



Fatherhood and Health **outcomes** in Europe



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Contents

| | |
|--|----|
| Acknowledgments | iv |
| Executive Summary | v |
| Introduction | 1 |
| Structure | 2 |
| Fatherhood and reproductive health | 3 |
| • Becoming a father and maternal and child health care | 3 |
| • Planning to become a parent | 4 |
| • Men and antenatal care | 4 |
| • Men's presence during delivery | 5 |
| • Fatherhood and positive health outcomes for women | 6 |
| • Special groups – special needs | 7 |
| • Parents who are immigrants | 7 |
| • Fatherhood, poor economic conditions and class | 8 |
| • Adolescent fathers | 9 |
| • Summary | 10 |
| Managing fathering: on fatherhood and health in everyday life | 11 |
| • The meaning of fatherhood and how it affects men's health | 11 |
| Combining work and family life | 13 |
| • Fatherhood and parental leave | 13 |
| • Gender differences in adapting work to family life | 14 |
| • Work – family boundaries – affecting well-being and health | 15 |
| • Fathers' influence on the health of their children | 16 |
| • Summary | 17 |
| Summary and Conclusions | 18 |
| References | 20 |

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Executive Summary

What is known about fatherhood and reproductive health? How can men, by being more involved in parenting, contribute to better health outcomes for themselves and their children and partners? What factors affect men's involvement in parenthood and reproductive health positively? The report *Fatherhood and health outcomes* explores these issues. The report is based on a literature review with a special focus on fatherhood in Europe.

Examination of the research literature shows, generally speaking, that increased involvement by men in fatherhood can benefit men, as well as women and children, in the form of better health. For example, men can give important psychological and emotional support to the woman during pregnancy and delivery. This, in turn, can reduce pain, panic and exhaustion during delivery. Studies have also shown that men's involvement in maternal and child health programmes can reduce maternal and child mortality during pregnancy and labour by being prepared, for example, for obstetric emergencies.

However, increased involvement in fatherhood can also benefit men's own health and well-being. For example, men who have been recognized in their new position as fathers and experienced emotional support during the pregnancy have better physical and mental health. Several studies have also concluded that men's health is stimulated by the relationships between their different positions as husbands, parents and professional workers. Fathers who are equally active in the domestic sphere and engage themselves in their children also develop less negative health behaviour and have lower associated risks of death and ill health.

Although the research literature shows how increased involvement by the fathers can affect health outcomes positively for the men themselves, their partners and their children, the maternal and child health care services in Europe still have difficulty in attracting and increasing the involvement of fathers in various programmes. This means that most men get less information and are often less prepared for parenting than women. Maternal and child health programmes have also had particular difficulty in reaching certain groups of parents and fathers, such as immigrant fathers, economically marginalized fathers, fathers with low socioeconomic status and adolescent fathers. Targeting these groups would greatly benefit the health outcomes of many parents and children.

The support for men's increased involvement in parenthood and reproductive health also depends on more multifaceted support from the welfare state and employment. For example, numerous studies have showed that a generous parental leave system, enabling longer paid parental leave, gives parents better opportunities to combine work and family life; several studies have found that this positively affects both gender equality and health outcomes. However, this support varies greatly between the different countries in Europe but generally is very poor. The same situation applies to employment, where fathers most often are not seen as parents and therefore get limited support for combining work and family life.

Introduction

In 1994, the International Conference on Population and Development established the importance of involving men in the challenge of improving sexual and reproductive health. Above all, the Conference emphasized developing efforts that would increase men's involvement in parenting and measures that could lead to men taking greater responsibility for their sexual and reproductive behaviour – including family planning and maternal and child health. The background to this was a growing realization that men's attitudes, knowledge and ways of reacting influenced not only their own but also women's reproductive health.

Parallel to this, academic interest has been growing in how men live their lives, create their male identity and form relationships with their immediate environment. One context in which these questions are being explored is in the research on men, masculinity and fatherhood. Fatherhood research has increased dramatically during the past decade and become a multidisciplinary scientific field of knowledge. Behind this development are several major changes in modern society, such as shifting marriage and divorce patterns and changes in working life with increasing labour force participation among women. The growth of the women's movement has also contributed to a strong focus on fatherhood, since increasing gender equality in society requires increased involvement by men in family life. The result is that scientists from various scientific disciplines are studying a broad variety of different perspectives and questions related to men's parenting. The questions are no longer focused solely on how fathers' behavioural patterns influence their children's development but also on the men themselves, their partners and how fatherhood is constructed in everyday practice and in relationships (Plantin, 2003). This means that several questions have been raised about men's parenting, reflecting the positive as well as the problematic sides of it. The challenging and difficult side of men's parenting has mostly been framed in discussions about "deadbeat dads" or "feckless fathers" who ignore their parenting responsibilities and how this negatively affects the children's emotional, mental and financial well-being. Fathers' lack of taking equal responsibility for the internal family work and the household tasks is another example of problematic behaviour that has been discussed and related to negative effects on women's potential to combine work and family life. Men and fathers have also been discussed in connection with domestic violence and other destructive behaviour that negatively affects their own health as well as that of their family.

However, another part of fatherhood research has challenged the deficit perspective on men's parenting and instead focused on the positive sides of fatherhood that might contribute to better health outcomes. The significance of fathers for children's and adolescents' development and well-being and the positive meaning of being a father that many men experience are examples of topics in this research. Discussions about various policies and legislation to support fathers in becoming more involved in caring for their children are also closely connected to this perspective. Policies on parental leave or various forms of support to combine work and family life provide better opportunities for men to be more engaged and involved in all parts of domestic life.

But more specifically, what is known from this perspective about the relationship between fatherhood and health? How can increasing involvement by fathers in sexual and reproductive health contribute to better health and well-being for themselves as well as their partners and children? Does existing literature provide evidence that supports the idea that men should be more involved during delivery and antenatal and postnatal care? What about gender equality and the modern ideas related to new, equal and nurturing fatherhood – what is known about the health outcomes of this? Do policies that support fathers in being both working fathers and caring men affect the health of men, women and children?

Structure

This report examines these questions more closely. The report contains three different sections and starts by describing the methods for the literature review. It then continues with a chapter on fatherhood and reproductive health. This chapter focuses on expectant and new fathers and discusses what is known about men's experiences of the childbearing decision, pregnancy and delivery. How can men be supportive and engaged during these stages in the process of becoming a father, and how are these experiences related to the health outcomes of the mother, child and men themselves? This chapter ends by highlighting groups of fathers that might need special support and concern from a health perspective.

The next chapter focuses on managing fathering: fatherhood and health in everyday life. This chapter discusses fathers' practices in everyday life and how they can be related to various health outcomes. It starts with a general overview of the research that has studied how becoming a parent, and in this case becoming a father, affects men's health. Is becoming a father positive for men's health as it adds new meaning to life and a healthier way of living, or can it actually have negative effects as it means increased stress, marital conflicts and more worries?

This is followed by a section focusing on the potential for men to be both working fathers and caring men. It highlights existing policies for fathers in Europe to combine work and family life and investigates whether there is evidence for linking these to positive health outcomes. This includes policies on parental leave, parents' access to child care and family-friendly policies at the workplace. There is also a special focus on the relationships between work–family boundaries, stress, illness and well-being.

The next section draws on research studying internal family life in Europe, with a special focus on men's participation in childrearing and household work. The father–child relationship and the importance of fathers for children's well-being, health and development are also highlighted.

Finally, the report ends with a summary and conclusion highlighting and discussing the main results.

The overall structure of the report follows a chronological time line in the fatherhood career, from the childbearing decision to men's interaction with children and strategies for combining work and family life. The report focuses on men's

experiences and practices as fathers and how this can be related to their health and well-being and those of their partner and children. As WHO already does profound work on domestic violence (García-Moreno et al., 2005) and in this discusses the destructive sides of many men's actions in family life, this report concentrates instead on the more constructive aspects of men's parenting – how fathers can contribute to improving health and well-being for themselves as well as for their partners and children.

However, as indicated in the introduction, the research on fatherhood has expanded dramatically during recent decades, and including all studies in the field is more or less impossible in a report like this. The review is therefore delimited to mainly focus on existing studies and fatherhood literature in Europe. Nevertheless, some prominent literature from outside Europe is also mentioned and included. This means the report has an overall purpose of focusing on men's parenting and experiences of fatherhood in Europe. Within this framework, a special focus is the relationship between fatherhood and health to determine how fatherhood can be related to improving health and well-being for the men as well as their partners and children.

Mostly English-language refereed articles were considered, even if some information was collected through other sources, such as government reports or information from the web sites of various organizations. Most of the material was located through database searches in MEDLINE (PubMed), Oxford journals, Cambridge journals online, Sage premier journals online and Sociological Abstracts. Searches have also been performed at such web sites as WHO, Family Health International, United Nations, Allan Guttmacher Institute and the International Planned Parenthood Federation. Searches for figures and statistics were mostly done at Eurostat and in the archives of the International Social Service.

Men's parenting has been broadly defined during the search through the different databases as a response to existing varieties in fatherhood. It means not only a focus on heterosexual men's parenting in a nuclear family context but also other forms of fatherhood. Central and important search terms have been: fatherhood and health; men and masculinities; adolescent fathers; single fathers; family relations; gender relations; paternal involvement; health in Europe; and parental leave in Europe.

Fatherhood and reproductive health

Becoming a father and maternal and child health care

Maternal and child health care is an important health development in reproductive health in Europe today. It supports women and children before, during and after pregnancy and offers a wider range of health interventions such as preventing and treating sexually transmitted infections, introducing family planning, providing immunization, nutritional advice or other health programmes. However, the possibilities for new or expectant parents to get access to high-quality care vary widely within Europe. The best possibilities are offered within the countries in the European Union, while parents in the central Asian republics and central and south-eastern European countries get least support from maternal and child health care services. As a consequence, the figures for the morbidity and mortality of mothers and newborn babies follow the same patterns and differences between the countries (WHO Regional Office for Europe, 2005). The Nordic countries have among the lowest figures for infant mortality in the world, whereas such countries as Albania and the Republic of Moldova are much further down the list.

However, research shows that many negative conditions are avoidable if the pregnant mother gets social and psychological support, not only from high-quality maternal and child health care but also by a social network, especially from the partner of the pregnant woman (Hall & Carty, 1993; Chapman et al., 1997; Deijin-Karlsson, 2000; WHO Regional Office for Europe, 2003a).

The idea of increasing the involvement of prospective fathers in reproductive health is not new and has existed for several decades in many parts of Europe, especially in the countries in the European Union. During the 1960s and 1970s, men were encouraged to take part in parent groups and to participate during labour and to take a more active role in caring for their infants. The primary intention was to give greater support to the pregnant partner before, during and after birth. With this in mind, maternity care services offered fathers instruction and advice that focused primarily on the best way of supporting the pregnant woman. This could, for example, include teaching the man breathing exercises or other relaxation techniques with which he could help the woman. Since this, the purpose of the man's involvement has expanded. Today men are involved not only for the sake of the health of the mother and child but also for the man's own health and potential to develop an identity as a parent as early as possible.

There is, however, considerably more research today on the significance of the man's support to the pregnant woman before, during and after pregnancy. Reports from Africa and Asia show that the man's participation in maternal and child health programmes can counteract maternal and infant mortality in relation to pregnancy and birth by increasing the possibility of women receiving immediate care in obstetric emergencies (Dudgeon & Inhorn, 2004). At present, about 95% of all maternal deaths occur in Africa and Asia (United Nations Population Fund, 2005). Research shows that increasing the involvement and support from the man can also benefit in tackling other significant problems addressed by care services such as preterm birth, low birth weight and fetal harm (Dudgeon & Inhorn, 2004).

The situation in countries with lower maternal and infant mortality rates differs, even if much of the research here has also examined men's involvement in relation to harm to the mother and fetus. There is extensive research in this area assuming that there is access to an existing professional maternal and child health service. At the same time, many studies show that many people in Europe receive considerably less support than expected from these services, such as teenage parents or parents who have migrated to Europe from other parts of the world (Schott & Henley, 1997; Jansson, 2000). This is discussed later.

Planning to become a parent

In many parts of Europe, the fertility rate has drastically diminished during the past decade. In most countries this rate is now below the replacement level, which is 2.1 children per woman on average. Most affected are the countries in southern and eastern Europe, where the birth rate is 1.0–1.3 children per woman. The explanation for the lower birth rate in Europe varies between subregions, but generally speaking most research points to an extended youth period, increased demands for education from employers and difficulty for today's youth in combining work and family life (Plantin & Bäck-Wiklund, 2004). In eastern Europe and central Asia, an increase in poverty and difficulty in economically managing parenthood have led to a dramatic reduction in fertility rates after the dissolution of the USSR. For example, Estonia, Lithuania, Latvia, Romania and the Ukraine all have fertility rates of less than 1.4 children per woman. The rise of unplanned pregnancies and number of abortions is significantly greater in eastern Europe than in western Europe. Henshaw et al. (1999) showed that eastern Europe has the highest rate of unplanned pregnancies and the highest abortion rate of any area of the world: 90 abortions per 1000 women of childbearing age. Western Europe has the lowest abortion rate, 11 per 1000 women, although its abortion laws are similar to those in eastern Europe. The study concludes that the disparity could be because of the greater availability and use of contraceptives in western Europe.

Despite the lower figures in western Europe, a survey on contraception by researchers in France (Bajos et al., 2003) found that one third of the pregnancies among women in their study were unplanned and that two thirds of these pregnancies occurred among contraception users. The still significantly high numbers of unplanned pregnancies, particularly in eastern Europe, shows the importance of increasing men's awareness and responsibility in family planning and reproductive health. All available research in this area shows that male involvement is positive and necessary, as this influences the contraceptive decision-making both directly and indirectly (Edwards, 1994; Bankole, 1998). However, support from a partner is not only important in avoiding unplanned pregnancies but can also have a beneficial effect on the mother's wish to keep an unplanned pregnancy. Kroelinger & Oths' (2000) study of women with unplanned pregnancies showed, for example, that if the woman could rely on her partner for both emotional and instrumental support this clearly affected whether they wanted pregnancy positively. They write that "women who experience unwanted pregnancies are at greater risk of complicated pregnancy outcomes, and their children are more likely to experience physical or psychological problems in infancy". It is important to pay attention to this knowledge and include men "more in the prenatal care process".

Studies show that men are often cautious and less ready to have opinions regarding the birth itself. Willén (1994) found that men were less interested than women in having children and regarded it as a natural consequence of having a relationship. Women, in contrast, considered producing a child to be an exciting and challenging life project, and Willén claimed that this had been established early in development of the

personality. The caution expressed by the men can negatively influence their ability to create an identity as a father. Others claim that this attitude, in combination with the immediate environments focusing on the woman's pregnancy (Early, 2001), leads to the man acting as a back-up to the woman and child rather than taking parental responsibility (Jordan 1990; Donovan, 1995; Plantin, 2001). This is reflected, as shown in the following section, in the man's presence and involvement in maternity care activities for parents.

Men and antenatal care

The main goal of antenatal care is to prevent health problems in both the infant and the mother. The care includes planning for pregnancy and continues into the early neonatal and postpartum period. During pregnancy, prenatal care comprises mainly examinations that focus on the status of the developing fetus and the preparations for a safe delivery. The man has therefore had, historically speaking, a much more withdrawn role in this context.

Maternal and child health services have made efforts to involve men for several decades in many western European countries. The most commonplace is that the man is often invited to come along to the regular prenatal checkups as well as parent training being offered to both men and women. A study on fathers in Denmark (Madsen et al., 2002) showed that 80% participate in prenatal preparation courses and preventive health care consultations. In Sweden, the corresponding figure is 90% (Ministry of Health and Social Affairs, 1997). In several countries, mainly in Scandinavia, parent groups are offered specifically targeting the expectant fathers. Further, in Sweden the interest among men in participating in parent education has increased significantly during the past 20–30 years. Almost 90% of the men who attend maternal and child health services take part in their parent education (Ministry of Health and Social Affairs, 1997). The education groups that target fathers only have also been successful in attracting men. Evaluations show that men who have taken part in these groups are very positive towards this form of education. Most men who take part in these groups are primarily first-time middle-class fathers (Blom, 1996). Similar findings are reported in England (Lewis, 1987).

Despite these efforts, studies show that many men feel themselves marginalized and excluded in their contact with maternal and child health services (Chalmers & Mayers, 1996; Lester & Moorsom, 1997; Finnbogadóttir et al., 2003). Some researchers claim that this feeling of being left out makes it harder for the man to feel involved straight away at a deeper level of parenthood (Henderson & Brouse, 1991; Hawkins et al., 1995; Early, 2001). An important explanation as to why many men feel left out although they take part in the parent groups is that childbirth or parent education classes most often still tend to mainly focus on women and motherhood and seldom also focus on the men's own concerns and situation (Early, 2001; Plantin, 2001). A quantitative survey among fathers in Denmark (Madsen et al., 2002) showed that 40% of the men did not feel the midwives directly addressed them during consultations. Other studies have also shown that the use of open discussion groups, which is common within maternal and child health



services, leave men at a disadvantage as the women are more used to talking about pregnancy, birth and parenting (Bremberg, 2006).

Parent education may target men but only as to how the man can best support the woman (Barclay et al., 1996, Hildingsson & Häggström, 1999; Kaila-Behm & Vehviläinen-Julkunen, 2000; Mander, 2004). Lewis (2002) says that, at least in England, this should be seen in the light of a persistent social policy that has focused more on men's responsibility to support and provide for their families than their caring capabilities. However, in Sweden there is a clear change in both policy and attitudes from cash to care: fathers are no longer expected to take responsibility only for family finances but instead are expected to provide a new, more caring and egalitarian parenting (Bergman & Hobson, 2002). Fatherhood is consequently seen in a new light and has been given a stronger position in the arena that had previously only been afforded to motherhood.

Today, for example, significant research describes men's experiences of pregnancy (Lupton & Barclay, 1997; Hagström, 1999; Persson & Dykes 2002; Nyström, 2004). Finnbogadóttir et al. (2003) found, for example, that most expectant first-time fathers in their study not only had a feeling of unreality during pregnancy but also experienced feelings of insufficiency, inadequacy, anxiety and insecurity. This indicates the importance of recognizing the men's situation and their need for support to handle their transition to fatherhood. The results of Diemer's (1997) study of expectant fathers also underlines this; men who were recognized in their new position as becoming fathers and experienced emotional support during the pregnancy showed better physical and mental health. These men reported fewer problems in the relationship with their partner after birth than those who did not receive this support.

During recent years, the Internet has been seen as an important channel in spreading information and advice to people about to become parents. A variety of commercial web sites already address parents, but this knowledge is limited depending on how expectant parents use the Internet for collecting information. However, a study in Sweden of a web site for parents (Sarkadi & Bremberg, 2005) showed a very interesting result. The study was based on a web questionnaire with 2499 participants and showed that 65% of parents used the web site as the first source when they needed advice and information, regardless of the user's level of education. The web site was not only used as a source of information but most of the users reported that it also had an important function as social support and an opportunity to identify with others. Single parents and those with low incomes or basic education especially experienced better social support than other people offered by the opportunities for chat rooms on the web sites. The author thus concluded that the Internet can meet an important need of parents because they can receive almost unlimited advice and support from people in a similar situation at any time.

The results and conclusions are interesting considering that many researchers have criticized the traditional maternal and child health services because of the domination of middle-class values (Jansson, 2000; Petersson et al., 2004) as well as being too general in their construction and not able to address individual parents and families (Ministry of Health and Social Affairs, 1997; Olsson, 2000). The web site examined by Sarkadi & Bremberg (2005) was presented in a way that it did not succeed in attracting all groups of parents. Many of the fathers taking part in the study complained that they felt themselves marginalized because discussion groups were often dominated by women and reflected the norms of motherhood. One conclusion made by the study was that specific discussion forums for men should be introduced to be able to meet this need. This has been attempted in various countries. In the United States, there are numerous web sites for fathers with virtual family life education, a type of parent education that is informative as well as interactive (Morris et al., 1999). Many of the sites seem to be well visited according to the web sites' own visitor counts, but generally speaking there has been no scientific evaluation of the effects of these web-based contributions compared with other forms of support. An interesting exception to this is Hudson et al. (2003), who made a comparative study of two groups of fathers: one took part in Internet-based parent education and one was only offered participation in the usual maternity and child welfare services group. The fathers who took part in the Internet education met on the web site New Fathers Network, where they gained access to a virtual library with literature about children and parenting, a discussion forum for meetings with other parents and the possibility of accessing a midwife via e-mail. The study focused on the fathers' abilities and trust in themselves as parents, and conducted measurements four and eight weeks after delivery. The Internet group showed a much more positive result than the other group and reported an increase of both competence and self-confidence during the study period.

However, some research stresses the importance of not only focusing on the parent education classes but also encouraging men to participate in ultrasound examinations. Draper (2002) found in the United Kingdom that ultrasound was very important for the men, as it helped them to "visualize the baby and realize their transition to fatherhood". Further, Ekelin et al. (2004) conclude in Sweden that many men experience the ultrasound as confirmation of a new life and therefore "an important milestone" in developing a paternal identity. Some research today identifies the importance of involving the fathers during pregnancy, as it can positively influence their mental health, most of all their mental well-being.

Men's presence during delivery

In accordance with men's increased participation in the parent education offered by maternal and child health services, men's attendance at the birth has also dramatically increased during the past couple of decades, at least in high-income countries. In the mid-1990s, about 95% of the prospective fathers in England were present at the birth (Draper, 1997). Similar figures have been reported from Scandinavia. A study

in Denmark (Madsen et al. 2002) showed that 95% of the fathers attend delivery at the hospital and 98% of these do it because they want to. Seventy per cent also wish to stay overnight with the child and the mother at the hospital, which is seldom possible. Reports also show increasing participation of fathers at the birth in lower-income countries. For example, in Ukraine, the man's attendance at the birth has increased during the past decade from not much more than 0% to 52% (United States Agency for International Development, 2005).

Nevertheless, Chapman (1991) showed that men generally show mainly one of two types of behaviour during labour, either the passive role of the witness or the more active role of the birth coach or teammate. The couples in the studies that defined their relationship as sharing or more equal had a greater probability of regarding the delivery as a positive joint effort.

Nevertheless, several studies show that the demand on the man to be an active birth coach can also have negative effects. Many men report that they feel stressed by the demands and have doubts as to whether they can really contribute (Chapman, 1991; Plantin, 2001). Some actually experience a dread of the delivery that is primarily related to the child's life and health (Eriksson et al., 2006). The fathers feeling stressed and not sufficiently prepared is largely due to the role of the mother predominating in parenting classes as well as a lack of support and instruction during the birth itself (Hallgren et al., 1999).

An important argument for the man's active involvement during labour has been that the man is given an opportunity to develop a relation to the child early (Lupton & Barclay, 1997). Both Ferketich & Mercer (1995) and Sullivan (1999) conclude that the more the father engages himself during the birth and postnatal period, the stronger is his attachment to the baby. Pruett (1987) continues with this idea and states that a father with strong attachment to his baby will participate more in the child's growing up. Chronholm's (2004) study of men who had taken long paternity leave early on showed similar results.

Based on this, Person & Dykes (2002) say that it is important to support the decision of the new family to go home as soon as possible after the birth, as this will further improve the father's feeling of participation. The father's early involvement in giving care after the birth has also been associated with improved outcomes for the cognitive development of preterm and low-birth-weight babies (Yogman et al., 1995). Nevertheless, in Europe relatively little support is given to fathers after the birth. In Scandinavia and several other European countries, maternal and child health services offer support through parenting groups, which focus on the child's health and development, need for stimulation and proper diet etc. However, few fathers take part in this. A study of fathers who attended maternal and child health services in Sweden (Fåggerskiöld, 2006) showed that the child health nurses are unaccustomed to meeting fathers, lack expectations related to fathers' caring ability and almost solely focus on the mother.

Fatherhood and positive health outcomes for women

Many research studies show that the fathers have an important function in supporting women during both pregnancy and labour (Dudgeon & Inhorn, 2004). Liamputton & Naksook (2002) state, for example, that the women in their study highly valued the men's support and saw it as important for the transition to motherhood. This support included the psychological support for the woman during pregnancy as well as the immediate help in the form of shared responsibility for the child after birth. Early (2001) indicated that much of the research during the past 30 years states that prospective fathers can offer the pregnant woman important psychological, emotional and moral support. For example, Kroelinger & Oths (2000) showed that the increased involvement of men during pregnancy can positively affect the health of the woman and child. Several studies that examined smoking during pregnancy also stated that lack of sufficient psychosocial resources, especially from the child's father, increases the risk for continued smoking among pregnant women (Dejin-Karlsson, 1999). As for the men themselves, however, imminent parenthood is not considered to influence smoking habits. Blackburn et al. (2005a) found, for example, in England that men who have children quit smoking at the same rate as other men. Nevertheless, many try to avoid exposing the child to environmental tobacco smoke and thus quit smoking after the birth (Blackburn, 2005b).

Other research relating to pregnancy indicates a relationship between the man's support and the woman's health. Both Pagel et al. (1990) and Mutale et al. (1991) found, for example, that lack of social support, especially from the husband or family, has major negative effects on fetal growth. Dejin-Karlsson's (1999) study, however, did not find any similar association.

In much poorer countries, the increase in the man's involvement during pregnancy has also been seen as a possible factor in reducing the number of children with low birth weight. The reason for this is that low birth weight is often caused by insufficient caloric and micronutrient intake during pregnancy, and men often control women's nutritional status as they mediate their access to economic resources (Dudgeon & Inhorn, 2004).

Several studies even show that the man's presence in the labour room shortens the labour and reduces the epidural rate (Berry, 1988). The presence of a labour companion has also been shown to reduce the pain, panic and exhaustion of the woman (Kennell et al., 1991; Somers-Smith, 1999). However, the most common reason why women want to have their husbands present in the labour room is that they simply want to share the experience with their partner. It gives a feeling of enhancing the relationship between the prospective parents (Bobdas-Salonen, 1998). Enkin et al. (1995) found that most women are satisfied with the support they receive from their partners and are often more satisfied than with the support from the midwife.

Special groups – special needs

Even if considerable efforts have been made to build up maternal and child health services in Europe, the support offered to parents still differs significantly from country to country. Maternal and child mortality rates clearly show that the quality of reproductive health services can vary between countries as well as regions (WHO Regional Office for Europe, 2003a,b, 2005). These differences occur not only between countries but within countries as well: several studies show that maternal and child health services often have difficulty in reaching all groups of parents (Ministry of Health and Social Affairs, 1997; Hallgren et al., 1999; Ekeus & Christensson, 2003; Bremberg, 2006). Schott & Henley (1997) say, for example, that today there is general agreement that the endeavour to give “the same service for all” has failed where the same information has not reached all the groups in society. As mentioned earlier, maternal and child health services have difficulties in informing and involving fathers in the reproductive health work. Regardless of how developed maternal and child health services are in the various countries, the pattern is the same – that prospective fathers participate much less in their activities than the prospective mothers. However, fathers are not a homogeneous group and the ways they construct their parenthood vary greatly. Variation exists not only between men but also over time and within each individual's perspective of parenthood (Plantin, 2001).

Nevertheless, some research has shown that differences in the support men receive from maternal and child health services can be related to class and socioeconomic status, ethnicity, migration and age. The following section therefore examines the research into various groups of fathers and parents that receive less support by maternal and child health services. Many groups of parents have special needs other than those mentioned here; families with severe social problems, families with children who are functionally impaired, mentally impaired or have chronic illness or mental disorder. Nevertheless, these often receive services primarily from other authorities or organizations and not solely from maternal and child health services. As a result, this report does not specifically address them.

Parents who are immigrants

Each year the number of people migrating to Europe increases. According to the United Nations Population Division (2005), there were about 191 million migrants in the world in 2005, of which 64 million live in Europe. Some of these immigrants come from low-income and war-torn countries in Africa and Asia; other immigrants have moved within Europe, from poorer to the more affluent parts of the European Union. According to the European Health Forum (2005), this increased migration is one of the greatest challenges for European health care systems, as immigrants and ethnic minorities generally experience considerably poorer health than other population groups. The reason for this is their often lower social position, low income and health-endangering work. Studies have also shown that many immigrants lack health awareness because of language barriers or bureaucracy and often have no or reduced access to health-related information or services (EurActiv Network, 2006).

Studies in Sweden show, for example, that parents born outside Sweden make considerably fewer visits to maternity health care and child health care compared with parents born in Sweden (Dejin-Karlsson & Östergren, 2004; Fabian et al., 2004). Similarly, other surveys show that participation at parent education programmes is not only lower among fathers in general but particularly among fathers with lower socioeconomic status than middle class and among fathers born abroad (Plantin, 2001; Petersson et al., 2003, 2004; Fabian et al., 2004; Ny et al., 2006). The explanation for this varies from study to study, but in most research, which often takes staff perspectives as a reference point, it is “language difficulty” and “the problem in the meeting of different cultures” (Ministry of Health and Social Affairs, 1997; Nyberg, 2000; Darj & Lindmark, 2002). These problems “in the meeting of different cultures” are unclear, and researchers state that the reasons can be found in the normative structure of maternal and child health services, which are largely based on motherhood and white middle-class values (Jansson, 2000; Petersson et al., 2004).

The fact that many studies show that people born in another country receive poorer support when they become parents is worrying, given that they mostly live in very segregated housing areas and have much poorer health than other groups in society (Parliamentary Assembly, Council of Europe, 2001). A longitudinal study in southern Sweden of children's health and their living situation showed that non-native parents experienced greater financial stress and received weaker emotional and practical support than other groups of parents (Östergren, 2003). Carballo et al. (1998) also point to a high risk for separation among these parents, which in turn can negatively influence both the parents' and the child's sense of well-being (de Jong, 1994). Even Akhavan et al. (2004) state that many people with immigrant or refugee backgrounds often live under poor economic circumstances and have much more difficulty in finding employment. In their study of health in relation to unemployment and sick leave among immigrants, Akhavan et al. stated that most participants considered their health to be poor and many also experienced physical and/or mental disorders. The women in particular experienced poorer health than the men. Even the relationship between parents and child risks being negatively affected by migration as children generally adapt more rapidly to the cultural values and styles of the host culture than that of their parents (Roer Strier, 1996).

Many articles relating to physical health and pregnancy point to an increase in poor health among immigrant parents. Studies in Sweden show that women born outside Sweden (in this case, women born in African countries, Iraq or Lebanon) run a higher risk of giving birth to babies with limited growth, that they are significantly more obese with higher body mass index than the women born in Sweden and run a greater risk of perinatal death (Dejin-Karlsson, 1999; Essén, 2001; Ny, 2007). Similar results are reported in England, where black women have a much higher risk of maternal and perinatal death. Statistics also show that half of all acute Caesarean sections are performed in this group (Royal College of Obstetricians and Gynaecologists, 2001; Sallah, 2004). Studies from Belgium and Germany show similar

findings: many immigrant groups, particularly those from Morocco and Turkey, have very high perinatal and infant mortality rates (Huisman et al., 1997; Muynck, 1997). Finally, research from Spain shows that women from Africa and from Central and South America often experience problems with premature birth, low birth weight and complications during delivery compared with other women (Gaspar & Silès, 1997).

Just how the situation looks for immigrant fathers is rather unclear from a research perspective, as studies are scarce. However, Williams (2007) is an exception, as he has studied African-Caribbean fathers in the United Kingdom. He found that, for many of these fathers, “anticipated or perceived racist prejudice, abuse or discrimination influenced their health experiences”. Further, Ny et al. (2006) examined men of Middle Eastern origin living in Sweden and their experiences of maternal and child health care. The study was based on focus group interviews with Iraqi men living in Sweden for just a couple of years who became fathers during this time. The men had no contact with maternal and child health services before or after the birth. Nevertheless, almost all these men, with the help of a midwife and others, had participated in the birth itself and described it as a very positive experience. The men said that, apart from the increase in involvement, it had helped give them greater understanding and respect for the woman.

However, generally speaking men’s discussions about parenthood were of mostly negative experiences. Most emphasized, for example, the difficulty in establishing effective parenthood that meets the expectations of both oneself as well as of others. Some even said they “regretted” having children in Sweden, relating difficulty to economic and social segregation. When asked to speak more specifically about parenthood they described poverty, unemployment, living in highly segregated areas, overcrowding, limited social network, shame, isolation and inadequacy – in relation to the children, to the woman and to themselves. Many went on to say that the experience of powerlessness and lack of role as parent had led to deterioration in their emotional as well as physical health.

Similar studies confirm this result. Roer-Strier et al. (2005), whose study was based on fathers who had migrated to Canada and Israel, found that these fathers experienced great difficulty in finding employment and this adversely affected their parenthood. The study showed some positive effects of migration, where the men emphasized the opportunities for getting information about children and parenthood, the increased options for education for the children and a greater availability of places supporting contact between fathers and children, such as playgrounds and sport arenas.

In the same vein, studies in sociology and social anthropology show how men’s parenthood is severely strained as a result of migration, including the loss of legitimacy and authority (Darvishpour, 1999). Al Badawi (2003) claims that the high rates of unemployment, dependence on social welfare and language problems that often characterize the situation of many immigrant men are key factors for their experience of losing vital and important aspects of their parenthood:

that is, the position as breadwinner or the position as spokesperson for the family. In contrast, motherhood is less exposed to strain as women often get better support in their parenthood from different health and welfare institutions. Through the closeness to the children, the mother also gets better and continuously updated knowledge about the new surrounding society.

Given this background, these experiences should be taken into consideration, including how they influence men’s health, their life situation and their role as parents.

Fatherhood, poor economic conditions and class

The previous discussion of immigrant parents clearly indicates that even position in the social class hierarchy and socioeconomic status influences both parent and child. Contemporary research generally shows that good social and economic status is beneficial to health. Much suggests that the conditions of life are accumulated over time, and so the first few years are particularly important.

The differences in the conditions for children vary greatly in Europe. For example, the proportion of children living in households with incomes below 50% of the national median (a conventional definition of relative poverty) varies between 3% in Finland and 21% in United Kingdom and Italy. Many of the countries in eastern Europe show much lower figures than the western countries, as these countries have a long history of low income inequality and a tradition of investment in the social sector (Micklewright & Stewart, 2000). An examination of 111 studies of social variation among children in Sweden convincingly shows how the children in the lower and more disadvantaged segments of society have poorer health (Bremberg, 2002). Physical illness is 60% more common and emotional difficulty 70% more common among socially disadvantaged children than among those socially advantaged. The study also shows that the risk of infant death is three times greater than the average if the child is from a socially disadvantaged group. Children who are not breastfed are three times more likely to be from this group. In an international comparison, the authors find a similar situation in other western European countries, and the situation for this group in the United States is much worse and much more serious.

Studies that directly examine the situation of the fathers or the relationship between fatherhood and class are more difficult to find. How do, for example, poor economic conditions affect everyday family life and men’s construction of fatherhood? How are men’s values and behaviour as parents influenced by social class or the positions within different social strata?

As mentioned earlier, fathers from the working class and fathers who live under poor economic conditions participate much less in parent education classes or other forms of activities in maternal and child health care. They read fewer newspapers and books that contain information about children and parenthood than other parents do (Bremberg,



2006). This means that these fathers are often more poorly prepared for the birth of the child than middle-class fathers are. Studies also show how poor economic conditions can clearly influence how men deal with parenthood. Elder et al. (1992), for example, show that financial stress in family life more greatly influences men's behaviour since the responsibility to provide for the family is often so deeply associated with fatherhood. According to the study, the anxiety, worry or depression that often results from financial difficulty tends to make many fathers more intolerant, authoritarian, punishing or lacking in energy in their parenting. Mosley & Thomson (1995) also examined this relationship but found no evident patterns that indicate that financial insecurity negatively influences fathers' relationships to their children.

However, a study by Plantin (2007) showed that traditional class patterns and structures have a huge influence on parenthood in both theory and in practice. For example, the fathers in working-class households often saw fatherhood as creating meaning in their lives and saw the process of becoming a parent as an explicit aspiration to establish something "natural", well known and predictable. Fathers in the middle-class households, on the other hand, considered fatherhood as something new, a reflexive project or an opportunity to develop their identity and to get to know new sides of themselves. In practice, these different ways of creating meaning in fatherhood are illustrated in how working-class fathers tend to take fewer parental leave days and uphold more traditional distribution patterns in family life than fathers in middle-class households. General statistics on parental leave also show that men with higher education, who are well-paid and are living with highly qualified women most frequently use their parental leave the most. Statistically, men in middle-class households benefit the most from the parental leave system (Statistics Sweden, 1995).

Adolescent fathers

This is yet another group with special needs that is difficult for maternal and child health services to reach. About 10% of all births worldwide take place to women 15–19 years old, a vast majority of them living in low- and middle-income countries (United Nations, 2002). In Europe, about 25 of 1000 births are by adolescents, but the countries differ considerably. England has the record for the most teenage pregnancies in western Europe – the teenage birth rates, 31 births per 1000 women aged 15–19 years, are twice as high as Germany, three times as high as France and six times as high as the Netherlands. Sweden, Switzerland and the Netherlands have the lowest teenage birth rates in Europe, all fewer than 7 births per 1000 adolescents (UNICEF, 2001). However, the situation in the eastern part of the European Region is worse. For example, the Republic of Moldova and Ukraine exceed 50 births per 1000 adolescents, and Belarus, Bulgaria, Lithuania, the Russian Federation and The former Yugoslav Republic of Macedonia all have 30–50 births per 1000 adolescents.

There are many reasons to highlight teenage pregnancy and teenage parents from a health perspective. The National Health Service (NHS) in England shows that infant mortality rates for babies born to teenage mothers are more than

50% higher than the average, accounting for almost 400 deaths in England in 2000 (12% of all infant deaths). The infant mortality rate for babies born to mothers younger than 18 years is more than double the average, and this group also has an increased risk of maternal mortality. UNICEF (2001) concludes that teenage births are an important issue to focus on as young mothers statistically are more likely to drop out of school, have low qualifications, to be unemployed, to live in poverty and to suffer from depression. Further, the children of teenage parents are more likely to live in poverty, grow up without a father and be involved in crimes and drugs etc.

Given this background, it is not surprising to find considerable research in adolescent and teenage parents. There are also quite a few studies on young adolescent fathers, even if they have been "frequently neglected both as potential resources to their children as well as clients with their own unmet needs" (Mazza, 2002). However, Bunting & McAuley (2004) indicate that most quantitative studies on the subject show a rather negative picture of adolescent fathers as feckless and absent in their "role" as fathers, whereas the qualitative research often provide a more optimistic and encouraging picture in which many young fathers want to be involved with their children but are counteracted by numerous structures and circumstances.

Most research, however, shows that most adolescent fathers, just like adolescent mothers, tend to come from low socio-economic backgrounds and have less education and fewer employment opportunities than their childless peers. They also tend to experience greater mental and emotional difficulty and more often have a history of delinquent behaviour than other parents (Quinlivan & Condon, 2005; Vinnerljung et al., 2007). The relationship between the teenage parents is also at a greater risk of breaking down over time, with the consequence that many young fathers lose contact with their children (Bunting & McAuley, 2004). But even if the adolescent fathers in this perspective comprise a vulnerable group needing various forms of support, many young fathers report that they had received virtually no professional support for their parenting, especially not from the maternal and child health care services. In some studies, the fathers even claim that the service providers are not only unsupportive but directly obstruct them in taking care of their children (Allen & Doherty, 1996). The lack of support from society leads to the young fathers looking for help elsewhere, often from within the family. Research shows that the greatest support comes from grandparents, especially grandmothers, who constitute an important source of help for young men (Miller, 1997).

Studies also show that the support of a partner, whether the biological father or a current partner, may be correlated with improving the mother's mental well-being as well as better developmental outcomes for the baby. Roye & Balk's (1996) study of partner support and its outcome for teenage mothers and their children showed that paternal involvement yields mixed results. It interfered with maternal educational attainment but also improved maternal self-esteem and reduced depressive symptoms during the postpartum period. Fathers' involvement also positively influenced maternal

sufficiency, maternal interaction with the infant and early language development. Other studies also found similar results: the support from the male partner is associated with greater life satisfaction (Stevenson et al., 1999), lower mental distress, positive mother–infant interaction (Diehl, 1997) and economic benefits (Furstenberg et al., 1987). However, positive findings in studies like these may be mitigated by the often short-lived nature of the relationship between teenage parents.

Summary

The examination of research literature in fatherhood and reproductive health clearly shows how men, by means of increased involvement in their parenthood and in questions relating to family planning and reproductive health, can contribute to the health of the woman, the child and themselves. Many studies make the following quite clear.

- By taking greater responsibility for their own use of contraception, men can not only reduce the transmission of HIV and sexually transmitted infections but also lessen the number of unplanned pregnancies. By giving women greater emotional and instrumental support, men can also clearly affect women's attitudes towards pregnancy positively.
- During pregnancy and delivery, men can give important psychological and emotional support to the woman. This, in turn, has been shown to reduce pain, panic and exhaustion during delivery. Some studies also show that men's presence in the labour room shortens the period of labour and reduces the rate of epidural blockade.
- Men's increasing involvement during pregnancy and delivery is related to the possibility of reducing the number of children born with low birth weight. This is explained by low birth weight often being caused by insufficient caloric and micronutrient intake during pregnancy, and men often control women's nutritional status as they mediate their access to economic resources. Studies have also shown that men's involvement in maternal and child welfare service programmes can reduce maternal and infant mortality in connection with pregnancy and labour by being prepared, for example, for obstetric emergencies.
- Increased involvement in fatherhood benefits the man's own health and well-being. For example, men who have been recognized in their new position as fathers and experienced emotional support during the pregnancy show better physical and mental health. The more the father engages himself during the birth and postnatal period, the stronger is his attachment to the baby. A father with a strong attachment to his baby will also participate more in the child's growing up.

Although the research literature shows how increased involvement by the fathers can affect health outcomes positively for the men themselves, for their partners and for their children, the maternal and child health care services in Europe still have difficulty in attracting and increasing the involvement

of fathers in programmes. Even if they attend these programmes, they often feel marginalized and not directly addressed by the staff. This means that men generally as a group get less information and are often less prepared for parenting. Maternal and child welfare service programmes have also had particular difficulty in reaching certain groups of parents and fathers, such as immigrant fathers, economically marginalized fathers, fathers with low socioeconomic status and adolescent fathers. Targeting these groups would greatly benefit the health outcomes of many parents and children.

An examination of literature relating to increasing the knowledge base of fatherhood and reproductive health shows the following.

- Most research in Europe is produced in western Europe and Scandinavia. Hardly any English-language articles or reports on the subject have been found from eastern, southern or south-eastern Europe.
- Most research on fatherhood and health outcomes consists of qualitative research with relatively few samples. More quantitative research is needed that can give a wider view of the patterns that appear in this examination.
- Most research in the area is also empirically based with a lack of a theoretical framework.

Managing fathering: on fatherhood and health in everyday life

The meaning of fatherhood and how it affects men's health

Most people see becoming a parent as being positive, as being important and giving meaning and a sense of purpose in life.

In Plantin's study (2001), most men described becoming a father as a process of maturity, which gives increased consciousness of the importance of relationships, new empathic abilities and better self-confidence. Some men also reported they had become more emotional and could more easily express their feelings. Maturity was thus experienced as an expansion of both the emotional and the behavioural repertoire. The men express this as having become "a more complete person" or as if they had gained access to "a hidden side of yourself". In many cases, the men's partners also confirmed these experiences as they often described the men as more "harmonious" or "softer" since becoming a father. Fatherhood was also said to entail a feeling of safety that makes you feel "loved for who you are" without having to "play a lot of roles" (Plantin, 2001).

However, becoming a parent can also lead to negative changes in life, such as difficulty in getting work and family life to coexist or greater expenses that lead to strained finances. How this influences people's health is far from clear. Several research studies show that becoming a parent means something positive for one's health, others say it has no significance and others claim that it can be negative for one's health (Nomaguchi & Milkie, 2003).

Ringbäck Weitoft's (2003) longitudinal registry-based study of 700 000 men in Sweden is the first line of research finding that parenthood and contact with children mostly positively affects men's health. It clearly shows that single non-custodial fathers and single childless men face a much higher risk of premature mortality than cohabiting fathers. Like Umberson (1987), she also found that fathers who lived with their children developed less negative health behaviour, such as various forms of drug abuse, than those who did not live with their children. A possible explanation for this, given by Ringbäck Weitoft, is that children give structure to their parents' lives; they provide much needed company and meaning in life as well as access to other adults. Popay & Jones (1990), Hallberg (1992), Umbertzon & Williams (1993) and Benzeval (1998) reported similar results: divorced and non-custodial fathers generally showed the worst health in form of mental distress and depression than married men living with their children. Bartlett (2004) argues along the same lines but stresses that the health effects of fatherhood are probably mediated by a variety of variables such as the number of children, lifestyle and role competence.

However, in the other camp, considerable research indicates that becoming a parent does not always lead to positive effects in health for either men or women. On the contrary, some researchers regard it as a "risk factor" that can lead to individual and/or marital distress (Cox et al., 1999). Nomaguchi & Milkie (2003) state that becoming a parent does not often enough provide a concrete measure of emotional well-being and can worsen it for both the man and the

woman. The causes are the changes that occur in life when one becomes a parent, increased workload and stress (especially for women), worsening finances, greater pressures on the relationship between parents and restrictions in the social network, mostly for men (Gähler & Rudolphi, 2004). For example, men who recently have become fathers report more often than mothers that the number of social relations diminishes as well as the time spent in socializing and the satisfaction with it (Bost, 2002).

But as Bartlett (2004) stated earlier, there are often differences depending on sex, gainful employment, children's age, number of children and other factors. In Sweden, Gähler & Rudolphi (2004) found that men's emotional health was not influenced in the same positive way as women when they became a parent. They also found that the mothers of young children showed better emotional health than did mothers with older children. This is linked to the close relationship to the child during infancy and early childhood, which often positively influences emotional well-being, which then weakens over time as the child becomes more independent. The authors stress that the fact that the study was carried out in Sweden can significantly influence the result because of the possibility to take long parental leave and be with one's children while they are young. Similar variation cannot be seen in studies in the United States, where such possibilities do not exist.

This result shows that encouraging fathers to take parental leave is important, as a close relationship to young children increases emotional well-being. Two relatively recently published studies from Sweden support this hypothesis. Chronholm (2004) studied fathers who had been on parental leave for a long time, and almost all were very satisfied with their time on leave and the relationship they had developed with the child.

Almost all the fathers stressed the importance of being alone with the child during a long period to be able to develop a deep relationship with the child. This is also the main reason why they describe their parental leave as positive.

Månsdotter (2006) found positive health effects of parental leave in a quantitative survey. Focusing on men, she found that fathers who were on parental leave 30–60 days have a statistically significantly reduced mortality risk of 25% compared with men who were not. The results of these two studies are in accordance with the results of Ruhm (2000), who estimated how parental leave entitlement in general affects child survival. Ruhm concluded that parental leave may be a cost-effective way of improving health among children.

However, even though parental leave for both men and women exists as a legal right in all countries in the European Union, it is most often unpaid and therefore less used than it could be.

Combining work and family life

Fatherhood and parental leave

The European Union directive on parental leave came into force in 1996. The directive guarantees all employees at least three months of (unpaid) parental leave after the birth or adoption of a child. Many countries outside the Union have also followed the same line, and in 2004, 38 countries in Europe offered a parental leave system. However, the opportunities to take parental leave vary considerably between the countries according to payment, length and flexibility (Duyvendak & Stavenuiter, 2004). Parental leave is paid in many countries, but the Scandinavian and eastern European countries mostly offer paid parental leave during long periods. In most countries parental leave is a statutory right available to either parent: family-based parental leave (Drew, 2004). This is distinct from individual leave, which is generally added on to family leave and cannot be transferred. For example, Finland has a six-month quota for the father, Norway four weeks of paternal leave and Sweden two months reserved for each parent. Another example is Iceland, where the parental leave is divided into three parts; three months for the mother, three months for the father and three months they can share. Outside Scandinavia, some countries also have special paternity leave. Belgium, France, the Netherlands, Portugal, Spain and the United Kingdom all offer, for example, paternity leave of 2–11 days (Duyvendak & Stavenuiter, 2004).

The Scandinavian countries offer the best conditions for parents, especially fathers, to be on paid parental leave even though individual employers in other countries can offer almost the same conditions for working parents. All fathers in Sweden have the right, in principle, to 420 days of parental leave when a child is born, and the compensation level for 330 of these days is 80% of previous salary (up to the same standard ceiling as for sick leave).

The most common arguments for introducing parental leave and also encouraging men to take leave are:

- to promote a better gender balance and equity in the family and in the labour market for both men and women;
- to counteract declining birth and fertility rates;
- to increase the well-being of children; and
- to increase women's economic independence.

Despite the difficulty in comparing data between countries in Europe – as the systems are so different – most research studies and figures show the same pattern; men have a relatively low uptake of parental leave, even in countries where they have access to extensive and generous leave systems. In Sweden, men have had the right to long parental leave for more than 30 years, but they still only use 17% of all the possible days. This figure is very low in one perspective – compared with the women – but high in comparison with men in many other countries. For example, in Portugal the men only used 4.4% of the days, and in Azerbaijan, Latvia and Spain less than 1.5% of those who took leave were men (Drew, 2004). Even if many countries report slowly increasing figures for men's uptake of parental leave, few can report as high figures as Iceland, where 86% of the men take leave and the average number of days they use is 97. This indicates the effectiveness of a system where the right to parental leave is individualized and is well paid for a fairly long period (but not too long, according to the experience in Sweden).

The traditional distribution patterns concerning parental leave have long puzzled both government authorities and the research world, especially in Scandinavia. Since the late 1970s, several different government inquiries and research reports have been presented that have attempted to explain the reasons for this uneven distribution between men and women and to propose measures to combat it. In this great variety of research results and explanatory models, four main reasons or obstacles against more equality in the distribution of parental leave stand out.

A remaining traditional view of the mother's and the father's tasks in the family. Despite increased consciousness regarding the expectations of equal and gender-transcending behaviour patterns, men and women still reproduce a series of different traditional gender patterns in parenthood, both in theory and in practice (Bäck-Wiklund & Bergsten 1997; Elvin-Nowak 2001; Bekkengen 2002). In accordance with traditional development psychological bonding theories, motherhood is often associated with the primary care responsibility for the children, especially during the first year of their lives. Fatherhood, in contrast, is more often connected with a secondary care responsibility, with a stronger emphasis on the family's financial and material supply situation. This means that many men primarily take the position of a back-up to the family while the

children are young. Not until later, when the children have grown older and can play and communicate, do men distinguish a more evident fatherhood responsibility in relation to their kids (Plantin, 2001). This situation is also reflected in the attitudes of many Europeans towards parenthood, work and family life. Studies through the International Social Survey Programme (2002) show that 40–60% of the respondents in Bulgaria, Croatia, Czech Republic, Hungary, Latvia, Poland, Russian Federation, Slovakia and Slovenia said they agreed or strongly agreed with the statement “A man’s job is to earn money; a woman’s job is to look after the home and family”. The corresponding figures for Scandinavia were 8–9%. Similarly, 20–50% of the participating Europeans think that “A preschool child is likely to suffer if his or her mother works full-time”. Again, the eastern European countries are at the top of the list in expressing the most traditional values on this matter.

Financial reasons. Since men often have higher wages, they are more established in working life than women and the compensation levels in the parents’ insurance are related to income, the family can often maximize income if men go on working and women take parental leave (Ministry of Integration and Gender Equality, 1998; Plantin, 2003). Research has also shown that men to a higher degree than women lose wage-wise on long-term parental leave, since employers expect women, and not men, to take long-term parental leave (Albrecht et al. 1999).

Employers’ negative attitudes towards men taking parental leave. Many work organizations in Europe are characterized by masculine norms, and employers often stay passive or indirectly reluctant to encourage men to increase their days of parental leave (Andersson 1997; Sundström & Duvander 1998; Haas & Hwang 2000; Bäck-Wiklund & Plantin, 2007). In times of labour shortage, employers tend, however, to become more supportive of family-friendly measures and to take more initiatives to increase the men’s number of parental leave days, mainly to entice attractive labour.

The superior position of the freedom-of-choice principle in the design of the parents’ insurance. Some researchers argue that the design of the parents’ insurance, with the possibility to transfer days between parents, is based on masculine hegemony, which in practice gives men greater opportunities than women to decline parental leave (Bekkengen, 2002; Klinth, 2002). This freedom of choice in combination with the expectations towards mothers to take long-term parental leave thus results in reproduction of traditional distribution patterns in the way men and women take their parental leave.

All these explanatory models have a predominantly consensual view concerning the negative influence of male hegemony and the patriarchal power structures on the distribution of parental leave. Nevertheless, the scope of the causal explanation, which concerns all areas in the relational triangle state, market and family, shows that the issue of distribution patterns in the parents’ insurance system is not solely understandable from a structural power perspective.

Negotiations about parental leave are often more complex than that and depend, among other things, on economic fluctuation, the situation in the labour market, education, individual life experiences, the family situation and other factors (Plantin, 2001). We have, moreover, only a vague picture today of how the construction of gender, parenthood and the distribution of parental leave are influenced by other social categories such as class and ethnicity (Plantin, 2003). Certainly, statistics indicate that working-class men take less parental leave than middle-class men do or that fathers born outside Sweden take less parental leave than men born in Sweden (Bekkengen 1996, Sundström & Duvander 1998, Plantin, 2003). However, the factors that influence these conditions on a deeper level are largely unknown. It is therefore important to increase the efforts to not only examine the structural conditions but also to examine how they are handled and implemented in different ways in the practice of everyday life. The situation in much of Scandinavian clearly signals this: despite extensive support from the welfare state, such as the long, paid parental leave, traditional gender patterns are still very predominant and men have a very modest uptake of parental leave.

But what is known about the correlation between men’s usage of parental leave and increased equality in everyday family life? How do men adjust their work to their family life and to what extent do they participate in the regular household work?

Gender differences in adapting work to family life

Although parental leave is an important statutory instrument that enables parents to stay home with their children, it constitutes only a temporary solution. At the end of parental leave, when the parents have to return to work, new adaptation strategies for combining work and family life are needed. Research shows that women generally use various and more long-term strategies in which work is highly adapted to family life (Bekkengen, 2002). After parental leave, women very frequently reduce their working hours to part time to obtain more time for family life. One of the attitude surveys within the International Social Survey Programme indicates that this is also how most Europeans think it should be. Most respondents within the 23 participating European countries agreed with the statement that “a woman with a child under school age should not work full time but instead part time”. The reading was even higher when the time period was extended, and 50–70% of the respondents agreed with the statement that “a woman with a child of school age should work part time” (International Social Survey Programme, 2002).

But, as Fagnani et al. (2004) note, this matter varies greatly in practice in European countries. The proportion of women (aged 25–49) working part time varies from 70% in the Netherlands to 11% in Portugal. Men on average longer hours than women, particularly when they have young children. For example, such men in the United Kingdom work 47 hours per week on average and 41 hours in France.



Research thus shows that several factors influence the strategies parents use to combine work and family life. However, women seem generally more family-oriented than men are, since they more highly adapt their work to family life. This means that women often force through more long-term radical changes in their professional life, for instance by working part-time or by changing assignments to cope better with the needs of children and family life. Men, in contrast, often maintain their full-time employment, take only short periods of parental leave or temporary cash benefits and concentrate instead on temporary efforts to solve the problems that arise between work and family life. One challenge is ensuring compensatory leave for overtime done or flex-time for specific situations that may arise in family life. At the same time, much of the research suggests that motherhood and fatherhood in a historical perspective have approached each other in a larger overlapping of family responsibility (Tyrkkö, 2001). Men have moved their positions closer to family life, while women spend more time in professional life. Further, the latest time-observation survey in Sweden discovered that fathers with young children have reduced their working hours during the past decade (Statistics Sweden, 2003). Research has also showed that family life has become more subject to negotiations, which consequently has established new family patterns parallel to the remaining old patterns (Ahrne & Roman, 1997). However, again countries in Europe vary widely. For example, research into European time budgets on housekeeping shows that women generally do much more of the household work than men do, but the differences are less striking in Nordic countries such as Denmark, Finland and Sweden. In Italy and Austria the differences between men and women in this perspective are more striking, and the Netherlands has a middle position. The differences are also generally smaller in families where both the man and the woman work full time (Duyvendak & Stavenuiter, 2004). The same pattern can be seen in time budgets focusing on time spent on child care by women and men. The figures also show here, in a comparison over time, that men change in accordance with the expectations related to the new modern fatherhood and spend more time with their children. Men in the United Kingdom spent 44 minutes per day on child care in 1987 and 90 minutes in 1999 (Duyvendak & Stavenuiter, 2004).

But how do these strategies to combine work and family life affect men's health? Is there a spill-over between the two spheres resulting in stress and increased ill-health or do the two arenas contribute to better well-being among the working parents?

Work-family boundaries – affecting well-being and health

Knowledge about the situation of parents with young children and the connection between parenthood, working life and health is relatively limited. In most studies the family situation is often used only as one of several other background factors, and few surveys have specifically focused on gainfully employed parents' ill health and their sick-leave situation, although the public debate often puts forward the assumption that gainfully employed parents with young children are stressed and on sick leave to a higher extent than others, due to their double roles. However, research provides no unambiguous picture of evidence that supports this idea. Instead, some studies claim that parents with young children have more ill health than others, and other studies indicate that other factors, such as the psychosocial work environment, age or the physical work environment more strongly influence the sick-leave pattern. The Swedish Social Insurance Board (2003) established that the individual's family situation has been shown to have no influence on long-term sick leave. Also Margaretha Voss' (2002) questionnaire survey on work and health shows similar results. Voss maintains that there exists no general and strong connection between having children and a higher rate of sickness absence. However in a more detailed analysis she discovered that mothers with young children tend to be on sick leave for a longer time, especially in connection with a longer stay at home to care for a sick child (infections being transmitted from child to mother). Even married and cohabiting women with children living at home who worked full-time and had the main responsibility for domestic work turned out to be more often on sick leave than others were. The most recurrent reason for sick leave was physical exhaustion and weariness.

Qualitative questionnaire surveys within family and parenthood research (Bäck-Wiklund & Bergsten 1997; Elvin-Nowak 2001) have established that parents with young children often suffer from stress, feelings of guilt, weariness or feelings of insufficiency. Women torn between traditional and modern maternal ideals seem to live with permanent pressure (Davies & McAlpine 1998).

But also fathers with young children are stressed, in different ways, by the problems of combining work and family life (Bäck-Wiklund & Bergsten 1997). They often express dissatisfaction with the lack of time to reconcile all demands from family life, professional life and the social surroundings. Conflicts of interest mainly arise when the demands and expectations increase in the different spheres, and this leads to stress. However, clear gender differences exist in how fathers and mothers experience stress; one reason is remaining traditional parenthood ideals and enhanced focus on the child's psychosocial development. Among women, stress and feelings of guilt are more highly connected with children and family life, whereas men's stress is more linked to work and traditional breadwinning (Bäck-Wiklund & Bergsten 1997; Elvin-Nowak 2001).

Research shows that women who shift from domestic work to part-time work or from part-time to full-time work have better health than unemployed women do. The connection is not unique to women; men's health is also stimulated by the relationship between their different roles as a husband, parent and worker (Johansson, 2002). As mentioned earlier, this pattern emerged clearly in Plantin's (2001) study on fathers in Sweden. Most of the men emphasized that the combination of professional work and parenthood not only generated problems in itself but served also as a springboard to better personality development, which had positive side effects on their behaviour in both life spheres. They said that understanding and experience gained in family life enriched their efforts in their career and experienced work and the value of the social contacts at the workplace as stimulating to their well-being in family life. Studies by Arendell (2000) and Glass & Fujimoto (1994) show similar results, as they found that paid work generates economic, social and mental resources that contribute to individual well-being.

Finally, Månsdotter also showed in an epidemiological study on death and sickness leave among "traditional" and "equal" men in Sweden that being equal in the domestic sphere is associated with lower risks for death and ill health.

Fathers' influence on the health of their children

Many studies have examined the importance of the father in relation to the health and development of the child. For some time psychology research has been interested in studying the importance of both the mother and of the father for the child, from infancy until adolescence. Some differences have been found in the parenting of men and women but in most studies the similarities appear to be most striking. Both men and women play a multidimensional role in family life, and stereotyped images of fathers' uniqueness are therefore misleading. In fact, fathers are often associated with play, even if they do not spend more time in play or social interactions with children than mothers do (Lamb & Tamis-LeMonda, 2004).

However, significant database material and longitudinal studies around the world have followed the influence of the parents on the child's health and development over a long period of time. The Early Childhood Longitudinal Study (ECLS) in the United States, National Child Development Study (NCDS) in Great Britain and Australian Temperament Project (ATP) in Australia are just a few of the significant studies that are constantly being updated. The results of many longitudinal studies of children from around the world support the idea that fathers have an important function in determining the health of the child. Sarkadi et al. (2004) investigated the outcome of 22 longitudinal studies and found that most show that fathers involved with their child also promote the child's physical health and social skills. This positive result applied to infants 0–3 years old, preschool children, schoolchildren and young adults. Many of these studies included large samples (more than 900 individuals) and were based on follow-up questionnaires, observations and interviews. The extent of the father's importance was measured by a range of variables

relating to the child such as behaviour problems, depression, social ability, aggression, hyperactivity, criminality, intellectual ability, self-esteem, empathy and mental problems. Five of the studies treated only the significance of the physical presence of the father in the family. The analysis of these gave no clear picture, and thus whether the mere presence of the father can influence the child's development and welfare cannot be determined.

Of the 22 studies, several failed to consider the families' social relationships, which can dramatically influence the results. Research shows that fathers are often more involved with their children in families living under favourable social conditions, and these children have better health. Other research has pointed out the difficulty of showing a clear cause-and-effect relationship in this area, which involves a significant risk for confounders: apparent or illusory connections between different factors. The result is thus (Marsiglio, 1995) that:

... most scholars agree that, although fathers typically interact with their children differently than do mothers, men are not inherently deficient in their ability to parent and a father's gender is far less important in influencing child development than are his qualities as a parent.

Sarkadi et al. (2004) drew a similar conclusion.

The studies are not designed to determine if the positive effects of the father's involvement are connected to whether this person is the biological father to the child or even to whether he is a man or not. Other studies show that those adult persons who have been involved with a child for a longer period can have a favourable influence, irrespective if that person is a man or a woman.

There is also difficulty in defining what is exactly meant by "quality parenting" or "fathers' involvement with their children". What does it mean to be an involved father and how can the degree of involvement be measured? Palkovitz (1995) from the United States says that measuring and discussing involvement with the child often focuses on "direct child care" or "hands-on care" and often disregards other forms of involvement. Instead Palkovitz wants the definition of the word expanded to include planning for the child's well-being, monitoring, providing protection, giving emotional support and affection and having shared interests and activities.

Lamb (1986) has also criticized how the word involvement is used for measuring the fathers' commitment and engagement and has thus presented a model of analysis. The model consists of three aspects of parenthood that are essential for guaranteeing the child's welfare engagement and interaction, accessibility and responsibility. Lamb defines engagement and interaction as the activities in which the parent is directly involved (such as playing and physical care of the child); accessibility is defined as how available the parent is for the child. Responsibility is seen as the parent's acceptance of long-term liability for the child.



Involvement can be defined in other ways, and there is generally considerable difficulty in determining direct causality between the father's involvement and the child's physical and emotional development.

Instead it is thought that variables other than the parent's sex can be more decisive for the child's health, such as social class, local social environment, level of parent's education and income. Nevertheless, researchers and laypeople generally assume that young boys need "male role models" – especially young boys who grow up with only their mother. Research shows that the term "male role model" is unclear and has different meanings in different contexts (Johansson, 2006). Such a traditional male stereotype is often characterized by norms, discipline, courage, physical activity and heterosexuality – a manliness that young boys are considered to need to be able to grow up and take themselves out of "the female world of childhood" (Johansson, 2006). This viewpoint is concomitant to thoughts on gender differences, where "maleness" is invested with values that seem absent in "femaleness". Sometimes it is an opposite view of maleness that is considered when addressing the male as equal, emotionally sensitive and relationship oriented. In this discussion men and women are seen as alike, a perspective that challenges rather than reinforces the traditional view of gender (Johansson, 2006).

The view developed by research of the father's importance for the child's development and health is certainly complex. Many studies show that the long-term and active involvement of an adult in the close environment positively influences children. Nevertheless, whether the sex of this adult pronouncedly affects this relation more than a range of other variables that influence children's health and development is difficult to ascertain.

Summary

Much of the research into fatherhood and health in everyday life shows that men involving themselves on an equal footing and are active in parenting and in the life of their child can lead to positive health effects not only for the men themselves but for their partners and children.

- Many studies show positive effects of parenthood on men's health in the form of lower risk of premature mortality, less negative health behaviour such as drug abuse, less mental distress and lower risk for depression. Other researchers point out the presence of negative effects such as increased workload and stress, a worsening in finances, greater pressures on the relationship between parents and restrictions in the social network. However, most research emphasizes that the health effects of fatherhood are mediated by a variety of variables such as number of children, lifestyle, role competency, gainful employment, children's age, social class and social environment.

- Research focusing more specifically on the relationship between increasing gender equality and health shows a distinctly positive relationship. Men who take a longer period of parental leave, are family oriented and on an equal footing with their partner demonstrate better health than other men.
- Research also shows that men are taking a place closer to family life while women are spending more time in professional life. Family life has also become the subject of more negotiations, which consequently establish new family patterns parallel to the remaining old patterns. However, women more often than men use various more long-term strategies in which work is highly adapted to family life.
- Men's health is stimulated by the relationship between their different roles as a husband, parent and worker.
- European countries differ considerably in the support provided for the fathers of infants in attempts to combine work with family life. Paid parental leave is most common in northern Europe, and publicly subsidized child care is not available in many countries.
- Research from the Nordic countries shows that even when fathers are offered paid parental leave they do not take it to any great extent. The main explanations are financial reasons, employers' negative attitudes and a remaining traditional view of the tasks of mothers and fathers in family life.
- Most studies show that fathers being involved with their children also promote their physical health and social adaptability. However, involvement can be defined in different ways, and there is considerable difficulty in determining a direct line of causality between the father's involvement and the child's intellectual and emotional development. Instead, variables other than the sex of the parents are thought to be more decisive for the health of the child – in particular the child's experience of the relationship to the adult, the social environment, social class, level of education, income and other factors.

The literature review on fatherhood in everyday life also shows that more quantitative studies are available here than in fatherhood and reproductive health. This includes studies that focus on how parenthood influences men's health, on men's strategies in combining work and family life and on how fathers can influence their children's health and development. The connection is not always clear, and more studies are needed based on multivariate analysis: simultaneously considering many factors that may influence the result. Much of the research on paternity including this area comes from Scandinavia and from English-speaking countries such as Australia, Canada, Ireland, New Zealand, the United Kingdom and the United States and is notably deficient in eastern Europe.

Summary and conclusion

This examination of research shows, generally speaking, that increased involvement in fatherhood can give increased well-being and other positive health effects for the man.

For example, many men describe their experiences of parenthood as a process of maturity that gives increased awareness of the importance of relationships, new empathic abilities and better self-confidence. Parenthood is described as providing an important relationship and giving meaning to men's lives, which can be associated with better health outcomes.

Several studies have also showed that the relationship between men's roles as a husband, parent and worker stimulates men's health. Fathers who are equal in the domestic sphere and engage themselves in their children also develop less negative health behaviour and have lower risks for death and ill health.

Research shows that fathers experience receiving less support in parenting than do mothers. Many studies show that maternal and child health services have considerable difficulty in reaching out to men. This applies to Europe and the rest of the world and results in fewer men seeking information and advice on questions relating to sexual and reproductive health and taking part in parent education. This can partly be seen as maintaining traditional patterns between men and women in which the man takes greater responsibility for work and support rather than child care and housework. The rewards of patriarchal dominance lead to men taking fewer initiatives that would lead to change towards more active, equal and democratic participation in family life. However, researchers also advocate a parental support programme by maternal and child health services that more clearly involves the fathers. Reaching that far requires a variety of new strategies, from symbolic changes in which maternal and child health services change their name to parent and child welfare services to using new paths of communication to be able to reach men in their impending paternity. Today's parent education, which is often based on the participation of parents in open discussion

groups, leaves men at a disadvantage, as the women are more used to talking about pregnancy, birth and parenting. The attempt to pursue parent education for men over the Internet has shown to be more successful, as indeed has more individualized support.

Fathers are not a homogeneous group, and all men do not have the same prerequisites for being a parent or related needs. A range of forms of parent education should therefore be offered. A particularly vulnerable group of fathers needs more direct support. Today it is the fathers from the middle classes that make best use of the support from maternal and child health services; other men avail themselves to a lesser degree.

The literature shows that increasing active involvement in fatherhood not only leads to beneficial health effects for the men themselves but also for their partners and children. For example, numerous studies show that men can give important psychological and emotional support to the woman during pregnancy and delivery. This, in turn, has been shown to reduce pain, panic and exhaustion during delivery. Some studies also show that men's presence in the labour room shortens the period of labour and reduces the rate of epidural blockade. The research also shows a relationship between men's increasing involvement during pregnancy and delivery and the possibility of reducing the number of children born with low birth weight. This is explained by low birth weight often being caused by insufficient caloric and micronutrient intake during pregnancy and men often controlling women's nutritional status as they mediate their access to economic resources. Studies have also shown that men's involvement in maternal and child welfare programmes can reduce maternal and infant mortality in connection with pregnancy and labour by being prepared for obstetric emergencies.

Men's support towards their partners is also especially important in vulnerable groups in which the women (and the men) have poorer health than average. Immigrant families are one such group that generally experiences considerably



poorer health than other groups. Several studies have showed that women born abroad run a higher risk of giving birth to babies with limited growth, that they are significantly more obese with higher body mass index than women born inside the relevant country (in this case Sweden) and run a greater risk of perinatal death. Since previous research has shown that increasing men's involvement can positively influence this situation, it is particularly important to reach out and involve these men.

The reason for the immigrants' worse health situation is their often poorer social position, low income and health-endangering work. Studies have also shown that many immigrants lack health awareness because of language barriers or bureaucracy and often have no or reduced access to health-related information or services. High rates of unemployment, dependence on social welfare and language problems may also lead to an experience among immigrant men of losing vital and important aspects of their parenthood: the position as breadwinner or the position as spokesperson for the family. The mother, in contrast, is less exposed to strain as various health and welfare institutions often give women better support in their parenthood. By being close to the children, the mother also gets better and continuously updated knowledge about society.

Health problems related to low social and economic status are not limited to immigrant families; native families in similarly vulnerable situations are also affected. Research shows, for example, that children in the lower and more disadvantaged reaches of society have poorer health and are stricken much more by physical illness and emotional difficulties than children who are more socially advantaged. The risk of infant death is also three times greater than normal if the child is from a socially disadvantaged group.

Teenage parents belong to these more disadvantaged groups and are statistically more likely to drop out from school, have low qualifications, to be unemployed, to live in poverty and to have depression. This group also has higher rates of infant mortality. Infant mortality for babies born to teenage mothers is more than 50% higher than the average, accounting for almost 400 deaths in 2000 in England (12% of all infant deaths). The infant mortality rate for babies born to mothers younger than 18 years is more than double the average, and the risk of maternal mortality is also increased for this group.

The research relating to this group of parents has also showed that increasing support to the men can lead to better health outcomes for the fathers as well as for other members of the family. For example, several studies have showed

that support from the partner, whether the biological father or a current partner, may be correlated with improvement of the mother's mental well-being as well as better developmental outcomes for the baby. Nevertheless, many studies show that the young fathers are frequently neglected both as potential resources to their children as well as clients with their own unmet needs.

In conclusion, although many fathers want to be involved with their children and there is evidence that this can positively influence the health outcomes for both the man, his partner and children, very few activities and initiatives are planned to help most men in their parenting. Maternal and child health services are much more focused on the health of the mother and child and therefore often exclude men and their needs for information as parents. Support is better accessed by the middle classes or by parents with better life conditions, whereas contact with other groups who show poorer health is weaker. This shows that not only do resources need to be increased to reach these men but also a new way to distribute or restructure the contributions is needed so that they address both parents. Perhaps information and advice can take place through more effective paths of communication (such as the Internet) and thus provide opportunities for channelling more resources to groups that are more difficult to reach and who have poorer health.

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