacqueline Hope, social work student at Monash University for her diligence and professionalism in undertaking key evaluation activities
- Drummond Street Services for their work through the William Buckland Foundation funded *Just Families Project* to add value to *Baby Makes 3*
- The Preventing Violence Against Women Team at VicHealth for their unwavering support and guidance, especially Wei Leng Kwok (Research Leader) for her important contribution to the evaluation framework
- All the first time parents who participated in the *Baby Makes 3* program, especially those involved in evaluation activities that were essential to the preparation of this report

Baby Makes 3



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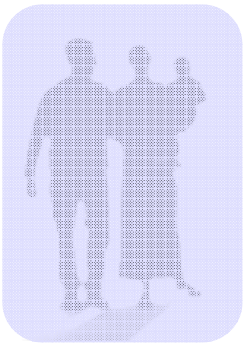

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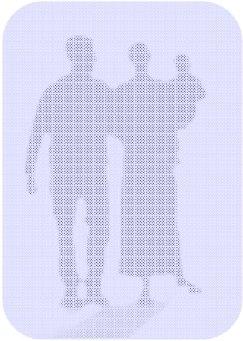


Executive Summary

Project Background

The *Baby Makes 3* project is an example of promising practice in the emerging field of preventing violence against women. It is a *primary* prevention program that seeks to prevent violence *before* it occurs, by promoting equal and respectful relationships between men and women during the transition to parenthood.

First time parents are a key target group for primary prevention activity. The transition to parenthood represents a 'window period' during which it is possible to engage and work with both men and women when traditional notions of parenthood are exerting a powerful influence on how they approach and negotiate their parenting roles. The decisions that couples make during this key stage of life can have important consequences on the level of equality within their relationship, and between men and women more generally.

Funded by VicHealth, the *Baby Makes* 3 project involved a partnership between Whitehorse Community Health Service, the lead agency, and the City of Whitehorse Maternal Child Health Service, a key service for engaging first time parents. A valuable partnership was also established with Drummond Street Services *Just Families* project.

Project goal

To promote equal and respectful relationships between men and women during the transition to parenthood

Project objectives

1. To increase the capacity of first time parents to build equal and respectful relationships in response to the lifestyle and relationship changes that follow the birth of a child.
2. To increase the capacity of health professionals and organisations to promote equal and respectful relationships during the transition to parenthood

Project activities

1. *The development and delivery of the Baby Makes 3 group program.*

   A three-week discussion based program for new parents covering a number of key topics relevant to the lifestyle and relationship changes that follow the birth of a child.

2. *The facilitation of group discussions at Maternal Child Health fathers nights.*

   One-off evening sessions for first time fathers promoting positive father involvement in new families.

3. *Workforce capacity building through the development and delivery of professional development workshops.*

   Professional development workshops for Maternal Child Health nurses focussing on practical strategies for promoting gender equality during the transition to parenthood.

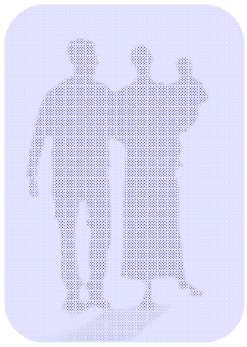
Evaluation Approach

The impact of the *Baby Makes 3* project was evaluated using a comprehensive evaluation framework consisting of a combination of qualitative and quantitative methods including questionnaires, interviews and focus groups.

Evaluation findings

Over 90% of participants rated the *Baby Makes 3* program either very good or excellent, with nearly all participants agreeing, or strongly agreeing, that the program was relevant, helpful and enjoyable.

The evaluation data indicated that despite couples professing minimal attitudinal support for traditional gender roles, the structure of couples' relationships, in terms of 'who does what', became highly traditional following the birth of their baby. Yet couples reported being generally unaware of how



these traditional gender roles may be impacting on their relationship.

A key impact of the *Baby Makes 3* program was that participants developed a greater awareness of how traditional attitudes to gender and parenting roles were shaping their new families. Through their involvement with the program couples developed a shared understanding of the influence of gendered norms and expectations and a shared language for openly discussing their impacts and effects.

Participation in the *Baby Makes 3* program led to a significant shift in couples' attitudes characterised by greater understanding of their partner's role, and greater support for gender equality in new families. In addition, there was evidence that some couples had implemented changes to how they structured their parenting and relationship roles, and that this was in response to seeking a more equal relationship.

The workforce capacity building aspects of the project were successful in ensuring messages of gender equality were reinforced at an organisational level, and in the day-to-day interactions between Maternal Child Health nurses and the new parents who access their services.

Discussion

Issues of gender equality are central to the transition to parenthood. Following the birth of a baby men and women begin doing things differently, and often by default, adopt more traditional roles which in turn can lead to gender inequalities that stem from the 'undervaluing' of women's traditional contributions (the baby care and housework).

A key objective of the *Baby Makes 3* program is to give first time parents the awareness and understanding required to critically reflect on the new level of equality within their relationship. The program achieves this by encouraging participants to acknowledge and value the contribution of the stay-at-home parent and to share the tasks and responsibilities of parenthood more equally.

A key achievement of the program has been engaging men, overcoming their resistance and gaining their support for gender equality.

The future direction of the project involves endeavouring to facilitate the implementation of *Baby Makes 3* in other local government areas. To enable this, a number of key resources are being produced, including:

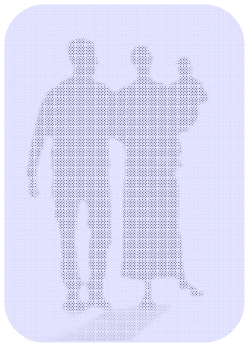
- A *Baby Makes 3* group work manual
- A *Baby Makes 3* facilitator training program
- A local government step-by-step guide for implementing *Baby Makes 3*
- Professional development workshops and community education seminars

Conclusion

The main achievement of the *Baby Makes 3* project has been the development and implementation of the '*Baby Makes 3* model', a unique contribution to the field of primary prevention, consisting of a three-week group program exploring issues of gender equality from the perspective of first time parents, supported by organisational and workforce development within a local government Maternal Child Health setting.

The evaluation findings demonstrate that *Baby Makes 3* is a successful and effective means of promoting equal and respectful relationships between men and women. The program is readily transferable and given the necessary resources and organisational support it could easily be integrated into existing Maternal Child Health Services and implemented in all local governments.

Given its ability to constructively engage large numbers of first time parents, particularly men, *Baby Makes 3* has the potential to form an integral part of a population wide approach to the primary prevention of violence against women.



1. Introduction

As the name suggests, *Baby Makes 3* is concerned with that stage of life when the arrival of a new baby signifies the creation of a new family.

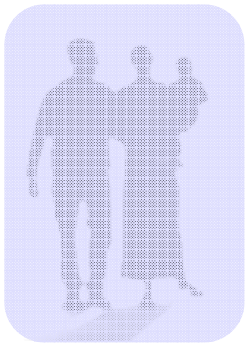
For most couples, the birth of their first child is a major turning point as they transition into their new roles of 'mother' and 'father' and become acquainted with the demands and expectations of parenthood. It is a time of major lifestyle changes, when many practical adjustments need to be made, and a time of major relationship changes as couples increasingly focus their energy and attention 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 time that families often expect to be filled with happiness and joy but unfortunately, it is also a time when relationship difficulties can become established, and male family violence can escalate.

The *Baby Makes 3* project seeks to assist first time parents adapt to the demands and expectations of parenthood. It is a community-based project that aims to promote equal and respectful relationships between men and women during the transition to parenthood. As such, it is an example of promising practice in the emerging field of the primary prevention of violence against women.

Funded by VicHealth, *Baby Makes 3* is a partnership between Whitehorse Community Health Service, the lead agency, and the City of Whitehorse located in the eastern metropolitan region of Melbourne, Australia. The project operates at the community and organisational levels, working with the local Maternal Child Health Service and the hundreds of first time parents who access the service every year.

This report describes the implementation of the project over the three year period from 2009 to 2011. It describes the project planning and outlines the project objectives and activities. The evaluation framework is presented and the impacts of the project are identified and discussed in detail.

As an example of promising practice, the *Baby Makes 3* Project Report seeks to build the evidence base in the primary prevention of violence against women.



2. Project Background

2.1 Primary prevention of violence against women

Violence against women is a significant problem with serious social, economic and health consequences for women, their families and communities. Over the years society has sought to address this problem by focussing on reforming the response – by the police, the courts, and the service sector – to incidents of violence, and on improving support for women and children experiencing violence. Yet despite a range of efforts on these fronts the prevalence of violence against women seems undiminished.

Violence against women is increasingly being seen as a public health issue that is not only serious and prevalent but is wholly preventable. Consequently, while responding to incidents of violence remains critical in the first instance, attention is now turning to efforts aimed at primary prevention.

The prevention of violence against women can occur at three levels: primary, secondary and tertiary. Tertiary prevention occurs *after* an incident of violence and is focussed on preventing the violence from re-occurring. Secondary prevention occurs as the violent incident is taking place. The primary prevention of violence against women, however, is focussed on preventing violence *before* it occurs. The *Baby Makes 3* project is an example of primary prevention.

There is currently growing momentum in support of preventing violence against women from all levels of government. The National Council to Reduce Violence against Women and their Children, in their plan for 2009-2021, *Time for Action* (2009) argue for a sustained new level of investment in primary prevention. The State Government of Victoria, in *A Right to Respect* (Office of Women's Policy, 2009) has introduced a ten-year, whole-of-government prevention strategy to promote gender-equitable and non-violent communities, organisations and relationships across the state. There is also increasing interest from Victorian local governments, primary care partnerships and community health services in developing primary prevention strategies. Yet in Australia, and indeed the world, the primary prevention of violence against women is an emerging field of practice, and the evidence base for primary prevention activities is still being accumulated.

Throughout Victoria, VicHealth is playing a key role in guiding this emerging field of practice. The *Health Costs of Violence* report (VicHealth, 2004) established violence against women as a major public health issue. This report measured the health impacts of intimate partner violence and found this violence to be the largest preventable contributor to the disease burden in women aged 15 to 44 years.

In 2007 VicHealth released *Preventing Violence Before it Occurs: a framework and background paper to guide the prevention of violence against women.* This publication provided a comprehensive evidence based framework to guide primary prevention activity by the government, community, health and corporate sectors. It is this document that provides the framework for the planning and implementation of the *Baby Makes 3* project.

Preventing Violence Before it Occurs articulated the need for an ecological approach (as shown in *figure* 1) to understanding violence against women and implementing primary prevention activities. The advantage of this approach is that it shifts attention away from single-factor explanations and accounts for the complex array of factors implicated in violence against women. It locates the factors underlying or contributing to violence at a range of levels of influence, emphasising the need for many different forms of action and recognising the value of working at different levels (VicHealth, 2007).

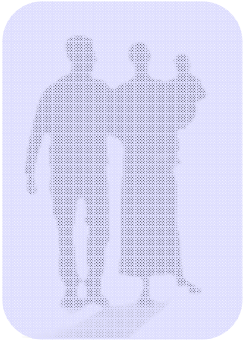
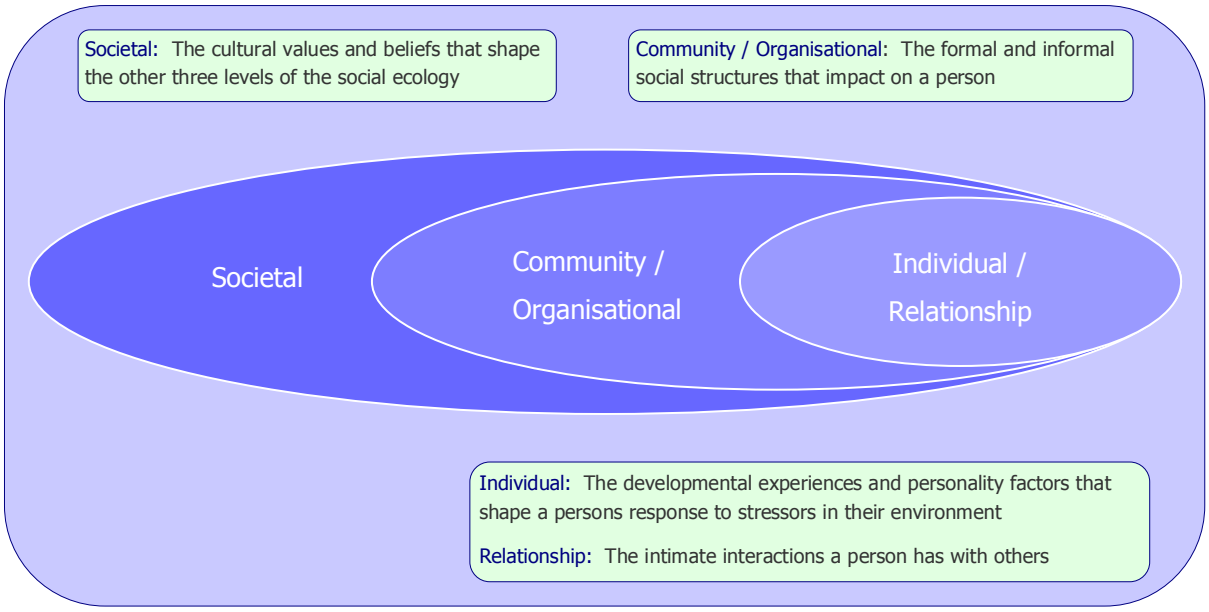


Figure 1: An ecological approach to understanding violence against women



From VicHealth (2007)

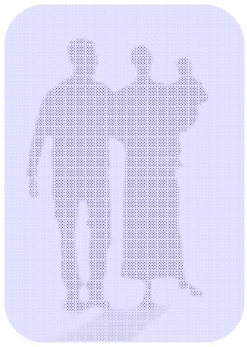
The VicHealth framework also identifies the social determinants – the causes – and contributing factors to violence against women and recommends three key themes for action. These are:

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

The *Baby Makes 3* project is primarily located within the first theme for action, although it does work, to a lesser extent, on the second and third themes. For the most part though – operating at the individual and organisational levels of the ecological model – *Baby Makes 3* concentrates on promoting equal and respectful relationships between men and women.

At the individual and relationship level the project is concerned with understandings of gender roles, particularly the roles of mothers and fathers, and understandings of femininity and masculinity and the extent to which individual attitudes and behaviours are shaped by these understandings. At the community and organisational level of the ecological model it is concerned with the cultural beliefs, norms and expectations of men and women within communities and organisations.

By critically examining these ideas and constructs, the project seeks to engage individuals, families, communities and organisations in a conversation that leads to greater gender equality, and in so doing, it represents a new and innovative approach to the primary prevention of violence against women.



2.2 *Baby Makes 3* – phase one

The *Baby Makes 3* project began as a research project exploring primary prevention activity with men during the transition to parenthood. In 2007 the project was funded by VicHealth, for one year, to undertake this research which served as a comprehensive needs analysis for the current project (*Baby Makes 3* – phase 2). The research project is described in the phase one report (Flynn, 2008).

The goal of phase one was to identify the means by which first time fathers could be supported in acting respectfully and responsibly and in non-violent ways through the various phases of starting a family.

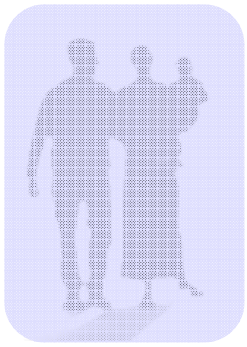
The activities undertaken included:

- A literature review investigating family violence prevention work with men, the challenges of engaging men in family violence prevention, and programs targeting first time fathers
- A review of services engaging first time fathers
- Interviews with first time fathers investigating their understandings of gender roles and gender relations during the transition to parenthood

The research from phase one put forward a number of recommendations relating to improving current services, including antenatal and postnatal services, and developing new and innovative primary prevention programs targeting first time parents. In particular, the research identified that a primary prevention project would need to:

- Target both men and women, rather than solely men (the difficulties of engaging men in prevention work can be partly overcome if the men are engaged with their partners, as couples, rather than as individuals)
- Promote relationship equality – by providing education on gender roles, balancing work and family, and the equal capacity of men and women to care for infants

The current *Baby Makes 3* project (phase 2) represents an implementation of the findings from phase one. It applies the VicHealth framework to a specific target group: men and women undergoing the transition to parenthood, a time when their lifestyles and relationships are undergoing significant change.



2.3 Why target first time parents?

The transition to parenthood can be a time of great joy. Yet it is a time of major lifestyle changes as women and men transition into their new roles of 'mothers' and 'fathers' and become acquainted with the stress, difficulties and expectations associated with looking after a new born baby.

During this time it is inevitable that couples' relationships will undergo a significant shift. Whilst many couples find that becoming parents brings them closer together, others may experience a significant period of relationship decline (Twenge, Campbell, & Foster, 2003). This change in couples' relationships is particularly evident following the birth of a first child but may go completely unnoticed by first time parents who are primarily focussed on the near overwhelming task of caring for a baby. As a result, relationship changes during the transition to parenthood can lead to significant impacts on the long term quality of the relationship (Lawrence, *et.al.,* 2008).

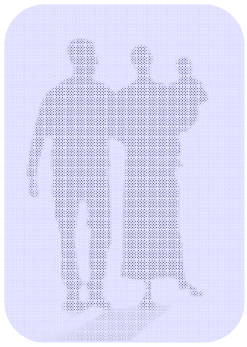
The transition to parenthood is also a time when women are particularly vulnerable to violence (VicHealth, 2007). Family violence is often seen to intensify during pregnancy and in the period following the birth of a child (Dept. of Victorian Communities, 2007; Taft, 2002; Gielen, *et.al*, 1994) and can have significant effects on child development (Doss, *et.al.,* 2009). There is a wealth of research showing a wide range of impacts on children including psychological and behavioural impacts, health and socioeconomic impacts, as well as impacts connected to the inter-generational transmission of violence (Richards, K., 2011; Russel, *et.al*., 1999; Erel & Burman, 1995; Sarkadi, *et.al,* 2007). So preventing violence during this key risk period is critical for both women and children's wellbeing.

But the primary prevention of violence against women is about far more than just responding to risk factors. It is about creating cultural change, particularly in relation to the key theme for action – promoting equal and respectful relationships between men and women. There are, therefore, two additional fundamental reasons why it is important to engage first time parents in primary prevention activity.

Firstly, the transition to parenthood is a key time for engaging men. It is a specific time in men's lives when they are in contact with health services and are 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), during which it is possible to promote alternate models of masculinity based on the model of men as carers and nurturers of infants. As such, it provides a real opportunity which does not readily present itself during other life stages.

The second key reason why it is important to engage first time parents in primary prevention activity is that the transition to parenthood is a time when gender roles and relations are changing. A recent briefing paper from the Australian Institute of Family Studies (Parker & Hunter, 2011) identified attitudes connected with gender and gender roles as the key factor affecting relationship satisfaction across the transition to parenthood. These attitudes are heavily influenced by the gendered norms and expectations that accompany the roles of 'mother' and 'father' (Koivunen, *et. al.*, 2009). Attitudes to gender roles have been shown to become more traditional during the 12 months following the birth of a child (Katz-wise, Priess & Hyde, 2008), so it is undeniably a time when gender equality is directly relevant to the lived experience of first time parents.

The transition to parenthood, therefore, presents a major opportunity to engage and work with both men and women, to challenge traditional attitudes to gender roles, and to promote gender equality during this key life-stage in which gender roles are shaping the level of equality in relationships.



2.4 Gender roles and equality during the transition to parenthood

A generation ago, in Australia, our notions of motherhood and fatherhood were heavily influenced by what has come to be known as the 'traditional' model of family. Under this model, a father's main role was to be a good economic provider – a 'breadwinner' – and to work outside the home, while a mother's role was to be responsible for all the unpaid work inside the home. It was not expected that men would undertake more than a minimal role in the care and nurturing of children, which was considered to be the natural domain of women.

In contemporary Australia, however, the traditional family is becoming far less common. The past generation has seen the emergence of a new 'shared-parenting' model of family, characterised by increasing expectations of fathers' involvement in childcare and household tasks, and greater equality between men and women. And while the majority of Australian fathers continue to define their role with reference to 'breadwinning' there is, without doubt, an increased expectation that contemporary fathers will be more involved in the lives of their children than men of previous generations (Berlyn, Wise & Soriano, 2008).

This change has been parallelled by an increasing recognition of the developmental benefits for children of positive father involvement. It is now widely recognised that fathers have a significant impact on child development outcomes, and there is 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). However, it is important to establish that 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).

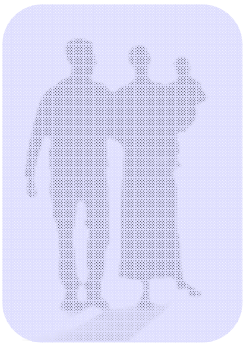
Despite indications that our notions of family have significantly shifted to place greater value on involved fathering, there is also reason to suggest that traditional notions of parenthood continue to exert a powerful influence on how men and women approach and negotiate parenting roles (Berlyn, Wise & Soriano, 2008; Wall & Arnold, 2007). The traditional model of family still has considerable bearing on how parents think about their roles (Hatten, Vinter, & Williams, 2002). Our definitions of parenthood may be changing, but the role of 'mother' and 'father' remain stereotypically gendered (Russell, *et.al.,* 1999).

While many men appear more visibly involved in child care (it is not uncommon to see fathers out by themselves, or with their partners, pushing strollers or carrying young babies) the available Australian evidence suggests there are still large differences between the amounts of time mothers and fathers spend with children, and the types of care activities they engage in (Berlyn, Wise & Soriano, 2008). This has significant bearing on the level of equality within a relationship, and between men and women more generally.

Caring for children

The most recent statistics from the *Growing Up in Australia: Longitudinal Study of Australian Children (LSAC)* research shows a considerable difference in the amount of hours children spend alone with their father compared to their mother (AIFS, 2011). On average, fathers spend just 30 minutes alone with their babies on weekdays, compared to mothers' 5.8 hours. On weekends, fathers spend more time with their baby, but the actual time they spend *alone* with their baby increases, on average, only 12 minutes to a total of 42 minutes per day.

In relative terms fathers are rarely alone with their children, implying that fathers do not undertake child care in a way that relieves women of responsibility. And as Craig (2006) points out, men typically join their partners as 'helpers' in the task whilst mothers continue to carry the burden of responsibility for



managing care. This also has potential effects on father child relations, for if fathers are rarely alone with their children they are not forging independent bonds with their children.

The other key observation from the *LSAC* data is that the time that fathers and mothers spend with their children each day, varies very little during the first 9 years of life, with the only significant change being a reduction in mum's hours when the child begins school (Baxter & Smart, 2010). This illustrates that the initial pattern of involvement that is established in the months after birth can easily become entrenched, and that if active father involvement is to be encouraged, then it needs to be encouraged early on. The transition to parenthood, then, is a key time to be engaging in a conversation about gender roles and equality.

It should come as no surprise that on average, mothers spend much longer than fathers in absolute time caring for children. However, there are further significant differences in the *type* of care performed by mothers and fathers. Fathers spend more of their time involved in interactive care (i.e. talking, playing, etc…) whereas mothers spend the greater proportion of their time on physical care (i.e. bathing, feeding, dressing, etc…)(Craig, 2006). The child care tasks in which men mostly engage are arguably the more 'fun' ones, which imply that a father's time with children is less like 'work' than is a mother's time.

Housework

The dominance of traditional gender roles can also be seen in the vast inequalities in the amount of housework undertaken by men and women.

According to the Australian Bureau of Statistics (2009):

> "While men are doing slightly more household work than in the past, in 2006, women still did 1.8 times as much as men. Although women are spending less time cleaning and doing laundry, they still spent almost six times as long on laundry as men in 2006, and more than three times as long on other household work such as cleaning. Women also spent almost two and a half times as long on food preparation and clean up, despite men doing more cooking than in the past."

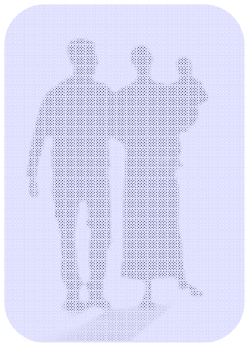
With regard to the transition to parenting, Baxter, Haynes & Hewitt (2008) demonstrate that having a baby dramatically increases the time spent on housework for new mums, but has only minimal impact on the hours spent on housework for new dads.

And again, according to the Australian Bureau of Statistics (2009):

> "In 2006, mothers aged 20 to 49 years in couple relationships spent an extra 7 hours per week on household work than those without children, (whereas) fathers aged 20 to 49 in couple relationships spent roughly the same amount of time on domestic activities compared with those without children."

Of course, caring for children and housework are not the only measures of relationship equality, but they are important components, nonetheless. The Human Rights and Equal Opportunity Commission identifies the widespread acceptance of traditional gender roles in parenting as a key factor in explaining why expectations of gender equality in terms of work and family are not being realised (Squire & Tilly, 2007). The transition to parenthood is a key time when these gender disparities are emerging.

The transition to parenthood is a time when men and women are negotiating new roles and responsibilities, and one of the greatest factors influencing this negotiation is new parents' assumptions about what it means to be a 'mother' and 'father'.



2.5 The construction of fatherhood and motherhood

Many men clearly want to be involved in their children's lives and invest heavily in their family relationships, yet the most recent statistics indicate that despite most men expressing support for a shared-parenting model of family, there are substantial gaps between attitudes and actions.

The factors that determine the level of father involvement include the amount of paid employment undertaken, personal motivation, and the quality of the relationship between mum and dad. However, the most fundamental factor relates to how a father's role is socially constructed and understood. As Berlyn, Wise and Soriano (2008) explain:

> "Social discourses surrounding involved and traditional constructions of fathering can be understood as the overarching context shaping how contemporary men practice fathering. Fatherhood and motherhood have historically been defined dichotomously in terms of contrasting and complementary roles, identities and traits (that is, the 'breadwinner' father and 'stay-at-home' mother). These broad stereotypes deeply penetrate cultural scripts about parenting and affect (consciously and subconsciously) how parenting is performed and constructed at individual, interpersonal and institutional levels. Traditional ideas about parenting affect men's predisposition and ability to be involved parents, and women's ability to let men be more involved…."

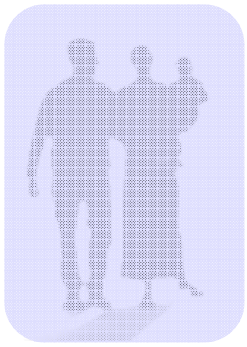
A common view of fatherhood is that fathers do not have the natural ability that mothers have to care for and nurture children. It is a view that, whilst not denying that fathers make an important contribution to the upbringing of children, argues that a father's contribution is fundamentally and inherently 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) and ultimately, these gendered patterns of parenting are a major constraint on fathers' interactions with children (Flood, 2003).

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

Conversely, the same 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 (Goward, *et al.* , 2005).

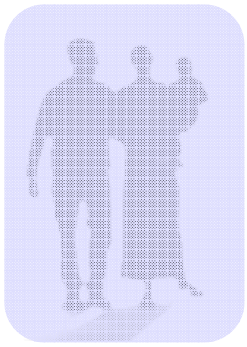
Maternal gatekeeping is deeply rooted in women's profoundly felt obligation to care for their children (Doucet, 2004). For example, the vast majority of mothers say they are comfortable taking on the bulk of childcare responsibility while their husband is the main provider (Hatten, Vinter & Williams, 2002). Similarly, mothers are major contributors to the decision for some families to adopt a pattern in which fathers are significant caregivers (Russell, *et.al.,* 1999). Indeed, if mothers are not supportive of increasing the involvement of their male partners, new fathers can experience difficulty in finding the time and space to interact with their babies. Understandings of what it means to be a 'mother'



and a 'father' are integral to the structuring of family roles.

The notion that the roles of mothers and fathers are largely determined by the natural ability of women and men is pervasive but 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 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).

The idea of fathers making a unique contribution to their children is a popular belief that many men (and women) 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, that more often than not reflects a gendered power imbalance. Promoting gender equality demands that 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 to which women can be caring, loving and nurturing.



2.6 Maternal Child Health – a key setting for primary prevention

The most accessible and appropriate setting for engaging first time parents in primary prevention work throughout Victoria is undoubtedly the Maternal Child Health Service. In local governments throughout Victoria these services play a central role in providing all families with children, from birth to school age, on-going primary health care to improve their health and development. For first time families in particular, the Maternal Child Health Service is an important source of knowledge, skills and support. The service is in regular contact (through home visits and centre-based appointments) with new families, especially during the early months of parenthood.

In addition to the regular visits and appointments, a key service provided by Maternal Child Health is the formation of 'New Parent Groups'. These groups are coordinated and facilitated by Maternal Child Health nurses and run weekly, over five to six sessions. All new parents within a local catchment area are invited to attend a group when their baby is approximately four to eight weeks old, the purpose being (from Edgecombe, *et.al.*, 2009) 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.

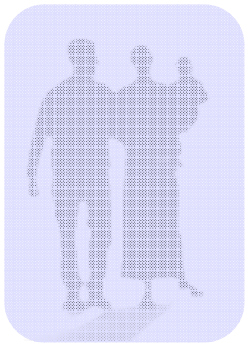
Whilst the new parent groups are aimed at both mothers and fathers, in reality it is mostly mothers who attend, and informally the groups are known as new 'mums' groups. It is rare for fathers to attend. This is, in part, due to the timing of the groups – usually during the day, when many men are at work and unable to attend. But the absence of men from the first time parents groups is also a reflection of the gendered expectations about whose role it is to care for a baby. Many men, for example, perceive these groups as being exclusively for new mums, whilst the mums, themselves, can be protective of what has come to be culturally understood as a woman's rite of passage into motherhood. Anecdotal evidence suggests this is a common dynamic in new parent groups throughout Victoria, illustrating the powerful influence that traditional gender roles continue to exert over contemporary families.

So although Maternal Child Health Services are surely the most appropriate setting for engaging first time parents, a pressing issue relates to just *how* this key target group is engaged. A fundamental challenge for Maternal Child Health is to develop ways of engaging new families that avoid traditional gender norms and promote gender equality.

It is completely fitting that after the birth of a child the wellbeing of women and children should be of paramount importance and that this be where Maternal Child Health services are rightly focussed. But 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.

The pervasive influence of traditional gender roles cannot help but influence the way workers and services engage with families (Berlyn, Wise & Soriano, 2008). And whilst, to some extent, this is unavoidable, Maternal Child Health nurses and health professionals in general must remain mindful of the risk of reinforcing traditional gender roles and sustaining gendered power inequalities between men and women, remembering that this has been identified as the fundamental social determinant of violence against women.

The ecological approach to understanding violence provides importance guidance here. The cultural change necessary for preventing violence before it occurs is best achieved through a multi-level approach of mutually reinforcing strategies, where activity at the individual level is complemented by activity at the community level. This is the primary prevention approach adopted by *Baby Makes 3.*



2.7 Rationale for *Baby Makes 3*

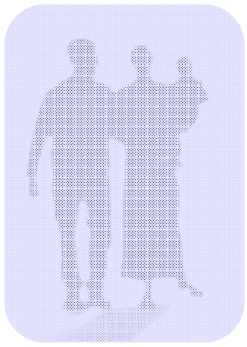
The primary prevention of violence against women is focussed on preventing violence *before* it occurs, with a key theme for action being the promotion of equal and respectful relationships between men and women. One approach to primary prevention, then, is to address the gendered inequalities in terms of work and family that present during the transition to parenthood.

Despite increasing expectations of men's involvement in childcare and housework tasks, the roles of mothers and fathers in contemporary Australian families remain stereotypically gendered. It is this widespread acceptance of these traditional gender roles in parenting that is a key factor in explaining why expectations of gender equality in terms of work and family are not being realised.

The transition to parenthood provides a major opportunity to engage women and men, in particular, in the work of primary prevention, to challenge traditional attitudes to gender roles, and to promote gender equality. Maternal Child Health Services are the ideal setting in which this work can take place.

However, current services fail to address the relationship changes between men and women following the birth of a child. Current programs for first time parents focus on practical aspects of caring for a baby and, to a lesser extent, adjusting to lifestyle changes, but they pay scant attention to the nature of the changing relationship between mum and dad. There is a clear need then, for some form of relationship education for first time parents, and this education should take the form of raising awareness of the gendered norms and expectations that accompany the transition to parenthood and the ways of responding to these changes that lead to healthier relationships based on equality and respect.

The *Baby Makes 3* project has responded to this need by developing an innovative and promising approach to primary prevention, that focuses on raising awareness of the importance of maintaining equal and respectful relationships during the transition to parenthood, and in a way that provides first time parents with practical strategies for doing so.



3. Project Description

Following the initial research and needs analysis that was undertaken during phase one of *Baby Makes 3*, the second phase of the *Baby Makes 3* project began in January, 2009. *Baby Makes 3* was envisaged as a three-year project addressing the primary prevention of violence against women, focussing on first time parents and the organisations and services that support them. The project was located in the City of Whitehorse (in the eastern metropolitan region of Melbourne) and began as a partnership between the following:

- Whitehorse Community Health Service
- The City of Whitehorse Maternal Child Health Service
- Birralee Maternity Service[1] at Box Hill Hospital

A project coordinator was employed to coordinate and implement the project and a project reference group was established, consisting of representatives from the partner organisations, to assist in guiding the project.

Being the first project of its kind, anywhere in the world to focus on addressing gender role equality in couples during the transition to parenthood *Baby Makes 3* had no existing examples of successful primary prevention work with first time families from which to guide the planning process and project activities. Instead, the project planning drew heavily from the VicHealth (2007) framework, *Preventing Violence Before it Occurs* to develop its approach and priorities.

Subsequently, the project adopted an ecological approach that would entail working with first time parents and the organisations that support and interact with them, and as much as possible, integrating with and building on existing services. Action theme one from the framework document – promoting equal and respectful relationships between men and women – was identified as a priority on which to concentrate activity.

Significant energy was invested in the program planning stage of the project to develop project objectives and proposed activities, and from these, identifying a number of expected impacts. *Figure 2* – the program logic for the *Baby Makes 3* project – shows the links and relationships between each of these components of the planning framework.

(Note: the expected impacts shown in *fig.2* are the impacts that were envisaged during the planning process. A fuller identification of project impacts is provided in sections 4 and 5, detailing the project's evaluation activities and findings.)

[1] Originally, it was planned to locate some of the project activity at Birralee Maternity Service, however, due to organisational restraints, Birralee was unable to take part in phase two of *Baby Makes 3*

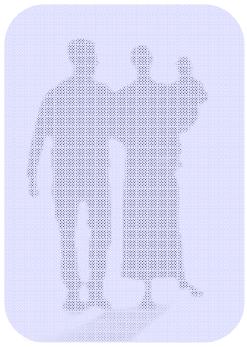
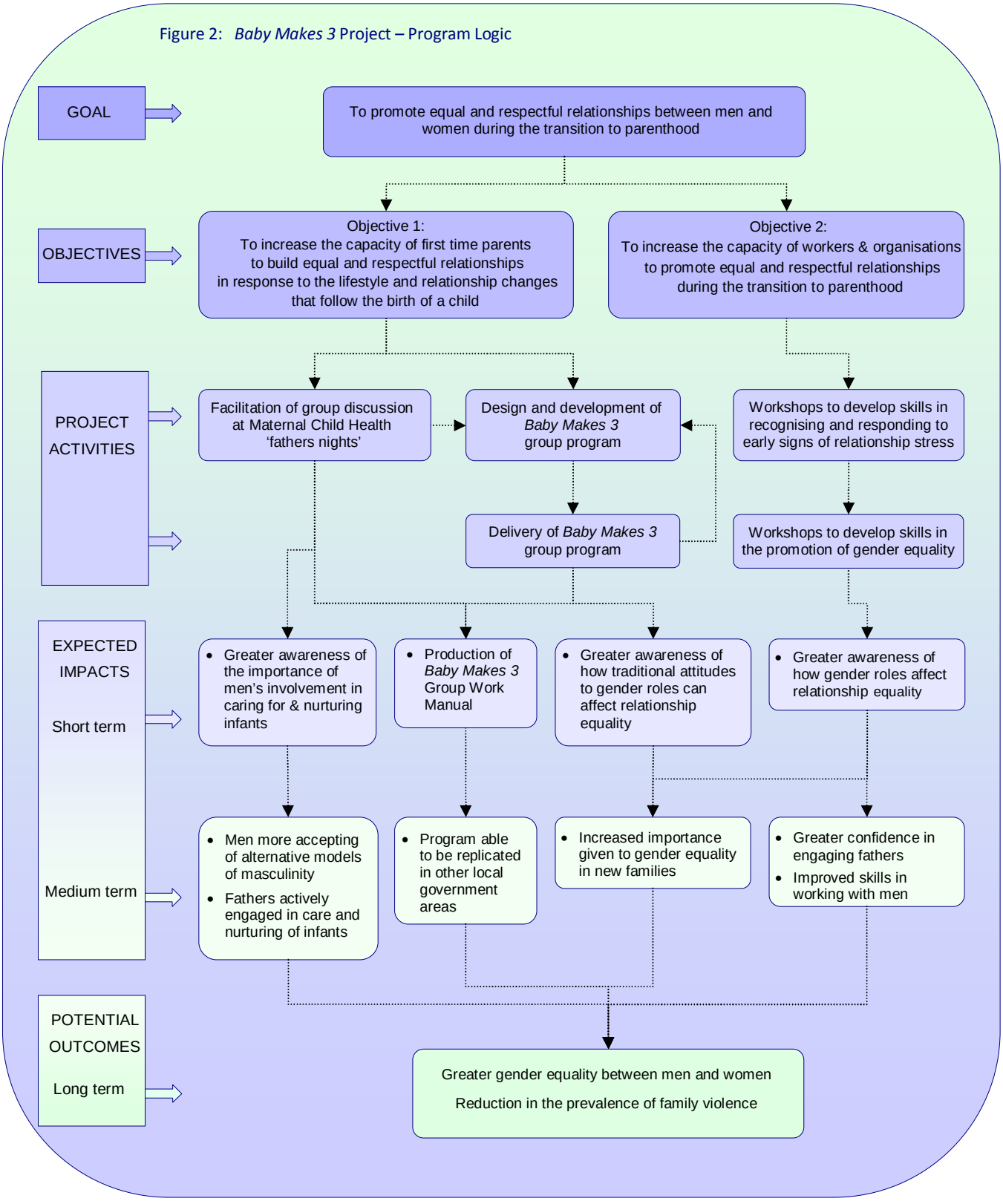
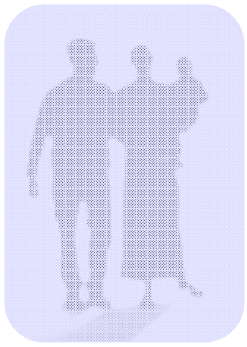


Figure 2: *Baby Makes 3* Project – Program Logic





3.1 Project goal, objectives and activities

Project goal

To promote equal and respectful relationships between men and women during the transition to parenthood

Project objectives

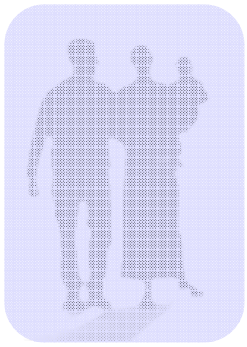
1. To increase the capacity of first time parents to build equal and respectful relationships in response to the lifestyle and relationship changes that follow the birth of a child.
2. To increase the capacity of health professionals and organisations to promote equal and respectful relationships during the transition to parenthood

Project activities

As shown in the program logic, the three sets of project activities were:

1. The development and delivery of the *Baby Makes 3* group program
2. The facilitation of group discussions at Maternal Child Health fathers nights
3. Workforce capacity building through the development and delivery of professional development workshops.

The central project activity was the development and delivery of the *Baby Makes 3* group program, with most of the project's time and resources focussed on this activity, however this was complemented and supported by the two other key activities – the facilitation of Maternal Child Health fathers nights, and design and delivery of professional development workshops. These activities are described in greater detail in the following pages.



3.2 *Baby Makes 3* – group program

The primary activity of the *Baby Makes 3* project was the development and delivery of the *Baby Makes 3* group program. Seventeen group programs were delivered from August 2009 through until August 2011, with over 120 couples attending the program during this time. Key aspects of the design and development of the group program are summarised in *Table 1*.

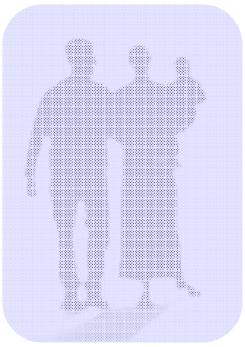
Table 1: Key aspects of the *Baby Makes 3* group program

Aspect of the Group Program	Details
Group format	• Three 2-hour sessions, over 3 weeks • Evening sessions • Male and female co-facilitators
Target group	• First time parents (either mum's first time, dad's first time, or both) • Babies up to the age of 12 months • Couples attend with their baby
Partnership with Maternal Child Health	• Couples recruited from Maternal Child Health 'New Parents Groups' • Couples participate in New Parents Group prior to enrolling in *Baby Makes 3*
Content	• Structured discussion of key topics: Transition to parenthood, gender expectations, division of household labour, equality as the basis for a healthy relationship, building intimacy after the birth, dealing with conflict, communication.

A group-based program was the preferred option over a more individual focus for two reasons. Firstly, because a group program is an effective use of time and resources, being able to reach a larger number of people, and secondly, because the group process is well suited to exploring shared experiences such as the transition to parenthood.

The length of the group was also given much deliberation. A one-off group was considered likely to be ineffective and could risk being perceived as tokenistic whilst it was also apparent that the topics of interest could not be covered in only one session. The program needed to be long enough to be able to cover the proposed topics in sufficient depth, yet the program could not be too long, and needed to represent a realistic commitment of time for a couple with a new baby. Other factors, such as the resources and time that would be needed to offer the group as a universal program were also taken into account. Three 2-hour weekly sessions were considered to offer the right balance.

Holding the groups in the evening was identified as central to the requirements of the target group. Despite requiring more resources in order to hold the groups after business hours it was considered the only way of enabling fathers to attend the sessions. Throughout the planning process it was always considered desirable that both mum, dad *and* their baby attend the group, despite the obvious



limitations this could place on their ability to participate in the group.

The target group for the *Baby Makes 3* group program was first time parents whose baby was less than 12 months old. This included couples where it was mum's first baby, but not dad's, or conversely, where it was dad's first baby, but not mum's. The age limit of 12 months was set because after this time it was deemed that the couples were no longer experiencing the 'transition' to parenthood. Also, as a primary prevention program, the focus was on the early months of parenthood.

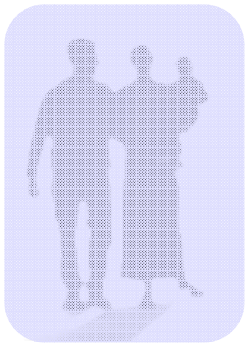
The focus on the transition to parenthood 'after' the birth rather than 'before' the birth, (i.e. postnatal, rather than antenatal) was chosen because of the strong theme that emerged during the needs analysis that antenatally, couples find it difficult to imagine the extent of the lifestyle and relationship changes they are likely to experience as they enter parenthood. Prior to the birth, couples are focussed *on* the birth and little else. The advantage of conducting the group program in a postnatal environment is that two to three months after the birth, the novelty of having a new baby has worn off, couples have had time to grapple with their new roles and become familiar with the challenges of balancing work and family roles, and life with a baby and the division of roles that accompanies it is a reality.

The content of the group consisted of structured discussions and activities concerning a number of key topics including:

- Lifestyle and relationship changes following the birth of a child
- Gendered expectations of new mums and new dads
- Gendered division of household labour and childcare
- Equality as the basis of a healthy relationship
- Building intimacy after the birth of a child
- Dealing with conflict
- Communication

These topics were selected and developed based on three criteria. The content had to be relevant to at least one of the following: promoting equality between men and women, preventing violence against women and/or the transition to parenthood. For a detailed description of the course content, discussions and activities, see the accompanying publication, the *Baby Makes 3* Facilitators Handbook (Flynn, 2011).

Another important aspect of the group is the model whereby the program is delivered by male and female co-facilitators. This allows the modelling of equal gender relations and was useful for conducting small, same-sex discussion groups, an integral component of the program.



3.2.1 Theory of change

A theory of change (*figure* 3) was developed to explain how the *Baby Makes 3* group program was likely to produce change within the target group. It describes how participation in the group program leads to an increase in first time parents' capacity to build equal and respectful relationships in response to the lifestyle and relationship changes that follow the birth of a child.

Program activities

The *Baby Makes 3* program activities are designed to increase participant's *awareness* of key issues during the transition to parenthood. By participating in the program and taking part in the group activities and facilitated group discussions couples develop increased awareness and understanding of the range of individual and social factors that are impacting on their relationship.

Of particular relevance are issues of gender and equality. A 'gender' lens is applied to group discussions to highlight the different experiences of men and women during the transition to parenthood and how these are a result of gendered norms and expectations. An 'equality' lens highlights how these gendered norms and expectations can lead to gender inequalities within new families.

Expected impacts

The expected program impacts are those changes that occur as a direct result of participation in the *Baby Makes 3* program. They are short term changes that should be observable in the weeks and months following the program and include improved *communication* and changes in *attitudes* to gender equality.

By participating in the group discussions couples develop a 'shared language' to describe the changes they are experiencing. They are empowered to engage in meaningful communication and to apply what they learned during the group sessions to their own unique circumstances.

The combination of greater awareness and improved communication produces attitudinal change characterised by greater understanding of their partner's experience and greater support for gender equality.

Potential impacts

The theory of change also suggests that these short term impacts have the potential to create positive medium to long term impacts. These include changes in *behaviours* related to how couples structure their parenting roles and increased levels of *equality* as a result of this restructuring.

A potential medium term impact is that couples are able to consciously and deliberately negotiate and structure their parenting roles and relationships and to problem solve issues as they arise, rather than simply adopting traditional gender roles by default. A potential long term impact is that this restructuring of their parenting roles produces a relationship that demonstrates greater understanding, respect and equality.

However, it is conceivable that these potential impacts may not be observable within the evaluation data. This is because these higher order changes, to some extent, rely on factors that lie outside the scope of the *Baby Makes 3* program. For example, a couple's capacity to restructure their parenting roles is determined, not just by their attitudes to these roles, but by a number of additional structural factors over which they may have little control. In addition, these higher order impacts may occur, but in a timeframe that stretches beyond that captured by the project evaluation.

We can expect the evaluation framework to capture evidence of changes in awareness, communication and attitudes, however, evidence of changes in behaviours and equality may not be present in the evaluation data.

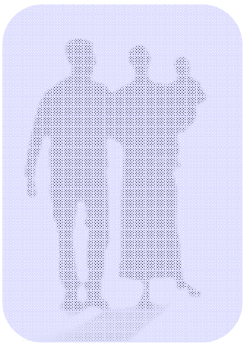
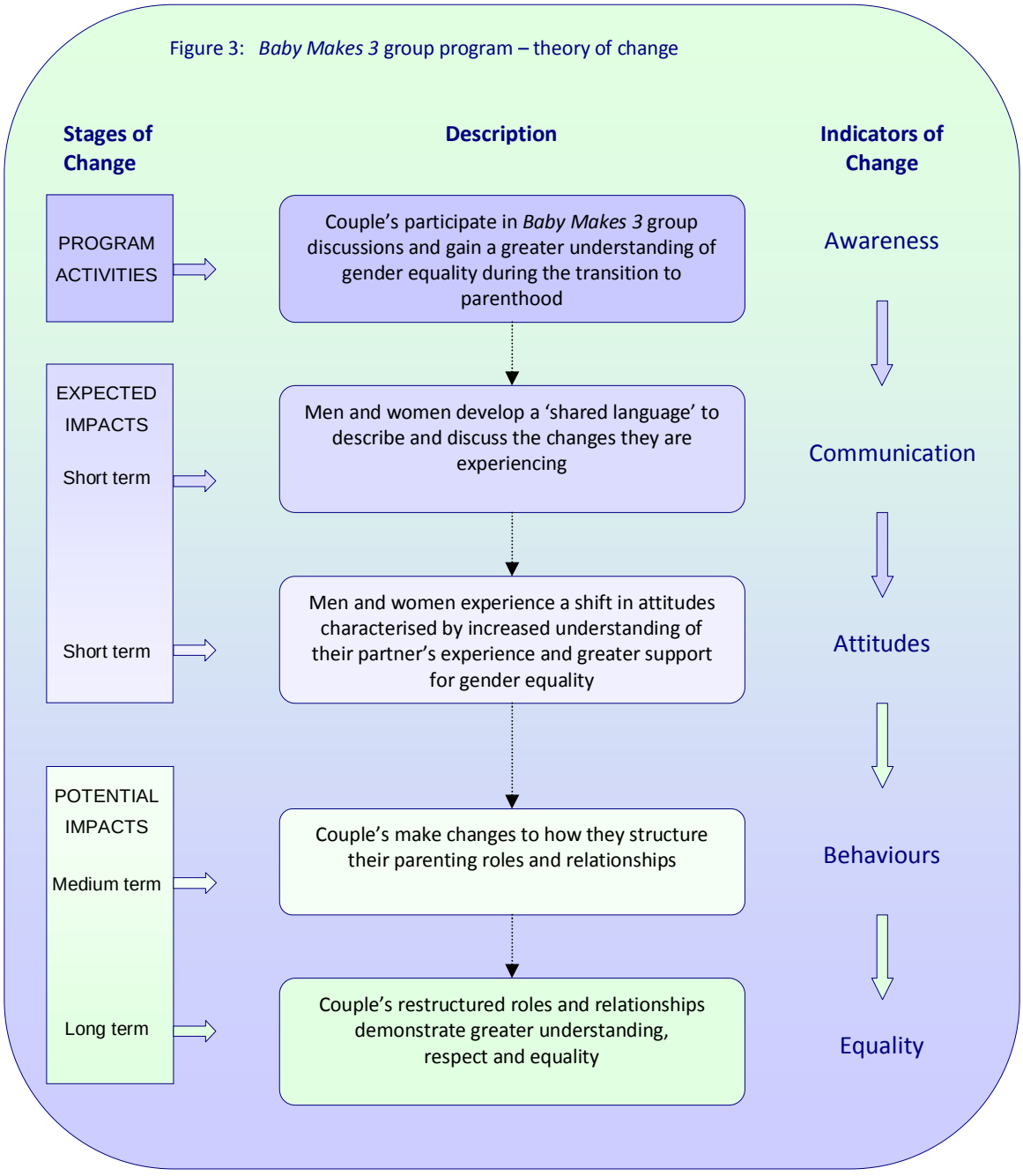
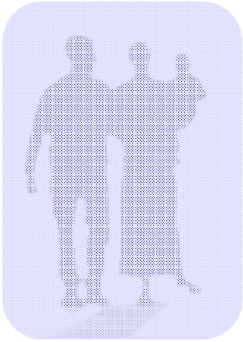


Figure 3: *Baby Makes 3* group program – theory of change





3.3 Fathers nights

The Maternal Child Health Service in the City of Whitehorse has, over the past decade, done much pioneering work in engaging first time fathers in their New Parent Groups. In the City of Whitehorse, these groups are unique in that one of the six group sessions is held after hours – as a designated 'Fathers Night' – where men are invited to attend (with their partners and babies) and to participate in a structured discussion of 'fatherhood'.

The fathers night, itself, runs for 2 hours and is divided into two halves. During the first half the new dads remain in a group room, with their babies, and participate in a facilitated group discussion, whilst the mums, in another room, enjoy an hour of social conversation. The second half provides an opportunity for the group to come together as a whole for social interaction and an informal supper.

When the fathers evenings were first trialled there was some reluctance from men to participate, but over time, with modifications and improvements to the format of the evening, and with considerable persistence on behalf of the Maternal Child Health service and nurses, a successful model was developed. This involved the fathers night being incorporated within the structure of the new parents group. New parents, when invited to join the group, are now given the dates and times of each session, including the fathers evening. In this way, the fathers evening is understood as a standard component of the group, which creates the expectation that the partners of all the new mums in the group will attend. This mechanism usually ensures a high attendance by men at the fathers night.

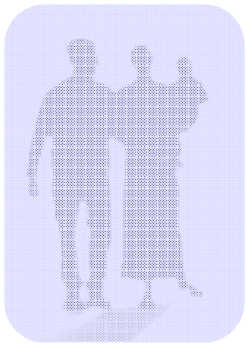
Prior to the *Baby Makes 3* project, the evenings were facilitated by Maternal Child Health nurses. However, no training had been provided to the nurses on how to facilitate these evenings, with some nurses feeling less confident than others in facilitating a discussion about fatherhood. As a result of the lack of training and lack of structure to the father's 'discussion', the evenings operated mostly as a social event.

The *Baby Makes 3* project introduced significant changes to the fathers nights. These changes included the establishment of clear objectives for the evening, consolidating the approach to facilitating the dad's discussion, and providing training for the Maternal Child Health nurses.

The first objective set for the fathers nights was 'to facilitate social interaction and support among new fathers'. This was in keeping with the objectives for new parent groups in general. This objective seeks to address the sense of isolation that men can experience during the transition to parenthood. It seeks to normalise the difficulties and demands they may be experiencing. It can be very worthwhile for men to realise that they are not alone in experiencing the challenges (and joys) associated with the transition to parenthood, and to share thoughts and observations with other men with similar experiences.

The second objective – 'to promote positive father involvement in new families' – was introduced to complement the objectives of the *Baby Makes 3* project. This broad objective seeks to encapsulate a number of more specific aims of the discussion with men about their role as fathers. Promoting positive father involvement involves creating an expectation among the group that:

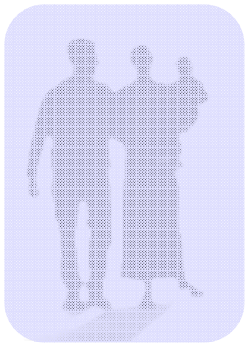
- men can be caring and nurturing and connect with infants on an emotional level
- fathers be actively involved in all aspects of child care
- fathers be able to care for infants in the absence of the child's mother
- fathers be understanding of the demands placed on new mothers
- fathers participate in parenting in ways that relieve their female partners of the burden of responsibility



It should be noted that the two objectives for a fathers night are not always mutually reinforcing. For example it is possible to run the evening in a way that encourages social interaction, but does not promote positive father involvement. That is to say, it is possible for the social interaction among men to reinforce traditional notions of fatherhood that do not promote active father involvement. Ensuring that both objectives are achieved on the night is the primary task of the facilitator, but it is not without difficulties and challenges.

In order to assist the facilitators to achieve this second objective, a guide to running the father's discussion was developed (see *Appendix A*). This document provides a step-by-step guide to facilitating the fathers nights, including the key topics for discussion. All the Maternal Child Health nurses were provided with training on how to use the guide, thus consolidating and standardising the approach to fathers nights in the City of Whitehorse.

During the period from April 2009 to April 2011, the *Baby Makes 3* Project Coordinator facilitated 82 fathers evenings that were attended by 680 first time fathers. The fathers evenings also served as a key means of recruiting couples into the *Baby Makes 3* group program.



3.4 Maternal Child Health workforce capacity building

The third set of activities undertaken for the *Baby Makes 3* project was the building of organisational capacity within the Maternal Child Health Service for the primary prevention of violence against women.

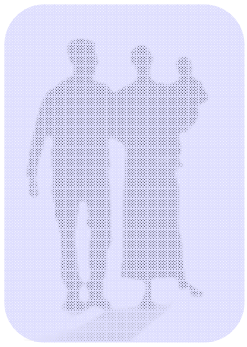
This was considered necessary in response to the findings from phase one that certain structures within the organisation were reinforcing traditional gender roles and gendered expectations, and in recognition that working at both the individual and the organisational level provides mutually reinforcing strategies which are central to an ecological approach to primary prevention.

The activities undertaken were both informal and formal. There were many informal discussions between nurses and the project coordinator – primarily during the delivery of fathers nights for new parent groups – about violence against women, the *Baby Makes 3* project, and about the connection between gender equality and primary prevention. All of these, although varying in length, contributed to raising awareness about the issues involved in primary prevention work and the application of key concepts to the work of Maternal Child Health.

The formal aspect of the workforce capacity building was the design and delivery of two professional development workshops. These were conducted in the second half of 2010 and were developed following consultation with the Maternal Child Health Coordinator and nurses, based on the needs they perceived and identified for themselves.

The first workshop was titled 'Relationships under Stress' and was developed in collaboration with and delivered by Drummond Street Services *Just Families* project staff. The focus of this workshop was on recognising and identifying the precursors or risk factors for family violence. This workshop aimed to help participants understand the differences between 'harmful' levels of stress and the 'normal' stress that most new parents experience.

The second workshop was titled 'Working with Men in ways that Promote Gender Equality', and was developed by the *Baby Makes 3* Project Coordinator. The focus of this workshop was on understanding the determinants of father involvement and the influence of gender roles and cultural norms. The workshop also covered practical strategies for working with men that promote gender equality and ways of responding to and overcoming men's resistance to gender equality.



4. Evaluation Approach

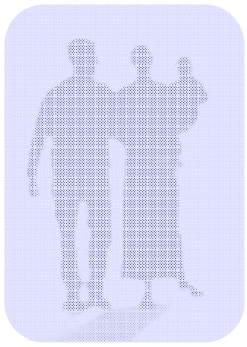
The evaluation framework was designed in consultation with the Preventing Violence Against Women Research Leader at VicHealth. The approach undertaken is detailed in *Appendix B*. The development of the framework took place during the project planning stage and sought to design a means of capturing evidence of the project's impact by establishing linkages between the project activities and identified short and medium-term outcomes.

The framework included an evaluation of each of the three main project activities – the *Baby Makes 3* group program, the fathers nights and the workforce capacity building – as well as the implementation of the project as a whole. Each of these components of the framework is discussed in greater detail below.

Table 2 lists the individual evaluation activities undertaken for each aspect of the *Baby Makes 3* project. A combination of qualitative and quantitative methods was employed to conduct both process and impact evaluations.

Table 2: Evaluation methods

Aspect of *Baby Makes 3* Project	**Evaluation Methods**
Baby Makes 3 – Group Program	Process evaluation • Post-group feedback form (completed after session 3) • Interviews with couples • Reflections and observations of program facilitators Impact evaluation • Pre and Post-group Questionnaires (post-group questionnaires completed 2 months following completion of group) • Interviews with couples • Reflections and observations of program facilitators
Fathers Nights	Process evaluation • Focus group conducted with Maternal Child Health Nurses
Workforce Capacity Building	Process and impact evaluation • Post-workshop feedback forms • Focus group conducted with Maternal Child Health Nurses
Project Implementation	Process and impact evaluation • Focus group conducted with Maternal Child Health Nurses • Focus group conducted with Project Reference Group



4.1 *Baby Makes 3* – group program

The evaluation of the *Baby Makes 3* group program sought to establish the impact of the program by seeking evidence in support of the theory of change outlined in *figure 3.* The evaluation methods, then, were looking to obtain evidence of increased awareness of gender roles and gender equality during the transition to parenthood, greater communication among couples about these issues and evidence of changing attitudes or behaviours leading to greater equality.

There were four main methods used to obtain this data. These were:

- Pre and post-group questionnaires
- A post group feedback form
- In-depth interviews with couples who had completed the group program
- Reflections and observations of group facilitators

These combined methods provided a rigorous evaluation of both the group process and its impacts.

Questionnaires

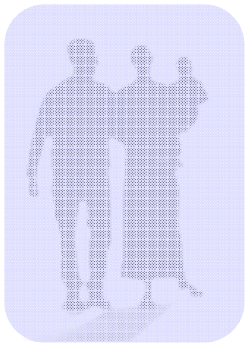
A questionnaire (shown in *Appendix B)* was completed by all group participants before the group, at the start of session one, and then again two months following the completion of the group. This time frame was selected so as to capture both the short and medium term impacts of the program.

The questionnaire was divided into two sections. The first section measured attitudes to the gender roles and norms associated with the transition to parenthood. The second section measured the perceived level of equality in the relationship, in terms of the couple's actual behaviours and contributions to work and family. This section asked participants to apply an 'equality lens' to 'who does what' in terms of baby care, paid and unpaid work, and household management.

The design of the questionnaire was finalised after a literature search that attempted to identify existing scales and measures of relationship equality. It soon became apparent, however, that there were no existing measures that focussed on relationship equality following the transition to parenthood. The original design of the questionnaire included two additional sections that drew upon the 'Egalitarian Relationships Scale' (Harrison, *et.al.,* 2006) and the 'Sexual Relationships Power Scale' (Pulerwitz, *et.al.,* 2000) and attempted to measure any power imbalance in the relationship in terms of the relationship dynamics and decision making. However, these were dropped from the questionnaire after the first twelve months because they were perceived by the participants as being too intrusive, and were proving too blunt an instrument by which to measure the changes in equality during the transition to parenthood. One limitation then, of the group program evaluation was that the final questionnaire design failed to capture the more 'hidden' aspects of power imbalances within relationships. This limitation was overcome by adopting a qualitative means (the in-depth interviews) of capturing this data.

Another limitation of the design was the process by which participants completed the follow-up questionnaires. The questionnaires were mailed to participants (with a return envelope), thus requiring they complete the questionnaires and then return them by mail. As a result, not all the questionnaires were returned, although there was a considerably high return rate despite this limitation.

There was a large amount of quantitative data generated by the pre and post-group questionnaires, allowing the data to be analysed for statistical significance and allowing comparisons between the two groups of male and female participants.



Feedback form

A feedback form (shown in *Appendix* B) was completed by participants at the conclusion of the final session of the group program. This form asked participants to assess the degree to which the group was enjoyable, relevant and helpful, and provided a number of open-ended questions to gather comments about the program. As such, the feedback form was predominantly used as an evaluation of the group process, although the comments provided by participants related also to the program's impact.

The analysis of the feedback form involved the coding of participant's comments and the identification of key themes.

In-depth interviews

In-depth interviews were conducted with 7 couples in the months following their participation in the *Baby Makes 3* group program. Three couples were interviewed three months after their involvement in the program, while four couples were interviewed six months after their involvement. This provided an evaluation of both the short and medium term impacts of the group.

The couples who participated in the interviews were the first seven couples to respond to an email invitation that was sent to former participants. As such, they were self-selected for the interviews.

An interview schedule (shown in *Appendix B*) was developed in consultation with the VicHealth Preventing Violence Against Women Research Leader. The interview questions were based on the program's theory of change (*figure 3*) and included visual cues – slides from the *Baby Makes 3* program – that participants were invited to comment on. This provided a useful method of obtaining data from the participants that relied on minimal verbal prompts from the interviewer.

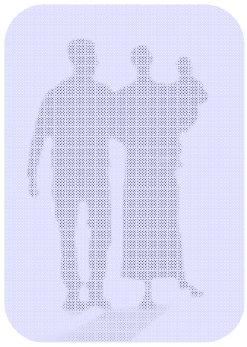
Prior to the interviews, participants were asked to read a plain language statement and to sign a consent form, officially agreeing to participate in the project evaluation (these are shown in *Appendix B*).

It was planned to interview the couples together, rather than separately, because it was hoped that the interactions between the couple would provide richer detail about their experience of *Baby Makes 3.* Couples were given the opportunity to contribute, separately, following the interview, any individual information they may have been reluctant to input during the interview, but no one took advantage of this method of contributing.

The interviews were conducted by an independent interviewer who had not met the couple prior to the interview appointment, and who was not involved in the delivery of the group program. This ensured that the couples felt free to speak openly about their experience of the program. The interviews were audio recorded and typically lasted between 30 to 45 minutes. The audio recordings were transcribed and analysed by a process of coding responses and identifying key themes.

Reflections of program facilitators

The reflections and observations of the *Baby Makes 3* program facilitators were accumulated throughout the project, during team meetings and in post-group debriefing sessions. The feedback from facilitators was used to evaluate both the process and impact of the program, and provided a useful perspective and context for interpreting participant's comments and feedback.



4.2 Fathers nights

The fathers nights, despite being numerous, were 'one-off' groups, and consequently it wasn't deemed realistic to conduct an impact evaluation with the attendees based on only one session. Instead, the evaluation of the fathers nights was via the focus group with Maternal Child Health nurses and focussed on the differences observed in the fathers nights before and after the *Baby Makes 3* project.

The procedure and analysis of the focus group with Maternal Child Health nurses is outlined below in section 4.3.

4.3 Maternal Child Health workforce capacity building

The workforce capacity building aspect of the *Baby Makes 3* project was evaluated using mixed methods. At each professional development workshop, participants were invited to complete feedback forms (presented in *Appendix B*) that were specific to the objectives of the workshop. These were completed at the end of the workshop and consisted of two sections. In the first section participants were asked a series of 5 open-ended questions as a process evaluation and in the second section participants were asked to rank, over six criteria, the impact of the workshop on individual's professional practice.

The feedback forms were analysed by tabulating the impact data and coding the participant's comments in order to identify key themes.

In addition to the feedback forms, a focus group was conducted with Maternal Child Health nurses to evaluate the impact of the capacity building activity. The schedule for the focus group questions (*Appendix B*) covered topics including the observed impacts of the *Baby Makes 3* project on clients, on father's nights, on the nurses themselves, and on the Maternal Child Health organisation as a whole. The purpose of this evaluation was to investigate the nurses understanding of the primary prevention of violence against women and to assess whether, at the organisational level, the nurses felt better equipped to undertake primary prevention work.

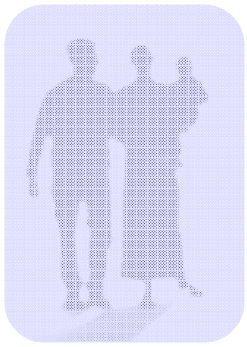
Aspects of the workforce capacity building were also evaluated during the focus group conducted with the *Baby Makes 3* Reference Group as part of the evaluation of the project implementation. This process is described below in section 4.4.

4.4 Project implementation and Partnerships

The key method for evaluating the project implementation was a focus group conducted with all members of the *Baby Makes 3* Project Reference Group.

A schedule of focus group questions (*Appendix B*) was developed in consultation with the VicHealth Preventing Violence Against Women Research Leader (who also facilitated the focus group) and covered both the process of implementation and impact of the project as a whole. The schedule included questions about the project coordination, the operation of the Reference Group, the impact on individual organisations, and on the partnership between organisations.

The focus group was audio recorded. Responses from participants were coded and key themes were identified.



5. Evaluation Findings

5.1 *Baby Makes 3* – group program

The evaluation data for the *Baby Makes 3* group program were obtained from 13 group programs that were conducted during the period from August 2009 to November 2010.

The group attendance during this time is presented in *table 3* along with the numbers of participants involved in the evaluation activities. A total of ninety couples enrolled in the groups and completed the pre-group questionnaire during session one of the relevant program. A post-group feedback form was completed by the 81 mums, and 77 dads who attended session three (a retention rate of 90% and 87% respectively). The post-group questionnaires, which were mailed to participants two months after the final session, were returned by 71 mums and 64 dads (a return rate of 79% and 72% respectively).

In addition, seven couples participated in in-depth interviews between three and six months after their participation in a program.

Table 3: Numbers attending *Baby Makes 3* program and participating in evaluation questionnaires

Participants	**Session 1** Pre-group questionnaire	**Session 3** Post-group feedback form	**2 months** Post-group questionnaire
Mums	90	81	71
Dads	89	77	64

5.1.1 Experiencing the program

The key sources for evaluating the couple's experience of the program were the post-group feedback forms, the in-depth interviews, and the reflections of program facilitators.

As shown in *table 3* the post-group feedback form was completed by 81 mums and 77 dads. The participants were asked how they would rate the program overall and their responses are summarised in *table 4*. Over 90% of participants rated the program either very good or excellent.

Participants were also asked to rate their level of agreement with the statements that the *Baby Makes 3* group was enjoyable, relevant and helpful. Their responses are summarised in *table 5.* Nearly all of the participants either agreed or strongly agreed that the program was enjoyable, relevant and helpful, with the female participants more likely than the males to strongly agree with these statements.

Table 4: How would you rate the program overall?

Participants	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
Mums	0	0	5 %	41 %	54 %
Dads	0	1 %	9 %	40 %	49 %

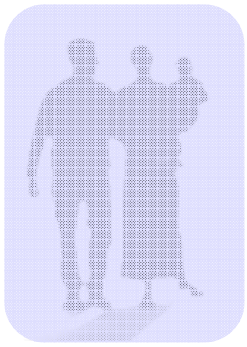


Table 5: Results of group process evaluation statements from post-group feedback forms

Statement		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
The *Baby Makes 3* group was… enjoyable	Mums	0	0	0	33 %	67 %
	Dads	0	1 %	0	48 %	51 %
The *Baby Makes 3* group was… relevant to my situation	Mums	0	1 %	1 %	43 %	54 %
	Dads	0	1 %	3 %	49 %	47 %
The *Baby Makes 3* group was… helpful	Mums	0	0	1 %	37 %	62 %
	Dads	0	0	0	48 %	52 %

A number of key themes about the group program emerged from the evaluation activities. These included:

- A perception that the program was worthwhile
- A considerable sense of sharing with others in the group
- An expressed desire for the program to continue for longer than 3 sessions
- An appreciation of the skills of the program facilitators

In addition, there were some comments (a minority of comments, but noteworthy, nonetheless) that the program was less supportive of dads, than of mums. These themes are discussed in detail below:

The program was perceived as being worthwhile

A significant number of participants found the program to be worthwhile. 37 feedback forms from the dads, and 22 from the mums, commented that the program had been either worthwhile, or that they would recommend it to others. One comment to this effect was that the group was 'definitely worth going'. Or as one dad explained,

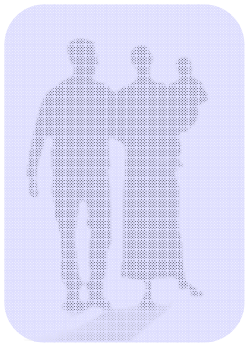
> I thought it was brilliant and as I said, it should be mandatory. I kept telling the guys at work, 'guys, you should be doing this course'. And they said 'why?' I said 'just flipping do it because it will open your eyes'. (dad 7)[2]

Sharing with others

Another key theme was that couples appreciated being able to share the experience with others. This theme emerged strongly from both the feedback form (17 dads and 34 mums) and also from the interviews, where every couple that was interviewed specifically mentioned this aspect of their experience. In the words of one participant:

> It was good just to have a whole group of people in there that were all going through the same thing. There was a broad cross-section but there was also a lot of similarities…you can kind of relate and see how it's affecting everyone in a similar way even though people had different life roles. (dad 1)

[2] There were 7 in-depth interviews conducted with couples who had completed the *Baby Makes 3* group program. For the purposes of presenting the evaluation findings, these individuals will be referred to as either mum or dad, with a number to signify which interview the couple participated in.



The effect of sharing the experience with others was to gain a sense of belonging or, as a couple, to feel more 'normal' or at ease with their own situation. As one dad explained:

> It makes you realise there are a whole bunch of other people out there going through the same thing. So if anything, it made us feel connected to the community and also made us feel maybe a bit more normal than we thought we were. (dad 4)

Or as this mum put it:

> I think the most I got out of it was seeing other people going through exactly the same thing. When you think everybody's got it together on the outside but knowing that everybody else is in the exact same situation, that was really comforting. (mum 5)

This sense of a shared experience with other couples was also considered unique, in some respects, by participants. As one mum identified:

> You don't really get to have that forum very often – you have the mothers group where it's just all mums, but it was nice to have the mums *and* the dads and being able to discuss it all. (mum 1)

Or as this mum explained:

> When you go to the mother's group you don't talk much about… what their relationships are like. It's more like 'what's your baby doing? Mine's doing this…' It's always about the baby, it's never about how are *you* going? (mum 7)

This was a sentiment that was also expressed by the male participants. For many of the dads, it was the only time they had participated in a discussion of their experience of becoming a father. One dad identified the benefits as:

> I was able to get a bit more of an insight into what other fathers were going through. (dad 4)

Whilst another described:

> What surprised me was the openness of some of the blokes. (dad 7)

From the program facilitator's perspective, this key theme comes as no surprise. In fact, there are a number of strategies within the design of the program (e.g. breaking up to do small group work in same-sex groups, ensuring discussion topics are focussed on real examples, playing music within the supper break to facilitate social interaction etc…) to encourage this process.

More sessions

A number of participants, particularly the mums commented that they would have liked the program to run for more sessions: 22 mums and 6 dads made this comment on their feedback forms. A typical comment being, 'an extra session would have been nice as we only had time to scratch the surface'. Or in the words of another mum:

> I think three sessions is good. I don't know if four is not too much. I really don't know but I think in a way after three we felt. 'oh three, that's it?'. Because this was our time to actually have time out . (mum 4)

Skilled facilitators

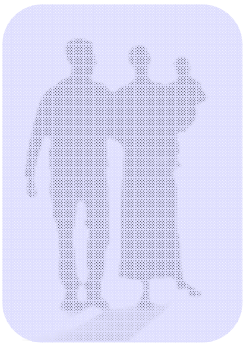
Yet another theme to emerge was the praise that many participants awarded to the facilitators for the way in which the program was conducted. There were a range of contributions here, but for the most part participants responded well to the groups being 'fun' and 'relaxed'. Typical comments were:

> The way the presenters… set the group up, it was all very comical. It was all very laid back and very humorous. (dad 1)

> They were quite relaxed about the whole thing. It wasn't like a lecture. (mum 2)

> It was presented just in a very low key, relaxed atmosphere. (dad 7)

There was also a level of appreciation for the facilitator's skills in holding and directing the group discussion. As one dad described in connection to one such discussion:



> The way they brought it around to be a positive rather than it started off – being really negative – but they brought it around and we all had a good laugh as well about it and it was quite a learning experience for a lot of people. (dad 1)

In addition, the participants also identified that the facilitators were not judging the group in any way. As this dad explains:

> Anything you say is fine. You're not being judged. You're in a nice, comfortable environment. So yes, that was a very good thing as well. (dad 3)

Or as this mum describes:

> The atmosphere was quite laid back… it's not finger pointing, it's as a group. (mum 2)

Yet despite the overwhelmingly positive response to the way the facilitators conducted the group, the participants were also quick to identify when facilitators were having difficulty explaining some of the content. This was particularly relevant to facilitators who were new to the program or who were facilitating a discussion for the first time, and is evidence that program facilitators need to be well versed in the content of the course and confident in their delivery in order to successfully deliver the program.

Not supporting dads?

There were some comments, although not many, that the program was biased towards women's experience of the transition to parenthood and was not supportive of dads in the same way. The following comments were indicative of this sentiment:

> The program seemed to be about the load on the mothers. (dad 4)

> The thing that surprised me was that it seemed to be a bit more female focussed, like mother role focussed than father role focussed. I felt a little bit sorry for the dads in some ways. (mum 6)

> Some of the husband's were kind of like 'no, stop picking on me.' (dad 1)

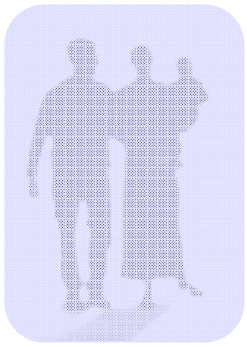
These comments are also in keeping with the program facilitator's comments, who recognised that, at times, the content of the group – particularly the aspects which focus on gender roles and contributions to household labour and baby care – was met with some resistance from the male participants. Indeed, the facilitators remarked that a small degree of resistance is to be expected from male participants who are undertaking the program and this resistance needs to be acknowledged and actively managed. The task for facilitators is to ensure that the level of resistance does not reach such a level that it is detrimental to a couple's participation in the program. In fact, the content of the course did evolve over the course of the 18 month period in which the program was evaluated and it is with respect to earlier versions of the program that the above comments were made. Following feedback of this kind, the program, and indeed the facilitator's way of working with the group, was altered slightly and new activities were introduced so that the content would not be perceived as biased.

Yet despite a number of male participants demonstrating resistance to certain aspects of the program content, there is evidence to suggest that this is not necessarily detrimental to their experience of the program. The following comments were made via the feedback forms, by men who in early sessions of the program had been resistant during some of the discussion:

> Initially I was skeptical *[sic]* about the program but I found it to be a valuable exercise.
> (feedback form #53)

> Honestly, I didn't really want to do program before we started but now am glad we did.
> (feedback form #57)

These comments indicate that, rather than being something to be avoided, men's resistance to certain topics can actually be something that can be worked with, and may even be a necessary part of the process of change.



Babies welcome

The only other finding In relation to the group process that should be mentioned is that a number of couples commented how extremely helpful it was that the group format allowed couples to bring their baby to the program. As one mum explained:

> It was good that you were able to take your baby. They had mats for the babies and there was plenty of room around you. At one stage [our baby], on one night, was really bad and I pretty much walked around the whole night holding him, you know, and because of the way the group was structured you could walk around and still add bits to the conversation. (mum 1)

The program facilitators found that for the most part, having the babies present during the sessions did not cause any problems. Of course, there were times when couples were distracted by a crying baby and were unable to participate in the discussion, but on the whole, the benefits that came with having the babies present far outweighed the difficulties.

5.1.2 Program Impacts – quantitative data

The pre and post-group questionnaires were designed as a measure of the group program's impact. As shown in *table 3*, there were 90 mums and 89 dads who completed the pre-group questionnaire. Of these, 71 mums and 64 dads completed the follow-up questionnaire 2 months after the group's conclusion. This was a return rate of 79% and 72% respectively.

Attitudes to gender roles and norms

The first section of the questionnaire measured the participant's attitudes to gender roles and gender norms associated with the transition to parenthood. The raw data from the participant's responses is presented in *Appendix C.*

Participants were asked to rate their level of agreement with the following six statements:

1. With the exception of birthing and breastfeeding, a father can do everything that a mother can do
2. The parent who stays at home to care for the children should also be responsible for the housework
3. Mothers are more nurturing than fathers
4. Gender equality is an important part of a healthy relationship
5. It is more important for a mother than a father to stay at home and care for an infant
6. The most important role a father can play is to be a breadwinner

Participant's responses were scored on a scale of 1 to 5 (strongly disagree = 1, disagree = 2, neutral = 3, agree = 4, strongly agree = 5) and a figure representing the average response was calculated. The average responses for each question were then compared for statistical significance using the 'students t-test' to account for the sample size and spread of the data (these results are also shown in *Appendix C*).

The average response for the two groups of mums and dads, both pre and post-group, are shown in *figure 4.*

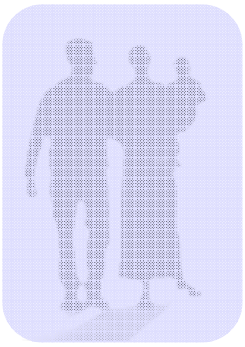
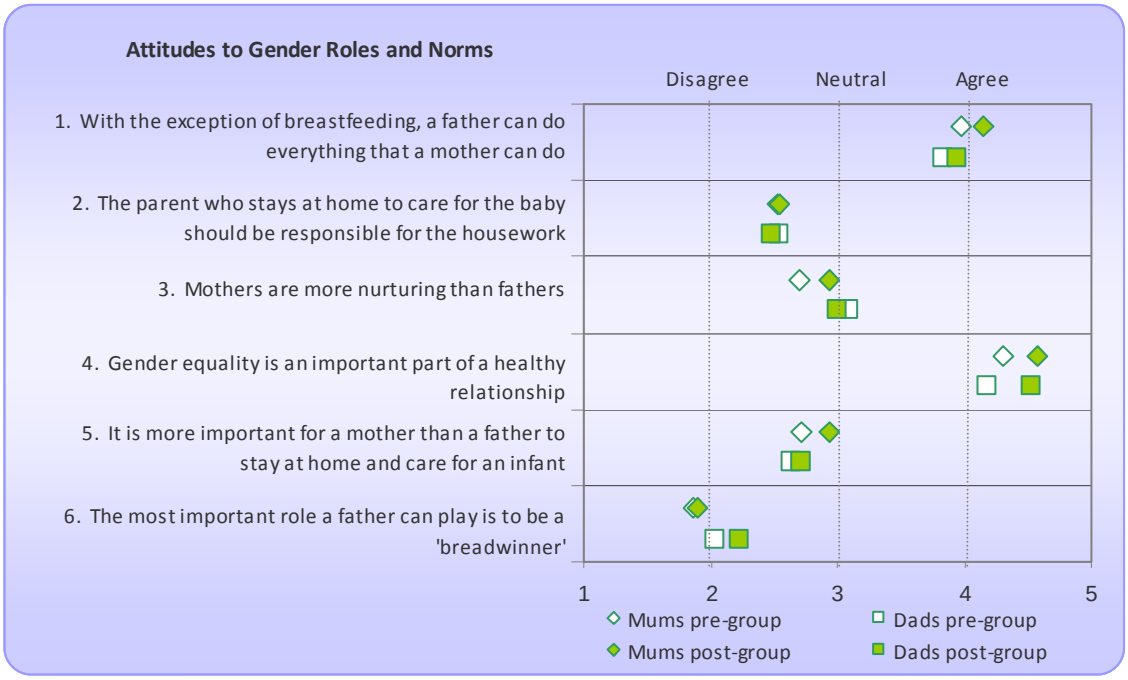


Figure 4: Average pre and post-group responses for mums and dads to questions in section one of the evaluation questionnaire



For each question, *figure 4* shows that there was close agreement between mums and dads. In addition, there was no great difference in attitudes before and after the group.

Three of the questions from section one asked participants to rate their agreement with statements that described 'traditional' gender roles (questions 2, 5 & 6). The average responses to these questions tended to disagree with traditional gender roles, indicating that, at an attitudinal level at least, support for traditional gender roles was relatively weak.

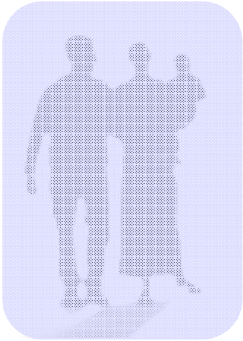
Two questions related to women's and men's capacity or ability to undertake parenting tasks (questions 1 & 3). Again, the tendency was to disagree with the traditional assumption that women are naturally better at parenting infants, than men.

There was also one question that related specifically to the concept of gender equality (question 4). It is noteworthy that this was the only question that produced a statistically significant change over time (t=1%). Having completed the group, participants were more likely to 'strongly agree', rather than 'agree' that gender equality is an important part of a healthy relationship. This is an important finding, given the overall goal of the *Baby Makes 3* program: to promote equal and respectful relationships during the transition to parenthood.

Who does what at home?

The second section of the questionnaire measured the perceived level of equality in the relationship, in terms of the couple's actual behaviours and contributions to work and family (again, the raw data from the participant's responses is presented in *Appendix C)*.

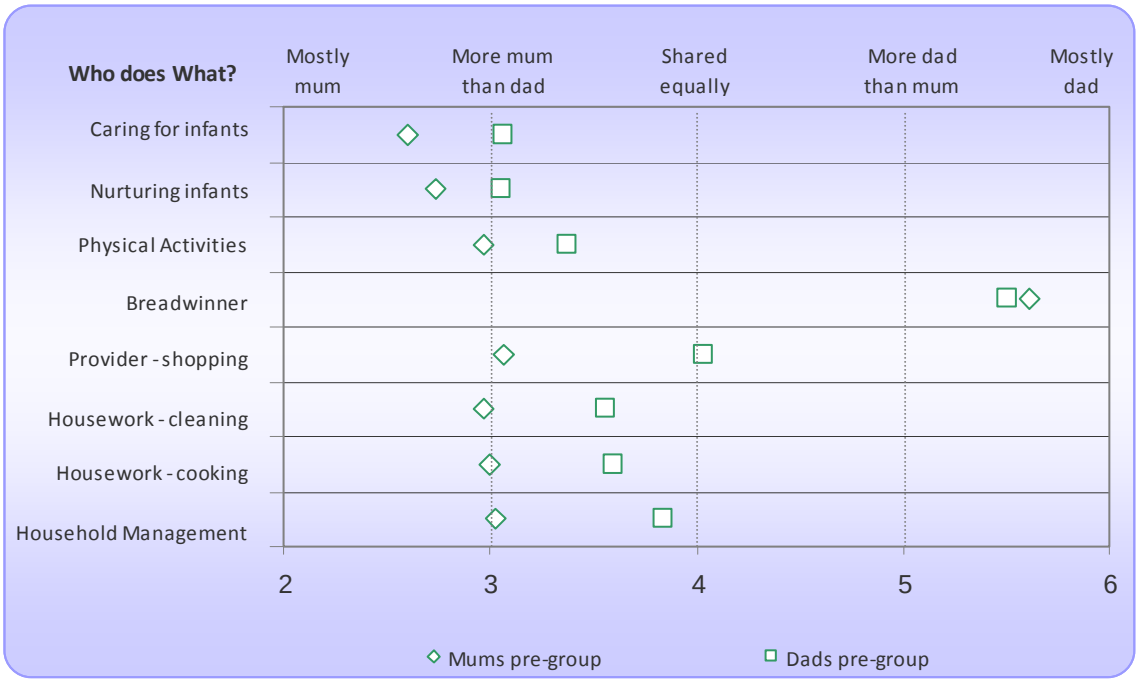
This section asked participants to apply an 'equality lens' to 'who does what' in terms of baby care, paid and unpaid work, and household management. It asked participants to specify whether a particular set of tasks was performed more by their partner, or themselves.



The sets of tasks were described on the questionnaire as:

- *Caring for infants*: child care activities such as changing nappies, dressing, bathing, feeding etc…
- *Nurturing Infants*: nurturing activities such as soothing, comforting, responding to crying, etc…
- *Physical activities*: activities such as playing with your child, taking for a walk in the pram, creative interaction, etc…
- *Breadwinner*: providing an income
- *Provider:* 'providing' activities such as grocery shopping, clothes shopping, etc…
- *Housework – cleaning*: housework activities such as cleaning, tidying, washing clothes, washing dishes, etc…
- *Housework – cooking*: kitchen duties such as planning and cooking meals etc…
- *Household Management*: activities such as paying bills, organising family/social activities, appointments, decision making etc…

Figure 5: Average pre-group responses for mums and dads to questions in section two of the evaluation questionnaire.



Participant's responses were scored on a scale of 1 to 7 (always mum = 1, mostly mum = 2, more mum than dad = 3, shared equally = 4, more dad than mum = 5, mostly dad = 6, always dad = 7) and a figure representing the average response was calculated. As with section one, the average responses for each question were then compared for statistical significance using the 'students t-test' to account for the sample size and spread of the data (these results are also shown in *Appendix C*).

The average responses for the two groups of mums and dads from the pre-group questionnaire are shown in *figure 5.*

Baby Makes 3

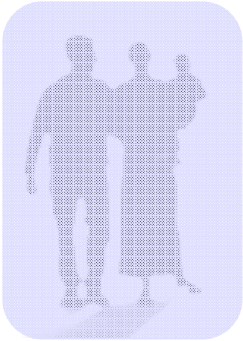
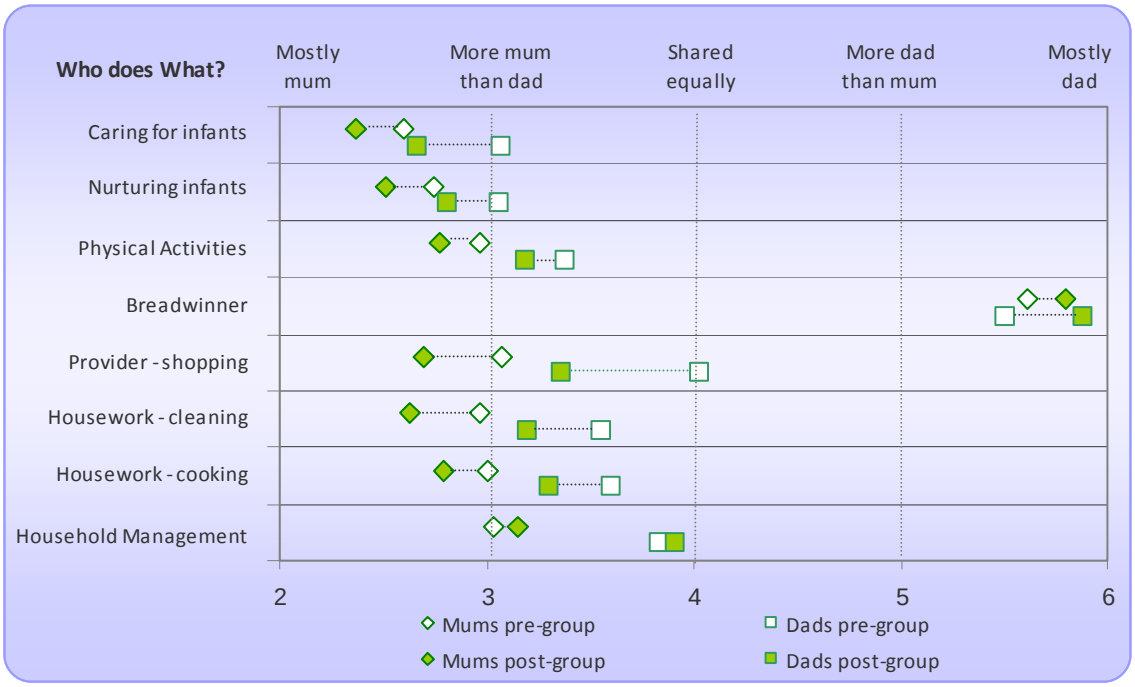


Figure 5 serves as a visual representation of couples' perceptions of 'who does what' in terms of work and family tasks prior to their participation in the group. The results clearly indicate a statistically significant difference (t<1%) between mums and dads on all sets of tasks, with the exception of the 'breadwinner' task.

At the outset of the *Baby Makes* 3 program, the mums perceive that they contribute more to household tasks than their partners. The dads also perceive that mums do more, although not to the same degree. The dads are more likely to perceive that the tasks are more equally shared. This finding indicates that prior to the *Baby Makes 3* program, the group participants have different perceptions of how 'equal' their relationship is.

After their participation in the program however, the findings indicate a significant shift in perceptions. This change is indicated in *figure 6* which serves as a visual representation of the size and direction of the change in the average responses.

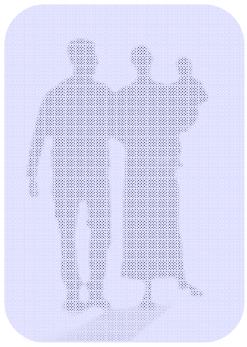
Figure 6: Average pre and post-group responses for mums and dads to questions in section two of the evaluation questionnaire.



The post-group results are interesting for one key reason: the direction of the change. According to the theory of change for the *Baby Makes 3* program (*figure 3*) one expected outcome is that relationships should become more equal. Yet the post-group results of the questionnaire indicate that the direction of change is *away* from equality.

The dad's post-group results all shift away from the 'shared equally' position. For the tasks of 'nurturing', 'breadwinner' and 'cleaning', this is a statistically significant change (t<5%), while for the tasks of 'caring' and 'shopping', the change is highly significant (t<1%).

The mum's post group results also demonstrate a shift away from the 'shared equally' position, although the only tasks where this change is statistically significant is for the tasks of 'caring' and 'cleaning' (t<5%).



The end result however, is that at 2 months after the group program, not only have the contributions to work and family tasks become perceived as being less equal, but there remains a significant difference in perceptions of mums and dads of the degree to which each partner is contributing to these tasks.

This anomaly in the questionnaire results will be further explored in the 'Discussion' section of this report, and one of the key sets of data for interpreting the questionnaire results will be the findings from the in-depth interviews conducted with former group participants.

5.1.3 Program Impacts – qualitative data

The qualitative data pertaining to the program impacts were provided by the post-group feedback form and the in-depth interviews conducted with seven couples following their participation in the program. This data was used to evaluate the short to medium term impacts of the *Baby Makes 3* group program. The transcripts of interviews were analysed to identify the key themes connected to the program's *theory of change*, outlined in figure 3. These themes are identified below, in connection to the following stages of change:

Short term *expected* impacts:

- Increased awareness
- Greater communication
- Changed attitudes

Medium to long term *potential* impacts

- Changed behaviours
- Greater equality

There was strong evidence that the expected impacts were achieved and some (although weaker) evidence that the potential impacts of the program were also achieved.

Awareness

The major theme to emerge from the interviews was the greater awareness of a range of issues connected to the transition to parenthood that participants had gained through their involvement in the course. In many cases, the interviews highlighted that, had the couples not participated in the program, they simply would not have been cognisant that these issues were impacting on them, or even relevant to them. As one man pointed out:

> We had issues coming up that we didn't even realise we had. (dad 7)

Or in the words of another man:

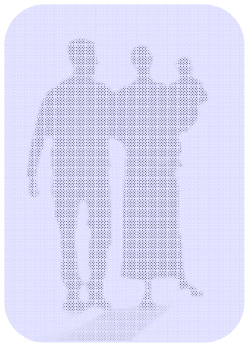
> I think it covered a lot of subjects, a lot of different areas. I think most, if not all of them, were very to the point of what we should have gone through and things that we probably hadn't thought of prior to that. So yeah, I think it was very good and very enlightening. (dad 3)

In most cases, the result of this increased awareness was seen as a positive outcome in and of itself. As one mum explained:

> I think the education of it, the concepts, seeing things from the other side, from a different perspective, I think most of them are things that we probably wouldn't have considered or thought of on our own, or it would have taken us a long time to get there, and I think it really did open our eyes and make a big difference. In a way we didn't even know we needed the sessions. We didn't even know what to expect and it was really good because it was like, 'oh, that's really helpful.' (mum 3)

Yet further to this, it was recognised that for the men, in particular, becoming aware of their partner's experience of motherhood was a revelation. As this mum explains:

> The dads would kind of not realise what goes on through the day. You're at home and the baby has a really bad day and you're trying to get stuff done



> and then he'll come home and say something like 'what's for tea?' and you want to rip his face off. Becoming more aware of that part of it was probably quite a good thing. (mum 1)

And as her partner elaborated:

> In many cases, the dads, our lives haven't changed that much. I continued on and got home from work and stuff like that and just kept acting as normal and not realising there was a lot more demands on my partner's time. Well, probably realised but didn't take it on as much. (dad 1)

In most of the interviews dad's increased awareness of mum's experience was identified as having a positive impact on the dads. As the same man describes:

> Early on I couldn't understand why [my partner] used to get so angry about the house. Especially with the new baby, and stuff everywhere, still trying to settle him in, work out routines and stuff for how he was going to be, and then she'd just be going ballistic about housework and I'd be like, 'it doesn't matter, doesn't matter'. I couldn't understand why she was getting so emotional and we talked a lot in the group about that women are judged how well they keep their home and that sort of thing. I think it was a bit of an eye opener because I couldn't work out why she was getting so angry and I didn't think it was healthy. (dad 1)

Or in the words of this man:

> I think after I realised it [what it's like for new mums] we got an understanding that she's not alone in this, we're in it together. I think that was the biggest thing for me. (dad 3)

And indeed, the fact that their male partners had listened to and acknowledged mum's experience, served to validate the mums in a way that was seen as important and beneficial. As the following mum describes:

> Just to have that open forum and to probably get [my partner] to understand things... If I try and tell him at home certain things he may have thought that I was complaining. (mum 6)

Or as this mum put it:

> A lot of the dads didn't sort of realise what mums go through, and vice versa. So it was good to get that out in the open and it didn't make you sound like – if I was home and saying something to [my partner] it might sound like I was having a whinge, whereas in a group thing like that, and everybody is going, 'yeah same.' It was good in that regard. (mum 1)

Conversely, it also emerged that the mum's had become increasingly aware of the dad's experience. As this dad put it:

> A lot of the mothers weren't listening to what the dads were saying either. A lot of the mums had forgotten that the dads – they've almost forgotten what it was like to go to work and come home and they expect the dads to be quite fresh. (dad 1)

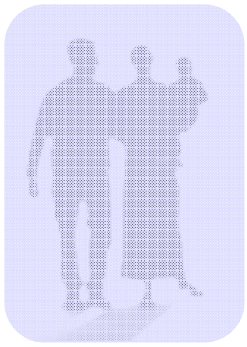
Or as this mum describes:

> I didn't even think about any pressure that was on him, because what the hell are you talking about, it's everything on me. It was just me, I didn't see his part. (mum 3)

Another key theme from the interviews was the degree to which participants had become aware of the gendered expectations that were experienced by new parents. This was a particularly important finding as it relates specifically to the expressed aim of the *Baby Makes 3* group – to raise awareness of the importance and benefits of maintaining gender equality during the transition to parenthood – and to a specific group discussion from session one.

It is noteworthy that the dads, in particular, were clearly able to articulate the way gendered expectations are experienced differently by men and women. The following quotes illustrate that the male interviewees had fully grasped the relevance and importance of this concept:

> If dads do something everyone goes, 'oh, well done! You've changed a nappy, well done!' whereas if a mum does it, it's like 'oh, you waited that long to change a nappy.' It's kind of like we got rewarded, where a woman, the mum, there



> was an expectation that she did it, and maybe questioning how she did it. She doesn't get rewarded, whereas we do, when really it was just our role anyway. (dad 1)

> Mums have got an expectation on them to do all the housework, that general thing being a mother, child care, which is placing a lot of pressure on them and that could be either an expectation, or a society norm or an actual occurrence in a specific household. (dad 2)

> Well certainly it was pointed out in a way that I wouldn't have put much thought into before – which is handy – where either the dad takes the baby down to the shops and people go 'oh, you are such a good dad', or something but they don't say, 'you're such a good mum' if mum takes the baby down to the shops. It's just that's what mums do so mums don't get any of that. The dads get everything. And all of the things about …is the baby sleeping through? …are you breastfeeding or bottle? …those questions go to mum, they don't go to dad, and if they do, dad's not responsible for the answer. So there's no expectations really in that way and a lot of it falls to mum. (dad 4)

> The actual group opened my eyes to the expectations on a new mother. If they go back to work – they shouldn't go back to work. If they don't go back to work – why haven't you gone back to work? Why aren't they breastfeeding? Or if they are breastfeeding when are they going to stop? You know, all the connotations. And everything you did you were being judged and I actually never realised that was such a situation for first time mothers or for mothers in general. I wasn't aware of that and once I learnt that information from the group it certainly taught me some things and I think I was able to act on them and get a better understanding of where [my partner] was at. (dad 5)

Realising the significance of the impacts of gendered expectations has a real impact on the dads. As this man describes:

> I didn't understand the expectations on women and particularly society's expectations. Once I saw it I thought, 'well it's not only a battle, it's a battle that [my partner] needs me to be part of. I can't be part of what society says about things. I need a better team work approach'. So it helped me. It definitely helped me. I'll put my hand up and say that was pretty good for me. (dad 5)

Furthermore, the greater awareness of gendered expectations was also beneficial outcome for the mums. As this mum explains:

> I think the burden of expectations was probably the area for me that had the most impact. I think all the women think it but seeing it up on the whiteboard and talking about it and giving examples is the thing. (mum 5)

Or in the words of this mum:

> It pointed out so many things. For myself it was 'oh, my god, that's true' you know? Like 'oh, that's what they're saying, it's kind of right'. It was interesting for me to hear that. (mum 3)

Communication

Another key theme to emerge from the interviews was that participation in the group program served as an important step in initiating conversations and fostering greater communication between mums and dads.

The group itself was identified as a forum that encouraged communication, especially for the men:

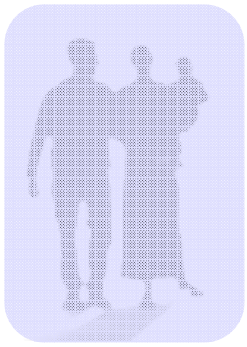
> It forces you to converse about it and dudes don't do that very often… so the program was the only time that I've seen a bunch of other dads together and having a talk about stuff with their baby. So I wouldn't have ever had that opportunity. (dad 4)

But most importantly, the program generated discussions between partners outside of the group sessions. One dad described:

> We talked about it in the car on the way home. (dad 4)

Or as this exchange between partners describes:

> The number one thing was the communication bit, keeping the lines of communication open, having



> an open mind to our partner and seeing things from their perspective. (dad 3)
>
> I remember at the end of every session in the car and during the night we were really… (mum 3)
>
> Yeah, talking about the issues that were raised and really trying to understand things and keep working on it. It was good. (dad 3)

The program facilitators also pointed out that a common occurence within the groups is that many couples will mention how they had discussed a particular topic during the week, in between sessions. Indeed, the structure of the program – including 'homework' tasks – is specifically designed so that couples are encouraged to continue to discuss the content of the sessions at home. An interesting observation by the program facilitators is that when couples talk about the discussions they have had they, more often than not, do so using the same terminology that was used in the group. This observation is evidence that, by participating in the group discussions, couples are developing a 'shared language' that enables them to continue discussing topics outside of the group setting. This idea of a shared language can also be identified in the couples' interviews where certain terms (e.g., 'expectations') are used in the same manner and context that they were used in group discussions.

There is clear evidence from the interviews that participation in the *Baby Makes 3* program has encouraged couples to discuss topics they had previously not talked about. This is identifiable in the follow comments:

> I guess I saw more. It opened my eyes in a way. And we are trying to talk more about stuff, so I could explain more and he would respond to it. So it was kind of good. Because after we discussed that, he was more aware of my thoughts and feelings. (mum 3)
>
> The group certainly gave us, I think, ideas to discuss. Things that I didn't know [my partner] thought of that were problems, or potential problems, that she brought to talk to me about. (dad 5)
>
> It got my husband and I talking about things that we hadn't thought or previously talked about. (mum, feedback form 25)

The benefits of this increased communication are clearly identified in the following quote, made by one of the mums on her post-group feedback form:

> 'We really found the program to be beneficial and it has helped open conversations and helped us start to rebuild our relationship.' (mum, feedback form 55)

Changed attitudes

In addition to the strong evidence of increased awareness and greater communication among couples, the interviews also reveal a subsequent change in participant's attitudes. These 'inner' changes were described as occurring on a personal or emotional level for many participants, but also on a relationship level.

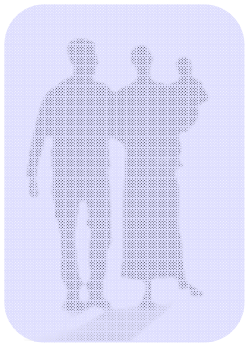
One man described the personal change he experienced in the following way:

> I would say it certainly added value to our parenting experience, no doubt. I think it actually helped to contribute to me as an individual too though. It gave me more of a selfless focus. I was pretty focussed at that point, I remember, on making sure that my role was in check, like my traditional role, as in working and money and that side of things, but I think it opened up the softer side of me, too - supporting and helping [my partner] and making sure that the home life is the best as it can be, too. (dad 5)

For the female participants, the changes were described as equally personal. One mum expressed that participating in the group had 'helped to validate my feelings' (mum's feedback form 35), whilst for others the changes were of an even more compelling emotional nature. As this mum describes:

> Sometimes you would leave and you'd almost feel like a bit of a weight had been lifted off. (mum 1)

Or in the words of this mum:



> I've placed less expectations on myself. I don't feel that pressure any more because that was part of what I think brought on the postnatal depression. I guess I had expectations that… not only do I look after [the baby] but I've got to wash dishes, iron clothes, this, that and the other and it's like well, no, I shouldn't feel guilty. I shouldn't have to feel guilty that I don't do those things and so it's just that load of guilt off my back that lets me function a bit better and get out of bed in the morning whereas previously I just wanted to go back under. (mum 2)

And the changes in attitudes also extended to what was described as an increased level of support for each other. In the words of this mum:

> [We became] probably a little bit more understanding of each other. (mum 4)

Or as this dad describes it:

> It has helped me to be aware of and recognise what we're doing and to be able to support each other in our roles, certainly. (dad 6)

Changed behaviours

Couples were easily able to articulate the impact of the program in terms of raised awareness, improved communication and changed attitudes. However, many found it harder to identify specific changes in actual behaviours as a result of participating in the *Baby Makes 3* program.

As this mum describes it:

> It [the program] made us feel normal. It was good. I think it was very positive. I mean the program was positive for us. Yeah, I don't think we changed much. Perhaps we've changed in subtle ways just because there has been the awareness, but yeah… (mum 4)

Or as this mum puts it:

> I had the realisation that the way that we were continuing, the way we divided up household chores and that might not work when I went back to work. And that hadn't occurred to me – that when I looked at these expectations I was like 'alright, so if I take on part time work plus have all these expectations on me, that's going to be a lot to deal with'. We didn't actually change how we dealt with housework or those expectations, but that was the realisation I had. (mum 6)

Likewise, the following dad was certain that there had been positive changes, but was unable to describe exactly what those changes were:

> I think both of us made very subtle changes to our behaviours that on a day to day basis is not noticeable but when you add it all up it does actually make, maybe not a substantial change, but a change for the good that makes the relationship and life a lot easier to manage (dad 2)

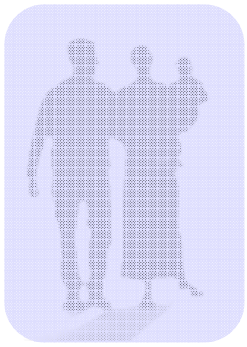
Yet there is noteworthy evidence that, for some couples, behavioural changes did indeed occur. For these couples, there clearly were some conscious changes made to the way they were structuring their roles and deciding 'who does what'. Although, for the most part, these changes were described as being small or minor changes – using phrases such as 'a bit', 'a few', 'sometimes', or 'trying to'. See, for example, the following quotes from interviewees as they describe the changes they made in response to the *Baby Makes 3* program:

> So I've taken that on – a bit more of the housework I've taken on. So yeah, I think we've improved it a bit. (dad 1)

> You give me more of a break now since the sessions. I think he realised to take a bit more on. (mum 2)

> There's a few little things that have changed that I've really appreciated, being that I get to have an hour sleep in on a Saturday morning while he'll look after her, that sort of thing. Or he'll take her to the supermarket with him and give me just 'me time'. No 'is she going to wake up crying?' None of that. Just to be at peace sort of thing. (mum 2)

> Now I'm more aware that, well, before I'd go off to my mates and watch footy. so it was sort of like that awareness of maybe I should be more



> considerate. And they are the sorts of things you pick up with all the other fathers or couples in that session where yes it's good to do your own thing but sometimes you need to sacrifice a bit to make it work. (dad 2)

> I've been trying much harder to help around the house, do some of the chores and not let her do everything and not think 'yeah, she's at home, she'll do it', and really try and pitch in more. Prior to the session, or even prior to the baby, I never really helped with laundry or cooking too much. So yes, I never really pitched in with any of the housework and now I'm trying to. I'm cleaning a bit more, trying to take care of [the baby] at least a few hours per day to give her a bit of time off. (dad 3)

One theme that did emerge from the analysis of the interview transcripts – and this goes some way to explaining the small degree of change in terms of actual behaviours – was that the gendered norms and expectations connected with the roles of men and women during parenting are simply so entrenched that they are very difficult to change, even when couples have greater awareness and understanding of their impacts.

This mum describes the effect quite well:

> I take care of the baby and look after the housework because I'm at home, so I have to do all this stuff and I have to clean and cook and everything because I'm at home and I don't do anything, so I've got to. In a way I still feel it, you know? I know that we discussed that and I know that he said, 'that's okay, you're doing enough with her', and he's really good with me but in a way I still feel like at the end of the day, where the whole day I just played with her and I didn't cook and I didn't clean, I still feel like I didn't do anything today which is really wrong I guess, but… (mum 3)

And the overarching presence of gendered expectations is something that also influences men's behaviours, as this mum identifies:

> I mean, you're kind of sporadic with your helping and stuff. Because he knows what needs to be done, like one of his mates came and stayed the other weekend so he just went into 'clean the house' mode. So I think he knows what needs to be done, but is happy to avoid doing stuff. (mum 1)

The difficulty of changing entrenched gendered behaviours is something that couples unavoidably come up against, even though they may have greater awareness and changed attitudes, as this exchange between a couple and the interviewer demonstrates:

> It would be great in some ways if [my partner] did take more initiative with doing housework and identifying things but then if he tried, then I might find that I don't like it because I'm a control freak at the same time, so it's kind of like I don't know what we could change. (mum 6)

> What do you think [dad]? (interviewer)

> I tend to support her view. Yeah, I like to try new and different things as much as anybody else but sometimes if you have a particular way of doing things, or not doing things or that kind of thing, if I try and make some changes I meet resistance and so I'm like 'okay, I'll just keep doing what I was doing'. (dad 6)

> So the housework, child care… it hasn't changed on a day to day? (interviewer)

> No. (mum 6)

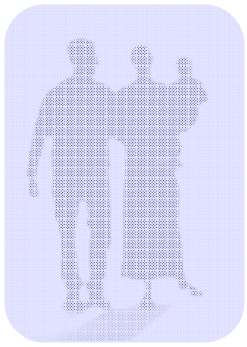
> Not really. (dad 6)

Equality

In addition to the evidence in support of some modest behavioural change, the analysis of the couples' interviews also yielded evidence of changes in the perceived level of equality within the relationship.

Here, couples tend to use the word 'balance' to describe this non-tangible aspect of their relationship. The following interaction between one of the couples demonstrates this well:

> It kind of made things in order, I guess, in balance. (mum 3)



> Yes, I think it's more of a balance now. I think it doesn't fall all on mum. (dad 3)

> I wouldn't say It's fifty-fifty. I don't think it's really *balanced.* (mum 3)

> I'm not saying it's fifty-fifty. Yeah I think it's *more* balanced. It's not all on mum and I'm pitching in more around housework and maintenance and stuff like that. (dad 3)

Or as this mum describes it:

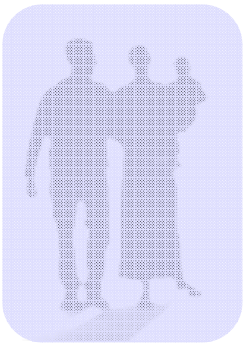
> Maybe it's helped [my partner] understand that in terms of child care and things, that help is needed, it's not just now I've returned to work, it's that there's more of a balance now. (mum 4)

Or in the words of this mum:

> We really try to consider each other's load and really try to be fair… social time and work time and balance it. (mum 5)

Yet even if couples are finding it difficult to change their way of doing things, and struggling to re-structure their roles to create a more equal relationship, at the very least, they seem to have an idea that the goal of increased equality is something they should be aiming for. This comes through in the following quote from one of the dads:

> It's changed my way of thinking so I hope as a result of that it's contributed to my change of action. I think I was hands on to start with, but now I have an understanding of *why* it's important to be hands on and important to have a balanced and well-rounded household . (dad 5)



5.2 Fathers nights

During the two-year period from April 2009 to April 2011, 82 fathers evenings were held in the City of Whitehorse, and these were attended by a total of 680 first time fathers. Feedback from the couples who attended these evenings suggest they are perceived as a positive experience. For the Maternal Child Health Service, the evenings represent a significant strategy for, and commitment to, engaging first time fathers.

Benefits of fathers nights

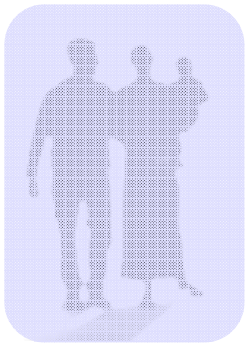
The benefits of the fathers nights include the creation of networks of support among new dads, but most importantly, the evenings provide the opportunity to acknowledge and promote the positive role fathers can play in families. The fathers nights create opportunities for new fathers to observe how other men interact with their babies, to learn from each other directly, and indirectly, by sharing experiences and discussing practical baby care. A well facilitated fathers night promotes alternate models of masculinity, where men are nurturers and carers, and challenges traditional gender roles and expectations.

Although men, as a group, can be difficult to engage in family services, the level of engagement of the first time fathers in the City of Whitehorse is high and the *Baby Makes 3* project has been able to contribute to this high level of engagement by providing a male facilitator to lead the fathers nights discussion. The Maternal Child Health nurses, who co-facilitated the evenings, agreed that having a male facilitator was valuable because it increased the level of engagement and the openness of the discussion. A male facilitator at these evenings did not encourage any additional attendance of first time fathers, but guaranteed that those who did attend were more engaged. And having been engaged in this way during the fathers night, the dads were more likely to engage with the Maternal Child Health Service as a whole and the service system more broadly. Indeed, the evidence suggests that those men who attended a fathers night were more likely to go on to participate in a *Baby Makes 3* group program, illustrating the key role that the fathers nights had in the success of the *Baby Makes 3* project.

Limitations of Fathers Nights

Although the fathers nights are generally considered a major success in the City of Whitehorse there are, nonetheless, a number of issues that could be considered problematic, particularly from a primary prevention perspective.

Firstly, there is only *one* fathers' session. So no matter how successful the evening is in promoting positive father involvement, there is always the risk that a 'one-off' session such as this can be viewed as tokenistic, and may actually reinforce traditional gender roles, i.e. by suggesting that a father's contribution to parenting is naturally less than that of a mother's. A further limitation is that a 'one-off' session must, by necessity, focus primarily on engaging the men present and making them feel comfortable in a group situation, leaving little time for any significant structured content, with what little structured content there is focussed mainly on the father/child relationship, whilst little attention is paid to father/mother relationship.



5.3 Maternal Child Health workforce capacity building

The *Baby Makes 3* project sought to build workforce capacity within the Maternal Child Health Service through both informal and formal means. Regular discussions took place about preventing violence against women by promoting gender equality when working with new families. Two professional development workshops were developed and conducted in collaboration with Drummond Street Services *Just Families* project. The evaluation findings are presented below.

Workshop one: 'Relationships Under Stress'

This workshop was conducted by *Just* Families project staff and aimed to strengthen the Maternal Child Health Service's capacity in early identification of couples experiencing relationship difficulties. It was attended by 13 Maternal Child Health nurses. On the post-workshop feedback forms nurses were asked to rate the impact of the workshop through a series of questions as shown in *Table 6.* These results indicate that most of nurses gained a number of perceived benefits from participating in the workshop.

The key theme to emerge from the feedback comments was that the workshop was beneficial in reinforcing the nurses' practice in relation to addressing family violence issues, particularly given that Maternal Child Health nurses are required to respond to such a vast range of issues related to mums' and babies' wellbeing. As one nurse commented:

> I think we need to have this training every year, or more often, because we have to provide so much information and have so much to discuss with parents, we need to keep mindful of what is really important – the couple's relationship.

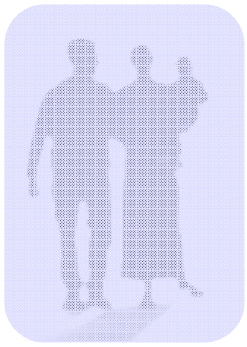
Table 6: Results of post-workshop impact evaluation for workshop one

How much do you think the workshop helped you with each of the following?	Not Much	A Little	A Fair Bit	Lots
Understanding the signs of relationships under 'normal' stress	0	1	8	4
Understanding the signs of relationships under 'harmful' stress	0	1	7	5
Understanding the difference between 'normal' and 'harmful' stress	0	2	7	4
Identifying the precursors of family violence	0	1	9	3
Knowing where to refer couples with differing levels of relationship stress	0	0	4	9
Being confident to seek a secondary consult	0	3	4	6

Workshop two: 'Working with Men in ways that Promote Gender Equality'

This workshop was conducted by the *Baby Makes 3* coordinator and was attended by 17 Maternal Child Health nurses. The results from the post workshop feedback forms are presented in *Table 7.*

The results show that, again, most nurses perceived a number of benefits resulting from participating in the workshop. In some areas, however, the benefits were minor, reflecting the lack of confidence that many nurses express when it comes to engaging and working with men, particularly from the perspective of gender equality.



The key theme to emerge from the feedback comments was that participants were focussed on 'practical strategies' for engaging and working with men. This is noteworthy because it suggests that Maternal Child Health nurses do have a basic understanding that they should be working with men in ways that promote gender equality, but require a more developed understanding of what that might 'look like' in practice.

Table 7: Results of post-workshop impact evaluation for workshop two

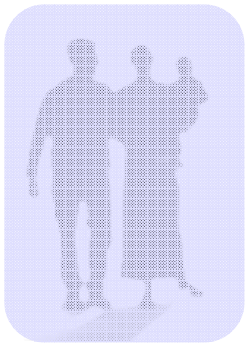
How much do you think the workshop helped you with each of the following?	Not Much	A Little	A Fair Bit	Lots
Understanding first time fathers	0	7	5	5
Being clear about the objectives of a fathers evening	0	0	10	7
Developing group work skills and techniques	0	2	10	5
Ability to deal with challenging group situations	0	0	10	6
Knowing what topics to talk about on a fathers evening	0	5	5	7
Being confident to facilitate a fathers night	0	5	9	3

Impact of capacity building

From the perspective of workforce capacity building, Maternal Child Health nurses were able to identify a number of perceived benefits of the *Baby Makes 3* project. These included a greater emphasis across the organisation on engaging first time fathers and a greater awareness of the role nurses could play in promoting equal and respectful relationships.

In the City of Whitehorse, there is a strong philosophy and culture that supports father engagement in the Maternal Child Health Service. This is demonstrated by the significant investment required to run fathers nights for every new parents group. The *Baby Makes 3* project has brought an added dimension and awareness to the level of father engagement. Many nurses are able to describe specific strategies they use to engage first time fathers and many report greater confidence in their ability to engage men in conversations about being a dad.

A key impact of *Baby Makes 3* was that, following the project, Maternal Child Health nurses reported greater awareness of the primary prevention approach to violence against women and the role they can play in achieving it. The identification of the social determinants of violence against women and education about the gendered roles and expectations, and the gendered division of labour among first time parents, were identified as key topics for achieving this increased awareness. Maternal Child Health nurses reported that they now had a 'language', an approach, and increased confidence in talking to men and women about relationship issues, and were more likely to focus on the needs of the family, rather than the needs of the mum. In addition, many nurses reported that they felt more able to engage men as carers in their own right, rather than as 'supports' for mum.



5.4 Project implementation and Partnerships

The *Baby Makes 3* Project Reference Group participated in a focus group discussion to evaluate the implementation and impact of the project as a whole. Overall the project was seen as a success in a number of ways, ranging from the individual level to the organisational level with a number of benefits for each organisation and the partnership in general.

First and foremost, the project was seen as filling a gap in current services. Not only was the project identified as one of the few primary prevention projects in the eastern Melbourne metropolitan region, but the focus on first time parents and the transition to parenthood was seen as a unique and significant programmatic response to the needs of the target group during what was universally acknowledged as a crucial stage of life.

There were a number of factors identified during the focus group that were considered central to the success of the project. The significant size and time frame of the project funding provided by VicHealth – $90,000 per year over three years – was seen as being fundamental in allowing the project coordinator sufficient time and resources with which to undertake a detailed period of project planning, including the creation of an evaluation framework. The project coordinator – the vision, capacity to build partnerships, and understanding of primary prevention as opposed to early intervention that was brought to the role – was also perceived as central to the success of the project, as was the good will within the partnership that had been established during phase one, and the willingness, particularly on the part of Maternal Child Health, to reflect on current practice and consider new models of service provision.

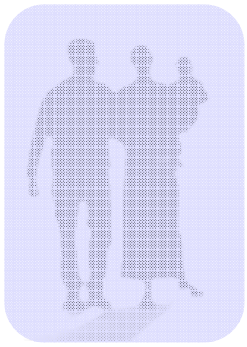
Yet the project's implementation was not without barriers and limitations. Chief among these was the difficulty in recruiting program facilitators to deliver the *Baby Makes 3* group program. Factors mentioned here included the after hours requirement of the work and the relatively low numbers of males, in particular, with a working knowledge of, and interest in, primary prevention. And despite the successes of the group program, it was noted that a large number of first time parents, especially fathers, remained unengaged – from the *Baby Makes 3* project specifically and from Maternal Child Health more generally. In addition, it was further noted that cultural groups such as the Indian and Chinese-communities, despite being well represented in the City of Whitehorse, are not well represented in the centre-based New Parent Groups.

Whitehorse Community Health Service

Whitehorse Community Health Service has a long and proud history of providing a tertiary response to the issue of violence against women through services to both women and men. The *Men Making Change* program has been established for over twenty years and was one of the first men's behaviour change programs in Victoria. There is also a well established family violence counselling service for women who have experienced or are experiencing intimate partner violence.

As a primary prevention project, *Baby Makes 3* has complemented these existing services and prompted the organisation to reassess the ways in which it engages in the field of family violence. There is an increasing organisation-wide involvement in primary prevention. Workers from within the organisation have become involved in the delivery of *Baby Makes 3* activities, including the facilitation of fathers nights and *Baby Makes 3* groups. There has also been an exchange of ideas and methods of working between the primary and tertiary services, evidenced by group facilitators working across both the *Baby Makes 3* and *Men Making Change* programs.

Increasingly, the organisation is paying greater attention to primary prevention. The current Integrated Health Promotion Plan includes the primary prevention work of promoting equal and respectful relationships between men and women



among its key priorities. Those present at the focus group noted that this would not have occurred in the absence of the *Baby Makes 3* project.

Maternal Child Health Service

At a local government level, the *Baby Makes 3* project has been considered a positive initiative for the City of Whitehorse. It was perceived by those present at the focus group to represent a positive local government response to the issue of family violence and to complement an increased focus on existing primary prevention activities, such as the White Ribbon Day action undertaken by the City of Whitehorse in recent years. In addition, the Maternal Child Health Coordinator has spoken about the *Baby Makes 3* project at a number of conferences throughout Australia, adding to the reputation of the City of Whitehorse as a leader in Maternal Child Health Services in Victoria.

There were a range of positive impacts identified for the Maternal Child Health Service. Chief among these was the sustained support that was offered to Maternal Child Health nurses. It was noted that, as a result of the *Baby Makes 3* project, nurses now have a shared language with which to talk to couples about their relationship, whereas before the project the lack of a widely accepted means of discussing relationship changes meant, more often than not, that those conversations would simply not have occurred.

The Maternal Child Health Coordinator stated that the *Baby Makes 3* project has contributed to the process of organisational cultural change within the service, where nurses are increasingly seeing primary prevention work as an aspect of their core business. This was identified as having a direct benefit for new mothers in particular by providing an environment in which women have permission to talk about and explore any concerns they may have. The cultural change in this respect has also helped create an environment that assists the early intervention work that nurses are frequently required to undertake.

Partnerships

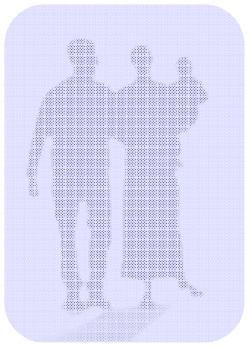
A strong partnership has developed between the two partner organisations, with Maternal Child Health nurses in the City of Whitehorse having a well developed understanding of the *Baby Makes 3* project, and of the services offered by Whitehorse Community Health Service more generally. Yet despite the close working relationship between Maternal Child Health nurses and the *Baby Makes 3* Project Coordinator, it was acknowledged that the partnership at the management level was not as strong.

For the project to continue into the future it was acknowledged that the partnership will need to develop to a point where it does not rest on individual workers, but functions more as a multi-level collaboration. The steps for building the partnership have been identified as establishing shared goals, identifying clear roles and responsibilities, and formalising the lines of communication, particularly in relation to decision making and the dissemination of information. It has also been suggested that it would be beneficial to identify processes for acknowledging and celebrating partnership milestones and successes. Without doubt though, the goodwill between organisations that has been created by the *Baby Makes 3* project has laid fertile ground for the future of the partnership.

Drummond Street Services

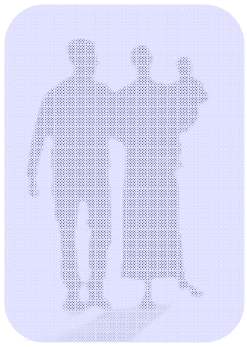
The valuable partnership with the *Just Families* project was made possible through funding granted to Drummond Street Services by the William Buckland Foundation.

Synergies were recognised between the two projects which were both concerned with targeting couples transitioning into parenthood and with building capacity in Maternal Child Health Services to support healthy relationships. The projects exchanged information and ideas including theory and frameworks, evaluation methods and measures, and



the design and development of professional development workshops.

The partnership added value to *Baby Makes 3* primarily through the creation of a relationship counselling position funded by the *Just Families* project and located at Whitehorse Community Health Services within the counselling program. The focus of this position was specifically on working with first time families, utilising a model of early intervention to address relationship problems that arise during the transition to parenthood. To date, four of the couples who participated in the *Baby Makes 3* group program have also received relationship counselling.



6. Discussion

Baby Makes 3 represents a new approach to preventing violence against women; a primary prevention approach that asks, 'what can be done to prevent violence *before* it occurs'? It is an approach that identifies fundamental gender inequality as the key social determinant, or cause, of violence against women, and acknowledges gender inequality, itself, as a direct result of traditional, cultural gendered norms and expectations.

The pervasive nature of these gendered norms and expectations means that promoting and fostering gender equality is a difficult task. But it is a task made easier by recognising that there are key life stages – the transition to parenthood is foremost among them – where these norms and expectations become increasingly prominent and during which it is possible to significantly influence and shift people's attitudes and behaviours in the direction of greater gender equality. Simply raising people's awareness of gendered norms and expectations and relating these to their lived experience can assist them to structure their relationships in ways that demonstrate greater equality and respect.

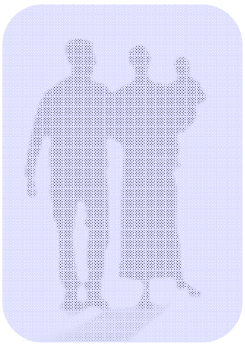
The main achievement of the project has been the development and implementation of the *'Baby Makes 3* model', a unique contribution to the field of primary prevention, consisting of a three-week group program exploring issues of gender equality from the perspective of first time parents, supported by organisational and workforce development within a local government Maternal Child Health setting.

The evaluation findings demonstrate that the *Baby Makes 3* model is a successful and effective means of promoting equal and respectful relationships between men and women. The group program was rated very highly, with strong evidence that the experience was not only enjoyable and helpful, but highly relevant to first time parents. Couples reported gaining a high level of awareness through participation in the program, resulting in greater communication between partners, and a significant change in attitudes characterised by an increased level of support for gender equality. The findings in relation to the workforce capacity building activities similarly demonstrate the benefits of increased knowledge and awareness of gendered roles, norms and expectations during the transition to parenthood, their influence on the relationship between new mums and dads, and the important role that health professionals can play in promoting gender equality.

By successfully promoting gender equality among first time parents the *Baby Makes 3* project has demonstrated a promising example of what primary prevention 'looks like' in practice and in so doing it has provided a number of lessons for workers undertaking primary prevention activities.

The following discussion draws on the project's evaluation findings to explore the concept of gender equality as it relates to first time parents. It reflects on the capacity of the *Baby Makes 3* model to influence people's attitudes and behaviours in relation to the gendered roles, norms and expectations that accompany the transition to parenthood and outlines the benefits of engaging first time parents in a direct participation group work program. It discusses key issues in the field of preventing violence against women including strategies for engaging men and overcoming resistance to messages of gender equality. The discussion also identifies key issues in regard to the future of the *Baby Makes 3* model, namely, strategies for increasing the reach of the program and facilitating its expansion into other local government areas.

Baby Makes 3



6.1 Reflections on the *Baby Makes 3* Program

Gender equality during the transition to parenthood

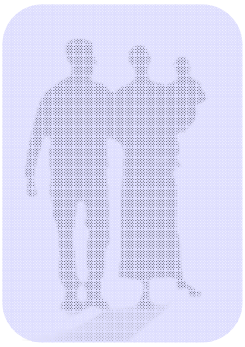
Gender equality is central to a healthy relationship between men and women. As the 'healthy relationships' exercise from the *Baby Makes 3* program demonstrates (see Flynn, 2011, *Baby Makes 3* Facilitators Handbook) gender equality is, in fact, the most fundamental component of a healthy couple relationship. Yet there are different models of equality – different ways of structuring relationships in order to obtain gender equality – and throughout the life course it may be necessary for couples to move between these models so that their relationship remains healthy and respectful. Issues of gender equality are central to the transition to parenthood, primarily because the model of equality between men and women must change, by necessity, following the birth of a baby.

Before the birth of a baby, the model of equality that is most applicable is what we can term the 'fifty-fifty model'. In essence, this is a model of gender equality based on equal contributions to the relationship where, in theory, both partners contribute equally to household and domestic tasks and decision making. So for example, under this model of equality both partners are employed and contributing their income to the relationship, but they also contributing equally to tasks such as shopping, cooking, cleaning, etc… This is a common means of achieving equality within a relationship when couples are co-habiting prior to the arrival of a baby.

However, following the birth of a baby, the fifty-fifty model of equality becomes increasingly unrealistic. This is because during the transition to parenthood men and women begin doing things differently, and often, by default, adopt more traditional roles. The reality for most new parents is that mum is at home caring for the baby while dad is at work. This can be clearly seen in the *Baby Makes 3* 'who does what?' evaluation findings where both men and women agreed that household and baby care tasks were performed mostly by mums, whereas dads were the predominant income providers. It is, more often than not, a rather traditional arrangement that follows the birth of a baby and one that the fifty-fifty model of equality is fundamentally at odds with. A key question, then, is how can new parents maintain an 'equal' relationship when each partner is doing 'different' things?

The transition to parenthood and the differentiation of roles that accompanies it requires a different model of equality in order for new parents to maintain a healthy relationship. The model of equality that is most relevant here is one based, not on equal contributions, but on contributions of equal value. Let's call it the 'equal-value model' of equality. This model allows for new parents to be occupying different roles and performing different tasks, provided the sum total of these tasks are of equal value. So for example, it is possible to have an equal relationship that is also a very traditional relationship (i.e. mum at home, dad at work) provided the different contributions of each partner are of equal value. That is to say, the relationship is equal when mum's contribution, the unpaid domestic labour and baby care activities, is perceived as being of equal value to dad's paid employment. This, in theory, is the equal-value model of equality and it differs from the fifty-fifty model because it doesn't rely on partners contributing to the relationship in the exact same way. However, there is a fundamental problem with this model of equality and it concerns the 'undervaluing' of domestic work.

'Difference' and 'equality' are not mutually exclusive. It is possible to have an equal relationship in the presence of different contributions to the relationship, but it is fraught with difficulty. This is because of the disadvantages that can flow from the differences. As Doucet (2004) points out, the important issue is not difference, but the difference difference makes. The reason why the traditional model of family is likely to produce gender inequality is not because men and women are performing



different roles; it is because traditionally, women's work (the nurturing, caring and domestic work) has been undervalued, and it is this undervaluing of women's contribution to the family that results in disadvantages and inequality.

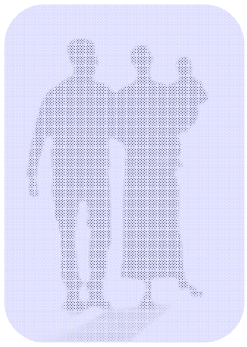
A key objective of the *Baby Makes 3* group program, then, is to ensure that the contributions of the stay-at-home parent (most often the mum) are not undervalued, and there are clear indications that the program was successful in achieving this. The evidence, in fact, can be found in the apparent anomaly within the 'who does what?' questionnaire data, where two months after participation in the *Baby Makes 3* program there is a clear shift away from the 'shared equally' position towards greater acknowledgement that women are performing most of the cleaning, cooking, shopping and baby care tasks.

The shift away from the 'shared equally' position seems counter intuitive given the strong focus on gender equality throughout the group program. One might expect couples to report a greater sharing of domestic tasks as a result of their participation in the program. However we must remember that the fifty-fifty model of equality is not the chosen model for most couples. The chosen model, instead, is the equal-value model of equality. What the evaluation data clearly indicate is that following the program, couples are acknowledging mum's contributions to a far greater extent. In other words, couples are attaching far greater value to previously undervalued domestic tasks. It is not the case that, after participating in the program, women's contributions to household and family tasks increases, rather it is that, as a result of *Baby Makes 3*, there is greater acknowledgement – both from women and men – that mum's contribution is more significant and more valued than originally perceived.

The *Baby Makes 3* program achieves this shift in attitudes by harnessing the power of group discussions. There is open discussion within the program (and hence more recognition) of the 'hidden' aspects of domestic work, such as the responsibility for the planning and organisation of tasks, rather than the mere 'doing' of tasks. In addition, through the group discussions and hearing the experiences of a range of couples, it becomes clear that the burden of domestic tasks and baby care falls most heavily on the mums, that it is not a case of one individual mum experiencing this, but it is a phenomenon that is shared between the group of mums. As a result of this group process, dads come to the realisation that their own contribution was not perhaps as great as initially thought – it is widely evidenced that in the absence of education about these issues, men are more likely to overestimate their household contributions (Milkie, *et.al.,* 2002; Baxter & Smart, 2010). So, one of the products of these discussions, for men especially, is a realisation of the full extent of domestic tasks, and greater acknowledgement of their partner's role in completing these tasks.

Many of the group activities involve small group discussions that are undertaken in single sex groups of mums and dads, with each group reporting back to the other group at the end of the discussion. This process allows the dads in the group to hear the mums' perspective, and vice versa, in a way that emphasises the similarities between couples rather than the individual differences. In other words, it presents a social perspective, rather than an individual perspective, pointing out that issues related to gender roles and expectations are common concerns for all couples and as such, deserve a considered response.

The small group work allows the mums to identify and discuss how traditional gender roles and expectations can impact negatively on women. The process of reporting back serves to emphasise to the dads that this is a shared experience for all new mums, not just an individual 'complaint' by their own partner, and as such, it must be taken seriously, rather than dismissed. In this way, the group process serves to validate the experience of new mum's while placing gender equality firmly on the agenda for first time parents.



As a result of their participation in the group, couples come to a greater acknowledgement of the value of domestic work and it's equivalence to paid work, and women are more likely to claim ownership of their unpaid work and feel more entitled to fully acknowledge their own contributions. The difference between the pre and post-group questionnaires – the shift away from the shared equally position – should not be interpreted as evidence of negative behaviour change, but as evidence of changed attitudes to gendered contributions to home and family. This interpretation of the data is further supported by evidence from the qualitative interviews of attitudinal change towards affirming and validating the experience of new mums by acknowledging the value of their unpaid domestic contributions.

There is strong evidence, then, that the *Baby Makes 3* program has successfully achieved its aim of fostering a deeper understanding of the nature of gender equality, particularly as it relates to first time parents. This is despite the fact that traditional gender roles are deeply entrenched in contemporary Australian culture.

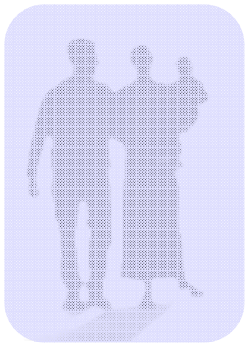
Entrenched gender roles

The equal-value model of equality resonates with first time parents because it provides a means for couples to respond in a positive way to the gendered norms and expectations that influence their parenting roles. But it is one thing for individuals to give more value to mums contribution, when what is really needed in order to create gender equality is for society as a whole to value these contributions. Gender inequalities will continue to exist whilst these social norms and expectations continue to differentiate between mothers and fathers and to value the traditional male role more highly. Obtaining gender equality requires a shift not just in a couple's response to norms and expectations, but in the norms and expectations themselves. Authentic gender equality will only occur when men and women are able to make changes, not just in their attitudes to gender equality, but in the gendered behaviours that create the norms and expectations in the first place.

There are, however, a number of barriers to changing gendered behaviours during the transition to parenthood. These include structural barriers that lie outside the control of couples. For example, if a new father has to be at work for 8 hours a day, there is a limit to how involved he can be as a parent and how much he can contribute to housework. But the main barrier to changing gendered patterns of behaviour during the transition to parenthood is the fact that traditional gender roles and expectations are solidly entrenched in contemporary culture. This barrier, certainly, emerged as a theme in the *Baby Makes 3* evaluation findings. Despite couples being keenly aware of the pitfalls of traditional gender roles, their day-to-day behaviours and actions were ultimately determined by deeply held beliefs about the roles of mothers and fathers.

There are many traditional rewards that flow to both men and women as a result of maintaining traditional roles. Men are the recipients of many formal and informal benefits because traditional gender norms excuse them from much of the difficult 'baby' work (settling crying babies, waking in the middle of the night, balancing caring with a part-time job, *etc…*) and much of the mundane housework (cleaning, cooking, washing, *etc*…). In contrast, many women receive the rewards associated with fulfilling their profoundly felt obligation to care for children. The role of 'home-maker' is still something that provides women with a sense of worth especially during the transition to parenthood.

Deeply entrenched traditional gender roles continue to exert a large influence on the behaviours of new mothers and fathers, and for these to be altered to any significant amount, it will require more than the raised awareness that comes from participation in the *Baby Makes 3* program. It will require a change in parenting behaviours. It will require men, in particular, as the recipients of many of the benefits that flow from traditional gender roles, to give up these benefits and take on more of the (undervalued)



tasks of domestic labour and baby care. The fifty-fifty model of equality might, for many couples, be unobtainable in the months following the birth of a child but it remains a worthy goal for which to aim. Authentic gender equality will only come when all parenting and household tasks are valued equally *and* shared equally.

It is encouraging that the evaluation findings suggest that some couples, at least, are beginning this process.

Overcoming men's resistance

A key achievement of the *Baby Makes 3* program has been its successful engagement of men in primary prevention, gaining their support for gender equality and overcoming resistance.

There were two key strategies used to engage men. The first was the facilitation of the fathers nights and the linking of these evenings to the *Baby Makes 3* group program. The fathers nights engaged men by centring discussion on the positive contribution that new fathers can make to their children's development, and by emphasising the similarities and shared experiences of first time fathers. This approach ensured that the men's (often) first experience of participating in a facilitated group discussion was a positive and non-threatening one, and contributed to the likelihood of them going on to enrol in the *Baby Makes 3* program.

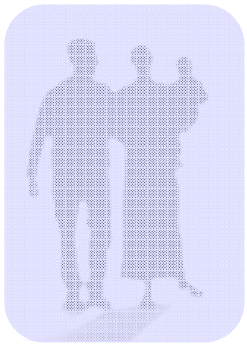
The second strategy utilised was to engage men as members of a couple. It is highly unlikely that the men would have willingly participated in the program if it was a group solely for dads, but accompanied by their partners (and sometimes 'dragged along' by their partners) the men were more likely to engage with the program.

Furthermore, it is worth highlighting that the strategy was to consciously engage men and women as equal partners. This is different from the popular approach to working with first time parents, where men are often enlisted as 'helpers' or as a 'support' for new mums. In the *Baby Makes 3* program, men are engaged as partners, as parents and as caregivers in their own right, and the emphasis is on assuming equal responsibility for (if not equal contributions to) household and family tasks. This method of engagement challenges traditional gender norms and expectations and serves to foster attitudes that prioritise a shared response to the changes that accompany the transition to parenthood and which support greater equality as a fundamental aspect of parenthood. It was also a strategy for overcoming levels of resistance that some men displayed, at times, throughout the program.

It can generally be expected that many men will demonstrate some degree of resistance to the concept of gender equality (Connell, 2003; Pease, 2006) and this is commonly understood as a significant barrier to men's engagement in any primary prevention program (Flood, 2005). The source of this resistance is generally that the men feel targeted, or threatened, or even reluctant to give up some of the privileges that come their way via the norms and expectations associated with traditional gender roles.

However, one of the key learning's from *Baby Makes 3* is that this resistance is to be expected, and that, rather than seeing it as a barrier, it can be understood as a part of the engagement process – after all, at the very least, it shows that the men are sufficiently engaged with the concept to generate a response, even if it is a resistant one. For some men, even, resistance can be a necessary part of the process of change that demonstrates they are being challenged by the ideas that are being presented. The key issue is how to work with it.

When men's resistance is encountered, the program facilitator's response is critical. Often, the temptation is to wind back the discussion, so that the resistance dissipates, but this can be counter-productive to the change process. A better way is to work *with* the resistance. This often involves striking a balance – maintaining the discussion at a level that is sufficient to stimulate interest and engagement with the topic, but preventing it from reaching a level where the

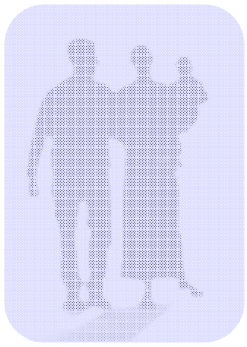


man feels that he, personally, is under attack. If this happens, the man is likely to become defensive and disengage from the discussion altogether. In addition, his partner may even come to his defence and the facilitators can find that both members of a couple have become resistant to the equality message. Program facilitators are required to make judgements about how far they can 'push' a discussion and consequently, it is highly desirable that facilitators have sufficient training in how to work with men who are resistant to messages of gender equality.

There are a number of strategies that facilitators can use to overcome men's resistance. One of the most basic strategies that were employed in the *Baby Makes 3* group was to refer to 'equality' between mums and dads, rather than referring to 'gender equality'. It was apparent that simply leaving out the word 'gender' produced significantly less resistance (for some reason the very words 'gender equality' are perceived as being anti-men), even though the content of the discussion remained exactly the same.

Another strategy is to harness the power of the group and invite other group members into the conversation, rather than engaging in a long discussion with any one man. Indeed, the *Baby Makes 3* program is designed in such a way that it is the group themselves who produce the content of the discussion, rather than the facilitators, whose key role is to guide the process and assist in interpreting the group's contributions. Simply pointing out that it is the group themselves who came up with the content of the discussion is often enough to reduce resistance among the male participants. The key, however, is not to impose a particular viewpoint on the group, but rather have respect for the participants and allow them to come to their own conclusions in their own time.

The overwhelming positive feedback from both men and women who participated in *Baby Makes 3* is evidence that the program was highly successful in gaining men's support for more equal relationships between men and women during the transition to parenthood.



6.2 Future directions

Improving the reach of the program

One issue for consideration in any future *Baby Makes 3* project will be the program's mode of delivery. During the current project, the *Baby Makes 3* program operated as an 'opt-in' program. It was offered to all new parents in the City of Whitehorse, yet it was only attended by those who took the time to actively enrol in the program.

The disadvantage of this mode of delivery is that the program will only ever be attended by those couples who are suitably motivated to take the time to enquire about, and enrol in, an upcoming group, and as a consequence, the program is likely to reach only a small proportion of the intended target group.

In addition, as an opt-in group the *Baby Makes 3* program is competing with a large number of other groups that are aimed at first time parents, in particular, the vast array of early intervention programs targeting families with infants and young children. It is perhaps not surprising that, given a choice, parents are more motivated to enrol in an early intervention program that focuses on their child's development rather than a primary prevention program that focuses their relationship.

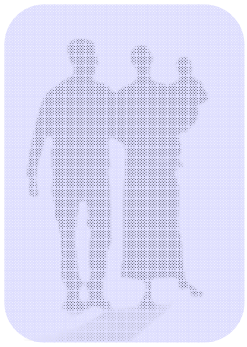
One of the challenges for any prevention program that seeks to attract individual participants is the task of making the program appealing enough so that people are compelled to attend. But this is a difficult task for prevention programs as they require participants to consider potential problems that have not yet occurred and early intervention programs will always have an advantage when it comes to attracting participants, as it is human nature to seek help for problems after they have arisen rather than seek assistance before the problem has appeared.

An alternative model of delivery for the *Baby Makes 3* program, which goes some way to overcoming this barrier would be to offer the program as an 'opt-out' group. This could be achieved by integrating *Baby Makes 3* into the existing new parents groups. So, for example, a standard six week new parents group would become a standard nine week new parents group (including the three *Baby Makes* 3 sessions). In this way, the group would not be compulsory – couples could 'opt-out' of it – but couples would be more likely to attend because they would see the *Baby Makes 3* program as simply a normal part of the new parents group. Building the program into the existing service assists in recruiting participants because when couples take up their invitation to join the new parents group they are also agreeing to attend *Baby Makes 3.* It is a method that creates an expectation that all couples will attend.

At the time of writing, the opt-out group is being trialled at one Maternal Child Health centre in the City of Whitehorse. Early results are positive and demonstrate that couples are far more likely to attend an opt-out group, rather than an opt-in group, where the extra step of having to actively enrol in the program serves as a barrier to participation. So any future *Baby Makes 3* programs should seriously consider integrating the program into existing new parent groups.

There are also other arguments for offering the *Baby Makes 3* program as an additional component of new parents groups. Foremost among these is that the issues involved in the transition to parenthood are experienced universally by all couples and so it is fitting that the program be offered universally. Furthermore, as a primary prevention program, the goal of the program is completely compatible with the aims of new parents groups, which themselves are a preventative intervention. The *Baby Makes 3* program complements the existing new parents groups by filling a gap in the current service, extending the primary prevention approach from the child to the parents (including fathers), and to the family as a whole.

Another reason for integrating *Baby Makes 3* into existing new parents groups is that it is aimed at preventing a problem – violence against women –



that is so prevalent and so serious, that it demands a universal response. Adding *Baby Makes 3* to the existing service will, of course, require more resources to be invested in Maternal Child Health services, but the positive results reported in the program's evaluation suggest that this would be a sensible investment. If local governments are serious about preventing violence then they should consider offering the *Baby Makes 3* program as an 'opt-out' group to all local residents undergoing the transition parenthood. This will, however, require support at an organisational level.

A key factor in the success of *Baby Makes 3* was Maternal Child Health's readiness to embrace the project. Their was widespread acknowledgement that the relationship between women and men was an aspect of the transition to parenthood that is often neglected by the current service system, but is becoming increasingly relevant and important to the wellbeing of families, particularly given the changing nature and structure of contemporary families. There were, of course, some barriers to the project's implementation at the organisational level, including the competing priorities for the Maternal Child Health Service and the nurses own, often unconscious, acceptance of traditional gendered norms and expectations, yet these were not major barriers. On the whole, the willingness of Maternal Child Health nurses to accept the *Baby Makes 3* project as an important component of their service was a fundamental component of its success and central to achieving the project's expected impacts.

Maternal Child Health nurses as program facilitators

Another suggestion for any future *Baby Makes 3* programs would be to consider having the Maternal Child Health nurses, themselves, fulfilling the role of the program's female co-facilitator. This model of delivery would have significant advantages, primarily because the nurses would have a pre-existing connection to the group, having previously met the couples during home visits and centre-based appointments. The nurses would also, most likely, have played a role in convening and facilitating the initial sessions of the new parents group. Having the nurses go on to facilitate the *Baby Makes 3* sessions would provide greater continuity for the group and ideally, foster greater participation. In addition, this model would require less resources as local governments would hot have to employ a specialist female co-facilitator, although this could remain an option (a male co-facilitator would still be required).

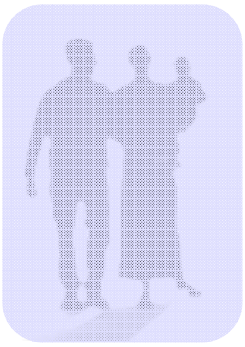
The major advantage of utilising the Maternal Child Health nurses as program co-facilitators, however, is in connection to the ecological model. The training undertaken by the nurses to assist them to facilitate the group program would have benefits for the organisation as a whole and this, in turn, would influence the nurse's practice when working with individuals. This strategy epitomises the ecological model: greater integration between the individual and organisational levels where multi-level activities serve to mutually reinforce key messages.

Resources

One of the key outcomes from the project was the production of the *Baby Makes 3* group work manual. The 'Facilitators Handbook' is designed to guide program facilitators through the delivery of each step of the three week *Baby Makes 3* program. It details the objectives and strategies for each session and provides all the materials and script required to deliver the course. The publication of this handbook will allow the *Baby Makes 3* program to be implemented by Maternal Child Health Services in other local government areas.

To enable any future expansion of the *Baby Makes 3* program of this kind a facilitator training program is required. The '*Baby Makes 3* Facilitator Training' program is currently under development and will provide future facilitators with the necessary training to deliver the program. It will include an orientation to the program and the theory underlying it, and will focus on the knowledge and skills required to deliver the program to a group of first time parents.

Baby Makes 3

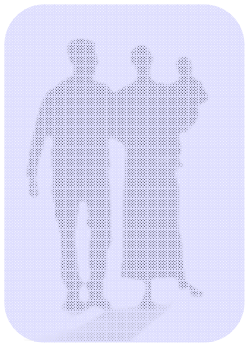


In addition, a step-by-step guide to implementing *Baby Makes 3* is being produced for local government. This publication will contain all the necessary information required to begin implementing the *Baby Makes 3* program under the auspices of local Maternal Child Health Services. It will detail information including the background to the project, evaluation findings, required organisational resources, the costs of implementing the program and a guide to the recruitment and training of staff.

Implementing the *Baby Makes 3* program on a larger scale will require an on-going organisational commitment to developing the structures necessary to support the program. These may include the sustained professional development of Maternal Child Health nurses, and education seminars for local government managers and councillors about the *Baby Makes 3* approach and how it relates to the goal of preventing violence against women. These supports are also, currently being developed.

Other future directions for the project will include the continued refinement and adaptation of the content of the program for specific target groups and the development of further supports for program facilitators. During future stages of *Baby Makes 3* additional optional exercises and discussions will be introduced and made available for special groups such as young parents, culturally and linguistically diverse groups, same-sex families *etc*… On-going refresher training and opportunities for skill development will be made available to program facilitators.

It is hoped that by developing a suite of individual and organisational supports such as those listed above, the *Baby Makes 3* program will easily be able to be implemented throughout Victoria and further afield.



7. Conclusion

The transition to parenthood is a time of significant lifestyle and relationship changes, when traditional gender norms and expectations exert a large influence over how women and men enact their new roles of mothers and fathers. For most new parents, the traditional arrangement of the 'stay-at-home' mother and the 'breadwinner' father is the most practical, but traditional gender roles bring with them the baggage of gender inequality. Men's lives are certainly altered by the arrival of a baby, but the changes experienced by women are more profound. They can include limited personal freedoms, a loss of financial independence and greater social expectations. Under the influence of these gendered expectations, stay-at-home mums tend to take on the bulk of the additional (and undervalued) housework and baby care tasks as well as the burden of responsibility for these tasks.

The transition to parenthood, therefore, is a time when gender inequalities can appear in relationships or when pre-existing inequalities can be exacerbated. What's more, couples who are focussed on the care and wellbeing of a new baby are generally unaware of these relationship changes and the impact they may have on their new family. They may lack the awareness to identify the changes, the language to talk about them, or the strategies to respond to them in ways that help maintain equal and respectful relationships. A potential issue for first time parents is that, if not recognised and attended to, these relationship changes may develop into 'problems', not the least of which is family violence.

The *Baby Makes 3* approach is to intervene *before* these problems occur. As a primary prevention project its goal is to promote equal and respectful relationships between men and women during the transition to parenthood.

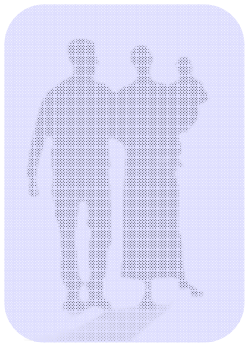
The main activity of the project was the development of a group program for first time parents which has proved successful in engaging both women and men in discussions about recognising and responding to gender inequalities during the transition to parenthood. This strategy was complemented by working with the local Maternal Child Health Service to delivery one-off fathers nights and to build capacity within the workforce to promote equal and respectful relationships.

The *Baby Makes 3* group program provides a forum for first time parents to critically reflect on cultural norms and expectations and how these influence the relationships between men and women during the transition to parenthood. It has proved successful in engaging men and women in discussions about gender roles and gender equality in a way that is challenging but enjoyable.

Participation in *Baby Makes 3* allows first time parents to develop a shared understanding of the changes they are experiencing and a shared language for describing them. The program impels couples to openly discuss issues that are too often unacknowledged and neglected, and leads to attitudinal change characterised by greater understanding of, and support for, gender equality.

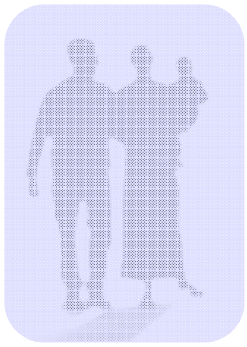
The *Baby Makes 3* program is readily transferable and, given the necessary resources and organisational support, could easily be integrated into existing Maternal Child Health Services and implemented in all local governments. Work is already underway to enable and facilitate this process.

Baby Makes 3 makes a valuable contribution to the primary prevention of violence against women. It represents an innovative example of applying theory to practice and demonstrates to the sector and to the community more widely what primary prevention looks like, how it operates, and the significant change it can create. Importantly, the project has provided the evidence that primary prevention programs of this kind can have a real and positive impact on the social determinants of violence against women, and



by inference, can contribute to the reduction in the prevalence of violence over the long term.

Creating equal and respectful relationships between women and men requires raising awareness, changing attitudes and ultimately, changing behaviours. *Baby Makes 3* is not a panacea that will, by itself, lead to significant changes in gender equality, but given it's potential to constructively engage large numbers of first time parents, particularly men, it can certainly form an integral part of a population wide approach to the primary prevention of violence against women.



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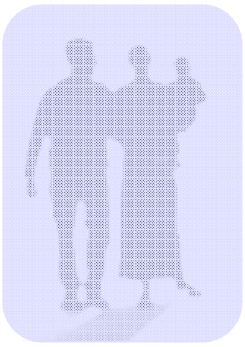

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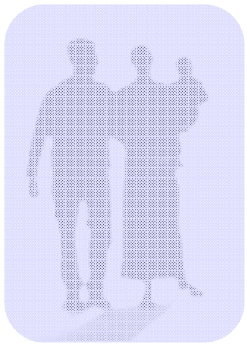
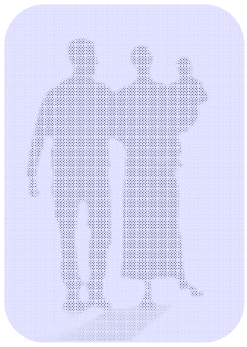


Appendices

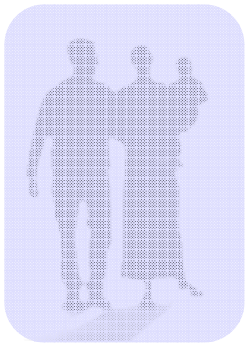


APPENDIX A

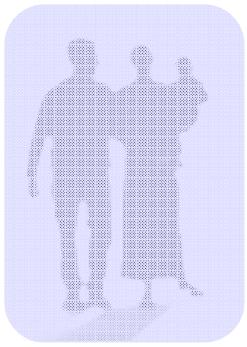
Running an Effective Fathers Evening

1. Basic Considerations	
Scheduling	Ideally week 5 or week 6 of the New Parents Group
Timing	6:30 to 8:30pm
Group size	Minimum numbers • At least 4 new fathers • If less than 4, consider merging with another group Maximum numbers • 12 to 14 fathers
Room set-up	Chairs in a circle Music playing
Name tags	Name tags prepared in advance for mums *and* dads Include baby's name on both name tags
2. Beginning the Group	
Welcome	Begin the group in one room with mums and dads together • Welcome mums and dads to the centre • Introduce yourself to the group
Housekeeping	Tell the group where the toilets and baby change facilities are located
Introductory Comments	Explain the *purpose* of the evening 1. For the dads to meet the other dads and mums in the new parents group 2. For the dads to talk about their experiences of becoming a father Explain how the night will operate • that soon we will split up into two groups, with the mums moving into another room and dads remaining with babies • that mums will order the pizza • when the pizza arrives we will come back together and have social chat until home time
Divide the group	Divide the group into mums and dads (and babies) • Explain that we are now going divide into two groups and that mums will leave the room • Explain that if the babies need their mum, dads can bring baby into mum • Invite the mums to leave to the room • (mums may need to take money for pizza)
3. Beginning the Dad's Discussion	
Explain your role	Explain that you are not here to tell the dads how to be fathers and what they should or should not be doing. Explain that even though you may be able to answer some questions the dad's may have, your main role is to facilitate a discussion between the dads themselves.
Normalise baby's crying	Explain that the babies will cry during the discussion. Make sure the dads feel free to stand up and move about the room in order to settle their baby.
Introductions & Icebreaker	Go around the group and invite each dad to introduce themselves and their baby, and to answer an *Icebreaker* question or two. Examples of good icebreaker questions: • How did your baby get their name? • How long have you lived in the local area? • What was your first car?

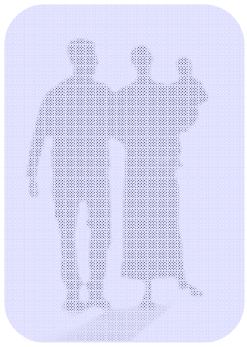
Baby Makes 3



4. Topics for Discussion	
Changes	This is a good topic for getting the ball rolling… Explain that becoming a father's a very significant time in your life but also a time of great change. • What's changed for you since the birth of the baby? • How is your life different since you became a dad? Use further questions to invite others into the conversation • Have other men experienced that change? • Is that a similar experience for you…?
Looking after the baby by yourself	Explain… now that your baby is a couple of months old, we would expect that you would have looked after the baby by yourself for a length of time while your partner has gone out. • Have you had the opportunity to look after the baby by yourself yet? • How long for? • How did it go? • Is there anyone in the group who hasn't done that yet? • What's been stopping you? • Why do you think we recommend that dads have one-on-one time with their baby?
Settling techniques	Explore the different techniques that dads can use to settle babies when mum is not around. • What are some good techniques for settling a baby when mum is not around? • What settling techniques would you recommend to others?
Maintaining a social life	Ask questions to explore whether couples have been able to get out of the house regularly with the baby. • How has having a baby affected your social life? • Has anyone managed to get out of the house and visit coffee shops? …Restaurants? • How did it go?
Work / family balance	Explore how dads are managing the dual role of being a provider and being an involved father. • How has having a baby affected your work life? • How long did you have off work after the birth? • How was it to go back to work? • Do you feel that there are more pressures on you now? • What is it like to return home to your (sometimes screaming) baby after a long day at work?
Managing stress	Try to normalise the fact that having a new baby can at times be very stressful. • How are you managing to look after yourself during this period? • In between work and looking after your baby, when do you get time to relax? • How do you negotiate this with your partner?
Supporting your partner	Explain that even though becoming a father is a time of major change for men, for women, the degree of change is often greater. For men, their life usually retains some normality because of their connection to work, whereas new mums are faced with the responsibilities of motherhood 7 days a week, 24 hours a day. • What are some of the ways that dads can support their partner during this time? Try to draw out examples that suggest men take greater responsibility for day to day tasks including housework, caring for baby, bath time etc… Mention that looking after the baby by themselves while their partner has some time out is important for mum's wellbeing.



Relationship issues	Explain that having a baby also changes the relationship dynamics between mum and dad. • Has anyone had time to think how having a baby may have changed your relationship with your partner? • Have you talked about these changes with your partner? Explain that 'resuming your sex life' is often an important issues for couples after the birth. It is not uncommon for couples to go many months without having sex after the birth of a baby. Suggest to the dads that the first step is to invest energy into rebuilding intimacy levels in their relationship
Extended family	Ask questions to establish how couples are being supported by their extended family. • How has having a baby changed your relationship with your own parents? • How are the dads coping with the increased contact with extended family members? • Is there anyone who doesn't have family support nearby?
Changing nature of Fatherhood	Explain that, a generation ago, your own fathers would not have sat in a circle at a Maternal Child Health Centre, talking about their babies! • Do you sense a greater expectation that fathers will be more involved with there babies? • How fair is this, given that fathers still have to be the main provider? • What benefits are there to being highly involved with your baby? For you… for your baby… and for your family?
The difficult stuff…	New fathers may be reluctant to talk about the difficulties and challenges they have experienced, however, it is valuable topic to discuss, if possible. Useful questions include… • What's been the worst bit so far? • What's the thing you've found most difficult to cope with?
5. Closing the Group	
No secret men's business	Thank the dads for their participation. Explain that you are now going to wrap-up the discussion Mention that the topics we have discussed are *not* 'secret men's business' and encourage the dads to discuss these topics with their partner.
Closing question	Close the discussion by going around the group and asking each man one final question. Thinking about our discussion tonight… • What's one thing you found helpful? • What's one thing you might share with your partner?



APPENDIX B

Approach to evaluation

The approach to evaluation used by the five VicHealth scale-up projects has been informed by participatory and empowerment models of evaluation. Where traditional modes of program evaluation utilise external experts to conduct evaluation activities, participatory and empowerment models strengthen the evaluation capacity of individuals, groups and organisations involved in programs so that evaluation expertise is integrated into core program aspects. 'Evaluation capacity building' (ECB) is therefore a key concept and strategy of participatory and empowerment models.

ECB is defined as the design and implementation of learning activities to support program stakeholders in learning about and undertaking effective evaluation practice (Preskill and Boyle 2008). In the context of public health and health promotion, ECB:

- prioritises the participation of those involved in program implementation in the conduct of their own evaluation activities;
- operates within a learning environment where stakeholders learn about evaluation by doing it (a 'learn-by-doing method);
- enables stakeholders to draw upon evaluation findings 'in real time' for program improvement (as part of an action research cycle); and
- focuses on empowering stakeholders with the view to sustaining evaluation practice well beyond the program for which ECB activities were initially devised.

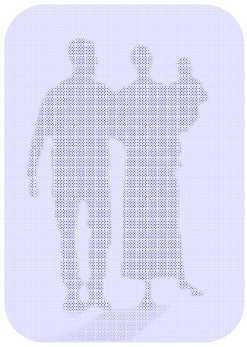
In practice, ECB engages the evaluator in a coaching and/or structured guidance role. They act as a sounding-board to support stakeholders in solving evaluation problems, such as establishing indicators of effectiveness or developing methods of data collection. But the evaluator's involvement stops short of actually conducting the evaluation, since the point of ECB is to encourage stakeholders to 'learn-by-doing'.

In certain situations, the evaluator can be involved in undertaking discrete evaluation activities that have been identified and developed as part of ECB practice (e.g. facilitating focus groups). In these cases, the evaluator is seen as part of the program rather than as an external investigator conducting an independent evaluation.

ECB is not commonplace in preventing violence against women practice; however, VicHealth's Preventing Violence against Women program has recognised the importance of such an approach to the evidence base for primary prevention in Victoria – and beyond. Strengthening the capacity of programs to conduct evaluation helps to ensure evaluation practice is 'mainstreamed' into core program activities. A workforce strengthened in evaluation know-how increases the chances of program evaluation. And the more programs are evaluated, the greater the contribution of findings and learnings to the emerging field of primary prevention.

For these reasons, VicHealth has adapted overseas examples of ECB in primary prevention – such as those documented by the Centres for Disease Control and Prevention (CDC) in the USA (Cox et al 2009) – to conceptualise an ECB model for the five scale-up projects. VicHealth's ECB model is a partnership model where:

- Project Coordinators are positioned as the main researchers for their project evaluation activities;



- a considerable level of evaluation support is provided to Project Coordinators by the funding body through a Research Practice Leader (RPL), a core staff member of the Preventing Violence against Women program at VicHealth;
- Project Coordinators are expected to work closely with the RPL for the duration of their projects to develop all aspects of their evaluation design/research and for technical assistance in implementing various evaluation strategies; and
- specific processes are put in place and continuously refined throughout the funding period to foster a 'learn-by-doing' environment for Project Coordinators so that the RPL's evaluation support is both meaningful and effective (processes include a combination of group instruction and individual assistance).

This ECB model was highly successful and has been documented in detail by VicHealth. More information can be found at www.vichealth.vic.gov.au.

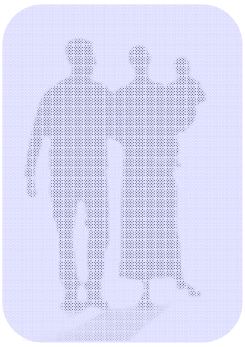
Written by: Wei Leng Kwok
Research Leader
Preventing Violence Against Women Program
VicHealth

References

Preskill and Boyle (2008) 'A Multidisciplinary Model of Evaluation Capacity Building' in *American Journal of Evaluation*, vol. 29 no. 4 pp. 443–59

Cox, P. J., Keener D, Woodard T, Wandersman A (2009) *Evaluation for Improvement: A Seven-step Empowerment Evaluation Approach for Violence Prevention Organisations*, Centres for Disease Control and Prevention, Atlanta GA

Baby Makes 3

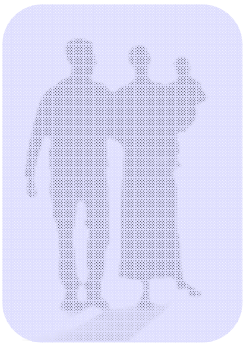


Baby Makes 3 Pre and Post-group Questionnaire

Attitudes towards parenting - please indicate (✓) whether you agree or disagree with the following statements…						
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	With the exception of birthing and breastfeeding, a father can do everything that a mother can do	○	○	○	○	○
2	The parent who stays home to care for the children should also be responsible for the housework	○	○	○	○	○
3	Mothers are more nurturing than fathers	○	○	○	○	○
4	Gender equality is an important part of a healthy relationship	○	○	○	○	○
5	It is more important for a mother than a father to stay at home and care for an infant	○	○	○	○	○
6	The most important role a father can play is to be a 'breadwinner'	○	○	○	○	○

Who does what at home? - Please indicate (✓) who does the following activities…								
		Always Mum	Mostly Mum	More Mum than Dad	Shared equally	More Dad than Mum	Mostly Dad	Always Dad
Caring for infants								
1	Childcare activities such as changing nappies, dressing, bathing, feeding etc…	○	○	○	○	○	○	○
Nurturing infants								
2	Nurturing activities such as soothing, comforting, responding to crying, etc…	○	○	○	○	○	○	○
Physical activities								
3	Activities such as playing with child, taking for a walk in the pram, creative interaction, etc…	○	○	○	○	○	○	○
Breadwinner								
4	Providing an income etc…	○	○	○	○	○	○	○
Provider								
5	Activities such as grocery shopping, clothes shopping etc…	○	○	○	○	○	○	○
Housework								
6a	Housework activities such as cleaning, tidying, washing up, washing, etc …	○	○	○	○	○	○	○
6b	Kitchen duties such as planning and cooking meals etc…	○	○	○	○	○	○	○
Managing the household								
7a	Activities such as paying bills, organising family/social activities, appointments, decision making, etc…	○	○	○	○	○	○	○

Baby Makes 3



Baby Makes 3 Post-group Feedback Form

Please indicate (✓) whether you agree or disagree with the following statements…						
		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	The *Baby Makes 3* group was enjoyable	○	○	○	○	○
2	The *Baby Makes 3* group was relevant to my situation	○	○	○	○	○
3	The *Baby Makes 3* group was helpful	○	○	○	○	○

4. The 3 main things I have learned from this program are:

1) ……

2) ……

3) ……

5. How would you describe this program to another person who was thinking of doing it?

……

……

……

6. Any additional comments?

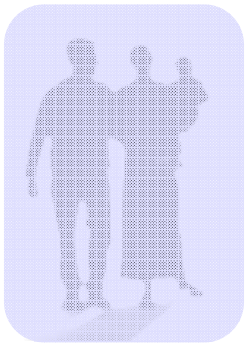
……

……

……

7. How would you rate the program overall?

poor fair good very good excellent



Couples Interview - Plain Language Statement

You are invited to participate in the evaluation of the *Baby Makes 3* project. You have been identified as a participant because you completed the *Baby Makes 3* group program during the past six months.

The *Baby Makes 3* project is a three year project being carried out by Whitehorse Community Health Service, in partnership with the City of Whitehorse, Maternal Child Health Service, and funded by the Victorian Health Promotion Foundation.

The project aims to promote healthy relationships between men and women during the transition to parenthood, and to assist couples to adapt to the relationship and lifestyle changes that occur during family formation.

Should you agree to participate, you will be asked to take part in an interview (approx 30 to 45 minutes), with your partner, which will be conducted by an independent interviewer. The purpose of the interview is to gather information about your experience of participating in the *Baby Makes 3* group, and its impact on your new family. With your permission, the interviews will be audio recorded.

The information collected will contribute to the final report on the *Baby Makes 3* project. This report will help disseminate information about the project to other local governments and interested parties.

We will protect your anonymity and the confidentiality of your responses to the fullest possible extent, in compliance with privacy legislation. Any information used in the final report will be anonymous and non-identifying. Your name and personal details will be kept separate from information collected during the interview. Your personal details and the audio recording of your interview will be destroyed at the completion of the project.

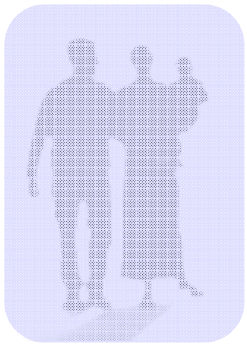
Please be advised that your participation in this study is completely voluntary. Should you wish to withdraw at any stage prior to completion of the final report, you are free to do so without prejudice.

At the completion of the interview, you will be provided with access to support services should you wish it. You will also have the opportunity to contribute additional written comments post-interview should you wish to clarify or add to the comments you make during the interview.

If you wish to participate, please indicate that you have read and understood this information by signing the accompanying consent form at the time of interview.

Should you require any further information, or have any concerns, please do not hesitate to contact the *Baby Makes 3* Project Coordinator, David Flynn, on 8843 2350. Should you have any concerns about the conduct of the interviews, you are welcome to contact the CEO at Whitehorse Community Health Service, Ms Gillian Leach, on 9890 2220.

Baby Makes 3



Couples Interview – Consent Form

Name of Participant: ……

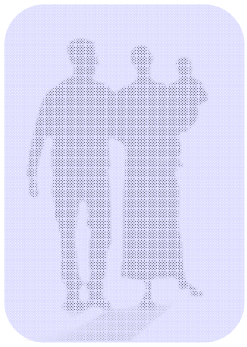
Name of Evaluator: David Flynn, Project Coordinator – *Baby Makes 3*

Name of Interviewer: Jacqueline Hope, Social Work Student, Monash University.

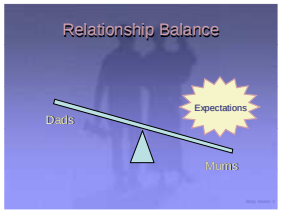
1. I consent to participate in a semi-structured interview about my experience of participating in the *Baby Makes 3* program.
2. The details of the interview have been explained to me and I have been given a written copy of this information to keep.
3. I give my permission for the interview to be audio recorded.
4. I have been informed that I am free to withdraw from the project at any time without explanation or prejudice, and to withdraw any information I have provided.
5. I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements and my name and personal details will be kept confidential.

Signature: ……

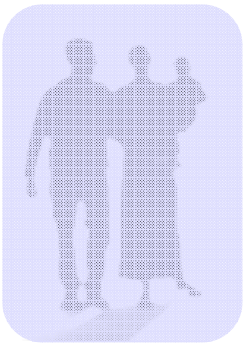
Date: / /

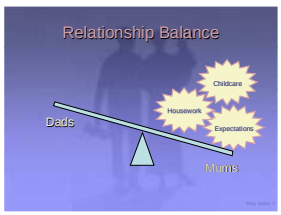
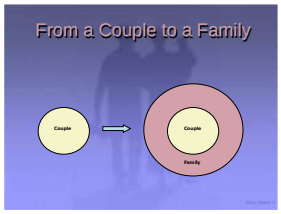


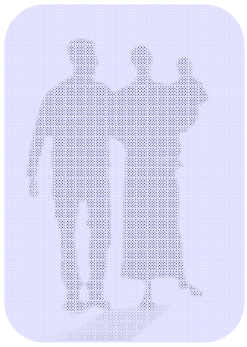
Couples Interview – Schedule of Questions

Introduction	5 minutes
About this interview…	"Thankyou for participating in this interview. As you have been informed, this interview forms part of the evaluation of the *Baby Makes 3* project, and I will be asking you some questions about your participation in the group program, and any impact it has had on your relationship as a couple, and on your new family as a whole."
Consent form	• Show the couple the 'plain language statement' and the consent form. • Would you like few minutes to read or shall I go through it with you? • Ask couples to sign the form
Clarity of Role/Follow up	• Independent evaluator /researcher asking questions. • BM3 want couples to feel supported during this process, sometimes, during an interview such as this issues may arise that may be difficult for couples to process" • Follow up *Baby Makes 3* Relationship Counsellor is available free of charge if you want to utilise this service in order to talk about any issues that have arisen during the interview.
Warm-up Questions	3 minutes
	• How long ago did you do the *Baby Makes 3* program?
	• How did you hear about it?
	• Whose idea was it to participate?
General Questions	7 minutes
Overview questions	• What was your overall impression of the group? • What were you expecting when you began the group? • How was the group different from what you expected?
Specific Questions	15 minutes
	Taking a look at this slide… • Can you explain what this slide was referring to? • In terms of your relationship, has your understanding of this slide changed what you do in any way? (i.e has your understanding of the expectations on new mums resulted in any changes to your day-to-day life?) • Can you give examples of things you may now do differently as a result of thinking about these expectations? • Any other examples…?

Baby Makes 3



	Taking a look at this slide… • Can you explain what this slide was referring to? • In terms of your relationship, has your understanding of this slide changed what you do in any way? (i.e. has your understanding of 'who does what' in terms of housework and childcare, resulted in any changes to your day-to-day life?) • Can you give examples of things you may now do differently as a result of thinking about these issues? • Any other examples…?
Intimacy 	Another of the topics in the group was *Intimacy* or building couple relationship and in particular, the need to re-build intimacy after the birth of your baby… • Have you been able to rebuild or maintain the couple relationship after the birth? • How? • Has this changed awareness in your relationship? • Was the slide relevant to you at the time? In what ways (if any) is it still relevant to you today?
Wrap-up	10 minutes
Describing the overall change	Thinking about your involvement in the group, what you got out of it and how your family life has changed since then… • Is it possible to describe how much of a change the *Baby Makes 3* program has made to your situation?
Value	• What was the value in the program for you as a couple?
Significance	What was the most significant aspect of the program… • For you mum? • For you dad?
Other comments	Are there any other comments you would care to make about the program?
Thankyou	Thank the couple for their participation in the interview
Follow-up (handout)	Relationship Counselling • Explain… "we want couples to feel supported during this process, yet sometimes, during an interview such as this issues can arise that may be difficult for couples to process" • Explain that the *Baby Makes 3* Relationship Counsellor is available free of charge should couples wish to utilise this service in order to talk about any issues that have arisen during the interview. Further comments • Explain that should couples wish to make any further comments about the issues discussed in the interview, or should they wish to amend or clarify anything the have said, they can do so. …contact details on handout.



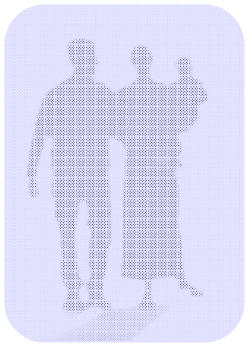
Professional Development Workshop – Feedback Form

'Relationships Under Stress'

What did you like most about the training?	
What did you like least about it?	
What did you find the most useful?	
What's the main thing you learned?	
How could the training be improved?	

How much do you think the workshop helped you with each of the following?

	not much	a little	a fair bit	lots
Understanding the signs of relationships under 'normal' stress	○	○	○	○
Understanding the signs of relationships under 'harmful' stress	○	○	○	○
Understanding the difference between 'normal' and 'harmful' stress	○	○	○	○
Identifying the precursors of family violence	○	○	○	○
Knowing where to refer couples with differing levels of relationship stress	○	○	○	○
Being confident to seek a secondary consult	○	○	○	○



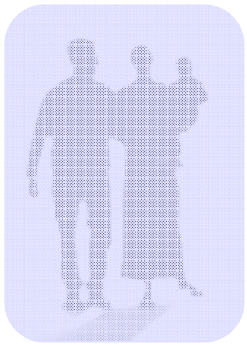
Professional Development Workshop – Feedback Form

'Running an Effective Fathers Evening'

What did you like most about the training?	
What did you like least about it?	
What did you find the most useful?	
What's the main thing you learned?	
How could the training be improved?	

How much do you think the workshop helped you with each of the following?

	not much	a little	a fair bit	lots
Understanding first time fathers	○	○	○	○
Being clear about the objectives of a fathers evening	○	○	○	○
Developing group work skills and techniques	○	○	○	○
Ability to deal with challenging group situations	○	○	○	○
Knowing what topics to talk about on a fathers evening	○	○	○	○
Being confident to facilitate a fathers evening	○	○	○	○



Maternal Child Health – Focus Group: Schedule of Questions

Attendance

Wendy O'Donnell	MCH Nurse	Mitcham Family Centre
Jo Freeman	MCH Nurse	Vermont South Family Centre
Fiona Turland	MCH Nurse	Box Hill South Family Centre
Jenny Poulter	MCH Nurse	Box Hill South Family Centre
Linda Teng	MCH Nurse	Forest Hill Family Centre
Margaret Warner	MCH Nurse	Forest Hill Family Centre
Jenni McGorlick	MCH Nurse	Blackburn North Family Centre

Focus Group Facilitator

David Flynn	Project Coordinator

Questions about the Baby Makes 3 *Project*

1. What has the *Baby Makes 3* project meant for Maternal Child Health in the City of Whitehorse ?
   PROMPT: has it added value?
   which activities in particular?
   PROMPT: how has it contributed to the prevention of family violence?

Questions about Fathers Nights

2. How has the *Baby Makes 3* project contributed to Fathers nights in the City of Whitehorse ?
   PROMPT: have there been any changes to the fathers nights since the *Baby Makes 3* project?
   What are you observations of fathers nights?
   Have you received any feedback from clients?

Questions about the Baby Makes 3 *Group Program*

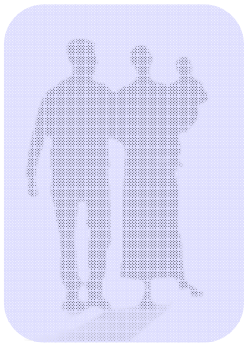
3. What has the introduction of the *Baby Makes 3* Group Program meant for Maternal Child Health?
   PROMPT: Think about the range of services offered by MCH
   Have you received any feedback from clients?

Questions about the workforce capacity building

4. How has the *Baby Makes 3* project impacted on your professional practice?
   PROMPT: How confident do you feel in being able to promote equal and respectful relationships?
   Can you explain why gender roles and expectations can impact on relationships?
   How confident do you feel to promote positive father involvement?
   Has the project changed what you 'do'?

Questions about the Baby Makes 3 *Partnership*

5. Thinking about the partnership between Whitehorse Community Health Service and the Maternal Child Health service, in what ways has the partnership been successful?
   PROMPT: what has enabled this?
   Are there (or have there been) any barriers to the partnership's development?



Baby Makes 3 Project Reference Group – Focus Group: Schedule of Questions

Attendance

Olive Aumann	General Manager, Health Development,	WCHS
Chris Grace	Team Leader, Men's Health,	WCHS
Jan Mattrow	Team Leader, Health Development	WCHS
Pam Heselev	MCH Coordinator	City of Whitehorse
Tricia Kunek	MCH Nurse	City of Whitehorse
	Childbirth Education Coordinator	Birralee Maternity Service
Lea Fitcher	Coordinator, Specialist Women's Clinic	Birralee Maternity Service

Focus Group Facilitator

Wei Leng Kwok	Research Leader	VicHealth

Questions about project implementation

Thinking about the projects objectives…

6. In what ways do you think the project has been successful?
   - PROMPT: ask for specific examples of the difference the project has made on first time parents
     …and/or the workforce
     as observed first hand or heard about
   - PROMPT: explore whether the successes identified were expected or unexpected
     If unexpected, explore why they think they happened
7. What do you think have been the key factors in determining the projects success?
   - PROMPT: get participants to relate the key factors to *specific* successes
8. What, in your view, have been the main challenges or barriers encountered to implementing the project as planned?
   - PROMPT: do you think these were overcome? how?

Questions about the Reference Group

Here is the Reference Group's *Terms of Reference* (hand out to refresh memories)

9. Thinking about your purpose in the 4th paragraph, how do you think you've gone in fulfilling this over the last 2½ years?
   - PROMPT: ask for specific examples of leadership/guidance on critical decisions
     ask for any advice given on planning and implementation
   - PROMPT: explore whether they think the right people have been at the table during Phase 2

As you are aware, there is the likelihood that BM3 will be sustained into the future and 'rolled out' in other local government area

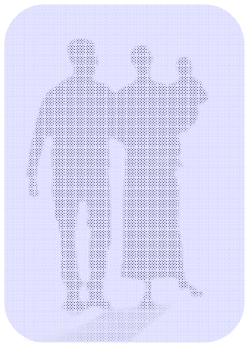
10. Who do you think needs to be around this table for the next phase of BM3
    - PROMPT: ask if this means a different structure, i.e. a Steering Committee
      Can you articulate the difference in function between a Reference Group and a Steering Committee?

Questions about Individual organisations

11. What do you think has been the benefit of your involvement in BM3 to your own organisation?
    And to each other's organisation?

Questions about the Partnership

12. What do you think has been the benefit of having BM3, for local partnerships and ways of working together in Whitehorse?

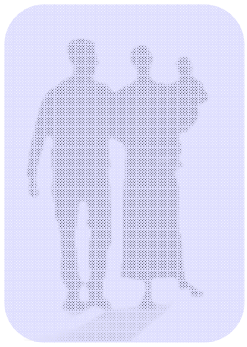


APPENDIX C

Pre and Post-group Questionnaires: Results from Section 1

Table shows the raw data from section 1 of the pre and post group questionnaires for mums and dads. Questionnaire responses were scored on a scale of one to five and averages scores calculated.

SECTION 1 **Attitudes to gender roles and norms**		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Average Score
	SCORE	1	2	3	4	5	
1. With the exception of birthing and breastfeeding, a father can do everything that a mother can do	Pre-mums	3	11	8	31	37	**3.98**
	Post-mums	0	6	10	22	33	**4.15**
	Pre-dads	1	13	5	50	20	**3.84**
	Post-dads	0	6	9	32	17	**3.94**
2. The parent who stays home to care for the children should also be responsible for the housework	Pre-mums	12	43	17	11	7	**2.53**
	Post-mums	12	27	15	15	2	**2.55**
	Pre-dads	12	35	24	17	1	**2.55**
	Post-dads	5	32	18	9	0	**2.48**
3. Mothers are more nurturing than fathers	Pre-mums	12	29	27	18	4	**2.70**
	Post-mums	5	22	20	21	3	**2.93**
	Pre-dads	4	21	29	33	2	**3.09**
	Post-dads	3	22	15	20	4	**3.00**
4. Gender equality is an important part of a healthy relationship	Pre-mums	1	1	10	36	42	**4.30**
	Post-mums	0	1	3	21	46	**4.58**
	Pre-dads	0	3	5	54	27	**4.18**
	Post-dads	0	0	1	29	34	**4.52**
5. It is more important for a mother than a father to stay at home and care for an infant	Pre-mums	15	28	20	21	6	**2.72**
	Post-mums	8	18	20	21	4	**2.93**
	Pre-dads	8	40	22	15	4	**2.63**
	Post-dads	3	29	16	15	1	**2.72**
6. The most important role a father can play is to be a breadwinner	Pre-mums	33	43	9	4	1	**1.86**
	Post-mums	28	27	11	5	0	**1.90**
	Pre-dads	27	41	12	8	1	**2.04**
	Post-dads	14	29	13	8	0	**2.23**



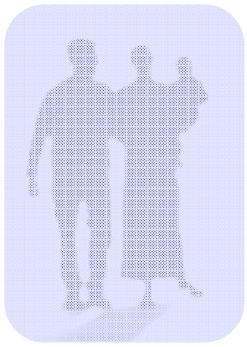
Pre and Post-group Questionnaires: Section 1 – T-tests Results

Table shows the results of 'student t-tests' conducted on the differences in average scores from section 1 of the pre and post-group questionnaires, for mums and dads.

SECTION 1 **Attitudes to gender roles and norms**		Average Score	Ttest: Mums pre-group Vs Mums post-group	Ttest: Mums pre-group Vs Dads pre-group	Ttest: Dads pre-group Vs Dads post-group	Ttest: Mums post-group Vs Dads post-group
1. With the exception of birthing and breastfeeding, a father can do everything that a mother can do	Pre-mums	3.98	0.288	0.396	0.533	0.175
	Post-mums	4.15				
	Pre-dads	3.84				
	Post-dads	3.94				
2. The parent who stays home to care for the children should also be responsible for the housework	Pre-mums	2.53	0.927	0.913	0.655	0.697
	Post-mums	2.55				
	Pre-dads	2.55				
	Post-dads	2.48				
3. Mothers are more nurturing than fathers	Pre-mums	2.70	0.171	0.010*	0.587	0.696
	Post-mums	2.93				
	Pre-dads	3.09				
	Post-dads	3.00				
4. Gender equality is an important part of a healthy relationship	Pre-mums	4.30	0.016**	0.281	0.001**	0.545
	Post-mums	4.58				
	Pre-dads	4.18				
	Post-dads	4.52				
5. It is more important for a mother than a father to stay at home and care for an infant	Pre-mums	2.72	0.257	0.574	0.574	0.234
	Post-mums	2.93				
	Pre-dads	2.63				
	Post-dads	2.72				
6. The most important role a father can play is to be a breadwinner	Pre-mums	1.86	0.745	0.164	0.223	0.039*
	Post-mums	1.90				
	Pre-dads	2.04				
	Post-dads	2.23				

* significant difference in average scores at the 5% level

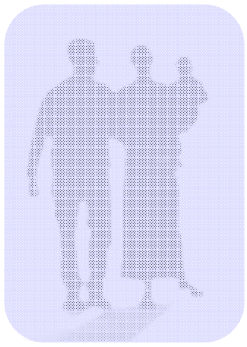
** significant difference in average scores at the 1% level



Pre and Post-group Questionnaires: Results from Section 2

Table shows the raw data from section 2 of the pre and post group questionnaires for mums and dads. Questionnaire responses were scored on a scale of one to five and averages scores calculated.

SECTION 2 **Who does what at home?**		Always mum	Mostly mum	More mum than dad	Shared equally	More dad than mum	Mostly dad	Always dad	Average Score
	SCORE	1	2	3	4	5	6	7	
1. Caring for infants Childcare activities such as changing, nappies, dressing, bathing, feeding, etc…	Pre-mums	3	40	34	11	0	0	0	**2.6**
	Post-mums	4	41	22	4	0	0	0	**2.37**
	Pre-dads	2	14	49	22	1	0	0	**3.07**
	Post-dads	1	25	32	6	0	0	0	**2.67**
2. Nurturing Infants Nurturing activities such as soothing, comforting, responding to crying, etc…	Pre-mums	3	31	41	12	1	0	0	**2.74**
	Post-mums	2	40	20	9	0	0	0	**2.51**
	Pre-dads	3	13	49	22	1	0	0	**3.06**
	Post-dads	0	21	34	9	0	0	0	**2.81**
3. Physical Activities …playing with baby, taking for walk in the pram, creative interaction etc…	Pre-mums	3	22	39	23	1	0	0	**2.97**
	Post-mums	0	29	29	13	0	0	0	**2.77**
	Pre-dads	0	9	41	34	4	0	0	**3.38**
	Post-dads	0	8	36	20	0	0	0	**3.19**
4. Breadwinner Providing an income, etc…	Pre-mums	0	3	3	14	15	23	30	**5.61**
	Post-mums	0	2	0	9	9	30	21	**5.80**
	Pre-dads	0	0	7	12	17	33	19	**5.51**
	Post-dads	0	0	1	5	15	23	20	**5.88**
5. Provider Activities such as grocery shopping, clothes shopping, etc…	Pre-mums	10	22	22	26	3	4	1	**3.07**
	Post-mums	11	25	16	13	5	1	0	**2.70**
	Pre-dads	1	5	20	39	14	5	4	**4.03**
	Post-dads	5	7	23	22	3	4	0	**3.36**
6a. Housework Housework activities such as cleaning, tidying, washing up, washing, etc…	Pre-mums	5	27	30	18	8	0	0	**2.97**
	Post-mums	8	27	20	15	1	0	0	**2.63**
	Pre-dads	0	13	31	28	14	2	0	**3.56**
	Post-dads	3	9	28	20	4	0	0	**3.20**
6b. Housework Kitchen duties such as planning and cooking meals	Pre-mums	14	25	18	20	4	3	4	**3.00**
	Post-mums	15	14	21	15	4	2	0	**2.79**
	Pre-dads	2	13	32	20	15	4	2	**3.60**
	Post-dads	4	11	22	19	5	3	0	**3.30**
7. Household Management Paying bills, appointments, organising family activities, decision making, etc…	Pre-mums	7	28	16	31	4	2	0	**3.03**
	Post-mums	5	25	9	24	3	4	1	**3.15**
	Pre-dads	1	12	23	30	11	8	3	**3.0**
	Post-dads	1	7	17	20	10	9	0	**3.91**



Pre and Post-group Questionnaires: Section 2 – T-tests results

Table shows the results of 'student t-tests' conducted on the differences in average scores from section 2 of the pre and post-group questionnaires, for mums and dads.

SECTION 2 **Who does what at home?**		Average Score	Ttest: Mums pre-group Vs Mums post-group	Ttest: Mums pre-group Vs Dads pre-group	Ttest: Dads pre-group Vs Dads post-group	Ttest: Mums post-group Vs Dads post-group
1. Caring for infants Childcare activities such as changing, nappies, dressing, bathing, feeding, etc…	Pre-mums	2.6	0.040*	0.000**	0.001**	0.010*
	Post-mums	2.37				
	Pre-dads	3.07				
	Post-dads	2.67				
2. Nurturing Infants Nurturing activities such as soothing, comforting, responding to crying, etc…	Pre-mums	2.74	0.060	0.007**	0.037*	0.013*
	Post-mums	2.51				
	Pre-dads	3.06				
	Post-dads	2.81				
3. Physical Activities …playing with baby, taking for walk in the pram, creative interaction etc…	Pre-mums	2.97	0.129	0.001**	0.095	0.001**
	Post-mums	2.77				
	Pre-dads	3.38				
	Post-dads	3.19				
4. Breadwinner Providing an income, etc…	Pre-mums	5.61	0.348	0.599	0.044*	0.699
	Post-mums	5.80				
	Pre-dads	5.51				
	Post-dads	5.88				
5. Provider Activities such as grocery shopping, clothes shopping, etc…	Pre-mums	3.07	0.074	0.000**	0.001**	0.002**
	Post-mums	2.70				
	Pre-dads	4.03				
	Post-dads	3.36				
6a. Housework Housework activities such as cleaning, tidying, washing up, washing, etc…	Pre-mums	2.97	0.043*	0.000**	0.027*	0.001**
	Post-mums	2.63				
	Pre-dads	3.56				
	Post-dads	3.20				
6b. Housework Kitchen duties such as planning and cooking meals	Pre-mums	3.00	0.352	0.005**	0.127	0.019*
	Post-mums	2.79				
	Pre-dads	3.60				
	Post-dads	3.30				
8. Household Management Paying bills, appointments, organising family activities, decision making, etc…	Pre-mums	3.03	0.557	0.000**	0.756	0.001**
	Post-mums	3.15				
	Pre-dads	3.0				
	Post-dads	3.91				

* significant difference in average scores at the 5% level

** significant difference in average scores at the 1% level