Evidence to the Health and Social Care Committee's First 1000 Days of Life Enquiry, September 2018

1.0 Executive Summary

A key priority for any national First 1000 Days strategy should be the provision of detailed guidance to ensure that pre-conception, maternity and post-natal services reach out to, engage with and support expectant and new fathers – whom evidence shows are extremely influential on maternal and child outcomes. The guidance would specify key 'touchpoints' during parents' journey from conception (and before) through to the child's second birthday, and methods through which services should engage with and support fathers.

1.1 Introduction

1.1.1 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, 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.

1.2 Our submission

1.2.1 We submit that a key priority for any national First 1000 Days strategy should be the provision of detailed guidance to ensure that pre-conception, maternity and post-natal services reach out to, engage with and support expectant and new fathers (including mothers' partners, where these are not the biological father – a rare occurrence, in fact). Through effective and systematic engagement with the father and the couple, such services could enhance men's confidence and parenting skills, enable them better to support their child and child's mother, and address conflicted couple relationships, thus leading to improvements in outcomes for young children and their mothers, and the fathers themselves.

1.2.2 A robust body of research internationally, demonstrates associations between expectant and new fathers' behaviour, experiences, attitudes and characteristics, and maternal and infant health and wellbeing. In light of this, the World Health Organisation has set out, among ten recommendations on health promotion interventions for maternal and newborn health, a recommendation ('Recommendation Two') on engaging fathers:

> "Interventions to promote the involvement of men during pregnancy, childbirth and after birth are recommended to facilitate and support improved self-care of women, improved home care practices for women and newborns, improved use of skilled care during pregnancy, childbirth and the postnatal period for women and newborns, and to increase the timely use of facility care for obstetric and newborn complications." (World Health Organisation, 2015: p.3)

1.2.3 In the UK, professional bodies, including the Royal College of Obstetricians and Gynaecologists (RCOG, 2017), NHS England (National Maternity Review, 2016), Barnardo's (Cundy, 2012), the NSPCC (Hogg, 2014), the Royal College of Midwives, endorsed by the Department of Health (RCM, 2011) and the National Institute for Health and Clinical Excellence (NICE, 2010a) have also advised healthcare practitioners (HCPs) to engage fathers or 'mothers' partners' in maternity care and education. However, such well-meaning exhortations have failed to result in widespread changes in practice, leading to criticisms that father-inclusive policy-making to date has been more 'rhetoric than reality' (Sherriff & Hall, 2014). And even in Scotland, where interest in fathers is most current (The Maternity Services Action Group, 2011)

and is continuing (Scottish Government, 2017, there has been little or no monitoring of impact on practice, thus rendering policy potentially 'toothless'.

1.2.4 All too often, fathers 'fall between the cracks' because 'standard' ways of doing things – intentionally or otherwise – exclude them. For example, even when the father is sitting beside his pregnant partner in an antenatal appointment, the NHS Pregnancy Notes direct the healthcare professional to ask *her* the questions relating to him: his age, his citizenship status, his employment status, his mental health, medical issues in his family, whether 'anyone at home' smokes or whether there are drug/alcohol issues 'in the home'. This is just one example of how, as he sets off on arguably the most important and exciting journey of his life – that towards fatherhood – the expectant father is pushed out of the process, rather than pulled in. And the individually small but collectively devastating acts of exclusion continue from there (see 1.2.5 below).

1.2.5 A Fatherhood Institute/Fathers Network Scotland survey of more than 1,800 fathers conducted in May 2018 found that:

- 65% of respondents said healthcare professionals had rarely or never discussed fathers' roles
- More than half (56%) said they had rarely or never been addressed by name Fewer than a quarter had been asked about their physical health (22%) or diet and exercise (18%)
- Even though a father's mental health is closely correlated with a mother's, only 18% had been questioned about it
- Around half (48%) had not been asked about smoking, despite the risks of passive smoking to babies, and fathers' key role in supporting pregnant mums to give up
- More than 40% of fathers said that hospitals had not allowed sufficient time for the new family to spend together after the birth
- Only 17% reported that their hospital had facilities for fathers to stay overnight afterwards, even though the then Prime Minister Gordon Brown called eight years ago for hospitals to provide such facilities.

1.3 What father-inclusive services might look like

1.3.1 So…what would a high-quality, evidence-based approach to father-inclusive service provision look like for the First 1000 Days of life? We submit that as a starting point, the guidance referred to in 1.2.1 above should

support/ set the conditions for the creation of, the following father-inclusive approaches:

1.3.2 Pre-conception

NHS England and/or local health services/ public health teams would run campaigns/ clinics (ideally in places where men are already found, for example workplaces, gyms, sports clubs, sexual health clinics) to address men's fitness-for-conception. These would cover issues such as:

- Family planning and preparation for pregnancy
- Alcohol, smoking, drugs, obesity and their impact on the unborn child
- Inherited disease and testing
- Mental health
- Intimate partner violence

Such engagement would create opportunities to offer health assessments, e.g. measuring BMI, and advice, e.g. about healthy eating, exercise, alcohol consumption and smoking; and to refer on to specialist services (e.g. smoking cessation services).

1.3.3 Pregnancy

Throughout the perinatal period, services would recognise and support the father's key role as (in most cases the main) provider of emotional support to the mother, but also view him as an independently and uniquely significant figure in the life of the growing baby. When looked at from a child's point of view, ALL fathers matter, whether good or bad, alive or dead, hands-on or absent.

Maternity services would explicitly invite the expectant father (having, as a matter of routine, obtained his contact details from the mother – making clear to her that services recognise his important role in the child's life, regardless of their marital/couple status) to routine ante-natal appointments, at the first of which he would be 'enrolled' onto the NHS electronic system (this would include, wherever possible, those fathers not living in the same household as the mother). Fear of men as perpetrators of domestic violence – unjustified by evidence - underpins many practitioners' attitude towards fathers (for an analysis of this, see our report *Who's the Bloke in the Room?* pages 23-25, available online at http://www.fatherhoodinstitute.org/wp-content/uploads/2017/12/Whos-the-Bloke-in-the-Room-Full-Report.pdf).

Services would provide the father with tailored information clarifying his vital role during and after pregnancy (as has been offered previously via the

Department of Health/ Department for Education and Skills *Guide for New Dads* http://www.fatherhoodinstitute.org/wp-content/uploads/2010/10/Guide-for-New-Dads.pdf); involve him directly in screening for fetal abnormality (including where he himself needs to undergo testing, as for cystic fibrosis or sickle cell disease); signpost him to relevant services to assess/ improve his own health (as per pre-conception clinics above); prepare him to be a confident birth partner; do everything possible to support him as a future hands-on father; and support both members of the parent-couple to communicate and collaborate successfully as co-parents (for example via a parent-couple-relationship programme such as Family Foundations).

1.3.4 Labour and birth

Maternity professionals would routinely greet fathers – well-prepared as birth partners by their previous training (see Pregnancy above) - as important, welcome members of the 'team' around the labouring mother and unborn child. This inclusive attitude would extend, for example, to being greeted by name by staff; being included in offers of cups of tea; and being able to stay overnight during labour and birth, and afterwards while mother and infant remain in hospital.

1.3.5 Post-natal

In the immediate post-natal period, staff would support skin-to-skin 'kangaroo' care by fathers; offer guidance on baby-care (e.g. bathing and how to hold newborns) to fathers as well as mothers; and be supportive of fathers spending substantial time in the maternity unit, so as to help their wives/partners and themselves bond with their new babies.

Where the infant was admitted to an NICU, fathers would be routinely addressed and supported, alongside mothers (recommendations for how to do this well have recently been produced by the Family Initiative's International Neonatal Fathers Working Group (ref)).

Fathers as well as mothers would receive tailored information about why and how to register the baby's birth, and the benefits of including the father's name on the birth certificate.

Maternity/health visiting staff would recognize fathers' key role in influencing their partners' decisions around breastfeeding, for example by providing

fathers with clear messages about its benefits for babies, and involving them in breastfeeding education.

Fathers would be directly invited by the health visiting team to the primary 'at home' post-birth visit and subsequent appointments; and would be seen as an important 'sub-client', because of their potential impact on maternal and child outcomes, as well as in terms of their own health. Fathers' impact on maternal mental health is significant, for example – and they themselves can experience mental health problems postnatally too.

For evidence underpinning our submission, read our press release http://www.fatherhoodinstitute.org/2018/nhs-fails-new-mums-and-babies-by-ignoring-dads-our-new-research-review-survey/ and the full report on which it is based ('*Who's the Bloke in the Room?*') – which also includes the full references cited here: http://www.fatherhoodinstitute.org/wp-content/uploads/2017/12/Whos-the-Bloke-in-the-Room-Full-Report.pdf).

Another useful paper from the Journal of Neonatal Nursing, published since *Who's the Bloke in the Room?*, is available online here https://www.journalofneonatalnursing.com/article/S1355-1841(18)30093-0/fulltext.