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**“Fathers experiences of the Health visiting service”**  
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**Abstract**

Inappropriate and ineffective care of men and fathers is a barrier to positive family care development within the public health nursing and health visiting service. This care in relation to fathers needs to be addressed in light of changes in social climate. The purpose of the study was to inform the health visiting service of the experiences father's have of the current service. The research study investigated the way the health visiting service is delivered and if it is targeting fathers and families effectively and equitably.

The study was of a qualitative interpretive design, using a purposive sample, of between five and seven fathers who regularly attended a father's group. These fathers had one semi-structured interview, which was designed to establish their experiences of the health visiting service. Using a phenomenological approach, and open coding analysis the experiences of the fathers explored.

**KEY WORDS**

**Fathers, health visiting, transition, qualitative research, matriarchal care.**

|   |  |
|---|--|
| <p><b><i>What do fathers think the health visitor's role is?</i></b></p>          | <p><i>"I never saw her it's the missus job. I just went out the room when the bairn was born and never saw her except at clinics when she had her jabs "</i></p> <p><i>"I haven't personally had very much experience with the family health visitor and then we split up and me son was living with his mam so I never saw him"</i></p> <p><i>"I've seen ours twice and he's three now she never spoke to me"</i></p> <p><i>"Never saw her, she helped the bairn when she was bad n that but that's it"</i></p> <p><i>"She came quite a bit when he was small but then after about two we didn't see her" "My health visitor was at the clinic if you had any worries n that."</i></p> <p><i>"To visit the house and see if you're all alright and if not to get the doctor or help."</i></p> <p><i>"It's the checking on if your child is growing right and that it's doing ok."</i></p> |
| <p><b><i>What are father's experience of the health visiting service?</i></b></p> | <p><i>"I've had a couple at the minute I've not seen her that much maybe a couple</i></p>  |

*of times since birth. She seems alright, the first one was very good or seemed to know what she was talking about. I was always happy and I knew how to get in touch if I needed to although I did once try and it was difficult, but she did ring me back eventually”*

*“I never saw her it’s the missus job. I just went out the room when the bairn was born and never saw her except at clinics when she had her jabs “*

*“I haven’t personally had very much experience with the family health visitor and then we split up and me son was living with his mam so I never saw him”*

*“I’ve seen ours twice and he’s three now she never spoke to me”*

*“Never saw her, she helped the bairn when she was bad n that but that’s it”*

*“She came quite a bit when he was small but then after about two we didn’t see her”*

***How could health visitors help fathers more?***

*“I think to know that groups like this one are out there and men like us can get help about our health and the families from health visitors without feeling your in the women’s place”*

*“I think just helping Dads to feel part of looking after their kids. I look after mine all day cos I don’t work cos of me back but it’d be me wife that they called if they wanted something but it’s me who knows them best “*

*more for Dad’s especially if they’re separated from their kids like the dads group too so we can get information as well cos were still dads and we need it to look after the kids when we have them too”*

*“Just to know you can get help and advice off the health visitor without going with the missus or having a bairn”*

*“my health visitor was at the clinic if you had any worries n that but the*

|   |   |
|---|---|
|   | <p>wife went cos it's all, like the nurses n that"</p> <p>"I never saw her it's the missus job. I just went out the room"</p>   |
| <p><b>What could the health visiting service do to include fathers?</b></p> | <p>"eh, keep in touch a bit more , more visits and having a look if the fathers separated from the bairn have an appointment with the bairn when he's with him or arrange with Dad and Mam to see them together"</p> <p>"To include fathers more and get them more involved especially if you're a Dad on his own like me"</p> <p>"Everything could improve by communication and more for Dad's especially if they're separated from their kids like the dads group too so we can get information as well cos were still dads and we need it to look after the kids when we have them too"</p> <p>"Just more stuff to help Dads and know who is there for them with the kids and stuff"</p> |

|  |   |
|--|---|
|  | <p><i>“I haven’t personally had very much experience with the family health visitor and then we split up and me son was living with his mam so I never saw him”</i></p> |
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## **Abstract**

Inappropriate and ineffective care of men and fathers is a barrier to positive family care development within the public health nursing and health visiting service. This care in relation to fathers needs to be addressed in light of changes in social climate. The purpose of the study was to inform the health visiting service of the experiences father's have of the current service. The research study investigated the way the health visiting service is delivered and if it is targeting fathers and families effectively and equitably.

The study was of a qualitative interpretive design, using a purposive sample, of between five and seven fathers who regularly attended a father's group. These fathers had one semi-structured interview, which was designed to establish their experiences of the health visiting service. Using a phenomenological approach, and open coding analysis the experiences of the fathers were explored.

### **KEY WORDS**

**Fathers, health visiting, transition, qualitative research, matriarchal care.**

### **Body**

Inappropriate and ineffective care of men and fathers is a barrier to positive family care development within the public health nursing and health visiting service. This care in relation to fathers needs to be addressed in light of changes in social climate. Men often identify involved fatherhood as private, and are often so controlled, and unforthcoming, that research and engagement with them is often difficult to interpret, and sometimes impossible. This provides both the health service and the health professional with a barrier.



Many papers and policies identify the importance of paternal contribution to child health and development and the detrimental effects on the whole family when it is ignored resulting in paternal depression.(DoH 2019,Sheehan and Fisher 2017,) Garfield et al (2014),Identifies increase in male depressive symptoms in key attachment years of 0-5 can be improved by addressing social factors and designing effective interventions which ultimately improve entire family outcomes.

This study was a basis from which to find out if and how the service needs to change to encompass fathers need **from a fathers perspective**. The findings were used as an evidence base from which to address service change from a user context, and to initiate a more equitable service to parents. **Some of the solutions lie in training, supervision, reflecting on our own ideas of men in families and overcoming female gatekeeping**(Bateson et al 2018). **Much of the literature that exists was completed more than two decades ago it is important to acknowledge a positive societal and cultural** change in both the home and workplace has taken place with the number of fathers working from home to provide childcare tripling. Curtis (2006), Leach (2017) believe this is evidence of a social revolution with fathers renegotiating their lives to be more involved in their children's lives. Research exists to support this suggesting positive father involvement is associated with decreased child behavioral problems, better social competence and cognitive function and decreased risk of social and psychological problems(Amato and Rivera,1999,Goncy and van Dulmen ,2010,Carlson 2006, Dubowitz et al 2001).If this is so, the nursing services need to change to embrace and target men and new family needs more effectively. Burgess and Ruxton (1996) found health visitors guilty of ignoring fathers and erecting barriers to their child's care. This study investigated men's experiences of the health visiting service and provides

evidence for the need of service modifications to the nursing profession and Health visiting provision. Thus, being better able to prevent traumas associated with new fathers needs and the negative effects these can have on the child and family unit by providing equal support and provision of care. (Watson and Doyle, 1999; Trevelyan, 1996).

Men in general are difficult to engage in and access health care delivery. The health visiting service, despite being a whole family service, is often viewed as a mother and baby service by the public. Fathers are addressed but more so as a supporter of the mother or mother and child unit rather than being integral. As a result of this men fail to engage with practitioners, this may disadvantage fathers, who play an integral part in the health of future generations. To inform the service and improve it the views and experiences of fathers as service users are imperative to moving health visiting forward.

Fishbein (1984) believes that little attention is paid to male parental development, because the health service views them primarily as a support person; this is a barrier to positive family care development within the public health nursing and health visiting service, and needs to be addressed with the change in social climate. Whilst 1000 critical days (2019) and early years High Impact areas (DoH 2014) call to address the importance of fathers interaction and mental adaptation to parenthood no provision is provided within the new NHS plan or guidance.

Lamb 2010, identifies five determinants associated with positive paternal outcome amongst them institutional policy and practice and early conceptualization of fatherhood the very essence of the Health visiting service. This is supported in earlier research by Belsky (1984), who also reiterates the importance of social support in the fathering

process which Lamb(2010), breaks down into social support and community and cultural influences including socio-economic opportunity.

This research sets the scene in social and professional terms to outline the need for this and future research projects and the justification for undertaking it. If nursing care remains at a standstill, it not only fails to address need, it also is ineffective and can be damaging. Evidence, and a solid research base is required to provide the most effective and appropriate care in all areas of nursing and including family community care and health visiting.

**The aim of the Research:**

To investigate and explore fathers experience of the local family health visiting service.

The aim has been broken down into four research questions:

Research questions:

1. What do fathers think the health visitor's role is?
2. What are father's experiences of the health visiting service?
3. How could health visitors help fathers more?
4. What could the health visiting service do to include fathers?

**Method**

The study was of a qualitative interpretive design, using a purposive sample, of between five and seven fathers who regularly attended a father's group. These fathers had one

semi-structured interview, which was designed to establish their experiences of the health visiting service. Using a phenomenological approach, and open coding analysis the experiences of the fathers explored.

Qualitative research was chosen for this study to provide a deeper meaning and understanding of the social phenomena under study i.e.” Fathers experiences of the health visiting service .” In relation to the professional context of the author as Nurse and Health visitor as well as researcher, a qualitative naturalistic approach sits well within the reality situation of nursing, as it concerns the constantly changing interaction and behavior of humans, the main focus of this study and studies within the profession.

Inductive reasoning; begins with the collection of data which is developed into a theory. It was my goal as the qualitative researcher to identify patterns, or commonalities, by inference of examination. The purpose being to identify concepts and relationships within the data and to understand what was being said by analytic induction.

The phenomenology paradigm is a focus on “*the way the experiential world every person takes for granted is produced and experienced by its members*” (Holliday 2002:18). It is a combination of these two paradigms that formed the basis of this study. The phenomenon being fathers, and how they themselves view their world of fatherhood in relation to the social structure. Progressive qualitative research looks at reality and science and how it is constructed socially, aiming to problematize and reveal hidden realities, and from initiate discussions. By combining this with phenomenology this study set aside the taken for

granted orientation of fatherhood and investigated 'what' and 'why' fathers experience services, and fatherhood, as they do.

### **Ethical consideration**

Research ethics committee approval for the study was gained and all procedures were performed in compliance with relevant laws and institutional policies and procedures. To adhere to strict professional and ethical guidelines participants were asked to give consideration, written consent, and were given patient information, which outlined anonymity and confidentiality for the project and professional accountability in relation to any information disclosed.

### **Data collection**

Study participants were fathers who attended a weekly fathers group; they were asked by letter, if they would like to participate. The study was explained to them in written format and they were given two weeks to consider taking part in it. Participants who agreed to take part in the study were given an agreement to sign for consent. Informed consent is essential in any research project to ensure participants are fully aware of the use of the information they give, and its purpose, to prevent damage or distress and litigation. All participants had the right to withdraw at any point this was outlined in the patient information issued with the letter of invitation.

This study was of a qualitative interpretative design and used a purposive sample of six fathers who regularly attended a fathers group.

Data was collected via a semi-structured interview, which was audio taped. The interview was designed to establish the men's experiences of the health visiting service and incorporated a number of open questions.

The principal inclusion criteria were fathers who live in the local geographical area and that attend a weekly fathers group, and who had experienced the South Tyneside health visiting service.

### **Data analysis**

Following interview, the tapes were transcribed and analyzed using concepts from grounded theory. The method of grounded theory provides a path through the qualitative research process. I was able to adapt and adopt these methods to construct the data in a flexible way. Both data and analysis created from shared experiences and relationships with participants, and researcher lie squarely in the interpretive tradition. This is a phenomenological study, and as such, open and then axial coding was used to identify categories and themes. Coding examined each incident, sentence, and word and built categories by identifying those words, and their commonalities, within the text, that have meaning in the context of the research phenomenon. As researcher I made links and relationships between the concepts and categories derived from coding and these formed the 4 themes: Police or health Promoter, Matriarchal exclusion, Changing services for a changed society and masculinity as a barrier

Coding was selected as by fracturing the data, then conceptually grouping it into codes which became themes allowed me to explain what was happening in the data.

Themes and categories were the result of data analysis and born during data collection. The data categories selected relate to reliability and validity, in that they are grounded within the transcribed texts, and the methods employed by the researcher are appropriate to the phenomenon studied in this instance the fathers experiences.

## Results Discussion

### Police or health Promoter

The results of this research demonstrated that in many of the responses by the fathers they saw the health visitor's role in a policing capacity. For example; they used words such as "monitor", and "checking", in relation to child growth and health, and used statements such as "check if you're looking after the bairn well", and "that things are being done correct" and "the house is clean".

Hamill and Bigger (2005) acknowledge the relationship of professional power to health visiting, they state that clients often understand health visiting in terms of either support, or surveillance.

On a positive note it was reported that the health visitor was there to "help" and to see if the child is "growing right" and to deal with "any worries"

Support is one of the main aspects of health visiting, and it is good that **this was** recognized by the fathers interviewed. Contrary to the study by Almond (1996), who believes lack of knowledge of the health visiting role and support to fathers and men, is why they are reluctant to engage with family nursing care. The fathers in this study clearly knew what role the health visitor had, and their remit in relation to health. Luanaigh (2002:142), found clients to perceive the most useful aspect of health visiting to be **support for clients and families engaged with the service**. However, it is the inclusion of the whole family, and themselves that comes into question. Responses in this study denote the relationship between the professional and the child even their partner but not themselves. For example;

*“checking on child,” “monitor wellbeing of child” and “if your child is growing right”* Price (2001) believes this is because the health visitor has previously focused on mother and child, and not challenged the basis of gendered assumptions regarding childcare. Whilst modern health visitors are in a position, working to meet needs of families, and communities, the women centered history and prevalence of care reinforces and perpetuates the notion that women are the most natural providers of care for children. This therefore leads to the exclusion of men.

### **Masculinity as a barrier to health engagement**

The views of the fathers in relation to their experiences of the family health visitor in this study, were negative in relation to their contact and time experience. For example question 2 responses; *“I never saw her” “I never saw her except at clinics “and “after two we didn’t see her.*

Several explanations exist within the literature that may clarify this. Fisher (2005; 201) relates to this, stating that, often the exclusion of fathers plays itself out in the living room. Is it because as men they do not wish to engage in health seeking behavior? One suggestion is that “gender differences in socialization may make it easier for women to engage in help seeking behavior without losing face, (Robertson and Williams, 1997). Often men’s health issues are dealt with on a one to one basis, colluding with the stereotype that men should not openly discuss their problems and feelings (Robertson, 1995). Also men’s perception of what fatherhood is can lead to exclusion of themselves, by themselves. Williams (1998) found that men conceptualized fatherhood as being about responsibility, and provision, and not of carer, or facilitator of health. La Rossa (1989), identifies two elements of fatherhood



as an institution firstly the culture i.e., the shared norms, values and expectations that surround parenting. Secondly the conduct i.e. what fathers actually do. He states that whilst the culture of fatherhood has changed somewhat, conduct has changed very little. Williams (1998) agrees with this, stating that whilst fathers see the health visiting service to be valuable to their partners and children, they see it as not applicable to them. In relation to them, health is only a functional capacity, paying little relevance to fatherhood. If fathers see little relevance to fatherhood in accessing health, or healthcare services, then that would account for them having little or non-conducive contact with the health visitor.

Whilst the responses(see results table), suggest little or no contact it may be father's disengagement that leads to this experience. This may be because of the relation to their own perception of fatherhood and perception of their own role as fathers. Daniel and Taylor (2001) suggest that a barrier to fatherhood, indeed good fatherhood, is confusion. Fatherhood suggests a good male role model with the masculine traits that go with that, such as "stiff upper lip", and "tower of strength." These can lead to reluctance to engage in feminine qualities such as healthcare engagement. If there is a unique role that is fatherhood, then parenting needs to include fathers as equal participants, and not just helpers of mothers.

Failure to engage with men in their fathering role, has clear consequences for family dynamics, child health and development and society as a whole.

Traditional notions of masculinity may limit a man's ability to seek and accept emotional support and exacerbate conservative masculinity. New fathering roles need addressed to contradict traditional gender role and notions of masculinity. Conflict and confusion interrupts parenting in both men, and women, as emergent demands of the real-world clash

with traditional unrelinquished social norms (Taylor 2005, Price, 2001). Even highly motivated fathers lack an inter-male space, to identify themselves. As fathers assume multiple roles, and struggle in redefining relationships, health professionals can offer anticipative support and advice, to prevent familial disharmony and negative effects on child and family. Even before the child arrives the dynamics change, and an area of support for fathers is required to assist in role change and begin with the engagement in healthcare. Fisher (2005) talks of health visitors worrying deep down that they might be withdrawing attention from mothers and children by including fathers in our practice. He states that this may be because we view fatherhood as separate from mothers and children, and therefore not really part of family care. Fathers within this theme stated that they were to some degree happy with the service that they were experiencing, and an awareness of how to contact the health visitor and how she could help expressed.

### **Matriarchal exclusion; A fatherhood fact**

This theme identified the father's feelings around how health visitors could include and help them more. It was startling to find that these men still identified their children's healthcare as a matriarchal act in both parental and professional terms.

Whilst healthcare is patriarchally dominated by medicine, nursing is entrenched in matriarchal delivery with mother and baby central, and often the father left on the periphery. The social pressure to be a "tower of strength", plus the reluctance of society to

acknowledge men's feelings, is a contributing factor to both family degeneration and erosion of men's mental health.

The results identify a need for nursing to link the birth transition, to fatherhood, rather than simply prepare men to support their partners, which currently leads to professional and family exclusion and feelings of inadequacy. Healthcare professionals need to recognise parenthood is no longer gender specific. Fisher (2005) believes that core skills for everyone working with families is essential and that this must include effective communication, and engagement, with parents with them defined prominently, and explicitly, as both mothers and fathers.

Much evidence exists in this research study that relates to the concept of “mother and baby” focused care, with the father on the periphery, and excluded,

Society has failed to count the social, economic, and emotional costs of father absence in health care. By resorting and supporting, only half of the parenting unit i.e., mothers, we are as professionals shortsighted, and not acting in children's best interests. Whilst gender roles, parenting, and family life, may have changed, this is not reflected by actual fathers or health professional's behavior. Torr (2003) suggests that the key to family, and partnerships, may lie in childcare equality, which in turn reduces family stress, marital breakdown, and increases parenting role satisfaction. The National service framework for children's services (DoH, 2005), the New NHS long term plan (DoH 2019), 1001 critical days (Leadstrom 2013), identify the exclusion that the men in this research talk of. It uses the phrase “women focused, and family centered”, and includes a strong focus on dealing with the full social context into which a modern-day child is being born, indicating that the

family is the main influence over the child. policies recognize fathers positive contribution but apply little in service delivery and formation to support this.

The birth of a first baby brings health visitors into contact with a group of men previously inaccessible, which creates opportunities for health promotion, parenting support and relationship re-evaluation,

### **Changing services for a changed society**

The research identified the need for health visiting input on a greater scale for the fathers, especially where they were separated from the birth mother.

In a society that is turning its back on marital institution (ONS 2018), with soaring divorce rates, and children born outside marriage we must acknowledge the need to foster egalitarian relationships between biological parents. To do this we need to offer support, advice, and health care, to the child without the exclusion of a parent, regardless of where they live, or marital status.

It is recognised male family influence, is an important aspect in the wellbeing of the child and that paternal deprivation could lead to both cognitive and emotional developmental delay in the child (Watson and Doyle 1999). This is well documented, and recognized, within the literature but despite this, healthcare services have not changed in their method of delivery. In Britain, just over sixty three percent of children now live with both birth parents. Cohabiting families with dependent children increasing with many fathers living with none of their biological children, and the remainder with only some of their biological children. (ONS 2018). This has clear consequences for healthcare delivery, and necessity

for readjustment of family service provision to encompass fathers in their biological children's care.

The fathers, within this study clearly demonstrate that whilst the social construct of fatherhood has changed, neither culture nor health in Britain have acknowledged this.

A consequence of increasing female employment outside the home, has meant that fathers have become more involved in the day-to-day care of their children. This can only be seen as positive for both fathers and children; this shift is reflected in this studies results. Society's attitudes, norms and desirable parenting patterns, have changed significantly. This study identifies how as a health service we need to engage with fathers, and involve them systematically as key people of influence in children's lives, in a social context where the caring role of men is acknowledged.

Four of the six fathers interviewed stated that they wanted to be more involved and wanted more communication, more groups and to know how to access information and support without having to have a female partner or child.

The fathers interviewed clearly enthuse about the fathers group they attend. By involving fathers more in health visiting, we will begin to recognize their contribution, and address their needs more effectively. Like all new initiatives the fathers group the interviewees attend was a challenge to my professional practice, and the service as no other group like it exists within the local area.

### **Limitations and strengths**

Validity and reliability are fundamental requirements to good research. The greater the reliability and validity of investigation, the greater the quality of research because irrelevant, and obstructive issues are excluded.

Qualitative data analysis can be quoted as subjective because the researcher has to make judgments related to the data, and to aspects of the phenomenon, in this case the fathers in the local area. Validity of data in qualitative studies is verified by the methods, approaches and techniques employed, and within this study measured accurately the issues and subject in the research questions. It was important to this study that the appropriate method was used to analyze the presented data, to enhance the validity, and reliability of the findings. It is my individual interpretation that gives me a unique insight and experience that enhances, not bias, the data results. The data has been discussed in relation to other research to strengthen the reliability and validity of the study. To counteract the subjectivity in the study and enhance the validity respondent validation was used and all six fathers validated the transcription results confirming that nothing had been lost in the transcription from audio tape to text. They also verified that no hidden meanings had been omitted or generated in transcription. Reliability in this study may have produced the same data in a group of fathers attending a fathers group anywhere in the country. Limitation in respect of this is that the sample had the benefit of having attended a fathers group, and contact through this with a health visitor, whilst another sample of fathers may have had a different perception of what the health visitor's role was. The sample number used was a relatively small number, six, and a larger sample may have simply produced the same data on a larger scale and not necessarily enhanced the study. A positive consequence of the way the technique was used, was that the researcher was able to gain the answers to the exact research questions. The researcher could have, however, gained more information, and a richer insight, by being more probing and interviewing in a less structured way. **Whilst a grounded theory**

approach was used for this project, the small size and time limits involved in an MSc project, meant it was not possible to fully saturate the categories using selective coding, or utilize a true grounded theory as concurrent data was not collected or analysed. This was a limitation which could be corrected by completion of further studies in differing geographical areas.

### **Implications for practice**

This study clearly identifies that fathers are asking to, and want to, be included in their children's and families care.

Health visiting needs to promote its role to fathers and needs to be aware of the barriers it faces in getting men to engage with health. By doing so it will be able to formulate a service that not only enhances men's, and children's care, but also helps support, and facilitate a positive fathering role for future generations. In recognizing father's needs, the service can begin to constructively ask, what real needs men have, and begin to address them in a male friendly way, and not simply as an added bonus to the mother.

Nursing needs to recognize the family unit as a whole and remove the presumption of a 'mother and baby' service. This is possible by engaging with fathers actively, and not by simply including them in policies, and guidelines. The fathers in this study felt alienated by the traditional male stereotype, and stated that more communication, and literature specific to them, was required and not simply passed through the female partner. Society has changed, and some of the men despite living apart from their children, want to play

an active role as fathers. As health professionals we must embrace this interaction, and not assume that just because the man is not present he does not wish to be a father to his child. 1001 critical days(2019),Marmot report(2010) and long term plan all call for early intervention address of marginalized groups and formation of services to prevent child and family ill health and long term effects.

For some of the fathers in this research, they were the main, or sole carer and professionals were failing to recognize this, possibly to the detriment of the children, by asking for information from secondary less familiar carers. By exclusion from health care appointments for their children and parenting information, the fathers interviewed felt a lack of communication. The assumption is at present within health that estranged fathers do not want to be involved in their children's care. A recommendation for practice would therefore be that when contact information is gained at birth, it should be regularly be updated at all family contacts, so if relationship breakdown has occurred, but the father wants to be included in his child's care, he can be invited and sent details of appointments. The fathers in this study clearly stated the benefits they had received by attending the fathers group, and that more groups like it need to be constructed. They stated that they wanted groups that offered support, and information, and not ones that encourage the "dads and lads" stereotype. Health visitors also need to be aware of local and national support services and resources specifically available for fathers so that they can share them.

Further research is required to gain a deeper understanding of why men, continue to fail to engage with services. The implications from this study for practice, need to be



implemented using evidence based provision and services as called for by government and the public to improve the future health of generations to come.

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