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Engaging Inner-City Fathers in Breastfeeding Support

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Abstract

Purpose: Our objective was to pilot a method of engaging fathers/partners of high-risk inner-city mothers in breastfeeding support.
Materials and Methods: Breast for Success was a breastfeeding promotion initiative with a father engagement component. In collaboration with Community Endeavors, Inc., we organized father-friendly evening programs (one night per week for 3 weeks, repeating quarterly) led by a male facilitator to provide breastfeeding education, with ongoing availability of a resource specialist to link men to community resources relevant to their legal, financial, and health needs. Fathers/partners were recruited from community programs and via our community partner, The City of Cleveland Department of Public Health MomsFirst™ Project, a federally funded Healthy Start program. University Hospitals Case Medical Center Institutional Review Board approved the study.
Results: Sixty-six fathers/partners attended eight evening programs, and 30 (45%) attended all three nights. Their median age was 27.5 years (range, 17–64 years), and 49 (74%) self-described themselves as African American. At the start of the groups, 39% (21/54 responding) had a breastfed child, and 64% (39/61 responding) said they were comfortable with breastfeeding for their own child. After Sessions 1, 2, and 3, respectively, 40 (85%), 42 (89%), and 33 (80%) were ''more likely'' to want their next baby to breastfeed. On average, in 62% of all responses (278/450 possible), men endorsed learning ''a lot more'' about the 10 breastfeeding curriculum topics presented.
Conclusions: Recruitment of inner-city fathers/partners for a breastfeeding education program was feasible, and among men who attended, fathers' perceptions about their breastfeeding knowledge were positively impacted.

Introduction

Breastfeeding is the optimal method of infant feeding, with benefits to the infant, the mother, the family, and society.[1,2] The Healthy People 2020 goal for breastfeeding initiation is 81.9%, with 46.2% and 25.5% exclusive continuation at 3 months and 6 months, respectively.[3] Risk factors for low rates of breastfeeding are well known and include African American race, younger age, lower educational level, lower socioeconomic status, and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) participation.[4]

In Cleveland, OH, rates of breastfeeding among inner-city, predominantly African American mothers do not yet approach national levels, with a discouragingly low rate of any breastfeeding of 11.3% among WIC recipients in Cuyahoga County at program inception.[5]

The support of the father has been increasingly recognized as a critical factor in the mother's prenatal feeding intentions and in her decision to initiate and continue breastfeeding, and recent literature extends this finding to infant feeding decisions of high-risk inner-city mothers.[6–10] We sought to leverage the potential positive influence of the father in support of breastfeeding but recognized that practical barriers in the target population included frequent lack of cohabitation with the mother, estrangement of many men from traditional sources of health information, and a perceived formula culture.

Successful programs for fathers/partners across multiple cultures and ethnicities have included both hospital-based and WIC-led programs that offer prenatal or postnatal breastfeeding classes for fathers/partners.[11–22] Prior studies have required directed partner identification for program entry for fathers/partners, which was considered relatively infeasible in our setting. We sought to locate our program within the community, rather than at a hospital or medical site, to promote accessibility and aimed to engage fathers prenatally to co-occur with the breastfeeding education their expectant partners were receiving. The goal was to create a

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model that included and welcomed fathers/partners, that eliminated stigma or barriers to their attendance, and that increased both their knowledge about breastfeeding and their ability to support their partner in breastfeeding current or future children.

Materials and Methods

Our objective was to pilot a method of engaging fathers/partners of high-risk inner-city mothers in breastfeeding support. The program was developed within the context of a larger community-based participatory research project called Breast for Success, whose aim was to promote and support breastfeeding among high-risk inner-city mothers in the City of Cleveland.[23] Breast for Success included creation of a culturally competent curriculum for expectant mothers with education and support, as well as a father engagement component. The father engagement program of the Breast for Success project is described here.

Partnerships and program development

We established a working collaboration with our community partners, Community Endeavors Foundation Inc. Health Fathering Collaborative of Cleveland and The Cleveland Department of Public Health MomsFirst™ Program. Community Endeavors Foundation's mission is to provide quality services to fathers and families in Greater Cleveland by addressing barriers and increasing access to supportive services for fathers. MomsFirst is a federally funded Healthy Start initiative that serves approximately 2,000 women annually, with a mission to reduce health disparities in infant mortality and improve birth outcomes among African American women in the City of Cleveland. Our initial process included coalition building through monthly meetings with lay and professional stakeholders who shared concern about low rates of breastfeeding among African American mothers in the City of Cleveland. We then conducted focus groups in a methodology called ''broad involvement design'' that involved members of the target population, including two focus groups with fathers/partners that were facilitated by male group leaders. Additional input for overall program design included literature review, consultation from a lactation consultant (International Board Certified Lactation Consultant), and rereview with partner staff and stakeholders.

Program components

The evening groups for fathers/partners of high-risk inner-city women were conducted in an approach designed to include men in breastfeeding education and promotion: each program component was purposed to engage fathers/partners. These components included the location of group meetings in community centers within the community, the evening timing, the availability of transportation, hiring of a male community-savvy facilitator, use of a curriculum that referred directly to fathers rather than focusing solely on the mother, handouts that were pocket- rather than purse-sized, choice of incentives, and finally inclusion of a resource specialist for men. Breastfeeding informational material was adapted for men by author S.K. from the parallel Breast for Success curriculum for expectant mothers. Two colorful pocket-sized cards addressed specifically to dads with concise breastfeeding teaching points were also provided.

The full curriculum and all materials are free and available online.[24] Specific topics covered included benefits of breastfeeding for the infant, mother, and family, how to integrate breastfeeding into a busy lifestyle that includes work, school, and other siblings, good latch, how to know if the baby is getting enough milk and how to increase milk supply, how fathers/partners can support breastfeeding and the breastfeeding mother, and common misconceptions about diet, medications, and lifestyle while breastfeeding (see Table 1 and curriculum online[24]).

Additionally, the program included access to a male resource specialist, who was available at each session in person and by phone at all times between sessions, whose role was to provide nonbreastfeeding resources and support relevant to the fathers/partners; this service was intended as an incentive in recognition of the multiple social, financial, legal, and health needs that burden underserved fathers/partners.

Table 1. Fathers' Perceptions of How Much More They Know About Breastfeeding

Do you know more about …	*A lot more*	*A little more*	*About the same*
Week 1 topics ($n=47$)			
How breastfeeding would be for your baby's mother?	30 (64%)	13 (28%)	4 (9%)
What a mother can do to stay healthy while breastfeeding?	28 (60%)	12 (26%)	7 (15%)
The benefits of breastfeeding for your baby?	28 (60%)	13 (26%)	6 (15%)
The benefits of breastfeeding for your baby's mother?	30 (64%)	12 (26%)	5 (11%)
Week 2 topics ($n=47$)			
How breastfeeding can fit into a busy life?[a]	22 (47%)	15 (32%)	9 (19%)
How a baby should latch onto its mother's nipple?[a]	31 (66%)	9 (19%)	6 (13%)
How a baby gets enough milk while breastfeeding?	26 (55%)	14 (30%)	7 (15%)
Week 3 topics ($n=41$)			
How to discuss breastfeeding choices with your partner?	28 (68%)	9 (22%)	4 (10%)
How to help out during the pregnancy of your baby's mother?	29 (71%)	8 (20%)	4 (10%)
How to help out if your baby's mother breastfeeds?	26 (63%)	9 (22%)	6 (15%)
Total responses in each category (of total 450 responses over the entire 2 years of programming)	278	114	58

[a]One subject each gave no response to the question.

Administration of the program

The groups were conducted at community facilities in the City of Cleveland during the interval August 2011–May 2013 and were held one night per week for 3 weeks, repeating four times per year. Fathers/partners were invited to attend all three of the sequential weekly sessions; sign-in was required for participation and to receive incentives, but completion of de-identified demographic and pre/post opinion questionnaires was optional. Transportation, a hot meal, a $10 gift card, and a small gift (warm socks) were offered.

The programming was led by a male facilitator who provided breastfeeding education, with a male resource specialist present to link men to community resources for legal, health, parenting, employment, re-entry, custody issues, and other needs. The facilitator was an African American pastor and the director of Passages, Inc., a faith-based nonprofit in the City of Cleveland dedicated to connecting fathers and families. He had personal experience supporting breastfeeding and used the provided curriculum but did not have formal training; technical questions from attendees were referred to two authors (S.K. and L.F.), and responses were routed back to the facilitator. The male resource specialist was an African American outreach expert, also from Passages, Inc., who was available during and after the sessions in person and by telephone between sessions.

Recruitment and participants

Eligibility criteria for participation for fathers/partners included living in the City of Cleveland and being a father/partner with an expectant partner or children of any age. Fathers/partners of MomsFirst clients (high-risk expectant women) were specifically recruited via a written invitation (a colorful flyer) addressed to the father/partner, given via MomsFirst outreach from community health workers through their expectant female clients to the clients' partner. Fathers/partners were also recruited directly from community programs, including Passages, Inc. and community centers that host MomsFirst programming by both word of mouth and posted flyers. To maintain confidentiality, mothers were not asked to provide any identifying or linking information for their partner. The study was approved by the University Hospitals Case Medical Center Institutional Review Board. Informed consent was waived, and no personal identifiers were collected from participants.

Data collection

All questionnaires were paper-based. Raw data included the sign-in rosters from each group and the questionnaires. The initial questionnaire included basic demographic information. Subsequent pre- and postsession questionnaires focused on fathers' perceptions of how much more they know about breastfeeding regarding breastfeeding topics covered in the curriculum, as well as perceptions of likelihood of wanting their next child to be breastfed. The questionnaires were specific to the session number, assessed the topics that were covered during that session, and were offered before and after sessions as men entered and exited. Men signed in by name or initial in order to receive incentives, but questionnaire completion was voluntary and unsupervised, and questionnaires did not have identifying information and were not reviewed by the facilitator; this was explained both verbally and on the questionnaires to mitigate any social desirability bias.

Outcome measures

The primary outcome measure was self-endorsed changes in knowledge and attitudes about breastfeeding as measured by questionnaire. Literature review did not identify a breastfeeding knowledge and attitude questionnaire validated for men of potentially low health literacy, so the questionnaires were designed by the investigators and tested for face validity only. The prompt related to each breastfeeding content topic (knowledge) began ''Do you know more about…[content area]'' and offered three possible responses for the specific topic: ''a lot more,'' ''a little more,'' and ''about the same.'' Men were asked about content topics covered during the specific session only. The question related to plans for future children, ''Are you more or less likely to want your next baby to breastfeed?,'' assessed fathers' perceptions of likelihood of wanting their next child to be breastfeed, was asked after each session, and had three possible responses: ''less likely,'' ''more likely,'' and ''not sure.'' Men were also asked if they had talked with their partner about breastfeeding since the last session, how the conversation went, why they returned, if they had spoken with the resource specialist, and, if so, about what.

Data analysis

Program attendance was summarized in frequencies and percentages for each of the sessions. Continuous variables were summarized using means, medians, and ranges as appropriate, and nominal variables were summarized using frequencies and percentages. Responses to categorical knowledge and opinion questions were described as ''pre'' and ''post'' for each educational session, with missing responses noted but no values imputed. All father/partner data were de-identified to facilitate attendance and per request of our community partners and thus could not be linked to maternal feeding outcomes. No tests of significance were conducted because the program was not designed to test a specific hypothesis. A sample size calculation was not performed for the father program because the duration of funding guided enrollment.

Results

Over the 2-year period of the intervention, 66 fathers and partners attended a total of eight father evening programs, each comprising three consecutive weekly evenings. Thirty of the men (45%) attended all three sessions, 12 (18%) attended two sessions, and 24 (36%) attended one session only (Table 2). Their median age was 27.5 years (range, 17–64 years), and 49 (74%) self-described themselves as African American, eight (12%) as white, and four (6%) as Hispanic. Their median number of children was two (range, none to 13; 43 men reporting), their median age at the birth of the first child was 21 years (range, 13–32 years; 39 reporting), and 32 (57%) said their children lived with them full- or part-time, 12 (21%) did not live with their children, and 12 (21%) were still expecting (of 56 reporting if their partner was or was not pregnant). Regarding breastfeeding, 39% (21/54 responding)

Table 2. Attendance at Father Evening Programs

	Session[a]								Total attendees
	A	B	C	D	E	F	G	H	
Attended any 1 evening	4	0	1	2	7	4	4	2	24
Attended any 2 evenings	3	0	0	1	1	4	1	2	12
Attended all 3 evenings	0	5	8	14	0	0	3	0	30
Total attendees per session	7	5	9	17	8	8	8	4	66

[a]Each session included three consecutive weekly evenings.

had a child who was breastfed, 64% (39/61 responding) said they were comfortable with breastfeeding for their own child, and 80% (49/61 responding) thought it was a good idea for mothers to breastfeed.

Of the 52 men who returned and attended the second or third evening, 48 completed a questionnaire prior to the session. Twenty-eight men (58%) had talked with their partner about breastfeeding in the interim; anecdotally the facilitator reported that several men told him that they were hoping to obtain the partner's support for choosing to breastfeed. Thirty men (63%) said the conversation was ''good'' or ''okay,'' whereas several expressed disappointment with what they perceived as the mother's lack of interest. When asked why they came back, 31% (15/40 responding) wanted to learn more about breastfeeding, 8% (4/40) wanted to utilize the father resource specialist, and 38% (18/40) came back for both reasons.

Men were asked to complete anonymous questionnaires after each session: 98% (47/48), 94% (47/50), and 95% (41/43) completed these at the first, second, and third sessions, respectively. After Sessions 1, 2, and 3, respectively, 40/47 (85%), 42/47 (89%), and 33/41 (80%) were ''more likely'' to want their next baby to breastfeed. Postsession self-assessment of fathers' perceptions of how much more they know about breastfeeding is summarized in Table 1. In 62% of responses (278 of 450 possible responses; see Table 1), men endorsed learning ''a lot more'' about the breastfeeding curriculum topics that had been presented during the specific session, with the greatest gains in ''how to help out during the pregnancy of your baby's mother'' (71% ''a lot more'') and the least improvement in ''how breastfeeding can fit into a busy life'' (47% ''a lot more'').

Men were able to meet with a resource specialist at each session. Seventy percent of men (95/135) reported meeting with the resource specialist, with the topics most frequently discussed including parenting questions (49 mentions), men's health concerns (41 mentions), employment assistance (20 mentions), and custody issues (seven mentions).

Discussion

In tandem with a breastfeeding support and promotion program for high-risk inner-city expectant women, we created a father-friendly breastfeeding education program for fathers/partners. The 66 men who attended (mean age, 27.5 years; 74% African American) reported an improvement in their perceptions of how much more they know about breastfeeding after the program. Sixty-two percent of responses endorsed ''learned a lot more'' about the 10 breastfeeding topics presented, and 85% of responses indicated those who attended were ''more likely'' to want their next baby to breastfeed. The program is culturally competent, can be taught by a lay educator, and is fully replicable, with the curriculum available at no cost. This work contributes to the literature on engaging fathers/partners in breastfeeding support by describing a community-based prenatal program that successfully recruited inner-city, predominantly African American fathers/partners and demonstrated positive changes in fathers' perceptions of how much more they know about breastfeeding related to the weekly topics presented and in their perceptions of the likelihood of wanting their next child to be breastfed.

A recent systematic review of breastfeeding education and promotion programs for fathers identified just four interventions with a rigorous study design that included a control group.[25] All studies showed a positive impact of programming on maternal breastfeeding initiation or exclusivity and included low-income participants, and all noted issues with recruitment and retention of male participants.[11–16] All additionally used directed recruitment via the index mother, either at WIC or following delivery in the hospital. The programs are difficult to compare with our work due to the location and design of the interventions. Two studies were based outside of the United States, three were hospital based and included a single session only, and just one program used a lay facilitator as we did. Studies published after the cited review with randomized controlled study designs include a hospital-based intervention from Canada with a single 15-minute ''co-parenting intervention'' with video and Web site availability; the authors found an increase in any breastfeeding at 12 weeks in the intervention group, which was a secondary outcome for the study.[17] Additionally, a randomized controlled trial from Australia that included both an antenatal educational component and postnatal support demonstrated a significantly better rate of any breastfeeding at 6 weeks of an enviable 81.6% in the intervention group compared with 75.2% in the control group (odds ratio = 1.46; 95% confidence interval, 1.01–2.13).[18]

Other studies that have examined breastfeeding programs for fathers include a WIC-based pilot Peer Dad Program that demonstrated an increase in breastfeeding initiation but not duration among (predominantly Hispanic) couples who enrolled, compared with those who did not.[19,20] Two other studies with quasi-experimental designs that included couples education both demonstrated increases in exclusive breastfeeding but are less readily comparable due to locations in Vietnam and Turkey.[21,22] In summary, even very brief programming directed at educating fathers about breastfeeding appears to have a significant impact on paternal attitudes and knowledge, as well as maternal breastfeeding rates.

Our study contributes to this literature by piloting a multiple-session prenatal breastfeeding education program for fathers/partners that is based in the community, rather than at a health facility or hospital, and that uses a lay facilitator, rather than a healthcare professional. The strengths of this study include the ability to engage and recruit men without directed identification of the partner, which may be preferable for confidentiality in high-risk settings. The novel approach of including a men's resource specialist appeared to be a well-used benefit and may be particularly helpful in

drawing fathers/partners from low-income inner-city settings for whom access to information about jobs, re-entry, child support, and men's health is perceived as difficult.[26] The program is replicable and low cost and includes elements that support recruitment. We had planned for a larger group size with full continuity among the three sessions; a limitation, shared with other like studies, was the challenge of recruitment and retention of participants.

We had to balance the desire to measure the impact of the educational sessions with realistic expectations for questionnaire completion, so an additional limitation is that all knowledge change was self-described and thus reflected the individual father's perception of how much more he knew about breastfeeding after the sessions. There was a potential for social desirability bias in the questionnaire responses; however, questionnaires included no identifiers and were not reviewed by the facilitator, and completion was not required to receive program incentives. Finally, the questionnaires were tested for face validity only.

However, the major limitation of the study is that we were unable to measure changes in rates of breastfeeding: all information was de-identified, and thus we could not link to maternal outcomes.

Conclusions

Recruitment of inner-city fathers/partners for a community-based prenatal breastfeeding education program was feasible, and among men who attended, their perceptions of how much more they knew about breastfeeding and of the likelihood of wanting their next child to be breastfed were positively impacted. Father-friendly elements of program design that appear to contribute to success in this high-risk population included a father-focused curriculum, facilitation by a lay peer educator, availability of a resource specialist, and location of groups within the community. As lay and professional stakeholders work to achieve Healthy People 2020 goals for breastfeeding, the role of the father/partner in supporting breastfeeding is a key potential component of progress and success.[27] Given the known health disparities associated with breastfeeding rates, a focus on engaging inner-city and African American fathers/partners should be a high priority.

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Disclosure Statement

No competing financial interests exist.

References

1. World Health Organization. Breastfeeding. 2013. Available at www.who.int/topics/breastfeeding/en/ (accessed October 24, 2013).
2. American Academy of Pediatrics Section on Breastfeeding. Breastfeeding and the use of human milk. *Pediatrics* 2012;129:e827–e841.
3. Healthy People Maternal Infant and Child Health Objectives. Infant Care: MICH 21. Available at www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26 (accessed June 28, 2011).
4. Centers for Disease Control and Prevention. Breastfeeding Among U.S. Children Born 1999–2007, CDC National Immunization Survey. Provisional Breastfeeding Rates by Socio-demographic Factors, Among Children Born in 2007 (Percent ± Half 95% Confidence Interval). Available at www.cdc.gov/breastfeeding/data/NIS_data/2007/socio-demographic_any.htm (accessed June 28, 2011).
5. USDA/FNS Supplemental Food Programs Division WIC Breastfeeding Data Local Agency Report. Available at www.fns.usda.gov/sites/default/files/FY2011-BFdata-localagencyreport.pdf (accessed April 12, 2015).
6. Alexander A, O'Riordan MA, Furman L. Do breastfeeding intentions of pregnant inner-city teens and adult women differ? *Breastfeed Med* 2010;5:289–296.
7. Rose VA, Warrington VO, Linder R, et al. Factors influencing infant feeding method in an urban community. *J Natl Med Assoc* 2004;96:325–331.
8. Avery AA, Magnus JH. Expectant fathers' and mothers' perception of breastfeeding and formula feeding: A focus group study in three US cities. *J Hum Lact* 2011;27:147–154.
9. Nickerson LE, Sykes AC, Fung TT. Mothers' experience of fathers' support for breast-feeding. *Public Health Nutr* 2012;27:1–8.
10. Sipsma HL, Divney AA, Magriples U, et al. Breastfeeding intentions among pregnant adolescents and young adults and their partners. *Breastfeed Med* 2013;8:374–380.
11. Wolfberg AJ, Michels KB, Shields W, et al. Dads as breastfeeding advocates: Results from a randomized controlled trial of an educational intervention. *Am J Obstet Gynecol* 2004;191:708–712.
12. Sciacca JP, Dube DA, Phipps BL, et al. A breast feeding education and promotion program: Effects on knowledge, attitudes, and support for breast feeding. *J Community Health* 1995;20:473–490.
13. Sciacca JP, Phipps BL, Dube DA, et al. Influences on breast-feeding by lower-income women: An incentive-based, partner-supported educational program. *J Am Diet Assoc* 1995;95:323–328.
14. Pisacane A, Continisio GI, Aldinucci M, et al. A controlled trial of the father's role in breastfeeding promotion. *Pediatrics* 2005;116:e494–e498.
15. Susin LR, Giugliani ER. Inclusion of fathers in an intervention to promote breastfeeding: Impact on breastfeeding rates. *J Hum Lact* 2008;24:386–392.
16. Susin LR, Giugliani ER, Kummer SC, et al. Does parental breastfeeding knowledge increase breastfeeding rates? *Birth* 1999;26:149–156.
17. Abbass-Dick J, Stern SB, Nelson LE, et al. Coparenting breastfeeding support and exclusive breastfeeding: A randomized controlled trial. *Pediatrics* 2015;135:102–110.

18. Maycock B, Binns CW, Dhaliwal S, et al. Education and support for fathers improves breastfeeding rates: A randomized controlled trial. *J Hum Lact* 2013;29:484–490.
19. Lovera D, Sanderson M, Bogle ML, et al. Evaluation of a breastfeeding peer support program for fathers of Hispanic participants in a Texas Special Supplemental Nutrition Program for Women, Infants, and Children. *J Am Diet Assoc* 2010;110:1696–1702.
20. Stremler J, Lovera D. Insight from a breastfeeding peer support pilot program for husbands and fathers of Texas WIC participants. *J Hum Lact* 2004;20:417–422.
21. Bich TH, Hoa DT, Målqvist M. Fathers as supporters for improved exclusive breastfeeding in Viet Nam. *Matern Child Health J* 2014;18:1444–1453.
22. Ozlüses E, Celebioglu A. Educating fathers to improve breastfeeding rates and paternal-infant attachment. *Indian Pediatr* 2014;51:654–657.
23. Furman L, Matthews L, Davis V, et al. Breast for Success: A community-academic collaboration to increase breastfeeding among high-risk mothers in Cleveland. *Prog Community Health Partnersh* 2015 (in press).
24. Breast for Success. Available at www.uhhospitals.org/macdonald/health-and-wellness/pregnancy-resources/lactation-services/breast-for-success/for-fathers (accessed June 7, 2015).
25. Mitchell-Box KM, Braun KL. Impact of male-partner-focused interventions on breastfeeding initiation, exclusivity, and continuation. *J Hum Lact* 2013;29:473–479.
26. Martin SA, Harris K, Jack BW. The health of young African American men. *JAMA* 2015;313:1415–1416.
27. Healthy People 2020 Topics and Objectives; Maternal, Infant and Child Health Goals. U.S. Department of Health and Human Services. Available at www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=26 (accessed June 9, 2015).

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