



# Who's the bloke in the room?

## Fathers during pregnancy and at the birth in the UK

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### Executive Summary

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This document, published by the Fatherhood Institute and funded by the Nuffield Foundation, highlights some of the research evidence from our Full Report into fathers in the antenatal period and immediately after the birth, in the United Kingdom. Unless otherwise specified, all the research cited is derived from studies carried out with UK samples. More detail, discussion and the full references/ bibliography can be found in the Full Report (along with our Methodology) here:

<http://www.fatherhoodinstitute.org/2017/contemporary-fathers-in-the-uk/>.

*The views expressed are those of the authors and not necessarily those of the Nuffield Foundation.*

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## Insufficient attention paid to fathers, MATTERS...

*“The marginalisation of fathers presents three problems. It suggests that fathers are optional in children’s lives, and don’t contribute to children’s wellbeing. It is detrimental to mothers as it over-burdens them with sole rather than shared responsibility. It dissuades take-up of and participation in services by fathers and pushes men to accept a diminished role in the life of their families”*

*(Clapton, 2014, p.1)*

## What the evidence tells us about fathers’ impact...

### *Before conception*

#### **Their alcohol consumption, smoking and diet all affect conception and healthy child development**

Fathers’ impacts on their baby begin before conception: while 15% of the variability in fetal growth can be explained by the mother's characteristics, around 7% can be explained by the father's (Hennessy & Alberman, 1998). Genetic and environmental effects relating to the father, and potentially epigenetic effects, are connected with fetal growth rates (Hennessy & Alberman, 1998), risk of C-section (Stulp et al., 2011), birthweight (Dearden et al, 2005) and excessive weight gain in young children (Griffiths et al., 2007). When a man is a heavy smoker conception can be delayed (Hull et al. 2000) and his children are at risk of short stature, obesity and ADHD symptoms (Langley et al., 2012). Men’s heavy-drinking at conception is also linked with ADHD symptoms in his children and poor school achievement (Kukla et al., 1996).

#### **Unplanned fatherhood can have serious, negative consequences**

Reluctant fathers are more likely to use violence (Kothari et al., 2015), less likely to care for their child alone once born (Washbrook, 2007), and less likely to stay in touch if not living with their child (Marryat et al., 2009). Yet these unenthusiastic fathers (who may be in particular need of information and support) are rarely identified – even in research. Large-scale British studies define a pregnancy as planned when the mother planned it, and do not seek the father’s view. Identifying an expectant father’s initial hopes for the pregnancy could be significant in delivering optimum care to mother and infant. A recent survey found that

almost one-in-five dads in Britain had been taken by surprise by the pregnancy, and a third of these had negative or mixed feelings about it (Fatherhood Institute & Fathers Network Scotland, 2018).

### *During the pregnancy*

#### **Fathers are vital in helping pregnant mothers stop smoking and improve their health**

In the UK, as elsewhere, couples' circumstances, health behaviours and vulnerabilities tend to be inter-twined: weight (Brown et al, 2013), diet and physical activity (Northstone & Emmett, 2010), substance use (Kendler et al., 2013) and mental health and wellbeing (Deater-Deckard et al., 1998). By far the biggest predictor of a pregnant woman's smoking status is her partner's: expectant mothers are four times more likely to smoke if their partner smokes (Penn & Owen, 2002) and are less likely to quit if he continues and more likely to cut down if he cuts down (Prady et al., 2012). The recommended training module for staff to address pregnant women's smoking does not include reference to their partner (NCSCCT, UNDATED) – despite the dangers of passive smoking, and NICE recommendations that he be included.

#### **Fathers' mental health is crucial to mother and baby's well-being**

Depression in expectant fathers is linked with emotional, behavioural and psychiatric problems in their children later (Hanington et al., 2012; Van Batenburg-Eddes et al., 2013; Ramchandani et al., 2008). This effect is probably 'indirect' – and no less significant for being so: expectant fathers' depression is likely associated with couple conflict, unemployment, money and housing difficulties (Ramchandani & Psychogiou, 2009). These may distress the mother – and the stress may pass through to the foetus. Fathers' poor mental health after the birth also has direct effects on their baby' due to poorer-quality father-infant interactions (Dragonas et al., 1992; Thorpe et al., 1992).

### *At the birth*

#### **Most men attend ante-natal services with their partner but often feel unwelcome**

Stretching back at least 30 years, around 90% of fathers have been present at their babies' births in Britain (Dragonas et al., 1992; Kiernan & Smith, 2003; Redshaw & Henderson, 2013; Alderdice et al., 2016), with a similar percentage attending ultrasound scans (Redshaw & Henderson, 2013; Alderdice et al., 2016). And even though the NHS does not invite them in, three quarters of first-time fathers in England (Redshaw & Heikkila, 2010) and four fifths in Northern Ireland Alderdice et al., 2016, accompany their partner to at least one routine

antenatal care appointment. Most recently, an online survey found 93.7% attending (Fatherhood Institute & Fathers Network Scotland, 2018). A direct invitation would likely bring in many more: 10% of men questioned said they didn't know whether they would be welcome, whether their attendance was necessary or whether they would make a useful contribution (Newburn & Singh, 2000).

### **It's good for fathers to attend the birth**

There is no evidence of men being forced to attend their baby's birth; and relevant evidence suggests little ongoing serious distress (such as PTSD) resulting from it (Bradley et al., 2008), even where the birth was tragic or challenging. In Britain, fathers who suffer afterwards tend to have poor mental health beforehand (Greenhalgh et al., 2000), were very ill-prepared, or had been 'left in the dark' during emergency interventions, which they did not witness (Hinton et al., 2014). Identifying at-risk men, preparing them well for the birth and keeping all fathers informed during it, may greatly benefit the whole family. Only 61.3% of respondents to the recent online survey reported that medical staff had 'often' kept them informed (Fatherhood Institute & Fathers Network Scotland, 2018).

## What we know about what women want...

### **Mothers want and need their partner involved at every stage**

Expectant mothers in Britain want their partner to be included in antenatal classes (Young, 2008), antenatal care and antenatal screening, including participating 'as a couple' in discussions with health care practitioners (Skirton & Barr, 2010). UK research has found birthing women rating the support they received from their partner more highly than support received from midwives (Spiby et al., 1999); and when their partner is present and supportive, the women require less pain relief and evaluate the birth-experience more positively (Chan & Paterson-Brown, 2002). Women rate the quality of care they themselves received more negatively if they think maternity staff did not include and encourage their partner (Redshaw & Henderson, 2013). Women who give birth without a partner present also judge the care received more negatively (Raleigh et al., 2010). It has been suggested that some fathers' presence may be protective: almost half the NHS negligence bill is accounted for by claims relating to poor maternity services; and when two Units piloted overnight facilities for fathers after the birth, complaints plummeted and midwives were freed up to provide direct care (Higgs, 2010).

### **Fathers provide continuity of care**

The research also finds the expectant mother's pre-eminent support person to be her partner (who, as detailed below, is almost always her baby's biological father): if he is away during her pregnancy, she is more likely to be emotionally vulnerable (Thorpe et al., 1992); he is generally the first to know when she is developing depression (Boots Family Trust Alliance, 2013); and

his pre-natal support has even been associated with the quality of her parenting afterwards (Barnes et al., 1997). His supportiveness is associated with depressed new mothers' earlier recovery (Di Mascio, 2008), and breastfeeding success (Ingram & Johnson, 2002). In a system which rarely delivers midwife-led 'continuity of carer' to pregnant and birthing woman, the most consistent and continuous care she receives may be from her partner.

## How services are getting it wrong...

### **There is an exaggerated belief in the number of 'single mums', and resulting failure to 'see' and value fathers**

In its work with Health Care Professionals and other family workers, the Fatherhood Institute encounters myths and misunderstandings which act as barriers to staff engaging with fathers. The first of these are false beliefs about the numbers of 'single mums'. At the time of the birth, these are few and far between: 95% of births in the UK are registered by mother and father together, with most couples (85%) living at the same address. Among the 15% who live in separate households, two-thirds are described by the mother as 'romantically involved' or 'friends'. That leaves just 5% (one couple in twenty) who are allegedly 'not (or no longer) in a relationship' (Kiernan & Smith, 2003). But even among these, one in ten of the fathers attends the birth; one in four enters his name on the birth certificate; and one in four is still in touch with infant and mother nine months later (Kiernan, 2006).

There are approximately 700,000 births per year to men whose average age is 33. These men are almost always the baby's biological father. Even among teenage mothers (the demographic least likely to be in a stable relationship), only 2.2% have a new partner at the time of the birth; and among mothers aged 25+ this is virtually unheard-of (ONS, 2014). Nor are lesbian mothers the new norm: just one baby in a thousand is registered to two women (ONS, 2016); and the donor-father may be a continuing presence (Touroni & Coyle, 2002).

### **There is an exaggerated belief in the risk of domestic violence, leading to mistrust and a potentially dangerous failure to engage with fathers**

The second false belief that can inhibit engagement with fathers, is inflated notions of the prevalence of domestic violence. Men's use of intimate partner violence (IPV) in pregnancy (or at any other time) constitutes a serious health risk for their partner (Walby & Allen, 2004) and for their children both before and after they are born (Harne, 2010). Whenever it occurs, every act (or threat) of violence is one act (or threat) too many. But it is also important not to overstate risk: among other things, fear that their service may be overwhelmed may discourage practitioners from seeking to identify IPV or from engaging with fathers including with men who pose a risk.

Contrary to information disseminated by trusted websites including the NHS in England and Scotland, pregnancy is not a particularly high-risk period for Intimate Partner Violence (IPV)

either in terms of prevalence, initiation or escalation (Devries et al., 2010; Bowen et al., 2005; Bacchus et al., 2004). Even in relatively disadvantaged districts, domestic violence prevalence in the current relationship during pregnancy is unlikely to be greater than 3-4% (Johnson et al., 2003). For maternity staff, seeking to engage with women's partners does not mean having to engage with hordes of violent males. And where a man is using violence against his pregnant partner, it is surely in the interests of the woman and the service, that he be engaged-with.

### **NHS policy requires 'family-centred' maternity care – but this is ignored**

The research findings indicate that identifying expectant fathers' own strengths and challenges, and meeting their information and support needs, are likely to be key to delivering high quality maternity care. In recognition of this, the 2004 National Service Framework for Children, Young People and Maternity Services (England and Wales) and the 2017 Forward Plan for Maternity and Neonatal Care in Scotland have called for maternity care to be 'mother focused and family centred'. However, there is no evidence of systematic implementation of these policies, nor of any monitoring or evaluation.

### **Fathers – especially more disadvantaged fathers - experience 'institutional neglect'**

Thus inclusion depends on the motivation and skill of individuals. In a 1998 postal survey one-third of the respondents said the midwife had talked only to their pregnant partner (Newburn & Singh, 2000) – a figure that is not dissimilar to expectant fathers' experience in 2018: responding to the recent online survey, 29.4% said the midwife had 'rarely' or 'never' addressed them directly (Fatherhood Institute & Fathers Network Scotland, 2018). Maternity staff are more likely to overlook or discourage low income men (37%) than 'skilled manual' (24%) or 'professional/ managerial' (21%) men (TNS System Three, 2005).

### **Fathers are scarcely more than 'visitors' in maternity services – a major reason why they are overlooked**

The fact that the father-to-be has no formal status within maternity services (even his name may not be entered on the pregnant woman's record) is likely to be the main reason why he is not routinely addressed or engaged with. Other than during the birth itself, the father's position is little different from that of visitor; and when information about him and his family is requested, the mother is asked for it. This institutional neglect not only disallows the father's unique relationship to the infant but may also rob the service of vital information it needs to meet its primary objective, which is to keep mother and Infant safe (Knight, 2006). Systematic engagement with expectant fathers would also afford opportunities to address their health and wellbeing in relation to both current and future pregnancies.

Even simple changes in practice can reap dramatic rewards. While we found no positive model of systematic engagement with fathers antenatally, a health visiting team in Lincolnshire undertook a small Randomised Control Trial to establish whether they could increase the number of fathers they met during the first home visit after the birth. When they re-worded their usual approach to address both parents specifically ('Dear mum and dad'

rather than 'Dear Parents') and to make clear they would like to meet with both, the percentage of fathers attending increased from 20% to 70%. (Fatherhood Institute et al., 2009).

## What else we need to know...

### **There are big gaps in knowledge about expectant and new fathers' needs**

We identified many research gaps, including in large-scale data gathered directly from fathers. Data from and about the 15% of expectant and new fathers who are not cohabiting with their babies' mothers is especially scarce; and a lack of fathers in administrative data precludes sampling for research studies including birth cohorts. Research on fathers' attitudes and behaviours has problematized them while structural factors that might impede engagement have been less often explored. There has been no substantial recent investigation of expectant and new fathers' information needs; little is known from UK research about couple functioning at this time; and we know almost nothing about the ways in which healthcare professionals are engaging with 'the bloke in the room'. Alspac (in the early 1990s) is the most recent birth cohort study that has collected data directly from a large-scale sample of fathers/ mothers' partners during pregnancy. More about the research gaps is identified in footnotes to our main Report and in the two Appendices included in it. Available online: <http://www.fatherhoodinstitute.org/2017/contemporary-fathers-in-the-uk/>

## Our recommendations

Our recommendations are all about making fathers welcome throughout pregnancy, birth and early infancy, and valuing the role they play not just as supportive partners but also as independent parents with a unique connection to their baby.

### **1: Change NHS terminology to refer to fathers**

At the time of the birth, 95% of parents are in a couple relationship, and 95% register the birth together. For a woman to have a new partner at this stage is almost unheard-of; and only one birth in a thousand is registered to two women. Yet despite the overwhelming presence of the biological father, the term 'woman's partner' or 'mother's partner' (rather than 'father') is commonly used in maternity services. This defines the baby's father solely as a support-person and does not recognise his unique connections (both genetic and social) to his infant. The term 'woman's partner' should be widely replaced by 'father/ woman's partner'.

### **2: Invite, enrol and engage with expectant dads**

Employed fathers in Britain have a statutory right to time off to attend two antenatal appointments. Each father (or woman's partner) should (with the pregnant woman's consent)

be formally enrolled in maternity services and an official invitation to meet the maternity team issued. This will acknowledge the father as a parent as well as a support-person, and provide a pathway to welcoming, educating and informing him, identifying strengths and challenges associated with him, and referring him to relevant services (e.g. to smoking cessation). Working groups in each of the four countries in the UK should be established to consider mechanisms for enrolling the father/ woman's partner; and to identify potential pilot sites.

### **3: Deliver woman-focused, family-centred services**

Expectant fathers' direct impact on the mother and indirect impact on the unborn child, are significant. Maternity services should be formulated as 'woman-focused and family-centred' meaning that, while the obstetrics focus remains on the pregnant woman, the father (or, where relevant, woman's partner and other key supporters) are actively encouraged to become an integral part of all aspects of maternal and newborn care. Hospitals should collect information from both parents about their experiences of family-centred care, as part of the NHS Friends and Family Test. Working groups in each of the four countries in the UK should be established to define family-centred care during pregnancy, at the birth and in neonatal care; and to explore strategies, objectives and targets for implementation - including provision of facilities for fathers to stay overnight after the birth.

### **4: 'Father-proof' maternity staff training**

The term 'midwife' means 'with woman' and most practitioners in maternity and neonatal care services are not trained to engage effectively with men or to work in a 'partnership of care' with families. When guidelines for maternal and neonatal care are drawn up, these should include the evidence on the impacts of fathers' characteristics and behaviours on mother and infant; impacts of couple relationship functioning; and impacts of fatherhood on men.

Pre- and post- registration training curricula should be revised to include the 'whys' and 'hows' of engaging with fathers and families. When core competencies are time-tabled for revision, relevant new competencies should be drafted and included. Existing training modules (such as the NCSCCT module on smoking in pregnancy) should be revised to equip healthcare practitioners to engage with both parents, rather than only with the woman.

### **5: 'Father-proof' information for expectant and new parents**

Pre-natal health education and information should be directed at men as well as women, and maternity services should be required to provide information directly to the father/ woman's partner, rather than relying on the 'woman as educator'. To counter unconscious bias against men/ fathers as competent caregivers, the content should include the neurobiology of active fathering, co-operative caregiving (the 'parenting team') and the impacts of father involvement and couple functioning on the infant's health and development. 'Father-proofing' guidelines to equip authors of new resources (and of resources that are being revised) to address both parents effectively should be developed and made available to commissioners, authors and editors, with the requirement that these be applied and utilized as part of the Gender Equality Impact Assessment.



**6: Collect better data on expectant and new dads**

On the basis of our research review, and a recent independent Longitudinal Studies Strategic review, we recommend that any future 'birth' cohort study should collect data in pregnancy from both the father/ woman's partner and the mother (cohabiting or living separately), with a phase of testing for approaches to recruitment.

Where we have identified gaps in primary research and/ or in secondary analyses of data already collected, consideration should be given to commissioning primary research or secondary analysis of existing cohort data.

At birth registration, the father should be asked whether the infant being registered is his first child. Analysis of the data collected will then be able to establish fathers' age at birth of first child and men's fertility rates in Britain.

To read the FULL REPORT from which this EXECUTIVE SUMMARY is derived, click here: <http://www.fatherhoodinstitute.org/2017/contemporary-fathers-in-the-uk/>.



### **About the Fatherhood Institute**

The Fatherhood Institute (founded 1999, charity number 1075104) is a world leader in the fatherhood field, with a unique grasp of policy, practice and research. Our twin focus is child wellbeing and gender equality. Our research summaries, published free of charge on our much-visited website [www.fatherhoodinstitute.org](http://www.fatherhoodinstitute.org), are drawn on and cited all over the world; and our trainings in father-inclusive practice (online and face-to-face) are highly praised and evaluated by service providers. We work directly with fathers and couples in community, education and health settings, and train local facilitators to undertake this work. We also work with fathers and mothers in the workplace (seminars/ webinars/company intranet materials) and offer HR support to organisations aiming to develop competitive edge and reduce gender inequalities at work, through recognising and supporting male employees' caring responsibilities.

### **About the Nuffield Foundation**



The Nuffield Foundation is an endowed charitable trust that aims to improve social well-being in the widest sense. It funds research and innovation in education and social policy and also works to build capacity in education, science and social science research. More information is available at [www.nuffieldfoundation.org](http://www.nuffieldfoundation.org)

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