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Training of Health Professionals to Promote Active Fatherhood during the Pre and Post-Natal Care to Prevent Violence against Women

Francesca Zambri [1], Andrea Santoro [2], Annina Lubbock [2], Alessandro Volta [3], Giovanna Bestetti [4], Francesca Marchetti [1,5], Paola Pecilli [5], Elisabetta Nassa [5], Jessica Preziosi [1,5,*], Sofia Colaceci [6] and Angela Giusti [1]

1 National Centre for Diseases Prevention and Health Promotion, Italian National Institute of Health, 00161 Rome, Italy; francesca.zambri@guest.iss.it (F.Z.); francesca.marchetti@guest.iss.it (F.M.); angela.giusti@iss.it (A.G.)
2 Cerchio Degli Uomini, 10134 Turin, Italy; andrea.santoro78@gmail.com (A.S.); annina.lubbock@yahoo.it (A.L.)
3 Department of Mother and Child Health, Primary Care—Local Health Authority (AUSL), 42122 Reggio-Emilia, Italy; alessandro.volta@ausl.re.it
4 Research Institute on Health and Pratice (IRIS), 00168 Milan, Italy; bestetti.giovanna@gmail.com
5 Department of Biomedicine and Prevention, University of Rome Tor Vergata, 00133 Rome, Italy; pech8592@yahoo.it (P.P.); elisabetta.nassa@gmail.com (E.N.)
6 Departmental Faculty of Medicine and Surgery, Saint Camillus International University of Health and Medical Sciences (UniCamillus), 00131 Rome, Italy; sofia.colaceci@unicamillus.org
* Correspondence: jessica.preziosi@iss.it

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Abstract: Violence against women is a violation of human rights and a form of discrimination against women. Healthcare services play a key role in the care of women exposed to violence, and father involvement in delivery and childcare can reduce intimate partner violence and has positive effects during pre and post-natal care. Our study aims to assess attitudes, practices, and perceived competencies of social-healthcare professionals on fathers' active engagement in care and on prevention and management of violence against women after specific training. A pre–post study was carried out at two points in time: T0 (pre-training) and T1 within 15 days from the end of the course, using a semi-structured questionnaire. Changes were analyzed using paired *t*-test or *Wilcoxon signed-rank test*. Statistical analysis was carried out using Stata version 16. At T0, there were 129 participants. The most represented professions were midwives (66%). The average score of opinions at T0 and T1 improved, and this difference was significant (T0: 4.44; SD ± 0.6; T1: 4.42 SD ± 0.3; $p = 0.0126$). The same applies to perceived competencies (T0: 2.79; SD ± 0.6; T1: 2.99; SD ± 0.5; $p = 0.0198$). Professionals' training on active fatherhood and on prevention and management of violence against women for health professionals is an effective public health strategy for health promotion.

Keywords: active fatherhood; health promotion; health professional; intimate partner violence; training; pre and post-natal care

1. Introduction

The Istanbul Convention of 11 May 2011 defines gender-based violence as "any violence directed against a woman as such, or which affects women disproportionately" [1]. Therefore, violence against women is configured as a violation of human rights and as a form of discrimination against women. The Centre for Disease Control and Prevention defines intimate partner violence (IPV) as a preventable public health problem [2]. The term describes physical violence, sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy [2].

Since 1995, the World Health Organization (WHO) has considered the problem of violence against women and its effects as a problem of extreme importance for health and as a public health problem and a violation of human rights [3]. According to the WHO, one out of three women in the world has suffered physical and/or sexual violence, and in 30% of cases, it is IPV [4]. Moreover, from 38% to 50% of female murders at the global level are committed by intimate partners [4].

The prevalence of violence against women shows great geographic variability. The lowest values are recorded in Europe, where among the 29 countries that have available data, the female victims of violence are about 6.1%, while in Central and Southern Asia, the value reaches 23.1% [5]. According to the European Commission for Women's Rights and Gender Equality, about 20–25% of women in Europe have suffered physical violence at least once in their adult life (one in five women), and more than 10% suffered sexual violence with the use of force and 45% of women have suffered some form of violence [6].

In Italy, in the five-year period 2009–2014, 31.5% of Italian women between the ages of 16 and 70 suffered physical or sexual violence at least once in their lifetime [7]. According to these data, 20.2% suffered physical violence, 21% sexual violence, and 5.4% more serious forms of sexual violence such as rape and attempted rape. Rapes are committed in 62.7% of cases by a current or former partner. Strangers are, in most cases, perpetrators of sexual harassment (76.8% of all violence committed by strangers).

Rates of IPV during pregnancy vary widely, and this variation is likely due to the use of different screening tools (e.g., counselling in the form of a brief intervention or motivational interviewing), processes, different populations, and definitions applied [8]. In Italy, it was found that violence during pregnancy increased from 10.2% in 2006 to 11.8% in 2014 [7]. IPV can lead to several adverse effects during pregnancy, both on the mother and fetus. Furthermore, adverse health behaviors include late and missed prenatal care appointments, poor weight gain, higher rates of smoking and alcohol, and substance abuse [9,10]. Berhanie et al. showed that the maternal stress derived from IPV can lead to substance abuse with indirect negative effects on fetal health, such as slow birth weight, intra-uterine growth restriction, and fetal alcohol syndrome [11]. Pregnant women subjected to IPV also suffer from an increase in mental health problems [12].

Healthcare services play a key role in abused women's care [13], but, at the same time, their response can be slow [14]. A survey involving obstetricians and assessing their attitudes on monitoring IPV in patients showed that most of them declared a low level of training and knowledge [15]. The WHO developed a curriculum for training healthcare providers in order to provide health professionals with the tools for responding to violence against women and woman-centered clinical care [16]. It uses the LIVES approach (Listen, Inquire, Validate, Enhance safety and Support) with essential clinical care and identification of local support resources.

Father involvement in delivery and childcare can reduce IPV. According to the available evidence, the presence of fathers at prenatal visits and their taking paternity leave is predictive both of lower likelihood of IPV against women and better paternal health [17]. In Chan et al., the fathers' presence during antenatal visits was associated with a lower likelihood of physical, economic, and psychological IPV. [17] Paternity leave was associated with a lower likelihood of perpetration of psychological IPV. Health personnel is key to the greater involvement of fathers [18].

Active fatherhood has several effects during developmental age, such as fewer behavioral problems in adolescence, better academic achievement, and less violent and antisocial behavior [19]. This positive effect is showed also during breastfeeding. A controlled trial investigated the father's role in increasing the prevalence of breastfeeding, showing an improvement in the group in which fathers received a training session on breastfeeding support [20]. Furthermore, the presence of the father/partner during labor and birth improves maternal satisfaction with the birth experience [21,22]. Thus, it is important to ensure the early and active involvement of the father in childcare in order to promote better child health and neurobehavioral development [23].

Fathers' involvement is also associated with reduced parenting stress [24] and with gender equality and division of household labor [25]. Although there is still a research gap, men's participation in prenatal visits and parenting classes, the presence of the father/partner during labor, birth, and the care of the newborn are milestones of father involvement during the parenthood process [26]. The positive effect of active fatherhood in IPV prevention is possibly related to the fact that involved fathers are less likely to perpetrate partner violence due to more gender-equitable practices and less rigid gender roles and stereotypes in the family [27]. The role redistribution in care and other domestic work has a modeling effect that impacts the way boys and girls see themselves as future caregivers, as well as future employers [28].

The European Project PARENT (Promotion, Awareness-raising and Engagement of Men in Nurture Transformations, 2019–2021) aimed to combat violence against women by promoting since pregnancy the active participation of fathers in the role of care [29]. The actions included training and refresher courses for social and health personnel who come into contact with fathers during pregnancy, childbirth, and the first 1000 days of life. In Italy, there is weak evidence of knowledge and training of healthcare professionals in this field. Our study aims to assess attitudes, practices, and perceived competencies of social-healthcare professionals who participate in PARENT courses regarding fathers' active engagement in care and on prevention and management of violence against women. Therefore, we assess the changes in attitudes, practices, and perceived competencies pre- and post-intervention.

While the project addresses specifically men/fathers, the training is aimed to promote the active participation of any partners in any couple.

2. Materials and Methods

A pre-post study was carried out at two points in time: T0 (pre-training) and T1 within 15 days from the end of the course. The course, organized in 3 different regions, was structured in four modules and was implemented in three regions between November 2019 and March 2020. The first module (Module 1) aimed to present key content regarding reasons why fathers' early engagement is important and to build a common language related to the father's role in the development of the child and prevention of violence against women. This module covered social changes in fathering and obstacles to shared parenting; father discomfort; psychological, biological, and neuro-endocrine aspects of the father's role and its effects on the child development and co-parenting; fatherhood, caring masculinities, and gender-based violence (GBV) prevention. The next three modules, interactive and experiential (case-studies and self-case-studies, role-play, small group discussion, video modeling, and World Cafè), aimed to promote reflections on professional practice and operational methods for the active involvement of fathers, the prevention and recognition of violence in the different phases of pre and post-natal care (pregnancy, birth, and the new family) (Figure 1). In particular, Module 2 covered family lifestyle during pregnancy, the role of the father during pregnancy and antenatal classes, and the choice of birthplace. Module 3 focused on the moment of birth: admission of the father in the delivery room and bonding with the newborn. Module 4 was centered on the father figure within the newly formed family unit, his role in supporting breastfeeding, the post-natal period, the couple's sex life and contraception, possible paternal emotional disorders, and social support from peer-to-peer groups. Although participants in Module 3 were mainly from hospital services, all participants could attend more than one module.

The training was aimed at social and health professionals involved in mothers, fathers, and babies' care during pre and post-natal care. Different professional figures operating both in the community and at the hospital level were involved. Moreover, the course aimed to promote the topic of active fatherhood during midwifery pre-service training. For this reason, lecturers and coordinators from the bachelor's degree in Midwifery were included.

A semi-structured questionnaire was used adapted from the Programme P checklist for health services [30] and the GEM Scale [31]. Some specific items were added to suit the

Italian context. The questionnaire is structured in three sections. The first includes 15 items investigating the participants' opinions according to a 5-item Likert scale (1 = completely disagree; 5 = completely agree). The second section concerns the professional practices using a 4-item Likert scale (never, sometimes, often, always) and perceived competencies using a 4-item Likert (none, not much, enough, much). This section consists of 20 items and 2 open questions aimed to assess the personal suggestions on the increase in practices for the promotion of father/partner active participation. The third section consists of socio-demographic items. The questionnaire was self-administered. In one region, at T0, it was administered on paper, while at T1, it was sent via WhatsApp or email according to the participants' choice. A recall system has been provided: three calls were made on different days and times; subsequently, an email from the organizational team was sent. In case of failure to respond, WhatsApp was used to remind.

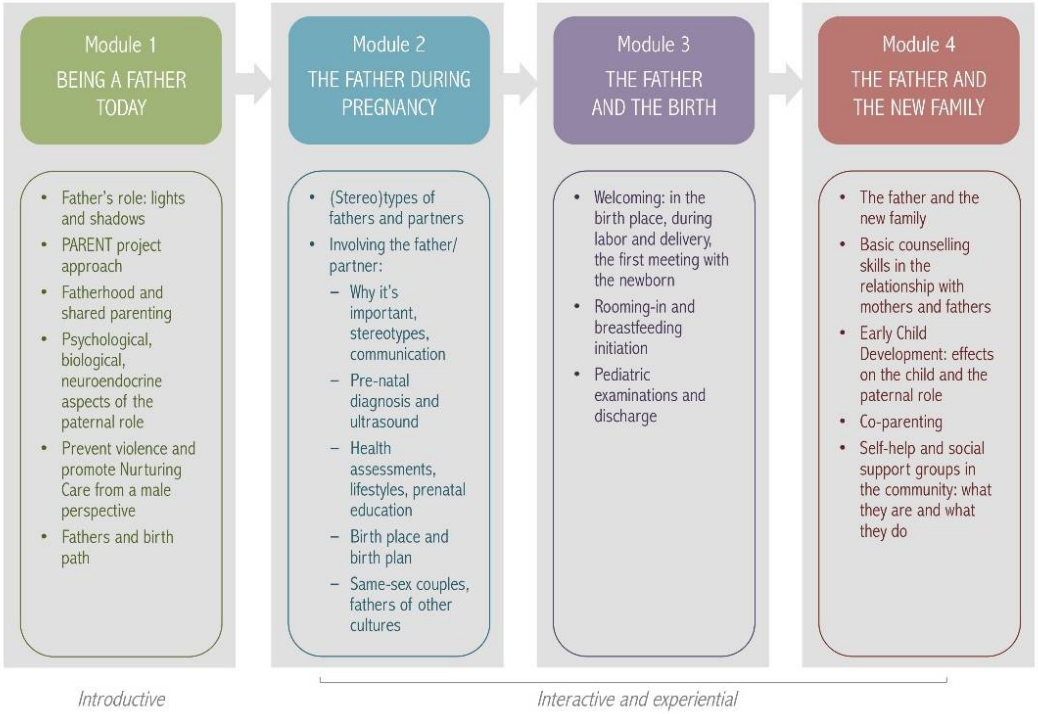

Figure 1. Structure of the training course.

The responders were informed and agreed to the use of anonymous data in accordance with Italian and European Data Protection legislation.

Descriptive and inferential analyses were performed. The frequency and percentage of demographic variables were determined, and a bivariate analysis was used to assess the presence of statistically significant associations. The total mean scores of opinions, practices, and perceived competencies were calculated, as were the mean scores for each item (T0 and T1), assuming that values at T1 were higher than T0. To assess the differences at T0 and T1, the paired sample *t*-test or *Wilcoxon signed-rank test* were used after verifying the normal distribution of variables. Statistical measurements were conducted using Stata v16. By convention, the significance level was set at 0.05 ($p < 0.05$).

3. Results

At T0, there were 129 participants. The average age was 46 years (SD $\pm$ 11.06). One hundred and twenty professionals (93%) were female, and most of them were married. In total, 88 professionals (68.2%) had children, and 92 (71.3%) declared to be graduates. The most represented professions were midwives (85), pediatricians/neonatologists (12), pediatric nurses (9), and nurses (8). In total, 64 (50.4%) worked in community healthcare services, 60 (47.2%) in hospitals, and 3 (2.4%) in academia or research. Asked whether

they had received any training/education on intimate partner violence or on nurturing fatherhood, 71 professionals (56%) declared they had none in either topic, 35 (27.6%) had received training on the prevention of domestic violence, and 12 (9.4%) on active fatherhood. Only nine (7%) had received training/education on both topics (Table 1).

Table 1. Participants' characteristics (N = 129).

Participants' Data	**N (%)**
Mean age in years	45.9 (SD ± 11.06)
Women	120 (93)
Men	9 (7)
Marital status	
Married	71 (55)
Unmarried	29 (22.5)
Cohabitant	16 (12.4)
Divorced/separated	10 (7.8)
Widower/widow	3 (2.3)
Children (Yes)	88 (68.2)
Educational level	
University degree	92 (71.3)
Specialization	20 (15.5)
Master's degree	17 (13.2)
Professionals (*n* = 128)	
Midwives	85 (66.4)
Pediatricians/neonatologist	12 (9.4)
Pediatric nurses	9 (7)
Nurses	8 (6.3)
Gynecologist	4 (3.1)
Health care assistant	4 (3.1)
Psychologist/psychotherapist	6 (4.7)
Workplace (*n* = 127)	
Community healthcare services	64 (50.4)
Hospital	60 (47.2)
Research	2 (1.6)
Academia	1 (0.8)
Specific training/education (*n* = 127)	
No	71 (56)
Yes, training on prevention of domestic violence	35 (27.6)
Yes, training on active fatherhood	12 (9.4)
Yes, training on both topics	9 (7)

As for opinions at T0 (Figure 2), 96% considered that the involvement of the father/partner during pregnancy visits is important, and 95% declared that healthcare facilities should organize meetings for fathers/partners and mothers on the birth pathway. About 4% disagreed with the opinion that healthcare facilities should provide a nappy-changing table in the men's bathroom. A high percentage agreed that healthcare professionals should encourage the presence of the father/partner during the check-ups of the baby (97.7%), that couples should decide jointly whether to have a child (95.3%), and that it is not the woman's responsibility to avoid getting pregnant. About 9% thought it might be misleading for boys to play with dolls; however, 93% agreed that women have the same right as men to work outside the home.

As for practices at T0 (Figure 3), 49% declared they always provide information and guidance on how the father/partner can support the mother during pregnancy when he/she is present. In total, 60 and 62% always encourage the father/partner to be present during labor and delivery (after verifying the mother's consent) and offer guidance on how the father/partner can provide support (physical and psychological) to the mother

during labor and delivery, respectively. In total, 31% declared they never mentioned to the father/partner the possibility of registering the newborn with the surname of both parents, and 27% that they never recorded the presence or absence of the father/partner during labor and delivery. On the other hand, about 54% always provide information to the father/partner on how to support the mother during breastfeeding, and 67% actively invite the father/partner to hold the infant or child in his arms.

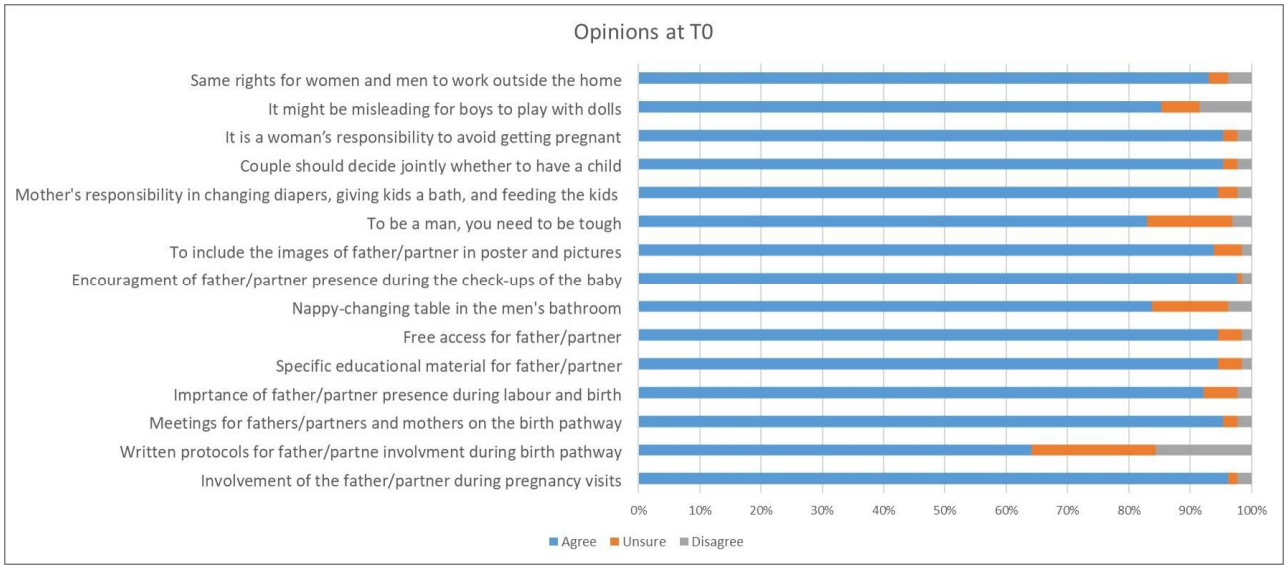

Figure 2. Distribution of participants' opinions at T0 according to 5-item Likert scale (1 = completely disagree; 5 = completely agree). Most of the opinions scored high, starting at T0.

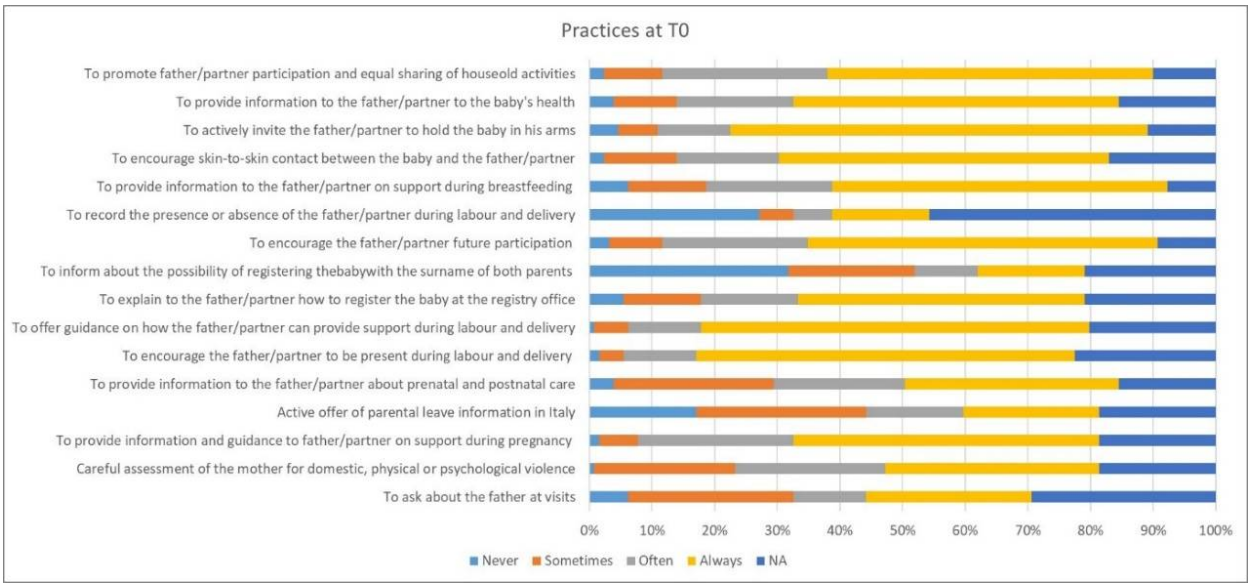

Figure 3. Distribution of professional practices on fathers' active engagement in care at T0, using a 4-item Likert scale (never, sometimes, often, always).

With regard to perceived competencies at T0 (Figure 4), 57% of respondents feel quite capable of actively involving the father/partner, but about 55% and 43% feel less capable of identifying a situation of domestic violence and activating adequate procedures for the management of a domestic violence situation, respectively.

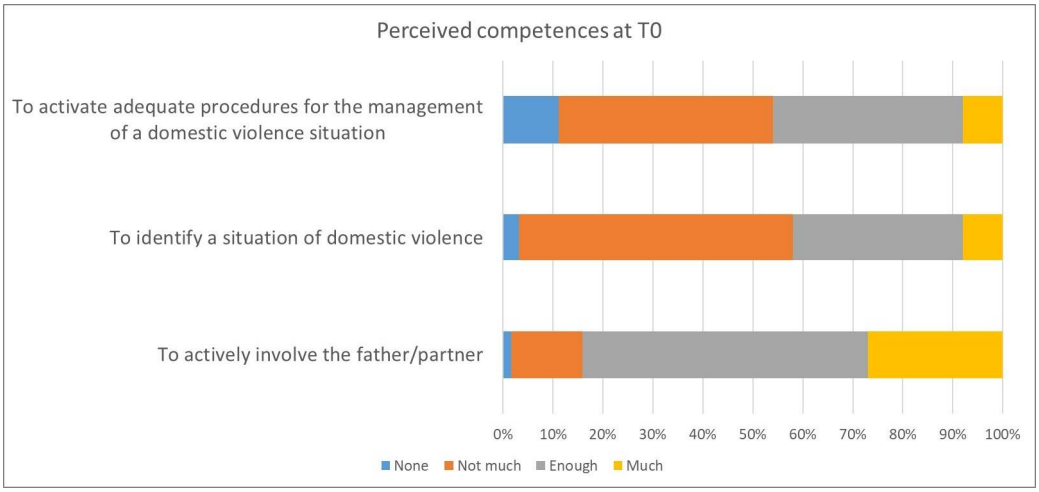

Figure 4. Distribution of perceived competencies at T0 using a 4-item Likert (none, not much, enough, much).

The respondents after the course (T1) were 105 (81.4%). Most opinions, such as those regarding the presence of the father/partner during labor and birth, the idea that 'to be a man' it is necessary to 'be strong', or that it might be misleading for boys to play with dolls, improved. The average score of opinions at T0 and T1 improved, and this difference was significant (T0: 4.44; SD ± 0.6; T1: 4.42 SD ± 0.3; $p = 0.0126$). The same applies for perceived competencies (T0: 2.79; SD ± 0.6; T1: 2.99; SD ± 0.5; $p = 0.0198$) (Figure 5).

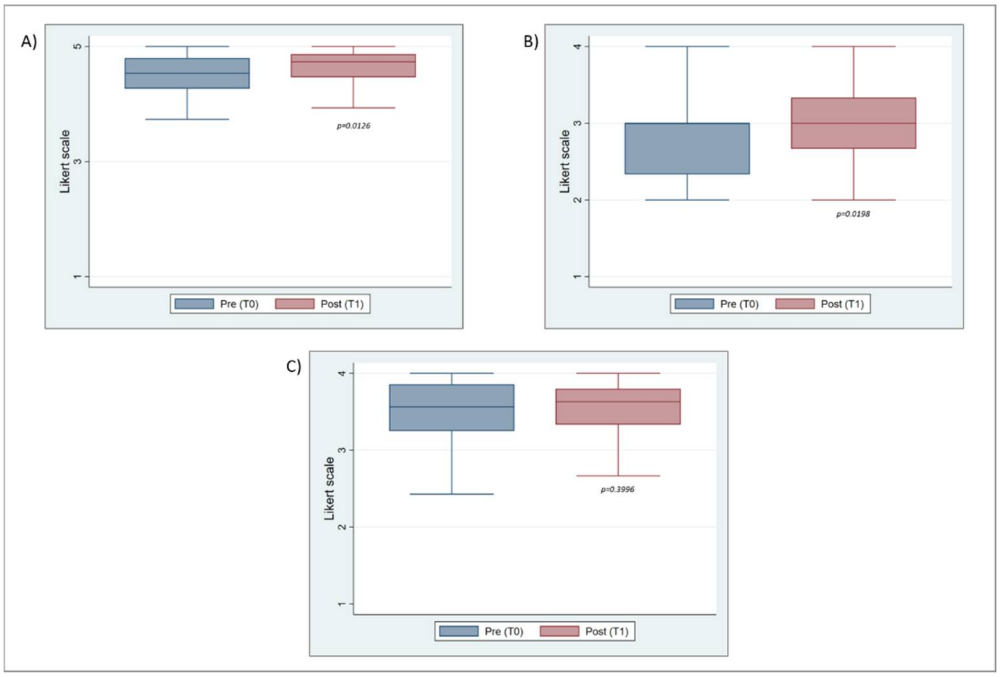

Figure 5. T0–T1 differences. (**A**) shows opinion pre–post differences (1 = Disagree, 2 = Unsure, 3 = Agree). (**B**) shows perceived competencies pre–post differences (1 = None, 2 = Not much, 3 = Enough, 4 = Much). (**C**) shows practices pre–post differences (1 = Never, 2= Sometimes, 3 = Often, 4 = Always).

Some practices, such as carefully assessing the mother for domestic, physical, or psychological violence, providing information directly to the father/partner on antenatal and post-natal care and on the development of the baby, and encouraging the fu-

ture participation of the father/partner, showed an increase, but the differences were not significant.

The bivariate analysis showed a significant association between specific education on the prevention of domestic violence and active fatherhood and the active offer of information to the father/partner on paternity leave available in Italy (ORa 3.6; CI95% 1.5–8.7; $p < 0.01$), and the recording of the presence or absence of the father/partner during labor and delivery (ORa 3.2; CI95% 1.05–9.6; $p < 0.05$).

4. Discussion

Our study shows that the training on the promotion of active fatherhood in pre and post-natal care is effective in improving attitudes, practices, and perceived competencies of healthcare professionals. Professionals' training confirms its key role in improving some professional practices. Similar results were observed in Colucci et al.'s study aimed to assess a blended course for Emergency Unit health workers with the aim to increase the professional competencies for diagnosis, management, and treatment of GBV [32].

Training of professionals on engaging fathers in collaborative, gender-equitable parenting is important both for primary and secondary prevention of GBV, in addition to the known benefits of fathers' early and intimate engagement for maternal and child health and their wellbeing as men. However, there is a fine line to tread between the two, between reinforcing the stereotype that all men are potential perpetrators and projecting an idealistic image of the perfect, harmonious couple.

A theoretical, interactive, and experiential training program can modify and improve knowledge, perceived competencies, attitudes, and practices. In our course, the main behaviors that changed over time were the encouragement of the presence of father/partner during labor and birth, skin-to-skin contact between father and child, stereotypes concerning men/fathers, the woman's responsibility to avoid pregnancy, the promotion of father/partner participation in all care and domestic activities, and the assessment of the mother for domestic, physical, or psychological violence. As documented in several studies and in different fields, participatory training methods such as role-playing, discussion of cases, and working groups are effective learning strategies for improving competencies and generating new knowledge [33–35]. Therefore, a structured curriculum that places a greater emphasis on active learning methodologies and learner-centered approaches is needed. The improvement of these behaviors is fundamental for the involvement of the father in pre and post-natal care. While the low-interaction e-learning experiences show their effectiveness in the promotion of mother and child health and breastfeeding [36,37], they cannot provide a shared and co-constructed learning experience. To combine the advantages of low-interaction e-learning (e.g., reduced costs, time, and environmental impact) and face-to-face training, we suggest as a training model for the health services an online course using a high interaction platform (including breakout rooms, whiteboards, and shared writing tools for small groups). This would reduce the costs and make the learning experience more sustainable and replicable.

As for breastfeeding support, at T0, participants already declared a high level of father's involvement, indicating that some facilities have a cultural organization that tends to promote active fatherhood in clinical practice and recognizes the father as being part of the solution not the problem. Unfortunately, the COVID-19 pandemic has, in some cases, been used as a pretext to keep the fathers out of the Maternity Unit, despite the national guidance recommending guaranteeing the presence of a birth partner during labor, childbirth, and hospital stay [38].

In our study, the screening of mothers for domestic, physical, or psychological violence showed a small increase with no significant differences. The improvement of health professionals' practices to identify the situations of violence early can help them to refer the women to specific support services. Therefore, it is important to verify that the referral pathways are available.

The training modules are effective in changing some attitudes and perceived competencies. The methodology should be highly interactive and based on social constructivism, and the contents can be easily adapted, e.g., focused on IPV or active fatherhood. This training format can be easily included both in continuous medical education (CME) or pre-service university education.

Our study presents some limitations. The limited sample size requires results to be interpreted with caution. It is, therefore, necessary to replicate this study in a larger population. We could not assess the long-term changes in attitudes and practices after 6 months from the beginning of the course because of the pandemic outbreak.

5. Conclusions

To conclude, our study demonstrates that training on active fatherhood and on prevention and management of violence against women for health professionals is an effective public health strategy for health promotion. Our program can be implemented in a different context to bring about changes in practice. The health systems should ensure that men are involved in healthcare during pregnancy, labor, birth, and post-partum, and the institutionalization of a positive approach to men's involvement [28].

Moreover, the pre-service training of midwives plays a key role in fostering cultural change in order to promote active fatherhood and Nurturing Fatherhood in care during pregnancy, childbirth, and the first years of life. In light of this, we developed pre-service training for university teachers, clinical tutors, and breastfeeding trainers in order to apply the contents and skills in their training practice [39].

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