Evaluation of “Welcome to the World”
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Report Summary:

This report outlines the findings from an evaluation of the Family Links “Welcome to the World” programme, conducted in partnership with researchers from the University of Hull. Welcome to the World is an 8-week antenatal programme, which aims to support expectant parents by improving parental wellbeing, increasing attunement and bonding to their baby, and developing knowledge and skills in breast-feeding and practical care.

131 participants from 18 parent groups completed evaluation booklets, which included the Edinburgh Postnatal Depression Scale (EPDS) for emotional wellbeing, the Pictorial Representation of Attachment Measure (PRAMS) and the Maternal/Partner Infant Bonding Scale (MIBS) for attunement and bonding. Data was collected at the start and end of the programme, and at a follow-up at the reunion session approximately 3 – 4 months after programme completion. Data was collected from 77 parents, with complete data sets from all three time points obtained for 54 participants. Additionally, 6 focus groups were conducted with 32 parents, along with 9 telephone interviews with Parent Group Leaders (PGLs).

Results showed that there was a statistically significant reduction in MIBS scores, showing that parents were displaying a more positive attitude to their baby. Additionally, there was a significant increase in perceived coping, and women showed a significant decrease in EPDS scores, indicating improvements in psychological wellbeing. There were no significant changes in PRAM scores.

Findings from focus groups suggest that the programme was perceived as positive and helpful by parents, who commented that it provided them with a safe, non-judgemental space to discuss concerns and ask questions. Parents felt the programme had a positive impact on their interaction with their babies, their relationship with their partner, their post-natal coping, and on their emotional wellbeing. PGL interviews suggest that PGLs are enthusiastic and committed to the programme, and are ensuring effective recruitment, and inclusive and engaging delivery.

Family Links are very grateful to Catriona Jones, Dr Fran Wadephul and Professor Julie Jomeen from the Faculty of Health and Social Care, University of Hull, for conducting this research. We would also like to thank the participants who took part in this study, and to the practitioners for sharing data which enables increased understanding of how WTTW impacts on expectant parents.

Family Links is committed to conducting and commissioning rigorous and innovative evaluations of our work with children, families and teachers. If you would like to find out more, please visit us at www.familylinks.org.uk or get in touch at research@familylinks.org.uk.
Evaluation of Welcome to the World

Final report

Prepared by Catriona Jones, Senior Research Fellow, and Dr Fran Wadephul, Research Assistant, Faculty of Health and Social Care, University of Hull

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Co-Investigators: Professor Julie Jomeen, Dr Fran Wadephul, Faculty of Health and Social Care, University of Hull, Dawn Harris (Senior Researcher) Family Links, Shirley Stephenson (Head of Programme Quality), Family Links
Executive summary
The purpose of this report is to outline the findings of the 12 month study ‘Evaluation of Welcome to the World’. Qualitative and quantitative data have been collected across 3 time points of the programme; the introduction week, the final week and the reunion session (approximately 3 – 4 months after completion of the programme).

The evaluation uses a number of evidence based measures; the Edinburgh Postnatal Depression Scale (EPDS) for emotional wellbeing, the Pictorial Representation of Attachment Measure (PRAMS) and the Maternal/Partner Infant Bonding Scale (MIBS) for attunement and bonding. Localities for inclusion in the evaluation were Armagh, Coventry, Bingley (2 groups), Bristol (2 groups), Cookstown, Stanley, Bridlington, Barry, Caterham, Allerton, Creggan, Bradford (3 groups), Liverpool, and Cwmbran. Data collection using the evaluation booklets commenced in October 2015 and was completed by end of August 2016. Focus groups took place between March 2016 and July 2016 and telephone interviews with PGLs were carried out in July, August and September.

A total of 131 participants (96 women, 35 men) completed evaluation booklets; 77 (58 women, 19 men) did so at T1 and T2 and 54 (43 women, 11 men) at all three time points. A total of 32 participants took part in the six focus groups; and nine Parent Group Leaders (PGLs) took part in the telephone interviews.

Findings: Quantitative
While the descriptive analysis suggests that there are improvements over time in all of the variables assessed in this evaluation, statistically analysis found only some significant changes:

- a significant reduction in MIBS scores between T1 and T2, T2 and T3, and T1 and T3, i.e. a more positive attitude towards the baby;
- for women, a significant decrease in EPDS scores between T1 and T2 and T1 and T3, i.e. an increase in psychological wellbeing;
- a significant increase in the coping scale score from T1 to T2 T1 to T3, i.e. increased perceived coping;
- no significant change in PRAM scores.

Findings: Qualitative
Open-ended questions: Participants expected to gain knowledge, gain confidence, feel supported and make connections from attending the sessions. Generally speaking all expectations were met across the timepoints.

Focus Group Discussions: Participants in the focus group experienced the WTTW programme as very positive and helpful; it provided them with a safe, non-judgemental place in which to discuss concerns and ask questions. For many participants the programme has had a positive impact on how they interact with their babies, their relationship with their partner, how they cope after the birth, and on their emotional wellbeing.

PGL interviews: Qualitative data from PGL interviews suggests that generally PGLs seem to be very enthusiastic and committed to providing the programme, ensuring good effective recruitment and delivering an inclusive, engaging programme.
Conclusion
Welcome to the World appears to play an important part in preparing parents for parenting specifically in the areas identified; improvements in attunement, bonding and attachment, parental wellbeing, breastfeeding, and practical care. Parents seem satisfied with the programme, and the way in which it is delivered. It meets their expectations. The qualitative and quantitative data combined suggests that the WTTW sessions have a significant role to play in achieving the 5 programme outcomes. Thus, parents engaging with the programme experience positive communication between each other, an understanding of their baby’s needs, an understanding of their own emotional health needs, a greater understanding of their roles as parents, and an increased understanding of the benefits of breastfeeding. PGLs are extremely enthusiastic and committed to the programme; they have a vital role to play in ensuring the sustainability of the programme, and they are key to successful recruitment.
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1 INTRODUCTION

1.1 Background

Supporting parents to develop effective parenting skills, including those around bonding and attachment, have been recognised as an important prevention and intervention strategy. A number of antenatal parenting programmes have been developed over the last few decades to support the mother-infant/child relationship (e.g. Guttentag et al 2014; Olds 2006) and a variety of approaches and models exist on which these programmes are based. In the United Kingdom (UK) a range of antenatal parenting programmes are available to expectant parents, which are based on skill acquisition, strengthening relationships, behaviour management, parent education and support, and improving parenting skills on an emotional and practical level.

This study is aimed at evaluating the efficacy of an antenatal parenting programme delivered by Family Links. The programme, called Welcome to the World (WTTW), is an 8-week (9-weeks including the introductory session) programme designed to help parents prepare for childbirth. Sessions are focused around aspects of childbearing such as improving attunement and bonding, improving parental wellbeing, improving skills in breastfeeding and improving practical care of the baby.

Parent Group Leaders (PGLs), trained by Family Links, deliver the 9-week programme to parents-to-be who have either self-referred onto the programme or have been referred through locally agreed arrangements between the Family/Children’s Centre and a range of other support services. The collective backgrounds of PGL’s can range from Health Visiting, Social Work, Midwifery, Children’s Centre Support Staff and Early Years Staff. To the best of our knowledge, WTTW is not routinely used as part of an NHS referral pathway.

Family Links routinely undertake evaluations across all sites delivering WTTW, however previous evaluations have used measures such as the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) to assess the impact of the programme on changes in wellbeing, and the Maternal Antenatal Attachment Scale (MAAS) and Paternal Antenatal Attachment Scale (PAAS) to assess the impact of the programme on attunement, bonding and attachment. Group discussions to evaluate the programmes have also been undertaken routinely, as have telephone interviews with those delivering the programmes (PGLs).

In order to take into account participants’ experiences of WTTW, feedback from previous evaluations has guided the design of this study. This evaluation uses a number of new evidence-based measures for the evaluation exercise. The Edinburgh Postnatal Depression Scale (EPDS) for emotional wellbeing, the Pictorial Representation of Attachment Measure (PRAMS) and the Maternal-to-Infant Bonding Scale (MIBS) for bonding. The evaluation employs a more robust framework than previous years with a specific focus on trying to establish if the programme has a measurable effect on attunement, bonding, and attachment, coping with being a new parent and emotional wellbeing.

This evaluation fills a gap in relation to whether antenatal nurturing programmes like WTTW have an impact upon important aspects of parenting: attachment and bonding, practical parenting and emotional wellbeing.
1.2 Aims and research questions

This study comprises a 12 month mixed methods approach to evaluate the efficacy of the WTTW programme in achieving its programme aims.

The specific aim of the study is

- To evaluate whether attending the Welcome to the World programme improves outcomes for parents-to-be during the transition to parenthood

The objectives of the study are to establish

- If the Welcome to the World programme is effective in preparing parents-to-be for parenthood, specifically around improvements in 4 keys areas: attunement, bonding and attachment, parental wellbeing, breastfeeding and practical care
- The extent to which programme outcomes are being achieved
- The factors affecting the successful implementation of the programme

1.3 Adverse events

When first sets of quantitative data were received at the University, it became clear that some participants had very high responses to the Edinburgh Postnatal Depression Scale (EPDS); one question specifically caused some concern within the evaluation team as a number of participants had answered positively to a question around self-harm and suicidal thoughts. As a team we acted quickly to ensure that these participants were followed up appropriately; a protocol was put in place to ensure that any high scores and positive responses were acted on as soon as the data was viewed by an evaluation team member at Family Links prior to passing the data onto the University team. The cut-off points above which action was taken were based, as much as possible, on research evidence. A review of validated EPDS cut-off points for women recommends 15 and above antenatally and 13 and above postnatally (Matthey, Henshaw, Elliott & Barnett 2006); however, we decided to use a lower cut-off point antenatally (14 and above) in order to improve outcomes for potentially vulnerable women. There is less research into appropriate cut-off points for men, but there is evidence that cut-off points should be lower for men (Matthey, Barnett, Kavanagh & Howie 2001). We decided to use 6 and above antenatally and 10 and above postnatally; these are, however, less robust than the cut-off points for women’s EPDS scores.

It is important to note that the EPDS is well utilised in research internationally and provided there is a clear action plan for dealing with high scores, this approach to its use is ethically acceptable. The EPDS is validated as a self-report tool not an administered measure. It is an indication of possible or probable depression not a diagnostic tool - it indicates the need for further assessment only, which is what our protocol ensures.
1.4 Recruitment to the evaluation advisory and management group

An advisory group has been formed and meet to discuss the appropriateness of the study, and to assist in various aspects of the study. Our plan was always to convene this group at the start of the study and 3 months into the evaluation. To date the group have met in November 2015, February 2016, May 2016 and July 2016; a final meeting took place in October to discuss the report and recommendations. The representatives of this group who include the evaluation team members and a service user and PGL are involved in aspects such as refining the methodology and assisting in interpreting the data. The management group for the evaluation (the project team) have met regularly throughout the course of the evaluation, normally on a monthly basis.
2 METHODOLOGY

2.1 Study design

This evaluation used a longitudinal mixed methods design in order to capture the complex processes and outcomes involved. A mixed methods approach allows a degree of triangulation, thus strengthening the reliability of the data and the validity of the findings and recommendations. Furthermore, such an approach broadens and deepens our understanding of the processes through which programme outcomes and impacts are achieved, and how these are affected by the context within which the programme is implemented (Bamberger 2012). Quantitative data were collected using measures assessing relationship to the baby, parental wellbeing, perceived coping, and parenting self-efficacy. Three types of qualitative data were used: focus group discussions with programme attendees, telephone interviews with Parent Group Leaders (PGLs), and open-ended questions for programme attendees. In addition, case studies drawing on qualitative and quantitative data were completed for six participants.

Quantitative data and qualitative data from the open-ended questions were collected in evaluation booklets at three time points: during Week 0 (T1) and Week 8 (T2) of the programme and at the postnatal reunion, 2 weeks to 4 months after birth (T3). Focus groups took place after completion of the programme; most participants had already given birth at this point, but a minority were still pregnant.

2.2 Procedure

2.2.1 Evaluation venues

The venues for the WTTW programme tend to be local authority centres such as Family and Children Centres. A number of localities for inclusion in the evaluation were identified by Family Links: Armagh, Coventry, Bingley (2 groups), Bristol (2 groups), Cookstown, Stanley, Bridlington, Barry, Caterham, Allerton, Creggan, Bradford (3 groups), Liverpool, and Cwmbran.

2.2.2 Evaluation process

Data collection using the evaluation booklets commenced in October 2015 and was completed by end of August 2016. Focus groups took place between March 2016 and July 2016 and telephone interviews with PGLs were carried out in July, August and September.

All attendees in the selected WTTW groups received an information leaflet about the evaluation before the start of the programme. During the first session (Week 0) PGLs gave them further information if required. Those who were willing to take part in the evaluation signed consent forms before completing the evaluation booklets during the session. Consent forms and booklets were also completed in Week 8 and at the postnatal reunion session. After completion, participants placed the consent form and evaluation booklet into individual envelopes, which were then collected by the PGL who passed them on to Family Links. Each participant was allocated a participant code and completed evaluation booklets were then forwarded to researchers at the University of Hull, who proceeded with data entry and analysis.
2.2.3 Ethical approval and changes to the protocol

Ethical approval for this evaluation was granted in early October 2015 by the Research Ethics Committee of the Faculty of Health and Social Care at the University of Hull. Subsequently, three amendments were made to the evaluation protocol: in late October we requested a change to the layout and presentation of the evaluation booklets; in December we requested a small change to the focus group design; and in January 2016 we requested a change to the way in which we gained consent from PGLs to undertake telephone interviews. These changes have largely been made in order to maximise the potential for data collection; we were granted chairs action on all occasions.

2.3 Participants

2.3.1 WTTW attendees

Participants who attended the WTTW programme in the selected locations were recruited by PGLs. Inclusion criteria for these participants were that they were attending the programme, were willing to give consent to take part, and were over 16 years of age.

A total of 131 participants (96 women, 35 men) completed evaluation booklets. However, not all participants did so at all three time points: 77 participants (58 women, 19 men) completed booklets for T1 and T2 and 54 (43 women, 11 men) at all three time points. A total of 32 participants were recruited by PGLs to take part in the six focus groups; the number of participants in the focus group varied from four to seven.

2.3.2 Parent Group Leaders

Parent Group Leaders were identified by Family Links for participation in telephone interviews. These included PGLs who had run courses included in the evaluation, as well as PGLs who had attempted to run a course which for a number of reasons did not take place. Nine PGLs took part in the telephone interviews.

2.4 Materials

2.4.1 Evaluation booklets

The first evaluation booklet asked for demographic information, including gender, age, relationship status, employment, existing children (number and ages), estimated due date, how participants had heard about the programme, and the location of the course they attended. All evaluation booklets included open-ended questions regarding breastfeeding intention and partner support for breastfeeding; expectations and experiences of the programme; the effect of WTTW on preparation for the early weeks after birth; and expectations for the early postnatal period. The booklet also included the following measures assessing emotional wellbeing, relationship to the baby, perceived coping and parenting self-efficacy.

The Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden & Sagovsky 1987) is widely used in research and clinical practice to screen for potential depression, both in pregnancy and after birth; there is evidence that it also has an anxiety sub-scale (Brouwers, Baar & Pop 2001; Ross, Gilbert Evans,
Sellers & Romach 2003; Jomeen & Martin 2005). The EPDS contains ten items scoring 0 to 3 each, resulting in a maximum score of 30, with higher scores indicating higher levels of depressive symptoms.

The Pictorial Representation of Attachment Measure (PRAM; van Bakel, Maas, Vreeswijk & Vingerhoets 2013) is a relatively new measure which assesses the closeness of the relationship to the baby non-verbally. Participants are provided with an A4-size sheet of paper with a 5cm circle in the middle representing themselves. They are then asked to place a 5cm sticker representing the baby on the sheet of paper where they would place the baby in their life at that moment. The distance between the centre of the two circles is then measured in centimetres. The Self-Baby Distance (SBD) can range from 0 to 93.0 mm, with a shorter distance indicating stronger feelings of ‘attachment’.

The Mother-to-Infant Bonding Scale (MIBS; Taylor, Atkins, Kumar, Adams & Glover 2005) is a self-assessment tool which uses eight adjectives to describe the baby; parents are asked to rate how strongly the adjective applies to them on a 4-point Likert scale, resulting in a score ranging from 0 to 24, with lower scores indicating more positive attitudes towards the baby.

A 5-point Likert scale was included to assess perceived coping, with higher scores indicating higher levels of perceived coping. At the first two time points the scale referred to parents’ expectations of how they would cope after the birth of their baby; at the third time point the scale related to how parents felt they were coping at that time.

The Perceived Maternal Parenting Self-Efficacy tool (PMP S-E; Barnes & Adamson-Macedo 2007) assesses parents’ perceived self-efficacy in 20 baby-related tasks, i.e. their belief in being able to successfully carry out these tasks. Each task is scored from one to four resulting in a maximum score of 80, with a higher score indicating higher self-efficacy. This scale was only included at the postnatal time point (T3).

2.4.2 Focus groups and telephone interviews
A schedule was used to guide questions and prompts for the focus groups discussions. Questions centred around their experience of attending the programme, communication and interaction with their baby, practical care of the baby, relationships and support. An interview schedule was used to guide the telephone interviews with PGLs; questions focused on the PGLs’ experience of running WTTW groups, their thoughts on the programme in general, and any challenges they encountered while setting up or running groups. All focus group discussions and telephone interviews were audio recorded and transcribed.

2.5 Analysis
2.5.1 Quantitative data
Quantitative data was entered into SPSS for further analysis. Demographic data was analysed descriptively and summarised. Changes over the three time points in relationship to the baby, parental emotional wellbeing, and perceived coping for women and men were analysed descriptively and presented in graphs. To explore whether any of these changes were statistically significant, Friedman’s ANOVA was carried out. This is a non-parametric alternative to ANOVA with repeated measures, which was chosen because data for all outcome variables was heavily positively (MIBS, PRAM, EPDS) or
negatively (perceived coping) skewed and consequently did not meet assumptions of normality. For those variables for which a Friedman’s ANOVA found a significant difference over time, a Wilcoxon signed-rank test was carried out to ascertain at which point significant differences occurred. Parenting self-efficacy scores were analysed descriptively and Mann-Whitney U tests were carried out to compare differences based on gender and age. It is important to note that the statistical analysis of the data is limited by the low number of participants (54) who completed questionnaires at all three time points, particularly for men (11).

2.5.2 Qualitative data
Interviews with PGLs, focus group discussions and responses to open-ended questions in the evaluation booklets were analysed separately using thematic analysis (Braun and Clarke 2006). Themes and subthemes were identified and summarised. Case studies for six participants who had attended WTTW were based on demographic information, quantitative data from the questionnaires and responses to the open-ended questions contained in the evaluation booklets.
3 RESULTS

3.1 Quantitative results

3.1.1 Demographic characteristics

The number of participants who completed booklets at each of the time points varied between locations (Table 1). The large drop-out of participants does not necessarily indicate that participants have dropped out of the evaluation itself, but is also likely to reflect that they have dropped out of the programme. In addition, there may have been some organisational challenges around the return of the booklets; for example, not all groups had a re-union which made it difficult to obtain T3 data. It is not unusual for drop-out rates in studies of similar antenatal interventions to be relatively high (Wadephul, Jones & Jomeen 2016). The demographic characteristics (gender, relationship status, employment, parity, age) for all participants and for those with data for all three time points are shown in Table 2.

Table 1 Number of participants in each location who completed evaluation at different time points (figures in brackets are for women/men)*

<table>
<thead>
<tr>
<th>Location</th>
<th>T1 only</th>
<th>T1 &amp; T2</th>
<th>T1, T2 &amp; T3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armagh</td>
<td>3 (3/0)</td>
<td>1 (1/0)</td>
<td>4 (4/0)</td>
</tr>
<tr>
<td>Bingley 1</td>
<td>0</td>
<td>3 (1/2)</td>
<td>3 (3/0)</td>
</tr>
<tr>
<td>Bristol 1</td>
<td>3 (2/1)</td>
<td>0</td>
<td>6 (4/2)</td>
</tr>
<tr>
<td>Cookstown</td>
<td>0</td>
<td>3 (2/1)</td>
<td>9 (6/3)</td>
</tr>
<tr>
<td>Durham</td>
<td>4 (2/2)</td>
<td>5 (3/2)</td>
<td>0</td>
</tr>
<tr>
<td>Bridlington</td>
<td>2 (1/1)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Barry</td>
<td>2 (2/0)</td>
<td>0</td>
<td>5 (5/0)</td>
</tr>
<tr>
<td>Caterham</td>
<td>0</td>
<td>5 (3/2)</td>
<td>2 (2/0)</td>
</tr>
<tr>
<td>Bristol 2</td>
<td>3 (2/1)</td>
<td>0</td>
<td>4 (2/2)</td>
</tr>
<tr>
<td>Bradford 1</td>
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<td>0</td>
<td>4 (3/1)</td>
</tr>
<tr>
<td>Creggan</td>
<td>4 (3/1)</td>
<td>0</td>
<td>3 (3/0)</td>
</tr>
<tr>
<td>Bradford 2</td>
<td>4 (4/0)</td>
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<td>1 (1/0)</td>
<td>1 (1/0)</td>
<td>5 (3/2)</td>
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<td>0</td>
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<td>0</td>
<td>7 (6/1)</td>
</tr>
<tr>
<td>Cwmbran</td>
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<td>2 (2/0)</td>
</tr>
<tr>
<td>Bradford 3</td>
<td>6 (6/0)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>131 (95/36)</td>
<td>37 (28/9)</td>
<td>23 (15/8)</td>
</tr>
</tbody>
</table>

* The numbers for the different time points do not necessarily add up to the total for each location as some participants completed evaluations at different combinations of time points, e.g. T1 and T3.

As shown in Table 2, there are some differences in the characteristics of participants depending on their level of participation: the more time points participants completed, the more likely were they to be married, in paid employment, expecting their first baby, and slightly older. There are also differences in terms of baseline levels for EPDS, PRAM, and MIBS scores: those who completed all three evaluation booklets had lower scores on the EPDS and felt closer and more positive towards
their baby. It does therefore appear that those who might be most in need of taking part in the WTTW programme were least engaged in the evaluation. It is, however, not clear whether they were not engaged in the programme itself or just in the evaluation.

Table 2  Demographic characteristics of participants

<table>
<thead>
<tr>
<th>Demographic characteristics</th>
<th>All participants (n=131)</th>
<th>Participants who completed only T1</th>
<th>Participants who completed T1 and T2</th>
<th>Participants with 3 TPs</th>
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<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women (%)</td>
<td>72.5</td>
<td>75.7</td>
<td>60.9</td>
<td>79.6</td>
</tr>
<tr>
<td>Men (%)</td>
<td>27.5</td>
<td>24.3</td>
<td>39.1</td>
<td>20.4</td>
</tr>
<tr>
<td>Relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married (%)</td>
<td>46.6</td>
<td>40.5</td>
<td>43.5</td>
<td>53.7</td>
</tr>
<tr>
<td>Living with partner (%)</td>
<td>36.6</td>
<td>35.1</td>
<td>43.5</td>
<td>37.0</td>
</tr>
<tr>
<td>Single (%)</td>
<td>11.5</td>
<td>21.6</td>
<td>13.0</td>
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</tr>
<tr>
<td>Other (%)</td>
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<td>2.7</td>
<td>-</td>
<td>1.9</td>
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<tr>
<td>Missing (%)</td>
<td>3.8</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paid employment (%)</td>
<td>61.8</td>
<td>40.5</td>
<td>60.9</td>
<td>81.5</td>
</tr>
<tr>
<td>No paid employment (%)</td>
<td>26.7</td>
<td>48.6</td>
<td>34.8</td>
<td>14.8</td>
</tr>
<tr>
<td>Missing (%)</td>
<td>11.5</td>
<td>10.8</td>
<td>4.3</td>
<td>3.7</td>
</tr>
<tr>
<td>Parity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First baby (%)</td>
<td>70.2</td>
<td>67.6</td>
<td>69.6</td>
<td>75.9</td>
</tr>
<tr>
<td>Second (%)</td>
<td>10.7</td>
<td>10.8</td>
<td>17.4</td>
<td>9.3</td>
</tr>
<tr>
<td>Third (%)</td>
<td>11.5</td>
<td>16.2</td>
<td>13.0</td>
<td>11.1</td>
</tr>
<tr>
<td>Fourth+ (%)</td>
<td>3.1</td>
<td>51.4</td>
<td>-</td>
<td>3.7</td>
</tr>
<tr>
<td>Missing (%)</td>
<td>4.6</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Age</td>
<td>All (years)</td>
<td>28.5 (SD 5.58)</td>
<td>27.6</td>
<td>28.4</td>
</tr>
<tr>
<td></td>
<td>(min-max)</td>
<td>(17-50)</td>
<td>(17-50)</td>
<td>(18-39)</td>
</tr>
<tr>
<td></td>
<td>≤ 19 years (%)</td>
<td>6.6%</td>
<td>10.8%</td>
<td>8.6%</td>
</tr>
<tr>
<td></td>
<td>Missing (%)</td>
<td>7.6%</td>
<td>-</td>
<td>4.3%</td>
</tr>
<tr>
<td>Baseline outcome measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EPDS at T1</td>
<td>7.7</td>
<td>8.5</td>
<td>9.8</td>
<td>6.4</td>
</tr>
<tr>
<td>PRAM at T1</td>
<td>20.9</td>
<td>25.0</td>
<td>23.5</td>
<td>16.5</td>
</tr>
<tr>
<td>MIBS at T1</td>
<td>1.4</td>
<td>1.5</td>
<td>2.1</td>
<td>0.9</td>
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<tr>
<td>Coping at T1</td>
<td>3.9</td>
<td>3.9</td>
<td>3.7</td>
<td>3.9</td>
</tr>
<tr>
<td>EPDS above cut-off* at T1</td>
<td>13.7</td>
<td>14.3</td>
<td>42.9</td>
<td>4.7</td>
</tr>
<tr>
<td>(women) (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EPDS above cut-off* at T1</td>
<td>30.6</td>
<td>22.2</td>
<td>50.0</td>
<td>45.5</td>
</tr>
<tr>
<td>(men)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* cut-off points: 14 and above for women antenatally, 13 and above for women postnatally, 6 and above for men antenatally, 10 and above for men postnatally
3.1.2 Relationship with the baby

The Pictorial Representation of Attachment Measure (PRAM) assesses the sense of ‘closeness’ a parent or prospective parent feels towards their baby. Figure 1 shows the mean PRAM scores, i.e. the Self-Baby Distances (SBDs) in mm, for women and men at the three time points. While this shows a trend towards increased ‘closeness’ for women and men, a Friedman’s ANOVA found no statistically significant difference over time ($\chi^2(2) = 2.653, p = .265$). The SBDs obtained in this evaluation are lower than those in a recent Dutch study, which used the PRAM at 28 weeks gestation and found SBDs of 36.6 and 45.6 for women and men respectively (van Bakel et al 2013).

![Figure 1 Change over time in mean PRAM SBDs (mm) for men and women*](image)

*based on participants with data for all three time points, $n = 54$

The Mother-to-Infant Bonding Scale (MIBS) assesses parents’ attitudes and feelings towards their baby, with a lower score indicating more positive attitudes and feelings. Figure 2 shows the changes in MIBS scores over time for women and men, suggesting a downward trend for women and an initial increase followed by a decrease for men. It is important to bear in mind, however, that these changes are relatively small. A Friedman’s ANOVA showed a statistically significant difference over time ($\chi^2(2) = 19.735, p < .001$). Post hoc analysis with Wilcoxon signed-rank tests was conducted with a Bonferroni correction applied, resulting in a significance level set at $p < .017$. There was no significant difference in MIBS scores between T1 and T2 ($Z = -1.493, p = .135$). There was a statistically significant reduction in the MIBS score between T1 and T3 ($Z = -2.955, p = .003$) and between T2 and T3 ($Z = -2.686, p = .007$). However, a Wilcoxon signed-rank test with all data from T1 and T2 (77 participants) showed a significant reduction in scores (i.e. more positive attitudes and feelings towards the baby) over the course of the WTTW programme ($X = -2.658, p = .008$), with a small to medium effect size.

This analysis was carried out using data from women and men together; it is likely that the change would not be significant for men alone. The MIBS scores in this evaluation are comparable to those found in previous research (Taylor et al 2005).
### 3.1.3 Parental emotional wellbeing

Emotional well-being, in terms of depressive and anxiety symptoms, was assessed using the Edinburgh Postnatal Depression Scale (EPDS). Figure 3 shows changes in EPDS scores over time for women and men. While this shows a downward trend for women and an apparent decrease followed by an increase for men, the differences are relatively small and need to be treated with caution, particularly for men as complete data is only available for eleven.

Ideally statistical analysis for EPDS scores would have been carried out to make comparisons between women and men as well as across the three time points using a factorial mixed ANOVA. Due to the low numbers of men it was, however, not possible to carry out the analyses separately. As the cut-off
points differ considerably between women and men (Matthey et al. 2006), it was not considered appropriate to analyse data for women and men jointly. Consequently statistical analysis was carried out only for women for whom data for all three time points were available. Friedman’s ANOVA showed a statistically significant difference over time for women’s EPDS scores ($\chi^2(2) = 10.148$, $p = .006$). Post hoc analysis with Wilcoxon signed-rank tests was conducted with a Bonferroni correction applied, resulting in a significance level set at $p < .017$. There was no significant difference in EPDS scores between T1 and T2 ($Z = -1.738$, $p = .082$) and between T2 and T3 ($Z = -1.668$, $p = .095$). There was, however, a statistically significant change in EPDS scores between T1 and T3 ($Z = -2.579$, $p = .010$). It is, however, important to bear in mind that EPDS scores tend to be higher in pregnancy (resulting in a higher cut-off score antenatally) (Matthey et al. 2006) and therefore this change may not signify a true reduction in depressive symptoms.

In a separate analysis of all T1 and T2 data (77 participants), a Wilcoxon signed-rank test found a significant reduction in women’s EPDS scores from T1 to T2 ($Z = -2.297$; $p = .022$) with a small to medium effect size, but no change in men’s scores. A large proportion of women who only completed booklets at T1 and T2 (but not T3) scored above the cut-off point on the EPDS (Table 2); scores for these women appear to have improved considerably.

Out of the 43 women who completed all three time points, four scored above the cut-off point (14 and above antenatally, 13 and above postnatally) on at least one time point (Table 3). Three of these women had high scores on T1, T2 or both; for all of them scores were below the cut-off point at the postnatal time point. One woman, however, had low scores in pregnancy and a considerably raised score postnatally, indicating a high likelihood of postnatal depression. At T1, 4.7% of the 43 women who completed all booklets scored above the cut-off point; at T3 this had dropped to 2.3%. These figures are lower than those commonly found in pregnant and postnatal women (10 to 15%). Conversely, the percentage of women who completed booklets at T1 and T2 and who scored above the cut-off point is, at 42.9%, very high; most of these women took part in a course which was targeted at emotionally vulnerable participants and which did not run a reunion (i.e. T3 booklets were not completed). Six men scored above the cut-off point (6 or more antenatally, 10 or more postnatally); considering that only 11 men completed evaluation forms at all three time points, this number seems very high. Nevertheless, evidence for cut-off points for men is much less robust than that for women and these figures should therefore be treated with caution. Most of these men show a reduction in the EPDS score from T1 to T2 and a further reduction to the postnatal time point. For two men, however, the EPDS score increases considerably postnatally.

Cochran’s Q tests showed that there was no significant difference in the proportion of women who scored above the EPDS cut-off point (i.e. cases of ‘probable depression’) over all three time points or for TP1 and TP2, i.e. there was no change in the number of cases of ‘probable depression’. These findings suggest that while psychological well-being in women improved over the course of the WTTW programme, the incidence of probable depression was not affected. However, it is important to bear in mind that this sample was relatively small and that the EPDS is a self-report measure which does not diagnose depression.
Table 3  Scores for women and men who scored above the EPDS cut-off point*

<table>
<thead>
<tr>
<th></th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EN16110</td>
<td>16</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>EN11075</td>
<td>14</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>WA08060</td>
<td>11</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>EN16105</td>
<td>6</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EN16107</td>
<td>9</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>EN11078</td>
<td>9</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>EN10071</td>
<td>8</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>EN14096</td>
<td>6</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>GR05031</td>
<td>6</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>GR05032</td>
<td>4</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

* based on participants with data for all three time points; cut-off points: 14 and above for women antenatally, 13 and above for women postnatally, 6 and above for men antenatally, 10 and above for men postnatally; bold numbers indicate scores above the cut-off point

3.1.4 Perceived coping

A five-point Likert scale was used to assess perceived coping, with higher numbers indicating a higher level of perceived coping. The change over time in perceived coping for women and men is shown in Figure 4. While this shows an increase in perceived coping, actual numbers are small. Nevertheless, Friedman’s ANOVA showed a statistically significant difference over time in perceived coping (for women and men jointly) ($\chi^2(2)= 12.881, p = .002$). Post hoc analysis with Wilcoxon signed-rank tests were conducted with a Bonferroni correction applied, resulting in a significance level set at $p < .017$. There was no significant difference in coping scale scores between T1 and T2 ($Z = -1.807, p = .071$) and between T2 and T3 ($Z = -1.869, p = .062$). There was, however, a statistically significant increase in the coping scale score between T1 and T3 ($Z = -2.637, p = .008$). A Wilcoxon’s signed-rank test using all T1 and T2 data (77 participants) showed a significant increase in coping scores from T1 to T2 ($Z = -2.346, p = .019$), with a small effect size.

Figure 4 Change over time in mean perceived coping for men and women*

*based on participants with data for all three time points, n = 54
3.1.5 Parenting self-efficacy

A total of 67 participants (51 women, 16 men) completed the Perceived Maternal Parenting Self-Efficacy (PMP S-E) scale which assesses parents’ perceived sense of self-efficacy. While the mean score for women (74.3) was higher than the mean score for men (68.7), a Mann-Whitney U test showed no significant difference between women and men. There were also no significant differences between those who were younger or older than 25 and between those who expecting their first or subsequent baby. The mean total score for women (74.3) is higher than that found for first-time mothers in an Irish study (65.9) (Leahy-Warren, McCarthy & Corcoran 2012). Mean scores for individual items are shown in Table 4; a higher scores indicates higher levels of perceived self-efficacy. It is interesting to note that the four items relating to ‘I am good at soothing my baby …’ have scored very differently; while three of them attracted some of the lowest scores (indicating less perceived self-efficacy), one had the highest mean score. It is possible that this reflects that parents differentiate between ‘types’ of crying in their baby and cope with these differently, as was discussed in some of the focus groups (see Section 3.2.4).

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can tell when my baby is sick.</td>
<td>3.42</td>
</tr>
<tr>
<td>I am good at soothing my baby when he/she continually cries.</td>
<td>3.42</td>
</tr>
<tr>
<td>I am good at soothing my baby when he/she becomes fussy.</td>
<td>3.48</td>
</tr>
<tr>
<td>I am good at soothing my baby when he/she becomes more restless.</td>
<td>3.52</td>
</tr>
<tr>
<td>I can read my baby’s cues.</td>
<td>3.53</td>
</tr>
<tr>
<td>I am good at knowing what activities my baby does not enjoy.</td>
<td>3.53</td>
</tr>
<tr>
<td>I am good at understanding what my baby wants.</td>
<td>3.56</td>
</tr>
<tr>
<td>I am good at keeping my baby occupied.</td>
<td>3.56</td>
</tr>
<tr>
<td>I am good at getting my baby’s attention.</td>
<td>3.59</td>
</tr>
<tr>
<td>I can make my baby calm when he/she has been crying.</td>
<td>3.62</td>
</tr>
<tr>
<td>I believe that I can tell when my baby is tired and needs to sleep.</td>
<td>3.68</td>
</tr>
<tr>
<td>I am good at feeding my baby.</td>
<td>3.71</td>
</tr>
<tr>
<td>I am good at bathing my baby.</td>
<td>3.71</td>
</tr>
<tr>
<td>I can make my baby happy.</td>
<td>3.76</td>
</tr>
<tr>
<td>I believe that my baby responds well to me.</td>
<td>3.76</td>
</tr>
<tr>
<td>I believe that I have control over my baby’s care.</td>
<td>3.77</td>
</tr>
<tr>
<td>I believe that my baby and I have a good interaction with each other.</td>
<td>3.77</td>
</tr>
<tr>
<td>I am good at changing my baby.</td>
<td>3.85</td>
</tr>
<tr>
<td>I can show affection to my baby.</td>
<td>3.92</td>
</tr>
<tr>
<td>I am good at soothing my baby when he/she becomes upset.</td>
<td>4.24</td>
</tr>
</tbody>
</table>

*The maximum score for each item is 5.

3.1.5 Summary of quantitative findings

While the descriptive analysis suggests that there are improvements over time in all of the variables assessed in this evaluation, statistically analysis found only some significant changes:

- no significant change in PRAM scores;
- a significant reduction in MIBS scores between T1 and T2, T2 and T3, and T1 and T3, i.e. a more positive attitude towards the baby;
- for women, a significant decrease in EPDS scores between T1 and T2 and T1 and T3, i.e. an increase in psychological wellbeing;
- a significant increase in the coping scale score from T1 to T2 T1 to T3, i.e. increased perceived coping.
Furthermore, due to the low numbers of participants with data for all three time points, these findings need to be treated with caution. As there was no control group, it is not possible to say whether these changes are due to the impact of the WTTW programme or would have occurred without it. It is notable that all significant changes occurred in respect to the postnatal time point.

3.2 Qualitative results

There are six sets of analysis of qualitative data to present:

1. Analysis of open-ended questions from T1 about expectations of the early weeks and months after the birth of the baby
2. Analysis of open-ended questions focusing on expectations and experiences of the programme at T1, T2 and T3 and whether these expectations have been met
3. Analysis of open-ended questions on preparation for becoming a parent at T2 and T3
4. Analysis of data from focus group discussions with attendees of the programme
5. Analysis of telephone interview data from parent group leaders
6. Case study presentations of significant/interesting cases

3.2.1 Open-ended questions about expectations of the early weeks and months after the birth of the baby at T1

Becoming a parent is a major developmental transition of adulthood. Individuals often have optimistic expectations about parenthood, yet this transition also presents a number of challenges (Harwood, McLean & Durkin 2007). The open-ended question ‘What are your expectations of the early weeks and months after the birth of the baby study?’ was aimed at understanding attendees expectations of the transition to parenthood, specifically with respect to caring for their infant, and the influence parenthood has on their well-being and their relationships with others.

Guided by the framework for thematic analysis by Braun and Clarke (2006), time point 1 (T1) responses were group together and analysed. Key themes emerging from the data were ‘relationship with baby’, ‘challenges and rewards, and ‘impact on relationships’.

Relationship with the baby

Data suggests that attendees recognise the importance that feeling connected to, and having a close relationship with the baby, has in contemporary society. Being close to, connecting with, feeling ‘lots of love towards’, spending time with and enjoying, were all identified as activities which attendees were expecting to embrace; the notion of ‘bonding with the baby’ was central to the ‘expectations of the early weeks and months’ data. The term itself featured regularly across the data. In addition, the hopes and expectations of attendees feeling a ‘bond’ with the baby appeared to be intrinsic to understanding the needs of the baby and feeling like a family.

‘To fully bond with her and understand and identify her needs properly’
‘… to bond with my baby and include my other 2 children …’
‘… bonding and family time’
Challenges and rewards
A second theme recognises the perceived challenges and rewards of parenthood. Among what emerged from the data as perceived challenges of the first few weeks and months of having a baby, parenthood was seen in terms of ‘sleepless nights and tiredness’, ‘hard work’, ‘emotionally, mentally and physically challenging’ and ‘the hardest thing ever’. Data indicates that for many attendees, the expected rewards of parenting, such as fulfilment and increased happiness, were perceived as a buffer against the challenges.

‘To feel tired but also happy and excited’
‘Hard work but rewarding’
‘Expect to be very tired but to fall in love straight away’

Impact on relationships
When expressing their expectations of the first few weeks and months, attendees identified the need for healthy supportive relationships with a number of ‘significant others’. Within this key theme of impact on relationships, there were expectations that friends, family members and partners would have specific contributions to make, and valuable roles during the first few weeks and months of parenthood.

‘Regular visit from friends/family/health visitor’
‘I feel I will be OK cos I have a child already and a close family with lots of grandwaynes’

Attendees gave consideration to the impact of parenthood on relationships with partners with respect to supporting each other and working together, communicating effectively and resolving conflict.

‘Important to have good communication with my husband’
‘Some conflict before we get into our own routine as new parents’

Generally speaking, the T1 data suggests that for many attendees of WTTW, the transition to parenthood was viewed with both optimism and realism. Expectations about the baby were typically viewed with enthusiasm and excitement, whilst being offset with some insights into the hard work and emotional upheaval of this period of time. Research by Staheva and Wittkowski (2013), in a sample of Bulgarian mothers, found that unrealistic expectations about motherhood were related to a more difficult postnatal adjustment, lowered self-esteem and feelings of inadequacy. Whilst the expectations of the early weeks and months of having a baby were not revisited at T2 and T3, the quantitative findings, and in particular the presentations of the individual case studies, from this evaluation, may illuminate some of these T1 findings around expectations of parenthood, to provide some insights into whether this has been the case for the parents-to-be in this study.

3.2.2 Open-ended questions focusing on expectations of the programme at T1, T2 and T3 and whether these expectations have been met

A. Expectations of the programme at T1
Time point 1 responses for all participants were group together and analysed. Guided by the framework for thematic analysis by Braun and Clarke (2006), the analysis was driven by the key evaluation question:
Is the programme effective in preparing parents-to-be for parenthood, specifically around 4 keys areas; attunement, bonding and attachment, parental wellbeing, breastfeeding and practical care?

Four overarching themes emerged from this data (knowledge, confidence, support and connections), each theme having a number of sub themes. Key themes and their related sub themes are identified as:

**Knowledge**
(Sub themes: of parenting, of how to care for a baby, of potential strategies for coping with a baby, of breastfeeding, of the ‘unknowns’ of parenting)
Attendees of the programme at time point 1 expected to gain knowledge. Expectations of knowledge as a key theme was then easily broken down into a number of sub themes; knowledge in relation to parenting, how to care for a baby, potential strategies for coping with a baby were all identified by attendees as expectations of the programme, as well as knowledge about breastfeeding, and the ‘unknowns’ of parenting.

**Confidence**
(Sub themes: to be around their babies, to be a parent, giving birth)
Attendees across all sites expected to gain confidence from the programme. Parents to be at week 1 identified that they had an expectation of the programme in terms of providing them with confidence to be ‘around’ their babies, to be a parent, and confidence at giving birth.

**Support**
(Sub themes: to develop new friendships, from group leaders and co-leaders, and from other group members)
Support was also identified as an expectation of the programme at T1. Attendees indicated that they hoped the programme would provide them with support networks from the development of new friendships, from group leaders and co-leaders, and from other group members. Additionally, T1 data suggests that attendees were hopeful that through attending the programme, they would develop skills which would enable them to support themselves.

**Connections**
(Sub themes: with the baby, with their partners, with other attendees and with health professionals)
Data at T1 indicates that attendees were hopeful of, and expected to make connections with others as a consequence of attending the programme. These connections seemed to focus upon the baby, their partners, other attendees and health professionals.

**B. Meeting of expectations of the programme at time point 2 (T2)**
At time points 2 and 3, attendees were asked if it had met their expectations. Using a general inductive approach to address the key evaluation question, the categories of knowledge, confidence, support and connections which emerged from the T1 data as an expectation, were imposed on the ‘meeting of expectations’ T2 and T3 data. This facilitated an exploration of the data in terms of the meeting of attendees’ expectations. Generally speaking, T2 data indicates that all 4 categories of knowledge expectations, confidence, support and connections had been met by many attendees. Where appropriate we have selected specific quotes which represent the meeting of these expectations.
Knowledge
How to be a good parent was identified as a knowledge expectation sub-theme from T1. T2 data suggests that this particular expectation had been met;

‘I have learned a lot of invaluable tips, which has helped me to feel ready for parenthood’
‘It has been very informative and nice to be able to take time out to focus on being a parent’

A number of attendees also identified at T1 that they hoped to gain more knowledge around how to care for their babies. Data from T2 indicates that for some attendees this expectation was met;

‘I have gained very useful information on antenatal + post-natal care of myself + baby’

Potential strategies for coping with their babies again was identified at T1 as an area for further knowledge gain. T2 data indicates that this expectation had been met;

‘Exceeded expectations – such good information and coping tips’

Attendees at T1 were hopeful that they would gain knowledge about breastfeeding. T2 data indicates that breastfeeding knowledge was gained by a small number of attendees;

‘Yes particularly …. How to encourage successful breastfeeding’
‘Yes – breastfeeding’

There were a number of responses across the T2 data which indicate that the programme addressed a number of ‘unknowns’ for attendees;

‘Yes, helped me by showing things I never knew, every week was an eye-opener’
‘Enabled me to think about things I have not thought of’

Confidence
T2 data suggests that by the end of the programme, many of the attendees expressed feelings of confidence; confidence in relation to being around their babies, and confidence at parenting as a result of attending the sessions were evident across the T2 data;

‘Provided information about caring for baby and feel a little more confident’
‘We discussed how to soothe the baby, how to massage the baby, how to talk to the baby. I feel more confident in becoming a parent’

Confidence giving birth was identified as an expectation at T1, and whilst there was no indication of the programme providing attendees with confidence to give birth, data suggests that for a small number of attendees, there was some informative content around this topic area, which may have resulted in increased confidence;

‘I have gained a good amount of knowledge for the birth/pregnancy journey’
‘The labour day session was very informative’

Support
Support was an issue for a number of attendees at T1. There was an expectation at the beginning of the programme that attendance would bring about increased support. Attendees were hoping to gain
support through the development of new friendships, from other attendees, and from group leaders and co-coordinators. It was evident in the T2 data that the course had met some of these expectations;

‘... great support and friendship and a comfortable environment to share concerns’
‘Yes, full of information and support. Very friendly’
‘Met some lovely people, gained support’

Connections
T1 data suggested that attendees were seeking connections with others. Connections with the baby, with partners, with other attendees and with health professionals were important to attendees at T1, and these connections featured across the T2 data;

‘It has also taught me about my baby and the role of my partner and his bonding time with the baby’
‘This course has helped me so much with my son who is 8 year old. And it has me so prepared for the twins.’

C. Meeting of expectations of the programme at time point 3 (T3)
The general inductive approach used on the T2 ‘meeting of expectations’ data, using the categories of knowledge, confidence, support and connections, were imposed on the ‘meeting of expectations’ T3 data. Again, this approach indicates that post birth, (anywhere between 1 – 4 months after their babies were born), attendees continued to feel that all 4 categories of knowledge, confidence, support and connections had been met. Again, we selected a number of quotes from the T3 ‘expectations’ data to reflect this finding.

Knowledge
As identified earlier, learning how to be a good parent was identified as an expectation at T1, this appeared to have been met at T2, and again, T3 data suggests that this particular expectation had been met.

‘A great opportunity to ask questions and to get your head around being a parent.
A safe environment with knowledgeable and empathetic course leaders’

‘... we feel we are slightly better parents for having the conversations upfront about what kind of parents we want to be’

A number of attendees also identified at T1 that they hoped to gain more knowledge around caring for their new-borns. Data from T2 suggested this had been met. T3 indicates that for some attendees this expectation was further met in reality;

‘It helped me with everything I needed to know and how to do everything the way I should’

Potential strategies for coping with their babies again was identified at T1 as an area for further knowledge gain. T3 data indicates that this expectation had been met;
‘The course has met my expectations by providing with the necessary information about my baby, how to deal with newborn and methods to assist and cope with a newborn’

Attendees at T1 were hopeful that they would gain knowledge about breastfeeding. T3 data indicates that for a number of attendees the breastfeeding knowledge which was gained, was invaluable in the first few weeks and months of parenting;

‘Though discussions around feeding, fears + our judgements in nurturing programme reduced my anxiety about breastfeeding + for this I am extremely thankful’

‘Yes, I found open discussion about breastfeeding beneficial’

‘I particularly liked the sessions with the midwives – labour & breastfeeding were particularly helpful’

‘Breastfeeding + reading baby’s cues was brilliant’

There were a number of responses across the T3 data which indicate that the programme addressed a number of ‘unknowns’ for attendees;

‘Yes the course was very helpful with what to expect, incl. things we would never of thought of’

Confidence
T2 data suggests that by the end of the programme, many of the attendees expressed feelings of confidence; confidence in relation to being around their babies, and confidence at parenting as a result of attending the sessions were evident across the T2 data. The T3 data continued to show similar results in relation to parenting and baby caring confidence. Data suggests that for a small number of attendees, there was some informative content around this topic area, which may have resulted in increased confidence;

‘Yes. Really enjoyed it & the support & confidence it gave me’

‘Yes. How to bathe my baby, interact and expectations. I felt more confident with the help and information provided’

‘Feel amazing. Can’t thank [name] + [name] enough. Shown me so much and really think it has helped with me and baby’

Support
Expectations of support was an issue for a number of attendees at T1. There was an expectation at the beginning of the programme that attendance would bring about increased support. Attendees were hoping to gain support through the development of new friendships, from other attendees, and from group leaders and co coordinators. It was evident in the T3 data that the course had met some of these expectations;
‘Very happy as she is content. Yes I [name] has been very supportive’

‘Felt confident to ask any questions and felt supported throughout course’

‘I also meet other Mothers-to-be which has been a great support & friendship’

‘Made some good friends, providing support for each other!’

**Connections**

Attendees at T1 indicated that they had expectations of what we classed as ‘connections’ with others as a result of engaging with WTTW. Connections with the baby, with partners, with other attendees and with health professionals were important to attendees at T1. Across the T3 data, connections, bonds and friendships featured strongly;

‘One of the things that really helped has been the community of friends we made on the course. We talk every day and meet every week. It has been invaluable. Thank you’

‘Yes, I enjoyed it + learned a lot, I’ve also met lots of friends 😊’

**3.2.3 Analysis of open-ended questions on preparation for becoming a parent at T2 and T3**

At T2, Attendees were asked if they felt the course had helped to prepare them for the early weeks and months with their baby. They were asked to express how they felt the course had helped them, and which aspects were particularly helpful. When asked these questions at T2, they were still expectant parents or parents-to-be as this report occasionally refers to them as. This data therefore reflects how prepared they felt for parenthood as a result of attending the programme. We undertook a thematic analysis on this data set, again, being guided by Braun and Clarke (2006).

Data suggests that the areas/aspects of becoming parents, in which expectant parents felt most prepared at T2 were bonding with the baby, breastfeeding, emotional wellbeing, labour and birth, partnerships and relationships.

Attendees indicated that learning about the importance of skin to skin contact, how to interact with the baby, how to bond effectively and develop strong attachments led them to feel more prepared for becoming parents. Further, parents felt that the sessions had highlighted the importance of breastfeeding and had equipped them with appropriate knowledge and understanding of breastfeeding to maximise their chances of success. Emotional wellbeing was a feature across this data; expectant parents referred to how the sessions had contributed to their understanding of emotional wellbeing and the importance of such; ‘nurturing oneself’, ‘normalising fears’, ‘helping oneself to be mentally prepared’, ‘building self – esteem’, ‘emotional preparation for giving birth and becoming a mum’ and ‘not placing pressure on oneself to be perfect’ were just some of the aspects of emotional wellbeing which couples identified that had been addressed in the sessions.

Another significant theme/finding in this data was the impact of the sessions on partnerships and relationships. Data indicates that expectant parents at T2 had a greater understanding of the importance of nurturing their relationships with their partners during the weeks and months ahead. ‘Understanding how my partner is feeling’, ‘listening to my partner’, ‘helping me to focus on what I should do to aid my wife’, and ‘consider how to bring my partner on board’ were some of the
comments across the data which related to this key theme of how the programme prepared attendees for the early weeks and months with a new baby.

Alongside being prepared for becoming parents, to a lesser extent but still identifiable as a theme, T2 data suggests that attendees felt they were adequately prepared for labour and giving birth as a result of the programme. The session which addressed labour and birth was considered to be ‘extremely informative’, and helped some attendees to feel ‘more relaxed and at ease’, helping to prepare couples for what to expect.

At T3, again, attendees were asked if they felt the course had helped to prepare them for the early weeks and months with their baby. They were asked to express how they felt the course had helped them, and which aspects were particularly helpful. When asked these questions at T3, they were parents, and had been so, for anywhere between 1 and 4 months. This data therefore reflects how prepared they were for parenthood as a result of attending the programme. We undertook a thematic analysis on this data set, again, being guided by Braun and Clarke (2006). Key themes emerging from this data were ‘breastfeeding’, bonding and attachment’, ‘health professionals’, ‘emotional wellbeing’ and ‘networking’.

Parents were less specific than they had been at T2, about the elements/aspects of parenting which they had been most prepared for as a result of attending WTTW, and instead many of the comments suggested that the programme prepared them for ‘the early weeks’ and gave them ‘plenty of information’. With respect to specific themes, data suggests that breastfeeding and bonding and attachment were key aspects taught on the programme which parents had found beneficial once their babies had been born; the input from midwives and health professionals featured regularly across the T3 data in terms of what aspects of the programme had been most beneficial. Further, at T3, parents were able to reflect on how the course had prepared them well in terms of understanding their own emotional needs and addressing their emotional wellbeing. The final key theme which emerged from the T3 data in terms of how WTTW helped parents to be prepared for parenting, was the development of networks and friendships. A number of attendees commented on the positive impact of new contacts and friendships and sharing experiences with other members of the group;

‘… generally a rounded course and some lovely friends and contacts made’
‘Meeting other expectant parents was the most useful part’
‘… promotes a good support network’
‘Great networking resource … ‘
‘… Met a good network of friends …’

Having had the opportunity to look at their experience retrospectively, many participants identified that the programme had prepared them very well, however, at T2 and T3 a small number of participants acknowledged that in reality, nothing can prepare one for the realities of parenthood.

‘Nothing can prepare you for the lack of sleep and the first full poo nappy’
‘No. nothing can prepare you but I’m more comfortable at realising I’m not going to get it all right’
3.2.4 Focus group data: experiences of the WTTW programme

Four themes emerged from the focus group discussion (Table 5). While the first theme relates to the experience of attending the programme, the other three themes are concerned with the impact of the programme on postnatal coping, relationships and wellbeing.

### Table 5  Focus group themes and subthemes

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### Theme 1: Attending WTTW

#### Subtheme 1.1: Accessing the programme

Participants’ experiences of accessing the programme varied to some degree. One of the courses (FG2) in particular was targeted at expectant parents identified as vulnerable in a pre-birth assessment; these participants were invited by letter to attend the course. The majority of the other participants decided to attend because the programme was recommended by family members, friends or their midwife. Several received an invitation from their health centre (FG4). Participants in several focus groups commented that they felt the programme needed to be promoted and advertised more as many people were not aware of it. Reasons for attending the course included wanting to meet others, support from others in the same situation, not wanting to be alone (FG2), wanting information and ‘needing all the help we could get’ (FG3), a lack of experience with babies and curiosity about the programme (FG2).

Attending all sessions was important to many participants. Barriers to attending sessions included the timing of the course (for example, one participant in FG6 said that evenings would have been better), fitting the sessions around existing commitments, and not having enough notice of the start date of the programme (FG6). Parking was a problem for one of the groups (FG3). Some participants commented that attendance in the evening (FG1) and afternoon (FG4) worked well for them.

#### Subtheme 1.2: Course format

The venues seemed to suit most participants, though one group (PG2) commented that the room had been rather small and cramped and that the original chairs were uncomfortable but had been changed to more comfortable ones. Participants appreciated having refreshments (FG2, FG3, FG4). Some said that the sessions were rather long (FG2, FG3) but having a break helped. Attending at a venue like a children’s centre, Sure Start centre or health centre also offered the opportunity to find out about
other courses run at the same venue (FG1, FG3). While some felt that at the beginning the length of
the programme seemed rather daunting (FG3), several groups said that they would have liked a longer
course as there was not enough time, particularly for discussions (FG2, FG4). One participant (FG4)
emphasized that she would have liked to have started the course earlier in pregnancy as it would have
helped her with the emotional aspects of pregnancy and talking to her partner about it. One woman
said that it helped to attend with others at a similar stage in pregnancy as they were experiencing
similar things (FG4), while others commented that postnatally it was helpful that they were at slightly
different stages as there were others to ask for advice who had already experienced a particular issue.

**Subtheme 1.3: People**

Participants included women who attended on their own as well as couples. Some of the men seemed
initially reluctant to attend (FG6) but on the whole appreciated the programme and felt they gained a
lot from it. Several participants said that it was good that partners had an opportunity to attend (FG4,
FG6), especially as they were often excluded from other aspects of care during pregnancy (FG4). The
effect on the couple relationship will be discussed below (Theme 2, Subtheme 2). One participant (FG2)
attended with her own mother, which she described as a very positive experience. Other programme
participants were on the whole experienced as positive, providing opportunities for new friendships
and support; this will also be discussed under Theme 2 (Subtheme 3). Participants felt that they learnt
from each other in group discussions (FG4) and generally got on well. However, there were also some
challenges and participants in one group (FG2) reported some conflict between group members.
Groups with between five and eight participants were described as being a good size (FG4, FG3), while
a group with only two or three participants was perceived to be too small (FG4).

The PGLs clearly played an important role in how participants experienced the programme. All
comments about PGLs were positive; they were described as friendly, funny and *‘making you want to
come back’* (FG2). Several groups commented on the importance of their facilitation skills (FG3, FG5,
FG6). They were also supportive on a one-to-one basis, taking time to talk to participants after sessions
(FG2). Some participants said that they found it reassuring that their PGLs had children themselves as
it meant they spoke from personal experience (FG1, FG3).

Those participants who took part in a group in which a midwife or health visitor was involved in at
least one of the sessions, experienced this as very positive (FG1, FG3, FG5) and appreciated the
opportunity to ask questions. One group (FG3) described the attendance by members of a
breastfeeding support group as positive, saying that it made it easier to approach the group for advice
after they had given birth. Another group (FG2) said that somebody had attended the course to talk
about how to register the baby, which was also described as positive. By contrast, those who had not
had input from a health professional said that they would have liked to have that opportunity (FG2).
The opportunity to meet health professionals and ask them questions was clearly experienced as a
positive component of those groups which offered this.

Some participants (FG2) said that having new parents with a baby attend would have been helpful,
particularly for sessions on bathing, nappy changing and dressing the baby, as this would have made
it more realistic. One group (FG3) had the opportunity to observe a real baby being given a bath, which
was experienced as very positive.
Subtheme 1.4: Expectations and experiences

Many participants were not sure what to expect from the programme (FG2, FG4) and some said that they initially felt a little apprehensive and were worried about being judged (FG2). There was also an expectation that the course would just focus on the baby, rather than the couple and whole family (FG3). One man (FG2) said that he expected the course to be boring, which was not the case. Despite some initial apprehensions, the programme met or exceeded expectations on the whole.

The majority of participants described the programme as enjoyable, interesting and helpful. Many particularly appreciated the relaxed, informal atmosphere which allowed them plenty of time to chat to others and make friends (FG3). The atmosphere was described as non-judgemental (particularly by very young parents), supportive and encouraging. Some groups described how the PGL set ground rules, including being non-judgemental, at the beginning of the course (FG2). It was made clear that there were no ‘silly’ questions and participants felt therefore encouraged and confident to ask questions (FG2, FG3, FG4). Some said that writing down questions was sometimes easier than asking them (FG3). The programme offered participants a safe space and time for themselves, both individually and as couples, in which they could think and talk about their concerns relating to the transition to parenthood (FG1, FG4).

Subtheme 1.5: Information

Participants mostly liked the Welcome to the World booklet for parents. Several said that it was helpful to dip in and out, to come back to some of the information later on (FG2, FG3, FG4). It was easy to read, ‘beautifully done’ (FG4) and generally helpful, including for partners who did not attend the programme. They also appreciated that the information was not prescriptive, but encouraged parents to find their own way (FG3). However, some participants said it was ‘helpful but scary’ (FG2) or that there was too much information, which sometimes increased their anxiety (FG2). Some of these points also applied to information provided in the programme generally: while participants wanted to increase their knowledge and most felt that the programme had helped them achieve this (FG4), some also said that too much information could increase their anxiety (FG1). Others expressed the opinion that more knowledge would make it easier (FG4), particularly for those who do not already have children (FG5). Some groups were also able to borrow books during the programme (FG1, FG3), which was appreciated.

The quality of the information provided was generally perceived positively, though one participant (FG2) said that there was some information in the handbook which was contradictory to other information they had received. Many participants appreciated that PGLs were not prescriptive in the information they provided, but offered them a range of options and emphasized that they would need to find their own way and what works for them and their baby (FG3): ‘We discussed tools but we also knew that not all of our babies were going to be the same’. The information was generally perceived as realistic (FG3), though some commented that they were not really interested until the information became relevant (FG1). What became clear in several focus groups was that while participants did not remember everything from the programme, they were able to take away those parts and ‘little tips’ (FG3) which were particularly relevant to them. In many cases they remembered information later on, when it became relevant to them after the birth of their baby (FG3). This included for example trying skin-to-skin contact after the birth (FG1, FG3) or responding to their crying baby. During the programme parents were also signposted to further information on particular topics, as well as other
local courses available to them. Some participants expressed a need for additional signposting on what to do and where to get help on some issues, particularly regarding minor health problems their baby might experience (FG3).

**Theme 2: Relationships**

*Subtheme 2.1: Interacting and communicating with the baby*

Many participants seem to have enjoyed the focus of WTTW on communicating and interacting with the baby. They often expressed amazement at fetal development and what the baby was able to perceive and do, both in pregnancy and after birth. Being shown images of brain development and growth helped them to understand the importance of stimulation: ‘*just even seeing the wee pictures of their wee brain [...] they showed a child that wasn’t being stimulated, and soothed, so now I’m a wee bit obsessed*’ (FG1). Prior to the programme, many participants were not aware that babies could hear in the womb or get used to music or speech. Several said they had started talking, singing or playing music to their unborn baby (FG2, FG3, FG4), even though it ‘*felt ridiculous*’ (FG4) at first, or rubbing their belly in pregnancy (FG1, FG2). One woman commented that talking to the baby in pregnancy had made it easier for her to talk to the baby after the birth (FG4). Generally, interacting with the unborn baby was perceived as helpful by participants (FG6).

The programme also influenced the way parents interacted with their babies after the birth. Learning about the baby’s cues helped them to learn about when their babies did and did not want to communicate (FG1). Many participants expressed amazement at babies’ ability to communicate and interact after the birth, including the baby copying parents sticking out their tongue, babies’ focusing distance, and smiling. Participants in several groups had tried sticking out their tongue (FG1, FG2, FG3); they described the baby’s response as moving, cute and impressive (FG3). Parents seem to gain satisfaction and confidence from being able to interact like this with their baby. The baby starting to respond to parents’ interactions with smiling, giggling and other noises was experienced as particularly rewarding (FG2, FG3). Even though several participants said that initially they had felt strange or self-conscious (FG1, FG4, FG5) when trying out some of the activities suggested in WTTW, the programme had clearly encouraged participants to interact, communicate and with their babies. One woman (FG3) said that the programme had helped her ‘*understand what I was supposed to do*’, while with her first child ‘*I didn’t know what to do with him*’. Furthermore, the information provided during the programme helped them understand the benefits of good communication with their baby before and after birth (FG1). Nevertheless, some participants also acknowledges that after the birth the baby might not like some of the activities (FG2).

Several participants said how helpful it had been to learn and talk about the baby’s crying, including different types of cries and how to respond (FG3, FG4). Some parents described going through the list of what to do when the baby’s is crying and how this had been helpful and made them feel more confident (FG3). Participants also talked about the programme’s advice not to leave the baby to cry; while some had not followed this, other had. The programme had helped them understand why it was important to respond to the baby and enabled them to do so despite other people, often their own mothers, telling them that they were spoiling their baby (FG3). Talking about different types of crying had been helpful (FG4); one woman described how she found it difficult to distinguish between different cries at first, but that she trusted in what the PGL had said and soon learned to recognise differences (FG3). Another woman said that she initially had felt little connection with her baby, but
that thanks to the course she knew that this was not unusual and felt reassured that this connection would come: ‘I’ve heard everybody say like, oh, you’ll know when it’s your own baby and you’ll know what to do and you’ll know their cries, and I can remember, [PGL] here said to me you might not know straight away, and I didn’t, like my instincts didn’t kick in straight away when she was born like they said they would, it took a few days for me to find my way and I just remembered her saying, it doesn’t happen straight away with everybody and it just settled me down, thinking you know I’m not, it’s not, I don’t know what I’m doing, it’s normal’ (FG3).

Subtheme 2: Couple relationships
Participants in all focus groups said that taking part in the programme increased couples’ understanding and empathy for each other. Women in particular suggested that the programmed helped their partners to understand how having a baby would affect them (FG1, FG2, FG6). One man (FG3) said that it helped him understand what his partner was going through and consequently he supported her more and gave her time for herself. Conversely, some participants also said that it helped the women to understand better what their partners might feel, as the programme was ‘not side-lining men’ (FG3).

The programme helped to improve communication between partners by increasing awareness of the importance of good communication, by providing strategies for effective communication, and giving couples a starting point for communication through their attendance of the programme. Taking part in the programme encouraged participants to express their feelings openly and to communicate with their partners about their needs and concerns (FG1, FG4). Couples were encouraged to communicate on a range of subjects which were discussed in WTTW, including parenting styles, family values, and practical issues, e.g. who does what (FG3, FG4, FG6). The programme seemed to provide a realistic picture of the effect on the couple and consequently the importance of good communication: ‘it taught us that it’s not all rosy and it’s give and take, all about open communication, and relationships’ (FG1). While attending the programme together had a beneficial effect in encourage couples to spend time together (especially when there were older children) and stimulating discussions about particular issues, communication was also improved for some of the couples in which the man did not attend the programme (FG4).

Taking part in the programme helped some men to feel more involved in the pregnancy: ‘It definitely made me feel more involved with the pregnancy, coming to this. Like I was part of it as well. And it weren’t just like doing the carrying and stuff. And when I came to the group I came as her partner’ (FG3). Many participants appreciated that the WTTW programme was not just about the baby, but also about them as a couple, and that there was an emphasis on how to protect their relationship during the transition to parenthood (FG3). Parents were encouraged to make time for each other, for example by going out together (FG1, FG3).

Subtheme 3: Other relationships
Relationships with other WTTW participants featured prominently in the focus group discussions. Many participants enjoyed meeting other expectant parents and making new friends. Attending the programme ‘helped with getting out and about’ (FG1) and was an opportunity to socialise with others, both individually and as couples. After the course, many participants were still meeting up and had formed new friendships, but this was not the case for all groups. Some participants in FG2, for example,
had no intention of meeting up with other participants in the programme. While most of the post-programme social network seemed to centre around women, men were also included to some extent (FG2), but this appeared to follow the lead of the women. One participant (FG6) commented specifically on the need for new fathers to support each other.

Those who were still in touch and meeting up after the birth did not just value the social aspect of this, but also the opportunities for mutual support and advice it provided. This peer support, which usually began in pregnancy and continued afterwards, was greatly valued by many participants, who liked ‘having someone to call upon’ (FG1) who was in a similar situation. Several groups were in frequent contact, often using WhatsApp or texting, to talk each other, ask for and give advice, and share what their babies were doing (FG3). These groups therefore often formed the foundations of a supportive network (FG1, FG2, FG5, FG6), which sometimes also included other new parents, e.g. friends of participants in the programme (FG6).

The sense of sharing experiences seemed to be particularly important. It allowed them to ‘compare notes’ (FG4) at different stages of their babies’ development (FG3) or if going through similar illnesses or problems (FG4). One teenager (FG2), for example, said that she liked having the support of others who were also very young and who were, in contrast to her friends at school, also expecting a baby. It was important for this that others were non-judgemental (FG2) and open to others. There were also some difficult experience; a participant in one group (FG2), for example, described how the baby of another participant in the programme had been taken into care.

Some participants also talked a little bit about their relationships with other people, particularly family members. This included conversations with their own mothers about their experiences (FG2, FG4). One participant (FG2) had attended the course with her mother, which she said had brought them closer together.

**Theme 3: Coping**

**Subtheme 1: Practical baby care**

Being able to provide practical care for the baby, i.e. changing nappies, bathing, dressing, was clearly important to parents; attending the programme appears to have had a positive influence on this on the whole. Those who had input from health professionals on WTTW generally considered this very beneficial (FG1). Practical activities on baby care were provided in several of the groups (FG3, FG4). Participants particularly liked it when new parents came in with their baby to demonstrate bathing (FG3) as it made it more real. Other groups agreed that while it was helpful to do these activities with dolls (FG2, FG4), this was not as good as seeing it done with a real baby (FG2). However, a considerable number of participants said that they did not cover any or just a few practical baby care activities and said that they would have liked more (FG1, FG2). Participants in several groups also commented that they would have liked more coverage of formula feeding during the programme (FG1, FG3, FG6). A desire for more information on how new mothers could cope after a caesarean section was expressed by some participants (FG2, FG3). Information about potential health issues was also raised; some said that it had been helpful that they had discussed colic and wind as it prepared them for when their baby was affected by these problems (FG3), while other new parents said they would have liked more information on minor health problems, such as a rash or cold, and where to get help (FG3). Some also said that they had not received enough information about changes occurring in the baby as
he/she grows, such as growth spurts, and their impact on behaviour (FG6). On the other hand, discussing changes in the colour of babies’ poo had been experienced as very helpful by some (FG3) and reassured new parents that what they experienced was normal and nothing to worry about.

Some participants talked about feeding; many had experienced the discussions on breastfeeding in the programme as helpful: ‘it made you want to have a go’ (FG1). Many, however, had experienced difficulties with breastfeeding (FG2, FG3, FG4) and some had felt pressurised to breastfeed, though this related to postnatal experiences in hospital rather than WTTW (FG2, FG4). Having members of a breastfeeding support group attend a session of the programme was seen as positive, making it easier to approach the group postnatally (FG3).

Subtheme 2: Expectations and reality
There was agreement in most focus groups that knowing what to expect and being prepared was helpful in the transition to parenthood. While participants acknowledged that ‘nothing can really prepare you’ (FG3), there was agreement amongst many participants that WTTW had helped them to have realistic expectations about life with a new baby (FG3, FG4). The programme ‘didn’t sugar coat how hard it can be’ but made it clear that ‘there is an end’ (FG3). One participant (FG1) suggested that new parents attending with their new baby would have helped participants to gain a more realistic understanding of what to expect. Activities specifically focused on encouraging participants to think about what life with a new baby might be like, such as comparisons of how time might be spent before and after the birth, were experienced as ‘scary but helpful’ (FG3), making postnatal life more realistic and helping expectant parents to prepare and plan ahead. The WTTW programme also seemed to encourage parents to be realistic once their baby had been born and not feel that they, or their lives, had to be perfect (FG4). In addition, several participants commented that the PGLs had not been prescriptive when talking about how to look after a baby, but had encouraged participants to find strategies that worked for them and their family, as ‘not all babies are the same’ (FG3).

Subtheme 3: Coping strategies
While participants found it generally helpful to know what to expect in order to prepare, there were also some specific coping strategies which had been discussed in the programme, for example learning to take a step back when they found themselves getting too stressed with the baby (FG4) and relaxation techniques (FG2). Taking part in the programme also helped some participants to challenge advice from others and do what works for them and their family (FG3, FG6). Activities which helped participants think about demands on their time after the birth of the baby and to develop a routine which worked for them and their baby were also experienced as beneficial (FG3, FG5). Several groups talked about how daunting two particular points in time could be: being signed off by the midwife (FG3) and the partner going back to work after the baby was born (FG3, FG4); participants said they would have like more discussions specifically around these topics.

Theme 4: Wellbeing
Subtheme 1: Nurturing oneself
Many participants clearly appreciated that WTTW did not just focus on nurturing their baby, but also on nurturing themselves and their relationship. They felt that the programme had helped them to better understand their emotions and what they might experience (FG1, FG4). There was also an emphasis on being kind to themselves and being realistic, i.e. not expecting too much from themselves,
particularly in the early weeks after the birth of their baby. Many talked about the need for them to take time for themselves, away from the baby, both as individuals and as couples (FG3). One group (FG3) talked about how during the programme they had been given fridge magnets with messages reminding them to look after themselves as well, for example by having time to themselves each day. The same group also said that they would have liked more specific discussions around ‘how to look after yourself when it gets tough’ (FG3) after the birth with regards to eating and sleep.

Subtheme 2: Growth
The programme seemed to foster in participants an increased understanding of their emotions and needs (FG1, FG3, FG4), particularly regarding the ‘emotional rollercoaster in the early days’ (FG4). This included an increased understanding and awareness of their own upbringing and the implications for how they wanted to bring up their own children (FG3, FG4). The increased knowledge and the emphasis on parents finding their own way of doing things resulted in many participants feeling more empowered and confident to trust their instincts (FG1, FG3, FG4, FG6). Overall, there was a sense that the WTTW programme helped to prepare them emotionally for the transition to parenthood and the changes the accompanying changes: ‘it gave me that time to sit and listen and think, well, this is me now’ (FG4).

Summary of themes
On the whole, participants had few problems accessing the programme and were happy with the format, though some would suggested minor changes, like a longer duration. Opinions of PGLs were very positive and the input of health professionals into the programme was valued. Other course participants were an important source of friendship and support. Participants in the focus group experienced the WTTW programme as very positive and helpful; it provided them with a safe, non-judgemental place in which to discuss concerns and ask questions. While their information needs varied, most clearly felt that they gained valuable knowledge which helped them to prepare for the transition to parenthood.

Attending the WTTW programme increased participants’ understanding of babies’ needs, cues and abilities. While some initially felt a little awkward about trying out the suggested activities, those who did found them on the whole beneficial, rewarding and interesting. For some participants at least, the programme seems to have had a very positive effect on how they relate to and interact with their baby. WTTW also had a positive impact on couple relationships for many of the participants, helping them to gain a better understanding of their partners’ experiences and needs and improve their communication skills. Taking part in the programme therefore helped participants to grow as a couple through the transition to parenthood; attending as a couple was particularly helpful, but women who attended on their own also reported benefits to their relationships. The programme offered an opportunity to socialise with others and form new friendships; many of the groups had also evolved into support networks and were still meeting up and communicating regularly using social media. This was however not the case for other groups.

The programme also had a positive impact on how many of the participants coped after the birth. Many participants particularly talked about the value of covering practical baby care during the programme, though many said they would have liked to do more of this during the course. Many of the participants in the focus groups said that the programme encouraged realistic expectations of life
with a new baby and helped them to make decisions which were right for their situation, rather than following rigid guidelines. They also gained valuable coping strategies to help them in the transition to parenthood. Participants’ emotional wellbeing also appears to have benefited from the programme, which encouraged them to nurture themselves and their relationships, as well as their babies. Many also gained from an increase in confidence, self-awareness and emotional understanding.

3.2.5 **Analysis of telephone interview data with PGLs**

Where possible, data from telephone interviews with parent group leaders (PGLs) were subjected to thematic analysis, being guided by Braun and Clarke (2006). 10 PGLs were identified as appropriate to contact, 9 PGLs consented to the process and were interviewed by telephone, of which, we have been able to include 8, one interview was disregarded due to the recording being inaudible.

Being guided by the evaluation aims and objectives, we were specifically interested in understanding if there were any factors affecting the successful implementation of the WTTW programme. Where we were unable to undertake a thematic analysis, for example, where the data was very descriptive, we present a synopsis of the most relevant information. A framework was applied to the analysis based on the PGL interview schedule which had been designed by, and agreed through the evaluation advisory team process. The full interview schedule which is available in the appendices of this report, was underpinned by 5 specific areas of exploration;

- Training and experience of the PGL delivering the programme
- The PGL views of parents reactions to the current evaluation of WTTW
- The PGL views of the WTTW programme in general
- The PGL approach to delivering WTTW
- The most recent programme that the PGL had delivered

**Synopsis of the data from training and experience of the PGL delivering the programme**

Of the PGLs interviewed, the length of time since they had attended the training to deliver the programme ranged from one to three years; some of them have also trained in other programmes provided by Family Links. The number of courses delivered by the PGLs ranged from one to twenty courses, with most of the programmes being delivered fully and successfully. Where programmes were not successfully delivered, reasons cited for this were, lack of expected attendees, identifying women in pregnancy and sending invitations out on time before they gave birth, clash of dates with other parenting programmes, and the closure of local maternity unit resulting in reduced referrals. The data suggests that for some PGLs when limited numbers are identified, a decision is made not to run the programme on that occasion, however, for other PGLs, irrespective of numbers the programme will run for the full 8 week period. On the whole, it appears that evenings appear to be more popular for attendance than day time sessions.

**Synopsis of PGL views of parents reactions to the current evaluation of WTTW**

PGLs were asked how attendees reacted to having to compete the evaluation booklets, and if anyone needed help with completing them. There were mixed reactions from PGLs to this question. About half the PGLs interviewed said they had provided assistance with completion of the booklets. In terms of the PGLs reflecting on attendee’s comments about, and reactions to having to complete the booklets, three PGLs identified that some attendees asked how they should respond to the questions and measures, particularly with reference to the PRAMs (Pictorial Representation of Attachment
Measure), where attendees were asked to ‘place the sticker (‘your baby’) where you would place your baby into your life at this moment’. According to the PGLs, there seemed to be a little confusion for some attendees about this measure, and where the sticker should be placed. In addition, one PGL commented that she didn’t think that fathers were very engaging with the evaluation process, however she didn’t feel that she should ‘push too much for that, because it was their first week’.

Of the PGLs themselves who commented on the booklets, opinions were varied;

‘Some of the questions were little in-depth, like the emotional questions. I don’t think a lot of the parents were ready for those in-depth questions. They did find it difficult to answer them ... but I do agree that they are necessary’
‘The booklet that I saw was brilliant, it also had the emotional stuff included which was good’

Synopsis of PGL views of the WTTW programme in general (views on recruitment, other local parenting services, resources, supervision, changes to the programme, the programme in general, the most recent experience of delivering the programme and feedback from parents)

When asked the question about whether their programme was targeted or universal, some PGLs responded that it was ‘targeted’ at first time parents; however, the question itself was designed to elicit if the recruitment to the programme was targeted to a specific vulnerable group, for example, teenage parents, known to social services, or parents living in an area of deprivation. The interview data regarding targeting and recruitment suggests that most of the programmes are provided with the view that attendance should be composed of predominantly first time parents, however, a number of PGLs have indicated that other groups have benefitted in the past; older parents, for example who have a significant gap between first second and third children.

There was a general sense across most of the PGL interviews that recruitment should be universal, and whilst some PGLs indicated that they had initially intended to ‘target’, through time they realised that in order to recruit appropriate numbers for the programme, a universal approach should be, and had been adopted. In terms of those who identified that targeting had taken place with previous cohorts, it didn’t always seem to work well, for example, recruitment would be too low, or in one case, where parents-to-be attended with child protection or safeguarding issues, there was a lot of uncertainty for these attendees with respect to having time with their baby when it was born which had an impact on how much they enjoyed the sessions. Alternatively, one PGL commented that having a parent with a previous safeguarding issue was beneficial, as she was able to communicate previous experiences of feeding with the group.

PGL’s were asked if they knew what other services were available for parents in their area. These included, mainly antenatal classes through local hospital provision. Other courses that were identified by PGLs were Bumps to Babies; a course ran by family health practitioners, Bumps for Birth (from birth to two years old), Communities First, reportedly a group aimed at raising self-esteem and confidence building, Family First and Shine which were thought to be parenting groups, iBumps for very young parents, and Mamta, for parents where English is not the first language.
When asked about the quality of the resources and the training for delivering the programme, responses were varied. Some of the resources were thought to be a little outdated, like the DVD’s. The books were said to be good but expensive; some PGLS were using their own photocopied versions to save money. One PGL commented that the quality of the books was poor. Comments about the quality of training for delivering WTTW were generally positive, although for 2 PGLs, training was too short and 2 days would have been preferred rather than just 1 day.

Supervision was discussed in each interview. Generally speaking, all PGLs felt adequately supervised locally with support from Family Links and comments were made about how responsive Family Links were whenever they were contacted. Comments were made about the processes for supervision locally, this appears to be quite effective, although for 3 PGLs, supervision locally was limited, didn’t always ‘capture the true pressures’, and provision wasn’t as accessible as it had been in the past.

All PGLs spoke very positively of the programme. Attunement and bonding content were seen as a real strength, as well as the practice based content addressing bathing, nappy changing, holding the baby and dressing. PGLs commented on how the content can surprise attendees at times in terms of addressing topics that they had never thought of. The open-ended questions from the booklets also reflects this. Other content which has been found to be thought provoking for the attendees, according to the PGLs we interviewed was the impact of one’s own upbringing on the way in which parents-to-be may choose to parent. One PGL commented that the advice and recommendations about seeking help when the baby is unwell was helpful as many parents indicated that they would attend accident and emergency as a first point of contact.

Some PGLs provide evaluation sheets at the end of the programme, others have a ‘call-back’ process with parents who have attended. According to all PGLs we interviewed, the feedback from parents is always positive. Evaluations from attendees highlight the value of the friendship and support networks, and the longer term impact of those friendships, which has made a difference to their parenting experience. The practical aspects of the sessions are always commented on favourably, as well as the session with health professionals such as preparing for labour and birth.

Synopsis of PGL approach to delivering WTTW
When discussing their approach to facilitating the sessions, PGLs used terms such as laid back, non-judgemental, friendly, inclusive, making sure parents felt comfortable, having fun while getting the hard stuff across, enthusiastic, and nurturing. Some PGLs tended to stick to the structure, and favoured having such a structured approach, whilst others were flexible in their approach.

PGLs were asked if they would, or did, change anything about the current programme. Introducing more content on bottle/formula feeding was a suggestion, as well as condensing the programme to 7 weeks, to ensure that everyone completed before they gave birth; the same PGL also felt that being more flexible about the gestation at which attendees can start, would ensure that most couples could complete. One PGL commented that they had condensed introduction and week 1, as they felt this worked better for parents. Inclusion of further DVDs, adding in extra resources, creating a version of the programme so that it can be delivered on a one to one basis and taking into account cultural differences were all suggestions that were made by PGLs. One PGL moved some content to earlier sessions such as Sudden Infant Death Syndrome (SIDS) and the ways to get baby back to sleep so that
if attendees didn’t come to further sessions, she had provided them with what she felt was the more important detail. One PGL commented that there have been some extremely positive ‘fantastic’ outcomes from attendees.

Almost half of the PGLs arranged re-unions. Of the PGLs that arranged re-unions, they commented that this was a positive experience. The cases where re-unions weren’t arranged this tended to be because it wasn’t possible due to logistics involved in recruiting to the programme from other areas, child protection issues, or previous unsuccessful re-unions. One PGL combined the re-union session at the week zero of the next programme which seemed to be an appropriate was of ensuring that the new parents could meet and chat to the expectant parents. PGLs were also asked if they had encountered any challenges with individuals or groups. These were minimum, one PGL commented on disruptions from a mum to be when she and partner were taking selfies and one PGL commented on the challenges being around managing targeted attendees with specific needs within group sessions. This was addressed through ensuring that targeted attendees were provided with one to one sessions, although it was acknowledged that FL do not provide a one to one version of this particular programme and this made the provision of such sessions problematic.

3.2.6 Case studies

This section of the report presents some specific cases which we feel are of particular interest in the evaluation of the WTTW programme.

Case 1: GR01004
For this mum to be, expectations for the early weeks and months after the birth of the baby were documented as ‘Hoping to successfully connect with baby + be able to cope effectively with worries around being first time mum’. The course met and exceeded all expectations, at both time points. At T1 EPDs scores were moderate to high, scoring high on anxiety items at T1 and T2 – one suggestion is that this attendee was anxious about the pending birth, and by T3 had reduced to low (3). The MIBs scoring was in a positive direction across the 3 time points. Breastfeeding was the planned choice for feeding the baby, and, at T3, the attendee was still breastfeeding and supplementing with formula. Qualitative data indicates that this parent had a very positive experience of breastfeeding, ‘Did not wish to breastfeed initially though discussions around feeding, fears + our judgements in nurturing programme reduced my anxiety about breastfeeding + for this I am extremely thankful as I loved BF. I am sad that my journey is coming to an end BF due to work commitments. Yes, partner very supportive of b. feeding’. Perceived maternal parenting self-efficacy score was high and this parent had an overall positive experience of the programme; ‘I found open discussion about breastfeeding beneficial. I found it beneficial to name my fears of others trying to exert control on baby’s care when I wished to be main caregiver. Now I feel I can truly appreciate + benefit from the support of others + acknowledge the importance of significant caregivers such as grandparents in my child’s life’. Coping scores remained the same throughout – ‘most of the time I feel I’m coping pretty well’.

Case 2: EN14094
For this mum to be, expectations for the early weeks and months after the birth of the baby were documented as ‘To be able to cope’, and ‘To gain support if needed’. The qualitative data from the open-ended questions indicates that for this mum to be, course met all expectations. Breastfeeding was the planned choice for feeding the baby, and, at T3, she was still breastfeeding, but commented
on ‘finding it hard work but partner very supportive’. By T3, this parent showed fairly significant increases in EPDS scores (from 0 at T1 to 12 at T3), MIBS and parenting self-efficacy scores were positive, PRAM score showed significant positive movement towards feeling closer to the baby at T3. Coping scores remained the same throughout – ‘most of the time I feel I’m coping pretty well’.

**Case 3: EN16110**
For this mum to be, expectations for the early weeks and months after the birth of the baby were documented as ‘Peace + quiet’. The course met and exceeded all expectations, at both time points. At T1 EPDs scores was high (16), dropping to 14 at T2, and 10 to T3, (scoring high on anxiety items). PRAM score showed significant positive movement towards feeling closer to the baby at T3. MIBS and parenting self-efficacy scores were positive with good scores on both. Bottle feeding was the chosen method of infant feeding and this parent was happy with their feeding choice across all 3 time points. Coping score increased positively from coping most of the time to, always feel I’m coping really well.

**Case 4: EN10071**
For this father-to-be, expectations for the early weeks and months were ‘Lack of sleep, Lots of love towards baby, Fun & happy times!’ The course content met and exceeded expectations, and was said to have ‘definitely helped’. His partner planned to breastfeed and has continued to breastfeed and at T3 was introducing some formula. His comments on this were ‘Delighted that she has taken so well to breastfeeding. We have supported each other. Now looking to take pressure off partner by doing feeding (with bottle) myself’. EPDS scores fell slightly between T1 and t2, and increased to 11 by T3 (scoring high on anxiety items at T3). Coping score increased positively from coping sometimes to coping most of the time.

**Case 5 and 6 (Partners): EN16105 and EN16107**
Research by Staneva and Wittkowski (2013), in a sample of Bulgarian mothers, found that unrealistic expectations about motherhood were related to a more difficult postnatal adjustment, lowered self-esteem and feelings of inadequacy. For this mum to be, expectations for the early weeks and months after the birth of the baby were documented as ‘Love’, ‘Confusion’. WTTW met and exceeded all expectations, and provided this mum-to-be at T2 with ‘so much information’. Breastfeeding was the planned choice for feeding the baby, and, at T3, she was still breastfeeding, but commented on feeling ‘tired, stressed, and trapped’ by the decision to breastfeed. Perhaps in relation to these comments, by T3, this parent showed fairly significant increases in EPDS scores, a decrease in the extent of love and joy she felt towards the baby, and a low perceived maternal parenting self-efficacy. Her partner, also demonstrated a slight increase in EPDS, a very low perceived parenting self-efficacy but reported positively about the course and the decision his partner had made to breastfeed. Without individual qualitative data to explore this further, it is difficult to comment on the changes in mood and attitude towards the baby. Coping scores for both attendees, reduced slightly across T2 and T3 from ‘coping pretty well most of the time’ to ‘sometimes I feel I’m coping but sometimes things get on top of me’.
4 DISCUSSION and CONCLUSION

This section of the report returns to the original aims and objectives of the evaluation. There are three overarching objectives to address.

4.1 Objective 1: Is WTTW effective in preparing parents-to-be for parenthood, specifically around improvements attunement, bonding and attachment, parental wellbeing, breastfeeding, practical care?

4.1.1 Improvements in attunement, bonding and attachment
Quantitative findings suggest that participants felt closer to their baby towards the end of the WTTW programme and at postnatal time point. While there was no significant change in PRAM scores over time, there was a trend towards increased ‘closeness’ with the baby for women and men. The MIBS showed an increase in positive attitudes towards the baby; this was only significant between the first and third time point and the second and third time point, i.e. there was no significant change over the duration of the programme itself. While these findings suggest a positive change in attitudes and in how parents relate to their baby, it is not possible to say with certainly whether this was due to the programme as there was no comparison group. The relevant literature suggests that bonding/attachment increases during pregnancy (Cannella 2010; Della Vedova, Dabrassi & Imbaschiti 2008), and increases further after the birth of the baby (Dubber, Reck, Müller & Gawlik 2015). As the significant increase in the MIBS occurred solely towards the postnatal time point, it is possible that this was due a stronger bond and/or more positive attitudes towards the baby after birth. An analysis of the perceived parenting self-efficacy scale shows that participants scored relatively low on the items relating to being able to read their baby’s cues and understanding what their baby wants, but scores for interacting with, and showing affection to, the baby were higher.

Qualitative data suggests that that participants had learned a lot about fetal/baby development, babies’ needs and cues, and effective ways of interacting with the baby, both during pregnancy and after birth. Most participants seemed to have enjoyed this aspect of the course. Many expressed amazement at the baby’s abilities, and acknowledged the importance of sensitive interaction with the baby. Analysis of the data from the open-ended questions at T2 and T3, specifically those relating to expectations, indicate that attendees have learned about the importance of skin to skin contact, how to interact with the baby, how to bond effectively and develop strong attachments, and this has led them to feel more prepared for becoming parents.

4.1.2 Improvement in parental wellbeing
Parental wellbeing was assess using the EPDS. There was a downward trend in EPDS scores over time, indicating an improvement in parental wellbeing; however, in a few individual cases the EPDS scores increased after the birth. For women, the reduction in EPDS scores over time was only statistically significant between the first and the third time point; these findings need to be treated with caution due to the low numbers. Furthermore, as there is no comparison group it is not possible to say whether this decrease was due to the WTTW programme. Research suggests that there is a decrease in depressive symptoms from pregnancy to the early postnatal period (Heron, O’Connor, Evans, Golding & Glover 2004), which might account for the reduction in EPDS scores.
Emotional wellbeing was a feature across the qualitative data; expectant parents referred to how the sessions had contributed to their understanding of emotional wellbeing and the importance of such; ‘nurturing oneself’, ‘normalising fears’, ‘helping oneself to be mentally prepared’, ‘building self–esteem’, ‘emotional preparation for giving birth and becoming a mum’ and ‘not placing pressure on oneself to be perfect’ were just some of the aspects of emotional wellbeing which couples identified that had been addressed in the sessions. In the focus groups many participants talked about how the programme had helped them to understand their own needs and emotions and had improved communication with their partner and others, as well as their ability to seek help and support if necessary. Furthermore, participants said that the programme helped them to have realistic expectations of life with their new baby and has given them some coping strategies. This suggests that the programme has improved parental wellbeing, at least for some participants

4.1.3 Improvements in breastfeeding

Out of the 60 participants with information on feeding method at the beginning of the programme (T1) and postnatally (T3), most did not change their planned feeding method (for the vast majority this was breastfeeding). Just over 10% change from breast to bottle feeding while only one changed from bottle to breast feeding; of those who were undecided most decided to bottle rather than breastfeed (10% vs 5%). Qualitative data suggests that breastfeeding was a key aspect taught on the programme which parents had found beneficial once their babies had been born.

4.1.4 Improvements in practical care

While improvements in practical care were not assessed quantitatively, perceived coping increased significantly from the first to the third time point; as there is no control group this increase may not be directly attributable to the programme. An analysis of the perceived parenting self-efficacy scale suggests that the majority of parents felt confident with the practical of their baby: the scores for the items ‘I am good at bathing my baby’, ‘I am good at changing my baby’ and ‘I believe that I have control over my baby’s care’ were relatively high. Scores for the items relating to soothing the baby were mixed; they were very high (highest of all the items) for ‘I am good at soothing my baby when he/she becomes upset’ but items relating to soothing the baby when he/she continually cries, becomes fussy or becomes more restless.

It was clear from the focus group discussions that participants felt that practical care of the baby was an important part of the programme. Many felt that WTTW had helped to prepare them and that they had gained valuable knowledge of skills; others, however, expressed a desire for more practical care activities in the programme, particularly involving health professionals or new parents with their baby.

Having had the opportunity to look at their experience retrospectively, many participants identified that the programme had prepared them very well, however, at T2 and T3 a small number of participants acknowledged that in reality, nothing can prepare one for the realities of parenthood;

‘Nothing can prepare you for the lack of sleep and the first full poo nappy’
‘No. nothing can prepare you but I’m more comfortable at realising I’m not going to get it all right’
4.2 Objective 2: Comment on the extent to which the programme outcomes achieved

There are 5 programme outcomes to consider here, we have addressed each outcome individually.

4.2.1 Programme Outcome 1: The development of strong communication between parents by sharing experiences and ideas

Qualitative data indicates this has been achieved. Enhanced connections with partners, family members, group members and significant others seems to be an outcome of attending the WTTW sessions. Connections was specifically important to many attendees and this emerged across the T1, T2 and T3 data of the open-ended questions. At T1, data suggests that attendees were hopeful of, and expected to make connections with others as a consequence of attending the programme. These connections seemed to focus upon the baby, their partners, other attendees and health professionals. Data from T2 open-ended questions highlighted that these expectations had been met by the end of programme;

‘I didn’t really know what to expect. But what I have learnt will definitely help me out and make me a better father to my son, and more help to my girlfriend’

‘Definitely, this course has taught me so much about affection and tending to the baby, the relationship between me and my baby. It has also taught me about my baby and the role of my partner and his bonding time with the baby. I love the nurturing aspect, it is outstanding’

Again at T3, attendees acknowledged the strength and sustainability of those connections throughout the first weeks and months after having a baby;

‘I feel helped me bond with my baby prior to birth & open discussion with my husband on certain topics prior to birth’

‘Yes – I met new friends, interacted well with leaders and other mums to be and it provided a safe environment to prepare myself for the new baby, particularly feeding’

4.2.2 Programme outcome 2: an increase parents reflective functioning and understanding of their baby

Reflective functioning refers to the essential human capacity to understand behaviour in light of underlying mental states and intentions. Qualitative data from the open-ended questions suggests that the content of the WTTW sessions plays an important part in the development of parents understanding of their babies. Data at T1 indicates that attendees were hopeful of, and expected to make connections with their babies. At T2, data specifically acknowledges the development/a further understanding of parent’s ability to bond with, feel attached to, connect with, feel close to, interact with, and respond to, their babies. When asked about how the programme. When asked about how the programme has helped them in the first weeks and months of being parents, at T3, parents referred to being equipped with skills to tools to bond with the baby, learning baby cues and react to their baby’s needs.
4.2.3 Programme outcome 3: An increase in parents’ understanding of their own emotional health and the need to nurture themselves to provide the best opportunities for the baby to grow and flourish

Qualitative data from open-ended questions at T2 and T3 highlights that for some parents, they were able to reflect on how the course had prepared them well in terms of understanding their own emotional needs and addressing their emotional wellbeing. Parents highlighted that through the sessions they had been able to develop skills in order to ‘nurture’ themselves. The individual responses from attendees indicated that emotional wellbeing was enhanced through the ability of the attendees to normalise their fear, and help themselves to become mentally prepared for labour and childbirth and for the first few weeks and months of having a baby. This was further reflected in the focus group data where participants referred to understanding their own needs and emotions, improved communication with their partners and others, as well as their ability to seek help and support if necessary. Furthermore, participants commented on how the programme has helped them to have realistic expectations of life with their new baby, and has provided them coping strategies.

4.2.4 Programme outcome 4: The enablement of parents to think about their future as parents and as a family

Qualitative data from the open-ended questions suggests that parents-to-be were considering the impact of their ability to ‘parent’ as early on as the introduction week. At T1, knowledge on how to become a good parent was an expectation of the programme, at T2 and T3, comments such as ‘A great opportunity to ask questions and to get your head around being a parent’, and ‘We feel we are slightly better parents for having the conversations upfront about what kind of parents we want to be’ suggests that for some attendees, the programme had enabled them to consider their future as parents and as a family.

4.2.5 Programme outcome 5: An increase in parents’ understanding of the benefits of breastfeeding and the practical tasks of caring for a new baby

Qualitative data from the open-ended questions indicates that the practical aspects which were covered in the sessions were extremely useful and have played a vital part in helping parents prepare for the first few weeks and months. Data from both T2 and T3 indicate that the practical aspects of parenting, and knowledge and understanding of breastfeeding had been enhanced through engagement with the sessions. T2 data suggests that by the end of the programme, many of the attendees expressed feelings of confidence; confidence in relation to being around their babies, and confidence at parenting, and confidence with practical skills. The T3 data continued to show similar results in relation to parenting and baby caring confidence. Data suggests that for a small number of attendees, there was some informative content around this topic area, which may have resulted in increased confidence;

‘The course has helped – in particular various techniques that can be used to help both us and the baby settle. Being shown how to bathe and change the baby was really helpful’

‘… and how to encourage successful breastfeeding. Also how important it is to nurture yourself in this journey’
Out of the 60 participants with information on feeding method at the beginning of the programme (T1) and postnatally (T3), most did not change their planned feeding method (for the vast majority this was breastfeeding). Just over 10% change from breast to bottle feeding while only one changed from bottle to breast feeding; of those who were undecided most decided to bottle rather than breastfeed (10% vs 5%). Qualitative data suggests that breastfeeding was a key aspect taught on the programme which parents had found beneficial once their babies had been born.

4.3 Objective 3: Comment on the factors affecting the successful implementation of the programme

Qualitative data from PGL interviews suggests that generally PGLs seem to be very enthusiastic and committed to providing the programme, ensuring good effective recruitment and delivering an inclusive, engaging programme. Overall, the factors affecting the successful implementation of the WTTW programme seem to be largely around the following key areas;

- Targeting of groups; this can lead to lower recruitment/numbers of attendees. Universal approach seems to be more effective
- Lack of flexibility of programme provision: PGLs whilst understanding the importance of structure should be encouraged to be flexible in their approach to delivery, in order to maximise the likelihood of attendees being able to attend all sessions
- Delays with recruiting potential attendees: this results in potential attendees accessing other programmes
- Lack of a recruitment strategy and limited advertising; this has an impact on recruitment – some PGLs had a clear strategy. This involves a collaborative approach with midwifery and seemed to be really effective in terms of recruitment, for example;

‘When they get green booklet, there is a sheet of A4 paper with all the antenatal classes, they either look at that or through discussion with midwife. And she gets them to book on’

‘They are referred by the midwife but again we weren’t getting enough in so what we’ve done is we’ve held workshops to promote it, and done presentations to generic midwives to get messages out about the programme and then we have devised an A5 colourful card to promote the programme as well’

- Changes occurring in the wider healthcare climate: closure of maternity units
4.4 Conclusion

Welcome to the World appears to play an important part in preparing parents for parenting specifically in the areas identified; improvements in attunement, bonding and attachment, parental wellbeing, breastfeeding, and practical care. Parents seem satisfied with the programme, and the way in which it is delivered. It meets their expectations. The qualitative and quantitative data combined suggests that the WTTW sessions have a significant role to play in achieving the 5 programme outcomes. Thus, parents engaging with the programme experience positive communication between each other, an understanding of their baby’s needs, an understanding of their own emotional health needs, a greater understanding of their roles as parents, and an increased understanding of the benefits of breastfeeding. PGLs are extremely enthusiastic and committed to the programme; they have a vital role to play in ensuring the sustainability of the programme, and they are key to successful recruitment.
5 RECOMMENDATIONS

The evaluation underscores a number of aspects within the current Welcome to the World programme which require consideration. These aspects/findings are subsumed in three recommendations that provide a framework that may guide future efforts in this area of antenatal nurturing.

5.1 Recruitment and implementation

5.1.1 Targeting

Data suggests that the targeting of groups, that is identifying a population or sub-group for whom WTTW as an intervention or programme is most appropriate, results in lower recruitment and retention numbers. Whilst targeting is a worthwhile endeavour, a universal approach seems to be more effective in obtaining appropriate numbers. If recruitment and retention figures play an important part in the continued success of WTTW, more attention needs to be given to the development of retention strategies for targeted groups.

5.1.2 Advertising

Lack of a recruitment strategy and limited advertising has an impact upon successful recruitment, and a collaborative approach to advertising and recruitment was found to be very effective. An effective recruitment and advertising strategy, should be aligned very closely to the strategies of the other health professionals involved in the care of pregnant women, taking into account where and when women engage with these health professionals and maximising these opportunities to facilitate recruitment.

5.1.3 Engaging men

Researchers are only beginning to understand men’s unique experience of perinatal mental illness. Recruitment and retention to this study for men was disappointing, and this suggests that recruitment to the WTTW programmes for men is generally low, particularly in some groups. Of the eleven men who completed data across the three timepoints, six scored above the cut-off point for the EPDS (6 or more antenatally, 10 or more postnatally), and this number seemed very high. The evidence for cut-off points for men is much less robust than that for women, so these figures should be treated with caution. Consideration however should be given to ways of improving attendance for men, given the emerging evidence which suggests that fathers do experience distress during the transition to parenting, including postpartum depression, that is not regularly screened for, diagnosed or treated (Musser et al 2013).

5.1.4 Timing of classes, venues and gestation at time of recruitment

Consideration should be given to the finding that evening classes seemed to be preferable to many attendees, that the venue is important in terms of being spacious and not too cramped, and that having access to parking is valuable. Attending all sessions was important to many participants and therefore, to maximise retention, where possible, attendees need to feel confident that they will be able to complete the full eight weeks before their estimated date of delivery. This may mean that women are recruited to the programme at an earlier gestation.
5.2 Programme content
Throughout the focus group data there were a number of suggestions from participants about aspects which were most valued in relation to the content, and aspects which should have been included. These have been listed below and we recommend that consideration is given for these topics in future provision: practical care (specifically nappy changing, bathing and dressing the baby), the attendance of health professionals so attendees could meet them and ask them questions (specifically midwives), the attendance of new parents (to share their experiences of the first few weeks), attendance of members of breastfeeding support groups, the use of formula milk (specifically how to prepare feeds, how to sterilise, and how to store formula milk), and covering potentially difficult times (specifically being discharged from midwifery care and the partner returning to work).

5.3 Further research
This evaluation raises a number of opportunities for future research. More research will in fact be necessary to refine and further elaborate our findings.

5.3.1 Sample size and study design
First, while we have generated a number of new and useful recommendations with respect to recruitment and retention and course content, due to the low numbers of participants who completed data for all three time points, the findings with respect to the Edinburgh Postnatal Depression Scale (EPDS) for emotional wellbeing, the Pictorial Representation of Attachment Measure (PRAMS), and the Maternal/Partner Infant Bonding Scale (MIBS) for attunement and bonding, whilst very interesting and at times pleasing, should be treated with caution. In addition, as there was no control group, it is not possible to say whether the changes noted across the three timepoints with respect to these measures are due to the impact of the WTTW programme or would have occurred without it. Consideration has to be given to a future project similar to this one with greater numbers and the use of a control group for comparison.

5.3.2 Collecting data on attendance and study participation
In terms of drop-out rates, a total of 131 participants (96 women, 35 men) completed evaluation booklets. However, not all participants did so at all three time points: 77 participants (58 women, 19 men) completed booklets for T1 and T2 and 54 (43 women, 11 men) at all three time points. Looking at these numbers, it has not been clear how many dropped out from the evaluation, and how many dropped out of the WTTW programme. Participants frequently drop out of research projects/evaluations, and this is frustrating, and threatens the validity of the findings; however, levels of drop-out from the programme are useful to know as this may be an indicator of a specific programme-related problem. Future evaluations of this type should endeavour to understand more about levels of drop-out, and measures should be taken to distinguish between drop-out from programme and drop-out from the evaluation.

5.3.3 Information on groups: targeting, venue, time
More detail should be provided in relation to targeting of groups, venues and the timing of the sessions as this will facilitate a greater understanding of the barriers and facilitators to attendance.
REFERENCES


