Engaging New Fathers: Learning from *Baby Makes 3*

Naomi Pfitzner

ORCID ID: 0000-0003-1757-9170

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ABSTRACT

Intimate partner violence is a global phenomenon with significant social, economic and health costs. The importance of engaging men in preventing intimate partner violence is well established with strategies that engage men as fathers through parenting programs showing some promise. Australia’s world first national primary prevention framework identifies gender inequality as the central driver of intimate partner violence. The transition to parenthood is a critical moment in the production of gender inequality and often leads to a retraditionalisation of gender roles for heterosexual couples. This life transition presents a prime opportunity to promote gender equality and engage fathers in interventions that seek to prevent intimate partner violence from ever occurring.

While policies and programs are increasingly seeking to engage men in violence prevention, engagement frameworks in the primary prevention field are underdeveloped. Current research focuses on the manner in which men are drawn into prevention work rather than the engagement process itself. Existing Australian primary prevention programs tend to focus on engaging boys in school-based respectful relationships programs with little attention paid to reaching adult men. This study sought to fill these gaps by developing an engagement model for fathers and exploring its application to intimate partner violence primary prevention strategies. Aligning with the gendered lens of our national framework my research explored how gender impacts on service providers’ engagement with new fathers in respectful relationships programs delivered in health settings.

Framed by a constructivist epistemology and ontology I employed a case study research design using the Baby Makes 3 (BM3) program, a three-week respectful relationships program for first time parents incorporated into New Parent Groups run by Maternal and Child Health Services in the Eastern Metropolitan Region of Victoria, as an illustrative example. I collected data from multiple sources including interviews with fathers who participated in the program and the Maternal and Child Health Nurses who recruited parents into the program as well as focus groups with the
facilitators who led the program. To identify the gender phenomena that influence father engagement in this context I applied a novel analytical framework combining a three-phase father engagement model with a multidimensional theory of gender. This multi-level, multi-phase framework was used as a heuristic through which the evidence about the gendered phenomena that impact on service providers’ engagement with new fathers in the BM3 program were analysed.

In terms of ‘getting’ fathers to attend BM3 in the first instance this study found that a complex, multidimensional interplay of gender related factors shapes men’s father identities, behaviours and ultimately their decisions to participate. In particular this study revealed that men’s differing paternal role identities and the gendered Maternal and Child Health Service setting play critical roles in fathers’ participation decisions. In regards to retaining father attendance and actively engaging them in the program the single-gender father group work led by male facilitators who are themselves fathers was key. BM3’s father group work provided a homosocial environment where men could engage in non-traditional gender practices and form intimate connections with other fathers.
DECLARATION

I, Naomi Pfitzner, do hereby declare:

i. That this thesis comprises only my original work towards the Doctor of Philosophy except where indicated in the preface;

ii. That due acknowledgement has been made in the text to all other material used; and

iii. That this thesis does not exceed the maximum word limit in length, exclusive of the bibliography.

Naomi Pfitzner
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CHAPTER 1: INTRODUCTION

INTRODUCTION

We don't just need to change the system that deals with family violence. We also need to change the culture that creates it. I've always believed that bad outcomes for women start with bad attitudes towards women (Andrews, 2016).

These were the words of Victorian Premier Daniel Andrews on the release of the findings from the 2016 Victorian Royal Commission into Family Violence. The Premier’s impetus for cultural change echoes the sentiments of Australia’s world first national primary prevention framework which calls upon Australians to change the story and end violence against women (Our Watch, Australia’s National Research Organisation for Women’s Safety (ANROWS), & VicHealth, 2015). Like Premier Andrews, our new national primary prevention framework places gender inequality at the core of intimate partner violence (Our Watch, et al., 2015). This attention to gender in primary prevention reflects recent research findings about the association between attitudes to gender and attitudes towards violence against women with violence supportive attitudes linked to traditional attitudes towards gender (Australian Institute of Criminology, The Social Research Centre, & VicHealth, 2010; Pulerwitz & Barker, 2008; VicHealth, 2014).

The transition to parenthood is a, if not the, critical period in the production of gender where traditional divisions of labour tend to prevail (Janeen Baxter, Hewitt, & Haynes, 2008; Dribe & Stanfors, 2009; B. Fox, 2001, 2009; Höfner, Schadler, & Richter, 2011). Parenthood produces gender differences and inequalities resulting in heterosexual couples being ‘more gender-divided than ever before’ (B. Fox, 2001; 2009, p. 5). This life transition presents a key opportunity to intervene and promote gender equality.

Despite increasing calls for preventative measures to combat intimate partner violence and other forms of violence against women, evidence for how to change the story and how to design and implement effective primary prevention strategies is in its infancy
Engaging New Fathers: Learning from *Baby Makes 3* (Staggs & Schewe, 2011; Whitaker, Murphy, Eckhardt, Hodges, & Cowart, 2013; World Health Organisation & London School of Hygiene and Tropical Medicine, 2010). Existing Australian primary prevention programs tend to focus on engaging boys in school-based respectful relationship programs (Carmody et al., 2009; Flood, 2006; Gleeson, Kearney, Leung, & Brislane, 2015; VicHealth, 2007). There is little known about how to reach adult men and what works for them in what settings. Aligning with the gender lens of our primary prevention framework, this research explored the impact of gender on service providers’ engagement with new fathers in respectful relationships programs delivered in health settings.

This introductory chapter begins by situating my research by explaining its background and context. I go on to identify the research problem and outline the aim and scope my study. I then discuss the contributions my research makes to the field and end with an overview of the structure of my thesis.

**BACKGROUND AND CONTEXT OF THE STUDY**

This section outlines the importance of preventing violence against women, the reasons for engaging men in violence prevention and the opportunity that new fatherhood provides for engaging men. It goes on to summarise primary prevention approaches to the problem briefly explaining the theoretical models and the policies that informed the design of the study.

**THE IMPORTANCE OF PREVENTING VIOLENCE AGAINST WOMEN**

Violence against women (VAW) knows no boundaries; it is a widespread social phenomenon overwhelmingly perpetrated by men against women (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Victims Support Agency, 2012; World Health Organisation & London School of Hygiene and Tropical Medicine, 2010). Globally, one in three ever-partnered women is physically and/or sexually assaulted by an intimate partner in her lifetime (World Health Organisation, London School of Hygiene and Tropical Medicine, & South African Medical Research Council, 2013). In Australia, 17% per cent of women will report being
victims of sexual partner violence during their lifetimes (Australian Bureau of Statistics, 2013h). Intimate Partner Violence (IPV) is the leading cause of death, disability and illness for Victorian women aged 15 to 44 years (VicHealth, 2004). IPV results in significant health, social and economic costs both locally and globally and places a heavy burden on legal, community and health systems worldwide (Duvvury, Callan, Carney, & Raghavendra, 2013; PricewaterhouseCoopers Australia (PwC), 2015; The National Council to Reduce Violence against Women and their Children, 2009; VicHealth, 2004; World Health Organisation, United Nations Office on Drugs and Crime, & United Nations Development Programme, 2014).

VAW is used as an umbrella term to refer to the various forms of violence against women, such as intimate partner violence, sexual violence, female genital mutilation, femicide and human trafficking. The United Nations defines violence against women as ‘any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life’ ("United Nations Declaration on the Elimination of Violence against Women, 85th plenary meeting, 20 December 1993, Art 1,"). This thesis focuses on one form of violence against women, intimate partner violence (IPV). Intimate Partner Violence is also known as partner violence, relationship violence, domestic violence, battering and partner abuse. This thesis uses the terms domestic violence and IPV interchangeably.

The World Health Organisation defines intimate partner violence as:

Behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours (2010, p. 11).

Given the significant prevalence of IPV experienced by women both locally and globally efforts to prevent violence are increasing across the world (World Health Organisation, et al., 2014). The following section focuses on violence prevention efforts that seek to engage men and explains why men are key targets in anti-violence work.
RATIONALE FOR ENGAGING MEN IN VIOLENCE PREVENTION

There is a growing body of literature on the importance of engaging men in violence prevention and strategies for doing so (Carlson et al., 2015; Casey, 2010; Casey et al., 2013; Casey & Smith, 2010; Crooks, Goodall, Hughes, Jaffe, & Baker, 2007; Esplen, 2006; Fabiano, Perkins, Berkowitz, Linkenbach, & Stark, 2004; Flood, 2006, 2010, 2011; Flood et al., 2010; Kimball, Edleson, Tolman, Neugut, & Carlson, 2013; Mehta, Peacock, & Bernal, 2004; Peacock & Barker, 2012; Pease, 2008; World Health Organisation & London School of Hygiene and Tropical Medicine, 2010). As a starting point Victorian and National plans for reducing VAW identify men as central targets for IPV primary prevention interventions based on the rationale that men are the main perpetrators of IPV and are more than women likely to hold violence supportive attitudes (Council of Australian Governments, 2009, 2010; Office of Women's Policy (State of Victoria), 2012; Our Watch, et al., 2015; VicHealth, 2007). The evidence for this rationale is discussed below.

Men are the main perpetrators of VAW

While men can be victims of IPV, research demonstrates that IPV is predominantly perpetrated by men against women and their children (Australian Bureau of Statistics, 2006, 2013h; Krug, et al., 2002; Mouzos & Makkai, 2004; Mouzos & Rushforth, 2003; Victims Support Agency, 2012). Although Australian men and women are both more likely to experience violence perpetrated by a man than a woman, for men the perpetrator is more likely to be a stranger while for women the perpetrator is overwhelmingly more likely to be someone known to them, most likely a current or former partner (Australian Bureau of Statistics, 2013h; Cox, 2015). In 2012 94% of Australian women who had experienced violence reported that it was perpetrated by a male with 88% of these men known to the women (Australian Bureau of Statistics, 2013h). Just under half of these known male perpetrators were a current or former partner (44%) and a further third were a boyfriend or male date (29%) (Australian Bureau of Statistics, 2013h). All these data suggest that as a population group men are more likely than women to perpetrate IPV and therefore are important targets for
primary prevention interventions (Harvey, Garcia-Moreno, & Butchart, 2007; VicHealth, 2007).

**Men more likely to hold violence supportive attitudes**

Given that men are the main perpetrators of IPV, it is not surprising that research also shows that men are more likely to have attitudes that support IPV (Australian Institute of Criminology, et al., 2010; National Crime Prevention, 2001; Nayak, Byrne, Martin, & Abraham, 2003; Uthman, Lawoko, & Moradi, 2009; VicHealth, 2014). Research on the interaction between attitudes to violence against women and perpetration of such violence has shown that positive attitudes towards violence against women are strongly aligned with the perpetration of violence against women (Murnen, Wright, & Kaluzny, 2002; Pulerwitz & Barker, 2008; Uthman, et al., 2009). Evidence that this is the case has resulted in the targeting of men as a key population group for IPV prevention interventions (Harvey, et al., 2007; VicHealth, 2007).

Significantly, community sample surveys in Australia and overseas of attitudes towards violence against women have revealed a persistent gender gap in attitudes towards violence (ANOP Research Services, 1995; Australian Institute of Criminology, et al., 2010; National Crime Prevention, 2001; Nayak, et al., 2003; Pulerwitz & Barker, 2008; Uthman, et al., 2009; VicHealth, 2014). In 2001 an Australian national survey of 5,000 young people aged between 12 and 20 revealed that young men are more likely to agree with pro-violence statements than young women (National Crime Prevention, 2001). For example, 12% of males and only 3% of females agreed that it was *okay for a boy to make a girl have sex, if she's flirted with him, or led him on*, with 79% of females disagreeing strongly compared to only 52% of males (National Crime Prevention, 2001, p. 65). Little had changed by 2013 when an Australian national survey of 1,923 young people aged between 16 and 24 revealed that young men are more likely to hold violence supportive attitudes than young women (Harris, Honey, Webster, Diemer, & Politoff, 2014). For example, 8% of young men compared with 5% of young women felt that violence against a current partner was justified if she admits to having sex with another man (Harris, et al., 2014). Similarly, a cross-national survey of 1,076 female and male undergraduate students in Japan, India, Kuwait and the United States
revealed that men in all four countries studied had more supportive attitudes towards sexual assault and physical violence against women (Nayak, et al., 2003). This study measured attitudes towards sexual assault and physical violence against women by rating students’ agreement with violence supportive statements and myths using a 4-point Likert-type scale with higher attitude scores reflecting greater endorsement for sexual assault and physical violence against women (Nayak, et al., 2003). The average attitude scores for men towards spousal physical violence against women were 11.84 (India), 11.35 (Japan), 12.38 (Kuwait) and 8.07 (United States) whereas the average score for women in these countries were 8.95, 10.02, 11.60 and 6.35 (Nayak, et al., 2003).

This gender gap applies not only to gender differences in definitions and perceptions of violence against women but, more notably, also indicates a relationship between attitudes towards gender roles and attitudes towards violence against women. Community surveys by Murnen et al. (2002), Nayak et al. (2003), Pulerwitz and Baker (2008) and VicHealth (2014) have found that attitudes towards gender are one of the strong predictors of attitudes towards violence against women with men who hold traditional attitudes towards gender roles being more likely to hold violence supportive attitudes. For example, the 2013 VicHealth national survey of community attitudes towards violence against women found that men are more likely than women to have low support for gender equality, poorer understandings of VAW and hold violence supportive attitudes (VicHealth, 2014; Webster et al., 2014). The survey revealed that having low levels of support for gender equality and a poor understanding of VAW were the strongest predictors for holding violence supportive attitudes. Respondents’ support for gender equality was calculated on the basis of responses given to a set of attitudinal questions on women’s status and role in society (Webster, et al., 2014). The survey showed that respondents with high support for gender equality had more nuanced understandings of VAW and were less likely to hold violence supportive attitudes (VicHealth, 2014). For instance, only 64% of people with low gender equality scores thought that forcing a partner to have sex is always domestic violence whereas 92% of people with high gender equity scores understood this (Webster, et al., 2014). Similarly, 81% of people with high gender equity scores
thought slapping or pushing a partner to cause harm or fear was always domestic violence and only 53% of people with low gender equity scores thought this was the case (Webster, et al., 2014). Respondents with low gender equality scores were also more likely to justify or excuse violence (Webster, et al., 2014). For example, while 88% of respondents with high gender equality did not agree that violence can be excused if the person genuinely regrets it only 55% of respondents with low gender equality scores disagreed (Webster, et al., 2014). Researchers in several countries have investigated factors associated with community attitudes to VAW (Murnen, et al., 2002; Uthman, et al., 2009). They include Pulerwitz and Barker (2008) who conducted a community sample survey of 223 Brazilian men aged 15 to 24 which found that young men with less support for equitable gender norms were more likely to report that they had perpetrated intimate partner violence than men with moderate or high support for equitable gender norms.

Although the findings from these community surveys suggest a relationship between support for traditional gender roles and violence supportive attitudes and IPV perpetration, further research is necessary to explore causal pathways. Nevertheless, the work of VicHealth (2014), Pulerwitz and Barker (2008) and others highlights how gender norms shape people’s attitudes to violence against women (Barker, Ricardo, & Nascimento, 2007; Murnen, et al., 2002; Nayak, et al., 2003; Pulerwitz & Barker, 2008; Uthman, et al., 2009). These findings about the association between attitudes to gender norms and attitudes to violence against women suggest that effective prevention strategies must address not only men’s attitudes towards violence against women but also the social fabric in which violence supportive attitudes are formed and sustained, namely conceptualisations of gender roles and masculinity that reinforce violence supportive beliefs (Australian Institute of Criminology, et al., 2010; Flood & Pease, 2009; Heise, 1998; Nayak, et al., 2003; Uthman, et al., 2009; VicHealth, 2014). The importance of critical discussions of gender and masculinity in violence prevention interventions that seek to engage men was illustrated by Barker, Ricardo and Nascimento (Barker, et al., 2007) in a review of 58 evaluated health programs conducted with boys and men that sought to change gender-based inequalities including gender-based violence, such as IPV. Their review found that interventions
that were *gender transformative*, programs that sought to transform men’s understandings of gender roles and promote gender equitable relationships, were more effective in changing behaviours and attitudes than interventions that were gender-neutral or gender-sensitive (Barker, et al., 2007). Barker et al. found that 41% of the 27 programs assessed as being gender-transformative were effective in changing attitudes and behaviours whereas only 29% of the total 58 programs were assessed as effective in this regard (Barker, et al., 2007, p. 17).

Clearly there is increasingly compelling evidence that engaging men in changing their beliefs and attitudes is the key to reducing their violent behaviour towards women. In fact the United States Centre for Disease Control and Prevention named engaging boys and men to prevent VAW as one of the top twenty practice innovations in violence and injury prevention (Kress, Noonan, Freire, Marr, & Olson, 2012). The following section explains why fathers as a population group are being targeted as the foci for prevention programs.

**WHY FOCUS ON NEW FATHERS?**

Research suggests life transitions present prime opportunities for violence prevention interventions with the transition to parenthood identified as a key transition due to the gender-enforcing nature of parenthood and emerging evidence regarding the utility of men’s father identities in motivating behaviour (B. Fox, 2001, 2009; Greer Litton Fox, Sayers, & Bruce, 2001; Langhinrichsen-Rohling & Capaldi, 2012; Shortt et al., 2012; Stanley, Fell, Miller, Thomson, & Watson, 2012; Stanley, Graham-Kevan, & Borthwick, 2012; VicHealth, 2007).

**The transition to parenthood**

Numerous studies have shown that the transition to parenthood is a critical period in the production of gender (Janeen Baxter, et al., 2008; Dribe & Stanfors, 2009; B. Fox, 2009; Höfner, et al., 2011). Considered together with the aforementioned evidence about the relationship between attitudes to gender and violence supportive attitudes this collective evidence base suggests that the transition to fatherhood is a crucial period for engaging men in work to prevent IPV (Australian Institute of Criminology, et
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al., 2010; Murnen, et al., 2002; Nayak, et al., 2003; Pulerwitz & Barker, 2008; VicHealth, 2014).

**Fatherhood as motivation**

There is emerging research on the effectiveness of using fatherhood as an opportunity to engage men in strategies to prevent them from perpetrating IPV (Greer Litton Fox, et al., 2001; Stanley, Fell, et al., 2012; Stanley, Graham-Kevan, et al., 2012). Studies on motivations for behavioural change among perpetrators of IPV have highlighted the effectiveness of strategies that engage men as fathers in motivating behaviour change and reducing men’s violence. Stanley, Fell, Miller, Thomson and Watson (2012) investigating men’s attitudes to and perceptions of domestic violence and motivations for changing abusive behaviour showed that fatherhood can be utilised to motivate behavioural change. This formative research involving 15 focus groups with 84 men was conducted to inform the development of a social marketing campaign seeking to engage men who perpetrate or are at risk of perpetrating domestic violence in a new voluntary perpetrator program, *Strength to Change*, in Hull north-east of England (Stanley, Fell, et al., 2012).

Stanley and colleagues (2012) found that children’s reflections of their fathers’ abusive behaviour can be used as a powerful motivational tool to change behaviour. The male participants in their study were extremely concerned with maintaining positive images of themselves as fathers (Stanley, Fell, et al., 2012). Stanley et al. explained that:

Group participants also acknowledged their vulnerability to the damage to their self-image that was inflicted when their own violence was reflected back to them. When this reflective gaze was that of their child, it carried a heavy emotional weight that appeared to be based in part on their own identification with the child. This gaze was described as particularly powerful and as having the capacity to stimulate change and the process of help-seeking (2012, p. 1314).
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Evaluations of the Strength to Change program itself reinforced earlier findings about men’s fathering identities being a source of intrinsic motivation (Stanley, Graham-Kevan, et al., 2012).

Similar findings about the motivational power of children’s reflective gaze have been made by Fox, Sayers and Bruce (2001). These researchers studied the fathering identities and experiences of men who were court-mandated to attend group counselling for intimate partner violence in the United States (Greer Litton Fox, et al., 2001). Fox et al. observed two different counselling groups for a period of two months and carried out in-depth interviews with eight fathers from these groups (Greer Litton Fox, et al., 2001). Like Stanley et al. (2012), they found that for some of the men the catalyst for self-reconstruction was seeing themselves through their children’s eyes (Greer Litton Fox, et al., 2001). Their children’s critical reflection of the father’s abusive behaviour prompted the men to re-assess their identity and motivated them to attempt to change their behaviour:

It was through their father role connections that many of the men began to absorb the impact of their violence on family members and on themselves. And it was their father role connections that gave rise to the impetus for change and provided continued support for change (Greer Litton Fox, et al., 2001, p. 158).

Discussing men’s fathering identities Fox et al. (2001, p. 159) conclude that ‘the responsibilities, ties, and commitments embedded in that role have been found in this study to be important building blocks in personal rehabilitation’. Aligned with these findings, a consultation exercise carried out by Featherstone and Fraser (2012) with academics and practitioners in the domestic violence field on practice interventions with fathers who are domestically violent also identified that men’s fathering identities are a source of motivation for violent men to engage with interventions.

As a result of this growing research evidence engaging men as fathers is an increasingly popular approach to working with men on violence prevention (Featherstone & Fraser,
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2012; Ferguson & Gates, 2015; Fleming & King, 2010; Greer Litton Fox, et al., 2001; N. Maxwell, Scourfield, Holland, Featherstone, & Lee, 2012; Stanley, Fell, et al., 2012; Stanley, Graham-Kevan, et al., 2012). However, much of what is known about such engagement strategies stems from work on interventions for male perpetrators of domestic violence and working with fathers in a context where violence has not already occurred may present different challenges. For example, the reflective gaze of children may be less powerful when they are not responding to the use of violence or the salience of men’s fathering identities may be less prominent during the transition to fatherhood, particularly for non-resident and non-biological prospective fathers. Nevertheless, these studies suggest that the transition to parenthood may be an opportune time to engage men in violence prevention by tapping into their emerging fathering identities and building on their sense of care and responsibility for others.

**PREVENTING INTIMATE PARTNER VIOLENCE**

A global shift in responses to intimate partner violence (IPV) has seen a move away from concentrating on working with victims and perpetrators towards activities designed to prevent violence from occurring in the first place or *primary prevention* (Heise, 2011; Our Watch, et al., 2015; World Health Organisation & London School of Hygiene and Tropical Medicine, 2010). Primary prevention strategies aim to address the underlying causes and risk factors thought to be associated with IPV, intervening before the violence occurs. Interventions can be delivered to a whole population or target a specific population group, be implemented in a range of environments, such as education, sports and recreation and health settings, and operate at multiple levels of social influence (Flood, Fergus, Heenan, & Victorian Health Promotion Foundation, 2009; VicHealth, 2007; World Health Organisation & London School of Hygiene and Tropical Medicine, 2010).

**Framing primary prevention interventions**

A variety of theoretical lenses have been applied to the causes of IPV, conceiving it in terms of gender (Bograd, 1988, 1999; DeKeseredy & Dragiewicz, 2007; Dobash & Dobash, 1979; McPhail, Busch, Kulkarni, & Rice, 2007), conflict in relationships (Stets &
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Straus, 1990; Straus, 1979, 2008; Straus & Gelles, 1986) and psychopathology (Dutton, 2006; Oram, Trevillion, Khalifeh, Feder, & Howard, 2013). The timing, content, setting and targets of IPV primary prevention strategies are largely dependent on the theoretical understanding of the causes of IPV adopted by policy makers, program developers and service providers. Theoretical perspectives of IPV based on psychopathology tend to favour therapeutic interventions, such as counselling (Ali & Naylor, 2013; Klostermann, Kelle, Mignone, Pusateri, & Fals-Stewart, 2010; Oram, et al., 2013) whilst feminist and human rights based frameworks often involve education programs to promote gender equality and non-violent social norms or structural interventions such as policy and legislative reform (Barker, Ricardo, Nascimento, Olukoya, & Santos, 2010; Flood, et al., 2010; Peacock & Barker, 2012; van den Berg et al., 2013).

**Public health perspectives on IPV prevention**

Public health prevention models dominate IPV prevention literature and are based on a three level, science-based approach to prevention that characterises interventions according to temporal dimensions (Hammond, Whitaker, Lutzker, Mercy, & Chin, 2006; Heise, 2011; Storer, Casey, Carlson, Edleson, & Tolman, 2016; World Health Organisation & London School of Hygiene and Tropical Medicine, 2010). Interventions that seek to prevent violence from occurring in the first place are classified as primary prevention; interventions that facilitate the early identification or occur immediately following violence are referred to as secondary prevention, and interventions that focus on long-term care and treatment are defined as tertiary prevention (Heise, 2011; Storer, et al., 2016; World Health Organisation & London School of Hygiene and Tropical Medicine, 2010). Some researchers further distinguish public health prevention efforts according to the population group targeted with *universal interventions* targeting the general population, *selected interventions* directed towards vulnerable or at risk populations and *indicated interventions* aimed at individuals who have already experienced or engaged in violent behaviour (Quadara & Wall, 2012; Storer, et al., 2016; VicHealth, 2007).
Public health violence prevention models draw on multidisciplinary frameworks, such as ecological models, to conceptualise the causes of IPV (Harvey, et al., 2007; Heise, 2011; Sethi, Marais, Seedat, Nurse, & Butchart, 2004). Based on Bronfenbrenner’s ecological systems theory, ecological understandings of IPV are premised on the belief that there is no single explanation for IPV rather conceiving of IPV as resulting from the interplay of multiple factors which operate on four levels to influence behaviour (Heise, 1998, 2011). Such ecological perspectives conceptualise ‘the causes of violence as probabilistic rather than deterministic’ estimating the collective influence of factors on and between all four levels to establish a likelihood of abuse occurring (Heise, 2011, p. 6).

An ecological framework was first applied to IPV by Heise in 1998 who subsequently published a revised model in 2011 based on updated evidence (Heise, 1998, 2011). The updated model includes four embedded levels referred to as the individual, the relationship, the community and the macrosystem (Heise, 2011). The individual level includes witnessing or experiencing violence in childhood, attitudes that accept violence as a means to resolve conflict or tolerate ‘wife beating’, and sociodemographics such as young age and levels of educational attainment (Heise, 2011). The relationship level examines the influence of relationship dynamics such as ‘non-equalitarian’ decision-making, poor communication and high relationship conflict (Heise, 2011). This level also includes situational triggers, such as infidelity, male drinking and money, and patriarchal triggers, such as failure to meeting gender role expectations and assertions of female autonomy (Heise, 2011). The community level looks at gender norms, such as family privacy and male right to control female behaviour, as well as a lack of sanctions for violence and neighbourhood characteristics, such as poverty and high unemployment (Heise, 2011). The macrosystem or macro-social factors include cultural, economic and political systems that shape the other three levels of the social ecology (Heise, 2011). For Heise’s depiction of the ecological framework for IPV based on existing evidence see Figure 1.1 below. The following section narrows in on the Victorian content and the theoretical frameworks employed to guide prevention actions in the state.
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Figure 1.1: Heise’s Ecological Framework for Intimate Partner Violence


The Victorian Primary Prevention Policy Environment

In Victoria, as in other regions, the IPV primary prevention policy environment is dominated by the public health discourse (Office of Women’s Policy (State of Victoria), 2012; Our Watch, et al., 2015; VicHealth, 2007). In 2006 the Victorian Government Family Violence Interdepartmental Committee in consultation with the Statewide
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Steering Committee to Reduce Family Violence instigated the development of a whole-of-government plan for the primary prevention of violence against women (VicHealth, 2007). As part of this process, VicHealth was engaged to undertake a review of existing research evidence and develop a conceptual framework to guide prevention action (VicHealth, 2007). This led to the VicHealth publication, *Preventing Violence Before It Occurs*, which has largely shaped the primary prevention landscape in Victoria (VicHealth, 2007). Drawing on the conceptual model promoted by the World Health Organisation in its 2002 *World Report on Violence and Health*, the VicHealth framework took a public health approach employing an adapted version of the ecological model that identified support gender inequality and rigid gender roles as key determinants of violence (Krug, et al., 2002; VicHealth, 2007). The VicHealth (2007) primary prevention framework identified three key themes for action:

- Promoting equal and respectful relationships between men and women
- Promoting non-violent social norms and reducing the effects of prior exposure to violence (especially on children)
- Improving access to resources and systems of support

Like the Victorian framework, Australia’s *National Plan to Reduce Violence against Women and their Children* establishes the promotion of respectful relationships as a priority action (Council of Australian Governments, 2009, 2010). Respectful relationships education has existed in Victoria for some years, however as in other high-income countries, interventions tend to target boys and young men in school-based programs (Ellsberg et al., 2015; Flood, et al., 2009; Wolfe et al., 2009). Little attention has been given to reaching adult men. Aligning with the research evidence discussed earlier the 2007 VicHealth framework situated men as central targets for primary prevention interventions and identified the transition to parenthood as an opportune time for intervention (VicHealth, 2007). These policy developments together with the research evidence previously discussed built growing momentum for the development of respectful relationships education for men transitioning to parenthood. Although the public health approach provides a meta-framework for intervention, research is needed to investigate the practical implications of how, when
and where to involve fathers in programs aimed at preventing violence against women. The next section identifies the gaps in the existing research literature and articulates the research problem addressed by this thesis.

THE RESEARCH PROBLEM

Whilst policies and programs are increasingly seeking to involve men in violence prevention, strategies for engaging men as fathers in IPV primary prevention interventions remain largely unexplored (Flood, 2011, 2015; Pease, 2008). Much of the existing primary prevention research on engaging men explores different approaches to involving men in anti-violence work whether as anti-violence allies, champions of change or bystanders, rather than the engagement process itself (Casey, 2010; Casey & Ohler, 2012; Fabiano, et al., 2004; Powell, 2011). Conceptualisations of father engagement in IPV primary prevention are underdeveloped and the little evidence there is comes from work on engaging men in behavioural change after violence has already been perpetrated (Featherstone & Fraser, 2012; Greer Litton Fox, et al., 2001; Stanley, Fell, et al., 2012; Stanley, Graham-Kevan, et al., 2012). Related work on father engagement in child and family services is largely drawn from reports of mothers with father participation in programs and associated evaluations remaining low (Panter-Brick et al., 2014; Stahlschmidt, Threlfall, Seay, Lewis, & Kohl, 2013).

An engagement framework based on evidence that include insights from fathers and attention to gender is required to underpin effective primary prevention efforts seeking to engage men as fathers. While the centrality of gender is a somewhat contentious issue among theorists and researchers in conceptualisations of violence in intimate relationships and perpetration patterns, the role of gender in the engagement process has drawn little attention and does require further study (Barrett Meyering & Braaf, 2013; Braaf & Barrett Meyering, 2013; Reed, Raj, Miller, & Silverman, 2010).
AIM AND SCOPE

This project aimed to investigate the impact of gender on service providers’ engagement with new fathers in respectful relationships programs delivered in health settings. As discussed earlier VAW is a broad and complex area, this research focused on IPV and was limited to universal interventions that sought to engage men as fathers to prevent IPV from ever occurring rather than for those at risk of perpetration or identified perpetrators of intimate partner violence. The study was guided by the following research question:

- How does gender impact on service providers’ engagement with new fathers in respectful relationships programs delivered in health settings?

SIGNIFICANCE OF THE STUDY

This study makes a significant and relevant contribution to the field by proposing an engagement model to guide primary prevention interventions that seek to engage men. This research builds an evidence base of gender related factors that influence service providers’ engagement with new fathers in respectful relationships programs in health settings. The findings provide potentially valuable information for health services seeking to engage new fathers in violence prevention and enhance the evidence base for primary prevention initiatives targeting men. Finally, the findings from this study form a potentially valuable contribution to government and non-government policy planning to reduce the prevalence and impact of violence against women.

THESIS OVERVIEW

The first half of this thesis sets out the parameters of this study and how it addresses the research problem. Chapter Two explores father engagement frameworks, explains the three-phase engagement model adopted in this research and reviews relevant literature. The following two chapters go on to discuss the integrative gender theory
that guides this enquiry as well as the research methodology employed. I explain the constructivist epistemological and ontological stance that underpins this research and describe the case study research design including the data collection and analysis methods used.

The second half of this thesis presents the results of the data analysis about the impact of gender on service providers’ engagement with new fathers in respectful relationships programs from the perspectives of men transitioning to parenthood and the staff who work with them. The findings are reported according to the three-phase engagement model: ‘getting’, ‘keeping’ and ‘engaging’, employed in this study. In Chapter Five I present the findings in relating to the first phase, ‘getting’ fathers across the three dimensions of Risman’s (2004) gender model. Chapter Six provides an account of the gender phenomena that influence ‘keeping’ and ‘engaging’ fathers. The findings in relation to these two stages reflected the interconnectivity of Risman’s multidimensional model and are reported collectively rather than as discrete levels. The final chapter further discusses the research findings including implications for policy and practice as well as recommendations for future research. The strengths and limitations of this study are also outlined.

CONCLUSION

Although efforts to reduce IPV are increasingly focused on preventing rather than responding to IPV, the practical process of engaging new fathers in IPV primary prevention interventions has been overlooked (Heise, 2011; Our Watch, et al., 2015). Existing research in the parenting support context tends to put the cart before the horse, focusing on intervention outcomes rather than the engagement process (Moran, Ghate, & Van der Merwe, 2004). Before we can assess the effectiveness of primary prevention interventions, we must first determine how to get and keep people involved.
CHAPTER 2: CONCEPTUALISING FATHER ENGAGEMENT

OVERVIEW

A necessary first step in investigating the impact of gender on service providers’ engagement with new fathers delivered in health settings was to conceptualise and understand the engagement process from the perspective of health service providers. Drawing together work on father engagement from a range of fields this chapter explores conceptualisations of father engagement. I begin this chapter by explaining the search strategy employed to identify relevant literature. I go on to explore different father engagement models using Moran and colleagues’ (2004) three-phase multilevel model as heuristic through which existing evidence about the father engagement process is discussed.

LITERATURE SEARCH STRATEGY

To review the evidence in this field I undertook a narrative review. As Baumeister and Leary explain, narrative reviews discuss and integrate previous findings from a methodologically diverse range of studies to map current knowledge on a specific topic from a theoretical standpoint (Baumeister & Leary, 1997). This narrative literature review took a broad approach, drawing together father engagement findings from a range of fields to develop a guiding framework for father engagement in primary prevention. The research question was as follows:

- How does gender impact on service providers’ engagement with new fathers in respectful relationships programs in health settings?

Databases from a range of disciplines were searched including Families & Society Collection, Family & Society Studies Worldwide, FAMILY, AGIS Plus Text, Health Collection, PsycINFO, SocIndex and Social Services Abstracts. The search strategy involved multiple keyword searches using the terms ‘engag*’, ‘involv*’, ‘father*’, 
‘dads’, ‘men’, ‘new parents’, ‘parent* + education/training/program’ and ‘prevention + program/intervention’. No limit was placed on date and non-English publications were not reviewed. The term ‘fathers’ is used inclusively to encompass non-biological fathers.

Studies were included if they addressed engagement and/or retention as primary outcomes and the intervention or prevention program involved fathers in the parenting support context. In addition studies were included if they reported on fathers or parents where gender was not differentiated. Papers were excluded if they were based on father involvement in interventions for at risk or identified perpetrators of IPV as opposed to universal prevention interventions. Due to the IPV prevention focus of this review, articles about interventions that primarily centred on preventing child maltreatment were excluded. Studies based upon mothers were excluded. As the research in the parenting support context focuses on program theories and outcomes rather than engagement, the majority of articles identified were retrieved through a snowball approach in which citations within key articles (Moran, Ghate & Van der Merwe, 2004; Ghate, Shaw & Hazel, 2000; Maxwell, Scourfield, Featherstone, Holland, & Tolman, 2012) provided the lead to further articles of relevance. The search identified 34 sources that met the specified criteria including 23 original research reports, 10 reviews and 1 editorial. Of these, 21 were based on qualitative research, 5 were quantitative and 8 used mixed methods. It should be noted that two of the original research reports relate to one study and a further two relate to one study that involved multi-phase evaluations.

This narrative review draws on work on father engagement in the parenting support context to identify a multi-level model of father engagement and discusses the literature in relation to this model. This discussion is reported in relation to the five dimensions of influence identified in this model: practical, relational, cultural and contextual, strategic and structural.
DEFINING ‘ENGAGEMENT’

Researchers have viewed father engagement through varying perspectives. Moran, Ghate and Van der Merwe (2004) and Lindsay and colleagues (2008) apply a temporal lens conceiving engagement as a three phased process involving ‘getting’, ‘keeping’ and ‘engaging’ clients. Others take a multi-level systems approach, conceptualising engagement in terms of multiple factors operating on different dimensions to influence an individual’s engagement (Carbone, Fraser, Ramburuth, & Nelms, 2004; Forehand & Kotchick, 2002). This paper endorses the amalgamated approach taken by Moran et al. (2004) which uses a three-phased temporal model to understand the process of engaging individuals and draws on ecological perspectives to gain contextual insights into factors that impact on engagement. I have depicted this model in the following diagram (see Figure 2.1). Effective father engagement models from child and family services provide valuable insights into father engagement approaches in the primary prevention field and are explored further below.
A TEMPORAL MODEL OF ENGAGEMENT

Many researchers have conceptualised engagement as a sequential process (Lindsay, Band, et al., 2008; Moran, et al., 2004). Ghate and Ramella (2002) also take a temporal approach in their review of 34 new parenting projects as part of a wider three-year national evaluation of the Youth Justice Board’s Parenting Programme in England. They perceived engagement as a two-stage process: the initial stage involves the ‘take up’ of program referrals by parents, that is getting parents to attend programs in the first place, while the second stage centres on sustaining parents’ engagement beyond initial contact (Ghate & Ramella, 2002).

Expanding on this temporal model, Moran and colleagues (2004) conceived of engagement in terms of ‘implementation hurdles’ in a review of 88 English language evaluations of parenting support programs with direct links to outcomes for children. The first ‘hurdle’ or engagement phase is ‘getting’ parents, that is recruiting parents and getting them to attend initially, the second stage involves ‘keeping’ parents, retaining parent attendance through to course completion, and the final phase
‘engaging’ parents refers to actively engaging parents during the program (Moran, et al., 2004). A similar three-phased model of engagement was proposed by Lindsay et al. (2008) in an evaluation of the UK Parenting Early Intervention Pathfinder (PEIP) initiative, which funded local authorities to implement one of three parenting programs. Its 2007 evaluation focused on program implementation through interviews with 94 facilitators, 18 strategic leads and 21 operational leads across the 20 Local Authorities involved (Lindsay, Band, et al., 2008). Like Moran and colleagues, Lindsay et al. (2008) distinguished between recruiting and retaining parents and engaging parents in the program, labelling these three phases as getting parents to ‘attend’ the course, ‘stay’ the course and engaging parents ‘while attending’ the course.

ECOLOGY OF ENGAGEMENT

On the other hand multi-level systems approaches conceptualise engagement in terms of multiple factors that operate on different levels to influence an individual’s engagement (Carbone, et al., 2004; Forehand & Kotchick, 2002; Moore, McDonald, Sanjeevan, & Price, 2012). The grouping of factors that impact on engagement varies with most researchers at least distinguishing between individual and structural factors (Carbone, et al., 2004; Forehand & Kotchick, 2002; Moore, et al., 2012; Moran, et al., 2004). This chapter adopts the engagement framework espoused by Moran et al. (2004) that differentiates amongst five dimensions: practical, relational, cultural and contextual, strategic and structural (See Figure 2.1 for my diagramming of this model). The practical dimension relates to accessibility and program marketing; the relational level involves factors pertaining to the client relationships; while the cultural and contextual dimension considers participants’ life circumstances (Moran, et al., 2004). Strategic factors include attendance incentives and retention strategies, while the structural dimension in this context (and somewhat differently from terminology commonly used in ecological frameworks) considers factors associated with the format of service delivery (Moran, et al., 2004).
WHAT DOES THE LITERATURE SAY ABOUT ENGAGEMENT?

Studies on father engagement in parent interventions tend to report low levels of participation by fathers both in the programs themselves and in the associated evaluations (Lindsay et al., 2008; Panter-Brick, et al., 2014; Stahlschmidt, et al., 2013). I draw on findings from broader studies about engaging fathers and parents in child and family services. It is not clear how the factors identified apply to parenting programs focused specifically on domestic violence prevention. Despite these limitations, learnings from this literature provide a more evidence informed understanding of father engagement. The table below summarises the factors identified as influencing father engagement according to the multi-level model I propose (see Table 2.1). The following discussion describes each dimension of this model and provides examples of its application.
### Table 2.1: Multi-Level Model of Father Engagement

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<tr>
<th>Dimensions of engagement</th>
<th>Examples of factors</th>
<th>Researchers</th>
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<td>Practical</td>
<td>Accessibility</td>
<td>Ghate, Shaw &amp; Hazel (2000)</td>
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<td>Program marketing</td>
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<td>Trust</td>
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<td>Delivery style</td>
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Dimensions of engagement | Examples of factors | Researchers
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Strategic | Retention strategies | Cooney, Small & O’Connor (2007)  
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Ingoldsby (2010)  
Lindsay, Band, et al. (2008)  
Stahlschmidt et al. (2013)
Extrinsic incentives | Gross, Julion and Fogg (2001)  
Heinrichs (2006)  
Jago et al. (2012)  
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Stahlschmidt et al. (2013)
Structural | Group format | Ghate & Ramella (2002)  
Jago et al. (2012)  
Jago et al. (2013)  
Lindsay, Davies, et al. (2008)  
Spoth et al. (1996)
Delivery medium | Lindsay, Band, et al. (2008)  
Lindsay, Davies, et al. (2008)  
Moran, Ghate & Van der Merwe (2004)
Program length | Lindsay, Band, et al. (2008)  
Spoth (1993)

PRACTICAL FACTORS

Accessibility

Practical factors are particularly influential during the first two phases, ‘getting’ and ‘keeping’ fathers, and relate primarily to accessibility issues, such as timing, venue location, proximity to public transport, service costs and the provision of childcare (Ghate, Shaw, & Hazel, 2000; Gross, Julion, & Fogg, 2001; Soriano, Clark, & Wise, 2008; Spoth, 1993).

In a narrative review of the impact of the physical environment on social service delivery, Weeks (2004) differentiates between three aspects of accessibility: geographical, psychological and physical. Venue location and access by public transport are examples of geographical aspects, whereas physical aspects relate to a person’s capacity to enter the building, such as disabled access and the useability of facilities (Weeks, 2004). Psychological accessibility refers to individuals’ perceptions of the service delivery environment acknowledging that social and cultural attitudes may inhibit or facilitate access to services. Weeks describes psychological accessibility as the ‘absence of features which might stimulate stigma or…a sense of fear about the
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entry' (Weeks, 2004, p. 322). Psychological accessibility extends to the naming of services, recognising that attendance may be inhibited by association with stigmatised services, such as domestic violence services (Weeks, 2004).

For Weeks (2004), the key to creating psychologically accessible services, and thus ‘getting’ fathers, is the provision of a ‘neutral doorway’, a non-stigmatising entry point. This approach is reinforced by research on parent engagement that continuously highlights the facilitative nature of welcoming, non-stigmatising service environments (Moran, et al., 2004; Soriano, et al., 2008). Aligned with these research findings, domestic violence primary prevention strategies are increasingly being embedded into mainstream services, such as education and health services, in an effort to diminish psychological barriers to engagement (Flood, et al., 2009; Florsheim, McArthur, Hudak, Heavin, & Burrow-Sanchez, 2011; Wolfe, et al., 2009).

Timing of courses is often cited as a critical factor in father and parent engagement (Gross, et al., 2001; Spoth, 1993). In a survey of parents’ preferred program features, Spoth (1993) found that meeting time was the highest rated with 57.7% of parents rating it extremely or most important (N=202). Overwhelmingly these parents preferred weekday evening meetings to weekday daytime or weekend meetings (86.6% compared to 7.4% and 5.9%) (Spoth, 1993). Similar findings about parents’ preferences were made by Gross, Julion and Fogg (2001) in their research on motivations for participation and attrition in parent training among low income non-Caucasian families in Chicago. They found that program timing, namely holding sessions on weekday evenings, was the only factor associated with parent retention (Gross, et al., 2001).

Research also suggests men’s relationships with their partners can act as a barrier to service use with their partners acting as gatekeepers facilitating or inhibiting their engagement (Ghate, et al., 2000; N. Maxwell, Scourfield, Featherstone, Holland, & Tolman, 2012; Roggman, Boyce, Cook, & Cook, 2002). For example in a small qualitative study of 40 fathers, their partners and staff from 13 Family Centres across England and Wales Ghate, Shaw and Hazel (2000) found that some women preferred
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their male partners not to be present at Family Centre visits (Ghate, et al., 2000). However, Ghate and colleagues (2000) more commonly found that the men themselves preferred not to be present at the Family Centre visits seeing such visits as an opportunity for them to have time away from their partners and children.

Program marketing

Knowing the ‘market’ for the service and publicising it appropriately is another practical factor central to ‘getting’ fathers (Levant, 1987; Moran et al., 2004). Research on program promotion indicates that personal referrals from trusted information sources such as friends and family are effective (Cooney, Small, & O'Connor, 2007; Jago et al., 2012; Stahlschmidt, et al., 2013). In an American survey of 300 parents about their interest in parent education programs, Levant found that personal sources of information were highly valued by parents with friend or relative being rated the source most likely to influence parents to attend (Levant, 1987). Similarly Soriano et al. (2008) in their review of parenting and family support interventions as part of the Stronger Families and Communities Strategy, found that father recruitment requires personal approaches at places frequented by fathers, such as schools.

Jago et al. (2012) evaluating recruitment for a physical activity parenting course through telephone interviews with 32 parents discovered that parents preferred ‘word of mouth’ and in-person recruitment with schools seen as effective recruitment agents. A subsequent online survey of 750 parents distributed by a national parenting website found that these parents also saw schools as a trusted sources of information with just over 90% of parents reporting that they always pay attention to school correspondence and nearly 85% always or often paying attention to school staff (Jago, et al., 2012). A later process evaluation of a two-arm individualised randomised controlled feasibility trial of a physical activity parenting course by Jago et al. (2013) showed that in person promotion by members of the program team at schools and community venues as well as encouragement from friends facilitated parent engagement (Jago, et al., 2013). The UK PEIP evaluations also highlighted the effectiveness of school-based program promotion: ‘school is a community resource
and has no connotations associated with its being only for those with difficulties’ (Lindsay, Davies, et al., 2008, p. 40). PEIP facilitators reported that the invitation process is key to ‘getting’ parents with personal invitations delivered at home visits prior to program commencement being effective (Lindsay, Band, et al., 2008).

RELATIONAL FACTORS

Interactions between service providers and clients, and the nature of relationships formed are central to all three stages of engagement.

**Staff attitudes and behaviours**

Staff attitudes and behaviours and their interaction with service users impact directly on engagement. This influence extends beyond workers directly involved in programs to recruiters and reception staff, all of whom contribute to setting the tone of the service (Weeks, 2004). As Weeks (2004) and others have noted, reception areas are usually the first point of contact between users and service providers and relational factors, such as the hospitality of reception staff, together with the physical waiting room environment influence initial engagement (Gutheil, 1992, 1997; Ornstein, 1992). In addition to having a welcoming manner, previous research by Carbone et al. (2004) with parents, service providers and government staff conducted as part of a study on creating inclusive antenatal and universal early childhood services indicates that empathetic and non-judgemental attitudes facilitate engagement. Similarly, parents in the Teamplay trial by Jago et al. (2013) reported that empathetic interaction style of facilitators promoted retention.

**Trust**

Engagement studies have consistently demonstrated that trusting and respectful relationships with staff motivate client engagement (Barnes et al., 2011; Gross, et al., 2001). For example, Gross, Julion and Fogg (2001) conducted a study of 155 families enrolled in a 12 week parent training group at licensed day care centres serving low-income families in Chicago. They focused on the parents’ motivations for participating in parent training and reasons for withdrawal finding that over 88% of parents cited
the personality and trustworthiness of the recruiter as an important incentive for their participation (Gross, et al., 2001). Likewise, qualitative interviews with eight mothers who participated in a home visitation program about their perspectives on program engagement by Paton, Grant and Tsourtos (2013) revealed that trusting and respectful relationships with program staff were central to engagement.

The links between trust and program engagement were also noted by Soriano et al. (2008) in a study that reviewed interventions from Australian early childhood development, early intervention and community development sectors to identify promising practices as part of a cross-strategy national evaluation of the *Stronger Families & Communities Strategy* (SFCS) 2004 -2009. Fifty-seven interventions were identified as ‘promising practice’ based on the following six assessment criteria: the intervention is effective, draws on the evidence base, contributes to the existing evidence base, is replicable, is innovation and is sustainable (Soriano, et al., 2008, p. 8). This review found that relationship building, which relies on trust, promotes client engagement (Soriano, et al., 2008). It highlighted one promising practice which promoted client engagement, the use of facilitated, peer-based activities to develop trusting relationships between workers and clients (Soriano, et al., 2008).

**Delivery style and building rapport**

The presentation and delivery of programs is a key factor to ‘getting’ parents. It is important to recognise parents’ expertise in their own lives and emphasise that the service is a partnership by working *with* parents rather than *on* them (Carbone et al., 2004; Moran et al., 2004). This strengths-based approach aligns with research that suggests strategies, which engage men in positive roles are more effective for primary prevention (Esplen, 2006; Flood, 2010; Harvey, et al., 2007).

Previous research has indicated that building rapport with parents before they formally begin using a service promotes user attendance (Lindsay, Davies, et al., 2008; Moran, et al., 2004). For example, facilitators interviewed as part of the PEIP evaluation reported that home visits prior to the start of the course were an effective means of ensuring attendance (Lindsay, Band, et al., 2008). Similarly, research by
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Ghate, Shaw and Hazel (2000) into father engagement in Family Centres across England and Wales showed that a proactive approach to getting fathers facilitated father engagement. Staff and fathers alike reported that personal introductions, such as home visits, were an effective means of ‘getting’ fathers (Ghate, et al., 2000). Later research by Ghate and Ramella (2002) showed that initial home visits by program staff put a face to the program and enabled staff to address parents’ anxiety and hostility about participating.

**CULTURAL, CONTEXTUAL AND SITUATIONAL FACTORS**

**Life circumstances and stresses**

Addressing clients’ personal situations and how these intersect with service use is a necessary precursor to getting, keeping and engaging fathers, especially hard to reach vulnerable fathers (Barnes, et al., 2011; Roggman, et al., 2002). Carbone et al. (2004) documented several situational factors that can inhibit service use including homelessness, limited income, lack of social support, physical and mental health issues, and fear of child protection services. They identified the engagement challenges faced by vulnerable parents with multiple life stressors:

Vulnerable parents have to overcome numerous obstacles and balance competing needs. It is likely that at times, ‘survival’ needs take priority over attendance at a service (particularly services which lack an immediate, tangible benefit) or barriers collectively become overwhelming, preventing parents from making use of services (Carbone, et al., 2004, p. 19).

Several researchers have noted the positive impact of preparatory work addressing life circumstances with parents to facilitate engagement (Forehand & Kotchick, 2002; Moran, et al., 2004).

Low socioeconomic status and young age also appear to adversely influence men’s engagement (L. D. Brown, Feinberg, & Kan, 2012). Research on new parent engagement in the *Family Foundations* program by Brown et al. (2012) indicates that
men’s engagement is associated with higher levels of income and older age. This study found that for low income earners, participation costs and financial stress restricts men’s engagement (L. D. Brown, et al., 2012).

Gender of participants

Mother-centric practices, policies and service provider orientations can negatively impact on getting, keeping and engaging fathers (Bayley, Wallace, & Choudhry, 2009; Berlyn, Wise, & Soriano, 2008; Ferguson, 2016; N. Maxwell, Scourfield, Featherstone, et al., 2012). The Ghate, Shaw and Hazel (2000) study on father engagement revealed that referral policies and systems filter men’s access to family services. Family Centre staff who were interviewed attributed the absence of fathers to the fact that mothers are the referred clients and the parent with whom the centres develop a relationship (Ghate, et al., 2000). Similarly, research by Ferguson and Gates (2015) on men’s experiences of the Family Nurse Partnership (FNP) in England found that policy directives identifying mothers as the primary clients of the FNP led some staff to exclude fathers. Ghate and colleagues (2000, p. 45) contend that these ‘feminised environments’ inhibit father engagement by only allowing men to engage with family services on women’s terms or by becoming ‘pseudo-women’. Likewise mother-centric program content may not resonate with fathers although in the absence of gender disaggregated evidence little is known about how program content impacts on father engagement (Panter-Brick, et al., 2014). These findings indicate that the service environment together with service provider policies and orientation can discourage father access impacting negatively on engagement.

Some researchers have found that cultural constructions of masculinity inhibit father engagement by depicting help-seeking as weakness and discouraging emotional expression (Dolan, 2014; Ferguson, 2016; Ferguson & Gates, 2015; Paull, 2004). For example, in the aforementioned study on the FNP 23% of fathers were never present at Family Nurse visits and 18% at half or less of the visits (Ferguson & Gates, 2015). Ferguson and Gates found that the fathers’ lack of involvement partly stemmed from the men’s constructions of masculinity that saw help-seeking as weakness (Ferguson &
Gates, 2015). The fathers’ reluctance to show and express their feelings also inhibited their involvement and was sometimes perceived by the nurses as disinterest thereby justifying their focus on mothers (Ferguson, 2016). Like Ferguson and Gates, Dolan’s (2014) research with eleven fathers who participated in a ‘dads only’ parenting program in the United Kingdom revealed that fathers’ use of parenting services can compromise their masculine identities. Dolan (2014) found that fathers who seek out parenting services have to negotiate a tension between conforming to hegemonic ideals of masculinity that discourage help-seeking as weakness and their desire to be involved fathers.

Cultural sensitivity

There is a large and well documented body of research on the need for cultural awareness and sensitivity in service delivery to support engagement (Cortis, Katz, & Patulny, 2009; Forehand & Kotchick, 1996; Katz, La Placa, & Hunter, 2007; Sawrikar & Katz, 2008). A comprehensive discussion is beyond this review however some key factors shown to facilitate engagement of parents from minority ethnic communities are discussed below.

Cultural sensitivity is likely to influence parent engagement during all three phases. Previous literature on engaging culturally and linguistically diverse communities indicates that program recruiters and workers have a significant impact on ‘getting’ parents from culturally diverse backgrounds (Cooney, et al., 2007; Gross, et al., 2001; Julion, Gross, & Barclay-Mclaughlin, 2000). Interestingly, it seems that good interpersonal skills rather than the ethnic-racial background of service providers facilitates engagement. The six family interviewers, who acted as recruiters and data collectors in the earlier mentioned study of non-Caucasian parents by Gross, Julion and Fogg, reported that establishing trust was the ‘single most important’ recruitment technique (2000, p. 232). While some of the family interviewers were matched with target communities from the same racial-ethnic background and others not, they all identified sensitivity, flexibility and adaptability as the personal attributes that contributed to successful recruitment and retention efforts (Julion, et al., 2000).
female European-American family interviewer who did not come from the same ethnic-racial background as the families she recruited felt that taking the time to develop a trusting and respectful relationship with potential participants was more important than being from the same ethnic-racial background for recruitment purposes (Julion, et al., 2000). Another recruiter who was matched with potential participants from the same ethnic-racial background felt that communities can be equally suspicious of community insiders acting as recruiters because they were uncertain of their motives (Julion, et al., 2000). These findings imply that relational factors facilitate getting and keeping parents from culturally diverse backgrounds and impact on engagement with such parents across all three phases.

Other work on parent interventions has examined the transferability of parenting programs between different populations identifying the need to tailor programs to parents and their contexts (Lindsay, Band, et al., 2008; Short & Johnston, 1994). Facilitators involved in evaluations of the previously described UK PEIP project reported transferability issues with the delivery of American and Australian developed parenting programs in England (Lindsay, Band, et al., 2008; Lindsay, Davies, et al., 2008). Some facilitators felt the program materials were culturally inappropriate and raised concerns about the linguistic and cultural specificity of scenarios used in the program materials (Lindsay, Band, et al., 2008; Lindsay, Davies, et al., 2008). Such studies exemplify the need for cultural sensitivity in recruitment and retention practices and in delivery and content of programs.

**STRATEGIC FACTORS**

**Retention strategies**

Previous research has identified numerous strategies for discouraging attrition such as reminders, phone calls after missed sessions, home visits, transport provision and supported participation through buddy systems (Cooney, et al., 2007; Gross, et al., 2001; Ingoldsby, 2010; Stahlschmidt, et al., 2013). Some researchers believe that the level of parental need impacts on gaining and maintaining engagement. The Lindsay, Band, et al. (2008) PEIP study indicated that individualised attention and support
mechanisms can facilitate ‘keeping’ parents with greater needs. Similarly, Ingoldsby’s (2010) review of 17 randomised control trials of interventions designed to improve family engagement and retention in child mental health programs suggests that retention strategies which include integrated treatment sessions to address parents’ life stressors, are effective in promoting participant retention. Ingoldsby (2010) found further that strategies implemented prior to, or in the early stages of, an intervention where providers acknowledged and addressed psychological and practical barriers were more effective than telephone reminders in facilitating engagement and retention.

Extrinsic Incentives

Dropout is commonly discouraged by providing extrinsic incentives for attendance, such as monetary payments, free childcare, refreshments, transportation costs and gift certificates (Heinrichs, 2006; Jago, et al., 2013; Jago, et al., 2012; Stahlschmidt, et al., 2013). Interestingly, work on retention strategies in parenting programs reveals that monetary incentives may attract parents but be less effective in retaining them (Gross, et al., 2001; Heinrichs, 2006; Stahlschmidt, et al., 2013). The Gross, Julion and Fogg (2001) study found that while monetary incentives piqued parents’ interest, parents did not report it as a motivation for participating. Only three parents reported that they signed up because of monetary incentives with two of these parents dropping out and the third attending only half the program (Gross, et al., 2001). Parents stated their main reasons for participation as wanting to learn about children at this age (29.7%), to share experiences with other parents (27.7%) and get help managing children’s difficult behaviours (23.9%), suggesting that parents participate in interventions that meet a perceived need and that monetary incentives will not necessarily encourage participation (Gross, et al., 2001).

Correspondingly, Heinrichs (2006) compared the impact of two different extrinsic incentives, paid participation and program format, on the recruitment and retention rates of 690 families from 15 preschools in a socially disadvantaged area of Germany. Families were assigned to group format or individual family sessions and were to be
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paid for attending and completing the program or to receive no payment (Heinrichs, 2006). Higher recruitment rates were achieved for paid participation than unpaid regardless of program format (46.1% or 155/336 paid families recruited versus 26.3% or 93/354 unpaid families recruited) however monetary incentives were less effective in retaining participants (Heinrichs, 2006). Although there was a higher initial dropout rate among unpaid families who enrolled but never attended a session, the completion rates for paid and unpaid participants were relatively similar if those who never attended a session were excluded (97% or 130/134 and 90.5% or 57/63 respectively) (Heinrichs, 2006). Together these studies suggest that monetary incentives may facilitate ‘getting’ fathers but may have little impact on ‘keeping’ them.

STRUCTURAL FACTORS

Structural factors in this context refer to the format or structure of service provision, such as the delivery mode and medium. These are particularly relevant to the last two stages of engagement.

Group format

Research suggests that the social aspect of group programs attracts parents and maintains their engagement (Ghate & Ramella, 2002; Jago, et al., 2013; Jago, et al., 2012). For instance, parents in the PEIP project found comfort and support in the group format, speaking of how meeting other parents with similar experiences provided a sense of relief and the realisation they were not alone (Lindsay, Davies, et al., 2008). The support systems provided by group interventions motivated their continued engagement (Lindsay, Davies, et al., 2008). Similarly, Jago and colleagues (2013; 2012) found that parents value the social relationships, support and knowledge sharing opportunities that stem from group work.

The power of group-based programs to facilitate ‘keeping’ parents appears to be dependent on achieving a critical mass of attendees (Ghate & Ramella, 2002; Jago, et al., 2013). Interviews with parents in the intervention arm of the Teamplay randomised controlled trial by Jago et al. (2013) revealed that irregular attendance
negatively impacted on group identity with parents reporting that small group numbers limited the ability to share and learn from other parents. Notably, some researchers have suggested that vulnerable parents may find the public nature of group work too exposing inhibiting all three phases of engagement (Ghate & Ramella, 2002; Moran, et al., 2004). This position is somewhat supported by Spoth and colleagues’ research on reasons for non-participation that showed an inverse association between socioeconomic status and privacy concerns as a reason for nonparticipation (Spoth, Redmond, Hockaday, & Shin, 1996).

Delivery medium

The media used to deliver programs have been shown to impact on ‘keeping’ and ‘engaging’ users (Lindsay, Band, et al., 2008; Lindsay, Davies, et al., 2008; Moran, et al., 2004). For example, the literacy levels required to engage with the printed materials used in the PEIP parenting programs were seen to exclude some parents (Lindsay, Band, et al., 2008; Lindsay, Davies, et al., 2008) indicating the need to tailor the delivery medium to the audience to ‘engage’ parents.

Program length

There is some evidence to suggest that program length influences ‘keeping’ fathers with lengthy courses reducing parent retention (Lindsay, Band, et al., 2008; Spoth, 1993). Spoth (1993) showed that shorter programs are more appealing to parents. From a set of programs that ranged in length from between 1 to 15 weeks, over 75% of parents preferred programs that last for 5 weeks or less (N=202) (Spoth, et al., 1996). Furthermore, program duration was rated the fourth most important category of program features with 42.1% of parents rating ‘program duration’ as an extremely or most important (Spoth, 1993). Some PEIP program facilitators also viewed course length as an inhibitor to parent engagement (Lindsay, Band, et al., 2008). The next section outlines the limitations of engaging men as fathers.
LIMITATIONS OF ENGAGING MEN AS FATHERS

Although using fatherhood to engage men in violence prevention interventions is an increasingly popular strategy, this approach does have some limitations which include:

- Engaging men as fathers - valuing the father role as a necessary precursor
- Limited impact of one dimensional interventions
- Self-selection bias
- Hierarchy of abusers
- Risk or resource

Each of these problems is discussed in more detail below.

VALUING THE FATHER ROLE AS A NECESSARY PRECURSOR

Sheehy (2004) suggests that men’s perceptions of the father role and the value they attach to it is an important precursor to engaging men as fathers. Based on findings from an evaluation workshop with nine fathers who had participated in fatherhood groups as part of the *South Australian Fatherhood Support Project*, Sheehy (2004) found that the value men place on their parenting roles influences men’s engagement as fathers. Sheehy (2004) contends that in order to use fatherhood as motivation you must first help men understand the importance of their role and the positive impact it can have on their child’s or children’s development. The generalisability of Sheehy’s findings are limited by the small scale of the study. However, the fact that a group of highly engaged fathers who had chosen to participate in fatherhood groups for new and expectant fathers identified valuing the fathering role as an initial step to engaging men as fathers carries some weight. This finding provides insight into motivating men’s initial engagement as fathers suggesting that service providers seeking to engage men as fathers must first promote the importance of fathering roles and conceptualisations of masculinity that value fatherhood.
LIMITED IMPACT OF ONE DIMENSIONAL INTERVENTIONS

While the use of fathering narratives may be effective in engaging men, individual level fathering or parenting education programs may have limited transformative effect on men’s constructions of fathering and masculinity linked to attitudes to, and perpetration of, IPV (Casey, et al., 2013; Moran, et al., 2004; Salter, 2015). For example, a study by Doherty, Erickson and LaRossa (2006) of a group fathering education intervention during the transition to parenthood found that while the intervention improved individual parenting skills, it had no impact on the distribution of parental responsibility. Doherty et al. (2006) suggest that this is attributable to the fact that men’s father identities are shaped not only by their individual experiences but also by structural forces such as social constructions of fathering and the roles of men and women in relationships. This research indicates that fathering or parenting programs cannot stand alone and must form part of multidimensional, multipronged prevention strategies in order to comprehensively change wider social norms regarding family dynamics and gender roles associated with the acceptance of IPV.

SELF-SELECTION BIAS

Although there is some evidence of the effectiveness of interventions during the transition to parenthood in preventing child maltreatment, the effectiveness of such interventions in preventing IPV is unknown (World Health Organisation & London School of Hygiene and Tropical Medicine, 2010). Engaging men as fathers through parenting programs may have limited applicability in terms of primary prevention. Men who participate in parenting programs may already be engaged as fathers and less likely to hold attitudes towards gender associated with violence supportive attitudes. Perhaps more appropriate targets for primary prevention interventions during the transition to parenthood are those men who do not attend parenting programs. The value placed on the father role by these men may be lower and alternate strategies may be required to engage them in IPV primary prevention.
HIERARCHY OF ABUSE

Current research and literature on working with men in violence prevention highlights the effectiveness of strategies that seek to engage men by investing them in their children’s wellbeing. Missing from this work is discussion about the appropriateness of engaging men in IPV prevention by advocating the positive impact non-violence could have on their children rather than the positive impact it could have on their partners. Engaging men in IPV prevention through their identities as fathers may promote an ordering of violence that views the abuse of adult partners as more acceptable than the abuse of children. For example, Fox and colleagues’ (2001) study of fathers court-mandated to attend group counselling for IPV in the United States revealed that fathers were eager to establish they were not child abusers. The fathers involved in their study clearly differentiated between abusing female partners and abusing children with the later seen as more reprehensible (Greer Litton Fox, et al., 2001). Further consideration must be given to the efficacy of these engagement strategies and whether they will contribute to the perceived hierarchy of abuse phenomenon observed by Fox et al. (2001).

RISK OR RESOURCE?

Work on engaging fathers in parenting-based violence prevention interventions originated with practitioners and researchers in the child protection, family law and domestic violence areas. The earlier programs sought to engage men who were identified as violent (‘maltreating fathers’). Division among tertiary intervention workers and researchers regarding male perpetrators’ involvement with children has led to dichotomous constructions of fathers as either resources for children in terms of development outcomes, even though they perpetrate IPV, or as perpetrators of IPV and therefore as risks to children (Featherstone, 2004; Featherstone & Fraser, 2012; Ferguson & Gates, 2015; N. Maxwell, Scourfield, Featherstone, et al., 2012). The risk versus resource discourses that characterise such approaches to working with men in these fields appears to be largely disregarded in the area of primary prevention. Primary prevention work in the health field has adopted a ‘resource’ perspective of fathers, viewing them not only as a resource for children but also as resource for
gender equality in intimate relationships (Barker, et al., 2007; Featherstone & Fraser, 2012). The assumption that the risk lens does not apply to primary prevention work is seemingly based on the premise that primary prevention addresses violence before it occurs and such programs do not engage with identified or unidentified perpetrators. This perspective is dependent on effective screening and the wholehearted abandonment of the risk discourse by primary prevention practitioners seems premature.

**CONCLUSION**

Engaging men as fathers is an increasingly popular approach to working with men on violence prevention (Featherstone & Fraser, 2012; Ferguson & Gates, 2015; Fleming & King, 2010; Greer Litton Fox, et al., 2001; N. Maxwell, Scourfield, Holland, et al., 2012; Stanley, Fell, et al., 2012; Stanley, Graham-Kevan, et al., 2012). A necessary but largely overlooked first step in this process, is the development of a father engagement framework. This thesis proposes adapting Moran and colleagues (2004) multiphase approach for IPV primary prevention. Their three-phase model emphasises the ongoing nature of engagement prompting service providers to reflect not only on how to obtain initial attendance but also sustain active long-term engagement.

While this model provides insights into the varied factors that impact on father engagement the distinctions between the ecological levels are somewhat artificial and depart from general use (for example structural factors referring to the format of service delivery rather than macro-level structures). Furthermore, it provides no weighting in regards to which dimension(s) holds the key to unlocking father engagement. Moran and colleagues conceive of father engagement as a multifaceted process that situates the gendered aspect of engagement in service systems as one of many dimensions. Contrary to Moran et al. (2004), this thesis argues that gender is the rather than a factor in father engagement in Maternal and Child Health settings. Accordingly this research uses an adapted version of Moran’s (2004) model retaining the three-phase approach while dispensing with their ecological categorisations and applying a gender lens. The rationale for using a gender lens to consider the transition
to parenthood and the centrality of gender to men’s father identities are explained in the following chapter.

A better understanding of the engagement process and clearly developed strategies are required to ensure getting, keeping and engaging fathers in primary prevention programs. Nevertheless, it is important to remember that the factors identified above as part of this model largely come from studies on parent engagement in parent education interventions not specifically designed for IPV primary prevention. The weight these factors carry for father engagement in IPV primary prevention strategies is unknown and this study contributes to filling this gap by identifying factors unique to engaging fathers in IPV primary prevention efforts.

**DISSEMINATION**

In regards to this chapter the findings from my review of the research literature were first presented in a peer-reviewed paper.

CHAPTER 3: A MULTIDIMENSIONAL GENDER LENS

INTRODUCTION

There are many approaches to studying gender (Risman & Davis, 2013). On the one hand, sex role theories frame gender in terms of individual biological and social sex differences while structural perspectives consider gender is created by organisational structures (Beilby, 2000; Connell, 1985; Richard R. Peterson & Gerson, 1992; Weitzman, Eifler, Hokada, & Ross, 1972). Yet other theories apply an interactional analysis focusing on how social expectations and interactions produce gender (West & Zimmerman, 1987). More recently, gender theorists have integrated micro and macro level approaches moving towards multidimensional models (Connell, 2012; Lorber, 1994; Martin, 2004; Risman, 2004). These integrative approaches see gender as a socially constructed stratification system that operates simultaneously at multiple levels (Connell, 2012; Lorber, 1994; Martin, 2004; Risman, 2004; Risman & Davis, 2013).

Using Risman's (2004) integrative gender theory, this study explores the impact of gender on service providers’ engagement with new fathers in respectful relationships programs delivered in health settings. This chapter begins by discussing the relevance of gender for men transitioning to parenthood and goes on to a detailed explanation of Risman’s model of gender employed in this thesis.

GENDER AND THE TRANSITION TO PARENTHOOD

The connections between gender and fatherhood are well documented with gender recognised as a core element in the construction of fatherhood; men’s paternal identities and behaviours are intertwined with cultural conceptions of masculinities (Coltrane, 1996, 1998; Dowd, 2000; Eerola & Mykkänen, 2015; B. Fox, 2009; Höfner, et al., 2011; Marsiglio, Day, & Lamb, 2000; Marsiglio & Pleck, 2005). Such thinking is captured well in Dowd’s comment that ‘men’s identities as fathers do not exist in
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isolation from their identities as men’ (2000, p. 181). Given this relationship it is inevitable that men’s perception and construction of their identities as men and as fathers affects father engagement in parenting programs.

Many researchers have noted that despite the prevalent ‘new father’ discourse, male parenting practices and the division of parental responsibilities remain relatively unchanged (Eerola & Mykkänen, 2015; Elliot, 2015; Höfner, et al., 2011; LaRossa, 1988). Moreover research continues to show that the transition to parenthood leads to a ‘retraditionalisation of gender roles’ for heterosexual couples (Janeen Baxter, et al., 2008; Dribe & Stanfors, 2009; B. Fox, 2001, 2009; Höfner, et al., 2011, p. 670). Fox (2001; 2009, p. 6) attributes this resistance to change to the deeply gendered nature of parenting responsibilities arguing that ‘parenthood creates gender more thoroughly than any other experience in most people’s lives’. Researchers have shown that parenting is connected to men’s and women’s sense of identity as men and women with fathering and mothering seen as expressions of femininity and masculinity (Dribe & Stanfors, 2009; B. Fox, 2001, 2009; LaRossa, 1997). As Marsiglio and colleagues astutely assert:

Gender issues therefore affect how men are viewed and treated as fathers, how they think about the prospects of paternity and fatherhood, how they view themselves as fathers, how they perceive their children, and how they are involved in and affect their children’s lives (Marsiglio, et al., 2000, p. 727).

This thesis extends this proposition arguing that gender also impacts on how men respond to programs that seek to engage them as fathers in health settings. A gender lens is particularly important in health settings where institutions that deliver health care have defined gender regimes and ‘where gender is named, but actually women are spoken about’ (Connell, 2012, p. 1676; Schofield, 2009). The following section discusses the gender theory applied in this study.
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GENDER AS A SOCIAL STRUCTURE

Risman views gender as an organising principle of social life, such as the economy or the polity, conceptualising it as a ‘socially constructed stratification system’ (Risman, 2004, p. 430). Her integrative theory envisages gender as a social structure operating on three different dimensions: the individual, the interactional and the institutional. This multi-level approach recognises that:

Gender structures social life not only by creating gendered selves and cultural expectations that shape interactions, but also by organising social institutions and organisations (Risman & Davis, 2013, p. 746).

Risman’s conceptualisation of gender does not privilege any one dimension at the expense of any other (Risman, 2004). This multidimensional approach allows researchers to identify how and why gender inequality is produced and to explore the causal processes that link individuals, social interaction and institutions (Risman, 2004). Risman (2004, p. 433) describes the interplay of causality within and between dimensions as the ‘web of interconnection’ explaining that there is a recursive relationship between all three dimensions. She emphasises that:

We must pay attention both to how structure shapes individual choice and social interaction and how human agency creates, sustains, and modifies current structure (Risman & Davis, 2013, p. 744).

Risman stresses that the gender structure is not static, ‘change is fluid and reverberates throughout the structure dynamically’ (2004, p. 435; 2011). Each dimension of Risman’s model is discussed in more detail below.

THE INSTITUTIONAL LEVEL

Risman describes the institutional dimensions as including legal regulations, organisational practices, the distribution of resources and ideological discourses (Risman, 2004; Risman & Davis, 2013). The institutional dimension emerges from the
work of structural theorists exploring how organisational structures produce gender (Risman, 2004; Risman & Davis, 2013). Institutional change is challenging and slow paced (Risman & Davis, 2013). Particularly pertinent at this level is the concept of gendered organisations (Acker, 1990, 1992). Acker explains that:

To say that an organisation, or any other analytic unit, is gendered means that advantage and disadvantage, exploitation and control, action and emotion, meaning and identities are patterned through and in terms of a distinction between male and female, masculine and feminine (1990, p. 146).

She argues that rather than being gender neutral or asexual, organisational processes, practices, images and ideologies are deeply gendered (Acker, 1990, 1992).

While much of the work on gender and parenthood at the institutional level focuses on how structural arrangements inhibit women’s participation in paid work and careers, and sustain a division of labour connected to traditional gender ideologies, this thesis explores the reverse effects of these institutional processes, the marginalisation of men from family life (Kan, Sullivan, & Gershuny, 2011; Sullivan, 2013). Research on gender and parenthood has found that institutional arrangements, such as economic, public and social policies, and organisational cultures, promote gender divisions, accompanying parenthood, that marginalise men from care work and the home (Coltrane, 1996; B. Fox, 2009; Haas & Hwang, 1995; Sullivan, 2013).

**Hegemonic Masculinity**

Ideological discourses of gender, particularly hegemonic masculinity are guiding forces in men’s construction of their identities as men and fathers (Eerola & Mykkänen, 2015; Elliot, 2015; Höfner, et al., 2011). The plurality and hierarchy of masculinities is widely accepted (Carrigan, Connell, & Lee, 1985; Connell, 1998; Connell & Messerschmidt, 2005). As Connell and Messerschmidt explain:

Masculinity is not a fixed entity embedded in the body or personality traits of individuals. Masculinities are configurations of practice that are accomplished
in social action and, therefore, can differ according to the gender relations in a particular social setting (2005, p. 836).

Aligned with multiple masculinities is the notion of a hierarchy of masculinities in which a hegemonic form of masculinity is conceived as representing the ideal ideological construction of being a man in a particular context (Connell & Messerschmidt, 2005). Connell and Messerschmidt (2005) explain that while hegemonic masculinities may not reflect the everyday lives of any actual men, hegemonic models of masculinity represent ideological exemplars that inform men’s construction of their masculinity and their involvement in gender relations that constitute the gender order. Hegemonic patterns are not fixed; they vary across class, history, race, geography and culture (Connell & Messerschmidt, 2005). The hierarchical subordination of non-hegemonic masculinities is achieved through ‘cultural consent, discursive centrality, institutionalisation, and the marginalisation or delegitimation of alternatives’ rather than simply physical force (Connell & Messerschmidt, 2005, p. 846). Hegemonic models of masculinity extend to fatherhood providing what Elliot describes as ‘cultural reference points’ in the construction of men’s father identities and practices (Elliot, 2015, p. 7).

THE INTERACTIONAL LEVEL

Drawing on interactionist contributions to gender theory that see gender as performative or something men and women do, this dimension explains how gender is enacted through social interaction (Connell, 2012; Risman, 2004, 2011; West & Zimmerman, 1987). Risman describes the interactional dimension as the ‘cultural component’ of social structure (2004, p. 433). This level looks at the cultural expectations attached to sex categories that govern social interaction to explain why individuals choose to ‘do’ gender (Risman, 2004; Risman & Davis, 2013).

Although Risman and others note that interactional expectations have often proved ‘impervious’ to change, they are not seen as deterministic (Deutsch, 2007; B. Fox, 2001; Risman, 2004, p. 436; 2009). Risman allows for individual agency arguing that gender-conscious men and women can choose not to follow traditional scripts thereby
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‘undoing gender’ (Deutsch, 2007; Risman, 2009). As Risman notes ‘social structures not only act on people; people act on social structures’ (Risman, 2004, p. 432). In the parenting context, the interactional dimension has proved to be particularly pertinent with Fox arguing that ‘the way people parent is largely a product of couples’ negotiations’ (2001, p. 377).

Aligning with Fox, role identity theorists acknowledge that fathering is partly interactionally defined. McCall explains that a person’s sense of self is mutually shaped by the individual and society through identity negotiation, a process that is both intra- and inter-personal (McCall, 1987). Applications of identity theory to fatherhood take a relational perspective; how men see themselves and behave as fathers is in part influenced by how others see them, particularly their partners (Greer Litton Fox & Bruce, 2001; Marsiglio & Cohan, 2000; Maurer, Pleck, & Rane, 2001). In this vein, fathering is seen to be co-constructed by interpersonal interactions and the social context in which they occur (Greer Litton Fox & Bruce, 2001; LaRossa & Reitzes, 1993; Olmstead, Futris, & Pasley, 2009).

**Homosociality**

One mechanism for maintaining hegemonic masculinity is homosociality which Lipman-Blumen defines as ‘the seeking, enjoyment, and/or preference for the company of the same sex’ (1976, p. 16). Bird argues that ‘homosocial interaction, among heterosexual men, contributes to the maintenance of hegemonic masculinity norms by supporting meanings associated with identities that fit hegemonic ideals while suppressing meanings associated with nonhegemonic masculinity identities’ (1996, p. 121).

**THE INDIVIDUAL LEVEL**

The individual level focuses on the development of gendered selves; how men and women develop a preference for gender-typical behaviour through identity work and socialisation (Risman, 2004; Risman & Davis, 2013).
Identity Theories

A key element of the individual dimension is identity work, the construction of the self (Risman, 2004). While there are many identity theories, this thesis focuses on *role identity theory* and its application to fatherhood research (Hogg, Terry, & White, 1995; McCall & Simmons, 1978; Stryker & Burke, 2000). Pioneered by McCall and Simmons, role identity theory posits that individuals develop a sense of self and role identities through social interaction (McCall & Simmons, 1978). McCall and Simmons define *role identity* as ‘the character and the role that an individual devises for himself as an occupant of a particular social position’ (McCall & Simmons, 1978, p. 65). Role identities represent individuals’ imaginative views of themselves as being and acting when holding specific social positions and are usually idealised rather than reflective of their actual everyday role-performance (McCall, 1987; McCall & Simmons, 1978). Although imagined, role identities provide a guide for actual role performance and self-appraisal (McCall & Simmons, 1978).

McCall and Simmons conceive of the self as a set of multiple role identities organised into a hierarchy of prominence (McCall & Simmons, 1978). They contend that higher status identities are more likely to influence behaviour and identify a number of factors that influence identity prominence: the level of self and social role support, the individual’s commitment to and investment in the role-identity, and the intrinsic and extrinsic rewards associated with role performance (McCall & Simmons, 1978).

The hierarchy of prominence is not static and can change over time (McCall & Simmons, 1978). Furthermore, since not all situations provide equal opportunity and/or rewards for role-identity enactment, role-identity enactment is also situationally based (McCall & Simmons, 1978). McCall and Simmons describe this as the situational self or salience hierarchy explaining that role performance is also influenced by individuals’ perceptions of the likelihood of rewards for role enactment in that given situation (McCall & Simmons, 1978).

Many researchers have sought to explain men’s fathering through identity theory (Greer Litton Fox & Bruce, 2001; Habib, 2012; Habib & Lancaster, 2006; LaRossa &
Engaging New Fathers: Learning from *Baby Makes 3*

Reitzes, 1993; Marsiglio & Cohan, 2000; Marsiglio, et al., 2000; Maurer, Pleck, & Rane, 2003; Olmstead, et al., 2009). In the Australian context, Habib and Lancaster have applied role identity theory to their work on fatherhood (Habib, 2012; Habib & Lancaster, 2006). In a 2006 study of 115 first time Australian fathers, Habib and Lancaster drew on McCall’s and Simmons’ role identity theory to develop a conceptual framework for theorising new fathers’ paternal identities and behaviours (2006). They distinguish between two facets of first time fathers’ paternal identities: their father status prominence and father status content (Habib, 2012; Habib & Lancaster, 2006).

**Father status prominence** refers to the subjective importance of a man’s father identity to his sense of self (Habib, 2012; Habib & Lancaster, 2006). The prominence of a man’s father identity among his other identities, such as worker, peer, husband, son or sportsman, is believed to influence the likelihood of performing role related behaviour with higher order identities more likely to be enacted (Habib, 2012; Habib & Lancaster, 2006). In contrast, **father status content** pertains to the behaviour men associate with the father role (Habib & Lancaster, 2006). Father status content is subjective, there are many ways to be a father and how men define fatherhood differs from man to man (Habib & Lancaster, 2006).

Identity theorists believe that men’s perceptions of, and commitment to, being particular types of fathers influence their actual paternal behaviour (Marsiglio, et al., 2000). As Habib and Lancaster explain a man who sees his father role primarily as provider is more likely to consider working to earn an income as fathering while a father who defines his father self as a caregiver is more likely to father his child by caring and nurturing the baby (Habib & Lancaster, 2006). Research has revealed that father identity content is multidimensional; men associate multiple behaviours with their father role, such as provider, caregiver, teacher and disciplinarian (Eerola & Mykkänen, 2015; Habib & Lancaster, 2006; Olmstead, et al., 2009).

In the fathering context, the majority of identity work focuses on explaining father involvement with their children. Framed by Risman’s multidimensional gender theory this thesis draws on Habib’s and Lancaster’s paternal identity framework at the
individual level to explore men’s father identities and the relevance of these to father engagement.

**SUMMARY**

In the context of father engagement, Risman’s conceptualisation of gender as a three-dimensional social structure operating on individual, interactional and institutional levels provides an insightful tool for identifying the many and varied gender related factors that impact on service providers’ engagement with fathers in health settings. In the following chapters, Risman’s model outlined above is used as a heuristic through which the evidence about the impact of gender on father engagement in respectful relationships programs in health settings is discussed. This discussion is reported in terms of the three-phased engagement process: ‘getting’, ‘keeping’ and ‘engaging’. The next chapter outlines the methods I used for this thesis.
CHAPTER 4: METHODOLOGY

OVERVIEW

In this chapter I outline the research design employed in this thesis including the epistemological approach taken, the design framework and the methods of data collection. I then discuss and reflect on the recruitment strategies and data collection methods used. Finally, I describe the approach to thematic analysis employed in the interpretation of the data collected. This section also discusses the verification of the research findings including reliability, validity, transferability, positionality and bias.

EPISTEMOLOGICAL AND ONTOLOGICAL PERSPECTIVE

The design of this study, my interpretation of the data and the conclusions reached are all informed by my perspective on the construction of knowledge. In this thesis I employ a constructivist epistemology and ontology. This philosophical paradigm is premised on the position that there is no one truth or objective knowledge, rather truth and knowledge are constructed by social actors (Schwandt, 1994). Accordingly, reality and meaning are seen to be construed in the minds of individuals allowing for multiple points of view on what is ‘real’ (Lincoln & Guba, 1985; Schwandt, 1994). This emphasis on perspective in the construction of knowledge leads constructivists to seek meaning by understanding the lived experience from the point of view of those who live it (Schwandt, 1994). Thus to understand how or why particular events or actions occur, it is necessary to see the experience through the eyes of those who live it. Accordingly, in seeking to learn how gender impacts on service providers’ engagement with new fathers in respectful relationships programs in health settings, I sought meaning from the fathers and staff who live these programs in the real-life context of the Baby Makes 3 program. Finally, we should not forget that context plays a central role in the construction of meaning providing the surroundings within which social interactions take place and people attempt to make sense of the world (Guba & Lincoln, 1989, p. 8).
Aligning with the view that knowledge is constructed, constructivist researchers openly recognise the active role they play in the interpretation of research findings; as Schwandt astutely puts it constructivist researchers offer an ‘inquirer’s construction of the constructions of the actors one studies’ (Schwandt, 1994, p. 118). This epistemological premise that inquiries and inquirers are inextricably intertwined acknowledges that research findings are inevitably value laden (Guba & Lincoln, 1989). As a constructivist researcher I openly recognise the role my subjectivity plays in the research process and detail my positioning and bias in this chapter to explain how my values influenced the conduct and conclusions of this study (J. A. Maxwell, 2005).

**RESEARCH DESIGN**

**METHODOLOGY OVERVIEW**

Informed by my constructivist outlook, this project utilised a case study design framework to explore how gender impacts on service providers’ engagement with new fathers in respectful relationships programs in health settings. Constructivists Lincoln and Guba (1989; 1985) argue that phenomena are inextricably shaped by their contexts and that readers must understand the context in order to understand the phenomenon studied. They believe that the thick descriptions provided in case study reports are one of the best methods of communicating contextual information to readers (Lincoln & Guba, 1985). Rather than offering abstract examples, case studies provide real-life examples of the phenomenon being studied, transporting readers into research participants’ worlds and experiences; creating a vicarious learning environment (Lincoln & Guba, 1985; Merriam, 2009; Patton, 2002). This approach not only enables researchers to observe and learn about phenomena in their natural environments but also provides readers with relatable concrete examples of the phenomenon under investigation (Merriam, 2009). Taking a case study approach ensures that the knowledge learned about service providers’ engagement with new fathers in respectful relationships programs in this project is grounded in real-life experiences (Merriam, 2009).
Just as constructivism takes the ontological stance that there is no one objective reality but rather multiple realities, case study research allows for varied perspectives. Rather than dismissing aberrant findings, case study researchers seek to preserve the paradoxes, thus highlighting the complexity of social interactions (Merriam, 2009; Stake, 1995).

CASE STUDY DESIGN

The case study design and methodology draw on aspects of Yin’s (2009), Creswell’s (2007) and Stake’s (1995) approaches discussed below. While some researchers such as Stake (2006) define case study research as the selection of a unit of analysis rather than a methodology, Yin (2009) and Creswell (2007) define case study research as a method of inquiry that involves the investigation of a phenomenon within its real-life context. Creswell’s definition provides an insightful description of this methodology:

Case study research is a qualitative approach in which the investigator explores a bounded system (a case) or multiple bounded systems (cases) over time, through detailed, in-depth data collection involving multiple sources of information (e.g., observations, interviews, audiovisual material, and documents and reports), and reports a case description and case-based themes (2007, p. 73).

Conversely, Stake is primarily interested in the object of a case study (1995). He sees the defining or bounding of a case topic, rather than the process undertaken to study a case, as the principal feature of case study research (Merriam, 2009; Stake, 1995). Like Yin and Creswell, I do not view case study research through such a narrow lens and prefer definitions that see it as a method of inquiry.

THE CASE

To explore how gender impacts on service providers’ engagement with new fathers in respectful relationships programs delivered in health settings this project employed a case study design framework. While the topic of this project is service providers’ engagement with new fathers’ in respectful relationships programs, the case or
bounded system is the Baby Makes 3 (BM3) program (Stake, 1995; Yin, 2009). BM3 is a three-week respectful relationships program for first time fathers and mothers, which is incorporated into New Parent Groups (NPGs) run by Maternal Child and Health Services (MCHS) in the Eastern Metropolitan Region (EMR) of Victoria. The MCHS is a free, voluntarily accessed, universal primary health service offered to all Victorian families with children aged from birth to school age (Department of Education and Early Childhood Development (State of Victoria), 2011). The BM3 program was purposefully sampled to provide an information rich case for the in-depth study of father engagement in respectful relationships programs (Patton, 2002). BM3 is one of the very few Australian respectful relationships programs that target fathers in health settings. There is some debate about the rationale for case selection in case study research. Yin (2009) would describe my selection of BM3 as a representative or typical case where a case is selected because of its typicality. Thomas (2010, 2011b) challenges claims of representativeness or typicality in regards to case studies arguing that the generalisability of a case study comes from abduction rather than induction as a case cannot be a representative sample of a population. He, and I, prefer the terminology key case where the case is selected because it exemplifies the analytical topic of the research study (Thomas, 2011b). The following section provides a detailed description of the BM3 program.

BABY MAKES 3

This section provides an overview of the Eastern Metropolitan Region BM3 pilot including:

- Program development and funding history
- Program description
- The physical service delivery environment
- The reach of the pilot program into the EMR
- New fathers’ pathway into BM3.
Program Background

*Baby Makes 3* (BM3) was originally developed by David Flynn for Carrington Health, formerly known as Whitehorse Community Health Service, in 2007 as part of VicHealth’s *Respect, Responsibility and Equality Program* (Flynn, 2008; VicHealth, 2012). Carrington Health received a 12 month grant as part of Phase I of VicHealth's funding program to develop a primary prevention intervention based in the Maternal and Child Health Service setting in the City of Whitehorse, Victoria (VicHealth, 2012). In 2008 Carrington Health received a further three year grant to scale up the BM3 program as part of Phase II of VicHealth’s funding stream (VicHealth, 2012). The 2013 expansion of the BM3 program beyond the City of Whitehorse into the whole Eastern Metropolitan Region of Victoria was funded through the 2012 *Reducing Violence against Women and their Children Grants* program from the Community Crime Prevention Unit of the Victorian Government Department of Justice and Regulation (Whitehorse Community Health Services, 2014) (See Table 4.1 below for a summary of BM3 funding). The three year Eastern Metropolitan Region pilot ran between 2013 and 2015 (Whitehorse Community Health Services, 2014). In total the program was delivered to 108 groups involving 1305 parents across nineteen Maternal and Child Health Centres (L. Hargreaves, personal communication, February 26, 2016). Six hundred and ninety one (53%) of participants were mothers and 614 (47%) were fathers (L. Hargreaves, personal communication, February 26, 2016). A description of BM3 program is provided below.
Table 4.1: Baby Makes 3 Funding Timeline

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Funding</th>
<th>Funding Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-2008</td>
<td>12 month grant - <em>Respect, Responsibility and Equality program</em> (Phase I)</td>
<td>VicHealth</td>
</tr>
<tr>
<td>2008-2011</td>
<td>3 year grant - <em>Respect, Responsibility and Equality program</em> (Phase II)</td>
<td>VicHealth</td>
</tr>
<tr>
<td>2011-2012</td>
<td>Specific purpose grant to develop program tools &amp; resources - <em>Respect, Responsibility and Equality program</em> (Phase III)</td>
<td>VicHealth</td>
</tr>
</tbody>
</table>

Program Description

*Baby Makes 3* is a three-week respectful relationships program for first time fathers and mothers incorporated into New Parent Groups run by Maternal and Child Health Services in the Eastern Metropolitan Region of Victoria (Bouma, 2012b; Whitehorse Community Health Services, 2014). It was designed as a primary prevention intervention intended to prevent intimate partner violence by promoting equal and respectful relationships between men and women during the transition to parenthood (Bouma, 2012b; Flynn, 2011; Whitehorse Community Health Services, 2014). BM3 was developed as a universal intervention that targeted all first time parents in the pilot region rather than those ‘at risk’ or already experiencing or engaged in violence (Bouma, 2012b; Whitehorse Community Health Services, 2014).

The program involves a group format where 8-10 couples attend three two-hour sessions with their babies. Each group is co-facilitated by one male and one female facilitator. Sessions involved mixed- and single-gender group discussions, role plays and homework exercises (Flynn & Whitehorse Community Health Services, 2011). The first session covers the transition to parenthood, expectations of mums and dads and housework (Flynn & Whitehorse Community Health Services, 2011). Session two centres on healthy relationships and meaningful equality (Flynn & Whitehorse Community Health Services, 2011). The final session discusses sex and intimacy,
Engaging New Fathers: Learning from Baby Makes 3

conflict in relationships and communication (Flynn & Whitehorse Community Health Services, 2011). The table below summarises the key aspects of the BM3 program (see Table 4.2). The following discussion explains the geographical spread of the BM3 program in the EMR.

Table 4.2 Key aspects of Baby Makes 3

<table>
<thead>
<tr>
<th>Program Elements</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group format</td>
<td>Three 2-hour sessions over 3 weeks</td>
</tr>
<tr>
<td></td>
<td>Evening weeknight sessions</td>
</tr>
<tr>
<td></td>
<td>Gender balanced co-facilitation</td>
</tr>
<tr>
<td>Target Population</td>
<td>First time parents</td>
</tr>
<tr>
<td></td>
<td>Couples attend with their baby</td>
</tr>
<tr>
<td>Partnership with Maternal and Child</td>
<td>Baby Makes 3 embedded into Maternal and Child Health Services’ New</td>
</tr>
<tr>
<td>Health</td>
<td>Parent Group program as an opt-out model</td>
</tr>
<tr>
<td>Content</td>
<td>Structured discussion of key topics: Transition to parenthood,</td>
</tr>
<tr>
<td></td>
<td>expectations of ‘family’, healthy relationships, meaningful equality,</td>
</tr>
<tr>
<td></td>
<td>sex and intimacy, conflict in relationships and communication</td>
</tr>
</tbody>
</table>

Program Reach

There were 15 pilot sites across the 70 Maternal and Child Health Centres in the EMR. Six of these involved feeder sites where two or more NPGs fed into the one BM3 group at the conclusion of the standard NPG program. A breakdown of participating Maternal and Child Health Centres and details of the delivery sites are specified in the tables below (see Table 4.3). The demographic characteristics of the delivery region are explored in detail further on in this chapter under the heading ‘The Boundary and Shape’. The following discussion describes the physical settings for the BM3 program.
Table 4.3: Number of Maternal and Child Health Centres, Eastern Metropolitan Region Local Government Areas

<table>
<thead>
<tr>
<th>Local Government Area</th>
<th>Number of MCH centres</th>
<th>Number of BM3 pilot sites in LGA</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGA1</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>LGA2</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>LGA3</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>LGA4</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>LGA5</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>LGA6</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>LGA7</td>
<td>19</td>
<td>2</td>
</tr>
<tr>
<td><strong>Eastern Metropolitan Region</strong></td>
<td><strong>70</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

Program Setting

BM3 sessions took place at select Maternal and Child Health centres across the EMR. These centres range in size from large multipurpose community buildings that house community libraries, childcare services, cafes, art galleries and other community services to single room centres attached to local kindergartens. Some centres can be found in small suburban streets, often near schools and parks, while those housed in multipurpose community centres tend to be located on main thoroughfares. Sessions generally began in the reception area of the MCH Centres, a familiar surrounding for the mothers attending the MCH service. These waiting areas are lined with toys and soft mats for children to crawl around on, wide chairs for breastfeeding mothers and the walls are peppered with health promotion materials directed at mothers and their babies. When the parents broke out into single gender groups the MCHN consulting rooms were used; here you will find the nurse’s desk and computer, typically covered in personal family photos, along with a couple of chairs, baby scales and a change table. The next section describes new fathers’ pathway into the BM3.
**Pathway into Baby Makes 3**

Within forty-eight hours of a child being born in Victoria, a Birth Notification is sent to the Maternal and Child Health Service (MCHS) in the local government area in which the mother of the child usually resides (*Child Wellbeing and Safety Act 2005* (Vic) (Austl.); Department of Education and Early Childhood Development (State of Victoria), 2011). Following this notification, nurses working at the mother’s local Maternal and Child Health Centre contact the mother and invite her to access their service (Department of Education and Early Childhood Development (State of Victoria), 2011).

As part of this service all new parents are invited to attend a New Parent Group (NPG) six to eight weeks after the birth of their baby (Bouma, 2012a; Department of Education and Early Childhood Development (State of Victoria), 2011). Although re-labelled as ‘New Parent Groups’ in the late 1990s, these groups are colloquially referred to as ‘mothers’ groups’ and held during weekday daytime hours (Edgecombe et al., 2001). In the Eastern Metropolitan Region of Victoria, first-time mothers and their partners had the opportunity to participate in the *Baby Makes 3* (BM3) program as part of the NPG program run by MCHS (Whitehorse Community Health Services, 2014). At pilot sites across the seven councils that comprise the Eastern Metropolitan Region, the three-week BM3 program was built into NPGs as an opt-out model where parents had to self-select out of the program (Whitehorse Community Health Services, 2014). I have depicted this model in the following diagram (See Figure 4.1). Some of the BM3 pilot sites had feeder sites where parents attending NPGs at other Maternal and Child Health Centres in the same local council were invited to attend the BM3 program at the pilot site as a continuance of the NPG. There were 1-2 pilot sites per council across the seven municipalities that make up the EMR (Whitehorse Community Health Services, 2014). Sessions were held on weeknights with the exception of LGA7 where Saturday sessions were scheduled to accommodate parent preferences (Whitehorse Community Health Services, 2014).
Father recruitment process

New fathers may have first encountered BM3 at home visits made by MCHNs in the week following their partner’s return from hospital after giving birth. An initial home visit with new mothers is one of ten key consultations carried out by the Victorian MCHS (Department of Education and Early Childhood Development (State of Victoria), 2011). An invitation to participate in the BM3 program was included in an information pack for new mothers given at the home visit. Where fathers were present at the home visit, the MCHN may have discussed the program with the couple and invited them to participate. Additional program promotion varied from nurse to nurse. While the invitation letter was the extent of program promotion by some MCH nurses, others promoted the program to mothers at every consultation and NPG sessions. In some councils, the BM3 Manager or a BM3 facilitator visited the NPGs to speak with the mothers about the program.

In general, fathers were rarely directly invited to participate in BM3 and instead were recruited through an inconsistent third party process where fathers were invited to attend by their female partners who receive referrals to the program from Maternal and Child Health Nurses. If fathers were not present at the home visit or BM3 was not
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raised by the MCHN, men were dependent on their partners for any information about the program. The boundaries of the BM3 program as the subject of this case study is further explained in the following section.

THE BOUNDARY AND SHAPE

A case must be bounded temporally through defining the time period studied (Miles & Huberman, 1994; Thomas, 2011b; Yin, 2009). Thomas provides three time-use classifications for case studies: retrospective, snapshot and diachronic (Thomas, 2011b). A retrospective case study collects data about a past phenomenon whilst a diachronic case study is similar to a longitudinal study exploring changes over time (Thomas, 2011b). This project is a snapshot case study in which a case was examined over a specific period of time (Thomas, 2011b). Data were collected from July to November 2014 providing a picture of the BM3 program over the five month period. The next section outlines the geographical boundaries of the case and the demographic makeup of the region studied.

Eastern Metropolitan Region of Victoria: Community Profile

A real-life case must also be defined geographically by establishing spatial boundaries (Yin, 2014). The BM3 pilot was set in the Eastern Metropolitan Region (EMR) of Victoria. The EMR comprises seven local government areas (LGAs); LGA1-LAG7 (Department of Health (State of Victoria), 2013). This mostly residential area accounts for around 18% of the Victorian population and is made up of inner and outer metropolitan suburbs and semi-rural and rural townships (Australian Bureau of Statistics, 2015b; Women's Health East, 2010). The EMR is a culturally diverse community with large populations of residents born overseas and who speak languages other than English at home (Australian Bureau of Statistics, 2013a, 2013b, 2013c, 2013d, 2013e, 2013f; Department of Health (State of Victoria), 2013). In 2011 one or both parents in nearly half of all families in LGA3, LGA5 and LGA6 were born overseas, including over 50% of LGA5 families (Australian Bureau of Statistics, 2013c, 2013e, 2013f). In contrast to the general Victorian population, overseas born and non-English speaking residents in the region tend to come from Asian rather than European
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backgrounds (Australian Bureau of Statistics, 2013a, 2013c, 2013e, 2013f). Across the region, the most common languages spoken, other than English, are Mandarin and Cantonese and overseas born residents are most likely to be born in China (Department of Health (State of Victoria), 2013). Residents living in the EMR have high levels of educational attainment with over a half of the population holding post-school qualifications, typically a bachelor degree (Australian Bureau of Statistics, 2013a, 2013b, 2013c, 2013d, 2013e, 2013f, 2013g). Wage and salary earners in LGA1, LGA3 and LGA6 have higher incomes compared to residents in the other areas who earn near or below the Victorian average (Australian Bureau of Statistics, 2015a). In 2011 LGA1 wage and salary earners had the third highest average income in Victoria (Australian Bureau of Statistics, 2015a).

LGA7 stands in stark contrast to its EMR counterparts. It is a predominantly rural area with high levels of disadvantage, a lack of cultural diversity and lower incomes and post-school educational attainment (Australian Bureau of Statistics, 2013g; Department of Health (State of Victoria), 2013). LGA7 residents are most likely to hold certificate level qualifications and work in trades (Australian Bureau of Statistics, 2013g). Although the area has a relatively higher proportion of Aboriginal and Torres Strait Islander residents, their numbers are low and the few overseas born residents tend to come from European backgrounds (Australian Bureau of Statistics, 2013g). Most notably while only 6% of LGA7 residents speak a language other than English at home, 21% to nearly 45% of residents in the other six municipalities speak a language other than English (Australian Bureau of Statistics, 2013a, 2013b, 2013c, 2013d, 2013e, 2013f, 2013g). See Appendix A for further demographic information about the EMR.

While the EMR is marked by low population growth and a progressively ageing population, fertility rates are slightly higher than the Victorian average (Australian Bureau of Statistics, 2014a, 2014b, 2014c, 2014d, 2014e, 2014f, 2014g; Department of Health (State of Victoria), 2013). In 2013-2014 over 90% of birth notifications received by MCHS across the EMR led to enrolments in the service (Department of Education and Early Childhood Development (State of Victoria), 2014c). Participation rates in consultations provided by the Victorian MCHS reflect statewide trends with high levels
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of uptake immediately following birth slowly petering off from the four month mark (Department of Education and Early Childhood Development (State of Victoria), 2014a, 2014c).

Data on the uptake of New Parent Groups (NPGs) or male service use is not routinely collected by MCHS therefore recruitment rates for NPGs and BM3 are unknown. However, research on NPGs with nurse facilitators and mother participants by Scott, Brady and Glynn (2001) found that nearly two thirds of first time mothers participated in NPGs in the two local government areas studied over a 12 month period. LGA7 was one of the LGAs studied and assuming the NPG participation rates in the other EMR councils have similar attendance levels this suggests a significant proportion of first time mothers are participating in NPGs delivered in the EMR. The type of case study employed in this research is described in the following discussion.

TYPES OF CASE STUDIES

There are various typologies of case studies (Stake, 1995; Thomas, 2011b; Yin, 2009). Yin (2009) and Stake (1995) use similar but different classifications for types of case study. Their first categories, descriptive (Yin, 2009) or intrinsic (Stake, 1995) are similar and describe case studies that are conducted when understanding a specific case or event is the primary aim. From here their typologies diverge. Stake’s second type instrumental case studies, use cases to learn about a more general phenomenon or issue (Stake, 1995). Here researchers study examples of wider phenomena hoping these will contribute to a greater understanding of the problem. Stake’s third category, collective case studies, is also referred to as a multiple case study (Stake, 1995). Like singular instrumental case studies, one issue or phenomenon is the primary object of the study and the researcher selects several cases or sites to illustrate the issue (Creswell, 2013; Stake, 1995). In contrast, Yin’s remaining categories differentiate between explanatory and exploratory case studies. Explanatory case studies aim to uncover the causal links between events and their effects (Yin, 2009). Whereas in exploratory case studies researchers seek to gain deeper insight into a problem in
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order to develop propositions or hypotheses and usually choose this approach to examine areas with underdeveloped knowledge bases (Yin, 2009).

Stake’s distinction between intrinsic, instrumental and collective case studies defines these as *types* of case studies, whereas Yin’s distinctions explain the intent or purpose of the study, that is whether the researcher intends to describe, explain or explore. Stake’s typology is useful for describing the current project which he would label as an instrumental case study, one undertaken to throw light on a more general phenomenon. This project uses the BM3 program as an illustrative example of how service providers engage new fathers in respectful relationships programs in health settings. In regards to Yin’s classification system, this project has two purposes. The first purpose is to provide a thick description of the gendered phenomena that influence service providers’ engagement with new fathers in respectful relationships programs delivered health settings. The second purpose is explanatory and uses the descriptions as a basis for drawing theory into the case study findings to build propositions about new fathers’ engagement with IPV primary prevention interventions. The next section describes the processes undertaken to collect data.

**DATA COLLECTION**

In this section I outline the data collection instruments used in this study. Unlike other forms of inquiry, case study research does not prescribe methods of data collection (Merriam, 2009). Drawing on Yin (2009) and Creswell’s (2013) case study methodology this project collected data from multiple sources, including interviews, focus groups and document analysis, to develop a detailed understanding of the complex impact gender has on service providers’ engagement with new fathers in respectful relationships education delivered in health settings (Yin, 2009). Unfortunately, direct observation of the program was not possible due to privacy concerns. However, the fathers and facilitators provided insider accounts and I viewed a DVD recording of an actual BM3 group from an earlier pilot. All collected data were entered into the case study database recording the name, description, date of collection and location of the evidence (Yin, 2009).
INTERVIEWS

Stake describes interviews as ‘the main road to multiple realities’; they elicit descriptions and interpretations enabling researchers to see the case through the many lens of those involved (Kvale, 1996; Stake, 1995, p. 64). Qualitative semi-structured interviews involve purposeful conversations between participants and researchers that centre on a particular theme while allowing researchers to pursue topics or points raised by respondents (Kvale, 1996).

Twenty-eight semi-structured open-ended interviews were conducted with MCHNs (n=13) and fathers (n=15). Interviews with MCHNs were conducted face-to-face at MCHN consulting rooms located at the BM3 pilot sites. These interviews ran for 30 to 45 minutes and I developed an interview guide to elicit nurses’ views on a series of topics that were explored in the course of the interview. The interview guide covered several topics including engaging fathers in the BM3 program, barriers and enablers, training for working with male clients, experiences working with fathers in their service and how the MCHS could be improved for men (See Appendix B, Attachment 9). MCHN interviews were piloted with a convenience sample of health professionals from the Department of General Practice University of Melbourne.

Thirty-minute telephone interviews were carried out with fathers using an interview guide I designed to explore fathers’ engagement experiences with the BM3 program. The interview guide covered a range of topics including motivations for participating in the BM3 program, factors that influenced participation, experiences of the BM3 program including least and most engaging aspects, experiences of working with other new parents and the program staff, and perceptions of the program and the MCHS more widely (see Appendix B, Attachment 10). Pilot interviews were conducted with a convenience sample of five men. All interviews with fathers took place after they had completed the BM3 program. Each interview participant received a $30 honorarium in compensation for their time. Some of the MCHN participants declined the honorarium citing professional guidelines.
FOCUS GROUPS

Aligning with constructivism’s search for meaning, focus groups examine the conversation between participants to explore how understandings of phenomena are constructed (Kitzinger, 1994). They centre on the interaction within the group drawing out similarities and differences through group discussion to get a multiplicity of views (Kitzinger, 1994). The group process allows participants to ask questions of one another, share anecdotes and comment on each other’s experiences and perspectives (Kitzinger, 1994, 1995). Face-to-face focus groups with facilitators were held at the council offices used by Carrington Health for regular BM3 facilitator Community of Practice meetings. The BM3 facilitators were spilt into groups of men and women and the two focus groups were led concurrently by experienced focus group facilitators with an observer present in each group to take notes. Professors Kelsey Hegarty and Cathy Humphreys from the University of Melbourne acted as focus group facilitators. They both have extensive experience in intimate partner violence research within their respective health and social work disciplines. I observed the male facilitator focus group and another violence researcher who is a clinical social worker and works with victims of sexual assault observed the female facilitator focus group. I developed an open-ended focus group topic guide to steer discussions about engaging men in the BM3 program while allowing participants to pursue issues important to them (Kitzinger, 1995). The guide opened with a short introductory phase and then covered two main topics: their experiences of engaging fathers in the BM3 program and any inhibitors or facilitators they had encountered (See Appendix B, Attachments 11 and 12). The focus group facilitators tried to maximise interaction between participants by exploring differences in engagement experiences and encouraging participants to theorise in situ about why such differences exists (Kitzinger, 1994, 1995). Each focus group participant received a $30 honorarium in compensation for their time. Each interview and focus group participant also completed a short demographic survey to assist with the analysis of focus group and interview data (See Appendix B, Attachments 13, 14 and 15).
DOCUMENTARY EVIDENCE

Reports and publications about the BM3 program including the Implementation Guide, Program Manual and previous evaluation reports were reviewed to understand the history, process and content of the program (Patton, 2002). Data relating to the context of the case, such as Maternal and Child Health guidelines and policies, were also collected and analysed (Yin, 2009). Documentary analysis was used to augment the interview and focus group data enabling an exploration of how congruent the ‘official’ account of father engagement was with the real-world experiences of fathers, facilitators and nurses (Yin, 2009).

FIELD NOTES

In the field observation was continuous and I used field notes to record interviews, focus groups and casual conversations as well as observations about physical and social context. Field notes were initially recorded in handwritten journals on site to prevent loss of detail and then word processed as soon as possible after the event occurred (Bazeley, 2013). For all entries the date and location were recorded. MCHN and father recruitment as well as nearly all the MCHN interviews were conducted at BM3 program venues. These site visits provided an appreciation of the physical program delivery environment and geographical context of the BM3 program. The next section describes how I gained access to the study site and recruited participants within the case.

RECRUITMENT

GAINING ACCESS TO STUDY SITE

To undertake this case study, I partnered with Carrington Health (formerly known as Whitehorse Community Health Services), the lead agency of the Baby Makes 3 program in the Eastern Metropolitan Region and developed a strong and facilitative relationship with the BM3 Manager. Carrington Health provided access to the pilot sites and facilitated the recruitment of participants (see Appendix B, Attachment 1). Involved in the BM3 program are Maternal and Child Health Nurses who recruit
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parents into the New Parent Groups, facilitators who deliver BM3 and first time fathers.

**MATERNAL AND CHILD HEALTH NURSES**

The BM3 program is delivered in partnership with local government Maternal and Child Health Services in the Eastern Metropolitan Region. Permission to approach the Maternal and Child Health Nurses (MCHNs) working at the pilot sites regarding participation in this study was sought from each local council in the region. This involved a written invitation to each council and Memoranda of Understanding (see Appendix B, Attachment 2). All seven local councils in the region agreed to participate in the project. Memoranda of Understanding were established with six of the councils. In the remaining council the MCHNs also act as BM3 facilitators and the Council preferred the researcher to approach these nurses in their capacity as facilitators therefore a Memorandum of Understanding was not required.

Individual MCHN recruitment involved site visits by the BM3 Manager and myself to the BM3 pilot sites (See Table 4.3). During the site visits, nurses were invited to participate in the project and received written information about the study (Plain Language Statement and Expression of Interest see Appendix B, Attachments 3 and 4). At these sessions I briefed nurses on the background to the study, what their participation would involve and answered any questions. Overall, interested individuals approached me directly at these visits expressing their willingness to participate in the study. In LGA7 and LGA2, the BM3 Manager and I met with the MCHNs working at the pilot sites during scheduled council-wide team meetings rather than individual site visits at the request of the local MCH coordinators. In LGA2 no individual MCHNs came forward to take part in the first instance. A further email invitation distributed by the MCHN Team Leader on behalf of the BM3 Manager led to one nurse accepting the invitation to participate.

In general reasons for declining the invitation to participate were not disclosed. However, anecdotal evidence indicated reasons for non-participation included some nurses perceiving their involvement in BM3 as insufficient to make a useful
contribution and others being concerned that participation required them to use their clients’ appointment times despite my offer of out of hours times. Finally, negative attitudes of some senior MCHNs towards research was offered as a reason for non-participation in some cases. In total 13 MCHNs participated in interviews (see Table 4.4 below for detailed information on MCHN recruitment rates for each participating site).
### Table 4.4: Maternal and Child Health Nurse Recruitment Rates

<table>
<thead>
<tr>
<th>Local Government Area</th>
<th>BM3 Pilot Site</th>
<th>Recruitment by pilot site (study participants/number invited to participate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGA1</td>
<td>B</td>
<td>1/3 *MCHN coordinator present</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>0/2 *MCHN coordinator present</td>
</tr>
<tr>
<td>LGA2</td>
<td>Recruited at council-wide MCHN meeting</td>
<td>1/12 *Conducted council wide recruitment rather than individual site visits *MCHN coordinator present</td>
</tr>
<tr>
<td>LGA3</td>
<td>F</td>
<td>2/2</td>
</tr>
<tr>
<td>LGA4</td>
<td>N/A (MCHN approached as facilitators)</td>
<td></td>
</tr>
<tr>
<td>LGA5</td>
<td>J</td>
<td>2/2</td>
</tr>
<tr>
<td></td>
<td>K</td>
<td>3/3</td>
</tr>
<tr>
<td>LGA6</td>
<td>M</td>
<td>1/2</td>
</tr>
<tr>
<td>LGA7</td>
<td>P</td>
<td>1/1 *MCHN coordinator present</td>
</tr>
<tr>
<td></td>
<td>O</td>
<td>2/2 *MCHN coordinator present</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>13/29</strong></td>
</tr>
</tbody>
</table>

*Letters used to refer to individual pilot sites within each Local Government Area.*

### FACILITATORS

Facilitators were approached to participate in the study at their regular Community of Practice meeting in May 2014. Written project information was disseminated to each facilitator at this meeting including the Plain Language Statement and Expression of Interest (see Appendix B, Attachments 5 and 6). A follow-up email invitation to the facilitators was forwarded by the BM3 Manager on my behalf.

At the time of data collection there were nineteen facilitators involved in the BM3 program. To be eligible to participate in the study the facilitators had to have delivered at least one BM3 group program. Fifteen facilitators were recruited consisting of ten
women and five men. Two additional male facilitators completed expressions of interest but were unavailable on the focus group date. A further male facilitator was ineligible to participate in the study as he had not delivered any BM3 groups at the time of data collection.

FATHERS

During the final session of the BM3 program at groups nominated by the BM3 Manager, I personally invited fathers to participate in this study. Written project information, a Plain Language Statement and Expression of Interest, was disseminated at this stage (see Appendix B, Attachments 7 and 8). I attended five BM3 groups across three councils. A further two recruitment visits to groups in LGA2 and LGA6 were scheduled but the groups were cancelled before the first session due to insufficient parent interest in the BM3 program. The BM3 Manager and a BM3 facilitator invited fathers in another three groups to participate in the study. The extent of father recruitment is summarised in Table 4.5 below. Overall, 15 fathers participated. A further three Expressions of Interest were received but the fathers did not subsequently respond to the three attempts made to contact them.
Table 4.5: Father Recruitment in the Eastern Metropolitan Region

<table>
<thead>
<tr>
<th>Local Government Area</th>
<th>BM3 Pilot Site</th>
<th>Date of site visit</th>
<th>Number of fathers present at recruitment visit</th>
<th>Recruiter</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGA1</td>
<td>A</td>
<td>23/07/14</td>
<td>1</td>
<td>Researcher</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>30/07/14</td>
<td>3</td>
<td>Researcher</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>16/10/14</td>
<td>3</td>
<td>BM3 Facilitator</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>15/10/14</td>
<td>3</td>
<td>BM3 Facilitator</td>
</tr>
<tr>
<td>LGA2</td>
<td>E</td>
<td>08/10/14</td>
<td>Group cancelled</td>
<td>Researcher</td>
</tr>
<tr>
<td>LGA3</td>
<td>F</td>
<td>23/10/14</td>
<td>1</td>
<td>BM3 Manager</td>
</tr>
<tr>
<td>LGA5</td>
<td>K</td>
<td>02/09/14</td>
<td>7</td>
<td>Researcher</td>
</tr>
<tr>
<td></td>
<td>J</td>
<td>01/10/14</td>
<td>5</td>
<td>Researcher</td>
</tr>
<tr>
<td>LGA6</td>
<td>M</td>
<td>26/08/14</td>
<td>3</td>
<td>Researcher</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>09/10/13</td>
<td>Group cancelled</td>
<td>Researcher</td>
</tr>
<tr>
<td><strong>Total number of fathers successfully recruited</strong></td>
<td><strong>15/26</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Letters used to refer to individual pilot sites within in each Local Government Area.

REFLECTIONS ON RECRUITMENT STRATEGY

Gaining access to MCHNs proved to be a bigger obstacle than anticipated. The first hurdle encountered was obtaining consent to approach the nurses from the local government run Maternal and Child Health services involved in the program. Carrington Health delivers BM3 through a partnership with the seven local governments, also referred to as councils, in the Eastern Metropolitan Region of Victoria. Several researchers have documented organisational-level barriers to accessing research participants with Wolff arguing that organisations have mechanisms designed to keep third parties out (Pini & Haslam McKenzie, 2007; Troman, 1996; Wolff, 2004).
As others have noted research involving local governments is challenging (Pini & Haslam McKenzie, 2007). Each council is an independent self-governing entity with its own unique procedures and varying degrees of support for BM3. While some senior local government managers sat on the BM3 Steering Committee and fully supported this research and the program more widely, other councils were resistant not only to the project but to the pilot program itself. Investing in developing a strong relationship with the BM3 Manager and thereby becoming an inaugural member of the BM3 Steering Committee proved to be essential steps in obtaining sign off from the senior Maternal and Child Health Service managers. Membership of the Steering Committee enabled me to form relationships with key gatekeepers in the Maternal and Child Health Services, in particular two senior MCHS managers who provided warm referrals to their colleagues. Their support for the project and strategic advice from the program manager about recruiting councils fostered commitment from the other councils.

Unfortunately, senior management approval did not guarantee access to nurses. I encountered unexpected gatekeepers in the form of Maternal and Child Health Coordinators (MCH Coordinators). My experience exemplified Wolff’s and others argument that access is a continual process involving multiple actors and negotiations and devoid of a definitive ‘inside-outside distinction’ meaning that researchers can simultaneously have and not have access (Høyland, Hollund, & Olsen, 2015; Pini & Haslam McKenzie, 2007; Wolff, 2004, p. 195).

Senior commitment from the councils was often undermined by lower level management with the attitudes of MCH Coordinators significantly impacting on nurse recruitment. I have depicted the organisational hierarchy of Local Government Maternal and Child Health Services (See Figure 4.2). Mirroring Roxburgh’s (2006) findings about factors that constrain nurse participation in research, I found that the level of support received by nurses to be research active played a key role in facilitating their participation. Roxburgh (2006) identified three aspects of support: time, peer and managerial support. Reflective of Roxburgh’s (2006) experience of accessing nurses, I found that MCH Coordinators acted as gatekeepers and used their
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Influence to both promote and discourage research participation. In two councils where MCH Coordinators insisted on being present at site visits, nurse recruitment was significantly inhibited. Nurses at site visits conducted without MCH Coordinators present were talkative, light hearted, easy going, expressed professional interest in the project and were receptive to invitations generally signing up on the spot. In comparison when MCH Coordinators were present at site visits, nurses tended to be less engaged. There was an absence of casual conversation not only with the researcher but also among the nurses themselves and they were hesitant to ask questions and take information sheets.

**Figure 4.2 Example Local Government Maternal and Child Health Service Organisational Hierarchy**

*Not all Local Government run Maternal and Child Health Services have the team leader position.*

In their research on accessing local governments Pini and Haslam McKenzie (2007) identified several macro-level factors that inhibit access to LGAs including increased roles and financial constraints, fear of scrutiny, an audit culture and negative attitudes...
towards academia. Similar to Pini and Haslam McKenzie’s (2007) accounts of accessing local governments, increased roles and financial constraints appeared to influence MCHN access. One MCH Coordinator who was present during the site visits explicitly flagged concerns about time and financial constraints and although this factor was not articulated by any MCHNs refusing participation it appeared to inform their refusals. This suspicion was confirmed by the one MCHN from this LGA who accepted the invitation to participate. This MCHN advised the reasons for other nurses declining the invitation was uncertainty regarding manager approval to participate in study and whether participation could occur during work time.

From the outset it seemed that two of the MCH Coordinators who insisted on being present at site visits for nurse recruitment, explicitly worked from the assumption that nurses would not want to participate and nurses in these councils seemed to mirror their managers’ attitudes. In comparison to other councils, these MCH Coordinators were not very encouraging of the research project or BM3 program. In contrast at the remaining council where a MCH Coordinator was present during site visits, this MCH Coordinator expressed support and enthusiasm for the study and encouraged involvement which undoubtedly helped secure MCHN participation. My experience echoes MacDougall and Fudge’s (2001) claims about the importance of having research champions at every level.

In one of these councils staff movement further inhibited nurse recruitment. Staff leave and associated movement due to acting positions led to internal communication issues and reluctance by individuals to assume authority for decision-making. At the time of recruitment, this council was also experiencing significant teething difficulties with the BM3 program. These issues included coordinating BM3 with New Parent Groups, invitations not being sent to parents and mistakes about program start dates. Unsurprisingly, nurse confidence in the program was low at this time and together with their coordinator’s less than supportive attitudes inhibited recruitment.

Tensions over ownership of the BM3 program between Carrington Health and the local councils also impacted on recruitment. For example father recruitment was delayed
due to divided opinion over whose clients the BM3 participants were and thus who could grant access to program participants for recruitment. Carrington Health who developed, staffed and delivered the program saw BM3 participants as their clients while some of the local councils felt that as their Maternal and Child Health Centres physically hosted the sessions, the BM3 participants were their clients. There was further divided opinion within the councils themselves with some line managers contradicting the views of their senior managers. Again my relationship with the program Manager and the two senior MCHS managers proved essential with their assistance helping to workshop an acceptable resolution for all parties.

Overall, in addition to numerous phone calls and emails I completed 13 site visits across the seven councils and attended two community of practice meetings and one facilitator training course as part of my recruitment efforts. A further eight site visits across six councils were made to conduct MCHNs interviews. I also attended the quarterly BM3 Steering Committee meetings throughout the three-year pilot period. The following section briefly explores the ethical considerations raised by this study.

**ETHICAL CONSIDERATIONS**

Ethical considerations in this study primarily related to the need to balance the value of the research with the protection of vulnerable subjects. Earlier in this chapter I explained the procedures for recruiting study participants. It was not possible to approach the facilitators and MCHNs involved in the BM3 program without the consent of their employers so recruitment of program staff was dependent on managerial support for this study. Recognising that employees are vulnerable subjects and in order to avoid the impression that individuals were obliged to participate in this study I paid particular attention to gaining individual consent from each participant (Schwenzer, 2008). At each recruitment stage and prior to obtaining written consent potential participants were made aware that all information provided would be strictly confidential, their participation in the research was completely voluntary, their consent could be withdrawn at any time and non-participation would not lead to any adverse consequences to work relationships. Facilitators were also given the option of
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participating in an interview if they wished to do so for privacy reasons. Furthermore, I carried out the recruitment of staff directly to signify that participation was voluntary and confidential and reduce the likelihood that consent resulted from undue influence on the part of employers.

Like the staff, clients of a service can also be considered vulnerable research subjects and it is important to ensure that clients do not perceive that participation in research is required to prevent discrimination in their receipt of services (Schwenzer, 2008). With this in mind I conducted recruitment visits with potential father participants at the final session of the BM3 groups to ensure that participation in this study would not impact on their participation in BM3. To further protect the fathers’ confidentiality and privacy, interested individuals were asked to contact me directly to ensure that participation in this study would not impact on their receipt of MCH services.

Throughout the data collection process I was particularly concerned with protecting the privacy of participants. For example, I insisted on interviewing MCHNs individually even where managers or colleagues requested to be present to ensure that they could speak freely and without repercussion. Likewise the identities of consenting BM3 facilitators were withheld from Carrington Health (their employer) and focus groups sessions were conducted privately. To safeguard the confidentiality of the information collected all recordings and transcripts were stored securely at the University and no external parties had access to the data. All interview and focus group transcripts were de-identified and pseudonyms were used in all reporting.

This project received ethical clearance from the University of Melbourne’s Human Ethics Advisory Group and complied with their policy and procedures for ethical conduct in human research (Ethics ID: 1340699). The following section profiles the participants in this study.
STUDY PARTICIPANTS

In total 43 individual participants were recruited including 13 Maternal and Child Health nurses, 15 facilitators and 15 fathers. Participants comprised 20 men and 23 women. A profile of study participants is provided below.

DEMOGRAPHIC PROFILE OF THE STUDY SAMPLE

Maternal and Child Health Nurses

Just under half (6) of the nurses were aged 45-54 years old, a third were from the 35-44 year old age group (4) and one each from the 25-34, 55-64 and, 65 and over age groups. Five of the MCHNs interviewed worked in LGA5, three from LGA7, two from LGA3 and one each from LGA1, LGA2 and LGA6 respectively. The number of years spent working as a MCHN ranged from 1 to 30 years with an average of 9.5 years. Table 4.6 summarises the MCHN participants.
Table 4.6: Profile of Maternal and Child Health Nurse Participants

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Number of MCHNs (n = 13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>25-34 years old</td>
<td>1</td>
</tr>
<tr>
<td>35-44 years old</td>
<td>4</td>
</tr>
<tr>
<td>45-54 years old</td>
<td>6</td>
</tr>
<tr>
<td>55-64 years old</td>
<td>1</td>
</tr>
<tr>
<td>65 &amp; over</td>
<td>1</td>
</tr>
<tr>
<td>Council</td>
<td></td>
</tr>
<tr>
<td>LGA1</td>
<td>1</td>
</tr>
<tr>
<td>LGA2</td>
<td>1</td>
</tr>
<tr>
<td>LGA3</td>
<td>2</td>
</tr>
<tr>
<td>LGA5</td>
<td>5</td>
</tr>
<tr>
<td>LGA6</td>
<td>1</td>
</tr>
<tr>
<td>LGA7</td>
<td>3</td>
</tr>
<tr>
<td>Years worked as MCHN</td>
<td>9.5*</td>
</tr>
<tr>
<td>Received training for working with male clients</td>
<td>2</td>
</tr>
</tbody>
</table>

*Data was missing for one participant and they were removed from the analysis (n = 12).

Facilitators

On average the female facilitators had worked in the profession for around 10.5 months while the men had worked as facilitators for just over 44 months (3.7 years). Despite these differences in professional history, the average number of groups delivered by the men and women were similar, six for the men and seven for the women. For both groups there was wide range in the number of groups delivered by individuals, between 3-12 for the men and 2-13 for the women. Aside from the two-day BM3 facilitator training only one female facilitator and two male facilitators had received training for working with male clients. Table 4.7 on the following page summarises the characteristics of the facilitator participants.
### Table 4.7: Profile of Facilitator Participants

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Number of Female Facilitators (n = 10)</th>
<th>Number of Male Facilitators (n = 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-34 years old</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>35-44 years old</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>45-54 years old</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>55-64 years old</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>LGA where facilitators worked*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LGA1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>LGA2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LGA3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>LGA4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>LGA5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>LGA6</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>LGA7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Average number of groups delivered</td>
<td>7.1</td>
<td>6.2</td>
</tr>
<tr>
<td>Average months worked as a facilitator</td>
<td>10.6</td>
<td>44.2</td>
</tr>
<tr>
<td>Received training for working with male clients</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Professional Background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social work</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Maternal &amp; Child Health Nurse</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Early Childhood Services</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Gender equality</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Community Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men’s behaviour change programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fathering services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*One female facilitator and one male facilitator worked across two LGAs and both of their respective regions were included in the analysis.
Fathers

Just over half the fathers were aged between 35-44, one third were aged between 25-34 years old and two fathers were aged 45-54 years (n=15). Ten of the fathers attended BM3 groups in LGA1, four in LGA5 and one father in LGA6 (n=15). The concentration of councils where interview participants attended BM3 is reflective of the group delivery rates across the councils at that stage in the pilot. The next section describes how the data were analysed. Table 4.8 provides a summary of the father participants.

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Number of Fathers (n = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>25-34 years old</td>
<td>5</td>
</tr>
<tr>
<td>35-44 years old</td>
<td>8</td>
</tr>
<tr>
<td>45-54 years old</td>
<td>2</td>
</tr>
<tr>
<td>Council where attended</td>
<td></td>
</tr>
<tr>
<td>BM3</td>
<td></td>
</tr>
<tr>
<td>LGA1</td>
<td>10</td>
</tr>
<tr>
<td>LGA5</td>
<td>4</td>
</tr>
<tr>
<td>LGA6</td>
<td>1</td>
</tr>
</tbody>
</table>

DATA CODING AND ANALYSIS

DATA PREPARATION AND MANAGEMENT

Interviews and focus groups were recorded using a digital recorder and uploaded to a secure database using pseudonymous file names. I transcribed a sample and the remaining recordings were transcribed by a commercial academic transcription service. The transcripts were de-identified using pseudonyms assigned to study participants. I used the qualitative data analysis software NVivo 10 to organise and manage my data. Raw data files were initially created outside NVivo and then imported into the software program. This preserved and backed up the original data files.
FAMILIARISATION AND IMMERSION

Before commencing coding, I immersed myself in the data commencing with transcribing samples of interview and focus group recordings to allow me to become intimately acquainted with my data. I continued my exploration of the data in NVivo, synchronising the audio recordings with the transcripts in NVivo. This allowed me to simultaneously listen to the audio and read the transcripts, increasing my familiarisation with the material and enabling me to review the transcripts for any typographical errors or gaps.

THEMATIC/QUALITATIVE CONTENT ANALYSIS

Data from the interviews, focus groups and document review were collated and thematically analysed to develop a thick description of how service providers engage new fathers with respectful relationships programs in health settings and to identify inhibiting and facilitating factors.

Coding

Miles and Huberman describe codes as ‘tags or labels for assigning units of meaning to the descriptive or inferential information complied during a study’ (Miles & Huberman, 1994, p. 56). Coding is analysis, interpretation and organisation of data into meaningful analytical units (Miles & Huberman, 1994). Drawing on Bazeley (2013) and Miles and Huberman (1994), I engaged in a two-stage coding process using NVivo 10. First level coding involved descriptive coding labelling passages of data with codes that summarised the data segments (Bazeley, 2013; Miles & Huberman, 1994). Second level coding built on these summaries refining, interpreting and grouping them into smaller analytical categories, themes or constructs (Bazeley, 2013; Miles & Huberman, 1994). This phase explores the interrelatedness of data within and across themes to construct meaningful explanations (Bazeley, 2013). This two-stage coding process is cyclical with researchers constantly moving from data to description to analysis (See Appendix B, Attachment 15 for example code framework) (Bazeley, 2013; Miles & Huberman, 1994). This process was conducted in NVivo 10 where codes are entered as nodes and data are coded by selecting segments and coding them at the relevant
Engaging New Fathers: Learning from Baby Makes 3

nodes. The qualitative data analysis software provided an efficient tool for easily locating, retrieving and reviewing all coded material for a particular code (Bazeley, 2013). NVivo also allows data segments to be coded with multiple codes and reduces the ‘fracturing’ of data by displaying the wider context of data passages (Bazeley, 2013). Demographic data were recorded in NVivo using its case nodes and attributes functions.

I employed a hybrid approach to coding using both \textit{a priori} codes generated from the literature and \textit{inductive} or \textit{emergent codes} derived directly from the data (Bazeley, 2013; Miles & Huberman, 1994). Miles and Huberman describe \textit{a priori} codes as providing ‘a provisional “start list” of codes’ and while I drew on the multilevel father engagement model discussed earlier in the literature review to create a tentative coding framework, the \textit{a priori} codes were not forced on the data and were revised or disregarded where they did not fit (Miles & Huberman, 1994, p. 58). I used the three temporal phases of father engagement; getting, keeping and engaging, identified in the multilevel model discussed in the literature review as metacategories to sort and organise codes.

I also utilised \textit{in vivo} coding, employing phrases used by participants as labels to code data segments because they captured the concept in the participants’ own words (Bazeley, 2013; Miles & Huberman, 1994). For instance, the term ‘normalisation’ was used repeatedly by fathers when describing their experience of father group work in the BM3 program and so the phrase was used as a code to label data segments discussing this process. Similarly, indigenous expressions used by participants to describe behaviour in their environment were also utilised as codes (Bazeley, 2013; Patton, 2002). For example, ‘mumma bear’ is a term used by male facilitators and fathers to describe how the fathers’ partners distrust their childcare capabilities and how mothers supervise fathers’ care of their children.

Throughout the coding process I used memos to record ideas, reflections about issues raised, key points and links to other codes, categories or concepts (Bazeley, 2013). Memoing helped to refine and clarify relationships between code categories and move
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from descriptive to conceptual analysis (Bazeley, 2013; Miles & Huberman, 1994). The following section explains the strategies I used to verify my research findings.

**VERIFICATION OF RESEARCH FINDINGS – RIGOUR IN RESEARCH DESIGN**

This section outlines how I verified the findings made in this case study and covers the following topics:

- Validity
- Reliability
- Transferability
- Positionality and bias.

**VALIDITY**

This project employed several strategies to ensure the validity of the findings including triangulation, exploring alternative explanations and researcher reflexivity which is discussed in positionality and bias (Creswell, 2009; Merriam, 2009).

Yin (2009, p. 115) argues that the use of many different evidentiary sources strengthens case study data collection as it enables triangulation and corroboration by developing ‘converging lines of inquiry’. He rightly contends that findings are more convincing when they are based on multiple but different evidentiary sources (Yin, 2009). Sound case study research requires researchers to provide multiple confirmations from a variety of data sources to confirm the findings made, if multiple data sources support the same observation or interpretation then the finding can be claimed (Yin, 2009). Following the case study methodology of Yin (2009) and Creswell (2007, 2013), I used multiple sources of evidence to triangulate the data and confirm my interpretations of what was being said (Stake, 2006; Yin, 2009).

In case study research, triangulation is used not only to confirm findings and discount rival explanations but also to identify other ways of seeing things; as Stake explains ‘the qualitative case researcher tries to preserve the multiple realities, the different
and even contradictory views of what is happening’ (Stake, 1995, p. 12). In this study I triangulated data from multiple sources to develop deep understanding of fathers’ experiences engaging with respectful relationships programs in the Victorian Maternal Child Health context.

Acknowledgement of the need to triangulate findings and consider rival or alternative explanations encouraged me to view the case in different ways and helped clarify the conditions under which findings held true (Bazeley, 2009). For instance, one father’s experience of group work stood in stark contrast to that of the other fathers leading me to probe and challenge the data in relation to this aspect ultimately helping to refine and develop the links between group work and father engagement. Triangulation was particularly important in the development of themes which relied on evidence from different data sources. I used it to check emergent themes for both the internal homogeneity of categories and external heterogeneity, ensuring that there were clear and distinct differences between categories (Patton, 2002).

RELIABILITY

Triangulation justifies the construction of study findings, so too does the rigour employed during data collection. This aspect of verification is called reliability. The primary concern of reliability in qualitative research is repeatability, the ability of readers to authenticate research findings (Lincoln & Guba, 1985; Merriam, 2009; Yin, 2009). Qualitative researchers address reliability by establishing an audit trail or chain of evidence with the aim of acknowledging researcher subjectivity and bias in a study (Merriam, 2009; Yin, 2009). Yin describes this process as the researcher operationally defining their methodological steps to ensure that another researcher could, in principle, undertake the same case study using the same procedures and arrive at the same findings (Yin, 2009, p. 45). He proposes two strategies for constructing an audit trail in case studies: the use of a case study protocol and the development of a case study database (Yin, 2009). Yin explains that a case study protocol increases the reliability of a case study by providing procedural guidelines for the investigation (Yin, 2009). According to Yin, a case study protocol comprises an overview of the case study
project, field procedures, the case study questions and a guide for the case study report (2009). The case study database also promotes reliability by documenting the evidentiary material collected during a study and enabling the independent review of the raw evidence at a later date (Yin, 2009). Both a case study protocol and a case study database act as quality control measures constructing an evidentiary trail for readers to trace a study’s findings back to the initial research questions asked and vice versa (Yin, 2009). This project employed both of these strategies in order to improve the repeatability of the project and increase the reliability of findings drawn from this study (See Appendix B, Attachments 16 and 17).

TRANSFERABILITY

As both Yin (2009) and Stake (1995) explain, the purpose of case study research, like other qualitative research, is not to produce statistical or universal generalisations. Rather, case study findings are intended to produce *particularisation* – an understanding of the complexity of a particular phenomenon (Creswell, 2009; Merriam, 2009; Stake, 1995). Accordingly, case study researchers strive for *transferability*; the process of transferring findings from one case study to other similar situations (Lincoln & Guba, 1985; Merriam, 2009; Stake, 1995). Judgements about the transferability of case study results are made possible by the thick descriptions contained in case study reports that detail the contextual environment of the phenomena investigated and allow audiences to determine whether the findings apply to their own context (Lincoln & Guba, 1985). Uniquely, transferability judgements in case study research are made by readers and later investigators rather than the original researchers as only the former are in a position to judge whether findings from the original context are transferable to the current (Lincoln & Guba, 1985; Merriam, 2009; Stake, 2006). In order to facilitate this process, this thesis provides a detailed description of the *Baby Makes 3* program setting to enable readers to assess the similarity of their own context and determine whether the findings are transferable (Lincoln & Guba, 1985; Merriam, 2009).
Yin believes analytical generalisations can be produced through case study research by using case study findings to confirm, distinguish or refute existing theories or propositions (2009, p. 15). As with the burden of proof for transferability falling on future users, Yin contends that case study findings can only be used as evidence to support analytical generalisations when the findings have been replicated in second and subsequent cases (2009). The case study design of this project should provide rich data that permit extrapolation to more general principles.

POSITIONALITY AND BIAS

Researcher reflexivity is intrinsically intertwined with the verification of qualitative research findings and it is essential that both researchers and their audience understand how an investigator’s positioning and bias shaped their research and interpretation of the findings (Creswell, 2007, 2013; Merriam, 2009). Earlier in this chapter I explained my constructivist paradigmatic positioning and how it influences my interpretation and understanding of knowledge and truth. In addition to my epistemological and ontological stance my personal biography has also influenced this research (Bourke, 2014; Herod, 1999). I acknowledge that every aspect of this study including the initial conceptualisation of the research problem stems from my own position and experience. As a sociologist and lawyer with background in family violence research and family law, my experience working as both a practitioner and researcher in tertiary prevention with respect to legal responses to family violence, triggered my interest in primary prevention. My experiences in the tertiary prevention field led me to question whether work done at the other end of the prevention spectrum could reduce the tidal wave of victims encountered in the legal system. Contemplating primary prevention from a sociological perspective, my understanding of cultural and social change caused me to wonder whether it is possible to prevent complex social phenomena, like violence against women, and how this could be achieved. Keen to explore these questions I decided to focus my Ph.D. research on engaging men in IPV primary prevention.
Engaging New Fathers: Learning from Baby Makes 3

Savin-Baden and Howell Major (2013) rightly argue that researcher positionality not only influences the research subject but also the participants and research process. As a childless female researcher interviewing men as new fathers I was acutely aware of the lack of social proximity between myself and the father participants. Although I could manipulate my positionality to some extent by choosing the aspects of my identity that I disclosed during data collection, many participants assumed my positionality based on physical attributes such as my gender and ethnicity (Herod, 1999; Mullings, 1999). However despite these perceived identity differences I found that I traversed both an insider and outsider status with the men studied (Herod, 1999). As Herod (1999) explains how researchers perceive their own positionality may vary from how others view them. While from my perspective my gender and childless status situated me firmly as an outsider, my partnership with the program provider and their support for my research led others to view me as a ‘pseudo-insider’ (Herod, 1999). This pseudo-insider status facilitated my access to and recruitment of fathers. My recruitment of fathers was further aided by the timing of recruitment visits. I recruited fathers for my study during the final session of the BM3 program. At this stage the fathers participating in BM3 had developed a level of trust with the program facilitators and were receptive to their encouragement for my research during recruitment visits. The gender of interviewers has also been shown to influence the research process and I reflect on the impact of my gendered positioning in the discussion of the strengths and limitations of this research in Chapter Seven (Herod, 1993).

SUMMARY

I began this chapter by explaining my perspective on the construction of knowledge. Underpinned by my constructivist epistemological and ontological outlook, I justified the utilisation of a case study research design to explore the impact of gender on service providers’ engagement with new fathers in respectful relationships programs delivered in health settings. From a constructivist standpoint I sought meaning from
the fathers and staff involved in such programs collecting data through interviews, focus groups and documentary sources. I detailed the process I used to thematically analyse the data collected and the strategies employed to verify the findings drawn from this process. Aligning with my constructivist positioning I outlined my positionality and bias acknowledging the inevitable impact these had on this research and my interpretation of the findings.

The next two chapters address the research question about the impact of gender on service providers’ engagement with new fathers in respectful relationships programs delivered in health settings. The findings are reported according to the three-phase father engagement model employed in this research. Chapter Five presents the findings in related to the gender phenomena that impact on service providers’ ‘getting’ new fathers in health settings and Chapter Six reports on the findings in relation to ‘keeping’ and ‘engaging’ new fathers.
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CHAPTER 5: GENDER AND ‘GETTING’ FATHERS

This thesis investigates how gender impacts on service providers’ engagement with new fathers in respectful relationships programs delivered in health settings. Using the three-phase engagement model outlined in Chapter Two this chapter presents this study’s findings about the gender phenomena that influence ‘getting’ fathers to attend BM3 in the first instance. Discussions about what motivates father participation in BM3 revealed that a complex, multidimensional interplay of gender related factors shapes men’s father identities, behaviours and ultimately their decisions to participate. To explore this interplay of factors, this thesis applies Risman’s (2004) concept of gender as a multidimensional social structure, described earlier in Chapter Three, to the data analysis. Facilitators and inhibitors to father participation will be discussed in relation to the three dimensions of gender identified in this model: individual, interactional and institutional. It is important to remember that these three levels are not discrete and that each level influences the others. As a consequence individual gender factors may operate at more than one level.

THE INDIVIDUAL LEVEL

HOW MENS’ PERCEPTIONS OF THEIR ROLE AS FATHERS MOTIVATES PARTICIPATION

I think it's all a part of their own image and how they see themselves. (Kate, MCHN)

Men’s father identities appear to play a key role in motivating their participation in BM3 with the value and behaviour first time fathers associate with their father identities strongly influencing their engagement in the program. This discussion draws on Habib and Lancaster’s (2012; 2006) paternal role identity framework to explore how men’s constructions of their father identities and related role behaviours affect strategies that seek to engage men as fathers. As previously discussed Habib and Lancaster’s framework identifies two facets of men’s paternal identities: their father status content being men’s subjective perceptions of how fathers behave and father
status prominence which pertains to the level of importance men’s father identities have to their sense of self (2012; 2006). Discussions with study participants about motivations for father participation revealed that the behaviour men associate with the father role heavily influenced their participation decisions. In particular it appears that men who see themselves as ‘involved’ fathers are more likely to engage with respectful relationships programs.

Gender factors identified as impacting on men’s perceptions of fatherhood and consequently service provider engagement with fathers are presented as four sub-thematic categories: ‘involved’ fathers, caregiving as women’s work, providing as men’s work and engaging already engaged fathers.

‘Involved’ fathers

Men’s conceptualisations of fatherhood and parental responsibility were identified by fathers as impacting on men’s involvement in BM3. In discussions about why fathers do not attend BM3, three fathers positioned themselves as involved fathers:

*I guess in a way in a simplistic view there is probably two types of dads. Those that get involved and those that are probably still a bit more dated or not as engaging. (Christopher, father)*

*I wanted to be hands on with the raising of my little one, so it was in my best interests, I felt, to go and do it. (Luke, father)*

These fathers indicated that men who do not engage with the program subscribe to traditional father scripts with essentialist parental roles where mothers are caregivers and fathers are breadwinners. Discussing the similarities and differences between himself and the other fathers in his group, Christopher indicated that his construction of fatherhood differed from the fathers who dropped out. He commented that:

*Between the fathers you could certainly see that the three of us that remained are probably very similar in views, thoughts and appreciation of the transition that needs to happen. Perhaps the other two who didn’t necessarily follow through... - you wouldn’t want to condemn them or anything. But I think their views, if you like, on how things needed to work probably seemed a bit dated,*
Engaging New Fathers: Learning from Baby Makes 3

compared to how the rest of - the three of us I think have got a bit more of a modern thinking of how much fathers need to get involved in the upbringing of babies and helping out and things like that. (Christopher, father)

Like Christopher, Simon also reported that he views fatherhood differently from most fathers:

I don't consider myself probably a good representative of male-hood in a lot of ways. I work as a nurse and I probably think differently. I think the guy that went there with me, he felt the same way. I think they talked about fatherhood in a different way, yeah. I don't know, maybe we're a bit softer, maybe there's a bit of a stigma still, about fatherhood and what it is. That's my suspicion. Because I felt we were pretty similar, the guy that went with me. We didn't really - and we're both from the country as well, I don't know if that's got to do with it, but we didn't mind talking and talking about stuff like that. We didn't feel like we had anything to prove... (Simon, father)

These fathers’ discussions about why men do not attend or drop out of BM3 indicate that some men’s perceptions of their father roles inhibit engagement. It seems that the continued prevalence of fatherhood ideologies where men play a supporting role in caregiving is a barrier to strategies that seek to engage men as caregivers.

Caregiving as women’s work

The prevalence of traditionalist perceptions of the work of caring for babies was emphasised by four fathers who reported that father engagement in BM3 is inhibited by men’s perceptions of caregiving as ‘women’s work’:

The people that aren't going are the ones that probably to be honest probably still go to the pub on Friday night or Saturday night and aren't home, leave their wife to do everything. I'm not stereotyping but that's just reality. I'm sure that's probably why they're not. (Craig, father)

Unfortunately, there is still that stereotype of babies as women's work. (Luke, father)

I suspect that some of them think that this is all something for the mothers to deal with and they shouldn't have to be involved. I think that that culture needs
Engaging New Fathers: Learning from Baby Makes 3

to be broken somehow, which is, I suspect, a big part of the issue, that they just think oh, no, that’s a mothers group thing, you go along to that. Somehow that culture needs to be broken. (Scott, father)

I think that’s the way our society is, it’s still focussed on mothers looking after babies. (Simon, father)

Like these fathers, some female facilitators and two MCHNs felt that community perceptions of caregiving as ‘women’s business’ inhibit father engagement in BM3:

So you’ve got your dads that actually just don’t think it’s their role and they’re the ones that actually need to sit there and hear this but they’ve got football training...I’ve had a lot of mums come on their own because dad’s at footy or dad works late and it’s like well. This is the exact reason why we’re doing this sort of thing but the ones that don’t think it’s part of their responsibility, don’t think it’s part of their responsibility to go to a Baby Makes 3. (female facilitator)

Men have always been on the outer with the child - with the pregnancies, the birth. (female facilitator)

I think a lot of men still see it as, you know, the women’s role. If you talk to them, they’ll say, oh no, wouldn't come to anything like that, even though they probably need it. (Kate, MCHN)

A few of the women say, oh I couldn't get my husband to drag along to anything to do with stuff like this. I want to come but he doesn't...I said to this mum, because he thinks it's women's business? She went, yeah definitely. (Alice, MCHN)

One female facilitator explained that a consequence of this thinking is that even when you ‘get’ these men they often do not come back:

Men might come along - once they realise what it is about I'm sure they wouldn't have come if they had have known beforehand...They come under sufferance. In fact you can often tell they're not coming back because this is just out of my league. I'm not into this at all. (female facilitator)

Since the new parents groups which lead into BM3 are services for caregivers, they are also seen as women’s business. Alice commented:
Engaging New Fathers: Learning from Baby Makes 3

I still think there’s a view in our communities that the new parents group is mothers group...I personally think that’s a bit of a barrier why we’re not getting so many dads for the Baby Makes 3 program because the mothers - they feel like the mothers have got this mothers’ group and it’s a women’s business sort of focus. (Alice, MCHN)

Many of the female facilitators agreed with Alice explaining that despite the recent name change New Parent Groups are still colloquially called mothers’ groups. These discussions about parental responsibility and childcare suggest that many people see men and women as having distinct parental gender roles. It seems that childcare is not part of the paternal role nor participation in programs offered from child related services, such as BM3.

Providing as men’s work

Aligning with the participants’ beliefs that caregiving is still seen as women’s work, many nurses reported that men who perceive their father role primarily as provider are unlikely to participate in BM3:

I think men think a lot of their main role is to be the provider of the finances. Even though we've come in leaps and bounds from how it used to be in the 40s and 50s, it’s still very much that mentality. (Jenny, MCHN)

It’s very difficult because most dads do consider themselves the breadwinner so they go back to the workforce. (Carolyn, MCHN)

...It is harder for them because they are very aware - especially the first-time dads - they're very aware that all of a sudden their role has changed to being the sole breadwinner. I think that's a real stress for a lot of men and they're grappling with that whilst the women are grappling with the baby a bit more. (Alice, MCHN)

...I think what they do is they have a panic attack, we're down to one wage. My role as seen in 1950's sitcoms is to go out and work and she'll do happy families at home and it's all going to be rosy... It's because they're actually trying to shore up their family and do the right thing and this is the way they think they can do it... I think they think that they need to go out and earn the money. (Jade, MCHN)
One father echoed this breadwinning discourse:

*My job is obviously to make sure that we're still getting money and everything, as well as do what I can when I'm here.* (Scott, father)

A successful economic provider must generate an income and overall six nurses and three fathers identified fathers’ work commitments as a barrier to ‘getting’ fathers.

Many female facilitators agreed commenting that fathers’ employment and financial responsibilities preclude or limit their involvement in BM3 and the MCHS more widely:

*Well I know when I send my letter out it says dear parents and then a father will say, is that the mothers group? I'll say, no, it's not it's the parent group and everyone is welcome. But the fact of the matter is that they are mostly going to work, so then they don't come.* (female facilitator/MCHN)

*It's not anyone’s fault. That's just the way it is. You guys need to work outside the home.* (female facilitator)

*I think now we are far more inclusive of fathers and we present it more as a family thing...So hopefully those traditional perceptions are fading but there’s the reality that most men will be back at work and most mothers will be at home in the initial period with their babies.* (Prue, MCHN)

In contrast, two MCHNs reported that men’s father roles have changed believing that involved fathers are the norm:

*I think the role of fathers has changed a lot and they expect to be more involved in, in their child's life. I think you know a couple of generations ago they weren't even in the delivery room and it was women's business and it was their job to go and earn the money and it was the mothers' job to raise the child and I think that um society influence has really changed that and they want to be part of their life and I often have, like tomorrow morning I've got an 8 o'clock appointment because the dad really wants to come to the appointment so he comes the appointment and then goes into work a bit late and we have lots of dads who do that or they arrange to work from home for a day so that they can come to the appointment or they arrange to finish early so they can come or they arrange... I think dads are really wanting to be involved in their children's life.* (Emilie, MCHN)
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Susan echoed Alice’s sentiments about men being more involved in childbirth and commented that:

*I also think it’s become more acceptable for dads to be much more involved in the parenting. Over the years there’s been much more of a change in that, that it’s much more of a shared thing than dad goes to work and mum looks after the kids.* (Susan, MCHN)

The nurses’ comments suggest that men who see the father role as provider are less likely to respond to strategies that seek to engage them as caregivers. Confirming recent research, the MCHN’s responses indicate that the breadwinner discourse continues to be the dominant discourse about fatherhood (Connell & Messerschmidt, 2005; Dienhart, 1998; Eerola & Mykkänen, 2015; Caroline J Gatrell & Cooper, 2008; Höfner, et al., 2011; Townsend, 2002; Wall & Arnold, 2007). These findings align with research on gender, work and family that continually highlights the centrality of providing in establishing men’s gender identities (Losocco & Spitze, 2007; Nock, 2001; Pyke, 1996). Although the participants in this study believe that paternal ideologies of fathers as economic providers strongly shape men’s paternal behaviour, it is important to note that where men view their father role as provider, their worker and father identities may overlap (Olmstead, et al., 2009). It is unclear whether the importance men place on their participation in paid work is an expression of their understanding of their paternal responsibilities or evidence that they attribute a higher status to their worker identities than their father identities. For example, research by Cowan and Cowan (1988) on men’s and women’s psychological investment in their partner, parent and work roles showed that men’s sense of self as worker increased during transition to parenthood. The present study was unable to provide insight into this as fathers were not asked about the comparable importance of their father identity among their other identities or how they differentiate between these role identities, further research is required.

Engaging already engaged fathers

Given the complexity of the gender influences on new fathers’ identities it is not surprising that participants consider that BM3 is engaging ‘involved’ or already
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engaged fathers. This was reinforced by the two MCH nurses, a father and a female facilitator:

*I think that we are preaching to the converted a little bit, I think we are capturing the people who are interested but you've got to start somewhere.* 
*(Emilie, MCHN)*

*I don't get the sense that dads feel that they shouldn't be there. But then I'm only talking about the dads that come.* 
*(Michelle, MCHN)*

*The ones that need to be there, they're not there.* 
*(female facilitator)*

*I had an interesting discussion with David [the facilitator] about this and he said that perhaps the people that most need to be here are the ones that aren't here, if you know what I mean. The people that aren't going are the ones that really need to be there, so the fact that we're turning up and all that sort of thing - I'm not saying that we didn't need to go. I got lots out of it, but I think there's probably some truth in that, that the people who most need to be there aren't actually the ones that are going.* 
*(Scott, father)*

These discussions confirm the fathers’ reports that the men attending BM3 already view the father role as a caregiving role suggesting that this engagement strategy may have a limited appeal for men who do not associate caregiving with the father role or who do not place a high level of prominence on this aspect of their fathering identity. This findings aligns with the views of some commentators that work with men around parenting and gender equality may be reaching those who need it least (Berlyn, et al., 2008; Jewkes, Flood, & Lang, 2015).

**SUMMARY – FATHER ROLE IDENTITY AND ENGAGEMENT**

Consideration of the impact of gender at the individual level illustrates that how men see and do fathering varies, and strategies that seek to engage men as caregiving fathers may have limited appeal to a broader group of men. Although recent research points to father roles being multifaceted with men integrating the provider role rather than seeing it as the defining characteristic, it appears the provider role is still the dominant marker of fatherhood (Eerola & Mykkänen, 2015; Caroline J Gatrell, Burnett,
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Cooper, & Sparrow, 2015; Höfner, et al., 2011; Olmstead, et al., 2009). Fathers’ continued adherence to provider role scripts is reflected in the labour force participation rates of Australian parents where fathers continue to participate in full-time employment at significantly higher rates than mothers (Wilkins, 2013). In the 10 year period between 2001 and 2010 the labour force participation rates of parents remained stable with partnered fathers participating in full-time employment at more than double the rate of partnered mothers (In 2001 65.8% of partnered fathers and 25.1% of partnered mothers were employed full-time compared to 66.8% of partnered fathers and 29% of partnered mothers in 2010) (Wilkins, 2013).

While changes in fatherhood ideologies have occurred with some proclaiming the arrival of the ‘new’, ‘involved’ or ‘nurturing’ father, research continues to show that corresponding changes in men’s actual father behaviour lags behind (Connell & Messerschmidt, 2005; Eerola & Mykkänen, 2015; Elliot, 2015; Höfner, et al., 2011; LaRossa, 1988). LaRossa (1988) calls this asynchrony between the culture and conduct of fatherhood. He emphasises the importance of distinguishing between ‘the culture of fatherhood, the norms, values, and beliefs surrounding men’s parenting, and the conduct of fatherhood, what fathers do, their paternal behaviour’ (LaRossa, 1997, p. 11). LaRossa argues that the two are often not synchronised with changes in culture occurring more rapidly than changes in conduct (LaRossa, 1988). Validating LaRossa’s claims of asynchrony, more recent studies on gender, work and family have repeatedly shown a disjuncture between what people think in comparison to what people actually do in regards to the distribution of paid and domestic work (Loscocco & Spitze, 2007; Miller, 2011; Zuo, 2004).

THE INTERACTIONAL LEVEL

At the interactional level cultural expectations and interactional processes construct gender (Risman, 2004). Relational theorists contend that social interactions are a means of ‘doing gender’ explaining that the performance of family work, particularly child care and housework, is strongly defined as feminine (Kan, et al., 2011; Risman, 2004; Sullivan, 2013). Analysis of the data identified several interactional level factors
that influence ‘getting’ fathers, which have been grouped into the three following categories: ‘a soft side of manhood’, ‘mummy bear’ and mothers as gatekeepers.

‘A SOFT SIDE OF MANHOOD’

As discussed earlier, Bird believes male homosocial heterosexual interactions maintain hegemonic masculinity by promoting emotional detachment, competitiveness and the sexual objectification of women (Bird, 1996).

Based on in-depth interviews and field observations of men from an academic community in Northwestern United States Bird (1996) explored the connection between men’s individual masculinities and gender norms in small group homosocial interactions. She found that male homosocial interactions among heterosexual men promote men’s adherence to hegemonic masculinity while suppressing practices associated with nonhegemonic masculinities, such as emotionality (Bird, 1996).

Aligning with Bird’s work fathers, Simon, Scott and Luke, suggest that traditional masculine discourses discourage emotional expression among men and that this inhibits men’s participation in BM3:

*I can see that some people think that they’re too manly to go to something like this, which I think is ridiculous, but perhaps that’s part of the reason.* (Scott, father)

*It could just be that male stereotype of being stoic and not wanting to speak and not be talking about your feelings...some of the guys didn't feel it was their place to be discussing babies and feelings.* (Luke, father)

*I was surprised to see a male there, I didn’t think there would be. I don’t know but I thought there’d be just women or something, yeah. I was surprised yeah. I think we’re quite anonymous in a lot of ways, like males when it comes to communication, talking and stuff. Because it’s almost as if he was - like for him to want to do that group, it’s like - it’s a soft side of manhood I suppose, isn’t it? When you’re talking about your emotions and your feelings.* (Simon, father)

Simon added:
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Yeah like so he put himself out there. So when I first met him it was like, well you’re putting yourself out there, so well I might as well as well. Because I think - like being a male nurse myself, I probably - yeah I still respected that but I don’t know if everyone would respect a male doing that. They’d be like, oh the bloody little poofter or something like that...Bit of a tough guy sort of attitude, yeah. (Simon, father)

Two nurses confirmed these fathers’ belief that dominant masculine discourses discourage the expression of emotion among men. For instance, Alice said ‘I just find them generally not as open as the women’ explaining that:

I think there’s a society thing. They’ve got to be the big, brave, wiser, stronger bloke...I think there’s society, environmental things that men have to break through to talk about their mental health generally...they’re not taught how to manage emotions as well as probably women have. It’s been a bit more acceptable to talk about how women handle their emotions rather than how men can manage their emotions. (Alice, MCHN)

Likewise, Jade commented:

They find it hard to talk about emotions...We’ve got men that aren’t articulate, vocal, they don’t want to do it, they don’t know how to do it. They haven’t had role models to do it. (Jade, MCHN)

Interestingly, Alice indicated that engaging men as protectors may be an alternative route:

I had one of the dads say that he doesn’t want to talk about his health because he’s more focused and worried about his wife and child...he said, I’m not okay all the time but even if I wasn’t I probably wouldn’t bring it up here because I want you to look after them. Now that was interesting so there was a protective element about - I said, so it’s a protective element why you’re not talking about how you’re going? He said, yeah definitely. (Alice, MCHN)

These responses suggest that men’s enactment of dominant masculine discourses may inhibit father engagement in discussion-based programs like BM3 and health services more generally. Research by Ghate, Shaw and Hazel (2000, p. 22) on father engagement in Family Centres across England and Wales showed that men perceived
these activities as passive, unconstructive gossip. The positioning by the men who participated in BM3 of their father selves as ‘alternative’ aligns with findings by Ghate, Shaw and Hazel that male users of family centres are ‘the ‘wrong’ sort of men’ described by other men as deviant or feminine (2000, p. 16). Similar findings were made by Dolan (2014) in his study of fathers who participated in a ‘dads only’ parenting program in the United Kingdom. Dolan found that fathers’ decisions to participate in parenting programs were influenced by their perceptions of male users of such services as ‘suboptimal men’ (2014, p. 818). The ‘otherness’ of fathers who adopt caregiving responsibilities was also identified by Höfner, Schadler and Richter in work on men’s fatherhood discourses during the transition to parenthood that showed that many men who adopt caregiving role are perceived as feminised men (Höfner, et al., 2011). These findings suggest that fathers’ adherence to hegemonic practices and values may lead to them avoiding ‘feminine’ activities, such as BM3.

‘MUMMY BEAR’ – WOMEN SHAPE MEN’S FATHER ROLES

Resonating with research evidence that fatherhood is constructed interactionally, focus group discussions with the male facilitators highlighted the role of women in shaping men’s father identities and behaviours (Allen & Hawkins, 1999; Fagan & Barnett, 2003; Marsiglio & Cohan, 2000; Maurer, et al., 2001; McBride et al., 2005). Describing men’s reports that their partners police their child care activities, they said:

That looking over their shoulder, not trusting them you know that sort of stuff and they came up with the word ‘just doing that mummy bear role’ that’s what they called it. (Mark, male facilitator)

One of the dads, David speaking, said that my partner’s too much of a lioness, she won’t let me so she says you can have, you can do the next hour and a half but she is standing there behind me the whole time. (David, male facilitator)

I did a group two weeks ago and it was the first group where the men were happy for me to say, for it to be put up there that um their partners don’t trust them with the children in terms of they tell them that its their time but they supervise it. (David, male facilitator)
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Discussing father involvement, one nurse confirmed the male facilitators’ reports that maternal perceptions of fatherhood influence paternal behaviour:

*I think, too, it’s probably the fault of some mothers who hover and if the dads don’t do it the way they like it, instead of just rely on them to do it their way, you know, it’s either my way or no way. So I think mothers actually do put the dads down a little bit. So it makes them a bit reluctant to initiate anything.*

(Kate, MCHN)

These comments indicate that fathers’ attempts at ‘undoing gender’ by participating in caregiving were met with resistance and seen by their partners as transgressing gender roles. The facilitators’ reports suggest that mothers’ gendered expectations and perceptions of parental responsibilities influence men’s father identities; in turn shaping their responses to parenting programs. These findings highlight the interactional aspect of paternal identity negotiation and confirm Fox’s (2001) finding based on in-depth interviews with 40 heterosexual couples transitioning to parenthood in Toronto that interpersonal negotiations between men and women in intimate relationships are deeply gendered.

MOTHERS AS GATEKEEPERS

Mothers’ co-construction of men’s fathering extends to their access of child and family services where mothers’ gatekeeping roles are well documented (Ghate, et al., 2000; N. Maxwell, Scourfield, Featherstone, et al., 2012). MCHNs’ discussions about getting fathers involved in BM3 revealed that the relationships the men’s partners form with the other new mothers in the New Parent Groups significantly influence ‘getting’ fathers. Some nurses reported that where the mothers form positive relationships they encouraged their partners to participate:

*I think that’s good, the fact that they’ve got a good core group of women that are close. I think then they encourage to meet the other dads.* (Alice, MCHN)

*I think if you can work on that group dynamic to start with and that they’re starting to become a close group after our six weeks during the day, then they go home and they say to the dads, yeah, we’re going along, we’re going to go and meet everybody.* (Carolyn, MCHN)
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I think if you get a good connection in the New Parents Group, I think you'll get a good connection in the Baby Makes 3 program. (Laura, MCHN)

While many of the participants in this study indicated mothers facilitated father engagement by promoting participation, mothers can also inhibit father engagement. A few MCHNs said that negative dynamics among the mothers in NPGs can adversely influence father participation in BM3. For instance, during interviews with nurses at one pilot it was revealed that the latest BM3 group was cancelled after the first session. All three nurses highlighted some mothers’ roles in destabilising the group attributing the failure of the group to a couple of mothers who they described as having ‘strong’ and ‘challenging’ personalities and who refused the facilitators’ request to establish some group rules for the BM3 program:

I think there were a couple of strong personalities and I think the two women particularly - I don't really understand why they made it awkward for the other women. I think it's part of that Gen-Y thing. I think they think they know everything and they can't be told things and then my bottom line was well, why did you go? (Liz, MCHN)

So the last group we had here at Jordanville, which I didn't run but one of the nurses did, they were a very cliquey group and so they attended the first BM3 and there were very strong personalities in that group and then the second group, the second night nobody turned up. (Steph, MCHN)

Discussing the impact of these group leaders on the dads’ involvement in BM3, Liz explained:

No-one went back. So that was - not only did they impact - not only did those two women impacted on their partners, they impacted on everyone. They put everyone else off coming back. It's pretty amazing, but then that's the first group that we've had that happen. (Liz, MCHN)

Recognising the influence partners’ have over father participation in BM3, a few of the female facilitators suggested getting dads involved earlier in the life of New Parent Groups may lead to better father engagement. They were not in agreement about how this process would work. One suggested that getting fathers to meet as a group before
the sessions started would facilitate engagement in BM3, others suggested scheduling BM3 earlier in NPG course so that the ‘mothers haven’t established themselves as a really strong group before the men’. Two female facilitators suggested:

*I think making - so within the New Parent Group encouraging the women to bring their partners on board with them is really important too. I know it works really well when that happens and someone has to drive it within the group and you can usually find the one that you think is going to be good to drive it. But to actually get that up and running so that you've got almost a dad's group on the outside and actually doing something together whether that's suggesting they do a swimming lessons together or they develop a Facebook page for the men.*

*(female facilitator)*

*Sewing those seeds in the New Parent Group can really facilitate the men really being on board long before that group finishes and long before you even start to flag Baby Makes 3.* *(female facilitator)*

Confirming previous research, it seems that mothers can both facilitate and inhibit service providers ‘getting’ fathers (Ghate, et al., 2000; N. Maxwell, Scourfield, Featherstone, et al., 2012). The female facilitators’ suggestions for strategies to increase father involvement are based on the assumption that it is the role of mothers to drive father engagement. This assumption reflects and reinforces traditional divisions of labour between men and women.

**THE INSTITUTIONAL LEVEL**

Men’s perceptions of their father identities and associated behaviours are shaped by the social and institutional context in which they live. Father involvement in both caregiving and early childhood programs, such as *Baby Makes 3*, is influenced by cultural ideologies about gender, caregiving and work as well as economic structures, public policies and organisational practices (Coltrane, 1996; Kan, et al., 2011; Sullivan, 2013; Zuo, 2004). This discussion explores how institutional level factors impact on the lives of new fathers and their involvement in respectful relationships programs in health settings. At the institutional level gender factors identified as impacting on
service provider engagement with fathers have been grouped into two categories: *gendered institutions* and *persistent gendered division of labour*.

**GENDERED INSTITUTIONS**

At the institutional level gender phenomena that restrict father engagement in child and family services are well documented with research finding that mother centric practices, policies and orientation exclude or inhibit father engagement (Bayley, et al., 2009; Berlyn, et al., 2008; Burgess, 2009; Ferguson & Gates, 2015; Fletcher, May, St George, Stoker, & Oshan, 2014; Ghate, et al., 2000; Lloyd, O’Brien, & Lewis, 2003; N. Maxwell, Scourfield, Featherstone, et al., 2012; C. L. McAllister, Wilson, & Burton, 2004; Panter-Brick, et al., 2014). This research evidence aligns with Acker’s theory of gendered organisations which explains that ‘gender is present in the processes, practices, images and ideologies, and distributions of power in the various sectors of social life’ (1992, p. 567). Acker argues that institutional structures are ‘organised on the assumption that reproduction takes place elsewhere and that responsibility for reproduction is also located elsewhere’, accordingly as an institution uniquely designed to support reproduction and childcare the Maternal and Child Health Service is aimed at people without paid work responsibilities (1992, p. 567). As Acker notes ‘the only institution in which women have had a central, defining, although subordinate, role is the family’ (1992, p. 567). The following discussion details how gender is constituted through MCHS organisational practices and processes and its impact on father engagement.

**A Gender-Blind Approach**

Participants identified the Maternal and Child Health Service’s approach to working with men as a significant obstacle to father engagement echoing research that has shown that staff attitudes and behaviours set the tone of a service (Ghate, et al., 2000; Weeks, 2004). A previous study of barriers and enablers to father involvement in United Kingdom Family Centres by Ghate and colleagues (2000) identified several institutional level factors that influence father engagement. They developed a classification system to describe the orientation of service providers’ work with men.
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based on three elements of service orientation: centre priorities and policies, service provision and activity, and the atmosphere and ‘feel’ of centres (Ghate, et al., 2000). Three descriptive categories were identified: a gender-blind approach where service providers are blind to the different needs of service users treating men as synonymous with women users, a gender-differentiated orientation which recognises and accommodates differences between men and women users and agnostic where views on working with men were not identifiable (Ghate, et al., 2000). In the present study only two of the thirteen nurses interviewed reported that they had received training for working with male clients. Discussions with MCHNs about how they work with fathers revealed a ‘gender-blind’ service orientation where nurses do not differentiate male and female service users (Ghate, et al., 2000):

*Same way as we work with mums. (Jade, MCHN)*

*I talk to them exactly the same as I would with mums. (Jenny, MCHN)*

*It doesn’t worry me...It’s just part of the normal conversation, whether they’re there or not. (Liz, MCHN)*

Commenting that ‘I don’t know if we make them involved’, one nurse indicated that the service does not develop relationships with fathers.

*We don’t have much to do with dads except maybe asking questions around violence but that’s towards the mum about dad you see. We often talk about dad as an afterthought, you know, like as kind of a follow on conversation rather than how are you going dad? (Jo, MCHN)*

Explaining how their service orientation impacts of their work with men, Jo said:

*I think because traditionally it’s been so mother orientated it’s just been hard to shift from that and to move more towards like a contemporary kind of model for family as opposed to just the mum. So it’s just been hard to shift away from that. (Jo, MCHN)*
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This indifferent, and consequently exclusive, approach to working with fathers was confirmed by the fathers in discussions about their experiences with MCHNs. Six of the fathers reported they were excluded from the service relationship:

"Yeah, probably a little bit exclusionary, only because the nurses focus on my partner and the baby. (Luke, father)"

"I'd say it was mostly focused on the partner. (John, father)"

"The mums group, the mums walk, the mums this, the mums bloody everything and there’s no parent there. (Simon, father)"

Discussing his experience of the maternal and child health service Daniel said:

"I guess from my perspective that relationship is certainly through my wife rather than necessarily a direct relationship. (Daniel, father)"

He added that:

"I was just sort of a third party to the discussion. (Daniel, father)"

Similarly, recalling his experiences of the MCHNs, Matthew commented:

"It's been - like I said, it's been pretty lightweight. They came to the house when our daughter was born and did the weigh-in and a bit of a general chitchat and conversation...Other than that, it's really just second hand experiences that my partner has shared with me. (Matthew, father)"

Asked whom he thought Maternal and Child Services provided services for, Matthew replied mothers saying:

"I guess the name kind of alludes to that. They could call it the Parental Health Services if they wanted to form something with more inclusion. (Matthew, father)"

These descriptions of MCHN practice match Ghate and colleagues’ description of gender-blind service and reflect the underlying mother-orientation of the Maternal
and Child Health service structure. This gender-blind service orientation is evident in Maternal and Child Health policy documents. Acker (1990, p. 147) has explained that organisational logic can take material form with institutional documents containing symbolic indicators of the gender structure. A review of Victorian Maternal and Child Health policy documents confirmed participant reports of a gender-blind service orientation. One of the most striking elements impacting on father engagement in this context is the invisibility of fathers in MCHS guidelines, practice and data reporting (Department of Education and Early Childhood Development (State of Victoria), 2011, 2012, 2014b, 2014c, 2014d). Referral policies and systems filter men’s access to MCHS limiting father engagement from the outset. In Australia, as in the United Kingdom, mothers are the clients referred to early childhood services and the party with which the service develops a relationship (Department of Education and Early Childhood Development (State of Victoria), 2011; Ghate, et al., 2000). Unlike for mothers, routine data is not collected about fathers, their presence at appointments is optional and their details are not required to be recorded (Department of Education and Early Childhood Development (State of Victoria), 2011, 2014a). As others have rightly argued, these policies communicate to fathers that their involvement in childcare services and by extension the care of their children is not important (Burgess, 2009; Ferguson & Hogan, 2004; C. L. McAllister, et al., 2004).

Maternal and Child Health Services marginalise fathers

Victorian Maternal and Child Health Services’ marginalisation of fathers is evident not only in nurses’ work with fathers but also in their operational policies. Ten participants, five fathers and five MCHNS, reported that the operating hours of Maternal and Child Health Centres inhibit father engagement in the service:

*My wife goes on her own because it’s during work hours. (Ahmet, father)*

*I went to a lot of these meetings in the early - when I was on paternity leave, for example, but now it’s just not feasible for me to go because I’m working. (Scott, father)*

*I guess the problem is that I work hours that they work. (Paul, father)*
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A lot of the time they want to come but because we offer basically a 9-5 or 8-4 service it’s difficult for them to leave work and be available. (Emile, MCHN)

I think work is the biggest detriment, no detriment but that’s biggest obstacle because they can’t get time off from work. (Steph, MCHN)

These comments confirm previous research findings that service scheduling is a critical factor in father engagement (Gross, et al., 2001; Spoth, 1993). Delivering programs at times inconvenient to many fathers and working mothers covertly aims services at at-home mothers limiting the engagement of fathers (and some working women). As McAllister and colleagues (2012, p. 60) have noted:

When provision of support remains predicted on the daily availability of mothers as primary caregivers, ‘parent’ comes to mean ‘mother’ and fathers (and working mothers) remain marginal to services and interventions, as well as to their evaluation.

The Maternal and Child Health Services’ marginalisation of fathers extends to BM3 program marketing where fathers are explicitly excluded from program promotion.

While a written invitation to parents to participate in BM3 is included in the information pack given to mothers at the home visit and mothers may hear about BM3 at New Parent Group sessions, there are no direct invitations to fathers and it appears that this information is not reaching them. Twelve of the fifteen fathers had no or very little knowledge about BM3 before attending on the first night:

I had no idea. (Matthew, father)

I wasn’t sure what I was getting into. (Quan, father)

I really didn’t know. (Simon, father)

The female facilitators confirmed the fathers’ reports regarding their lack of knowledge about BM3 prior to attending:
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They just look at the wives and say ‘I don’t know why I’m here’. (female facilitator)

In my experience the first week we always ask them what’s your expectation and 90% say ‘I don’t know’. (female facilitator)

Several female facilitators reported that men were reluctant to attend and only came because of their partners:

In every group there’s been a reluctance. ‘Oh, my wife has made me come’. ‘I’m just coming because I have been told it would be good’. So that’s often a hurdle. (female facilitator)

We were told to be here. (female facilitator)

Like his female colleagues, one male facilitator commented on men’s reluctance to attend:

I observe and I see the men resistant and struggling to be there so they name that up ‘not really comfortable here’, ‘not really, just doing it for me partner’…

(Mark, male facilitator)

The dads’ discussions about their reasons for attending confirm the facilitators’ reports that father attendance is mother-driven. Six fathers indicated that their wives strongly influenced their decision to participate with one father commenting that most fathers were ‘dragged along’ by their partners. Recalling what his partner had told him about BM3, John said ‘nothing more than it was on and we were going’. Likewise, Peter said ‘my wife said she wanted to do it and I just agreed for that reason alone’ while Michael commented ‘It was basically my wife’s idea’. Matthew explained:

My primary goal is to support my partner, so I didn’t really read the fine print or even look at the material because no matter what it was I was going to go anyway. (Matthew, father)

Mirroring these fathers’ experiences (or lack thereof) of BM3 program promotion, several of the MCHNs explicitly acknowledged that they did not engage fathers in
BM3. Four of the MCHNs positioned father engagement as outside their role; ‘it’s not really in our scope of practice’. These nurses distanced BM3 father recruitment from their service referring to BM3 as ‘an outside thing’ and stressing that ‘it’s run by Whitehorse - someone else. It’s not run by us’. Steph dissociated her service from BM3 commented that ‘we certainly don’t say it’s an initiative by the MCH service’ (Steph, MCHN).

Others nurses’ discussions about BM3 promotion indicate that father engagement is not a priority. Two MCHNs cited workloads and competing demands on their time as reasons for their limited recruitment efforts:

*I suppose at my home visits and the centre visits I don’t mention it, which is probably something that I could do. It’s really only New Parent Group that reminds me to talk about it because there’s so many other things that we talk about.* (Jenny, MCHN)

Although only four nurses reported they did not engage fathers in BM3 discussions with other MCHNs about to get more fathers involved in BM3 revealed an awareness of the exclusionary nature of their current approach:

*Most of the contact - the majority of information is provided through the mothers via the mothers' group...It's the rare father that comes to the New Parent Group/mothers' group. So really haven't had the opportunity to directly engage them through the mothers' group, yeah.* (Prue, MCHN)

Five MCHNs suggested personally approaching fathers might increase attendance:

*I just think it's really important they get that invitation one-on-one, not through the mother.* (Alice, MCHN)

Discussing how they could get more fathers involved, many of the nurses suggested a personal approach either inviting the dads face-to-face or over the phone. The inclusive language used in the nurses’ explanations for suggesting a personal approach indirectly acknowledges the marginalising nature of existing MCH practice:
Because people feel special if they are approached personally. I think they feel more important [emphasis added] and its perhaps more relevant to them rather than just a poster on a wall. (Emilie, MCHN)

So chatting to the dads directly about it saying that we haven’t forgotten about you [emphasis added] kind of almost makes them feel involved. (Jo, MCHN)

I just think it’s some sort of an invitation - come in out of the cold [emphasis added], the mums have had their new parents group, your turn now. That come on in sort of an approach somehow. (female facilitator)

Similarly, two female facilitators’ descriptions of the current approach connotes the marginalisation of dads:

I think it’s how you get - you’re starting off via the women, so I think they already feel like they’re not as important [emphasis added]. (female facilitator)

Well the fathers only hear from the mother. I mean we don’t speak to them [emphasis added]. (female facilitator)

This study indicates that the ‘gender-blind’ service orientation of maternal and child health services adversely influences ‘getting’ fathers. While the nurses professed to enjoy working with fathers, they continue to deliver mother-centric service provision missing opportunities to engage fathers. Although Ghate et al. (2000) describe gender-blind service orientation as an effort to treat users equally, this study indicates MCHS staff are blind in the literal sense with fathers reporting exclusionary practices on the part of nurses. This service provision is reflective of a wider policy environment where fathers are not positioned as service users. This study indicates that Maternal and Child Health Services see fathers as optional extras rather than users in their own right.

Inaccessible setting

Contributing to the MCHS’s marginalisation of fathers is the inaccessibility of the service setting to men. Previous research has identified accessibility issues as a key factor in father engagement (Ghate, et al., 2000; Gross, et al., 2001; Soriano, et al.,
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2008; Spoth, 1993). It appears that one consequence of the gender blind service culture discussed above is the development of feminised environments which men perceive as psychologically inaccessible (Ghate, et al., 2000; Weeks, 2004). Participant responses indicate that Maternal and Child Health Centres are psychologically inaccessible to fathers who perceive them as catering for women (and children):

My perception is that they might think it's just a mother and baby service. (Laura, MCHN)

If you don't explain to dads what we're about, and then they feel like it's not a place that they're wanted...I think if you don't engage the dads from the very beginning then they just don't come along at all. You find the dads that are at that home visit are the ones that will tend to keep coming back. It's the ones that aren't at that home visit that are harder to engage because I think they look at the name Maternal and Child Health and they say that's for mum and baby. It's not for the dad. (Carolyn, MCHN)

Well, I think a lot of them just feel that it's not a place for them and that's something that mum does. (Jenny, MCHN)

Well I think some fathers certainly feel like they've been left out, that they're not welcome to come. (Susan, MCHN)

Like these nurses, one third of the fathers interviewed think men see MCHS as a service for women:

I think some of them might look at it as it's a ladies thing. (Arjun, father)

Oh look I think some of them probably just sort of see it as a, only relevant to the mothers. (Daniel, father)

I think it's probably seen as something for mothers and babies, not really involving the fathers. (John, father)

As discussed in the literature review psychological accessibility extends to the naming of services, recognising that attendance may be inhibited by association with stigmatised services, such as domestic violence services (Weeks, 2004). Aligning with
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this research evidence, BM3 is marketed as a healthy relationships program rather than a domestic violence primary prevention program (Whitehorse Community Health Services, 2014). Despite this effort to avoid stigmatisation, it appears that housing the program within an organisation badged for women and children adversely influences father engagement. Seven of the nurses identified the name of their service as barrier to father access:

*It’s a shocking name, a shocking name for our role...I think if we could change our title that would help...it’s changing that perception that it is just all about the mother and the women.* (Susan, MCHN)

*I think a lot of them perceive it as it's more linked in with mum because of maybe the wording. We're maternal and child health and when they break it down there isn't - the dads not in it...I think a lot of them feel as if it's about the mum and the baby as opposed to the family.* (Jo, MCHN)

*I think the name’s a bit unfortunate really. When I worked in Queensland we were called Family Health Centres and I think that’s a more appropriate name. Yeah I mean I know that the health of the mother, the maternal health, is very important but we probably need to be family focused and I think our name should be more family focused.* (Michelle, MCHN)

*I'm from New South Wales so we didn’t have Maternal and Child Health in New South Wales so I know a lot of people hang onto that word maternal.* (Jade, MCHN)

Similarly, many female facilitators and one male facilitator believe that the service environment inhibits father engagement:

*There's no mention of dads - it's the maternal and child health. They can feel a bit excluded I think.* (female facilitator)

*It’s a space that again the women are familiar with and comfortable in.* (female facilitator)

*It's not maternal and child health - I did family and child health. I didn’t do maternal and child health as an education and it has to be inviting from the word go if it’s going to be run from the maternal and child health.* (female
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facilitator/MCHN)

*I think language is very important...you know don't underestimate it so ‘child maternal health’ there's no father in that.* (Mark, male facilitator)

Echoing these reports, several nurses and a female facilitator suggested the program should be held in more welcoming environment for men. Three of the nurses noted men’s unfamiliarity with the Maternal and Child Health environment suggesting settings more commonly frequented by men would be more appropriate:

*I mean if you tried to approach them in their sport or where they gather.* (Jade, MCHN)

*Perhaps if one of the nights was held in an environment like that, like a sporting environment or the pub or something’s that's a bit more social and a bit more what men are used to...approaching it to be in their general environment as opposed to that fear of going to that community centre that's all a bit weird.* (Jenny, MCHN)

*If they can be holding something that's in where they usually hang out that's more of a social situation as opposed to going to that community type thing that is unknown, a bit strange to them.* (Jenny, MCHN)

*Somewhere where they're more comfortable rather than a place that's identified mainly as mothers and children.* (Kate, MCHN)

One female facilitator echoed these nurses’ sentiments:

*I really do wonder about venue...Well the area that I'm in I think some of the men will be far more comfortable if it was at the footy oval.* (female facilitator)

In terms of alternative settings, four MCHNs suggested sport settings, two said workplaces (plus one female facilitator) and one suggested pubs. One MCHN suggested men in more regional areas lack homosocial support. Jade said:

*I don’t know that they gather a lot, the men in the valley.* (Jade, MCHN)

She added that:
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*I mean there's only a certain amount of participants in the footy clubs but a lot of the other men seem to be quite isolated really.* (Jade, MCHN)

Jade’s comments highlight the diversity among fathers suggesting that approaches need to be population specific. Similarly, Emilie indicated that the existing strategy is only reaching fathers who prescribe to ‘new’ or ‘involved’ fatherhood narratives and alternative strategies are needed to reach men who hold different paternal masculinities:

*I think sometimes the people that we're educating [are] those that are highly motivated and maybe if we could get the message through a different forum that would be really useful.* (Emilie, MCHN)

In contrast to these reports, two MCHNs believe their service has become father inclusive and provides a welcoming setting for men:

*I think it is much more acceptable for men to come to the centre now and we've tried to make the centres more men friendly so like we have more car magazines and things in the waiting room rather than Women's Weeklies and we welcome the men to come.* (Emilie, MCHN)

*I think now we are far more inclusive of fathers and we present it more as a family thing. We don't hone in on mum especially other than from a health perspective because they've just had a baby. So I think the environment is inviting and we are inviting to fathers.* (Prue, MCHN).

One father interviewed confirmed these nurses’ views:

*I thought it would be for the family as well. I thought it'd be for the mum and dad to go with the baby. Then when I got there I saw some of the pamphlets on the walls for the - they were advertising like a Chinese dads group so I thought - I knew - they had photos of the dads with the kids so I knew it was pretty family oriented as soon as I walked in. I was expecting it to be like that.* (Michael, father)

With the exception of these three participants, it appears that fathers perceive Maternal and Child Health centres as feminised environments (Ghate, et al., 2000).
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The nurses’ and female facilitators’ comments indicate that the name of the service acts as a psychological barrier to father engagement. Although embedded in a mainstream service, the Maternal and Child Health setting is not perceived by fathers as a welcoming ‘neutral doorway’ (Weeks, 2004).

An experiment in organisational change

Aligned with the nurses’ suggestions about creating a more inclusive environment for fathers, Carrington Health piloted a variety of recruitment methods to increase father engagement. One pilot site ran Family Nights as part of their New Parent Groups (NPG) where one of the sessions was held during the evening and mothers attended along with their partners and babies. The Family Nights were co-facilitated by the MCHN running the daytime NPG sessions and the male facilitator taking the BM3 sessions. One of the male facilitators who participated in the focus group had facilitated Family Nights as a lead in to BM3. Describing Family Nights as a ‘deliberate strategy’ to put a face to the program Steven explains he uses these sessions to gauge the parents’ responsiveness to the program material and tailor his approach to the BM3 program properly:

*I love it because I get a chance to meet these people before the program starts both you know both mums and dads so when they arrive on night one I have a little bit of an understanding of who they are and their experiences and the themes that we talk about at the Parent Night [Family Night] are very much what Baby Makes 3 covers and then we go into more detail so it’s sort of a nice little entry point as well so I can sense how they react or respond to what’s being presented. (Steven, male facilitator)*

While none of the female facilitators had firsthand experience of Family Nights, many of them felt the sessions make ‘a huge difference’ in ‘getting’ fathers because they familiarise the fathers with one another and the male facilitator prior to the program:

*I think that's makes a big difference because they're all meeting, they all know him. They don't know me at all. That's okay. He is the one that's the first point of call as well. I think that makes a huge difference. (female Facilitator)*

*Then when we start Baby Makes 3 it goes a lot better because they've had that*
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little conversation beforehand. So the men I feel start off a lot more comfortable. (female Facilitator)

It's them gelling. (female Facilitator)

It de-mystifies it. (female Facilitator)

Likewise, Emilie, a MCHN who has co-facilitated Family Nights with the male BM3 facilitators believes Family Nights promote father engagement by building relationships among fathers prior to the first session. She commented:

Well they are happier too, because they've met the other dads in the group and they've met the facilitator and so they, they have developed a level of confidence and trust I think in the other people in the group and so that they can see the value in it. It's not so scary if they have already met everybody um at least once. (Emilie, MCHN)

Although the two staff with firsthand experience as well as many of the female facilitators believe Family Nights play an important role in recruiting fathers, the one father who attended a Family Night indicated it had minimal impact on his engagement. Discussing the experience Paul said ‘I can’t I actually can't really remember what happened’. In terms of using Family Nights as a recruitment mechanism for BM3, Paul said the male facilitator ‘briefly mentioned it’.

Another two sites introduced phone calls to fathers in an attempt to increase numbers. The two male facilitators who made these calls had divergent views on their impact on fathers. Mark reported that he uses the phone calls to convey to the dads that ‘It's safe for him to come. Its inclusive for him, it's actually made for him to come’. Jason reported he felt resistance from fathers when calling to invite them to BM3 with the fathers’ responses to the phone calls indicating that they too see this area as ‘women’s business’.

This particular program just gone I made some calls and I found it quite difficult. Like I say I'm trying to mirror and match what was on the end of the phone but there was this real resistance...they would say ‘oh I'll go get my wife’ and I'll say ‘no that's okay I can give you all the details' it was all, a couple of them
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defaulted to just 'I’m going to get my wife, she knows all about it’. ‘No, no nah I need to talk to you'. [laughter] So there is this real reluctance and often they do come to the program you know what is this about, my wife wants me here. (Jason, male facilitator)

The fathers’ reluctance to take Jason’s calls is an example of them acting out their gender. Jason’s comments confirm participants’ reports that many fathers still see caregiving as women’s work and suggest that fathers may be reluctant to accept invitations to participate in women’s domain. His experience and those of the other facilitators underscore Risman’s (2004) emphasis on the interrelatedness of gender phenomena across the three dimensions. These two discrete recruitment practices occurred within a wider institutional setting that is highly mother-centric and were aimed at men who largely perceive caregiving as women’s work. The men’s perceptions of fatherhood and parental responsibility reverberate at the level of cultural expectations guiding their responses to their interactions with BM3 facilitators. Given these conditions the reported ineffectiveness of these recruitment processes is less surprising. The facilitators’ experiences demonstrate that conditions at all three dimensions influence strategies that seek to engage men as fathers in MCHS settings. As Risman (2004) argues gendered institutions depend on our willingness to ‘do’ gender. It seems that father engagement within the Maternal and Child Health Service is partly shaped by how individual men see themselves as fathers as well by men and women doing gender. Like the home where the causal processes that constrain men and women to do gender are strong, the causal processes that constrain men and women to do gender in the Maternal and Child Health setting appear equally powerful (Risman, 2004).

SUMMARY – GENDERED INSTITUTIONS

This study indicates that MCHS are gendered sites, they reflect, shape and maintain wider social attitudes towards parenting roles and responsibilities. It appears that the gender-blind service orientation of the Maternal and Child Health Service reinforces a gendered division of labour that marginalises men from caregiving roles and sustains cultural expectations that women take primary responsibility for childcare. At the institutional level, the ‘feminised’ environment in which the BM3 program takes places
discourages father engagement (Ghate, et al., 2000). The exclusionary environment of the service setting is reinforced by an all female staff that is not trained to include fathers in their practice. It is likely that father engagement would be improved if engaging fathers was integrated into service provision with staff building relationships with fathers in the same way as they currently do with mothers (Ghate, et al., 2000; C. L. McAllister, et al., 2004; F. McAllister, et al., 2012; Panter-Brick, et al., 2014).

PERSISTENT GENDERED DIVISION OF LABOUR

Reports about fathers’ financial responsibilities inhibiting their engagement are associated with ideological discourses and economic structures at the institutional level. The gendered organisation of the Maternal and Child Health Service exemplifies and amplifies the impact of other social institutions reinforcing the father as provider model. Previous research has shown that economic structures, particularly social benefits, parental leave and the gender wage gap, inhibit father engagement in caregiving and related services by reinforcing traditional divisions of labour between mothers and fathers (Bailey, 2015; Burgess, 2009; Coltrane, 1996; Dribe & Stanfors, 2009; Fletcher, et al., 2014; Kan, et al., 2011; C. L. McAllister, et al., 2004; Sullivan, 2013). Zuo (2004) and others suggest that structural constraints are particularly powerful during the transition to parenthood and inhibit men’s enactment of egalitarian fathering ideologies (Davis & Greenstein, 2009).

At the institutional level, economic structures that support male breadwinner models of fatherhood are connected to traditional gender ideologies that construct masculinity and femininity as binary opposites and define family work as ‘feminine’ (Höfner, et al., 2011; Kan, et al., 2011; Sullivan, 2013). As Höfner and colleagues explain these binary constructions lead to a division of labour that marginalises men from care giving activities:

The division of human beings in binary categories of women and men, masculinity and femininity, becomes connected with other sets of binary ascriptions such as rational/emotional, strong/weak or culture/nature. A consequence of such binary coding is a certain division of labour that forces
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men into breadwinning practices and marginalizes them from family life, while at once forcing women into caregiving practices and marginalizing them from working life and careers (2011, p. 673).

It seems that hegemonic discourses on parenting in which fathers are breadwinners and mothers are nurturers are so pervasive that even where parental leave is available to fathers, use is limited (Brandth & Kvande, 1998, 2002; Haas & Hwang, 1995; Mazzucchelli & Rossi, 2015). Norway is considered a progressive country in terms of gender equitable work-family policies moving from a four-week continuous leave period for fathers in 1993 to the current 10 week flexible quota (Brandth & Kvande, 2015). Norway provides a total of 49 weeks parental leave with a 10 week non-transferable quota allocated to both mothers and fathers with mothers receiving an additional three weeks before birth and the remaining 26 weeks shared between parents (Brandth & Kvande, 2015). The fathers’ 10 week quota can be taken on a full-time, part-time or combined basis and as a continuous period or periodically until the child is three years of age (Brandth & Kvande, 2015). While most eligible fathers take part or all of their 10 week quota, the potency of traditional work-family discourses is evident in the mothers taking the majority of the 26 weeks shared leave (Brandth & Kvande, 2015). A similar story is told in Australia where in comparison with mothers, Australian fathers are far less likely to use unpaid leave and take shorter periods of leave following the birth of a child with 70% of fathers who take leave returning to work within two weeks (Australian Bureau of Statistics, 2013i; Jennifer Baxter, 2013).

The participants’ views confirm previous research that traditional gender ideologies continue to shape public policies and economic structures (Caroline J Gatrell & Cooper, 2008; Höfner, et al., 2011; Kan, et al., 2011; Sullivan, 2013). These structures intersect with social practices to sustain childcare models where mothers are the primary care givers and users of family services.
CONCLUSION – ‘GETTING’ FATHERS

This study has produced a number of significant findings about the powerful role of gender phenomena in shaping the identity and behaviours of new fathers and the impact of these on their recruitment into respectful relationships programs, such as BM3. These findings are generally consistent with other studies on factors impacting men’s involvement with their children and family support services (Ghate, et al., 2000; Marsiglio & Cohan, 2000). However this is the first study looking at the impact of gender phenomena on service providers’ engagement of new fathers in a program such as BM3 and as such provides new insights into ‘getting’ fathers. These findings are summarised with reference to Risman’s levels.

At the individual level the responses of the father participants demonstrated that their engagement with BM3 depended on the importance of their identity as fathers, their perceptions of caregiving as father’s or mother’s work and the relative value they placed on caregiving. Consistent with Habib and Lancaster’s (2012; 2006) paternal role identity theory, for the BM3 fathers, men’s father status content or how men see fathering influences their father engagement. When it comes to ‘getting’ fathers this study shows that men who associate fathering with caregiving are more likely to engage in respectful relationships programs than those who primarily see the father role as financial provider and caregiving predominantly as women’s work. Extending identities theorists’ work on fatherhood, how men see fathering affects not only their involvement with their children but also their involvement in care related activities, such as respectful relationships programs.

At the interactional level this study confirms previous findings that interactional expectations shape paternal identities and behaviours. This study found that traditional parenting discourses are often reinforced through interactions with partners with mothers pushing men towards traditional divisions of labour thereby shaping men’s parenting behaviours and their access to the MCHS including the BM3 program. The pull of cultural expectations was not all one way with fathers ‘doing’ gender by resisting recruitment phone calls and family nights.
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Considering the significance of institutional level factors on BM3 fathers, it is clear that men’s responses to respectful relationships programs offered from MCHS are significantly affected by feminised service environments and their experiences of exclusionary service delivery. The MCHS practices and service orientation together with economic structures that support a gendered division of labour marginalise men from family life deterring their participation in BM3.

This chapter identifies a number of complex, interwoven gender phenomena that influence getting fathers to attend respectful relationships programs in the first instance. The following discussion in Chapter Six explores how gender impacts on ‘keeping’ and ‘engaging’ new fathers in respectful relationships programs across the three dimensions of Risman’s model.
CHAPTER 6: ‘KEEPING’ AND ‘ENGAGING’ FATHERS

This chapter outlines how gender impacts on the final two phases of the engagement process: ‘keeping’ and ‘engaging’ fathers (See discussion in Chapter Two). Analysis of the interviews and focus groups with fathers, facilitators and nurses revealed that certain aspects of program delivery were essential to ‘keeping’ and ‘engaging’ fathers in this sample. In particular discussions about how to engage fathers showed that the gender of both facilitators and fellow participants influence father engagement.

Participant responses indicate that ideological discourses on gender and the accompanying interactional expectations significantly shape fathers’ engagement experiences. It appears that hegemonic masculinities, particularly the promotion of homosocial relationships, shape men’s interaction in group-based programs. Responses to questions about how to engage fathers highlight the interconnectivity between the three dimensions of the gender structure: individual, interactional and institutional. Accordingly, this discussion explores how gender impacts on ‘keeping’ and ‘engaging’ fathers reporting on the three dimensions collectively rather than separately under each level.

The gender phenomena identified as impacting on ‘keeping’ and ‘engaging’ fathers are presented as five thematic categories: the importance of a male perspective, male facilitators as fathers – relevant life experience, homosociality and group programs, gender biases in professional practice and misrepresentation.

THE IMPORTANCE OF A MALE PERSPECTIVE

Several of the fathers mentioned the importance of having a male perspective in terms of their ability to relate to the facilitator. Peter felt the male facilitator promoted father engagement because men have the same frame of reference:

You weren’t trying to describe something to - if it had been two women, for example, it wouldn’t be trying to describe to three or four blokes, however
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many were there in the couples breakaway session, to describe the way men think about things to a woman. You’re kind of starting at a disadvantage, and vice versa. (Peter, father)

He further explained that fathers are often neglected during the transition to parenthood and said it is crucial to provide a male perspective because they speak the same language:

Whenever we talked about a subject everyone went, yeah, yeah, that’s right, yeah. There was that shared view, shared vision, shared experience type of thing. The things that were being put forward were looking very much from the male perspective, and the whole parenting, it’s quite often - certainly pregnancy and birth, it’s all about Mum, and Dad just fills the support role...So having the guys there to talk through that in language and feelings that you would expect, or I expect because that’s what I’m experiencing, was reassuring. Having a guy there to talk to just means that there's no misconstruing of what you’re saying, no argument about whether the terminology’s right. It just goes through them straight away without any of those issues. (Peter, father)

Matthew suggested the program content resonated with the fathers because of the male messenger:

The facilitator made comments where I was like, yeah, absolutely, I agree with that. But I think it was things that potentially he may have only been able to talk about, but he was talking about - he shared an example of a story whereby you’re in a shopping centre and you see a mother with some unruly kids and kind of your first thought is that mother should have those kids under control. But if you saw a dad in the same situation, you’d be like, what a good bloke, he’s out there trying to give it a go. For me, that example and that story really resonated. I think if it was delivered potentially by a female facilitator, I may not have even gotten the point. (Matthew, father)

Echoing Peter, MCHN Susan, also considered a male perspective important to counterbalance the mother-oriented focus of this transition. Explaining why the men respond well to the presence of male facilitator, Susan commented:

I think because they would feel - I mean I’m guessing a bit but perhaps they feel that a lot of hospital antenatal classes are all orientated to the mother, to
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labour, to giving birth...Perhaps they think that everything is - it's always from a female's perspective and that they're not getting a man's perspective on what it's like to be a parent. (Susan, MCHN)

Similarly, three of the MCHNs indicated that having male facilitators promotes father engagement because they see the world from the same perspective. Explaining the impact of the male BM3 facilitator co-leading the Family Nights that run as a lead in to BM3 in her LGA, Emilie commented that:

**Emilie:** I think it is better if, if a man can facilitate that group because it’s more of a bloke's business and I know that yeah I think there is just that more of a more what’s the word...not necessarily respect but probably greater understanding when it comes from a men's point of view. (Emilie, MCHN)

**Interviewer:** And why do you think that is?

**Emilie:** You ask all the hard questions (collective laugh) Why is that, I don’t know I think they are just a bit more comfortable talking to a man because they feel like they understand what it is like from their point of view a bit more.

Two nurses stated that the presence of male facilitators outwardly signals to fathers that the program caters for men. Emilie said:

**I think it is a big advantage in having the male leader there, because they know he can talk the talk...I just think it adds a bit more credibility to the program if you have a male leader. (Emilie, MCHN)**

Likewise, Susan believes the presence of a male facilitator promotes father attendance:

**I think the big encouragement is that you've got a male facilitator there for the men as well, that they're going to be catered to. (Susan, MCHN)**

Discussing the format in which programs should be delivered to fathers, Susan mentioned that:

**I do think it's good to take them separately to talk about - with the dads on
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their own about what’s different for them because certainly it’s different for them and it’s different for the women. So I think it is good to have a male do some of that debriefing with them. (Susan, MCHN)

In addition to this shared language, the fathers identified men being more comfortable with other men as a reason why fathers prefer male facilitators:

I think people would probably say they felt more comfortable speaking to a dude about dude things and the ladies probably felt more comfortable speaking to ladies about lady things. So I think that was probably well thought out. (Matthew, father)

I felt more comfortable when it was just with the dads. (Michael, father)

For us guys it was a bit easier to talk to him when we had the men only periods of time. (John, father)

Probably it’s a bit biased, but I did feel that having a male facilitator provided better - or helped me open up my train of thought better. (Quan, father)

Reflecting on his involvement in BM3, Michael explained he only engaged during the father breakout sessions:

Like we went into the room, just the dads and I got involved in that part but then when we came back as a whole group with the mums I pretty much didn’t say anything and I didn’t really get involved. I just felt more comfortable just with the dads. (Michael, father)

‘WHEN YOU GET MEN JUST WITH MEN THEY GO THERE’

Aligning with the fathers’ feelings of ease in the men only groups, several of the male facilitators also reported that fathers are reluctant to speak in the wider mixed-gender groups and only engaged in open discussions in the fathers’ group work. Discussing whether working with men differs from working with women, Mark commented on men’s reluctance to engage in mixed-gender group work explaining that single-gender group work provides a ‘safe space’ for dads. He said:

Of course it is, it’s a different context, it’s a whole different role is being played
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out. When you get men just with men they go there, to whatever ‘there’ is they can go there... So it gives that safe space to actually speak. (Mark, male facilitator)

Two other male facilitators attributed the dads’ aversion to participating in mixed-gender group work to concerns about their partners’ responses leading male facilitators to ‘water down’ their reports of the fathers’ discussions when sharing in the mixed-group work:

Yeah well the dads often will have a bit of some quite legitimate gripes from their side of things about [how] difficult things have been and I try and encourage them to sort of really bring that back into the room when the females come back but there is a lot of reluctance there at times to really sort of extend that conversation into that space whereas the females are much better at coming back and putting the difficult things out there and yeah I just find that difficult with the dads. (Jason, male facilitator)

I did a group two weeks ago and it was the first group where the men were happy for me to say, for it to be put up there that their partners don’t trust them with the children in terms of they tell them that its their time but they supervise it. So the dads in the previous groups were saying ‘oh you can’t put that up, you don’t put that up there, I’m dead if you put that up there’. (David, male facilitator)

One nurse sees men’s reluctance to engage in mixed-gender group work as a self-protection measure claiming that men feel less vulnerable among other men:

I actually think that they would work better how you do it now of separating them because dads are going to talk more openly with other dads and mums the same...It’s always very interesting to see, especially when you’re talking about your own health and protection, what you do to protect yourself. (Carolyn, MCHN)

Like the facilitators and nurses, the fathers’ experiences indicate that all-male group work facilitates ‘engaging’ dads. Many of the fathers reported they actively participated in the father breakout groups:

We were fortunate I suppose to have a relatively small group so you could be
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fairly open and honest and have a lot of time that you could talk to elaborate on what you were thinking and the people in our group were quite open in that regard. (Craig, father)

Two of the dads mentioned that men engaged in frank discussions when their partners were not present. Describing his experience of the father group work, Luke responded:

Really good, because the blokes would open up when the ladies weren’t around, so that was really good. Interesting to hear them saying things that they probably wouldn’t say in front of their partners. That was a really good thing. It was a bit like a blokes’ chat, which was really good. It let some of the guys that were perhaps a bit too timid to speak in front of everyone just say a few words, so that was good. (Luke, father)

Likewise, Michael said:

I thought that was a good idea because you can pretty much just say whatever you like because mums aren’t there to listen in. Not that we were saying anything bad. (Michael, father)

These comments suggest that mixed-gender settings foster emotional repression among some fathers inhibiting their engagement. It seems that father-only group work provides a private and safe environment that facilitates ‘engaging’ fathers.

Overall, it appears that having male-directed programs delivered by men fosters father engagement. The participants’ reports about the importance of having a male perspective aligns with research by Piccigallo, Lilley and Miller (2012) based on interviews with twenty-five male college students who are active members of all-male rape prevention groups from eleven campuses located on the East Coast of the United States. They found that men are most receptive to receiving violence prevention messages from other men identifying a number of reasons for this including: men are more comfortable being open with other men, the novelty of the message/messenger combination, messages being perceived as less accusatory when delivered by other men and men being more receptive to messages from male presenters due to male privilege (Piccigallo, et al., 2012).
There is limited evidence regarding whether mixed- or single-gender programs are more effective at preventing intimate partner violence but overall research indicates that single-gender programs are more effective for men (L. A. Anderson & Whitson, 2005; Berkowitz, 1994, 2002; Brecklin & Forde, 2001; Piccigallo, et al., 2012; Rozee & Koss, 2001; Vladutiu, Martin, & Macy, 2011). However, this evidence is based on evaluations of rape rather than intimate partner violence prevention programs and researchers have called for further investigation acknowledging that findings may vary or in fact be determined by the type and content of interventions rather than the gender of participants (L. A. Anderson & Whitson, 2005; Brecklin & Forde, 2001; Flood, 2015; Vladutiu, et al., 2011).

While the relationship between gender and program outcomes is unclear, there is stronger evidence regarding the role of gender in participant engagement (Berkowitz, 1994; Berkowitz, Burkhart, & Bourg, 1994; Piccigallo, et al., 2012; Ring & Kilmartin, 1992; Rozee & Koss, 2001). Aligning with participant reports in this current study, previous sexual assault prevention research indicates that men are more willing to participate and talk more openly and honestly in single-gender programs (Berkowitz, 1994, 2002; Lonsway, 1996; Piccigallo, et al., 2012; Ring & Kilmartin, 1992; Rozee & Koss, 2001). Furthermore, some research suggests that men may experience mixed-gender settings as threatening and accusatory (Berkowitz, 1994; Brecklin & Forde, 2001; Piccigallo, et al., 2012; Ring & Kilmartin, 1992).

The men’s responses indicate that the fathers feel a sense of unity and trust when working with other fathers that does not extend to mixed-gender group work. It appears that fathers’ group work provides a non-judgemental environment where men can talk openly about their experiences. Their mutual experience of the transition to fatherhood creates empathy and acceptance enabling active engagement with the program content. The fathers’ and facilitators’ comments suggest while mixed-gender group work may not deter father attendance, single-gender group work is a key to actively engaging fathers in the BM3 program.
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MALE FACILITATORS AS FATHERS - RELEVANT LIFE EXPERIENCE

While the presence of a male facilitator may ‘get’ fathers in the first instance, it appears that ‘keeping’ and ‘engaging’ fathers is dependent on the credibility of male facilitators in the eyes of the fathers. It seems that the shared experience of fatherhood with male facilitators gave father participants a feeling of being understood. While the five male facilitators who participated in this study are fathers, it is not a job requirement and not all BM3 male facilitators are fathers. Nevertheless, 10 of the fathers interviewed identified the facilitators’ experiences as fathers as enabling father engagement. The fathers described many benefits flowing from the male facilitators’ relevant life experience such as giving the facilitators credibility, authenticity, empathy and trustworthiness.

The participants’ acknowledgement of the facilitators’ credibility and authenticity as leaders and fathers was critical to engaging the new fathers in the group work:

*I found them - because we were in the fathers group, I found David brought a lot of experience with him. David, being a father himself of course, going back a number of years as a new father, he still remembered a lot of the challenges he faced and he helped us along by dropping hints on that, saying ‘these are the changes that I faced, these are the changes that I’ve heard other fathers faced when I’ve run the program at other places or while doing other programs. What do you think and how is your take on it?’ Some of the changes applied to us and others didn’t apply to us. (Arjun, father)*

*I think certainly for the first two sessions, where you do break up into the separate groups. I think having a father talking to us from his experiences, I think certainly helped. I found that quite useful, quite helpful. (Christopher, father)*

*The guys that were presenting it were really good, particularly the guy, James, who was running it. He was really good and really engaging. He was a new dad as well, so there was that angle to it. That was really good. (Luke, father)*

*Yeah because you’ve gone through similar stuff as well. The guy would say how has your life changed in the last three months and we made a list of all the*
changes and he said he’s gone through all this as well. It’s just helpful because he’s already experienced it and he can give advice because he’s gone through it. So yeah, I would think it’s pretty important to have a dad lead the group. (Michael, father)

I thought it was good for - it was a male person that ran the class, it was good to be around other men that have kids. Those that have kids already and are coming from a professional point of view. (Simon, father)

‘I FEEL THAT HE UNDERSTANDS’

Like the other fathers, Quan considered that the shared experience of fatherhood among male participants and the male facilitator created a social context in which the facilitators and new fathers could mutually empathise with each others’ experience of fathering and this strengthened the male participants engagement in the program. Discussing his experience with the male facilitator, Quan commented:

The gentleman, his name is David, but he uses his own experience and the things that he’s been through to give us ideas of the feelings that all the fathers will have. It does help; I feel that he understands the fathers. (Quan, father)

Quan explains that this mutuality created a supportive environment promoting father involvement in group discussion:

We actually open up quite quickly to share our side of the story, really, so I think that it helps, yes. (Quan, father)

Reflecting on the impact that the male facilitator’s experience of fatherhood had on his engagement, Craig highlighted the importance of relevant life experience when seeking to engage fathers. He commented:

It was quite good because knowing that he’d been through it and he was just trying to share some of his experiences. He was giving us information not trying to say that you should do it a certain way but talking about his experiences so then you can take out of it what you need to from him. So he’d tell - I suppose stories or events or whatever had transpired for him so that made it quite good in that regard. You could sort of relate to those stories and having that time where you could talk to other fathers as well about what they’re going through
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was quite good. (Craig, father)

Explaining why he enjoyed the father only group work, Matthew identified the shared experience of fatherhood as a unifying factor. He said:

I think it's one of sort of safety or perceived - it's kind of by association. You expect someone understands what you're talking about when they, you feel, understands who you are and what you are about...I don't think it's something that I've really sat down and thought about, like, I want to go and meet with other dads and talk to other dads because I feel that they're the only ones qualified. I think it's a very natural thing that you have one of each. When you broke up into groups it could have potentially been a bit contrived or maybe seemed condescending if you had a female, who may have gone through the birth process and had very strong feelings in her own mind about how things should be, as opposed to a father, who you could largely say is of a similar age, in a similar demographic, has had children and probably lived through some of the things that you've experienced. I think it just goes to personal experience more than anything. (Matthew, father)

Aligning with these reports, male facilitator Steven reflected that his father status establishes a connection with the fathers strengthening their engagement in the first instance:

I think that understanding is so important in that moment so that they feel that you understand their experience a bit will help and you can relate in that way. I think being able to relate to other men or couples in general and in that...yeah it goes a real long way in how the group develops I suppose just being able to be genuine is really, really important and that's what I think they're looking for is someone that's, that they can sit there and relate to and go this person understands where I'm coming from or understands the pressures a little bit. (Steven, male facilitator)

Facilitator, Mark, sees fatherhood as a rite of passage using it as an entry point to engage men by creating a sense of shared identity. He observed:

You know, this stuff about being fathers or dads I think that comes into that rite of passage. You know there are very few rites of passages that we have in when Western culture: fatherhood, parenthood, motherhood. They're benchmarks... so when you meet other men we can come from different varied worlds but we
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have this commonality that you’re naming up, if we name that, like if we go right we’re all dads here, we’re not just all men and I like that language, that we take away the man and we start calling it dads. It evokes a lot of good stuff to start digging into yeah... (Mark, male facilitator)

It seems very clear from the father participant and facilitator perspectives that being a father enhances a male facilitator’s ability to engage with fathers.

‘I THINK IT DOES MAKE IT – WHAT HE SAYS A BIT MORE TRUSTWORTHY’

Two of the fathers drew a connection between engagement and trust explaining that their male facilitators’ life experience as fathers established them as trusted information sources:

I think it does make it - what he says a bit more trustworthy, knowing that he has been there and gone through it. (John, father).

I don’t think many people would trust implicitly the word of someone unless they knew that they had some kind of experience in the subject matter...Like, if I’d have rocked up and the facilitator was 18 and never had children, I’d probably be like, what the heck’s going on here. (Matthew, father).

The male facilitators interviewed also attributed many benefits to their experience of fatherhood. Like John and Matthew, many of the male facilitators indicated that the trustworthiness of facilitators is a significant factor in father engagement. They feel their shared identity with the male participants as fathers helps them to connect and build trust with the dads. Jason explained that his real life experience of fatherhood helps him understand what the dads bring to the table, commenting that:

I’ve often thought that I think it certainly enriches the way that we facilitate and the way that we understand what parents bring to the program. So yeah I think its definitely possible to do it without being a parent but I would say it’s a much better experience if you have an understanding yourself and have been through what you are kind of talking about. (Jason, male facilitator)

Jason believes connecting the program content to his experiences as a father enhances his facilitation. He said:
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It’s quite a prescriptive content that we’re actually delivering and I think part of what enriches it is that as a dad I can bring my own experience and connect in that way. Otherwise I’d, like I said if I was facilitating from the unknown using that script I often wonder what it would come across as, forced or yeah not connected. (Jason, male facilitator)

Similarly, another facilitator, Mark explained that authenticity is essential when engaging men as fathers:

I just think if you are going to be congruent, if you've got, already had an experience of fatherhood then you can speak from the truth whereas if you are speaking from the unknown, all you can do is speak from the unknown and it doesn't weigh as much with men. (Mark, male facilitator)

He further remarked:

If you've lived the experience men'll, men'll be engaged with that...But if you're talking just theoretically from a distance it doesn't come across the same. (Mark, male facilitator)

‘IT DOES GIVE YOU A LITTLE BIT MORE KUDOS’

Both David and Ben believe their status as fathers legitimates their authority in the eyes of the fathers. Discussing the impact his father status has on father engagement, Ben commented:

I certainly think that it does give you a little bit more kudos I think in the night, on, during the group. I think the dads in attendance kind of they look at you a little bit sort of differently or view you as a peer I guess in that respect yeah. (Ben, male facilitator)

In a similar vein, David claimed that his status as a father is key to gaining credibility and engaging fathers in the BM3 program:

I don't think I'd actually put my hand up for a role like this unless I was a parent so and I, I don’t think I'd have the confidence to deliver it in the way I think it's intended ...so I think it actually helps me... it gives you some kind of entry point or some kind of credibility with them and their actually looking for that because
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*I think when they come on the first night, you know, a big percentage of those guys don't actually want to be there. Yeah so once they can, once they see a commonality with the facilitator which is different to the participants I think that helps with retention perhaps, well I believe anyway. (David, male facilitator)*

The experiences and perceptions of the fathers and male facilitators reveal that the relevant life experiences of the facilitators as fathers gives credibility to the male facilitators and the program in the eyes of the fathers. The male facilitators’ father status establishes a peer relationship among the men in the group and is an essential first step to building trust with the father participants (Piccigallo, et al., 2012). There is conflicting evidence regarding the effectiveness of peer versus professional facilitators (L. A. Anderson & Whitson, 2005; Hines & Palm Reed, 2015; Piccigallo, et al., 2012; Vladutiu, et al., 2011). In a meta-analysis of sixty-nine college sexual assault prevention programs Andersen and Whiston found that professional facilitators were more successful at changing rape-related attitudes and behavioural intentions than peer educators (2005). In contrast Piccigallo et al. contend that the effectiveness of different types of facilitators varies depending on the intervention aims arguing that professional facilitators are more effective at transferring information while peer facilitators are more effective at transferring norms, values and attitudes (Piccigallo, et al., 2012). Rather than the type of facilitator, Lonsway suggests particular facilitator characteristics are associated with program effectiveness including their ‘perceived expertise, trustworthiness, status, likability, and attractiveness’ (Lonsway, 1996, p. 255). It is no doubt a strength of the BM3 program that the male facilitators were both professional facilitators and fathers, the latter status situating them as peers cementing their trustworthiness and promoting father engagement.

**HOMOSOCIALITY AND GROUP PROGRAMS**

At the interactional level, several researchers have explored the influence of gender ideologies on men’s constructions of masculinity in their relations with other men with Kimmel claiming that ‘masculinity is largely a homosocial enactment’ (Arxer, 2011; Hammarén & Johansson, 2014; Kimmel, 1996, p. 7). Aligning with this body of work,
the female facilitators were notably absent from the fathers’ accounts of their engagement experiences. While the male facilitators featured heavily in fathers’ reports of engaging aspects of BM3, usually warmly referred to by name, if and when the female facilitators were mentioned in father interviews they were referred to as ‘the lady’. The fathers’ focus on their interactions with male facilitators and preference for all-male environments is reflective of hegemonic masculinity and its emphasis on homosocial investments (Bird, 1996; Flood, 2015; Kimmel, 1996). These findings suggest that the gender of program facilitators and participants plays an important role in father engagement. Researchers have conflicting views on the use of male educators in violence prevention work with men (Flood, 2015; Piccigallo, et al., 2012). Traditionally, promoting men’s homosocial relationships by matching educators with participants by gender was seen as reflecting and producing hegemonic masculinity and male privilege (Arxer, 2011; Bird, 1996; Flood, 2015; Hammarén & Johansson, 2014). This led some researchers to raise concerns about male-directed programs reproducing gender inequalities and sustaining rigid constructions of gender binaries by appealing to ‘real men’ (Flood, 2015; Salter, 2015).

However, recent research suggests that men’s preference for homosocial interactions can be leveraged as an entry point to engaging men in violence prevention (Piccigallo, et al., 2012). Based on their study of male college students involved in all-male rape prevention groups in the United States Piccigallo and colleagues (2012) argue that male homosocial peer environments can create a new social context that allows men to be emotionally expressive and provides social connectedness. Aligning with Piccigallo and colleagues (2012), masculinity theorists have explored the possibility that men’s homosocial relationships can foster inclusive or alternative forms of masculinity (E. Anderson & McGuire, 2010; Arxer, 2011; Hammarén & Johansson, 2014). More recently, Hammarén and Johansson (2014) revisited the concept of homosociality questioning whether all homosocial interactions among men aim to defend male privilege and power. They argue that men’s homosocial interactions are not always a mechanism of hegemonic masculinity or characterised by competition and exclusion (Hammarén & Johansson, 2014). Hammarén and Johansson distinguish between vertical/hierarchical homosociality described as ‘a means of strengthening
power and of creating close homosocial bonds to maintain and defend hegemony’ and horizontal homosociality which refers to relations between men that ‘are based on emotional closeness, intimacy and a nonprofitable form of friendship’ (2014, p. 5). The fathers’ constructions of the small group homosocial interactions between fathers in BM3 lend support for Hammarén and Johansson’s (2014) concept of horizontal homosociality. These interactions are explored in more detail in the following discussion. It will be seen that although BM3’s small group homosocial interactions engage and keep many fathers there are pitfalls and not all fathers are positive about the group experience.

FATHER SUPPORT NETWORKS

Several of the fathers reported male peer support as a key factor in ‘keeping’ and ‘engaging’ fathers and it appears that the single-gender group work involved in BM3 provides a unique opportunity for men to develop father support networks. Five fathers reported that the social interactions and relationships with other fathers they established during BM3 were the most engaging aspect of the program:

I guess the thing that really stood out was just the fact that it was able to bring together, not only the mums who had been seeing each other through the regular mothers group catch ups, but just to bring the fathers together. (Christopher, father)

It was just a good opportunity I think to sort of talk to a few other fathers that are going through similar sort, similar issues and yeah I think it was just sort of a good group dynamic. (Daniel, father)

It was a good opportunity for the partners’ husbands to engage and certainly that was a good starting point for us. Because with the three blokes in the room we were all of similar age, give or take...Certainly, in common interest, you get talking and you find other interests and so forth, so for that side of it, it’s been quite good in providing us with another couple of members to our circle of friends. (Peter, father)

For two of the fathers, the opportunity to make new friendship networks motivated their participation in the first instance. Christopher said:
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I guess it goes back to - we’re originally from the UK and I think one of the assets - so finding new social circles has always been a bit tricky. One of the key tips that came through in one of the forums was if someone invites you to something and you never say no. It’s very much that. If you’ve got people who already have a big group of friends or a big social network, they may not see the value in it. The argument is that these are people who are in the same boat and the same situation as you as a first time parent. There are experiences they share with each other. To me, that is a big pull or a draw. (Christopher, father)

Like Christopher, Peter saw BM3 as an opportunity to expand his social circle. However, he is uncertain whether the social aspect would appeal to younger fathers explaining that:

I suppose, I've looked at it as an opportunity to have - and also, preface this by saying being married for the second time around and I had no children in the first one, I'm in a different state of mind than a lot of other fathers who are doing it in their 20s and early 30s for the first time...I think automatically there’s probably some opportunity for guys to get together and talk about guy stuff in a man-cave type of way. They might find that appealing and the social side of it if they've got common interests, you know football, golf, cycling, whatever, motorsport, you know whatever it is. That is an aspect that I think they’d find appealing, certainly the guys - there’s three of us that have stayed in contact as a group of couples. The three girls have become very close. The guys actually get on quite well because we all have similar interests, for example we all like cycling. There's that common interest element of it as well. (Peter, father)

Although social contact was a key motivator for Christopher’s and Peter’s participation in BM3, they both noted that the impetus to form new friendships was cultivated by unique personal circumstances, immigration and later in life fatherhood, and expressed doubt as to whether this motivation would apply to all fathers.

Despite these dads’ concerns about the universality of social support as motivation for father participation, two female facilitators and over half of the MCHNs shared the view that developing social connections is a selling point for dads in regards to getting them to attend BM3:

I think sometimes it’s the first time that those dads have actually met with other
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new dads. There's always comments about how good that is just in itself. (female facilitator)

I think sometimes when a new parent - a mum and dad will come into the centre and I'll say, oh are you interested in a parent group. There are six sessions and three couple sessions, so it will be great for you, dad, to meet some other new dads as well in the same position as yourself. (MCHN/female facilitator)

When recruiting fathers for BM3, MCHN Alice uses the opportunity to build social relationships to attract fathers:

Because I think they're encouraging them to make friendships and the dads to be part of the friendship group sort of thing. That's what I think is helpful. That's another way I have sold it at night. You guys have got a good connection. It would be really lovely if your partners could all meet up. That's what I've said and I always make a bit of a thing about, you know, the guys don't get the opportunity like you do to have these moments so that's why we've started running these extra groups. (Alice, MCHN)

Several of the nurses believe the opportunity to meet other new fathers helps ‘get’ dads:

So we can say well look, dads are welcome to this, they can meet other dads. There are not many opportunities for new dads to have that, so a lot of the mums want their partner to be able to have that opportunity, I suppose (Liz, MCHN)

I always talk about it's a good way for dads to meet other dads because they're usually - well they are, they're all first-time parents and they really don't know a lot of other dads which is a good way to get them to come along because they think, oh great. I get to meet some other people. (Jenny, MCHN)

MCHN Susan also explained that BM3 is one of the rare opportunities where men can meet other new fathers:

I think that's something that parents are looking for, perhaps a connection with other parents. Particularly the dads because they - we put the mums together in a mothers' group so they get that connection but the dads, unless those mums
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Meet up, in the past they would never had got to meet that group. But with your thing they do because they do their six sessions, then they come in and the dads all meet. I think that's a good thing for them. (Susan, MCHN)

Although MCHN Laura doubts whether men perceive a need to make new friends she, like her fellow nurses, reported that BM3 gives men an opportunity to meet other fathers:

Well, I think they like it because it gives the opportunity - if the dads don't come along [to the New Parent Group] - for the dads to meet. It's like opening a door for them...I think men - from my experience - men think, well I already got my friends so why do I need to make new ones? But when you open that door for them they actually go, oh you're a really cool guy [laughs]. I can be friends with you. (Laura, MCHN)

One father, Peter, confirmed these nurses’ reports about the absence of formalised male parenting groups in the community commenting that:

Had this program not occurred, I doubt I would have met the husbands any earlier, and some of them I probably wouldn't have met at all. (Peter, father)

These comments suggest that part of the appeal of the BM3 program for fathers is that it provides a social context in which new fathers can meet and form relationships.

In addition to encouraging father attendance in the first instance, two male facilitators suggested that the social aspect of group work helps keep fathers. Male facilitator Mark commented that:

What's happened at the end of every group I've been in, is men have shared numbers with other men. So dads have gone ‘can we catch up’, they've made connections. Not with all the men but they've made connections with some men and thus they’re able to go ‘well can we catch up?’ ‘it'd be good, yeah’ ‘here's my number’ and we sort of promote that in a sense to give them networks, to give them an ongoing conversation with someone who knows what they've experienced and can actually get to that deeper and actually speak a bit of heart-to-heart stuff. (Mark, male facilitator)
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It seems that BM3 provides an interactional space for fathers to connect and support one another. As in Piccigallo and colleagues’ study (2012), the homosocial character of the father group work in BM3 is part of the program’s appeal. The small group male homosocial interactions in BM3 provide a rare opportunity for fathers to connect with fathers.

A NORMALISING SPACE FOR FATHERS

Nearly all of the fathers said that hearing from other dads transitioning to parenthood normalised their experiences with 12 of the fathers interviewed identifying these homosocial interactions as the most engaging aspect of BM3:

*It was good to talk to the other dads because they’re all experiencing the same thing and you just say what’s happening to yourself and then you realise everyone else is pretty much experiencing this. So it’s good to talk about it and see what they do in different situations and I can say what I’m doing in my situation. So yeah, that was pretty helpful. (Michael, father)*

*Certainly hearing it from others in the same situation going through the same thing and just getting an understanding that a lot of it is normal, some of it is not particularly special, but it is a change and it is normal and you need to adjust. (Christopher, father)*

*I thought that was one of the most positive things about it, having those discussions facilitated with other people who were experiencing the same as us. (Paul, father)*

*Also with the other fathers that are in a similar position, I thought that was very good. That you didn’t feel like a - it was almost a sense of embarrassment, for me, the position that you’re in when you got the kid. You realise other people are in that situation and you didn’t feel embarrassed or like a - yeah, it was a type of embarrassment I think, yeah. People say it’s like being a leper but I don’t like that term. Then when you realise other people, it’s like well who cares, this is the way it is. (Simon, father)*

Several of the fathers commented that the shared experience of transitioning to parenthood created a sense of community and empathy:
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I feel that there's a sense of community that we get to know there's someone else who's going through the same - similar experience of having a baby. (Quan, father)

What became clear, as you go through the session, is everyone, regardless of their background - like we said, we weren't all from the same socioeconomic or racial background, but we all had common ground in that we were struggling with some of these concepts around being a parent for the first time. (Matthew, father)

I think probably - in our work environment, we've had a number of people over the last probably year have a lot of babies. So there is definitely something in the water. So I guess from my point, we've been having conversations with new fathers and new parents at work already. But I think being able to take it to a point where you've actually - in terms of the babies' births it is probably only a couple of weeks difference as opposed to say the work environment where it's a couple of months. You are looking at four or five months. The developmental stages are different. I think just having that closeness of we're experiencing what you're experiencing kind of commonality was quite - yeah, it certainly - I guess comforting is probably not quite the right word. But it was a kind of a reassurance that yeah, this is doable and it's not the end of the world just yet. (Christopher, father)

Aligning with the fathers, two male facilitators identified the normalisation of men’s experiences during the transition to parenthood as facilitating father engagement:

I'm just jumping around a little bit here but that first when we spilt into two groups to talk about lifestyle changes I think that is the most important point to engage, to assess where each dad is at and to normalise the experience and to give them as much reassurance and a bit of humour in there and so that's always my favourite part of the initial program. It's just the, you sit alone with the dads and kind of get a real conversation happening because the energy certainly changes when the females leave the room and you start talking about some of those bigger changes they just haven't had a chance to talk about and that's when I think some of them start to realise they can get some value out of the group. (Jason, male facilitator)

You can see the guys sort of like ‘oh yeah that's the same for me’ and the commonalities really starting to come through and I think in many ways they're craving that in a similar to what the mums do having their mothers group,
Participant responses indicate that normalisation work with fellow new fathers promotes fathers engagement. It appears that the small group male homosocial interactions in BM3 provide an interactional space that allows new fathers to express their connections with one another. The fathers’ constructions of these interactions align with Hammarén and Johansson’s conceptualisation of horizontal homosociality (2014). Rather than competition and emotional detachment, the small group male homosocial interactions were characterised by emotional sharing and support. It appears that father group work provides a normalising space where men can share their parenting experiences and learn from other new fathers. The fathers’ responses indicate that the mutual experience of transitioning to parenthood created a sense of empathy and identification within the group facilitating father engagement.

‘IT’S HARD TO OPEN UP AND ELABORATE’

Although the majority of fathers responded positively to questions about the fathers’ group work, a few were uncomfortable with the forced intimacy and two fathers’ responses indicated that the emotional sharing inhibits ‘keeping’ and ‘engaging’ dads. One of them, Ahmet identified talking with strangers about private topics as an inhibitor to father engagement:

*It’s hard with a group situation as well because you’ve got people you haven’t seen or you don’t know that well and it’s hard to open up and elaborate on especially the intimacy topic as well. That’s a bit - it’s very personal. It’s understandable that people don’t want to elaborate on their answers.* (Ahmet, father)

Analogous to these fathers’ experiences, a third father’s comments about factors that inhibit father engagement suggest that some fathers (and mothers) find the public nature of group work too exposing:

*The whole thing was engaging, but I think part of the - one of hurdles was the other couples maybe not as comfortable speaking openly about how they’re*
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feeling in general. That’s more of a commentary on people rather than anything else. That was probably the hardest thing. I found that my partner and I - me, personally, anyway - would often lead many of the discussions at the Baby Makes Three, just because, maybe, there was a bit of trepidation, maybe a bit nervous to speak in front of people from the other participants. I’m not averse to that at all, but I did notice that I was - I didn’t want to come across as the guy always putting his hand up to speak, but that’s what ended up happening. (Luke, father)

These fathers’ reports align with traditional views on male homosocial heterosexual interactions which Bird (1996) claims maintain hegemonic masculinity by promoting emotional detachment, competitiveness and the sexual objectification of women, and subordinating non-hegemonic masculinities and femininities.

Similarly, while many of the fathers and MCHNs identified the opportunity to develop father networks as facilitating father engagement, a few facilitators were concerned that the lack of pre-existing relationships among the dads inhibited their engagement in discussions. One female facilitator commented:

I think they come in behind the eight ball because the mums know each other, so they're all sort of friends and the other mums know their child even. So it's a little bit like, hang on, you know my child, I don't know you. So that's a bit disengaging in itself I think. (female facilitator)

In terms of retaining fathers, two male facilitators felt the lack of pre-existing relationships amongst the father participants compared with the mothers, meant they had to pay great attention to engaging fathers in week one:

Look I think, I think session one we need more time and this is a basic practical thing. Just having time for the men to really get know each other because they are coming from no base, of not knowing each other. (Steven, male Facilitator)

There’s a different level of engagement that I think that needs to go into these guys on the first night compared to what may happen with the mums. (David, male Facilitator)
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Confirming these male facilitators’ views, new father Simon highlighted the importance of week one in setting the tone of the group and giving fathers permission to engage in non-hegemonic practices:

Because they weren't there the first week, there was that sense, for me anyway, that either they didn't take it seriously or they couldn't go there or that they missed out. Look I think that first week is important, it bound us as a group in a way, it really set the scene. (Simon, father)

These comments indicate that for some fathers emotional sharing in discussion-based programs inhibits engagement. It seems program facilitators need to work harder to ‘keep’ and ‘engage’ fathers when programs are delivered in a group format where participants are unknown to one another. They need to specifically focus on enabling fathers to get to know each other at the beginning of the program and promoting the acceptability of non-hegemonic gender practices, such as emotional sharing, in homosocial relationships.

‘SOME OF THEM DIDN’T REALLY PARTICIPATE’

Finally, it is important to note that some people have had negative past experiences with ‘group work’ and those promoting programs such as BM3 need to carefully consider how group work experiences are presented to prospective participants.

Ahmet and Luke were amongst several fathers who reported that non-participation by other fathers inhibited their own engagement. Discussions with fathers about the least engaging aspects of BM3 indicate that when programs are delivered in a group format father engagement is influenced by the willingness of other group members to participate. Daniel nominated non-participation by other group members as the least engaging aspect of BM3:

The difficulty was perhaps with some of the fathers, particularly the fathers some of them didn’t really participate very much (Daniel, father).

He believes that the discussion-based group format of the program led to father attrition:
I guess I sort of made a conscious effort of really sort of participating and trying to get the most out of it I could but I don’t think, like some of them, certainly the first week was the strongest turn out and there were a lot of people that didn’t come for the second...for the rest of the sessions. (Daniel, father)

Daniel highlighted that BM3 is designed to be participant driven so engagement is restricted when fathers do not participate:

I don’t think there is much that could be done to the program in terms of getting people to participate more other than really just emphasising that from sort of from day one that you know the more you participate the more you are sort of going to gain and ultimately the better it is for everyone in the session because it is designed for the parents to participate and really sort [of] guide the direction of the sessions. (Daniel, father)

Like these fathers, Christopher and Michael felt that people’s dislike of group work hinders father engagement with BM3:

I think there is definitely this - people never like, even in the work environment, people never like turning up to meetings or workshops. If you tell them it’s a bit of a workshop then people are always a bit nervous because they’ve got to get involved and engaged. If it is a bit more of a talk presentation and then you grab them once they’re in, then perhaps that’s what happened with some of the other dads or some of the other couples that they thought they were just going to get a bit of a lesson in what it is that they need to do. And after the door was closed it was a bit more we need to hear your views and we’ll have a proper conversation, which - and again, some people don’t like that and some people do. I’ve tried to facilitate, well I facilitate workshops in a business sense and sometimes as hard as you try, you just can’t get people to get engaged or to open up. Other times you’ll get people who just won’t stop talking. So a lot of it’s down to individuals. I think the facilitators you guys had were very good at opening up and cracking into the doors. (Christopher, father)

There are always quiet people in the group that are uncomfortable in talking in a big group but yeah, they tried to involve everyone. (Michael, father)

Discussing the appeal of group work, Michael cautioned against overtly advertising BM3’s group format believing this may disengage some men:
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If you advertise it you've got to be careful how you advertise it because if you advertise it as being just a big group or something it might scare away people because if I read that it would definitely scare me away because I don't want to - a lot of people are shy speaking up in a group. They'll hold back and they won't feel comfortable saying what they want. (Michael, father)

MCHNs Alice and Jenny also raised people’s dislike of group work as a barrier to father engagement in BM3. Alice said she often gets feedback from parents that they do not like group work:

A lot of people don't like groups. I do get that comment quite a bit. I've got lots of friends to talk about this with. Mothers and fathers will both say that. We've got our own friends, we'll probably just - don't like groups, we'll probably just do things with our own friends. (Alice, MCHN)

She attributes parents’ aversion to group work to shyness:

I think a lot of people don't like group format things because they're shy, they're not comfortable in groups. (Alice, MCHN)

Jenny said ‘people have negativity towards groups’. Discussing how negative attitudes to group work impact on father engagement, she commented further:

We do have a lot of people who just don’t want to come...People don’t want to walk into a room where they don’t know everybody and they feel awkward and that sort of thing. A lot of people don’t want to do that anymore. (Jenny, MCHN)

Jenny thinks people’s unfamiliarity with working with others is behind their reluctance to participate in a group environment:

I don’t know if it’s a - people feel too good to do that thing or if it’s just not something that they’re ever really used to. A lot of people go from school, which is a group thing, and then they go to uni, which is quite independent, then they work in an office all their life. Then all of a sudden they have this baby and they’re wanting to participate with all of these other people. It’s just not what they're used to. They're used to working by themselves. I think unless you have that job where you deal with the general public every day, it’s not something
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that a lot of people like to do, I think. But it's a really difficult thing to break through. As much as you say how positive it is [laughs], it's really hard to get people to want to come. (Jenny, MCHN)

The responses of these five fathers and two MCHNs suggest some fathers are reluctant to participate in discussion-based groups and that non-participation by some group members limits the engagement of other fathers. These discussions highlight the fact that our understanding of father engagement should be embedded in our understanding of masculinity (Dolan, 2014). It seems that some fathers’ emotional detachment in the all-male group work may reflect those fathers’ perceptions of what it means to be a man. Their reluctance to engage in emotional expression with other men in these homosocial settings can be construed as an effort to uphold masculine ideals and suppress non-hegemonic practices, such as emotionality. The following section explores how gender biases in facilitation practice impact on ‘engaging’ fathers with the program content.

GENDER BIASES IN PROFESSIONAL PRACTICE

This thesis makes the case that attention to gender is critical to successful outcomes from service providers’ engagement with fathers in respectful relationships programs. Interestingly it seems that the program facilitators themselves, or at least the female facilitators in this sample, are uncomfortable applying a gender perspective in respectful relationships programs with men. For example, rather than using the ‘Who Does What?’ exercise (see Box 6.1 on the following page) as an opportunity to address and explore the underlying reasons for the limited time fathers spend alone with their children, a few female facilitators reported that they ‘cushion’ or ‘soften’ the content for men:

I've only done actually about four groups now so I've done less than a lot of others but I find that when working with the male facilitator and often they've done more groups than I have and we're sort of in this thing where we kind of feel like we have to cushion some of the stuff for the men. (female facilitator)

I've noticed that we do have to really soften it a lot. (female facilitator)
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We need to make it very soft and general. (female facilitator)

**Box 6.1: Who Does What? – Baby Makes 3 Program Exercise**

This exercise in session two of the BM3 program involves a discussion about findings from the Growing Up in Australia: Longitudinal Study of Australian Children by the Australian Institute of Family Studies (Flynn & Whitehorse Community Health Services, 2011). Two graphs depicting the time children spend awake with parents on weekdays and weekends are shown to the groups (Flynn & Whitehorse Community Health Services, 2011). These graphs state that in their first year children spend on average 0.5 hours per day of awake time solely with their fathers and 5.8 hours per day solely with their mothers on weekdays and 0.7 hours alone with fathers and 3.5 hours alone with mothers on weekends (Flynn & Whitehorse Community Health Services, 2011). The BM3 Group Program Manual instructs facilitators to ask dads what barriers prevent men from spending alone time with their children as the first topic of discussion in this exercise (Flynn & Whitehorse Community Health Services, 2011).

Several female facilitators mentioned that the men find the discussion about the statistical data on time spent alone with children ‘confronting’. Three male facilitators agreed that this exercise is challenging with Ben reporting that the exercise can adversely influence ‘keeping’ fathers to the point that some do not return the following week:

*I find the second week the most challenging session because of that thing around time spent alone with your child...They dirty up completely and what are you trying to say and I've found that session...there's difficulty in navigating that in a way which retains the men.* (David, male Facilitator)

Yeah so you kind of can pick depending upon whether or not you recover from that part of the session if the guy is still feeling pretty narky at the end of the session two, I can say you can almost guarantee that he is not going to be back week three and I've had both scenarios where guys have been really receptive to it and where they haven't been. (Ben, male facilitator)
Conversely, their two remaining colleagues take a different view using the exercise as a transformative opportunity. Mark emphasised the importance of apply a gender perspective when working with fathers:

They can’t just keep the blinkers on, we have to actually pull the blinkers out. (Mark, male facilitator)

Jason loves this exercise and reported it has a transformative effect of the fathers’ parenting:

I love that part of the program and I’ve got a bit of a different experience I found it really positive. Like it has been confronting for dads but they’ve been like whoa that’s really important to know that this pattern is going to become entrenched... talking about the follow on around the barriers I can just see the self-awareness and the awareness of the situation grow hugely and yeah a couple of dads have been really blown away by those statistics you know but there’s been a positive kind of right I’m glad that I’ve been able to see that and dads go on to say my big thing is I want her when she’s older to be able to trust me so she can come talk to me and this is important I can start at this point you know. I’ve found it quite profound, I love it. (Jason, male facilitator)

Only three fathers mentioned program content when talking about their engagement experiences. Notable none of these expressed any issues with this exercise. In fact when discussing what he found most engaging about the BM3 program, Craig said:

I suppose the things that I benefited personally from was just around recognising that I need to maybe think through around how I prioritise things. I talked about it in my - my language was probably prioritising the things I’d like to do after the things I need to do. (Craig, father)

The fact that several of the female facilitators perceived the softening of content as essential to facilitating father engagement has wider ramifications in terms of program outcomes. The dilution of program content may limit the effectiveness of prevention strategies. As Barker and colleagues (2007; 2010) note, critical discussions of gender and masculinity are essential to violence prevention interventions that seek to engage men. As discussed in Chapter Two, programs that take a gender-transformative
approach to engaging men by seeking to transform gender norms and roles, and to promote gender equitable relationships between men and women, are more effective in changing behaviours and attitudes (Barker, et al., 2007; Barker, et al., 2010). By ‘softening’ reality the female facilitators and their co-facilitators are missing opportunities to transform the gender norms and inequalities that influence men’s fathering practices including their engagement in programs such as BM3. Additionally, these accounts highlight the importance of critical self-reflection by professionals about their own beliefs and attitudes towards gender and the impact on their practice (Ferguson, 2016; Ferguson & Hogan, 2004; Fletcher & Visser, 2008).

**MISREPRESENTATION**

Facilitator discussions about engaging fathers revealed a significant tension between psychologically accessible program names and misrepresentation. Previous research has found that hegemonic discourses of masculinity that view help-seeking as a sign of weakness inhibit father engagement (Dolan, 2014; Ferguson & Gates, 2015; O'Brien, Hunt, & Hart, 2005). As discussed in Chapter Two service names also influence men’s help-seeking with stigmatising service names discouraging father participation due to their fear of negative association or ridicule upon use (Weeks, 2004). For intimate partner violence primary prevention strategies, such as respectful relationships programs, the provision of a non-stigmatising entry point is believed to facilitate father engagement by reducing psychological barriers to service use (Pfitzner, Humphreys, & Hegarty, 2015; Weeks, 2004). Confirming previous research there was consensus among the female facilitators and MCHNs in this study that outwardly labelling the program as domestic violence prevention would adversely impact on ‘getting’ fathers:

_I think you’d probably lose them because I think it would just have a negative connotation to it because people are very touchy about domestic violence._ (Jenny, MCHN)

_I think you wouldn't have very many people. The men would be incredibly offended whether they've been family violent or not but they'll go you're judging me. It's very much about self-esteem and being judged up there._ (Jade, MCHN)
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I think that is pretty strong terminology. I think healthy relationships sounds better. (Steph, MCHN)

Conversely, some of the male facilitators reported that BM3’s non-stigmatising program name and marketing adversely impacts on ‘keeping’ and ‘engaging’ some fathers. Three of the male facilitators reported that fathers found the week three topic of Conflict in Relationships, particularly the Crossing the Line exercise, unexpected with some dads experiencing the program as duplicitous. A couple of the male facilitators suggested this topic could be flagged earlier on so that it is less of an affront to fathers at week three:

What's acceptable and unacceptable behaviour and you'll throw certain words out there but some of the words are very overt, like it’s not trying to hide what it’s trying to do, it’s pretty obvious what’s going on here and the men have expressed that they felt quite deceived so that they thought they were sold a certain program and then it got to week three and went are we being accused of something here? (Steven, male Facilitator)

I guess week three and that ‘crossing the line’ exercise I kind of agree with Steven it kind of, it hits like a sledge hammer. (Ben, male Facilitator)

I often think it's sometimes better to do it at the start and let them walk out if they want to. (David, male Facilitator)

Aligning with previous research, the participants’ comments indicate that BM3’s non-stigmatising program name helps ‘get’ fathers in the first instance. However, it seems that the desire to make programs psychologically accessible to men through the naming of programs can misrepresent programs to participants and adversely impact on ‘keeping’ and ‘engaging’ some fathers.

CONCLUSION

This study shows that cultural ideologies about gender and interactional expectations shape fathers’ participation in parenting programs. Participant reports revealed that gender ideologies at an institutional level influence fathers’ preferences in regards to
the delivery of group programs. Furthermore, the fathers’ discussions about their engagement experiences highlight that men’s gender identities are constructed not only on the basis of gender ideologies but also through their relations with other men.

At first glance it appears that ideological discourses on gender, particularly hegemonic masculinity, frame participants’ views regarding program delivery for fathers. Taken at face value the fathers’ preferences for all male environments reflects Bird’s (1996) conceptualisation of male homosocial interactions as a hegemonic process that separates men and women and sustains male privilege. However, a deeper analysis reveals that the fathers did not construct these interactions as a strategy for maintaining the gender order (Arxer, 2011; Hammarén & Johansson, 2014). Rather than facilitating the marginalisation of non-hegemonic masculinities and femininities, the small group interactions promoted non-hegemonic gender practices. Many fathers described homosocial interactions involving non-hegemonic gender practices, particularly emotional sharing and support, as the most engaging aspects of the BM3 program.

While the fathers’ emotional sharing did not function as a strategy to subordinate alternative masculinities, their preference for male facilitators and single-gender group work does perpetuate gendered hierarchical relationships (Arxer, 2011). Like the men in Piccigallo and colleagues’ study who were actively involved in violence prevention groups, these ‘engaged’ fathers were still more affected by the norms and evaluations of their male rather than female peers (2012). The blurred boundaries between vertical and horizontal homosociality are recognised by Hammarén and Johansson (2014) who note that there may be elements of both in homosocial relations. In contrast, Arxer (2011) sees men’s incorporation of non-hegemonic masculinities in homosocial settings as producing a hybrid form of hegemonic masculinity. Based on his study of small group homosocial interactions among men at a sports bar frequented by university students Arxer (2011) argues men may appropriate non-hegemonic practices as part of broader strategies for sustaining patriarchy. The men in Arxer’s (2011) study integrated hegemonic and non-hegemonic masculinity...
characteristics in their homosocial interactions using emotionality as a strategy to gain access to women’s bodies.

In the current study there was evidence of men integrating hegemonic and non-hegemonic gender practices. While the male facilitators engaged in non-hegemonic practices when they worked with the new fathers, some of the female facilitators allowed hegemonic beliefs and values about masculinity to influence and weaken their program delivery. Their own gender biases led them to soften program content for fathers potentially limiting the transformative effect of BM3.

The softening of this intervention extended to the program name. Rather than naming the program as intimate partner violence prevention the non-stigmatising label ‘Baby Makes 3’ is used. This study found that the softened program name masks the purpose of the program and the intimate partner violence prevention agenda sometimes comes as an affront to fathers when revealed in later sessions. This misrepresentation negatively impacts on ‘keeping’ and ‘engaging’ some fathers.

Overall, these findings emphasise the importance of an all-male environment and a transformative approach when delivering respectful relationships programs to new fathers in health settings. The implications for service providers and policymakers as well as directions for future directions research are explored in detail in the following chapter.
CHAPTER 7: DISCUSSION AND CONCLUSION

INTRODUCTION

This study has considered the impact of gender on service providers’ engagement with new fathers in respectful relationships programs delivered in health settings. Chapter Two explained the importance of engaging men in IPV primary prevention and the reasons for intervening during the transition to parenthood (Carlson, et al., 2015; Flood, 2011; B. Fox, 2009; Our Watch, et al., 2015). It also detailed the three-phase father engagement model adopted in this research using it as a heuristic through which previous research evidence about factors that facilitate and inhibit the father engagement process were discussed (Moran, et al., 2004). Chapter Three outlined the multidimensional gender perspective employed in this research (Risman, 2004). The epistemological stance and case study design of this research were defined in Chapter Four (Creswell, 2007; Schwandt, 1994; Stake, 1995; Yin, 2009). This chapter also outlined the subject of this case study setting the scene of the Baby Makes 3 program in the EMR. Chapters Five and Six demonstrated the varied and multidimensional gender phenomena that influenced ‘getting’, ‘keeping’ and ‘engaging’ fathers in the BM3 program. In this final chapter I revisit my research question and further discuss the findings of this study. This is followed by a brief summary of the findings, their implications for practice and policy and directions for future research. I end with a brief assessment of the strengths and limitations of this research followed by some concluding thoughts.

SUMMARY OF THE RESEARCH PROBLEM AND METHODOLOGY

Prevention programs are increasingly seeking to engage men in violence prevention based on well established evidence that men are the main perpetrators of intimate partner violence and are more likely to hold violence supportive attitudes (Australian Bureau of Statistics, 2006, 2013h; Krug, et al., 2002; Mouzos & Makkai, 2004; Mouzos & Rushforth, 2003; Murnen, et al., 2002; Pulerwitz & Barker, 2008; Uthman, et al.,
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2009; Victims Support Agency, 2012). Despite the growing body of work on the importance of engaging men in preventing violence against women and strategies for doing so, existing prevention work tends to focus on the manner in which men are drawn into anti-violence work rather than the engagement process itself (Casey, 2010; Casey & Ohler, 2012; Fabiano, et al., 2004; Powell, 2011). Missing from this body of work, is an exploration of the process of engaging men in intimate partner violence prevention, particularly from the perspectives of the men themselves. This study sought to fill this gap by developing an engagement model and exploring its application to intimate partner violence primary prevention strategies. This research focused on intimate partner violence primary prevention programs seeking to engage fathers with the overall aim of exploring how gender impacts on service providers’ engagement with new fathers in respectful relationships programs delivered in health settings.

Underpinned by a constructivist epistemology and ontology I employed a case study research design using the Baby Makes 3 (BM3) program, a three-week respectful relationships program for first time fathers and mothers, incorporated into New Parent Groups run by Maternal and Child Health Services (MCHS) in the Eastern Metropolitan Region of Victoria as an illustrative example. Data were collected from multiple sources, including interviews, focus groups and documentary sources, to develop a comprehensive understanding of the complex multidimensional role gender plays in service providers’ engagement with new fathers in respectful relationships programs delivered in health settings. There were 43 study participants. Fifteen fathers and 13 MCHN were interviewed and 15 BM3 facilitators participated in two single-gender focus groups.

My ability to comprehensively answer this research question was limited by a lack of access to fathers who did not engage in the BM3 program. The lack of access to these fathers is typical of the endemic absence of fathers in MCHS practices and policies and is a central finding of this study discussed in more detail below. The following section summarises the research findings with further discussion of their significance.
SUMMARY OF FINDINGS

CONCEPTUALISING ENGAGEMENT AND GENDER

A significant practical contribution of this research is that it provides much needed evidence about father engagement in IPV primary prevention programs, specifically respectful relationships programs. As discussed in Chapter Two, conceptualisations of father engagement in the primary prevention field are underdeveloped. The emerging evidence on using fatherhood as an opportunity to engage men is based on strategies to prevent child maltreatment and further acts of domestic violence rather than strategies to prevent IPV from occurring in the first instance (Bilukha et al., 2005; Greer Litton Fox, et al., 2001; Holzer et al., 2006; Mikton & Butchart, 2009; Pfitzner, et al., 2015; Stanley, Fell, et al., 2012; Stanley, Graham-Kevan, et al., 2012). Drawing on father engagement models from child and family services, the impact of gender on the engagement process was explored through a three-phase engagement model involving ‘getting’, ‘keeping’ and ‘engaging’ fathers (Pfitzner, et al., 2015). This engagement model was used as a heuristic through which the evidence about the gendered phenomena that influence father engagement was discussed in this thesis.

The main contribution of this research is its gender analysis and attention to fathers in an area with a dearth of father-specific evidence. This study responds to recent calls for gender disaggregated research evidence on father engagement in child and family services (F. McAllister, et al., 2012; Panter-Brick, et al., 2014). Unlike previous conceptualisations of father engagement in the child and family services, this research demonstrated that when engaging fathers, gender is the factor rather than a factor. Recognising that father engagement in respectful relationships programs does not occur in isolation but within a social fabric with particular norms, values and beliefs about parenting, work and gender, this thesis adopted Risman’s integrative theory of gender as a social structure. Risman (2004) envisages gender as a socially constructed stratification system that operates simultaneously at individual, interactional and institutional levels. The current study represents an original application of Risman’s model to the study of gender on father engagement and provides a conceptual tool for understanding and interpreting the impact of gender on health services providers’
engagement with new fathers. In a novel approach, this research combined the temporal father engagement model discussed earlier with Risman’s (2004) multidimensional gender theory to analyse the data collected.

FATHER ENGAGEMENT

Employing Risman’s (2004) multidimensional gender model this thesis illustrates how service providers’ engagement with new fathers in respectful relationships programs delivered in health settings is influenced by a complex interplay of gendered phenomena at individual, interactional and institutional levels. The next section briefly summarises the findings of this study according to the three phases of engagement: ‘getting’, ‘keeping’ and ‘engaging’ and across the three dimensions of Risman’s (2004) multidimensional gender theory.

‘GETTING’ FATHERS – FINDINGS SUMMARY

This thesis demonstrates the central role of gender in shaping men’s ideas about what it means to be a father – their paternal identities and behaviours - and the impact of these on their recruitment into respectful relationships programs. This study found that men’s paternal role identities and the Maternal and Child Health service setting play critical roles in motivating participation and ‘getting’ fathers to attend BM3 in the first instance. The following discussions will explore these roles utilising Risman’s (2004) model.

The Individual Level

This study demonstrates that gender shapes men’s fathering and consequently their involvement in programs that seek to engage men as fathers, such as BM3. In particular, the results highlight that the behaviour men associate with the father role fundamentally influences their participation. For example I found that breadwinning discourses strongly shape men’s paternal behaviour and ultimately their participation in BM3 with men who perceive the father role as provider less likely to respond to strategies that seek to engage them as caregivers. In tandem with men’s continued
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adherence to breadwinning discourses of fatherhood, men’s perceptions of caregiving as women’s work was also seen to inhibit ‘getting’ fathers in the first instance.

When it comes to ‘getting’ fathers the findings show that men who see themselves as ‘involved’ fathers are more likely to engage with respectful relationships programs. In a related noteworthy finding the self-identified ‘involved’ fathers who participated in BM3 and in this study highlighted the otherness of their conceptualisations of fatherhood emphasising that men who construe caregiving as part of the father role are exceptions rather than the norm. These findings indicate that BM3 is engaging those fathers already involved in caregiving and that programs such as BM3 which seek to engage men as caregivers may have limited widespread appeal. It seems that fathers’ attendance at respectful relationships programs delivered in MCHS settings is influenced by their perceptions and practices of fatherhood.

*Men’s perceptions of father role*

The individual dimension of Risman’s (2004) gender model centres on the development of gendered selves through identity work and socialisation. This thesis draws on Habib’s and Lancaster’s (2006) paternal role identity framework to explore how men construct their father identities and the impact of these on father engagement in BM3. The findings demonstrate that men’s gendered selves and their conformity to rigid gender roles influence father recruitment and retention. Extending identity theorists’ work on fathering this thesis found that how men define fatherhood affects not only their involvement with their children but also their involvement in care related activities, such as respectful relationships programs. The varied perceptions of the father role discussed in this study confirm Habib and Lancaster’s (2006) arguments that there is not one form of fatherhood and that men enact their father identity in a variety of ways.

*The Interactional Level*

At the interactional level, this research shows that men’s and women’s performance of gender impacts on father engagement. This thesis confirms Risman’s (2004) proposition that the cultural expectations attached to sex categories guide individual’s
interactions identifying several instances where men and women ‘doing’ gender influenced father engagement in BM3. For example, this study found that men’s participation in BM3 was inhibited by their adherence to hegemonic ideals of masculinity that discourage emotional expression. Aligning with both Risman’s (2004) integrative gender theory and Habib and Lancaster’s (2006) paternal role identity theory this study showed that in ‘doing’ gender some mothers contributed to both men’s constructions of fathering and their access to services including their engagement with the BM3 program. Some mothers shaped men’s paternal role identities by policing their caregiving activities and resisting fathers’ attempts at undoing gender. Mothers were also seen to both facilitate and inhibit father participation in BM3 depending on New Parent Group dynamics. This study highlights the bi-directional pull of cultural expectations regarding the parenting roles of men and women with, for example, fathers reluctant to take recruitment phone calls identifying BM3 as women’s work.

The Institutional Level

This study found that in addition to individual men’s constructions of fathering and ingrained cultural expectations regarding the parenting roles of men and women, the gendered Maternal and Child Health Service and economic structures at the interactional level shape men’s fathering and ultimately their involvement as fathers in programs such as BM3. This study raises significant doubts as to whether existing Maternal and Child Health Services are the most appropriate settings for delivering respectful relationships programs to new fathers. At the institutional level, the findings indicate that highly gendered MCHS settings explicitly and implicitly marginalise fathers from caregiving and related activities such as the BM3 program. As with other child and family services, the MCHS produces ‘ghost’ fathers who are invisible to MCHNs (L. Brown, Callahan, Strega, Walmsley, & Dominelli, 2009). In the MCHS context, fathers inhabit an unseen world existing in the shadows of MCHN recruitment. The spectral status of fathers adversely impacts on father recruitment for BM3. This research strengthens the argument for a game change in child and family services, such as MCHS, highlighting the powerful impact of professional and
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institutional practices on fathers’ engagement experiences (Ferguson, 2016; Panter-Brick, et al., 2014).

A major contribution of this study is the findings about the significant role of institutional structures, particularly the mother-oriented MCHS, have on ‘getting’ fathers into the BM3 program and fathers’ parenting roles more generally. Employing Thomas's (2011a, p. 187) counter-factual, ‘the imagination of a different state of affairs’, it is pertinent to consider what if the MCHS reoriented their focus from mothers to mothers and fathers. If Maternal and Child Health Services became *Parental and Child Health Services* and saw fathers and mothers equally as clients routinely engaging them as part of their core business, this could have a two-fold effect. Firstly it may change men’s and women’s constructions of fatherhood and promote caregiving roles for fathers and secondly it could increase father participation in programs like BM3.

Ferree (2010) has critiqued gender perspectives on families for failing to consider the multi-institutional relationships between families and economic and political structures arguing that most research frames issues in terms of individual rather than institutional change. An important implication of this study derives from the finding that MCHS reinforce a gendered division of labour that marginalises fathers from caregiving including engagement in programs such as BM3. These findings indicate the need for structural interventions that promote and support father involvement in childcare. Some researchers have even suggested that men’s participation in care work would in itself be a gender equality intervention (Elliot, 2015; Morrell & Jewkes, 2011). The implications of this finding are explored in more detail in the discussion on implications for policy and practice below.

*MCHS operate on gendered assumptions*

At the institutional level this study found that gender is constituted through MCHS organisational practices and processes adversely impacting on ‘getting’ fathers. A central finding of this study is the invisibility of fathers both in MCHN practice and in service provider policies, guidelines and data reporting. This finding extends recent
research by Brown et al. (2009) and Panter-Brick et a. (2014) on father involvement in child welfare services and parenting interventions respectively. Like the fathers’ experiences of the MCHS in the current study, Brown et al. (2009) found that in the child welfare context fathers are not seen even when they are present and are invisible in official records. They found that child welfare policies and practices, particularly the matriarchal filing system, promote uninvolved fathering by centering on mothers and mothering (L. Brown, et al., 2009). They contend that the child welfare sector produces ‘ghost fathers’ as in order to see fathers, services must first believe in their existence and relevance (L. Brown, et al., 2009). Similarly to Brown et al. (2009), Panter-Brick and colleagues (2014, p. 1190) found strong gender biases in parenting policies that reproduce mothering childrearing models and ‘tilt programmatic interventions toward mothers, rather than toward both fathers and mothers as coparents’. Parallels can be drawn with MCHS where the matriarchal referral system initiates and sustains mother-centric childrearing models and service provision. This focus on mothers is further reinforced by BM3’s lack of an explicit father engagement strategy contradicting the ethos of the BM3 program as articulated by the program developer David Flynn. Flynn claims BM3 specifically engages men as ‘partners, as parents and as caregivers in their own right’ rather than approaching fathers as ‘helpers’ or ‘support’ for first time mums (Flynn, 2011, p. 53). While the capacity in which men are drawn into the program is as a ‘partner’ and ‘parent’, the indirect manner in which they are recruited indicates a secondary rather than primary caregiving status. These findings point to the need for close examination of organisational processes in child and family services, such as MCHS, to ensure that institutions themselves do not propagate maternal caregiving models.

‘KEEPING’ AND ‘ENGAGING’ FATHERS - FINDINGS SUMMARY

This study’s findings about gender-related factors that influence ‘keeping’ and ‘engaging’ fathers exemplify the interplay of causality within and between the three dimensions of the gender structure and in Chapter Six were discussed rather than in relation to discrete levels. This summary takes the same approach.
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This research revealed that certain aspects of program delivery were essential to ‘keeping’ and ‘engaging’ fathers in the sample. Extending recent research evidence from rape prevention programs, this study found that the gender of both facilitators and fellow participants influences father engagement in respectful relationships programs (Piccigallo, et al., 2012). Nearly all of the participants in this study emphasised that having men work with men is an essential element in engaging fathers. The all-male environment provided fathers a safe space to honestly and openly express their emotions. This study demonstrates the importance of male perspective when delivering respectful relationships programs to fathers.

This study showed that the peer relationship among the men in the BM3 groups was key to ‘keeping’ and ‘engaging’ fathers. While the male facilitators in this study were trained professionals their shared experiences of fatherhood were critical to creating a sense of unity, empathy and trust with the father participants facilitating their engagement. Although being a father was not a formal job requirement for the male BM3 facilitators, the fathers in this study emphasised the authenticity of program messages when delivered by men who are themselves fathers. The father peer status of the male facilitators fostered credibility in the eyes of the father participants and cemented their trustworthiness thereby promoting father engagement.

This study shows that BM3 provides an opportunity for men to develop father networks and hear from other men transitioning to fatherhood that is not available in most social settings. A third of the father participants reported that the interactions and relationships formed with other fathers during BM3 were the most engaging aspects of the program. This research found that BM3 provides a unique male homosocial environment that allows men to engage in non-hegemonic gender practices, namely emotional sharing and support. The male homosocial group work also provided a normalising space for fathers where they could hear from other men transitioning to parenthood. These findings corroborate Hammarén and Johansson’s (2014) concept of horizontal homosociality as opposed to vertical/hierarchical homosociality demonstrating that not all male homosocial interactions aim to defend the existing gender order. Whilst BM3’s small group male homosocial interactions
were found to facilitate keeping and engaging most fathers, two fathers were uncomfortable with the intimacy and emotional closeness that characterised these interactions. This study suggests that these fathers’ reactions reflect their conformity to hegemonic ideals of masculinity and perceptions of acceptable masculine behaviour. Despite the fathers’ participation in non-hegemonic gender practices, their preference for same-gender group work delivered by male peers demonstrates the powerful strength of hegemonic masculinity and its emphasis on homosocial investments.

**Misrepresentation**

As discussed in Chapter Six this study found that some fathers viewed the badging of BM3 as a ‘healthy relationships’ rather than ‘domestic violence prevention’ program as misrepresentative and duplicitous. Non-stigmatising program labels are believed to facilitate engagement in violence prevention programs by reducing psychological barriers to service use (Pfitzner, et al., 2015). Clearly further considerations regarding the impact that non-stigmatising programs labels have on participant expectations, retention and engagement is required. As Olds and colleagues (2007) have highlighted many parenting interventions fall at the first hurdle as they fail to address the question of why would parents want to spend their time participating in the given program. Greater transparency in terms of the program name may reduce father participation in BM3. On the other hand, the heightened awareness of domestic violence stemming from the 2016 Royal Commission into Family Violence and several high profile family violence cases in Victoria may have created a social atmosphere in which it is possible for services to find a more transparent means of selling their respectful relationships programs ("Family violence: a concern beyond price," 2014; Stott Despoja, 2014).

This research provides important insights for both policymakers and practitioners into the impact of gender on services providers’ engagement with new fathers in respectful relationships programs delivered in health settings. However, this study has some limitations which are discussed together with the strengths of this research in the next section.
STRENGTHS AND LIMITATIONS OF THE RESEARCH

This section outlines the strengths and limitations of this research and includes the following topics:

- A focus on fathers
- Real-world research
- Multiple evidentiary sources
- Intersectionality
- No access to fathers who did not engage
- Social desirability bias and researcher gender.

A FOCUS ON FATHERS

A major strength of this research is its focus on fathers. Recent research has highlighted the invisibility of fathers in child and family services and called for a game change in parenting interventions (Ferguson, 2016; Gilligan, Manby, & Pickburn, 2012; F. McAllister, et al., 2012; Panter-Brick, et al., 2014). In contrast to these earlier findings, this research gave a central voice to fathers. In a service area devoid of attention to fathers, this study explored service providers’ engagement with new fathers in a respectful relationships program from the perspective of the fathers themselves and the staff who work with them. Furthermore, in the context of engaging fathers in violence prevention, this study uniquely focused on fathers who voluntarily attended a parenting program rather than those compelled by a court (Greer Litton Fox, et al., 2001).

REAL-WORLD RESEARCH

A significant strength of these research findings is that they are grounded in real-life experiences rather than abstract examples, transporting readers inside the case through the eyes of the people who live it (Lincoln & Guba, 1985; Merriam, 2009; Patton, 2002). My instrumental case study design enabled me to learn about the real-world conditions of service providers’ engagement with new fathers in respectful
relationships programs delivered in health settings. Instrumental case studies examine real-life examples of wider phenomena to gain a greater understanding of the issue investigated (Stake, 1995). The case study design framework allowed me to develop an in-depth understanding of the reality of how gender impacts on service providers’ engagement with new fathers in the BM3 program and explore the interactivity between men, the program and its Maternal and Child Health setting (Stake, 2006).

MULTIPLE EVIDENTIARY SOURCES

The use of several different evidentiary sources in the case study design of this research strengthens the findings drawn from this study. By using multiple sources of evidence I was able to compare and contrast the data collected from fathers, facilitators, MCHNs and documentary sources to corroborate the gender phenomena identified as influencing service providers’ engagement with fathers and develop converging lines of inquiry (Yin, 2009). This process of triangulation enhances the validity of my findings, as Yin rightly argues ‘any case study finding or conclusion is likely to be more convincing and accurate if it is based on several different sources of information’ (2009, p. 116). This process also enabled me to identify the different ways of seeing things and ‘preserve the multiple realities’ of father engagement in this setting (Stake, 1995, p. 12).

INTERSECTIONALITY

While this study emphasises gender as the key factor influencing service providers’ engagement with fathers in respectful relationships programs other social factors such as race, ethnicity, class and religion also impact on father engagement. As discussed in the Chapter Four, the Eastern Metropolitan Region (EMR) of Victoria is a largely middle class area. In comparison to the six other EMR councils, LGA7 has a lower-sociodemographic resident population and there were no fathers from this council in this study’s sample (Australian Bureau of Statistics, 2013g; Department of Health (State of Victoria), 2013). Additionally, BM3 is an English language speaking program and residents without adequate English literacy skills are likely to have self-selected out of the program.
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While the distribution of fathers in the study sample was representative of BM3 participation rates in each LGA at the time of data collection, it is unclear whether gender-related factors identified by fathers in this study’s sample would hold the same weight for fathers from other populations. In fact two male facilitators, Mark and David, questioned the cultural competency of the BM3 program with Mark remarking that:

   *It’s very white middle class male written, driven and shown.* (Mark, male facilitator)

Bearing in mind the need to identify what works for whom and in what circumstances, localised masculinities and other social variables should invariably inform father engagement strategies and programs (Casey, et al., 2013; Jewkes, et al., 2015; Pawson, Greenhalgh, Harvey, & Walshe, 2005). Future work could shed light on the differential impact of gender on service providers’ engagement with diverse father populations.

NO ACCESS TO FATHERS WHO DID NOT ENGAGE

A clear limitation of this study is the lack of access to men who choose not to engage in the BM3 program. Fathers are not clients of Maternal and Child Health Services and their contact details are not routinely recorded. Therefore we were unable to contact fathers who declined referrals to the BM3 program. The inaccessibility of fathers who declined invitations to BM3 or dropped out before the third session limited my ability to fully answer the research question and further research with such fathers is required. Nevertheless the insights from fathers and staff involved in this study indicate that the disengagement of such fathers arises partly from their perceptions of fathering and the gendered nature of the service delivery environment. While a limiting factor, I do not believe this detracts from the overall conclusions of this study and my assessment of the implications for practice and policy.

SOCIAL DESIRABILITY BIAS AND RESEARCHER GENDER

It is important to note these fathers’ reflections about their engagement experiences were completed after they had undergone gender equality education and social
desirability response bias may be present in their self-reports (van de Mortel, 2008). Research on gender-of-interviewer effects suggests men and women express more egalitarian views on gender equality to female interviewers (Huddy et al., 1997; Kane & Macaulay, 1993). However the effect size on responses is small and the gender-of-interviewer effects on engagement studies have not been examined (Huddy, et al., 1997). The fathers I interviewed were surprisingly open and frank about their engagement with BM3 and their experience of becoming parents. The fact that I was seeking to learn about their engagement experiences rather than evaluating the impact of gender equality education is likely to have reduced the potential for social desirability bias. The following section explores the implications for policy and practice stemming from my research findings and possibilities for future research.

**IMPLICATIONS FOR POLICY AND PRACTICE AND FUTURE RESEARCH**

The lessons learned from this case study can inform both policymakers and practitioners about effective and promising practice for engaging fathers in health settings. A number of the findings in this study have important implications for policy and practice and are discussed in detail below.

**MULTIDIMENSIONAL STRATEGIES SHOULD BE AN INTEGRAL THEME OF POLICY**

In terms of ‘getting’ fathers a central finding of this study was the recursive relationship between the institutional setting and men’s perceptions of their father role and the combined effect they have on fathers’ participation decisions. This study found that the gendered Maternal and Child Service intertwines with breadwinning discourses and economic structures to perpetuate male breadwinning parenting models and exclude men from participating in care related activities like BM3. An implication for policy drawing from this finding is that IPV primary prevention strategies that seek to engage men as fathers through respectful relationships programs delivered in health settings should be accompanied by structural interventions to facilitate father participation in such programs.
Risman (2004) explains that institutional structures both create and constrain choices. Much of the work on engaging fathers in the parenting support context focuses on micro-level strategies to recruit individual men. This study indicates that parallel interventions are required at the institutional level to facilitate fathers’ enactment of egalitarian fathering ideologies and consequently their participation in programs like BM3. Recent research by Zuo (2004) and others reinforces this implication arguing that structural changes are required to shift perceptions of breadwinning as a male responsibility and facilitate the transformation of fathering scripts (Davis & Greenstein, 2009; Pease, 2008). Reflective of these arguments, Salter (2015) has criticised VAW primary prevention strategies for their one-dimensional approach that focuses on gender norms at the exclusion of structural inequalities. He argues that ‘a comprehensive model of VAW prevention cannot be formulated by abstracting attitudes and norms from the contexts that produce and sustain them’ (2015, p. 13).

The same could be said for primary prevention engagement strategies. Participants in this study identified the gendered organisation of the MCHS as a significant barrier to ‘getting’ fathers in the first instance. An institutional level engagement strategy that reoriented the Maternal and Child Health Service to a Parental and Child Health Service could facilitate the transformation of fathering scripts and possibly change individual men’s paternal behaviours and increase father participation in programs like BM3. This reorientation should involve the introduction of father inclusive policies and practices, training for working with male clients, the recruitment of male MCHNs, flexible appointment schedules and the development of psychologically accessible service delivery environment for fathers. A multilevel approach to father engagement that addresses the institutional context in which father engagement occurs would enhance service providers’ efforts to engage fathers in health settings.

**INCORPORATE FATHER-ONLY PROGRAMS INTO MATERNAL AND CHILD HEALTH SERVICES**

An important finding of this study was that the unique homosocial environment provided by the BM3 program facilitated father engagement. The male led single-
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gender group work with fathers created a new social context where men could be emotionally expressive and share their fathering experiences. This horizontal homosociality fostered father engagement and could be extended beyond the BM3 program to increase male access of Maternal and Child Health Services.

RECOGNISE DIVERSITY IN FATHERING

This study’s observation that there are many ways to be a father indicates that service providers seeking to engage men through their father identities need to consider the various ways men view their father role. An implication for practice deriving from this finding is that service providers need to take multifaceted rather than one-size fits all approaches to father engagement that reflect the diverse behaviours men associate with the role. This study provides service providers with specific strategies and recommendations regarding a number of desirable attributes that future facilitators may need to effectively engage fathers in respectful relationships programs. These findings are being incorporated into existing BM3 resources and future capacity-building and workforce development programs.

PROFESSIONAL DEVELOPMENT

A clear recommendation for practice stemming from this study’s findings is the need for developmental work with facilitators to critically assess their professional practice and explore the importance of not promulgating traditional gender beliefs and biases. As discussed earlier in Chapters Two and Seven, research by Barker and colleagues (2007; 2010) has highlighted the effectiveness of gender transformative approaches when engaging men in violence prevention interventions finding that such approaches are more likely to lead to behaviour and attitude change. Prevention program personnel need to promote change rather than accepting gender stereotypes.

It is impossible for parenting interventions alone to comprehensively change gender relations. However, accompanied by structural interventions the transition to parenthood presents a prime opportunity to create effective change. One of the male facilitators in this study described this life transition as a rare rite of passage in Western culture. A multidimensional primary prevention strategy targeting this rite of
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passage offers the possibility of supporting new parents to passage into more egalitarian gender relations and of transforming the transition to parenthood from a producer of gender inequality to a promoter of gender equality.

THE PROMINENCE OF MEN’S FATHER IDENTITIES

A significant finding of this study was that men’s perceptions of the father role as provider inhibited father participation in BM3. Participant discussions did not explore the overlap between men’s father and worker identities and whether men’s breadwinning behaviour was also reflective of the level of status they attributed to their worker identity or purely the result of their perceptions of fatherhood. Future research could explore the connections between the prominence men place on their father identities among their other role identities, such as worker or sportsman, and father engagement. Habib and Lancaster (2012; 2006) suggest that higher order identities are more likely to lead to the performance of role related behaviour. Such research would assist in gaining a deeper understanding as to how men’s paternal identities interact with father engagement and clarify whether the importance men place on their participation in paid work is an expression of their perceived paternal responsibilities or evidence that they attribute a higher status to their worker identities than their father identities.

INVOLVED FATHERS

Tied to considerations of intersectionality some researchers have suggested that involved fatherhood and the adoption of more equitable caregiving models are the luxury of well-educated middle class men (Barker et al., 2004; Johansson & Ottemo, 2015; Plantin, Mansson, & Kearney, 2003). The privileged position of the fathers in this study presents two lines of inquiry for future research. Firstly, this study offers the opportunity to explore the causal relationships between involved fatherhood and family income. A question that could be asked is whether respectful relationships programs, such as BM3, only appeal to a minority of men who can financially afford to be ‘involved’ fathers. A second avenue for future research, is to refine and further elaborate on my novel findings regarding the nature of the small group male
homosocial interactions between fathers in BM3. For example future work could explore whether the fathers’ incorporation of gender practices associated with non-hegemonic masculinities was only possible due to their socio-economic status and the challenges this presents for transforming gender relations more widely. Further work is also necessary to determine whether the fathers’ incorporation of non-hegemonic masculine practices was an example of horizontal homosociality as suggested or a partial reconfiguration of hegemonic masculinity that appropriated alternative masculinities for the purpose of maintaining male privilege (Arxer, 2011; Hammarén & Johanssson, 2014).

CONCLUSION

While engaging fathers and other men in violence prevention education is critical to ending violence against women, this cannot happen without first developing effective strategies for engaging men with the problem. Understanding the engagement process and variations across settings will pave the way for the effective implementation of primary prevention interventions from theory into practice. This area has largely been overlooked and oversimplified by prevention and parenting support researchers alike.

Multiphase, multilevel models of father engagement that extend beyond strategies to engage individual men and address barriers and enablers at the interactional and institutional levels would greatly enhance existing engagement efforts. In addition to a multilevel approach, this research highlights the importance of considering men’s intersecting identities as fathers and as men when developing engagement strategies for respectful relationships programs. This study identifies the ways gender can both impede and facilitate father engagement in Maternal and Child Health settings and provides a clear way forward for service providers seeking to engage fathers in this context.

Research shows that the transition to parenthood often leads to a retraditionalisation of gender roles for heterosexual couples (Janeen Baxter, et al., 2008; Dribe & Stanfors, 2009; Höfner, et al., 2011). Given research linking traditional attitudes to gender roles
with violence supportive attitudes, it appears that the transition to parenthood is a critical moment in the development of gender inequality (Australian Institute of Criminology, et al., 2010; Murnen, et al., 2002; Nayak, et al., 2003; Pulerwitz & Barker, 2008; VicHealth, 2014). Fortunately, this transition also marks a period of regular contact with health services presenting a window of opportunity to intervene in health settings to address gender equality (Department of Education and Early Childhood Development (State of Victoria), 2014d; Gilligan, et al., 2012; Taft, 2002). Current Victorian Maternal and Child Health Services give centre stage to women’s passage through motherhood. If men’s passage to fatherhood is viewed with a similar level of attention this may not only increase father engagement in parenting support services but also potentially increase father participation in care work thereby helping to transform fathering practices. Valuing men’s transition to fatherhood and including them in related services may promote more gender equitable divisions of parental responsibilities and facilitate institutional change beyond health settings. Individual- and service-level support for shifts in fathering would challenge economic and workplace structures that reinforce male breadwinning models providing an opportunity to reconfigure structural inequalities that support violence against women.
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APPENDIX A

EASTERN METROPOLITAN DEMOGRAPHIC PROFILE

POPULATION BY SEX

Table B.1: Population Breakdown, 2013, Eastern Metropolitan Region Local Government Areas¹⁻⁸

<table>
<thead>
<tr>
<th>Local Government Area</th>
<th>Total Persons (No.)</th>
<th>Male (no.)</th>
<th>Female (no.)</th>
<th>Median Age (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGA1</td>
<td>170,553</td>
<td>82,574</td>
<td>87,979</td>
<td>38.2</td>
</tr>
<tr>
<td>LGA2</td>
<td>154,909</td>
<td>76,496</td>
<td>78,413</td>
<td>38.8</td>
</tr>
<tr>
<td>LGA3</td>
<td>117,537</td>
<td>57,223</td>
<td>60,314</td>
<td>43.1</td>
</tr>
<tr>
<td>LGA4</td>
<td>161,724</td>
<td>78,261</td>
<td>83,463</td>
<td>38.6</td>
</tr>
<tr>
<td>LGA5</td>
<td>182,485</td>
<td>90,478</td>
<td>92,007</td>
<td>37.9</td>
</tr>
<tr>
<td>LGA6</td>
<td>161,724</td>
<td>78,261</td>
<td>83,463</td>
<td>38.6</td>
</tr>
<tr>
<td>LGA7</td>
<td>149,538</td>
<td>74,146</td>
<td>75,392</td>
<td>39.3</td>
</tr>
<tr>
<td>Victoria</td>
<td>5,739,341</td>
<td>2,840,337</td>
<td>2,899,004</td>
<td>37.3</td>
</tr>
</tbody>
</table>

CULTURAL AND LINGUISTIC DIVERSITY

Table B.2: Indicators of Cultural Diversity, Eastern Metropolitan Region Local Government Areas⁹⁻¹⁵

<table>
<thead>
<tr>
<th>Local Government Area</th>
<th>Percentage of overseas born residents</th>
<th>Percentage residents who speak a language other than English at home</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGA1</td>
<td>32.3%</td>
<td>23.5%</td>
</tr>
<tr>
<td>LGA2</td>
<td>31%</td>
<td>21.1%</td>
</tr>
<tr>
<td>LGA3</td>
<td>40%</td>
<td>38.8%</td>
</tr>
<tr>
<td>LGA4</td>
<td>24.5%</td>
<td>12.6%</td>
</tr>
<tr>
<td>LGA5</td>
<td>48.9%</td>
<td>44.4%</td>
</tr>
<tr>
<td>LGA6</td>
<td>37.7%</td>
<td>30.3%</td>
</tr>
<tr>
<td>LGA7</td>
<td>20.5%</td>
<td>6%</td>
</tr>
<tr>
<td>Victoria</td>
<td>31.4%</td>
<td>23.1%</td>
</tr>
</tbody>
</table>
### Table B.3: Top 3 regions of birth for overseas born residents, 2011, Eastern Metropolitan Region Local Government Areas $^{9-15}$

<table>
<thead>
<tr>
<th>Local Government Area</th>
<th>Region 1</th>
<th>Region 2</th>
<th>Region 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGA1</td>
<td>North-East Asia (6.4%)</td>
<td>North-West Europe (5.3%)</td>
<td>South-East Asia (4.4%)</td>
</tr>
<tr>
<td>LGA2</td>
<td>North-West Europe (7.6%)</td>
<td>Southern &amp; Central Asia (4.2%)</td>
<td>Southern &amp; Eastern Europe (3.2%)</td>
</tr>
<tr>
<td>LGA3</td>
<td>North-East Asia (9.9%)</td>
<td>Southern &amp; Eastern Europe (8.4%)</td>
<td>South-East Asia (5.4%)</td>
</tr>
<tr>
<td>LGA4</td>
<td>North-West Europe (7.9%)</td>
<td>Southern &amp; Central Asia (8.5%)</td>
<td>Southern &amp; Central Asia (1.9%)</td>
</tr>
<tr>
<td>LGA5</td>
<td>North-East Asia (11.4%)</td>
<td>South-East Asia (6.1%)</td>
<td>South-East Asia (7.8%)</td>
</tr>
<tr>
<td>LGA6</td>
<td>North-East Asia (9.9%)</td>
<td>Southern &amp; Eastern Europe (1.7%)</td>
<td>Oceania, Antarctica (exc. Australia)</td>
</tr>
<tr>
<td>LGA7</td>
<td>North-West Europe (9.7%)</td>
<td>South-East Asia (6.1%)</td>
<td>Oceania, Antarctica (exc. Australia)</td>
</tr>
</tbody>
</table>

| Victoria              | North-West Europe (5.6%)  | Southern-Eastern Europe (5.1%)       | South-East Asia (3.9%)                |

### ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

#### Table B.4: Number of Aboriginal and Torres Strait Islander peoples, 2011, Eastern Metropolitan Region Local Government Areas $^{9-15}$

<table>
<thead>
<tr>
<th>Local Government Area</th>
<th>Number of Aboriginal &amp; Torres Strait Islander residents</th>
<th>Percentage of Aboriginal and Torres Strait Islander residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGA1</td>
<td>221</td>
<td>0.1%</td>
</tr>
<tr>
<td>LGA2</td>
<td>541</td>
<td>0.4%</td>
</tr>
<tr>
<td>LGA3</td>
<td>152</td>
<td>0.1%</td>
</tr>
<tr>
<td>LGA4</td>
<td>413</td>
<td>0.4%</td>
</tr>
<tr>
<td>LGA5</td>
<td>355</td>
<td>0.2%</td>
</tr>
<tr>
<td>LGA6</td>
<td>314</td>
<td>0.2%</td>
</tr>
<tr>
<td>LGA7</td>
<td>971</td>
<td>0.7%</td>
</tr>
<tr>
<td>Victoria</td>
<td>37,990</td>
<td>0.7%</td>
</tr>
</tbody>
</table>
**EDUCATION**

Table B.5: Post school qualifications of residents aged 16 years and over, 2011, Eastern Metropolitan Region Local Government Areas

<table>
<thead>
<tr>
<th>Local Government Area</th>
<th>Post School Qualifications</th>
<th>Percentage of total population with post school qualifications</th>
<th>Most common type of post school qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGA1</td>
<td>68.3% Bachelor degree (28.9%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LGA2</td>
<td>54.8% Certificate (19.5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LGA3</td>
<td>59.2% Bachelor degree (20.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LGA4</td>
<td>57.5% Certificate (19.2%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LGA5</td>
<td>60.1% Bachelor degree (20.5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LGA6</td>
<td>62.4% Bachelor degree (21.2%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LGA7</td>
<td>55.8% Certificate (23.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victoria</td>
<td>56.1% Certificate (16.4%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**EMPLOYMENT**

Table B.6: Top 3 occupations of employed residents, 2011, Eastern Metropolitan Region Local Government Areas

<table>
<thead>
<tr>
<th>Local Government Area</th>
<th>Occupation 1</th>
<th>Occupation 2</th>
<th>Occupation 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGA1</td>
<td>Professional (38.8%)</td>
<td>Managers (17.7%)</td>
<td>Clerical and Administrative Workers (13.8%)</td>
</tr>
<tr>
<td>LGA2</td>
<td>Professional (19.3%)</td>
<td>Clerical and Administrative Workers (17.1%)</td>
<td>Technicians and Trades Workers (16.2%)</td>
</tr>
<tr>
<td>LGA3</td>
<td>Professional (27.2%)</td>
<td>Managers (16.1%)</td>
<td>Clerical and Administrative Workers (15.6%)</td>
</tr>
<tr>
<td>LGA4</td>
<td>Professional (21.8%)</td>
<td>Clerical and Administrative Workers (16.8%)</td>
<td>Technicians and trades Workers (15.6%)</td>
</tr>
<tr>
<td>LGA5</td>
<td>Professional (28.8%)</td>
<td>Administrative Workers (15.7%)</td>
<td>Managers (12.6%)</td>
</tr>
<tr>
<td>LGA6</td>
<td>Professional (30.8%)</td>
<td>Administrative Workers (15.4%)</td>
<td>Managers (13.1%)</td>
</tr>
<tr>
<td>LGA7</td>
<td>Technicians and Trades Workers (18.9%)</td>
<td>Professionals (17.2%)</td>
<td>Clerical and Administrative Workers (14.6%)</td>
</tr>
<tr>
<td>Victoria</td>
<td>Professional (22.3%)</td>
<td>Clerical and Administrative Workers (14.4%)</td>
<td>Technicians and Trades Workers (13.9%)</td>
</tr>
</tbody>
</table>
### INCOME

Table B.7: Average wage & salary income in the Eastern Metropolitan region, year ending 30 June 2011\(^6\)

<table>
<thead>
<tr>
<th>Local Government Area</th>
<th>Average Wage &amp; Salary Income (2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGA1</td>
<td>$70,008</td>
</tr>
<tr>
<td>LGA2</td>
<td>$49,430</td>
</tr>
<tr>
<td>LGA3</td>
<td>$55,241</td>
</tr>
<tr>
<td>LGA4</td>
<td>$49,518</td>
</tr>
<tr>
<td>LGA5</td>
<td>$50,592</td>
</tr>
<tr>
<td>LGA6</td>
<td>$53,902</td>
</tr>
<tr>
<td>LGA7</td>
<td>$46,327</td>
</tr>
<tr>
<td><strong>Victoria</strong></td>
<td><strong>$50,276</strong></td>
</tr>
</tbody>
</table>

### NEW FAMILIES IN THE EASTERN METROPOLITAN REGION

Table B.8: Number of births & total fertility rate, year ended 31 December 2012, Eastern Metropolitan Region Local Government Areas\(^{1-8}\)

<table>
<thead>
<tr>
<th>Local Government Area</th>
<th>2012 Total number of births</th>
<th>2012 Total Fertility rate (per female)</th>
<th>2013 Total number of births</th>
<th>2013 Total Fertility rate (per female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGA1</td>
<td>1572</td>
<td>1</td>
<td>1507</td>
<td>1</td>
</tr>
<tr>
<td>LGA2</td>
<td>1911</td>
<td>2</td>
<td>1793</td>
<td>2</td>
</tr>
<tr>
<td>LGA3</td>
<td>1087</td>
<td>2</td>
<td>1028</td>
<td>2</td>
</tr>
<tr>
<td>LGA4</td>
<td>1446</td>
<td>2</td>
<td>1482</td>
<td>2</td>
</tr>
<tr>
<td>LGA5</td>
<td>1995</td>
<td>2</td>
<td>1825</td>
<td>2</td>
</tr>
<tr>
<td>LGA6</td>
<td>1911</td>
<td>2</td>
<td>1749</td>
<td>2</td>
</tr>
<tr>
<td>LGA7</td>
<td>1881</td>
<td>2</td>
<td>1789</td>
<td>2</td>
</tr>
<tr>
<td><strong>Victoria</strong></td>
<td><strong>77,405</strong></td>
<td><strong>1.8</strong></td>
<td><strong>73,969</strong></td>
<td><strong>1.8</strong></td>
</tr>
</tbody>
</table>
Table B.9: Number of first time mothers enrolled in Maternal and Child Health Services, 2011-2014 financial years, Eastern Metropolitan Region Local Government Areas\textsuperscript{17,18}

<table>
<thead>
<tr>
<th>Local Government Area</th>
<th>2012-2013 Financial Year</th>
<th>2013-2014 Financial Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGA1</td>
<td>770</td>
<td>765</td>
</tr>
<tr>
<td>LGA2</td>
<td>898</td>
<td>881</td>
</tr>
<tr>
<td>LGA3</td>
<td>502</td>
<td>491</td>
</tr>
<tr>
<td>LGA4</td>
<td>739</td>
<td>821</td>
</tr>
<tr>
<td>LGA5</td>
<td>997</td>
<td>1,017</td>
</tr>
<tr>
<td>LGA6</td>
<td>988</td>
<td>936</td>
</tr>
<tr>
<td>LGA7</td>
<td>825</td>
<td>787</td>
</tr>
<tr>
<td><strong>Eastern Metropolitan Region</strong></td>
<td><strong>5,729</strong></td>
<td><strong>5,698</strong></td>
</tr>
<tr>
<td><strong>Victoria</strong></td>
<td><strong>35,703</strong></td>
<td><strong>35,497</strong></td>
</tr>
</tbody>
</table>

*Note:*
1. “First time mothers” includes those mothers who have their first baby and are enrolled in the current financial year.

Table B.10: Composition of families with dependent children aged 0-4 years, 2011, Eastern Metropolitan Region Local Government Areas\textsuperscript{9-15}

<table>
<thead>
<tr>
<th>Local Government Area</th>
<th>Total number of one parent families with children aged 0-4 years</th>
<th>Total number of couple families with children aged 0-4 years</th>
<th>Total number of families with children aged 0-4 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGA1</td>
<td>314</td>
<td>7,419</td>
<td>7,733</td>
</tr>
<tr>
<td>LGA2</td>
<td>852</td>
<td>7,741</td>
<td>8,593</td>
</tr>
<tr>
<td>LGA3</td>
<td>317</td>
<td>4,891</td>
<td>5,208</td>
</tr>
<tr>
<td>LGA4</td>
<td>629</td>
<td>5,863</td>
<td>6,492</td>
</tr>
<tr>
<td>LGA5</td>
<td>610</td>
<td>7,697</td>
<td>8,307</td>
</tr>
<tr>
<td>LGA6</td>
<td>505</td>
<td>7,901</td>
<td>8,406</td>
</tr>
<tr>
<td>LGA7</td>
<td>1,007</td>
<td>7,905</td>
<td>8,912</td>
</tr>
</tbody>
</table>

*Note:*
1. Couple and one parent families will not sum to total as not all families reported birthplace status.
Figure B.11: Couple family composition by birthplace of parents with dependent children aged 0-4 years, 2011, Eastern Metropolitan Region Local Government Areas

Figure B.12: One parent family composition by birthplace of parents with dependent children aged 0-4 years, 2011, Eastern Metropolitan Region Local Government Areas
REFERENCES

### APPENDIX B

Appendix B consists of the following documents:

<table>
<thead>
<tr>
<th>Attachment</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Letter of support from Whitehorse Community Health Services</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Example Memorandum of Understanding</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Plain Language Statement – Nurses</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>Expression of Interest – Nurses</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>Plain Language Statement – Facilitators</td>
<td>7</td>
</tr>
<tr>
<td>6</td>
<td>Expression of Interest – Facilitators</td>
<td>9</td>
</tr>
<tr>
<td>7</td>
<td>Plain Language Statement – Fathers</td>
<td>10</td>
</tr>
<tr>
<td>8</td>
<td>Expression of Interest – Fathers</td>
<td>12</td>
</tr>
<tr>
<td>9</td>
<td>Interview Guide – Nurses</td>
<td>13</td>
</tr>
<tr>
<td>10</td>
<td>Interview Guide – Fathers</td>
<td>14</td>
</tr>
<tr>
<td>11</td>
<td>Focus Group Guide – Facilitators</td>
<td>15</td>
</tr>
<tr>
<td>12</td>
<td>Demographic Survey – Nurses</td>
<td>16</td>
</tr>
<tr>
<td>13</td>
<td>Demographic Survey – Fathers</td>
<td>17</td>
</tr>
<tr>
<td>14</td>
<td>Demographic Survey – Facilitators</td>
<td>18</td>
</tr>
<tr>
<td>15</td>
<td>Example Code Framework</td>
<td>19</td>
</tr>
<tr>
<td>16</td>
<td>Case Study Protocol</td>
<td>20</td>
</tr>
<tr>
<td>17</td>
<td>Case Study Database</td>
<td>28</td>
</tr>
</tbody>
</table>
30 September 2013

Naomi Pfitzner
General Practice and Primary Health Care Academic Centre
University of Melbourne
200 Berkeley Street
Carlton, VIC 3053

Dear Naomi Pfitzner (PhD student), A/Prof Kelsey Hegarty (Supervisor) and Prof Cathy Humphreys (Supervisor),

Engaging New Fathers: learning from Baby Makes 3

This letter is written in support of the Engaging New Fathers: learning from Baby Makes 3, a project being undertaken by PhD candidate Naomi Pfitzner under the supervision of A/Prof Kelsey Hegarty and Prof Cathy Humphreys at the University of Melbourne.

Whitehorse Community Health Service (WCHS) as developer of the Baby Makes 3 is the lead agency for the Baby Makes 3 project currently being undertaken in the Eastern Metropolitan Region of Victoria (2013-15). WCHS has signed memoranda of understandings with all 7 Local Government Authorities delivering the Baby Makes 3 program in the Eastern Metropolitan Region as part of this project. WCHS fully supports the 'Engaging New Fathers: learning from Baby Makes 3' project and recognises the value it can add to the current pilot it is undertaking and to research and practice in the area of primary prevention of violence against women.

Specifically, WCHS will provide support to this project by;

- administering a questionnaire to parents who participated in the Baby Makes 3 program;
- facilitating the recruitment of Baby Makes 3 pilot sites;
- providing the researchers with the opportunity to recruit staff and male participants at consenting Baby Makes 3 pilot sites; and
- providing access to the Baby Makes 3 Project Manager.

WCHS is experienced in carrying out program evaluations and engaging program participants and staff in research. We understand that participants’ privacy and anonymity will be respected and protected by the researchers who will administer the questionnaire in a manner that upholds this.

If you require any further information please contact Libby Hargreaves, Baby Makes 3 Project Manager, on (03) 8843 2250 or lhargreaves@wchs.org.au.

Yours faithfully,

Ronda Jacobs
Chief Executive Officer
Whitehorse Community Health Services Ltd.
MEMORANDUM OF UNDERSTANDING

Between the General Practice and Primary Health Care Academic Centre at The University of Melbourne and the (insert name of Local Council) with respect to the conduct of the Engaging New Fathers study.

1. The purpose of this memorandum is to identify the roles and responsibilities of the parties involved in conducting this project. The Engaging New Fathers study refers to involvement of local councils from the Eastern Metropolitan Region of Victoria in a research project that is conducted at the General Practice and Primary Health Care Academic Centre (GPPHCAC) at The University of Melbourne.

2. The individual collaborators are:
   - PhD student Naomi Pfitzner (NP), co-supervisor Prof Kelsey Hegarty (KH) both from the General Practice and Primary Health Care Academic Centre at The University of Melbourne and co-supervisor Prof Cathy Humphreys (CH) from the Department of Social Work at The University of Melbourne (GPPHCAC); and
   - (insert name of MCHS manager), manager of MCHS, (insert name of Council) and self-selected employees of the MCH service who have agreed to participate in the study.

3. NP, KH and CH from The University of Melbourne are responsible for the conduct of the study. NP will be engaging with participants during the data collection process. The data collection in the Council is planned from March 2014 – March 2015.

4. (insert name of Council) agrees to allow NP to attend and observe some Baby Makes 3 sessions, and make field notes. Whitehorse Community Health Service has given consent for researchers to observe sessions led by facilitators and the responsibility for obtaining parents’ consent lies with the facilitators. No identification of individuals will occur.

5. GPPHCAC want to hold interviews with Maternal Child and Health Nurses (MCHNs) who work at Baby Makes 3 pilot sites in the (insert name of Council) about their experiences engaging with the Baby Makes 3 program. All interviews will be recorded with a digital voice recorder and transcribed. All participants will be asked read and sign individual informed consent forms which they must return to the researcher before the interview can take place.

6. (insert name of Council) understands that MCHNs will be asked to participate in face-to-face interviews of up to one hour. The approximate time commitment per individual is up to one hour.

7. GPPHCAC acknowledges that organisational and individual participation is entirely voluntary, that participation may be withdrawn at any time and that the employment status of staff will not be in any way affected by said participation.

8. (insert name of Council) agrees that observation may take place on Council premises, and that interviews will be at a time and location suitable for the participants. N.B. Council premises will only be used if acceptable privacy levels can be guaranteed.
9. (insert name of Council) will be provided with a copy of the study results at the end of the project, which is anticipated to be March 2016. NP will be happy to present the project findings at appropriate Council forums, as requested. Once the thesis arising from this research has been completed, a brief summary of the findings will also be made available to (insert name of Council) upon application to the General Practice and Primary Health Care Academic Centre. (insert name of Council) gives the researchers from The University of Melbourne permission to discuss or publish the results at academic conferences and professionals journals.

10. GPPHCAC will ensure adequate supervision and support for NP, as well as providing ongoing training. KH and CH will monitor the project’s progress throughout the entire research period as well as provide advice and assistance on challenges and any concerns relating to the research. NP, who will attend (insert name of Council) for data collection, is covered by insurance provided through The University of Melbourne.

11. GPPHCAC undertakes that NP will abide by the rules and regulations of (insert name of Council) at all times.

12. GPPHCAC warrants that the study has received ethical clearance from The University of Melbourne but that any concerns about the conduct of the project may be discussed with the Manager, Human Resources Ethics, The University of Melbourne by telephoning (03) 8344 7507 or facsimile to 9347 6739. Complaints will be treated with strictest confidence and fully investigated.

13. This agreement commences from the date of signing this document and will be reviewed at the request of either party in writing or in June 2015. It remains effective until either modified or discontinued by the request of either party.

Confirmation of agreement

We agree to abide with all terms and agreements outlined in this document.

Name: __________________ Position: __________________

Signature: __________________ Date: ________________
(Signed on behalf of DGIP, University of Melbourne)

Name: __________________ Position: __________________

Insert name of Council: ____________________________

Signature: __________________ Date: ________________
(Signed on behalf of Council)

Please keep one copy of this form for your own record
ENGAGING NEW FATHERS: LEARNING FROM BABY MAKES 3

Introduction
You are invited to participate in a project on men’s and staff’s involvement with the Baby Makes 3 (BM3) program. This project is being conducted by Naomi Pfitzner, a PhD student from the General Practice and Primary Health Care Academic Centre at The University of Melbourne under the supervision of Professor Kelsey Hegarty from the General Practice and Primary Health Care Academic Centre at The University of Melbourne and Professor Cathy Humphreys of the Department of Social Work at The University of Melbourne. Naomi has worked as a researcher and legal practitioner in the family violence field for a number of years. Kelsey is a longstanding GP with extensive research experience in intimate partner violence. Cathy is a social work academic with over 20 years experience researching intimate partner violence and child abuse and neglect. This project has the support of Whitehorse Community Health Services, the Baby Makes 3 Steering Committee and your local MCHS managers.

What is the Engaging New Fathers study?
The aim of the project is to explore the experiences of men and staff with the BM3 program. We would like to interview people who are connected with the BM3 program, such as Maternal Child and Health nurses, to share their experiences of this program with us.

What will you be asked to do?
We have approached you as someone whose experiences of the BM3 program we would like to draw on. If you agree to participate in the project, you will be asked to take part in a recorded interview for approximately one hour. We will not tell anyone what you say and your comments will be kept anonymous (attributed to a ‘MCHN’). All possible steps will be taken to protect the confidentiality of the information you provide (such as removing any features that might link it to you before it is published), subject to legal requirements. However, you should be aware that, given the limited number of staff involved in the Baby Makes 3 program, there is a possibility of being identified. You will also be asked to complete a short demographic survey. This will assist us to understand a little about yourself and your background in Maternal and Child Health.

Are there any benefits for you?
Participants will receive a $30 honorarium in compensation for their time. We hope that the Engaging New Fathers study will assist you to better understand how to engage men in the Baby Makes 3 program and that participation will be professionally rewarding for you and your colleagues.

Are there any risks for you?
We do not anticipate that you will experience any distress from participating in the interviews. You will be free not to answer any question and you may leave at any time. Although unlikely, if you are distressed by some of the questions please refer to the resource card or call Naomi Pfitzner at the General Practice and Primary Health Care Academic Centre on (03) 8344 5023.

PROJECT TEAM
Naomi Pfitzner (PhD Student), Prof. Kelsey Hegarty, Prof. Cathy Humphreys (University of Melbourne)
HREC Approval Number 1340699.1 Date 10.10.2013 Version 1
How do I agree to participate?
If you would like to participate in this study please read and sign the accompanying expression of interest form and return it in the envelope provided. The researchers will then contact you to arrange a mutually convenient interview time and date. If we do not hear from you, Naomi Pfitzner will follow up with you to check whether or not you wish to participate during site visits.

How will my confidentiality be protected?
The transcribed records of the interviews will be kept securely at The University of Melbourne General Practice and Primary Health Care Academic Centre, and will only be available to be viewed by members of the research team. If after 5 years from the date of publication of the research the unprocessed data are no longer of relevance to the research team, the Chief Investigators will seek authorisation from their relevant Heads of Department for disposal of the data.

Can I withdraw from the study?
Your participation in this study is completely voluntary. If you wish to withdraw any information you have supplied, before publication, you are free to do so without prejudice.

Will participation prejudice me in any way?
Your involvement in this project will not affect your relationship with the BM3 program.

Where can I get further information?
This project has been approved by the University's Human Research Ethics Committee. If you require any further information, or have any concerns, please do not hesitate to contact Naomi Pfitzner on (03) 8344 5023 or naomip@unimelb.edu.au. If you have any concerns about the ethical conduct of the project, you are welcome to contact the Manager, Human Research Ethics, The University of Melbourne, on (03) 8344 2073 or by facsimile on (03) 9347 6739.
Expression of Interest Form - MCHN

ENGAGING NEW FATHERS: LEARNING FROM BABY MAKES 3

☐ Yes, I am interested to hear more about the Engaging New Fathers study.

My name is (please print): ________________________________

Please contact me on phone: ________________________________

Email: ________________________________

My preferred day and time for contact is ________________________________

Thank you for your interest in this research

Mail the completed form in the enclosed reply paid envelope (no stamp is required).

For further information, please contact Naomi Pfitzner from the General Practice and Primary Health Care Academic Centre at The University of Melbourne on (03) 8344 5023 or naomip@unimelb.edu.au.
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What is the Engaging New Fathers study?
The aim of the project is to explore the experiences of men and staff with the BM3 program. We would like to hold focus groups with people who are connected with the BM3 program, such as BM3 facilitators, to share their experiences of this program with us.

What will you be asked to do?
We have approached you as someone whose experiences of the BM3 program we would like to draw on. If you agree to participate in the project, you will be asked to take part in a recorded focus group for approximately one hour. We will not tell anyone what you say and your comments will be kept anonymous (attributed to a ‘facilitator’). All possible steps will be taken to protect the confidentiality of the information you provide (such as removing any features that might link it to you before it is published), subject to legal requirements. However, you should be aware that, given the limited number of staff involved in the Baby Makes 3 program, there is a possibility of being identified. You will also be asked to complete a short demographic survey. This will assist us to understand a little about yourself and your background in facilitation.

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Expression of Interest Form - Facilitators

ENGAGING NEW FATHERS: LEARNING FROM BABY MAKES 3

☐ Yes, I am interested to hear more about the Engaging New Fathers study.

My name is (please print): ______________________________________________

Please contact me on phone: _____________________________________________

Email: ________________________________________________________________

Best phone number(s) to contact me during:

Business hours: __________________________

After hours: __________________________

My preferred day and time for contact is____________________________________

Thank you for your interest in this research

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Your involvement in this project will not affect your relationship with the BM3 program.

Where can I get further information?
This project has been approved by the University’s Human Research Ethics Committee. If you require any further information, or have any concerns, please do not hesitate to contact Naomi Pfitzner on (03) 8344 5023 or naomip@unimelb.edu.au. If you have any concerns about the ethical conduct of the project, you are welcome to contact the Manager, Human Research Ethics, The University of Melbourne, on (03) 8344 2073 or by facsimile on (03) 9347 6739.
Expression of Interest Form – Fathers

ENGAGING NEW FATHERS: LEARNING FROM BABY MAKES 3

☐ Yes, I am interested to hear more about the Engaging New Fathers study.

My name is (please print): ____________________________________________________________

Please contact me on phone: __________________________________________________________

Email: __________________________________________________________________________

Address: __________________________________________________________________________

My preferred day & time for contact is: _________________________________________________

Thank you for your interest in this research

Mail the completed form in the enclosed reply paid envelope (no stamp is required).

For further information, please contact Naomi Pfitzner from the General Practice and Primary Health Care Academic Centre at The University of Melbourne on (03) 8344 5023 or naomip@unimelb.edu.au.
MCHNs Interview Guide

Introduction
Hi I’m Naomi & I’m doing research on engaging new fathers in the BM3 program.
I would like to explore your thoughts on this and hear about your experiences engaging fathers in the BM3 program and any challenges you have faced. The interview will take between 30-60 minutes and will be recorded. You may stop the interview at any time.
• Get consent form signed & start tape.

Recollections of their experiences with the BM3 program.

General
• Tell me about working with fathers in your service
  o How, if at all, does your work with fathers differ from your work with mothers?
  o How do you feel about working with fathers?

BM3s
• What’s your understanding of the BM3 program?
• How do you engage fathers in the program?
  o Tell me about the approach you take to getting fathers to attend Baby Makes 3?
  o How do the fathers respond?
  o How do the mothers respond?

BM3 Challenges
• Are there any particular challenges to getting fathers involved in BM3?
  o MCHS Environment
  o How do men feel about coming to MCHC? What makes them feel this?
• Who would lose/attract if parents were made aware of the violence prevention education involved in BM3 program?

BM3 facilitators
• What have you found works for getting fathers involved in BM3?
  o Do you have any other examples of how you get fathers to attend BM3?
  o How could you get more fathers involved in BM3?

Engaging fathers - MCHS
• What could be done to improve MCHS for men?
• I understand that Maternal and Child Health services have traditionally been female oriented, could you tell me if and how this impacts on your work with men?
• Are there some groups of fathers Baby Makes 3 is not reaching?
  o CALD
  o ATSI
  o Divorced or separated men
• How do you think health services could engage hard to reach men?
• Do you sometimes find there is a challenge about the engagement of some men?
  o Are there some groups of men you actively don’t engage with, such as identified perpetrators?

Close
• Is there anything else you would like to say about fathers’ involvement in BM3 that might help improve it?
• Stop tape

Demographic survey
Please complete this short survey to help us analyse the information you have provided.

Close interview
Should you feel distressed or affected by our discussion please remember that there is a list of numbers you can contact for professional advice on the resource card.
• Honorarium & information sheet about project for your records

Thank you again for participating.
Father Interview Guide

**Introduction**
Hi I’m Naomi & I’m doing research on engaging new fathers in the BM3 program. I would like to hear about your experiences of the BM3 program and ideas about how to reach more fathers. The interview will take around 30 minutes and will be recorded. You may stop the interview at any time.

• Get consent form signed & start tape.

**BM3 Motivation for participating**
• Tell me about how you ended up at the BM3 program.
  o What were your reasons for attending the program?
• What do you think this program is about?

**BM3 facilitators /challenges**
• What did you find most engaging about the BM3 program and why?
  o Meeting other fathers, support, relationship skills
• What did you find least engaging about the BM3 program and why?
  Prompt:
  o What was your experience of working with other new parents?
  o Were the other fathers in the group similar to you?
  o How many sessions did you take part in?
  o How did you feel about the number of sessions you had?

**Experiences of BM3 program staff**
• Tell me about how you found the facilitators.
  o Could you describe any positive/negative experiences you had with the BM3 staff?
• What are your thoughts on the gender of the facilitators?

**Perceptions of BM3 program**
• In your opinion, how could you get more men to participate in BM3?
• If you were advertising this program what would you say in your advert to get dads involved?
• Who would you recommend this program to?
• What do you think would be helpful for fathers?

**Perceptions of MCHS**
• Tell me about your relationship with the MCHS/MCHNs
• What was your perception of the MCHS before you participated in BM3?
• Who did you think they provide services for?
• How do you think other men perceive MCHS?

**Close**
• Is there anything else you would like to say about BM3 that might help improve it?

**Demographic survey**
I’m going to finish by asking you a couple of demographic questions to help us analyse the information you have provided.
• How old are?
  Under 25 □ 25-34 □ 35-44 □ 45-54 □ 55-64 □ Over 65 □
• What is your postcode?
  • Where was the Baby Makes 3 program you attended held?
• Stop tape

**Ask for address to send honorarium**

**Close interview**
Should you feel distressed or affected by our discussion please remember that there is a list of numbers you can contact for professional advice on the resource card.
Thank you again for participating.
Engaging New fathers

Facilitator Focus Group Topic Guide

1. Introduction
   • Participants’ involvement in the BM3 program – where are you from & background.
   • Women: any MCHN/facilitators?

2. Recollections of their experiences with the BM3 program.

Group experience
   • Tell us about your experience engaging new fathers in the Baby Makes 3 program.
   • How, if at all, does your work with men differ from your work with women?
   • What could be done to improve the Baby Makes 3 groups for men?

Facilitators/Barriers
   • Tell me about any challenges you have encountered engaging men in the BM3 program.
     Prompt:
     o Are there any sessions or topics that men struggle to engage with more than others?
   • In your experience, how does holding the Baby Makes 3 program at Maternal and Child Health Centres impact on men’s engagement?
   • In your opinion, how could you make the Baby Makes 3 program more attractive to men?
   • Who would you lose/attract if parents were made aware of the violence prevention education involved in the BM3 program?
   • In your experience, how should the Baby Makes 3 program be marketed to men?

If there anything else you would like to add?

Demographic survey
Please complete this short survey to help us analyse the information you have provided.

Close interview
Should you feel distressed or affected by our discussion please remember that there is a list of numbers you can contact for professional advice on the resource card.
   • Honorarium & information sheet about project for your records

Thank you again for participating.
**ENGAGING NEW FATHERS: LEARNING FROM BABY MAKES 3**

This short survey contains questions that will provide us with some information about your background that will help us to analyse the information you have provided in the interview.

1. How old are? *(please tick the box that matches your age group)*
   - Under 25 □
   - 25-34 □
   - 35-44 □
   - 45-54 □
   - 55-64 □
   - Over 65 □

2. Are you: Male □ Female □

3. Which Council do you work in? *(please tick the box that matches your answer)*
   - Boroondara □
   - Maroondah □
   - Knox □
   - Manningham □
   - Monash □
   - Whitehorse □
   - Yarra Ranges □

4. How long have you worked as a Maternal and Child Health Nurse? _________ *(years)*

5. a) Have you received specific training for working with male clients?
   - Yes □
   - No □
   - Please go to question 5b.

5. b) Who provided this training? *(please specify)*

5. c) How many hours of this kind of training have you received? _________ *(hours)*

6. What is the invitation process for BM3 at your site? *(please tick all boxes that apply)*
   - Include in NPG invite □
   - Facilitators phone parents to introduce themselves prior □
   - Discuss with both parents at home visit □
   - SMS reminder to parents □
   - Discuss with mothers at NPG □
   - Male facilitators phone fathers □
   - Project Manager/Facilitators visit NPG □
   - Male facilitators attend Family Night □
   - Phone reminders to parents by MCHN □
   - Other *(please specify)* □

Thank you for your assistance.

*PROJECT TEAM*
Naomi Pfitzner (PhD Student), Prof. Kelsey Hegarty, Prof. Cathy Humphreys (University of Melbourne)
HREC Approval Number 1340699.1 Date 10.10.2013 Version 1
ENGAGING NEW FATHERS: LEARNING FROM BABY MAKES 3

This short survey contains questions that will provide us with some information about your background that will help us to analyse the information you have provided in the interview.

1. How old are? (please tick the box that matches your age group)
   - Under 25
   - 25-34
   - 35-44
   - 45-54
   - 55-64
   - Over 65

2. What is your postcode? (please specify)

3. Where was the Baby Makes 3 program you attended held? (please tick the box that matches your answer)
   - Boroondara
   - Maroondah
   - Knox
   - Manningham
   - Monash
   - Whitehorse
   - Yarra Ranges

Thank you for your assistance.

PROJECT TEAM
Naomi Pfitzer (PhD Student), Prof. Kelsey Hegarty, Prof. Cathy Humphreys (University of Melbourne)
HREC Approval Number 1340699.1 Date 10.10.2013 Version 1
ENGAGING NEW FATHERS: LEARNING FROM BABY MAKES 3

This short survey contains questions that will provide us with some information about your background that will help us to analyse the information you have provided in the focus group.

1. How old are? (please tick the box that matches your age group)
   - Under 25 □
   - 25-34 □
   - 35-44 □
   - 45-54 □
   - 55-64 □
   - Over 65 □

2. Are you: Male □ Female □

3. Which Council do you work in? (please tick the box that matches your answer)
   - Boroondara □
   - Maroondah □
   - Knox □
   - Manningham □
   - Monash □
   - Whitehorse □
   - Yarra Ranges □

4. How many Baby Makes 3 groups have you delivered?

5. How long have you worked as a facilitator? ________ (years)

6. a) Have you received specific training for working with male clients?
   - Yes □ Please go to question 6b.
   - No □ Thank you for assistance.

6. b) Who provided this training? (please specify)

6. c) How many hours of this kind of training have you received? ________ (hours)

Thank you for your assistance.
Table 4.9: Example of first level coding from data analysis

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category Level 1</th>
<th>Sub-Category level 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Getting’</td>
<td>NPG dynamics</td>
<td>Transportation</td>
</tr>
<tr>
<td></td>
<td>Program timing</td>
<td>Facilities</td>
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<td>Program topic</td>
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<td></td>
<td>Program length</td>
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<td></td>
<td>Desire to make connections</td>
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<td></td>
<td>Refreshments</td>
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<td></td>
<td>Demographics</td>
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<td></td>
<td>Parenting</td>
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<td></td>
<td>Fathering</td>
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<td></td>
<td>Masculinity</td>
<td></td>
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<td></td>
<td>Mummy bear</td>
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<td></td>
<td>Cultural Competency</td>
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<td></td>
<td>Trust</td>
<td></td>
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<tr>
<td>Accessibility</td>
<td></td>
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<tr>
<td>MCHS setting</td>
<td>How fathers see MCHS</td>
<td></td>
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<td></td>
<td>MCHN views on working with fathers</td>
<td></td>
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<td></td>
<td>MCHS engagement with fathers</td>
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<td></td>
<td>Mother oriented service provision</td>
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<td>NPG</td>
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<td>MCHS opening hours</td>
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<td>MCHN views on BM3</td>
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<td></td>
<td>Services for dads</td>
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<td>Program promotion</td>
<td>Indirect recruitment</td>
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<td></td>
<td>Family Nights</td>
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<td></td>
<td>Facilitator/BM3 Manager visit</td>
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<td>NPGs</td>
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<td>Facilitator phone calls</td>
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<td>Feeder sites</td>
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<td>Personal approach</td>
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<td>Peer recruitment</td>
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<td></td>
<td>Word-of-mouth</td>
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</tr>
</tbody>
</table>
Engaging New Fathers: Learning From Baby Makes 3

Case Study Protocol
**BACKGROUND**

Policies for reducing intimate partner violence are increasingly calling for the involvement of men in violence prevention based on research that suggests men are the main perpetrators of violence against women and are more likely to hold violence supportive attitudes (Australian Bureau of Statistics, 2006, 2013; Australian Institute of Criminology, The Social Research Centre, & VicHealth, 2010; Flood, 2010; Flood et al., 2010; Mouzos & Makkai, 2004; Mouzos & Rushforth, 2003; Nayak, Byrne, Martin, & Abraham, 2003; Peacock & Barker, 2012; Pease, 2008; Uthman, Lawoko, & Moradi, 2009; VicHealth, 2007, 2014; Victims Support Agency, 2012). However, there is limited evidence on how to involve men in intimate partner violence primary prevention interventions. The available evidence tends to focus on engaging boys in school-based respectful relationship programs (Flood, Fergus, Heenan, & Victorian Health Promotion Foundation, 2009; Foshee et al., 1998; Wolfe et al., 2009). Emerging research indicates that engaging men as fathers through violence prevention programs shows some promise (Featherstone & Fraser, 2012; Fox, Sayers, & Bruce, 2001; Stanley, Fell, Miller, Thomson, & Watson, 2012; Stanley, Graham-Kevan, & Borthwick, 2012).

Engaging New Fathers: Learning from *Baby Makes 3* is an instrumental case study that examines new fathers’ engagement with respectful relationships education using the *Baby Makes 3* (BM3) as an illustrative example. More specifically this project explores how gender impacts on service providers’ engagement with new fathers in respectful relationships programs delivered in health settings.

**AIM**

The aim of this project is to:

- Develop an understanding of how gender impacts on service providers’ engagement with new fathers in respectful relationships programs delivered in health settings
- Build an evidence base of gender related factors that influence service providers’ engagement with new fathers in respectful relationships programs in health settings
- Contribute to government and non-government policy planning to reduce the prevalence and impact of intimate partner violence.

**RESEARCH QUESTION**

- How does gender impact on service providers’ engagement with new fathers in respectful relationships programs in health settings?
RESEARCH TEAM

- Naomi Pfitzner, PhD candidate, University of Melbourne
- Prof Kelsey Hegarty, Director of Researching Abuse and Violence Program, University of Melbourne
- Prof Cathy Humphreys, Alfred Felton Chair of Child and Family Welfare, University of Melbourne

This project is being conducted by Naomi Pfitzner, a PhD student from the General Practice and Primary Health Care Academic Centre at The University of Melbourne under the supervision of Professor Kelsey Hegarty from the General Practice and Primary Health Care Academic Centre at The University of Melbourne and Professor Cathy Humphreys of the Department of Social Work at The University of Melbourne. Naomi has worked as a researcher and legal practitioner in the family violence field for a number of years. Kelsey is a longstanding GP with extensive research experience in intimate partner violence. Cathy is a social work academic with over 20 years experience researching intimate partner violence and child abuse and neglect. This project has the full support of Carrington Health (formerly Whitehorse Community Health Services), the lead agency of the Baby Makes 3 program in the Eastern Metropolitan Region and the Baby Makes 3 Steering Committee.

STUDY DESIGN

This project will investigate how gender impacts on service providers’ engagement with new fathers in respectful relationships programs delivered in health settings by using the BM3 program as an illustrative example. The single case study design and methodology draws on elements of Yin (2009), Stake (1995) and Creswell (2007). Data will be collected from multiple sources, such as interviews, focus groups and documentary sources, to develop a detailed understanding of how gender impacts on service providers’ engagement with new fathers respectful relationships education in health settings (Yin, 2009). This project has received ethical clearance from the University of Melbourne’s Human Ethics Advisory Group (Ethics ID: 1340699).
**Data Collection Plan**

<table>
<thead>
<tr>
<th>Information Sources</th>
<th>Role</th>
<th>Data Collection Instrument</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal and Child Health Nurses</td>
<td>Recruit parents into NPGs (BM3 is embedded into the Victorian Maternal and Child Health NPG program)</td>
<td>Face-to-face interview, short demographic survey</td>
</tr>
<tr>
<td>Program Facilitators</td>
<td>Deliver BM3 program</td>
<td>Focus group, short demographic survey</td>
</tr>
<tr>
<td>Father participants</td>
<td>Participants in BM3 program</td>
<td>Telephone interview, short demographic survey</td>
</tr>
<tr>
<td>Program documents</td>
<td>Implementation guide &amp; program manual</td>
<td>Documentary analysis</td>
</tr>
</tbody>
</table>

The main data collection instruments will be qualitative semi-structured interviews and focus groups along with a review of program documents, such as the Baby Makes 3 Group Program Manual and Implementation Guide.

**Recruitment**

Participants will be recruited with the assistance of the Carrington Health, who are the lead agency of the BM3 program in the Eastern Metropolitan Region of Victoria and have agreed to facilitate the research team’s recruitment. Facilitators and MCH nurses will be approached through staff meetings and fathers will be recruited at the final session of the BM3 groups.

**Participation**

Individuals interested in participating in this study will complete and return the pre-paid expression of interest forms provided at recruitment visits. The PhD student researcher will then contact interested individuals to arrange a mutually convenient interview or focus group time and date.

Maternal and Child Health Nurses will be asked to participate in semi-structured audio-recorded individual interviews that will run for approximately one hour. Fathers will be asked to participate in thirty-minute semi-structured audio-recorded telephone interviews that will take no more than thirty minutes. Facilitators will participate in audio-recorded focus groups for approximately one hour. All participants will also be asked to complete a short demographic survey to assist with data analysis.

Maternal and Child Health Nurses will be asked about their understanding of the program, their approaches to getting fathers to attend BM3 including what works, challenges to getting fathers involved in the program and the impact of the Maternal
and Child Health setting on father engagement. The nurses’ experiences of working with fathers in their services more generally and thoughts on improving Maternal and Child Health Services for men will also explored.

Fathers will asked about their motivation for participation and perceptions of the program, their experiences with the program including the most and least engaging aspects of BM3, their thoughts on the facilitators and experience of gender-balanced facilitation as well as their ideas about how BM3 could get more fathers involved. The fathers’ wider experiences of engaging with Maternal and Child Health Services will also explored.

The focus groups with the BM3 facilitators will explore their experiences of engaging new fathers in BM3, challenges to engaging dads in the program, differences in working with men and women, and the impact of the Maternal and Child Health setting on fathers’ engagement. Facilitators will also be asked about how the program could be improved for men and their thoughts on marketing the program to fathers.

Low Risk to Participants
The risk to participants is minimal and it is not anticipated that they will experience any distress from participating in the focus groups or interviews. Participants will be free not to answer any question and may leave at any time. All participants will receive a resource card and, although unlikely, if any participant is distressed by some of the questions they can contact the services listed.

Consent and Confidentiality
Plain language statements will be distributed and discussed at recruitment visits. The student researcher will invite questions to allow interested individuals to clarify any concerns before giving consent. Written consent will be obtained prior to individuals participating in the interviews/focus groups and participants will be free to withdraw from the study at any time. All comments will be kept anonymous and participants will be assigned a pseudonym. References to comments made by participants in the PhD thesis or other publications related to this study will only refer to the assigned pseudonym. The transcribed records of the interviews and focus groups will be kept securely at The University of Melbourne General Practice and Primary Health Care Academic Centre, and will only be available to be viewed by members of the research team. If after 5 years from the date of publication of the research the unprocessed data are no longer of relevance to the research team, the Chief Investigators will seek authorisation from their relevant Heads of Department for disposal of the data.

Data Analysis
Data from the interviews, focus groups and document review will be collated and thematically analysed to develop a thick description of how gender impacts on service providers’ engagement with new fathers in respectful relationships programs delivered in health settings. The qualitative data analysis software NVivo 10 will be used to organise and manage the data collected.
## STUDY TIMELINE

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2013 - July 2013</td>
<td>Refine research questions &amp; frameworks, ethics application &amp; approval, secure sites for field research, research, writing</td>
</tr>
<tr>
<td>July 2013 - December 2013</td>
<td>Research, literature review, writing, field research planning</td>
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<tr>
<td>January 2013 - December 2014</td>
<td>Field research, writing</td>
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<tr>
<td>January 2015 - May 2015</td>
<td>Data analysis, writing</td>
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<td>May 2015 - May 2016</td>
<td>Write &amp; review thesis</td>
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<tr>
<td>May 2016</td>
<td>Submit thesis</td>
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REFERENCES


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<th>Source</th>
<th>Name</th>
<th>Description</th>
<th>Data Collected</th>
<th>Location</th>
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<tbody>
<tr>
<td>D1</td>
<td>Document</td>
<td>BM3 Training DVD</td>
<td>Copy of BM3 training DVD on USB</td>
<td>29/1/14</td>
<td>USB - secure storage DGP &amp; electronic – password protected case study data folder</td>
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<tr>
<td>D2</td>
<td>Document</td>
<td>Group Program Manual</td>
<td>Group program manual used for BM3 facilitator training includes handouts given to participants during sessions</td>
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<td>D6</td>
<td>Document</td>
<td>BM3 WCHS Interim Evaluation Report May 2014</td>
<td>BM3 WCHS Interim Evaluation Report May 2014</td>
<td>21/7/14</td>
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<tr>
<td>FN1</td>
<td>Field Notes</td>
<td>Notes from observing BM3 facilitators training</td>
<td>Notes from observing BM3 facilitators training of MCHNs from Maroondah council on 29/1/14</td>
<td>29/1/14</td>
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<td>Notes on council recruitment</td>
<td>Reflections on the process of recruiting councils for the study</td>
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<td>Notes on MCHN recruitment</td>
<td>Reflections on recruiting MCHNs for the study</td>
<td>10/4/14 onwards</td>
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<td>Notes on father recruitment</td>
<td>Reflections on recruiting fathers for the study</td>
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<td>FN5</td>
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<td>Notes from COP 22/5/14</td>
<td>Notes from BM3 facilitators COP meeting on 22/5/14</td>
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<td>Field notes from father interviews</td>
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<td>16/9/14 onwards</td>
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<td>Field Notes</td>
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<td>Field notes from MCHN interviews</td>
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<td>FN10</td>
<td>Field Notes</td>
<td>Field notes from focus groups</td>
<td>Field notes from facilitator focus groups</td>
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<td>QD1</td>
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