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*J Hum Lact* 2008; 24; 386 originally published online Sep 10, 2008;  
DOI: 10.1177/0890334408323545

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# Inclusion of Fathers in an Intervention to Promote Breastfeeding: Impact on Breastfeeding Rates

Lulie Rosane Odeh Susin, PhD, and Elsa Regina Justo Giugliani, PhD

## Abstract

This controlled clinical trial, conducted in southern Brazil, assessed the impact of paternal inclusion in a breastfeeding education program carried out in a maternity hospital. Rates of breastfeeding in the first 6 months of babies' lives were measured in 586 families: 201 in the control group, 192 in the group with only mothers exposed to the intervention, and 193 in the group with mothers and fathers exposed to the intervention. Paternal inclusion significantly increased the rates of exclusive breastfeeding but not the rates of any breastfeeding. Intervention with fathers with less than 8 years of schooling resulted in a decrease in the rate of breastfeeding when compared with the intervention with mothers only. The likelihood of success might have been greater if the cultural and behavioral complexities associated with this practice had received more attention. *J Hum Lact.* 24(4):386-392.

**Keywords:** breastfeeding, breastfeeding rates, breastfeeding promotion, education, fathers

In Brazil, breastfeeding practices do not usually follow the recommendations of the World Health Organization (WHO), that is, exclusive breastfeeding until the age of 6 months and complemented breastfeeding until the end of the second year of life or longer.<sup>1</sup> A national survey carried out in Brazilian state capitals in 1999 revealed a median duration of 10 months for breastfeeding and of only 23 days for exclusive breastfeeding.<sup>2</sup>

As a biological and cultural process, breastfeeding is affected by several factors. Paternal support has been shown to have a positive impact on the woman's decision to breastfeed<sup>3-5</sup> and on the maintenance of this practice.<sup>6-9</sup> However, the father is left out of most initiatives to promote breastfeeding, and a prominent role

of fathers in such interventions is rare. In addition, few studies have investigated the impact of paternal participation in interventions promoting breastfeeding. A randomized controlled trial showed that exposing expectant fathers to a 2-hour intervention class on infant care and breastfeeding promotion was successful in increasing breastfeeding initiation rates.<sup>10</sup> To our knowledge, only 1 controlled clinical trial has investigated the influence of fathers on the duration of breastfeeding.<sup>11</sup> This study showed that teaching fathers how to prevent and manage lactation problems increased rates of full breastfeeding at 6 months.

To contribute to the understanding of the father's role in breastfeeding promotion in different cultures, this study assessed the impact of paternal inclusion in an intervention to promote breastfeeding in Brazil.

## Methods

This controlled clinical trial included 586 mother-father-infant triads. Participants were selected at the maternity ward of Hospital de Clínicas de Porto Alegre, Brazil, a university hospital certified as a Baby Friendly Hospital in 1997, where approximately 4000 deliveries take place every year, mainly of low-income families. Participants were divided into the following groups: not exposed to the intervention (control group), intervention with mothers only, and intervention with both mothers and fathers.

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Received for review January 10, 2008; revised manuscript accepted for publication May 22, 2008.

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*J Hum Lact* 24(4), 2008

DOI: 10.1177/0890334408323545

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During 9 months, all triads with the following characteristics were enrolled: couples living together in the city of Porto Alegre who had infants born with no health problems and birth weight equal to or greater than 2500 g and who initiated breastfeeding. Triads whose parents separated during follow-up were excluded from the study.

Sample size calculation established that a minimum of 133 triads was required in each group for the following conditions:  $\alpha = .05$ ,  $\beta = .2$ ; prevalence of breastfeeding at 6 months in controls = 50%; difference between the control and intervention groups of at least 15%; and ratio between groups: 1:1:1. To compensate for possible losses and to enable multivariate analysis, the number of triads that was actually included in each group was 50% greater than the minimum. Thus, the first 208 couples and their respective newborns were included in the control group. The next 197 triads composed the group in which only mothers were exposed to the intervention, and the other 196 triads were included in the group in which mothers and fathers received the intervention. Block group allocation was used to avoid information exchange between mothers while at the maternity ward because rooms in the hospital where the study was conducted are shared by 6 mother-baby pairs. The hospital routine of assistance to mothers and newborns was not affected.

At the maternity wards, mothers and fathers, separately, answered a standard questionnaire after signing consent forms regardless of the group to which they were assigned. The questionnaires collected sociodemographic data and information on delivery, prenatal care and previous experience with breastfeeding. After the interview, mothers or mothers and fathers were exposed to the intervention according to the group to which they had been assigned. The intervention consisted of an educational session about breastfeeding conducted by a trained pediatrician. Participants watched an 18-minute video on the subject, followed by an open discussion and distribution of an explanatory handout. Both the video and the handout were specifically produced for this study. The video discussed some important aspects of breastfeeding, such as the WHO recommendations, prevention and management of common breastfeeding problems, and the importance of paternal participation. It directly stated that fathers could support the breastfeeding mother by helping out with household tasks and child care; it also showed several images of fathers helping with household tasks, such as changing diapers, washing dishes, or vacuum cleaning the carpet.

All families in the 3 groups were visited at the end of their infants' first, second, fourth, and sixth months of life, or until breastfeeding was interrupted, if this occurred before the end of the sixth month. During the visits, mothers answered a questionnaire about their babies' feeding habits. The visits were made by well-trained medical graduate students blinded to the group to which the mothers belonged.

Breastfeeding categories were established according to WHO recommendations.<sup>12</sup> Children were breastfed if they received any breast milk daily, regardless of other food they might be getting. Exclusive breastfeeding was defined when children received breast milk only, without any supplement, whether solid or fluid, either water or infusions.

Epi-Info 6.0 and SPSS for Windows 11.0 were used for statistical analyses. Kaplan-Meier curves were plotted to compare the rates of breastfeeding in the 3 groups and to compare breastfeeding rates between the 2 intervention groups according to paternal schooling (up to 8 years, more than 8 years). Bivariate analysis ( $\chi^2$ ) was used to compare variables between the 3 groups. As there were some baseline differences between groups, multivariate analysis using Cox regression was used to control for possible factors that might affect prevalence ratio estimates. The following variables, whose frequency was different in the 3 groups for a level of significance of  $P < .1$ , were included in the model: father's skin color, duration of breastfeeding of previous children, and mother's attendance at prenatal classes. Although the distribution of maternal skin color was different in the 3 groups, this variable was not included in the model because of its colinearity with father's skin color (Pearson correlation = 0.66).

The study was approved by the Ethics Committee of Hospital de Clínicas de Porto Alegre.

## Results

Six-hundred fifty-four mother-father-newborn triads were eligible for the study. Of these, 53 were not included: in 7 cases (1.1%), the mother and/or the father refused to participate, and in 46 (7.1%) cases, the research team was unable to interview the father at the maternity ward. The triads that were not included in the study did not differ from participants in type of delivery, sex of the newborn, income, marital status, maternal and paternal age, schooling, skin color, prenatal care, and length of breastfeeding of previous children. In the follow-up period, there were 39 losses

Table 1. Population Characteristics by Group

Characteristic	Control (n = 201) No. (%)	Intervention With Mothers (n = 192) No. (%)	Intervention With Mothers and Fathers (n = 193) No. (%)	P
Age				
Mother				
≤ 20 y	46 (22.9)	47 (24.5)	51 (26.4)	
> 20 y	155 (77.1)	145 (75.5)	142 (73.6)	.72
Father				
≤ 20 y	20 (10.0)	17 (8.9)	24 (12.4)	
> 20 y	181 (90.0)	175 (91.1)	169 (87.6)	.50
Skin color				
Mother				
White	137 (68.2)	93 (48.4)	108 (56.0)	
Other	64 (31.8)	99 (51.6)	85 (44.0)	.00
Father				
White	142 (70.6)	114 (59.4)	112 (58.0)	
Other	59 (29.4)	78 (40.6)	81 (42.0)	.02
Schooling				
Mother				
≤ 8 y	130 (64.7)	121 (63.0)	128 (66.3)	
> 8 y	71 (35.3)	71 (37.0)	65 (33.7)	.79
Father				
≤ 8 y	122 (60.7)	128 (66.7)	132 (68.4)	
> 8 y	79 (39.3)	64 (33.3)	61 (31.6)	.24
Per capita income				
≤ 0.5 SM	45 (22.4)	35 (18.2)	29 (15.0)	
0.6-1.9 SM	92 (45.8)	105 (54.7)	100 (51.8)	
≥ 2.0 SM	64 (31.8)	52 (27.1)	64 (33.2)	.22
Parent's marital status				
Single	123 (61.2)	123 (64.1)	122 (63.2)	
Married	78 (38.8)	69 (35.9)	71 (36.8)	.83
Newborn's sex				
Female	108 (53.7)	95 (49.5)	94 (48.7)	
Male	93 (46.3)	97 (50.5)	99 (51.3)	.56
Prenatal care				
No consultations	15 (7.5)	13 (6.8)	15 (7.8)	
1-4 consultations	27 (13.4)	26 (13.5)	25 (13.0)	
≥ 5 consultations	159 (79.1)	153 (79.7)	153 (79.3)	.99
Breastfeeding orientation during pregnancy				
Mother				
No	135 (67.2)	130 (67.7)	139 (72.0)	
Yes	66 (32.8)	62 (32.3)	54 (28.0)	.53
Father				
No	184 (91.5)	168 (87.5)	179 (92.7)	
Yes	17 (8.5)	24 (12.5)	14 (7.3)	.18
Participation in prenatal classes				
Mother				
No	184 (91.5)	159 (82.8)	164 (85.0)	
Yes	17 (8.5)	33 (17.2)	29 (15.0)	.03
Father				
No	191 (95.0)	184 (95.8)	187 (96.9)	
Yes	10 (5.0)	8 (4.2)	6 (3.1)	.65
Type of delivery				
Vaginal	160 (79.6)	145 (75.5)	157 (81.3)	
Cesarean	41 (20.4)	47 (24.5)	36 (18.7)	.36
Number of previous children				
None	85 (42.3)	75 (39.1)	80 (41.5)	
1-3	102 (50.7)	101 (52.6)	99 (51.3)	
> 3	14 (7.0)	16 (8.3)	14 (7.3)	.96
Breastfeeding duration with previous children				
≤ 3 mo	42 (20.9)	45 (23.4)	62 (32.1)	
> 3 mo	74 (36.8)	72 (37.5)	53 (27.5)	
Primiparous	85 (42.3)	75 (39.1)	78 (40.4)	.06

SM, minimum monthly wage.

(6.5%). The number of losses was similar in the 3 groups (control, 14; intervention with mothers, 12; intervention with mothers and fathers, 13); 15 triads were excluded from the study because of parents' separation, and 547 triads (91.0%) completed the study.

Table 1 shows the characteristics of participants in each group. The variables tested were not different between groups ( $P \geq .05$ ), except for maternal and paternal skin color, with significantly more white parents in the control group than in the other groups, and participation in prenatal classes, which was lower in the control group.

In the hospital interview, most mothers (93.3%) declared that they would like to receive help from their husband/partners during breastfeeding, although 21.3% did not know specifically what type of help they wished to receive. Most fathers (99.2%) said that they wished to help mothers during this period, but 21.5% did not know what they could do to help. Most mothers (64.9%) stated that they would like their partners to help with house chores and child care, and 37.2% of the fathers cited these tasks as a way to support breastfeeding.

Figure 1 shows Kaplan-Meier curves describing breastfeeding in the first 6 months of life for the babies in the 3 groups. At 6 months, the frequency of breastfeeding was 46.4% in the control group and 60.3% in the mothers-only intervention group. In the mothers-and-fathers intervention group, the frequency of breastfeeding was 50% at 6 months. The log rank test indicated that the breastfeeding Kaplan-Meier curves were significantly different between the groups ( $P = .006$ ). Cox regression indicated that the intervention with mothers only significantly reduced the risk of cessation of breastfeeding in the first 6 months (hazard ratio [HR], 0.64; 95% confidence interval [CI], 0.47-0.86). When fathers were included in the intervention, this reduction did not reach statistical significance (HR, 0.86; 95% CI, 0.65-1.14).

The exclusive breastfeeding Kaplan-Meier curves showed that the frequency of exclusive breastfeeding was higher in the mothers-and-fathers intervention group (16.5% at 4 months vs 11.1% in the mothers-only intervention group and 5.7% in the control group;  $P = .003$ ). The intervention with mothers only was protective against cessation of exclusive breastfeeding, but the difference was not statistically significant (HR, 0.86; 95% CI, 0.70-1.05). Nonetheless, the inclusion of fathers in the intervention significantly decreased the risk of discontinuing exclusive breastfeeding before 6 months (HR, 0.80; 95% CI, 0.65-0.98).

Table 2. Crude and Adjusted Hazard Ratio for Discontinuation of Breastfeeding and Exclusive Breastfeeding in the First 6 Months in the 3 Groups (N = 586)

Group	Exclusive Breastfeeding		Breastfeeding	
	Crude HR (95% CI)	Adjusted HR <sup>a</sup> (95% CI)	Crude HR (95% CI)	Adjusted HR <sup>a</sup> (95% CI)
Control	1.00	1.00	1.00	1.00
Intervention with mothers	0.86 (0.70-1.05)	0.93 (0.66-1.31)	0.64 (0.47-0.86)	0.59 (0.38-0.92)
Intervention with mothers and fathers	0.80 (0.65-0.98)	0.65 (0.45-0.96)	0.86 (0.65-1.14)	0.68 (0.45-1.05)
Father's skin color				
White	1.00	1.00	1.00	1.00
Other	1.01 (0.81-1.26)	0.99 (0.84-1.15)	0.88 (0.69-1.13)	1.10 (0.77-1.59)
Duration of breastfeeding of previous children				
> 3 mo	1.00	1.00	1.00	1.00
≤ 3 mo	1.15 (1.05-1.36)	1.38 (1.23-1.53)	1.95 (1.4-2.05)	2.21 (1.55-3.16)
Maternal participation in prenatal classes				
No	1.00	1.00	1.00	1.00
Yes	0.78 (0.65-1.12)	0.96 (0.74-1.18)	1.05 (0.92-1.15)	1.28 (0.73-2.29)

CI, confidence interval; HR, hazard ratio.

<sup>a</sup>Adjusted for father's skin color, duration of breastfeeding of previous children, and maternal participation in prenatal classes.

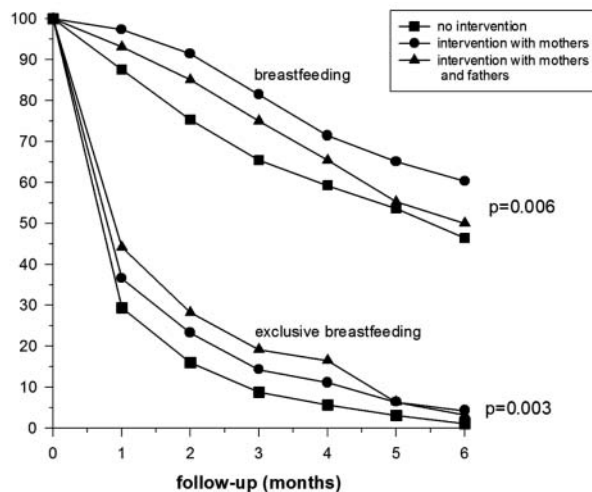


Figure 1. Exclusive breastfeeding and breastfeeding survival curves during the first 6 months of life, according to type of intervention.

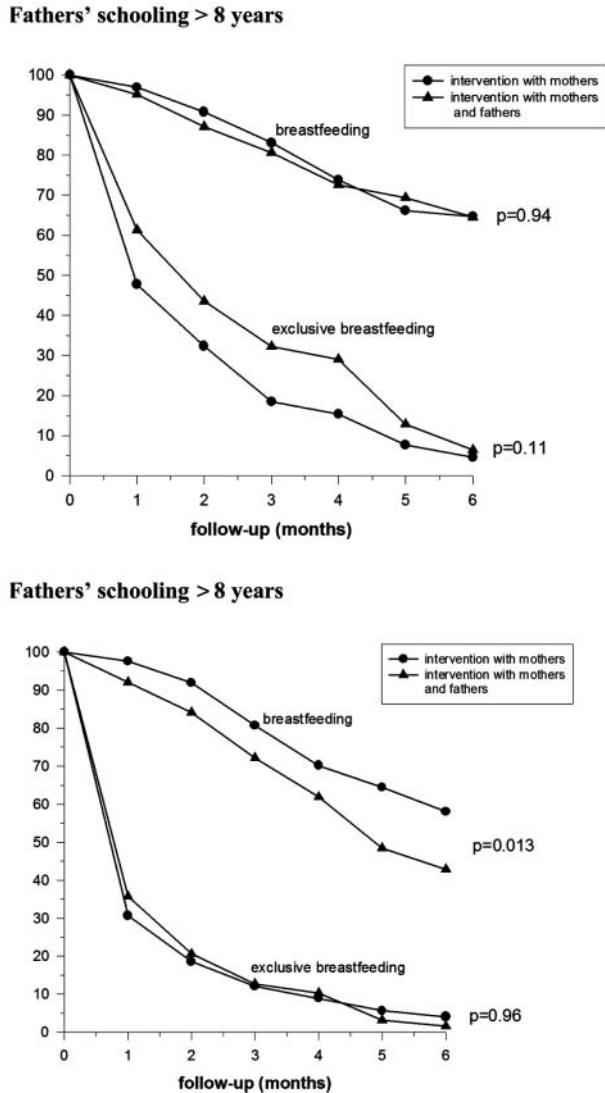
Multivariate analysis demonstrated that these results were independent of the differences between the 3 groups: that is, protection against cessation of exclusive breastfeeding in the mothers-and-fathers intervention group and of any breastfeeding in the mothers-only intervention group was maintained even after controlling for paternal skin color, duration of breastfeeding of previous children, and maternal attendance at prenatal classes. This analysis also revealed that none of these possible

confounders were associated with breastfeeding or exclusive breastfeeding duration (Table 2).

The comparison of breastfeeding rates between the 2 intervention groups according to paternal schooling (Figure 2) revealed that including fathers in the intervention had a negative impact on breastfeeding rates only when fathers had less than 8 years of schooling. There was also an increase in exclusive breastfeeding rates when fathers were included in the intervention but only when they had more years of schooling.

**Discussion**

The involvement of fathers in the breastfeeding process is a topic of increasing importance in initiatives to promote breastfeeding, especially in Western societies, where the experience of older women who practiced breastfeeding is no longer passed on to the younger generations because of the predominance of a nuclear family structure. Paternal inclusion has been encouraged in breastfeeding promotion programs, so that the father may be better prepared to provide emotional and practical support to the breastfeeding woman.<sup>13</sup> Fathers have been described as one of the most significant sources of stimulus to breastfeeding.<sup>14</sup> However, little is known about the type of support required and desired by women or the type of support that has been provided by men. Also, there is little information about the impact of such support on breastfeeding



**Figure 2.** Exclusive breastfeeding and breastfeeding survival curves during the first 6 months of life, according to type of intervention and paternal schooling.

rates. The results of this study added new knowledge to this field.

This study showed that paternal inclusion in a breastfeeding promotion program at the maternity ward could significantly increase the rates of exclusive breastfeeding in the infant's first 6 months of life. This fact is probably associated with information about the length of time a child should be exclusively breastfed, which was given to fathers as part of the intervention. This information may have encouraged fathers to influence mothers to avoid early introduction of water, herbal teas, or other types of milk. In Brazil, supplementation

of breastfeeding with water or herbal teas is a deeply ingrained practice. In some warm regions of the country, water or herbal teas are given to 80% of the children as early as the first week of life.<sup>15</sup> Only recently has this practice been challenged in Brazil. In Italy, Pisacane et al<sup>11</sup> showed that supporting fathers to recognize the relevance of their role in the breastfeeding process and teaching them how to prevent and manage common problems associated with lactation resulted in higher rates of full breastfeeding (breast milk plus water-based fluids) at 6 months (25% in the intervention group and 15% in the control group).

The most surprising finding in this study was the decrease in breastfeeding rates within the first 6 months of life (more sharply after the fourth month) when the father was included in the breastfeeding promotion strategy. This prompted us to reflect on the contents of the video on which the intervention was based. The video was devised based on a model of fatherhood that is emerging in Western societies, in which the father is present and available and shares the responsibility for raising children. Thus, the video shows fathers being asked to help with house chores and with the care of other children, so that the mother can breastfeed the baby more peacefully. The fact that Brazilian families may still be at a transitional stage in terms of this new model was not taken into account. The fathers in the present study may have concluded that for their wives to breastfeed, they would have to share tasks such as cleaning the house, doing dishes, changing diapers, and caring for the other children more actively than they were prepared to do. This might have caused a conflict that translated into a negative impact on the duration of breastfeeding. Supporting this hypothesis are the findings that most mothers said that they would like their partners to help with house chores and child care, while only one-third of the fathers mentioned these tasks as a way to support breastfeeding. In low-income Brazilian families, the target population of this study, patriarchal values are still predominant. Changes in the traditional male role are more noticeable in some sectors of the middle class, in which men are more than providers and share house chores with women.<sup>16</sup> This may be the reason for the difference associated with schooling: the negative impact of paternal inclusion in the intervention was felt only for fathers with fewer years of schooling, which supports the notion that the video was not culturally adequate for fathers of a lower socioeconomic status.

In a review about the efficacy of videos as educational tools for health issues,<sup>17</sup> the authors concluded that materials that attempt to influence attitudes and decision making are probably ineffective unless their content is culture sensitive. Some studies evaluating video interventions have shown their usefulness in increasing the occurrence and duration of breastfeeding.<sup>18,19</sup> Although the primary goal of this study was not to evaluate the impact of the intervention with mothers only, it is important to note that exposing mothers to a simple program with a video and discussion was effective in increasing the rate of breastfeeding in the infant's first 6 months of life.

One of the limitations of this study was the single-hospital setting. It seems that the intervention had different results with fathers from different social backgrounds; therefore, it would be of interest to test this intervention in different settings. Another possible limitation was the sequential rather than random allocation of the participants. Although we did not measure exposure to breastfeeding promotion other than the study intervention, we believe that our study design did not affect results because no large-scale pro-breastfeeding action was carried out in the city during the study. As participants' places of residence were spread all over the city, results would be affected only if a citywide intervention had been conducted.

Although the participants of the 3 groups were selected in the same setting, there were some baseline differences between groups. To minimize any possible bias due to differences such as father's skin color, previous maternal breastfeeding experience, and maternal participation in prenatal classes, these variables were included in the multivariate analysis model. This analysis confirmed that the differences between groups did not affect study results significantly.

Important lessons can be learned from this study. Although the results proved that fathers included in pro-breastfeeding interventions might enhance breastfeeding rates, special attention should be paid to the cultural and behavioral complexities associated with this practice. It is important to understand the man-father facing breastfeeding and the (often ambivalent) feelings involved, such as the feeling of being left out of feeding the baby, losing the interest of the baby's mother, and jealousy.<sup>8</sup> As is the case with women, fathers should be realistically prepared for this stage of family life; however, that preparation should always be guided by the cultural context in which it takes place.

Several questions about the role of fathers as promoters of breastfeeding remain open, and further studies should be conducted to evaluate paternal perceptions about the process of breastfeeding in different settings.

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**Resumen**

Este estudio clínico controlado, llevado a cabo en el sur de Brasil, evaluó el impacto de incluir al padre en el programa de educación sobre lactancia en el servicio de maternidad en el hospital. Se midieron los índices de lactancia materna en los primeros seis meses en 586 familias; 201 en el grupo control, 192 en el grupo de solo madres expuestas a la intervención, y 193 en el grupo de madres y padres expuestos a la intervención.

La inclusión paterna aumento significativamente los índices de lactancia materna exclusiva pero no los índices de cualquier tipo de lactancia. La intervención con padres con menos de 8 años de escolaridad resultó en la disminución de los índices de lactancia cuando se compararon con el grupo de intervención de madres solamente. La probabilidad de éxito pudo haber sido mayor si se hubiera tenido en cuenta la asociación de la complejidad cultural y de comportamiento.