parent.

PARENT European Manual

Promotion, Awareness Raising and Engagement of men in Nurture Transformations

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Preface

Why fathers? Why the push for gender equality in parenting? Why PARENT?

In spite of decades of activism and advances to achieve equality between women and men, there are some areas where we have as a planet made few advances. One of those, central among those, is parenting and caregiving. Globally women carry out more than 3 times the amount of daily care of homes, of bodies, of children, of the elderly. Europe has a region has moved closer to equality in unpaid care work but no country in the world has achieved equality when it comes to who does the care in our homes.

Similarly, in terms of paid care professions – nurses, childcare worker, front-line health care workers, elder care workers – the vast majority are women who are generally paid less than men in professions that require similar levels of training. At home and as a profession caring for others is seen, still, as mostly women's work.

That said, many men are doing more care work than in previous years, and many men want to do everything they can to be involved, equitable caregivers. But many, if not most men, face challenges in being equitable caregivers. Even as paternity leave has been extended or expanded in many countries, many men feel they will be seen as less than hard workers if they take leave, or take their full leave. Schools, health facilities and social service agencies continue to view men as "deficient" mothers or see mothers as he default parent. Non-binary or same-sex parents are even more likely to be invisible when it comes to public services.

Care and care policies are often the topics of dull-looking reports that get read by just a few economists or social policy experts. And yet care is central to our lives. It is what all humans need to flourish, grow, survive, heal – live. The ways we talk about care, as a burden or a chore, hides the fact that care and our reciprocal relationships with others in our households and beyond is what makes us human.

For men, involved fatherhood is an opportunity to actively participate in moving the world, and our households, closer to gender equality. It is also a space for many men to have richer emotional lives and to take care of their own health and mental health. Indeed, many studies find that men who care for themselves to a greater extent are more involved in the care of others, and that the effect also works the other men: men who care more for others, often care more for themselves. Involved fatherhood allows men to conjugate the verbs of love and connection in a variety of ways that bring benefits to female partners, children and men themselves.

This is lofty and necessary goal of PARENT – bringing men into nurturing relationships with children and others and in the process achieving better outcomes for maternal health, for child health and well-being, for gender equality and for men themselves. Our years of experience as Promundo, working to promote engaged fatherhood in multiple contexts has affirmed that health sector is an ideal entry point for advancing this conversation. Most men with an expectant female partner, want to be involved, or more involved; they want to support. But often they tell us, they're not sure how, or they don't feel welcome in a health system that feels foreign to them

PARENT invites men into the world of care and engages the health sector to be an ally and a partner in the process. The activities and processes here start with the positive, affirmational approach that men want to care, can care and should care, and that the pregnancy period is a strategic moment for supporting and engaging men in caregiving. These activities and processes emerge and build on years of experience in diverse settings that have affirmed that positive approach.

The co-authors of the PARENT methodology also acknowledge and call attention to the reality of gender-based violence and family violence. Some men are violent toward female partners, and toward children, and the health sector has a responsibility to be part of identifying when violence is present and intervening

as appropriate. Some men and women also bring legacies of past experiences of violence to their parenting and need support to overcome those and to learn non-violent, supporting parenting practices. PARENT also seeks to promote caregiving, child rearing and couple relationships free of violence and based in respect, connection and empathy.

Finally, in the context of COVID-19, care has become even more visible and more urgent. Households have faced economic stress, additional caregiving needs as children have been out of school, and additional health risks. Progressive policymakers, health personnel and employers have understood this and rolled out policies and supports for families with additional care needs during COVID. But too many have not. In this situation, men's equal and positive participation in caregiving becomes even more urgent and necessary.

Behind the activities, case studies and examples included here, are the many parents, particularly fathers, who participated in this learning journey, and who affirmed at every step of the way that they want to be involved, caring and connected. Indeed, they confirm by their actions that care is not feminine or masculine verb. But is simply a human verb.

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PARENT's framework

The promotion of healthy, equal relations among men and women, alongside strategies to combat and prevent violence against women and children, has been one of the priorities of the European Union (EU), (e.g. Stockholm Program 2010-2014, EU Regulation No 6060/2013, Directive 2012/29/EU. 2011/99/EU, 2011/36/EU, among others), not to mention that gender equality is one of the founding values of the union. Great strides have been made when it comes to gender equality by promoting equal treatment legislation and the integration of a gender-based perspective into all other policies (gender mainstreaming); however, gender gaps, perpetuation of stereotypes and violent acts against women and children still persist in today's EU society. These have encouraged the EU to adopt multiple strategies to encompass priority areas including women's economic independence, the promotion of equality in decision-making, combating gender-based violence, and supporting victims.1 Common to all these priority areas and challenges is the need to use gender-synchronized approaches (Greene et al., 2010) that recognize different gender-based roles and seek to dismantle gender stereotypes and inequitable gender roles.

Particular groups may face greater risk of gender-based violence, for example, due to having been dislocated from families and communities, or having witnessed or been exposed to violence perhaps as a child, refugee, migrant or someone with disabilities. While the associations are complex and should not be oversimplified,

1 Examples of such strategies include the Strategic Engagement for Gender Equality 2010-2015 & Strategic Engagement for Gender Equality 2016-2019.

numerous studies confirm that men who witness and experience violence growing up are more likely to use violence against children and women later in life (Fleming et al., 2015). Evidence demonstrates the impact that experiencing violence in childhood can have on the use of violence as an adult. Intergenerational transmission (IGT) of violence has been a key theoretical consideration from explaining the link between interparental aggression in the family of origin and intimate partner violence (IPV) in subsequent intimate relationships.

While discussion of the IGT of violence has increased, less attention has been given to the IGT of caregiving and gender equality. Research from the International Men and Gender Equality Survey (IMAGES) and other sources suggests that boys who experience a positive caregiving influence from men in the household are more likely to have gender-equitable attitudes, more likely to participate in care work and less likely to use violence against a female partner later on (Fleming et al., 2015). Girls growing up in such households are also less likely to be subservient to men.

When it comes to care work, data presented in several EU debates, studies and strategies stress that there is still a persisting gender gap. Overall, the largest gender gap is in terms of political empowerment, yet the economic gap between men and women is still expected to take 267.6 years to close despite improvements. Specifically in Europe, the ILO estimates that, at the current pace, gender parity may be reached in western Europe in approximately 52.1 years and over 100 years in eastern Europe. Differences in childcare responsibilities contribute to the gender gaps observed, especially but not exclusively those related to employment and income (World Economic Forum, 2021). Women across the EU spend more time per day on unpaid family caregiving activities than men (Greene et al., 2010). Such a gap has resulted in the recognition of the value of unpaid care and domestic work and has encouraged member states to take action through the provision of public services, infrastructure and social protection policies as a way to promote shared responsibility within the household.

While there is growing recognition of the integral role that men play in children's caregiving and that "massive changes in the workplace and in households are bringing changes to men's participation as caregivers" (Eurostat, 2019) too many still hold the belief (mirrored in regulation) that women should bear the greater responsibility in reproduction, caregiving and domestic chores. In fact, a recent

study conducted in the Netherlands has demonstrated that most fathers and mothers have few stereotypical gender norms regarding their role in the house, except for the role of women in caring for their children (Nikkelen & Blécourt, 2017). Women must have the right to determine when to have children, have access to quality health services, and gain economic independence, but men must also be engaged as allies in supporting women's access to services and the ability to work outside the home. To strengthen the foundations of a more equitable division of caregiving, men must be encouraged to take on equal responsibility for raising children and broader unpaid care work, without the use of violence, and contribute more equally to domestic work and sexual and reproductive health matters.

The push for gender equality is a global challenge that requires results-based gender transformative programming. Gender transformative programs are interventions that challenge gender norms to promote critical reflection and change the power dynamics that perpetuate gender gaps. **Gender synchronized** approaches take the gender transformative approach one step further by intentionally implementing efforts to reach people of all genders, specifically including men and boys and women and girls of all sexual orientations and gender identities. This approach uses a synchronized strategy to reach a variety of stakeholders in recognition that we are all impacted by and perpetuate harmful gender norms (Greene et al., 2010).

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CHAPTER 1

Working with health personnel to engage fathers

Annina Lubbock

The chapter was peer-reviewed by Giorgio Tamburlini, MD, and Andrea Santoro, Chairperson of Cerchio degli Uomini Turin. It builds onto the collective experience and reflections of the core team of PARENT-Italy: Dr Angela Giusti and Francesca Zambri of the Italian Institute of Health; Dr Alessandro Volta, paediatrician and author; Giovanna Bestetti and her colleagues from IRIS (Istituto Ricerca e Intervento Salute, MIlan) and also Andrea Santoro, coordinator of PARENT-Italy and Giorgio Tamburini and CSB (Centre for Child Health), Trieste

1. Introduction

1.1 – Premise

This chapter draws on the experience and lessons learned from the EU PARENT project implemented in Portugal, Italy, Austria and Lithuania (https://parent.ces.uc.pt/). One of the main components of PARENT was training professionals (principally health and early children's education professionals, but also social workers) on how to engage fathers, with the development of new models of 'nurturing care' among men, and thus the prevention of domestic violence, as an overarching goal.2

The PARENT program involved implementing training courses and communication

2 PARENT Italy and PARENT Portugal focused primarily on health professionals (130 and 100 respectively) who attended modular, interactive courses (in person before and online during the pandemic). PARENT Austria included health professionals in one multi-professional in-person course. PARENT Lithuania focused on social workers (experience also described in this Manual).

activities designed to bring a 'father-focused perspective' to the attitudes and practices of social, education and health professionals who come into contact with parents, from pregnancy to the child's early years (roughly the First Thousand Days), following up with the formation of groups of fathers and fathers-to-be as spaces for sharing and co-learning.

1.2 – Guiding principles

Policy framework for health and ECD

The framework within which the PARENT courses for health professionals were designed are consistent with international guidelines (WHO and UNICEF) on pregnancy, birth and Early Child Development (First Thousand Days, Nurturing Care WHO/UNICEF) and, where they exist, with related national guidelines (such as the Portuguese program to promoting caring masculinities IMPEC, see Box 5).

Respect for women's autonomy

When training health professionals, it is fundamental to recognize a mother's autonomy in making decisions regarding her own body, and therefore all that affects her physical and mental health. This has implications for the practices of health services and personnel, but also for the partner whose right to be there is recognized, but needs to be supportive, respectful and non-intrusive.

Gaining the support of mothers is key to fathers' engagement

Experience from projects promoting engaged fatherhood worldwide, and from professionals and fathers, indicates that mothers' attitudes regarding fathers' involvement are critical in determining if, how, and to what extent such participation actually takes place, starting from pregnancy.

Box 1 - Women's attitudes to fathers' involvement

Progressive health policies and services acknowledge the right of women to autonomous decision-making regarding the physiology of pregnancy, birth and lactation as processes that concern their bodies. In our training sessions, we found some evidence (in participants themselves and in their stories) of resistance by women to fathers' involvement on the grounds that it may limit women's autonomy, and may lead men to 'intrude' and 'mansplain' in aspects that relate to female physiology and where the woman's choice must be respected (Kruske). There is, however, a broader dimension to such resistance (lack of encouragement) that relates to a need to 'maintain control' over non physiology-related dimensions of parenting that have traditionally been regarded (by women, men and society) as predominantly a women's domain. Health services and professionals may contribute to this cultural marginalization of fathers. As one father said in a focus group, "You realize you have been 'coded' as a person who is not part of the caring space; or of feeling 'this is not about us"'. The couple may not fully accept the principle and practice of shared care (and thus also decision-making), with a tendency to consider the father as an adjunct, a 'helper'. This attitude is demotivating for fathers and may actually contribute to distancing them from parenting and their responsibilities and creating tension within the couple. Thus, it is hugely important for professionals interacting with the couple to convey to mothers the importance of fathers' engagement.

PARENT goal and principles

Within this overall policy framework for the health sector, the design of PARENT training activities for health personnel was led by the overarching goal of preventing domestic violence through the promotion of caring masculinities and a three-pronged approach to engaged fatherhood as being necessary for:

a. Mother & child health and well-being: the early engagement of fathers (from pregnancy) as fundamental for the healthy psycho-social and even physical development of the child, as well as for better pregnancy and birth outcomes

b. The wellbeing of fathers: it is necessary to involve fathers in order to respond to the growing and recognized desire among fathers to be involved from an early stage;

c. Gender equality: engaged fatherhood is necessary because care has to be shared in order to ease women's burden of work and responsibility, thus contributing to gender equality.

Combining a mainstreaming approach with recognizing the specificity of men's role as fathers

The objective of 'mainstreaming a father perspective' into the work of professionals and promoting co-parenting should always be combined with a father-focused approach that empowers men as fathers, recognizing their role as supportive but also complementary and specific in relation to that of mothers.

Same-sex/father-focus/neutral language

The messages and content of the PARENT-led courses that concern fathers can also be applied – as always stated upfront by the trainers - to same-sex partners. Nevertheless, the activities of PARENT (and therefore also the training) have focused specifically on men as fathers:

Because the prevention of gender-based-violence (mostly perpetrated by men) through the promotion of 'caring masculinities' is the meta-goal of the entire project;

Because gender stereotypes relating to the assumed parenting/caring roles of women and men have historically determined the exclusion or marginalization of men as fathers from pregnancy, birth and care-related processes, which have been viewed as exclusively or prevalently feminine spaces. One of the objectives of PARENT has been precisely to challenge/dismantle these stereotypes.

For these same reasons, we refer to 'mothers and fathers' rather than using the generic term 'parents', which by default still tends to be understood as generally meaning 'mothers'.

2. Why is it important to work with health professionals?

2.1 – The scientific evidence

Reasons for engaging men as fathers as early as possible - starting from pregnancy - are many, and health professionals play a major role in promoting this engagement, supported by what is by now an ample body of scientific evidence (see References and Boxes 2 & 3.)

An informed, supportive and involved father/partner right from pregnancy results in a better birth experience and health outcomes for both mother and child; a less stressful and more gratifying experience of pregnancy and birth for the mother; it encourages early father-child bonding (which in turn has lasting and positive effects on the cognitive and socio-emotional development of the child, especially in the critical First Thousand days, with positive outcomes in later years, and through adolescence to adulthood); it enables the father to feel relevant and useful, and not excluded from a process which, for physiological reasons, place the mother at the center. This positive engagement helps to relieve tension and improve the quality of the couple's relationship; it also decreases the burden of care and responsibility (the 'mental burden') on mothers (Redhaw et al., 2013; Lee et al., 2018; Suto et al., 2016).

Box 2 - Evidence from research

A) Pregnancy, birth and post-partum

There is by now ample evidence that fathers' early involvement (from pregnancy) is associated with children's improved cognitive and socio-emotional development (Redshaw & Henderson, 2013), as well as improved antenatal care, skilled birth attendance, postpartum care, preparedness for the birth and any complications, and maternal nutrition (Tokhi et al., 2018). Partner support during pregnancy may also encourage healthier maternal behavior and lifestyle, e.g. regarding smoking (Lu M et al. 2010, Redshaw & Henderson, 2013). The 'indvidualized emotional support' provided by a partner during pregnancy and birth is of special importance (Karlstrom et al., 2015), as is the role of fathers in complex care decision-making during pregnancy. Post-partum, fathers play a substantial role in shaping the future of the family unit by encouraging breastfeeding and creating a supportive environment for motherhood. (Kotan et al., 2007).

Greater paternal engagement is associated positively with early contact (before 12 weeks) with professionals, the number of antenatal checks, attendance of antenatal classes and breastfeeding. If the couple received continuous professional support from pregnancy, the man was more likely to take an active, empowered role, leading to greater satisfaction and involvement in early childcare (Backstrom et al., 2011; Hildingsson et al., 2011; Redshaw & Henderson, 2013). Fathers need to be made to feel they are playing a useful role in pregnancy and birth, and that they are heard and taken seriously with regard to decision-making. Fathers' engagement during the postnatal weeks correlates closely to their earlier engagement during pregnancy and at birth (Persson et al., 2012). Where paternal post-natal involvement was highest, women reported significantly better overall physical and psychological health after birth. First-time mothers were more likely to have a postnatal check with their doctor where paternal involvement was higher (Redshaw & Henderson, 2013).

Antenatal groups focused specifically on men's needs (e.g. sessions for fathers only) are beneficial in terms of reducing distress, increasing fathers' ability to cope and improved partner relations (Greenhalg et al., 2000; Redshaw & Henderson, 2013) and greater involvement in care, better mental health and more supportive behavior (Lee et al., 2018). Effective partner education during pregnancy can prevent postnatal mental health problems and thus support expectant fathers in their transition to parenthood. (Suto et al., 2016). Conversely, fathers' less positive experience of childbirth is associated with higher depressive symptoms six week after the birth (Redshaw & Henderson, 2013).

Studies have shown that having a 'labor companion' ensuring 'continuous care' during labor and birth improves outcomes for women and babies. This companion not only provides emotional support, but may also give physical comfort and undertake necessary advocacy on the mother's behalf, thus helping to reduce mistreatment and neglect (WHO, Companion of choice, Evidence-to-Action a brief, 2019; Hodnett et al., 2012; Boren et al., 2015). Women value their partners' presence and support in labor highly, leading to reduced anxiety, less perceived pain, greater satisfaction with the birth experience, lower postnatal depression rates and improved outcomes for children (Hanson et al., 2009; Dellman, 2004 cited in Fatherhood Institute, 2014; Redshaw & Henderson, 2013) Fathers' participation at this stage is based on self-motivation, achieved by participating in parental education meetings and antenatal dialogue with friends (Persson et al., 2012).

The inclusion of fathers/partners in breastfeeding interventions improves breastfeeding initiation, duration, and exclusivity rates. Interventions that include face-to-face information delivery, designed in a culturally appropriate manner, and that provide information on how partners can support breastfeeding, are more likely to have a beneficial effect (Dick-Abbas et al., 2019; Pisacane et al., 2005).

Box 3 - The scientific evidence:

B) The role of fathers/male caregivers in early child development

There is a growing body of scientific evidence (of which there have been periodic reviews over the last two decades) on the specific role of fathers/male caregivers in early childhood development (Cabrera & Shannon, 2007; Sarkadi et al., 2008;).

Fathers' engagement has been found to have a positive impact on social, behavioral, psychological and cognitive outcomes in children, and has been linked to: greater levels of cognitive and social competence; increased capacity for empathy; positive self-control and self-esteem; better interactions with siblings; and better academic progress.

Research indicates that fathers play a distinct role (different to that of mothers) in children's socialization. Fathers who model positive behaviors such as accessibility, engagement and responsibility contribute to: better psychosocial adjustment; increased social competence and maturity; and more positive child/adolescent-father relationships (Lit. review in Moore at al., 2006).

Regular active engagement with a child predicts a range of positive outcomes. Father engagement seems to reduce the frequency of behavioural problems in boys and psychological problems in young women, and enhances cognitive development, while decreasing delinquency and economic disadvantage in low SES families (Sarkadi et al., 2008).

Conversely, poor father-child relationships and fathering behaviors can have a lasting negative effect on a child's social adjustment and relationships, associated with inferior adult social skills (Moore et al., 2006; Goodwin, 2012).

Psychological and emotional aspects of paternal involvement in children's early upbringing, particularly how new fathers see themselves as parents and adjust to the role, rather than the amount of direct involvement in childcare, is associated with positive behavioral outcomes in children (Opondo et al., 2016).

Neuroscientists (in particular Ruth Feldman and Eyal Abraham) have studied the effects on fathers' brains of childcare experiences. Cerebral behaviour, oxytocin, and parenting behavior were measured in primary caregiving mothers, secondary caregiving fathers, and primary caregiving homosexual fathers raising infants without maternal involvement. Over the last two decades, human oxytocin research has revealed this hormone's involvement in all aspects of human social interaction, including empathy, social collaboration, theory of mind, and romantic love. It was found that fathers have similar levels of baseline oxytocin as mothers, and in both mothers and involved fathers oxytocin levels are higher compared to individuals who have not recently had a baby. This indicates that fathers are as biologically prepared to care for infants as mothers (Abraham et al., 2014).

2.2 – The changing expectations of fathers and couples

To an increasing extent in Europe, as elsewhere, fathers are now more present at different moments on the 'birth care path'[3] (pregnancy, birth and postnatal care) because they wish to be there and, increasingly, their partners request it. The way health professionals interact at different moments with couples, fathers in particular, has a big impact on the extent, quality and continuity of this involvement (Redshaw & Henderson, 2013).

3 The expression is used in Italy ('percorso nascita') to indicate the pregnancy-birth-postpartum-puerperium continuum.

Box 4 - 'We want to be there'
The increasing participation of fathers along the birth care path

According to survey data and everyday experience, it is becoming more commonplace for fathers/partners to accompany mothers to antenatal checks, ultrasound examinations and other screening tests and to participate – at least occasionally - in antenatal courses. Across the EU it is a generalized practice for fathers/partners to be present as 'companion of choice' at least at the moment of delivery in the case of a natural vaginal birth. Fathers may also sometimes be admitted for cesarian sections.

In over 90% of cases in the four EU countries involved in PARENT, mothers have a 'companion of choice' at their side at the moment of delivery, and in the majority of cases this is the father. It is less common for fathers to be present for the entire birth process (labor, delivery, rooming-in), and in some countries fathers are required to declare beforehand whether they want to do so in order for them to be 'instructed'. The fact that they are less likely to be present during labor goes against the WHO recommendation that mothers-to-be should be able to have 'a companion of choice' during labor and childbirth for improved quality of care (WHO Companion of Choice, Evidence-to-Action brief - and also the evidence regarding the need for 'emotional support' and 'continuous care' on a 1:1 basis throughout the process (Kalstrom et al., 2015; Boren & Vogel et al., 2015; Redshaw & Henderson, 2013; WHO, Companion of Choice) There are also significant variations in the way and extent to which fathers actually play an active supporting role or are simply spectators at the moment of birth, which largely depends on how prepared they are, the information they have received and the favorable/unfavorable or active/passive attitudes of health professionals towards fathers in the delivery room (ibidem).

It should be noted that, while fathers' presence at the birth is high for vaginal births, it is not common practice for cesarian sections – and it is worth noting that the number of cesarians is well above the 10-15% considered normal by WHO in most EU countries. The frequency and

manner of fathers' participation in the birth care path is influenced by prevailing socio-cultural norms. It tends to occur more frequently in middle-class, better educated urban couples. It also depends on the institutional culture of the services concerned and the respective personnel. This may vary considerably from one institution to another, especially in countries where management of health services is decentralized to regional authorities. Some health services may be more sensitive than others to the involvement of fathers (this was very evident during COVID 19 in Italy, for example, where some regional authorities made greater efforts than others to keep fathers involved). It is rare to find recommendations regarding fathers' engagement at a national level; Portugal is an exception in this regard (guidelines on fathers' engagement were issued by the Ministry of Health in 2020, see Box 6).

It is not common practice for health services (and medical doctors) to actively promote fathers' participation ('if they come it's good, but it's up to them' is often the attitude) except where services have a strong focus on enabling a positive birth experience that respects women's decision-making and fosters parent-child relations and bonding. Birth centers/ maternity wards that seek to create natural conditions for the birth and offer women choices in the way and the positions in which they give birth create an environment in which partners are also empowered to be more active and helpful. They also make efforts to enable the new parent-child triad to spend intimate time together for the critical first two hours, and may encourage the father to practice skin-to-skin contact with the child.

Beyond the moment of birth, fathers' participation may be limited by their work-related schedules (e.g. antenatal courses run at times when fathers are working) and public services' inflexibility in organizing consultations and classes at suitable times for couple participation.

The importance of making it possible for the parental couple to be together at key moments during the birth has been emphasized once again by the suffering and disappointment caused by the separation of expectant mothers from their partners at those critical moments during the COVID pandemic (see Box 6).

Given all of the above, it is evident that the health personnel (medical and non-medical) with whom mothers and couples come into contact during the pregnancy-birth-puerperium cycle (the First Thousand Days) have an essential role to play in terms of practices and attitudes that can either include, activate, and recognize the specificity and relevance of fathers/partners, or otherwise marginalize them, making them feel irrelevant or secondary, or more of a trouble than a help (as reported by many fathers in research surveys and in PARENT-led focus groups) (Suto et al., 2016; Redshaw & Henderson, 2013). How these professionals act, interact, communicate (in a way that is more or less inclusive of fathers) has a significant impact on the way mothers and fathers experience pregnancy-birth-puerperium, and sends a message about the culture of the institution to which they belong (Kruske et al., 2013; Persson et al., 2012; Verneulen et al., 2019).

3. An enabling (or 'disabling') social and institutional environment

3.1 – The prevailing culture regarding gender roles in parenting

In most countries in Europe, fathers are becoming increasingly involved in parenting from an early stage and are taking on more functions in care and domestic work, especially where progressive provisions exist regarding paternity leave and shared parental leave. However, it is not a generalized process of change and tends to be more evident in better-educated, better-off, younger, urban couples (and in couples where both work). In all countries, to a greater or lesser degree, childcare is largely a women's job; the father/breadwinner and mother/caregiver stereotype remains widespread, even when women also work. In most countries women's employment remains lower and more insecure and part-time than that of men; so women's work is a de visu and de facto 'accessory' to that of men, who remain the principal providers. Another construct that persists is that parenting a newborn and a very small child is primarily the responsibility of the mother, despite growing scientific evidence of the critical role played by the second parent right from the First Thousand days (Box. 2). Such a belief informs

policy choices concerning welfare and ECD provisions (for example, in Lithuania there are no ECD services before the age of two but there are generous parental leave provisions, used mainly by women). Another belief is that when the child is very small they should be cared for at home (which generally means by the mother) rather than in an ECD facility, provision for which remains low in many EU countries[4]. The 'care space' remains a largely feminized space from which fathers feel or are de facto excluded (a fact that may sometimes also be used by fathers as justification for self-exclusion). At best, a father may be seen as an accessory, as a 'helper' to the mother (in Italy the derogatory term 'mammo' - mamma/mother in the masculine- is often used to describe a man who performs a caring activity that is considered to be a women's role). PARENT has found that it is important to enable trainees to self-reflect on such stereotypes, since they affect what and how they communicate to mothers and fathers.

3.2 – Welfare and policy provisions, including paternity leave

The extent to which fathers participate from birth is strongly correlated with national legal provisions for paternity leave or shared parental leave, not only because it enables fathers (although generally those belonging to particular categories; it is not a universal measure) to take time off to be with the mother and child, but also because the existence and the extent of such provisions sends a cultural message to the effect that such time is important, for both the family and also society as a whole. The four countries involved in PARENT have different provisions, ranging from the lowest in Italy (10 days and only for private sector employees), to three weeks in Portugal and one month in Lithuania and Austria. Some countries in the EU, such as Lithuania, also have generous offers of parental leave that encourage mothers to stay at home for the first two years, thus affecting their employability and earning capacity. Similarly, use by fathers as well as by mothers of WLFB (work-life-family-balance) provisions at work also varies (in most countries is it used mainly by mothers, a gender inequality that negatively affects their employment status and career prospects). The inadequate offer of EC (0-3) education facilities (In Lithuania there are none before completion of year 2) also affects women's employment status and the persistence of the breadwinner/caregiver stereotype.

4 https://ec.europa.eu/education/policies/early-childhood-education-and-care_en

3.3 – Service culture in the health system

As discussed above (Box 4), fathers' presence at key moments on the birth care path is increasing across the EU. For this to be a positive experience for parents, and for the father/partner to actually be able to play a useful and supportive role, he needs to be involved and informed up front. The same is needed in order to enable him to be supportive and to care for both his partner and his child in puerperium, including knowing how to support breastfeeding and how to bond with his child. The attitudes and practices of individual professionals and how services are organized can favor or impede achieving these goals.

Box 5 – Couples'/fathers' experience with medical services

Couples report both positive and negative experiences in terms of father engagement by health services. When the experience is positive, this is generally attributed to 'luck' rather than assuming/recognizing that it is an established and normal practice in that particular institution or health authority. This is a reflection of notable differences in practice even between hospitals/polyclinics in the same area, despite existing national or regional guidelines where they exist. On a negative note, fathers sometimes observe that communication from health professionals was directed to the mother and/or is only about the mother and child, leaving them with the sense that 'this is not about us'. As one father said, 'You realize that you have been 'coded' as a person who is not part of the 'caring space'.

Consultations, especially in public services, may be very time-constrained with little time in general for a dialogue that includes fathers and is not exclusively centered on clinical aspects. Notably, couples report having a better, more relaxed experience in private consultations.

When the birth occurs in a highly medicalized environment that follows clinical protocols that allow women little choice in choosing how to deliver, it is difficult to engage fathers in an active/useful role rather than – at best

simply admitting them as spectators. The activism of women's movements for women's autonomy in birth choices and a humanized birth care path should be supported by men as well, since it directly concerns the likelihood and quality of their own participation in the process – their ability to be of real support to their partners, and to enjoy moments of intimacy that favor father-child bonding and the establishment of the parent-child relational triad. Unsurprisingly, in the limited number of cases (around 1% in Europe, as stated by Phelan & O'Connel (2015) in which the couple opted for a home birth, fathers played a major role in the decision.

3.4 – Medicalization of childbirth limits fathers' engagement

Increasing the medicalization of births even in the case of low-risk pregnancies and the now established belief that a hospital is the best place for a child to be born have limited women's birth choices, makes fathers' active involvement and parent-child intimacy after birth more difficult. The trend across Europe is for birth to occur in large units which have a higher propensity for interventions in labor and lower rates of spontaneous births (Phelan & O'Connel, 2015). Birth centers (generally midwife-led) offer a good alternative for low-risk pregnancies, either free-standing or within a maternity hospital.

Over-medicalization involving recourse by obstetric physicians to unnecessary tests and medical practices is largely motivated by the desire to avoid the exposure to medical malpractice litigation (Catino, 2011). This behavior creates an environment where birth is not a positive/natural experience for the mother or the partner or the newborn. Pregnancy and childbirth, which are natural phenomena, "…are driven by the development of surveillance medicine in a risk-averse society. This affects how both healthcare professionals and women perceive medicalization and is influencing changes in clinical practices surrounding childbirth" (Prosen & Krajnc, 2013)

Knowledge and application (within national health policy frameworks) of WHO and UNICEF guidelines on pregnancy, birth and puerperium are not widespread in either the EU or the four countries concerned, although the more progressive parts of the system make reference to them (Box 6).

Box 6 - IMPEC: Mobilizing Initiative for a Caring and Involved Fatherhood (Ministry of Health, Portugal)

The aim of the Mobilizing Initiative for a Caring and Involved Fatherhood – IMPEC (a directive of the Ministry of Health of Portugal approved in 2020) is to develop responses within the National Health Service to better support and empower men as self-determined persons in sexual and reproductive rights and as protagonists in caring for their child, particularly during the first two decades of life, alongside and in conjunction with women.

Main objectives:

- Promote gender equality, especially in intimate relationships, and sharing of domestic activities, in particular the tasks involved in caring for children;
- Increase the development of patterns of non-violence in family relationships and intimacy in all types of families;
- Support men's self-determination regarding unmet needs in terms of sexual and reproductive health and parenting, from the point of view of the involved father and caregiver;
- Encourage self-care and the protection and surveillance of health in men, especially those with parental responsibilities.

Axes of intervention

- Training health professionals to promote and protect involved and caring fatherhood;
- Creating technical references on involved and caring fatherhood and disseminating models of good practice;
- Adequately Incentivizing organizational models for services - Developing "Health Entities with Mobilizing Initiative for a Caring and Involved Fatherhood";

- Articulating IMPEC with other ongoing Projects and Programs within the area of Health, in the area of involved paternity and with pre-existing caregivers;
- Taking initiatives within the community to increase of the involved and caring fatherhood, and participation in relevant ongoing actions;
- Fostering health literacy on involved and caring fatherhood.

3.5 –...and during Covid things got worse

During the pandemic, the initial reaction when the virus struck and the mechanisms of infection were not yet well researched was to keep fathers/partners/people accompanying away during birth, and at other moments as well along the birth care path. As knowledge progressed and new guidance was issued by WHO and national or regional health authorities, some services made efforts to ensure that parents could be together, even through organizational innovations.

Regrettably, services/institutions that were already unfavorable to 'humanizing' low-risk births and including fathers/partners have tended to use the pandemic as an excuse for limiting fathers' participation even more, and this situation may persist beyond the end of the pandemic. The general sense – confirmed by studies in several countries (Benaglia & Canzini, 2021) – is that the pandemic has caused a set-back in terms of fathers' involvement, proving that partner companionship during birth and the right of parents to be together with their child in the moments after birth were not a well-established and recognized right, given how easily they were overturned. The COVID crisis revealed the extent and persistence of the medicalization process of birth informed by the "principle of separation", typical of the technocratic model of medicine (Benaglia & Canzini, 2021). There has been a tendency to "revert" to old practices, and despite progress towards less restrictive, more humanistic approaches and the revaluation of midwifery care, the medicalized model still shapes birth "management" in hospitals. It also brought to light divisions and issues of powerlessness within the midwifery profession. At the same time, it showed the importance of social pressure by activist organizations for women and parents' rights, as in the case below.

Box 7 - COVID 19 – Rolling back women and parents' rights: a case-study in Bologna, Italy

In their article "They Would Have Stopped Births, if They Only Could have": Short-and Long-Term Impacts of the COVID-19 Pandemic—a Case Study From Bologna, Italy, Daniela Canzini and Brenda Benaglia tell how the Voci di Nascita Association, active in promoting birth rights, successfully put pressure on local health authorities in Bologna and the region to ease restrictions regarding companionship at birth. The article also reports on a survey conducted with parents and midwives on their experience during COVID. Twenty-two percent of respondent mothers reported that they were unable to have their partners with them (but data that is currently – June 2021 - being processed put the figure at around 40% at a national level; services in Bologna tend to be more progressive).

Midwife respondents were vocal in denouncing the risks connected to leaving mothers alone and depriving them of personalized midwifery care, which requires presence, empathy, and close contact.

> *"Restricting access to the delivery room for fathers or an accompanying person has been detrimental to the mother's rights, the newborn baby, and the father. It has undoubtedly harmed the delicate process of birth at various levels. Increasing anxiety and fear in pregnant mothers, altering the dynamics and timing of labor and childbirth, exposing the mother to an excessive emotional and psychological burden postpartum, creating a fertile ground for emotional and psychological repercussions for the mother" (Midwife respondent).*

A mother confirmed that she and her partner eventually changed hospitals because "she could not even think" of giving birth without her husband. Partners usually remained outside the hospital premises, waiting to be called by the birthing mother herself or—more likely, given the circumstances—by the midwife on duty. One father said that this situation made him feel "powerless". Some partners specifically pointed at the

impossibility of reaching the necessary intimacy with the mother during childbirth because they could only be there for the very final moments.

Hospital prohibitions hit midwives hard and, partially due to their lack of power and authority in the biomedical hierarchy, their response was weak.

Respondents testified to the fact that not all midwives disagreed with the most restrictive measures and that, because of their own fear and exhaustion, some actually thought that it was better to exclude partners from the birthing room. The fact that there are no partners is seen by the majority as safer.

One midwife summarized the feelings of most respondents: "An unfortunate scenario has opened up: the little importance given to being born as a form of relationship."

At the time of writing this chapter (June 2021), the epidemic in Europe is on the downturn but semi-restrictive rules are still in place. It is as yet unclear how long it might take – if indeed possible - to return to the pre-CoVID situation in terms of fathers' involvement. There is a clear need for new rules and protocols that recognize professional roles and reinforce the rights of women and parents around birth.

3.6 – Involving medical doctors may not always be easy

Training courses for health personnel run by PARENT partners were designed to be multi-professional, with a focus on teamwork and coordination between different professionals involved at different moments in the pregnancy-birth-puerperium cycle. The most represented professional category was, unsurprisingly, midwives, whereas medical doctors were few. Relatively more pediatricians participated, as compared to obstetric physicians who tend to have a narrower focus on clinical and risk-related factors related to pregnancy and birth.

A more precise understanding of the causes of such limited participation would require a specific study. Based on PARENT experience it is possible to tentatively identify conditions that may encourage or limit their participation. More medical doctors participated when they were mandated (or at least invited) to attend by the management of their respective services. We therefore recommend that course attendance should be by invitation (via service management) where relevant rather than (entirely) voluntary.

Also – as in the case of PARENT, in Italy at least - considerably higher attendance by medical doctors of shorter (3-4 hr) events/webinars co-organized with partner organizations (in the case of Italy, the Italian Institute of Public Health and the Brazelton Touchpoints Centre) suggests that:

- given the time constraints of many health professionals, shorter events may be easier to attend, even if they do not provide CME (Continuing Medical Education) credits;
- presenting the event as a 'conference' may be more attractive than calling it a 'course';
- online events are perceived as more flexible (and recordings are generally available):
- organizing the event in collaboration with entities that have a well-established image/record within the medical and scientific community (such as the Brazelton Touchpoints network and the National Institute of Health) also helps to attract more medical doctors.
- professionals are more likely to be receptive to the messages on engaged fatherhood within progressive professional and scientific communities that are already active in promoting natural/humanized birth and total child health (one such organization in Italy, for example, is the greatly respected Cultural Association of Pediatricians, ACP).

Notably, both these shorter events had to be organized online due to the pandemic, which made it easier to participate. From the Italian experience it appears that medical doctors may have a preference for non-interactive Distance Learning modules, which they can more easily fit into their schedules.

However, the underlying causes of low motivation among medical doctors to attend are more complex and can only be listed here as assumptions that would require further study:

Box 8 - Why is it harder to reach and involve medical doctors?

The time constraints under which doctors operate, especially in the public sector, are evident from the complaints from couples, and especially fathers, regarding lack of time for dialogue on aspects that are not exclusively medical, and a mode of communication that is often not father-inclusive. Doctors often have high patient loads. In some cases, it is indeed hard for professionals to take the time off to attend a course and replacement staff might not be easy to find. In Italy, for example, there is a serious and growing shortage of pediatricians. One major constraint is also due to the fact that the majority of physicians (obstetric physicians and pediatricians) tend to combine public and private practice and they are unwilling or unable to limit the latter in order to attend a course.

Perception of relevance. The topic (fathers' engagement) also might not be perceived (in particular by obstetric physicians) as relevant given the type of professional training they have received and how they see their role, mainly as that of keeping the mother and child 'safe' and avoiding risks (defensive medicine). ("If fathers want to come, they can. But do we have to be the ones promoting it?", "Our job is to give medical treatment" are phrases pronounced by some doctors in the focus groups). Pediatricians, on the other hand, increasingly see the topic as being relevant and there is now a considerable body of scientific evidence on child development in the First Thousand Days (WHO/UNICEF Nurturing Care) focusing on the 'whole child' and on the relational context, which includes caregivers, with the father considered one of the primary caregivers.

Culture and training. While improvements have been made over the years at least in some countries, the basic training of medical doctors focuses almost entirely on clinical matters; attention to the person as a whole, to

socio-cultural, psychological and communication-related aspects continue to be significantly absent (Joo). It is as if medicine were, in effect, an exact science. More specifically, the role of fathers before, during and after birth has 'not been a key consideration for obstetric physicians'. (Kothari et al., 2019). Providing scientific evidence as to why fathers' engagement improves the birth and health outcomes for the child and the mother is necessary but not sufficient. Attitudes need to change, policy guidelines are needed that reflect international best practices (such as the Portuguese policy guidelines on engaged fatherhood, IMPEC, Box 6), and basic training needs to change.

Services organized along hierarchical lines. Also to be considered is the hierarchy (both formal and informal) that exists between different professional categories, despite official statements regarding collaborative work. Issues of hierarchy and power may affect the relationships between doctors (mainly male) and midwives/obstetric nurses (mainly female) whose degree of autonomy varies from one country and even one region to another (Vermeulen et al., 2019). PARENT courses are designed to be multi-professional assuming that teamwork will ensure the best possible birth experience (ibidem). This culture may be alien to many, and some doctors may feel uncomfortable sitting in the same course with professionals they consider to be their subordinates. And since the majority of non-medical professionals concerned tend to be women, sitting in a course that requires self-reflection and openness with a majority of women can add to the discomfort and unease.

Inconsistent recognition of women's autonomy. As mentioned above, in determining the buy-in of physicians, issues of gender and male power are also at stake, which is also the case in the greater tendency on the part of physicians, as compared to midwives, to override – on the grounds of safety – women's choices on how to give birth (Kruske), to the extent of enacting what is known as 'obstetric violence', a topic which is very hard to discuss with medical professionals (Sadler et al., 2016). This is evident in the well documented resistance by some of the medical profession to accepting the 'birth plans' submitted by the mother/ couple ('I've been

delivering babies for thirty years and now this woman comes along telling me how the baby should be delivered!"). Clearly this is a decision that needs to be negotiated, rather than imposed by one or the other, and here it is important for the couple to receive the information that will enable them to negotiate together. Promoting women's autonomy in the choice of how to give birth and control over her body becomes a political issue impinging on women's rights, and on women's empowerment, which male physicians may sometimes have a hard time accepting.

4.Organization

4.1 – Planning the training – who to involve

If you plan to train health professionals, the first thing to do is to 'map' those the couple is likely to interact with at different stages - pregnancy, childbirth, puerperium and early childcare. This will lead to the identification of multiple professionals including obstetric physicians, pediatricians, midwives, pediatric nurses, psychologists, family counsellors, ultrasound technicians, etc.

A multi-professional approach (and training team) is the best option, because different professionals are involved and there is evidence (Phelan & O'Connel, 2015; Karstrom et al., 2015) that, if they work as a team (collaborative practice), sharing common approaches and communicating well with each other, outcomes are better in terms of ensuring a positive birth experience for the mother, the child and the couple. "Trust and respect for each member of the multidisciplinary team is required and is particularly important for a seamless transfer of services between midwives and obstetric care when this is required" (Phelan & McConnel, 2015).

It may be more effective to target professionals already working as a team or at least those involved during the same time segment (pregnancy/birth/puerperium and ECC) by dividing the training according to possible phases, starting with a

common module to establish the 'science behind it', providing an overview of why it is important to engage fathers, and trying to get everyone 'on the same page'.

The more professionals actually attend all modules the better. The decision will also depend on how health services are structured. If they are organized by local geographic and administrative units that include extramural/community-based health services (that may also be linked to social services), as well as hospitals/ birth clinics, for greater impact it is advisable to select participants from the same unit/administrative entity. This option works best for in-person courses.

Online courses make it possible to include participants from different geographic areas, which is useful for learning, sharing and spreading new insights, but might ultimately have less impact at an institutional level.

Ideally, the professionals who can have the most impact are those who interact with the mother/couple most frequently from the beginning of pregnancy onwards. These have the best opportunities to get to know the couple, to establish a relationship not only with the mother but the father too, to get a sense of the dynamics that exist within the couple (which is also helpful in terms of early detection of possible GBV), and in general to be of greater assistance in helping them make informed choices, such as where and how they would like their child to be born, if and how the partner will be attending the birth, and so on.

For example, in some countries the first entry-point to health care for expectant mothers after a positive pregnancy test will be a polyclinic where the GP/family doctor is located. The GP may prescribe examinations, or (especially in the case of a low-risk pregnancy) direct the mother-to-be to midwives or obstetric nurses who may be operating in the same polyclinic or in a 'family clinic' (in Italy they are called 'consultori') where low-risk pregnancies are normally supported by midwives). This support may extend to year one, with the clinic – and the midwives - providing support for breastfeeding.

Hospital staff in general (both medical and non) may be harder to involve in training owing to staff shortages and work shifts.

There tends to be a rupture in continuity of care at the moment of birth, which generally occurs in a maternity hospital, attended by different staff. Lack of

continuity in pregnancy/birth care is a frequent complaint from parents. Seeking to have the delivery managed by the physician that provided care throughout pregnancy may result in planned caesarian-sections and oxytocin-induced births motivated by the need to fit in with the physicians' schedule. The level of institutionalized contact and collaboration between the place of birth and community services varies considerably. Furthermore, during the birth process, especially in cases of extended labor, there will be staff turnover between shifts. The professional taking over will rely on information and opinions provided to them by the previous member of staff. Providing correct (and unprejudiced) information regarding the situation of a particular mother and, where present, her partner to those covering the next shift is a topic that needs to be included in the training.

4.2 – Mandatory versus voluntary participation – aiming for sustainability and impact

Different methods (mandatory or voluntary or mixed) were used by PARENT partners to recruit trainees enabling us to evaluate the pros and cons of the different options.

The aim of the training activities was to change the way health services operate, and thus both attitudes and practices regarding the engagement of fathers, in order to have an impact at an organizational level. Focusing on a specific institution/service (health authority, maternity hospital/birth center or local government, depending on who is responsible) implies that professionals are more likely already to be working cooperatively (or at least be in coordination), which enables them to wield greater influence over their organization as a group than if they were acting individually. The importance of having a minimum critical mass of 'enlightened professionals' working as a team became evident during the COVID crisis, where the combined efforts of these teams, although small, plus the willingness of managers, made it possible to find ways to keep fathers present along the birth care path even during the pandemic.

It may also be necessary to recruit participants from one specific entity if the training credits are being released by the umbrella authority (e.g. a local health authority).

Asking managers to invite certain professionals to participate can favor a more balanced representation by professional category and service so as to cover the entire cycle right from pregnancy.

One lesson learned from using this format is that, to ensure impact in terms of organizational change, managers should be made aware of the training, either before or after (soon after works best since one can present results from the training).

When participation is voluntary, there is a greater likelihood of involving professionals, who are already motivated. Invitations may nevertheless be focused on a particular category, such as midwives or obstetric nurses or teaching staff, or on a particular institution/service or geographic area, or groups of professionals most likely to adopt and replicate the training (such as in the case of the progressive association of pediatricians, ACP, in Italy or the Brazelton Touchpoints Centre).

Running courses online has made it possible to involve participants from different areas and has facilitated attendance. PARENT partners found that it was useful to have participants from different parts of the country for greater diversity; as one participant from Sicily said after a webinar about how to engage fathers during the pandemic, "Thank you for showing us it is not impossible to do! You have encouraged us to try".

The general conclusion is that, ideally, training should not be a stand-alone event but part of a process, involving multiple partners, aiming to influence the modus operandi of institutions, for example by developing guidelines (such as the ISS guidance on involving fathers in pregnancy), follow-up activities and M&E.

4.3 – In service vs pre-service training and training of trainers

PARENT-led training focused mainly on in-service training where health professionals may access courses on a variety of topics, whereas basic pre-service courses follow standard university curricula that are relatively inflexible. Influencing pre-service training can have a greater and more sustainable impact

in the long term but may require changes in national training curricula and the ability to penetrate and influence university establishments and change consolidated academic traditions. This should definitely be an objective but requires longer-term efforts. Midwifery and nursing training institutions may be easier to influence than institutions training medical doctors, although they also follow standard practice. A proportion of participants in PARENT-organized courses were teachers and tutors of midwifery or obstetric nursing training. Some pre-service students (from midwifery courses) also participated.

4.4 – Organization – in person and online; geographical focus and non

During the PARENT project lifespan, due to the Covid-19 pandemic, it became necessary to replace in-person courses with online events. Thanks to new webinar applications that evolved quickly under the stimulus of the pandemic, even with online courses - while generally shorter in duration (given evidence on lesser retention and greater difficulty in maintaining interest with online courses) - it was possible to use interactive and participatory methods.

Four types of training can be envisaged:

a. In-person training using interactive and participatory methods;

b. Synchronous online training using IT tools to ensure interaction (such as virtual breakout rooms, working on shared documents, etc.);

c. Asynchronous interactive DL modules for individual use with tests (and feedback) (hybrid DL);

d. Asynchronous, non-interactive DL modules without tests (configured as online lectures).

PARENT partners used methods a) and b). Option c) requires a major investment in time and money. The effectiveness of option d) depends on individual motivation.

IT innovations have made it possible to make online sessions quite interactive, but in-person training is more effective: success largely depends on changing

attitudes and in-person training encourages collaborative group work and networking between professionals, which are the most effective in promoting sustainable change in attitudes and practices. It is likely that after the pandemic it will become more frequent to use a mix of the two.

It has proven useful (and possible if at least a significant proportion of participants attend all modules) to have some time lapse between modules to allow for self-reflection and 'homework' (for example, keeping diaries documenting participants' interactions with parents, especially fathers, between modules). With in-person courses this may not always be possible for cost reasons (bringing trainers from other parts of the country) and modules will have to be run back-to-back.

4.5 — Multi-professional versus single-profession — participants and trainers

PARENT opted for multi-professional work for the reasons stated in paragraph 4.1 (collaborative work within non-hierarchical teams ensures better pregnancy and birth outcomes and facilitates couple and father engagement).

For the same reasons, the training team should also be multi-professional and definitely include health professionals, preferably medical doctors as well as non-medical health personnel. This is necessary for credibility in the messaging and to better demonstrate how what is being taught is relevant their work. Furthermore, if the course provides training credits (see 4.6 below), there may be official requirements in terms of composition and qualifications of the trainers. Since PARENT's approach to engaged fatherhood is multifaceted (engaged fatherhood for mother and child health and welfare; men's well-being; gender equality and shared care; and violence prevention), the composition of the training team should reflect this and also be gender balanced. Trainers with experience in working with men who can convey their experiences and stories to trainees have proven to be very effective, especially when working with mainly female professionals.

A multi-professional training team and composition of participants sends the message that teamwork and a multidisciplinary approach are beneficial for all. We are, however, aware that a multidisciplinary approach is not yet mainstream within the basic education and training of health professionals (particularly

medical doctors); similarly, the prevailing professional hierarchy in health services, hospitals in particular, is not conducive to genuine teamwork in which the value of each and every professional is recognized.

4.6 – Course design and planning – preliminary focus groups

Focus groups conducted in the context of PARENT with fathers, parents and health professionals proved useful for curriculum planning and exploration of fathers' and parents' experiences and positive/negative expectations regarding fathers' engagement, particularly birth. Interviews with professionals brought to light attitudes regarding fathers' involvement and helped devise ways to make the training relevant to their actual practice and lead them to understand how better engaging fathers can make their work more effective and rewarding.

It is useful to conduct focus groups with fathers when planning in order to select which content and stories to discuss with participants. The world of men's/ fathers' emotions may be largely uncharted terrain for many professionals, especially females, and being exposed to real stories in the words of men (better still actually having a dialogue with some fathers during the course) can be transformative in terms of attitude.

… paying attention to mothers as well

Focus groups should capture women's perceptions as well. Women's attitudes towards and acceptance of fathers' closer participation in the birth process is an essential enabling factor. Unless they are convinced that it will be helpful for them, and not a hassle or an intrusion, fathers will at most be involved as spectators and possibly only at the moment of birth. While the attitudes and practices of health personnel can promote or discourage such participation, little can be done if the motivation does not come from the mothers as well. Mothers normally wish their partners to be with them during labor and birth. The importance of 'individualized emotional support' for the mother during pregnancy and birth has been shown to empower women and increase the possibility of a positive birth experience (Karlstrom et al, 2015).

Box 9 - Fathers' stories from PARENT focus groups

Several fathers reported being present at checkups, some antenatal classes or information sessions about birth and postnatal care, yet feeling that 'this is not about us', or 'excluded', 'ignored', 'invisibilized', 'not having a space'. Some complained of not having receive enough information, or that what was being said was not specific to their role as partners. Some said they were unable to attend antenatal classes due to timing and they felt the need for some time and space for men only. Some said they did not feel 'useful' at the birth, spoke of physicians' negative attitudes ('it was as if I wasn't there"), of not being given the child to hold, or not being able to have skin-to-skin contact with their child.

On a positive note, many were also pleased with the attitude and competence of staff, feeling included, being made to feel they were important and useful. They appreciated being talked to directly, when their opinion was asked, receiving clear and sensitive explanations during the ultrasound scans, being kept informed when unable to be present at the delivery. Some expressed special appreciation of the 'professionalism' and 'delicacy' of staff, especially midwives; of having been given the opportunity to spend quality time with their child after birth and to experience skin-to-skin contact (on the importance of father child skin-to-skin contact, see Erlandsson et al. (2007).

Such differences reflect the considerable variations in practice and organizational philosophy of different institutions. Interestingly, when the experience is positive, fathers tend to attribute it to 'luck' rather than the fact that it may actually be a policy/normal practice of that particular institution (as in Portugal's case, which has many laws promoting 'a positive birth experience' and engaged fatherhood, Box 6).

Fathers also report being worried about the financial implications of having children and the tension between their perceived role as the main breadwinner and wanting to spend time with their child (Hanson et al 2009; Lewis & Lamb, 2007; Redshaw & Henderson 2013)

4.6 – Credits

In most countries, systems of Continuing Medical Education (CME) credits for health personnel are in place. This is generally the case when the number of hours is more than a set minimum (such as, for example, a half-day event for which a certificate of attendance may be sufficient to ensure participation). Releasing credits may be a prerequisite to ensure regular attendance by targeted professionals, given time limitations or other constraints, and the fact that the course is organized during working hours. For the purposes of accreditation, there are generally minimum requirements that need to be complied with and the training teams will need to include health professionals (see above 4.5). Credits bear their own cost and there is also an organizational cost related to counting for and issuing credits for each participant. When budgeting for the training, remember to factor in the cost of the credits and provider thereof, if they are not released directly by the entity (health authority or local government) with which the course is being organized.

5. Content and methods

5.1 – Entry-points/drivers to motivate professionals

Participants may have joined because they have been mandated by their employers, or voluntarily as a matter of interest. Whatever the reason, for the change in attitudes and practices to become effective the subject of respecting the needs and desires of couples, and specifically fathers, must be perceived not just as the 'right thing to do', but as relevant to them and their work as professionals. They need to see and become convinced that doing so is an added value for them.

Training professionals on engaged fatherhood needs to be grounded on objectives that are more easily perceived by and of interest to them, for which the PARENT approach has proved effective, since it addresses engaged fatherhood from different (but complementary) perspectives:

a. Child development and mother & child health: early engagement of fathers (from pregnancy) as fundamental for the healthy psycho-social and even physical development of the child, and also for the physical and mental health of the mother;

b. A benefit/opportunity for fathers: involving fathers is necessary in order to respond to fathers' increasing and recognized desire to be involved from an early stage;

c. Gender equality: engaged fatherhood is necessary because care has to be shared, to ease women's burden of unpaid work and for gender equality.

Participants in PARENT courses were informed that the meta-goal of the project was to prevent GBV through the promotion of caring masculinities. However, the link between engaged fatherhood and the prevention of violence is neither intuitive nor widely recognized. Trainers should present the available evidence (e.g. research on reduced levels of testosterone and increased oxytocin when fathers practice 'caring behavior' (Abraham & Feldman; Gettlera) and on early father-infant bonding); and also research showing the link between greater gender equality in couple relations and reduced violence. However, there is a clear need for more empirical studies in this area.

Fathers' engagement for child development and mother & child health may prove to be the most immediate and understandable argument for health professionals. Evidence of how fathers' engagement right from pregnancy is conducive to better birth outcomes, maternal and child health and positive child development is by now substantive and growing, although knowledge is not yet generalized among health professionals (Boxes 2 & 3).

Box 10 - Why the First Thousand Days are key

The period between pregnancy and year 3 (the First Thousand Days) is the most critical, within which 80% of the child's brain formation takes place. Multiple findings from neuroscience and developmental psychology show that caregiver-child interactions are highly beneficial for early child development and have long-lasting effects. Starting from the first months, quality time with a baby – including smiling, touching, talking, storytelling, listening to music, sharing and reading books, and engaging in play – builds neural connections that strengthen the child's brain. (WHO, 2017).

The training can then be used as an opportunity to cast light on other aspects as well, such as men's wellbeing, gender equality and the prevention of violence (see below).

5.2 – Deconstructing stereotypes/ the world of fathers' emotions

It is necessary to address/dismantle stereotypes regarding men and fathers (and institutional practices that 'invisibilize' fathers) and raise awareness among predominantly female professionals about fatherhood as a social construct and also about the world of men's emotions and the cultural and practical constraints they face.

The training has much to do with changing attitudes and perceptions. Where in-person training can be held, it is useful to have posters on the walls with images of 'engaged fatherhood' in order to 'activate thoughts and feelings' and to put participants 'in context'. Showing videos and telling stories of fathers at the birth of their children is also very effective in influencing attitudes.

Box 11 - The transformative power of becoming a father – A story of past violence

He is a graduate, an intellectual, socially committed with strong values, from a middle-class family, with two sisters and a brother. The son of a successful craftsman - and a rigid, demanding, violent father ("I sent you to school, I got you through university, and you just don't understand the sacrifices we have made..."). His first child arrives when he is 41. His feelings during the wife's pregnancy are ambivalent: happiness, fear, inadequacy, desire, detachment... Here is his story.

"It all happened in an instant. Something overwhelming moved inside me when I saw my son being born. At precisely that moment and in the moments after... Until then, I had done everything, the best I could to be there, to support my wife, not to seem distant... but in actual fact my feelings were confused. There was always something that distracted me, Simona noticed and brought it to my attention. I denied it or justified myself. Actually, I felt that maybe she was expecting too much of me, that it was reasonable that I should be afraid of becoming a father considering the father I had had.

And then it happened. Thomas was born.
I saw it and felt a huge lump in my throat. I could hardly breathe. And then all the rest.
The delicate, soft touch of the midwife's hands. Yes, her hands...
They didn't grab him, they welcomed him.
Then she dried him so gently and handed him to Simona who held him as if he were the most precious being in the world.
They were both careful, slow, delicate.
And tiny Thomas stopped crying.
The skin, his skin, so fragile and delicate...
He was safe, he stopped crying.

It happened in an instant...A dam broke from the lump in my throat. I started crying, I couldn't stop, getting louder and louder, so loud that I had to leave the room. I went out into the corridor.

It wasn't just the emotion of a new father, I was crying because it was as if those careful hands that touched my child had also touched me, the child that I had been; they had held him but also me, they had swept away all the blows, the blows, the blows that I had received from my father.

A liberation, a release from the past, a melting heart, the end of fears and doubts, the certainty, finally, the certainty, that I would never do anything, ever, to harm Thomas".

Story collected by Giovanna Bestetti,
Iris (istituto ricerca intervento salute - Milano www.irisassociazione.it), project PARENT-Italy partner

With female participants (who were in fact the majority in all PARENT training events), knowledge/understanding of the 'world of fathers' emotions' is not a given, and stereotyping is not at all uncommon. Thus, deconstructing stereotypes and prejudices regarding how certain fathers are, in their view, 'likely to behave', and reflecting on how attitudes and stereotypes may make communicating with fathers difficult has been an important part of the training. Reading stories by men of their experience with health services and personnel during the 'birth care path', and their emotions, is also helpful. Even better, where possible, invite a group of fathers to have a conversation with course participants. Where this has been done it has proved effective in changing attitudes (interview with Adrienne Burgess, Fatherhood Institute, UK).

It is important to show that gender roles in parenting are social constructs (apart from the biological functions related to the physiology of pregnancy and birth). Whereas motherhood is grounded in biology, as well as in long-standing socio-cultural norms, fathers have to 'grow into fatherhood', and encouraging early father-child bonding (starting from pregnancy) is key to this process. Professionals can learn how they can facilitate this bonding process working directly with both fathers and mothers.

Female professionals may feel they don't know how to communicate well with fathers. It is therefore important to suggest ways such as simply using the plural,

asking the father '..and what about you?' 'What was your experience?'. Their own experiences as women in pregnancy and birth (especially for older professionals) may have been very different; participating in the course may lead to a process of self-reflection which can actually be emotionally disturbing for some, but also revealing. Avoiding stereotypes about migrant fathers is also critical.

Box 12 - Migrant women and their partners

Course participants agreed that stereotypes about migrant fathers being less able/willing to be present are generally not justified. When their work situation allows, and when information is provided and specific efforts made to include them, they are happy to do so. There are reports that fathers coming from cultures where it is not normal for fathers to be present at the birth are glad of the opportunity to be there. However, they come from very gender-unequal cultures that do not recognize women's autonomy, and this may lead them to 'mansplain' when it comes to having to translate for their wives who often have fewer opportunities to acquire the new language.

Professionals we trained noted that, in situations where there is a language barrier, migrant women are freer to make decisions when they are supported via a mediator/interpreter than when their husbands translate for them and often decide for them (the women won't contradict them in public). The midwives have said they explain to the husband that the mediator needs to be there because they, as professionals, need very precise information about symptoms and not because they do not trust him.

However, mediators/translators may not always be available, in which case it is essential to involve the fathers, who need to be empowered and informed so they can translate accurately without interpreting or adding their own views. In general, migrant fathers need to be informed about available health and welfare provisions.

Participants have sometimes observed that, although they themselves believe in gender equality within the couple, they often relate to people/couples who don't

necessarily believe in it. Some will say 'we must leave it to the couple to decide', others feel that professionals have an important role as change agents and role models. This was recognized as being especially important for professionals who are tutoring trainees: what they – as trainers/tutors - do in practice is more important and has more impact than what they might say in the class context (the importance of modeling actual behaviors).

A common conclusion by participants is that, yes, it is more complicated and time-consuming to have to relate to/communicate with the couple and not just the mother. But when one is able to do that effectively and at an early stage (so they come prepared) the results are much better. The supporting research evidence on this point is convincing and should be brought to their attention (Boxes 2 & 3).

Box 13 - Why involving fathers matters even (and more) when there are complications

Involving/communicating with fathers is not just a 'luxury', something than can be done only when all goes well and there are no complications. It is actually even more important when things don't go well. With an informed and supportive partner by her side, it will be easier for a woman to deal with the unexpected or painful and unintended decisions, to handle the 'bad news'.

Professionals we trained noted that, in situations where there is a language barrier, migrant women are freer to make decisions when they are supported via a mediator/interpreter than when their husbands translate for them and often decide for them (the women won't contradict them in public). The midwives have said they explain to the husband that the mediator needs to be there because they, as professionals, need very precise information about symptoms and not because they do not trust him.

However, mediators/translators may not always be available, in which case it is essential to involve the fathers, who need to be empowered and informed so they can translate accurately without interpreting or adding their own views. In general, migrant fathers need to be informed about available health and welfare provisions.

5.3 – Dealing with the issue of GBV

The overarching (meta) goal of PARENT was to contribute to the prevention of GBV by promoting engaged fatherhood and thus caring masculinities. It was evident, however, from the PARENT experience, that there is a delicate balance to be struck regarding how the issue of violence is treated during training with health personnel (different, for example, to social workers, who work with problematic cases and therefore also issues of violence: in this case the topic must be addressed directly). Training is likely to focus on the more immediate reasons why engaged fatherhood is important: child development and mother & child health; fathers' desire to be involved; gender equality and shared care. It is important not to project (for example by devoting too much time to the issue of violence) the idea/or reinforce the stereotype that most men are potentially violent, in favor of a more positive approach to the possibility of engaging fathers in care. It is important to raise awareness and provide available scientific evidence that caring behavior is in itself transformative for men, for example in terms of hormones/physiology (Abraham & Feldman, 2017; Gettler et al., 2011) and in terms of building a relationship of trust and mutual respect with both child and partner (connected to GBV prevention); and to stress the importance of developing an effective GBV screening process during the pregnancy. Professionals should nevertheless be aware of and be able to detect early signs of conflict within the couple, or the risk of violent behavior by the partner, which can evolve into actual violence (Box 14).

There also needs to be greater awareness about paternal depression, explaining symptoms, which are different to those of women, and showing that it is not something to hide or be ashamed of. Talking about it is often taboo, considered 'unmanly'.

Box 14 - Screening for domestic violence during pregnancy

A discussion on the incidence of GBV during pregnancy and its short- and long-term impacts should be part of the training (WHO Information Sheet, Intimate Partner Violence during Pregnancy).

The incidence of GBV in pregnancy is considered to be underreported in official statistics (11% in Italy according to ISTAT, the Institute of Statistics). Depending on existing legislation for the prevention of GBV, health services may or may not be required to screen for violence.

Research (O'Reilly & Peters, 2018) has revealed that, when care providers did not screen for domestic violence, contributing factors included: a lack of recognition that this was part of their role; and a lack of domestic violence screening policies and/or reminder systems. Further barriers to domestic violence screening were identified as a lack of time, resources and confidence in undertaking the screening and referral of women when domestic violence was detected, since such services, especially free services, may not be readily available in all contexts.

When screening is done it is based on a set of questions that are asked by professionals during pregnancy. The questions are repeated since there may be an initial tendency on the part of the mother to protect her partner by not declaring the act of violence.

5.4 – Methods

Knowledge, attitudes and practices

A portion of the training will consist in transfer of information and scientific content, for which classic lecture style followed by Q&A is recommended. This is the where scientific evidence can be provided on the impact of fathers' engagement, the link between caring masculinities/fatherhood and violence

prevention, and issues of gender equality and shared care. It is possible that, if the training is pre-service, frontal (as opposed to interactive) methods may be more widely applied. With in-service training where the aim is not so much to teach new practices as to reflect on how to adjust existing practices to be more inclusive and father-sensitive, and also to change attitudes and raise motivation, participatory methods are the most effective. PARENT partners responded to the challenge posed by having to go online due to COVID with an imaginative use of online tools which enabled use of most in-person methods (with the exception of role plays, replaced by presenting a situation in a video and having the participants comment). Most webinar software enables the organization of breakout groups, working on a shared document such as in Google Drive, electronic post-its, etc.

Methods used successfully (both online and offline) have included:

- Breakout groups discussing specific questions followed by plenary feedback;
- Exercises on stereotypes (e.g. showing photos of men and asking how they expect that man to behave at different moments along the birth care path, such as during delivery)
- Word Café exercise
- Story-telling
- Post-it sessions (online software such as Jamboard can be used), e.g. opportunities vs obstacles to fathers' involvement with a subsequent word frequency analysis using text analysis software

In-person only:

- Role plays
- Fishbowl exercises
- Circles

5.5 – Duration

The duration will depend on local factors and participants' availability. The recommended duration to cover the introduction and three phases of pregnancy, birth and puerperium/early childcare is from a minimum of 16 hours upwards. If the modules are not run back-to-back, participants can also be given 'homework' such as keeping a diary of their interactions with fathers during the intervening period and if/when fathers are not present reflect on/find out the reasons why.

5.6 – Monitoring and evaluation

Different methods of evaluation were used by PARENT partners. In Italy, a KAP questionnaire (adapted from the MenCare Program P Manual, with the addition of some GEM-scale questions, was used to test acquisition of knowledge, attitudes and practices on engaging fathers before, at and after the birth. Three versions of the questionnaire were applied: T0 before the training; T1 at the end of the course (within 15 days of completion); and T2 6 months after completion of the training. The questionnaires focused on knowledge, attitudes, practices and perceived competence in engaging fathers. Results show that statistically significant impact was achieved in all four domains.

Qualitative feedback on the course was also collected and analyzed.

5.7 – The curricula

The training curricula used by PARENT project partners (specifically Portugal, Italy and Austria) differed when training health professionals. Focus on particular topics or messages will depend on local needs which you will have explored in the planning phase also by conducting focus groups. Key content and messages are summarized in the annexes.

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ANNEX 1

PARENT Training Curricula for Professionals in Austria

Target groups:

Experts* working in the fields of birth preparation, postnatal care, early childhood education and parental education. These experts work in/for various institutions: in official healthcare/welfare institutions and social workers or other professionals working in commissioned institutions.

The participants of the training program have different professions and focus in their work: Doctors, social workers, midwives, lactation consultants, early interventionists and early interventionists in training, occupational therapists, consultants in birth preparation, flexible assistance, child protection centers, heads of parent-child centers or leaders of parent education groups.

Mode and time scope:

- face-to-face or online (e-learning module)
- two in-person or online modules, with a blended learning module in between

Curriculum for Professionals

Day 1

Time	Method	Content
14:00 / 14:30	Intro	Project presentation, benefits for the participants

14:30 / 15:30	Activity and exercise	• Changes in gender relations internationally and in Austria • Caring Masculinity • Paternity • 'Real Men' exercise
15:30 / 16:30	Brainstorming	Brainstorming in small groups on • Relevant topics on paternity (Who defines these topics? Fathers, mothers, literature, expert experience) • Fathers in pregnancy and birth • Parental education • Plenary presentation of the results • Summary
16:30 / 16:45	Break	
16:45 / 17:30	Exercise	Parental role/father role ('My father and me'), reflection in small groups
17:30 / 18:00	Impulse	PARENT Results I (topics, structure, how to address fathers – example Vaterwerkstatt – PARENT training program for fathers)
	Homework	How can I reach fathers in my work? Consider examples

Day 2

Time	Method	Content
14:00 / 15:00	Practice transfer	Relevance of active fatherhood in my field of practice (results of the homework)
15:00 / 15:30	Activity	PARENT Results II (topics, structure, how to address fathers)

15:30 / 15:45	Short Activity	Vaterwerkstatt – PARENT training program for fathers
15:45 / 17:00	Exercises	Methods in parental work (selection by participants by means of point allocation): - Gender-sensitive parenthood (reflecting gender structure, use of case vignettes) - Non-violent relations - Positive Parenting Exercise - Use of time (“cake”) in Austria
17:00 / 17:30	Speed Dating – then plenary and Short Activity	Benefits of active paternity for fathers, mothers, children, professionals Answer further questions about active paternity in speed dating
17:30 / 17:45	Short Activity	Benefits of active paternity
17:45 / 18:00	Evaluation	Evaluation (questionnaire)

Variation: Training Curriculum Blended learning only

1. Activity with slides on the following topics (PowerPoint presentation:

a. Data and facts on active paternity

b. Results of the PARENT needs assessment

c. Self-reflection on gender roles (activity)

d. Caring Masculinities Concept and changing father roles

2. Blended learning task to promote active fatherhood using the task sheet sent by e-mail:

- Keeping a gender diary: individual implementation by the participants within two weeks, exchange of experiences with the team (teleconference with preparation of the reflection protocol, sharing the diaries and protocols with the trainers).
- "Promotion of active fatherhood" Analysis on the basis of a recent internship in the setting of children in family support: reading the introductory article provided by the trainers, writing the analysis.

3. Evaluation (questionnaire)

ANNEX 2

PARENT-Italy – Training health personnel – curriculum

Structure, number of participants and duration

Module 1	Introduction – Why engaging fathers matter	8hrs	75-90 participants
Module 2	Engaging fathers during pregnancy	8 hrs	25-30 participants
Module 3	Engaging fathers at birth	8 hrs	25-30 participants
Module 4	Engaging fathers in postpartum and in early childhood	8 hrs	25-30 participants

Total: 32 hrs

Participating professionals

Module 1	All professionals participating in Modules 2,3 and 4
Module 2	Professionals providing prenatal care
Module 3	Professionals providing antepartum, labor and delivery care
Module 4	Health professionals providing postpartum and early childhood (First 1000 Days) care specifically: • Midwives from hospitals (birth units/punti nascita) and from community services such as family clinics (consultorio); • Obstetric physicians, from hospitals (birth units) and community services; • Pediatricians; • Pediatric nurses; • Also included: psychologists and social workers working in collaboration with health professionals.

Objectives

a. To raise awareness among health professionals of the importance of fathers' engagement in care in the First Thousand Days for the wellbeing of the child and the family; for gender equality; for the prevention of domestic violence.

b. To identify – through a participatory and experience-based process- ways in which individual and institutional practices can be modified/developed to promote greater and more effective father engagement, starting from pregnancy.

Evaluation:

- Through a KAP questionnaire (attached) applied pre-course (T0), immediately after completion (T1), and after one year T2.
- A course evaluation questionnaire is administered at the end of each module.

Methods

Module 1: Designed to provide the theoretical background and scientific evidence concerning the rationale for fathers' engagement in the First Thousand days (Objective 1): Formal presentations with Q&A; one post-it session (strengths/ weaknesses in engagement of fathers in the First Thousand Days, in our actual professional contexts); application of the KAP questionnaire.

Modules 2,3, 4 (Objective 2) For different topics, introduction of topic by trainers/experts + participatory working sessions using case studies, role plays, post-its, World Café and other participatory methods; summary and conclusions by trainer/s. Module 1 provides the scientific evidence and is also intended to provide the motivation to find ways to better engage fathers. In Modules 2, 3, and 4 the participants, who are experienced professionals, share their stories and reflections on the engagement of fathers and structure their thinking on best practice to better engage fathers.

Training team composition

The training team includes the following expertise:

- adult education specialist with experience working with health personnel and participatory methodologies (main facilitator for Modules 2, 3 & 4);
- midwife;
- gynecologist;
- pediatrician/neonatologist;
- medical doctor/technical expert in prenatal and pregnancy-related diagnostics;
- expert in working with men/masculinities and GBV prevention (Module 1);
- social scientist/gender specialist (Module 1).

Program

Module 1 - Why engaging fathers matters

Logistics and equipment

- Room for 90-100 people with movable chairs;
- PC and projector;
- Flipcharts;
- Post-its of two colors;
- Adhesive putty or tape;

Program

Module 1 / Session 1 - From 8.30 to 13.00		
Time	**Content**	**Method**
8.30 / 9.15	Welcome, outline of training program Pre-test	Frontal Distribution and compilation of KAP questionnaire T0
9.15 / 10.15	Description of PARENT Project and its objectives	Frontal
10.15 / 10.45	Discussion/sharing of participants' vision and expectations	Interactive Post-it session
10.45 / 11.30	Fatherhood today: social, cultural and demographic aspects	Frontal
11.30 / 11.45	Discussion and Q&A	Interactive
11.45 / 12.45	The paternal function: psychology, biology and neuroscience	Frontal
12.45 / 13.00	(continued)	Discussion/Interactive
Module 1 / Session 2 - From 14.00 To 18.00		
14.00 / 14.30	Paternal health and behavior 1: psychopathology; paternal depression	Frontal
14.30 / 14.45	(continued)	Discussion/interactive
14.45 / 15.30	Paternal health and behavior 2: gender-based violence	Frontal
15.30 / 15.45	(continued)	Discussion/interactive

15.45 / 16.15	Early child development: a father's role and its effects	Frontal
16.15 / 16.30	(continued)	Discussion/interactive
16.30 / 17.00	Screening for GBV during pregnancy	Frontal
17.00 / 17.30	Co-parenting	Frontal
17.30 / 17.45	Reflection on the day	Discussion/Interactive
17.45 / 18.00	Course evaluation	Compilation of evaluation questionnaire by participants

Module 2 – Engaging fathers during pregnancy

Logistics and equipment

- Room with enough space for at least 30 people; movable chairs; access to another room if possible for group work (3 groups).
- PC with internet connection and projector;
- Flipcharts;
- Post-its of two colors;
- Adhesive putty or tape.

Methods

Mainly interactive and work in small groups, using a variety of participatory tool role plays; group discussion and feedback to plenary; World Café; viewing and discussion of videos and photos; post-it sessions, etc.

Program

Module 2 - Session 1 - From 09.00 To 13.00		
Time	**Content**	**Method**
9.00 / 9.15	Recap of Module 1 content	Frontal
9.15 / 9.35	Our perceptions (and stereotypes) as professionals regarding fathers' roles.	Group work (GW) (photos of different men: 'what kind of father/partner do I imagine him to be (during pregnancy)?'
9.35 / 10.15	(continued)	Discussion/exchange between trainers and participants
10.15 / 10.45	Fathers and prenatal diagnostics - Our experience as professionals	Group work
10.45 / 11.30	Fathers and prenatal diagnostics - Issues and case stories ('including 'when the news is bad')	Frontal
11.30 - 12.00	Fathers and prenatal diagnostics - Feedback from groups and discussion	Discussion/exchange between trainers and participants
12.00 / 12.30	Fathers' engagement in 1) health checkups during pregnancy; 2) promotion of healthy lifestyles during pregnancy; 3) antenatal classes	Group work, one group for each of the three topics (groups composed to include professionals most involved in the different areas) - Our experience and issues we face as professionals in engaging fathers
12.30 / 13.00	Plenary feedback from Group 1 (fathers and check-ups) Discussion	Discussion/exchange between trainers and participants

Module 2 / Session 2 - 14.00 to 18.00		
14.00 / 14.30	Plenary feedback from Group 2 (fathers and promotion of healthy lifestyles) - Discussion	Discussion (exchange between trainers and participants)
14.30 / 15.15	Fathers and lifestyles during pregnancy	Roleplay
15.00 / 15.30	(continued)	Discussion in groups on the roleplay and feedback in plenary
15.30 /- 16.00	Plenary feedback from Group 3 (fathers and antenatal classes) & discussion	Discussion/exchange between trainers and participants.
16.00 / 17.00	Practical suggestions on how to improve fathers' engagement in different contexts; 1) health checkups during pregnancy; 2) promotion of healthy lifestyles during pregnancy; 3) antenatal classes	Group work by topic 1,2,3
17.00 / 17.30	(continued)	Plenary feedback by groups Discussion/exchange between trainers and participants.
17.30 / 17.45	Review of the day	Discussion/exchange between trainers and participants. (In circle 'what I take away')
17.45 / 18.00	Course evaluation	Compilation of course evaluation form

Module 3 – Engaging fathers during labor, delivery and the early hours

Logistics and equipment

Room with enough space for at least 30 people; movable chairs; access to another room if possible, for group work (3 groups).

- PC with internet connection and projector;
- Flip charts;
- Post-its of two colors;
- Adhesive putty or tape.

Methods

Mainly interactive and work in small groups, using a variety of participatory tool role plays; group discussion and feedback to plenary; World Café; viewing and discussion of videos and photos; post-it sessions; etc.

Module 3 / Session 1 - From 8.30 to 17.30

Time	Topic	Method
9.00 / 9.15	Recap of Module 1 content	Frontal
9.15 / 9.40	Our perceptions (and stereotypes) as professionals regarding fathers' roles	Group work (GW) (photos of different men: 'what kind of father/partner do I imagine him to be (during childbirth)?'
9.40 / 10.20	(continued)	Discussion/exchange between trainers and participants
10.20 / 10.50	Engaging fathers during: 1) prodromes 2) labor and delivery; 3) the first two hours	Participants, divided into three groups by topic are required to discuss and prepare a roleplay on a difficult (and typical) case in relating to fathers at that moment

10.50 / 11.10	(continued)	Roleplay – Group 1 (prodromes)
11.10 / 11.30	(continued)	Discussion/exchange between trainers and participants
11.30 / 11.50	(continued)	Roleplay – Group 2 – delivery
11.50 - 12.10	(continued)	Discussion/exchange between trainers and participants
12.10 - 12.30	(continued)	Roleplay Group 3 – first two hours
12.30 / 13.00	(Continued)	Discussion/exchange between trainers and participants

Session 2 - 14:00 - 18:00

Time	Content	Method
14.00 / 14.30	Video of a delivery where the father is present	Trainer/facilitator explains context Viewing video (where the father who did not originally want to be present gets involved and becomes supportive and proactive; and how he is guided and encouraged by the midwife)
14.30 / 14.50	(continued)	Discussion/exchange between trainers and participants on how /why the father's attitude changed and what helped.
14.50 / 15.10	Fathers and rooming-in	Trainer/facilitator chooses 'actors' among participants and assigns pre-prepared script. Roleplay by participants

15.10 / 15.30	(continued)	Feedback and discussion
15.30 / 15.50	Dealing with different types of fathers at birth: a) an overbearing father	Discussion/exchange between trainers and participants
15.50 / 16.10	Dealing with different types of fathers at birth: b) how to engage a father who seems passive and uninvolved	Discussion/exchange
16.10 / 16.30	Dealing with different types of fathers at birth: c) how to involve an absent father	Discussion/exchange
16.30 / 16.50	Engaging with fathers at discharge from hospital (e.g. giving advice on how to support breastfeeding)	Discussion/exchange
16.50 / 17.10	Practices to better engage fathers at birth and immediately after	Participants, divided into groups corresponding to different birth units where they operate, are asked to identify five things that could be done to better to engage fathers
17.10 / 17.30	(continued)	Feedback by groups; discussion and exchange
17.30 - 17.45	Thoughts on the day –wrap up	Frontal
17.45 18.00	Compilation of course evaluation	

Module 4 - Engaging fathers post-partum and in early childhood

Logistics and equipment

- Room with enough space for at least 30 people; movable chairs; access to another room if possible for group work (3 groups).
- PC with internet connection and projector;
- Flipcharts;
- Post-its of two colors;
- Adhesive putty or tape.

Methods

Mainly interactive and work in small groups, using a variety of participatory tool role plays; group discussion and feedback to plenary; World Café; viewing and discussion of videos and photos; post-it sessions, etc.

Module 4 / Session 1 - 09.00 - 13.00

Time	Content	Method
9.00 – 9.15	Recap of content of Module 1	
9.15 – 10.00	After childbirth – the father I would like… (visioning exercise)	World Café or other group exercise
10.00 – 10.30	(continued)	Feedback of results to plenary
10.30 - 11.00	(continued)	Discussion, with input/questions from facilitator on sharing the care – 'Do men mother'? How do my expectations affect the way I engage with fathers at this stage?

11.00 / 11.30	The new father: feelings and mental distress	Roleplay
11.30 / 12.00	(continued)	Discussion to identify when/ how to advise couples or fathers to seek counseling without excessive medicalization of symptoms and cure
12.00 / 13.00	The role of fathers in supporting breastfeeding	Introduction by trainer
	(continued)	Discussion in small groups on their experience as professionals
12.40 / 13.00	(continued)	Feedback to plenary and discussion

Module 4 / Session 2 - 14.00 - 18.00

Time	Content	Method
14.00 / 16-00	Engaging with fathers in different contexts: G1 child health check-ups; G2 Family clinic service for breastfeeding and early childcare; G3 Contraception and health: whose responsibility? G4 Gynecological check-up.	Work in small groups by topic annotating key thoughts on a flip chart Plenary discussion with additional input by trainer/s as needed on relevant topics
16.00 / 17.30	Self-help groups and social networks (peer groups, father/ parent groups, etc.)	Brainstorming session on what resources exist where we operate and how to mobilize them
17.00 / 17.30	Closing circle: my briefcase	Participants in a circle state their take-away from the day
17.45 / 18.00	Compilation of course evaluation questionnaire	

ANNEX 3

Portugal – Training health professionals / students for the promotion of involved paternity and caregiving

Type of course

Short course - 30 hours

- 20h of contact and 10h of autonomous work by the trainee
- 1 ECTS (European Credit Transfer System)

Framework and Justification

Caring masculinities can be seen as male identities that include the affective, relational and emotional dimensions associated with caring, and exclude forms of domination (Elliott, 2016). Thus, the promotion of gender equality emerges in men's lives whenever they assume caring practices in their daily lives (Scambor, Wojnicka & Bergmmann, 2013).

As far as the Portuguese reality is concerned, attitudes and practices regarding men's participation in family life and their role in the work-family articulation reveal significant changes in recent years. However, there is still a long way to go towards full equality between men and women (Wall, K. (coord.), Cunha et al. (2016)). According to these authors, the male pattern of low allocation of time to domestic work persists, with men remaining secondary performers of domestic production. An example of this is the study on "The Uses of Time of Men and Women in Portugal" by Perista, Cardoso, Brázia, Abrantes & Perista (2016), which confirms the gender disparity in the time that men undertake unpaid work, with regard to both care work and domestic tasks. In this study, taking the seven-day week as a reference, an attempt was made to estimate what the gender gap would be, and the conclusion was reached that women do more than 12 hours

and 22 minutes' more unpaid work than men. In 2015, domestic tasks remained, as they were in 1999, a largely feminized field. Women continue to play the role of the main person responsible for domestic tasks, with more or less collaboration from their spouse or partner. There continues to be a tendency for men to be viewed as those who 'help', those who 'support', far from a panorama of effective sharing of responsibility and execution of domestic tasks (Perista et al., 2016).

Childcare is permeated by tensions, negotiations and inequalities. Men's participation, always low compared to women, tends to be especially low in the early years of children's lives. It has been found that the longer it takes to provide childcare, the more unevenly it is distributed between women and men. However, it should be noted that, where care is more evenly distributed, men do not express dissatisfaction; on the contrary, they emphasize the satisfaction derived from the bonds that care allows them to develop with their children and the benefits of a symmetrical distribution of responsibilities between the couple (Perista et al., 2016).

The conditions and practices for exercizing motherhood and fatherhood are one of the key dimensions of effective equality between women and men. The birth of children, especially the birth of the first child, is often a decisive point in which gender asymmetries are defined or reinforced. In most couples, both elements continue to work full time and assume, at least from a discursive point of view, an equal share of responsibility for the economic support of the family. However, their dedication and availability to the family and to work is far from symmetrically distributed. Women in full-time employment with dependent children (especially children in the early years of life) suffer most from time constraints (Perista et al., 2016).

There have been several changes in the division of domestic tasks and in the care that men are most involved in, including the physical care of children. But conservative attitudes persist, with men themselves being the least in agreement with the idea that the father is as capable as the mother of caring for a baby under one year old (Wall et al., 2016). There are still clear asymmetries between the ideals of motherhood-femininity and fatherhood-masculinity. In various configurations, the distinction between the representations associated with 'being a woman' and 'being a man' continues to support practices that contribute to the reproduction of inequalities on a family scale (Perista et al., 2016).

According to the Report on Progress in Equality between Women and Men at Work, in Employment and in Vocational Training (CELE, 2018), tensions are already apparent in the take-up of initial parental leave, as it is typically the mother who ensures the child's well-being in the first months of life, while the father, if present, fulfils the role of economic provider along with a "helping" function in terms of physical or emotional care.

The legislative changes resulting from the 2009 Labor Code have encouraged the use of parental leave by men. The amendments made by Law no. 28/2015 of 14 April and Law no. 120/2015 of 1 September (enshrining gender identity within the scope of the right to equality in access to employment and work and strengthening the rights of parenthood, respectively) reinforced the number of days of compulsory and exclusive parental leave for the father, provided that they are taken at the same time as the mother's initial parental leave. The same legislation also introduced the possibility of the initial parental leave being taken by both fathers and mothers in cases where it is shared. This legislation sought to promote the reconciliation of work and family and the sharing of parental and domestic responsibilities, seeking to deconstruct gender stereotypes. According to the data available in the Commission for Equality in Labour and Employment annual reports, there have been changes, albeit with fluctuations, with an increase in the number of men who have received pay for compulsory parental leave for exclusive use of the father, compared to the percentage of compulsory leave for women: in 2009 (62.6%) and in 2018 (77.2%). In relation to the number of men who received pay for optional parental leave for exclusive use of the father, in 2009 it was 52.2%, increasing 18.4 p.p. compared to 2018 (70.6%) (CELE, 2018).

The recommendations of the White Paper - Men and Gender Equality in Portugal (Wall et al., 2016) state that it is necessary to continue to promote caring masculinities, more involved in fatherhood, as a way of preventing domestic violence. This implies valuing the role of carer among men and raising their awareness of the importance of caring for the well-being of the child.

With regard to the prevention of violence against children and adolescents and in intimate relations, the Directorate General of Health states that health services should: encourage the couple to accompany pregnancy and postpartum in order to strengthen the bond with the baby and to participate in its care in a shared way; promote the social recognition of more flexible models of masculinity and

paternity, an important factor in building healthier and more egalitarian affective and family relationships; and promote the organization of groups of women or men in order to work on gender, power and violence issues (Prazeres et al., 2016). One of the solutions is to involve men in workshops and courses that teach them how to value the care of their partner and their children. This must come from a perspective that understands fatherhood as a positive reference, with direct repercussions on the physical, emotional and social development of children and on the well-being of women and men.

One of the gateways to working with men and pregnant women is prenatal health consultations. Various research and initiatives to work with health professionals and populations served in public services have shown that it is difficult to recognize men as potential caregivers of their own health and the health of their families, their children, and those with whom they have affective relationships. The need to make men's presence visible in the health services is one of the strategies for carrying out work aimed at the social transformation of reality.

The involvement of parents and male caregivers during the prenatal and postnatal periods is vital for the health and well-being of both mother and child. The active involvement of men as allies helps to ensure higher quality care for their partners and helps to create a more gender-equal space in health services. In many parts of the world, healthcare providers tend to exclude men because their participation is not valued. Healthcare professionals wrongly consider a broader involvement of fathers as interference, and many of these providers are not trained to work with men. Men are also often denied participation in childbirth and postnatal activities because of the lack of laws and supportive policies that, for example, allow men to accompany their partners during labor.

At the community level, one strategy for preventing violence is to engage men in gender transformative education that demonstrates the benefits of an active partnership of care and involvement. From this, a clear understanding and awareness should emerge of the ways in which gender inequality perpetuates violence by the intimate partner and how non-violent and positive education can promote children's physical, emotional and social development through strong attachment to their mothers and fathers. In the health sector, getting involved and working with expecting men and women during antenatal clinic visits serves as a valuable entry point to promote involved and caring fatherhood and prevent violence.

The PARENT project - Promotion, Awareness Raising and Engagement of men in Nurture Transformations - brings a gender-synchronized approach to addressing the challenges of preventing and eradicating violence against women and children. The relevance of this project lies in the importance of involving men who are fathers so that they, together with their partners and other family members, can learn to teach and raise children without using violence and prevent violence against intimate partners.

PARENT then emerged with the aim of closing the gaps in the European Union involving men in care, as well as raising awareness of gender-based violence and the importance of involving men in strategies to combat violence against women and children. It also aims to increase gender equality in caring and to promote greater involvement in fatherhood.

PARENT's activities include the training of health and education professionals using the P-DPI (Parenting and Development during Early Childhood) Program, the organization of educational groups with the aim of raising the awareness of parents and their partners, a national campaign to promote gender equality in the provision of care and involved, caring paternity.

PARENT is being developed in 4 European Union countries (Portugal, Austria, Italy and Lithuania), in partnership with the Centre for Social Studies (CES - Centro de Estudos Sociais da Universidade de Coimbra, PORTUGAL), the Coimbra nursing school (ESEnfC - Escola Superior de Enfermagem de Coimbra, PORTUGAL), VMG -Verein für Männer- und Geschlechterthemen Steiermark (AUSTRIA), LGPC-CEA - Center for Equality Advancement/Lygiu galimybiu pletros centras (LITHUANIA), and CdU - Cerchio degli Uomini (ITALY). The project will benefit health and education professionals, parents and their partners, including refugees and migrants, national and European health policy makers, and gender equality advocates, as well as academia and gender equality-oriented NGOs across Europe. It is funded by the European Union's Rights, Equality and Citizenship Program under grant agreement No. 810458. In Portugal it has a partnership with the Directorate General for Health and is referred to as a good practice in the 2018-2019 report on Program 3 on-line (Program for the reconciliation of professional, personal and family life) under Measure 20 (IMPEC - Iniciativa Mobilizadora da Paternidade Envolvida e Cuidadora) of this program.

The training of health professionals and students was planned to be developed face-to-face, but due to current events in relation to the COVID-19 pandemic, some modifications had to be made, namely carrying out this training via digital platforms.

Objectives

The main objectives of this course are

- Promote the awareness of students and health professionals about the importance of developing strategies for involving men/fathers in their daily work practices.
- Promote the debate on gender equality and the involvement of men in care and fatherhood among students and health professionals.
- Raise awareness of gender-based violence and the importance of involving men in strategies to combat violence against women and children among students and health professionals.

End results

This course is intended:

- To increase awareness among health professionals of the importance of engaging men in involved and caring fatherhood and gender equality to promote the eradication of violence against women and children.
- To foster greater involvement of men as fathers in childcare and more gender-equitable attitudes and behaviors.
- To close gaps in Portugal in order to involve men in care.

Course recipients

- Health professionals
- Undergraduate students in the fields of health

Number of places

- Total: 100 places
- 4 courses (up to 25 students) or 5 courses (up to 20 students).

Conditions for admission

- Hold a degree in health and work professionally in Portugal.
- Be an undergraduate student in the area of health residing in Portugal.

The application must be made online, by filling in the appropriate form and biographical questionnaire in electronic format.

Documentation proving your degree or university attendance in the area of health must be attached to the form.

Dates and times of courses

Start - September 2020
End - June 2021
Schedule - Post-Labor

Dissemination of the course

The course will be disseminated on the pages of DGS, ESC, ESEnfC, DGS and the PARENT project. Social networks and the media will also be used.

Teachers/trainers

Team from the Centre of Social Studies (CES) and the Nursing School of Coimbra (ESEnfC) that compose the PARENT / Portugal project:

- Dr. *Tatiana Gonçalves Moura* - Permanent Researcher CES - UC
- Master *João Victor Pinto Dutra* - CES consultant - UC

- Graduate *Linda Miriam Moita Cerdeira* - PhD student and researcher CES - UC
- Master *Milena do Carmo Cunha dos Santos* - PhD student and junior researcher CES - UC
- Graduate *Tiago António Rolino Machado Carvalho Vieira* - junior researcher CES - UC
- Dr. *Armando Manuel Marques Silva* - Assistant Professor ESEnfC
- Master *Cristina Maria Figueira Veríssimo* - Assistant Professor ESEnfC
- Dr. *Isabel Maria Pinheiro Borges Moreira* - ESEnfC Coordinating Professor
- Dr. *Maria da Conceição Gonçalves Alegre de Sá* - Assistant Professor ESEnfC
- Dr. *Maria Isabel Domingues Fernandes* - ESEnfC Coordinating Professor
- Dr. *Maria Neto da Cruz Leitão* - ESEnfC Coordinator Professor

Contents / programmatic development

The course will cover the following content:

1. Involved and caring fatherhood
- 1.1 Evolution of the concept of paternity
- 1.2 Health benefits for children, men and women

2. Gender socialization
- 2.1 Hegemonic male identity and its construction process
- 2.2 Male caring

3. Different families
- 3.1 Diversity
- 3.2 Reconciliation of personal, family and professional life

4. Recognizing and preventing violence
- 4.1 Men, gender and violence
- 4.2 Everyday violence

5. The role of health services in promoting the fatherhood involved and caring
- 5.1 Innovation practices / promotion of change
- 5.2 Helping to conceive change
- 5.3 The place of men/parents in health units
- 5.4 Participating in change

The course includes 20 hours of synchronous sessions (10 sessions / 2h each) held on a digital platform (with emphasis on Zoom) and 10 hours for analysis / reflection and preparation of documents that will be sent to trainees.

Synchronous sessions will address issues related to fatherhood and care, gender equity, male self-care and community mobilization.

The sessions are structured as follows:

Session 1 - Introduction to the course and pre-test data collection

- Presentation trainees, trainers and course
- Pre-test Questionnaires
- Involved and caring fatherhood: national and international data
- Presentation and negotiation of homework - *My father's legacy*

Session 2 - Involved and Caring Fatherhood and Health Gains

- Workshop - *Lottery of Life*
- Presentation and negotiation of homework - *Where are the men in the health unit?*

Session 3 - Care for Men

- Homework presentation - *Where are the men in the health unit?*
- Workshop - *Father's testimony, mother's testimony: men take care too!*
- Presentation and negotiation of homework - *Observe how the division of care is applied within the home.*

Session 4 - Gender Socialization

- Gender Socialization - *Toys for Girls and Boys*
- Workshop - *Men Taking Care of a Boy, Men Taking Care of a Girl*.

Session 5 - Different families

- Workshop - *Various Families*
- Videos + Debate
- Presentation and negotiation of homework - *Field diary: working as a team*

Session 6 - Violence in everyday life

- Presentation of homework - *Field diary: working as a team*
- Workshop - The *violence around me*

Session 7 - Innovation practices / promotion of change

- The IMPEC project (Mobilizing Involved and Caring Paternity Initiative)
- Good practice, MenCare P & Campaign Program
- Community mobilization
- Presentation and negotiation of homework - *What are the potential partnerships for community mobilization?*

Session 8 - Helping to design change

- Presentation of the homework task - *Who are the potential partnerships for community mobilization?*
- Joint creation of a *Community Campaign*

Session 9 - The place of men/fathers in health and education units

- Presentation of the consolidated campaign
- Design - Health & presentation unit
- Presentation and negotiation of homework - *Action Plans*

Session 10 - Participating in change

- Homework Presentation - *Action Plans*
- Possibilities of making the IMPEC model viable
- Post-Test Questionnaires
- Course evaluation

Training methodologies

The active / participatory methodology will be structural throughout the course, with workshops being one of the most used techniques in synchronous sessions. In these sessions, documents created by Instituto Promundo and the Centre for Social Studies of the University of Coimbra, namely Program P - Manual for the exercise of paternity and care, [5]will be taken as fundamental resources. From this document we highlight the following workshops:

- **My Father's Legacy** - Trainees will be asked to write a "Letter to my Father". The focus is on reflecting on the influence of their own father as a model of man and father. They will discuss how to benefit from the positive points of their fathering and learn from the negative ones so as not to repeat them. The writing is individual and confidential (Page 105).
- **Lottery of Life** - *Lottery* letters are delivered with questions related to health problems, in which the answers promote reflection on men's attitudes towards their own health, focusing on prevention and self-care (Page 157).
- **Man caring for boy, man caring for girl** - A group dialogue is established on the implications of the socialization and education of a child by the father/carer. The dialogue is centered on the father-son and father-daughter relationship and deconstructs myths about the man caring for children (Page 223).
- **Field diary: working as a team** - Reflect on the time men dedicate to care tasks and compare it with the time dedicated by women, in order to

5 Available at: https://promundo.org.br/wp-content/uploads/sites/2/2014/08/promundo_manualp_07i_web.pdf

encourage a more equitable distribution of domestic work. Adaptation of the workshop "Care of my son/daughter: working in a team" (Page 145).

- **Developing community campaigns** - The aim is to produce a campaign within health units that has the power to awaken awareness of the importance of a man's involvement in fatherhood and care, through his active participation, reinforcing the fundamental character of the exercise of care with his partner, sons and daughters and himself (Page 178).

Another document used as a resource is the Equi-X Manual - Promotion of Gender Equality and Non-Violent Men,[6] of which the following workshops are highlighted and will be useful for this training:

- **Father's testimony, mother's testimony: men take care too!** - Talking about the models of fatherhood and motherhood that exist in our culture, problematizing the rigidity of roles and places available. Dialogue also on parenthood - via adoption - and the benefits of involvement for children, families and society. (Page 247)
- **Diverse Families** - Adaptation of the workshop "Sexual Diversity: what is it? "- This tries to reflect the concept of family, focusing on the diversity of models beyond the nuclear family, highlighting the role of caring figures in life. Space for dialogue about different cultures and perceived variations in this aspect, as in the case of immigrants, people in refugee situations and LGBT people. (Page 212)
- **The violence around me** - To dialogue critically about the violence that is present in everyday life, including that which happens in the street, at home, at school, in the workplace, and in the media. (Page 176)

Assessment methodologies

The training of professionals and students is linked to an impact assessment in which possible changes in attitudes and knowledge related to the course topics can be measured. For this purpose, surveys will be implemented in two stages: at the beginning and at the end of the course.

6 Available at: http://equixproject.eu/wp-content/uploads/2020/01/Portugal_guide.pdf

In addition to issues related to content, the effectiveness of virtual tools for the success of the process will also be assessed, using qualitative methodologies in order to understand in which contexts the themes and strategies used can be profitable in trainees' professional future. Taking into consideration the current state of health, digital harvesting methods will be chosen, which do not require physical contact between the trainees and the team of teachers/trainers, preserving the ethical and professional procedures of impact assessment.

In addition, reports of each session and regular meetings with the whole team will be held to monitor activities.

Certification

Certification will be awarded to trainees who participate in at least 75% of synchronous activities and carry out at least 75% of the proposed activities.

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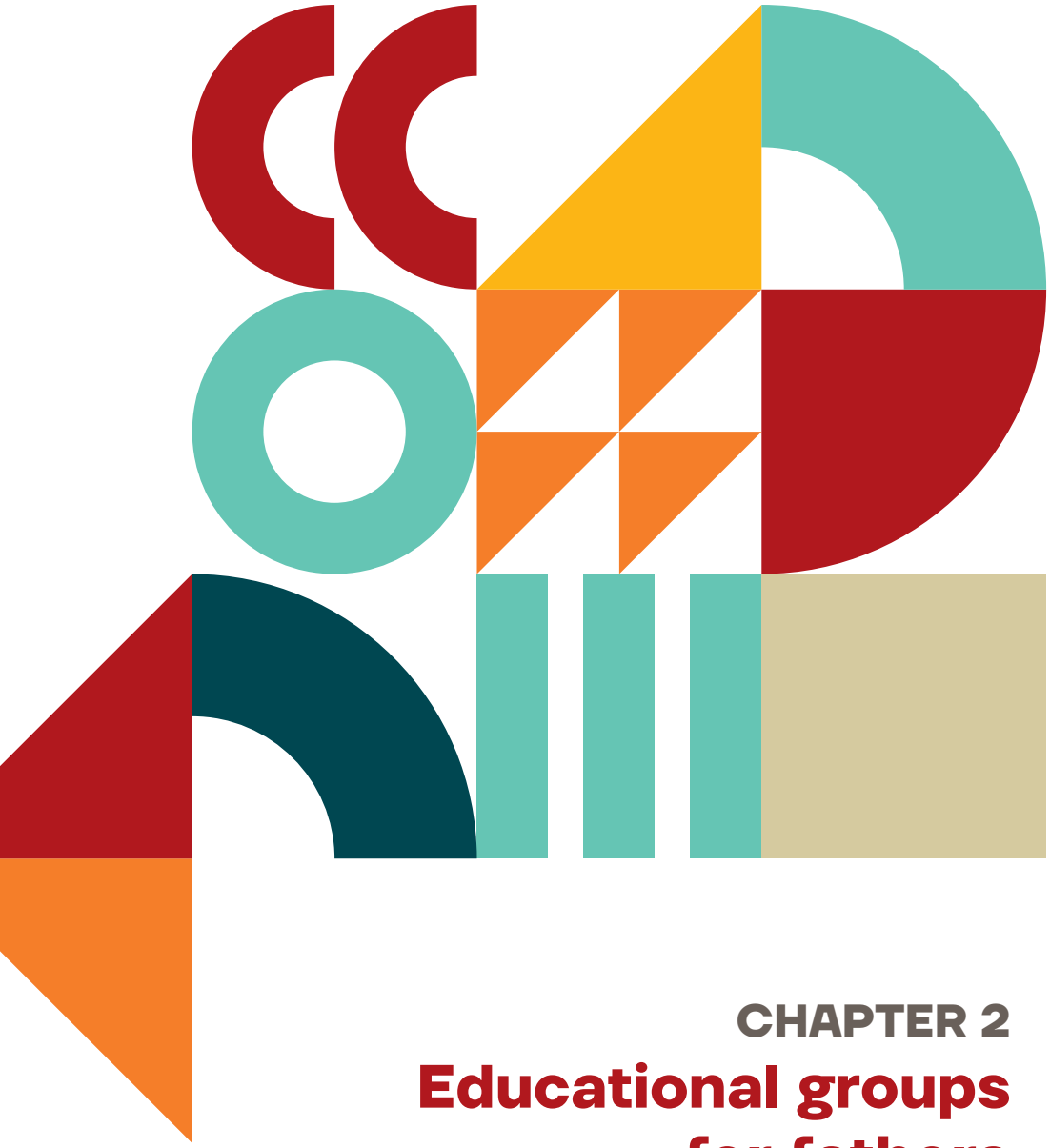

CHAPTER 2

Educational groups for fathers

Anna Kirchengast, Veronika Suppan
& Elli Scambor with contributions
from all PARENT partners

Introduction

For some years now, masculinity research has been discussing the "**Caring Masculinities concept**". This form of masculinity includes values like attention, interdependence, co-responsibility, support and empathy. The approach is related to practical caring activities –within the family and housework, for example, but also paid jobs in education and care (Gärtner & Scambor, 2020). Caring concepts of masculinity contribute to gender equality and reject violence and male dominance.

One area where Caring Masculinities can be realized is **engaged fatherhood**. **Engaged Fatherhood** means the participation of fathers in care work, childcare and housework - not only around the birth. It opens up opportunities to break out of old role models that only knew the role of provider or breadwinner.

Multiple benefits of involved fatherhood can be identified, including better relationship quality with partners and children and lower risks of conflict and domestic violence (see e.g. Swick, 2013; Borther et al., 2017; Holter & Krzaklewsla, 2017 in Gärtner & Scambor, 2020: 22). Active fatherhood contributes to children's health (see Moore et al., 2017: 67). The systematic review of Sarkadi et al. (2008) found that "father engagement positively impacted social, behavioral, psychological and cognitive outcomes in children".

Fields of action for engaged fatherhood. *MenCare* is a global fatherhood campaign active in more than 50 countries. Its members are "promoting men's active, equitable and nonviolent involvement as fathers and caregivers". One aspect of this is working with men and couples in parenting groups based on *Program P* to learn and practise parenting skills. It also aims to achieve change at an institutional level by training healthcare providers. *MenCare* encourages

fathers to become role models: *"As an involved and caring father, you become a positive role model for your children and an agent of change in your community"*. They want to motivate fathers with ten things they can do within defined fields of action:

1. **Be involved from the start.** You can play a critical role in ensuring a safe, comfortable birth for your children and for their mother.
2. **Share the care work.** When you share the care work, everyone wins. And you'll discover that being a dad gets even easier (and more fun).
3. **Be proud and show it.** You can be a man who earns the respect of your community and family. It's easy – just be a proud father.
4. **Provide healthcare.** Take care of your children's health. You can help make sure your children grow up healthy and safe from easily preventable illnesses.
5. **Just play.** You know that play is serious business. Take the time to laugh and play, every day.
6. **Educate.** You can give your child a great gift, so send them to school and teach them at home.
7. **Be brave.** Show Affection. You have a chance to be a father who cares deeply for those he loves. That's a rare thing in today's world.
8. **Raise without violence.** You know that a gentle arm over the shoulder is more powerful than any act of violence.
9. **Teach equality and respect.** You can give your child a bigger, fairer future when you teach them about respect and equality.
10. **Support the mother of your children.** You always have the choice to respect the mother of your children. Make the right one, every day. (http://men-care.org/get-involved/father)

Fathers' needs and educational training goals

The State of the World's Fathers 2019 Report (Van der Gaag et al., 2019) identified three major barriers for fathers to be involved in the early weeks and months of

caring for their child: the lack of adequate, paid paternity leave; restrictive gender norms; and the lack of economic security and governmental support for parents and caregivers. The dominant model of the father as sole breadwinner was regarded as a structural challenge for realizing active fatherhood in Austria as well (see the PARENT needs assessment based on focus groups and interviews with professionals – Scambor et al., 2019: 41). Other structural challenges for realizing active fatherhood were named: "scattered landscape of services and information, a lack of male professionals in caring professions & lack of resources in the social sector", along with the fact that fathers-to-be are not officially registered as such and therefore hard to target personally (Scambor et al., 2019: 41)

The PARENT needs assessment conducted in Austria found that there are already some existing measures that support engaged fatherhood, such as "*activities providing space for father-child-interactions, activities promoting exchange between fathers, skills and information offers available to fathers (e.g. courses, workshops, presentations), consultation-based services available to fathers (e.g. consultation hours)*" (Scambor et al., 2019: 41). Analysis of existing measures showed that fathers did not equally participate in the measures offered, either due to time constraints or due to the traditional distribution of responsibilities in the family. Nor were fathers systematically approached or addressed, and they often felt uncomfortable if they were the only men attending events. There were special barriers for families who lacked German language skills. Scambor et al. (2019: 41) found targeting fathers with incentives and course passes, sensitive scheduling and personal reminders, and offers which required no pre-planning by fathers, proved to be successful measures. Men-only groups, role models – and especially "trusting, personal relationships between organizers and fathers" were determined to be important characteristics for motivating fathers to take part in educational trainings.

In Austria there is no compulsory paternity leave immediately after birth. The so called "Papamonat" (father's month) applies to all fathers under certain conditions, as well as to the second parent in the case of same-sex couples. During a father's month, they are legally entitled to leave of absence from work for a period of one month. The employer does not have to pay any remuneration during this time. However, fathers can receive the family time bonus of €22.60 per day during that month, i.e. approximately €700 for one month. However, this amount will be deducted again if the father receives childcare benefits at a later date. A father is entitled to one additional week of paid time off per year if the

mother or child requires care after birth. Other countries such as Portugal have mandatory paternity leave of 5 days following the birth.

Results of the PARENT educational training groups with fathers

Educational training with fathers aimed to overcome gender norms and share information about extant opportunities for paternity leave and other public offerings/ support for fathers, fathers-to-be and their families. Parent-specific training could be regarded as one key area to achieve greater equality in care work and fathers' increased involvement:

> *"Father-specific parent training must be implemented and mandated nationally to build men's skills, confidence, and competence and to promote shared decision-making and good communication. Evidence-based, father-inclusive parent training exists and has shown to achieve reductions in violence against children, reduced violence by men against women, and increased participation by men in caregiving." (Van der Gaag et al., 2019: 99)*

Other authors have emphasized the importance of combining education with empowerment, as knowledge alone would not be enough: "We also require motivation and reinforcement" (Moore et al., 2017: 66).

- Educational training sessions with fathers thus deal with the following topics:
- transformation of social and gender norms
- learning about parenting (pedagogy, development psychology, health topics ...)
- sharing information about their options for paternity leave, for example public services for families (e.g. health checks for babies, parent counselling services, educational services such as walk-in Parent-Child Centers)
- Networking with other fathers
- and last but not least supporting individual fathers' actions.

Here we summarize the PARENT educational training with fathers in different countries:

Italy: "Dad Circle"

Italy organized workshops under the project name "Dad Circle" in Montecchio (Reggio-Emilia). The circle was run between February and June 2020 with **eight evening meetings (18:15-20:00), and, as a final meeting, a** barbecue **lunch** in a park. This cycle of meetings with fathers and fathers-to-be involved a total of **twenty fathers,** including the two facilitators. Most of the meetings were attended only by the fathers, but at the last meeting the wives or partners were also observed taking the floor. Many of them had learned about the offering for fathers at the birth preparation meetings in the family clinic and had personally encouraged their male partners to participate.

The meetings were organized according to a predefined sequence of topics that ideally covered the time during which 'a father is born', pregnancy, childbirth, care in the primary phase, right up to early childhood and with a view to the future. Since the project was dedicated to promoting paternal care also with a view to preventing domestic violence, the topics dealt with the importance of the exploration and "invention" of a father's caring role, as autonomous and ideally creatively different from the female one; of recognizing and preventing even the most subtle and invisible forms of violence in the relational dimension; of overcoming stereotypes in education; and of recognizing the subjectivity of children beyond cultural or parental projections/expectations.

The following titles of the "Dad Circle" meetings show the topics that the fathers worked on:

- From father to grandfather, from son to father, yesterday and today
- Pregnancy: stories, expectations, joys and fears
- 3... 2... 1...Delivery! A special moment, to remember or to prepare for
- Sharing family care, the beauty of doing it with your own resources

- Invisible violence: recognizing maltreatment for a conscious pregnancy
- Girls and boys: educating for recognition beyond stereotypes
- Rights and needs of children in early childhood
- The phases of fatherhood: changing as a father as children grow
- Final meeting: barbecue lunch in a public park.

Methodically, each session had a basic common structure: introduction (participants introduce themselves); a short introductory moment with a short reading, video or story; topic-specific questions to stimulate discussion; sharing and discussion in groups and all together; comments and final reflections; final stage: each person chooses and shares a word to convey an image of the meeting; shared reading of the "auspicious message". The first meeting required an initial presentation of the basic outline of the project as well as the compilation of the "father questionnaires" prepared by the project team. Since several of the children of the fathers involved were born during the course, each subsequent meeting devoted the first five to ten minutes to their birth stories.

Facilitators: The goal was to create a friendly, inclusive and non-judgmental environment that fostered involvement and personal narration, the sharing of emotional, psychological, relational and affective but also practical and organizational experiences. The management of the group was therefore as light as possible. The facilitators for the meetings were an expert of the Parma "Dad Circle" and the national network "Maschile Plurale", and a sociologist from the University of Parma. A pediatrician and neonatologist also participated in some meetings as an expert and as a contact person for the Italian Region and the local health authority.

The facilitators had in mind a basic common structure for all the meetings. With the change from "face to face" meetings to "virtual" meetings came some adjustments, in particular the smaller group structure. The first two meetings and the last social event were held in person, while meetings three to eight, given the health crisis caused by Covid-19, were held online.

Lithuania: sessions with parents recruited from kindergartens and leaflets

In Lithuania, the training sessions were not only for fathers, but mothers were also invited to join. **19 fathers and mothers attended the first session** (two meetings of four hours each, for a total of 8 hours) and **24 fathers and mothers attended the second training session** (one four-hour meeting). Because all participants were recruited through cooperating kindergartens, all participants already had children of kindergarten age. Additionally, the participants had to come voluntarily after work to the training sessions, which imposed a threshold for the participants in Lithuania, even though the kindergartens did everything in their capacity to attract fathers (and mothers) to the training.

Lithuania planned four meetings with fathers, whom they recruited with the help of kindergartens, as this was the only way to reach fathers at all. Each of the training sessions was dedicated to a specific topic. (1) The purpose of the first session was to introduce the concept and definitions of positive fatherhood to the participants. For this purpose, the following discussion questions were prepared: What does positive fatherhood mean? How do the participants relate to this topic? What challenges do they have in their relationships with their partners, wider family and society as a whole? What does it mean to be a father in the 21st century in Lithuania? To work on these questions, they used interactive games and discussions. Participants were then asked to write down their gender stereotypical experiences and impressions in a "gender diary" at home. (2) In the second meeting they worked with and on gender stereotypes. Participants reflected on their own childhoods and, through interactive exercises and discussions, they learned what and how stereotypes are internalized during the socialization process. After the second session, participants were asked to reflect on their own language and behavior towards gender in their gender diaries. (3) The third session was planned for working on the topic of coercive control and its impact on couples' relations and relations with a child. the topic of emotions and recognizing them was also planned for this session. Afterwards, the task was to write down one's own emotions and self-reactions in the gender diary. (4) The last meeting was planned as a training session on the topic of non-violent communication with children.

Because of the **pandemic and the accompanying restrictions, only the first and second meetings were held** (before March 2020). Because of this change,

the method of reaching fathers in Lithuania was **changed to preparing leaflets for fathers** that contained information about active fatherhood. They were shared with the cooperating kindergartens to be distributed to fathers. The kindergartens themselves also benefited from these brochures.

Portugal

Portugal planned four sessions/workshops in which they worked on fatherhood and care, gender equality, male self-care and masculinity and sexuality with fathers. One of the goals was to mobilize fathers, without neglecting other forms of mobilization, such as outreach to educational groups, the involvement of partner teams and partnerships with health professionals.

In the four sessions they worked on the following topics:

1. **Involved and Caring Fatherhood and Gender Socialization** - In this session they talked about existing models of paternity and maternity in their culture and which problems are connected to the rigidity of roles and places available. The topics of parenthood through adoption and the benefits of involvement for children, families and society were also discussed in this session.
2. **Fatherhood and Care** - The goal of this session was to touch on participants' needs, expectations and motivations. The fathers were encouraged to share their interest and together as a group the most pressing questions were answered. The remaining themes and questions were used to plan the subsequent two sessions and adapt them to outstanding topics and topics requested by the fathers.
3. **Pregnancy, pre and postpartum, marriage and sexuality -** This session was used to talk about what fathers can do during pregnancy to contribute to the health of their baby and the mother. Collectively they tried to find solutions to each other's concerns and questions.
4. **Past, present and future fatherhoods** - In this workshop, participants would have been asked to write a "Letter to your Father" or to their caring figure. They would have focused on reflecting on the influence they

received from their own father. Subsequently they would have discussed how to take the positive points from their own fathers and learn from the negative ones, so as not to repeat them.

In Portugal, 25 fathers participated in 3 parent groups. The educational groups were initially planned to take place in person (**face-to-face**). The first session was even held face-to-face (**10 participants, 4.5 hours**), whereas the other two sessions were **online (15 participants, 8 hours)**, due to current events in relation to the COVID-19 pandemic. Because of this, some modifications were necessary, namely the adaptation of the online courses of educational groups of fathers. The **trainers** were team members from the Center for Social Studies (CES) and the nursing school of Coimbra (ESEnfC), meaning researchers, university professors, and doctoral and masters' students.

All kinds of fathers were **targeted** for the sessions in Portugal. As a result, fathers at different stages of fatherhood (both pre- and post-natal) and also fathers with international family histories participated. However, no single parent participated. All the participants of the educational groups were recruited directly or indirectly through birth preparation groups held in health centers.

Austria: workshop series "Father laboratories"

Austria organized **25 workshops with 75 participants** on the topic of active fatherhood. For this purpose, the workshop series "Vater-Werkstatt" ("Father laboratories") was founded, which aimed to support and encourage fathers with children between the ages of zero and six, but also expectant fathers, in their role as active fathers. The Austrian educational groups took place between November 2019 and May 2021 and benefited a total of 72 people. The workshops took place in collaboration with seven cooperation partners from Styria. These included parent-child centers, the birth preparation department of the state hospital Graz, the city of Graz and the public parent counselling center of one district. The following overview of the workshop titles shows which different topics were dealt with:

- Planned and unplanned fatherhood
- Different families - My father and I

- Me as a man - raising girls and boys
- How can I take good care of my child? - Sharing the work in the family
- Life without violence - How can I solve conflicts?
- Life without violence - Preventing violence before it happens
- My father role: How can I succeed as a father?
- My father role: What kind of father do I want to be?
- How can I reconcile my job, child, partnership?
- What does it mean to be a father?
- How can I set limits for my child?
- Active fatherhood during pregnancy and afterwards
- Active fatherhood from the beginning
- Breastfeeding counselling for fathers

The structure of the father workshops in Austria was quite similar each time and each "Vater-Werkstatt" lasted between **1.5 and two hours**. At the beginning there was always a round of introductions. The workshop facilitators/trainers introduced themselves and the fathers introduced themselves to each other. Afterwards, the facilitators gave some input regarding the Parent Project. This was followed by a deepening of the respective topic of the workshop. For this purpose, discussion questions, small presentations, exercises or other introductory aids were prepared for each topic and presented by the facilitators, who held the workshops either in pairs or alone.

Facilitators of the workshops: All three facilitators had a solid foundation in the concept of "gender" as well as the different social and health issues to be addressed during the sessions. They had extensive experience in facilitating workshops with men on gender, caring masculinities and parenting. The Austrian workshop leaders had the following qualifications: one expert was a certified systemic life and social counselor, marriage and family counselor and certified sex educator. Another facilitator studied social work and is active in both violence prevention and addiction counselling. The third trainer holds a bachelor's degree in social work, is a counselor for men and conducts workshops with boys.

By March 2020, **ten workshops had been held face-to-face. At six of these workshops a dari-farsi (persian) interpreter** was present. The remaining 15 workshops had to be conducted online due to the pandemic. In both formats, the focus was always on the exchange between fathers. The leaders were responsible for creating a good atmosphere, stimulating the exchange and, in the case of questions, offering answers and assistance to strive for a joint solution process.

Fathers were **recruited** via announcements by our cooperation partners for these training sessions and for the project in general. After experience with training programs for fathers (12 modules) and a low participation rate of fathers, VMG decided also to include 'light' versions in order to reach a higher number of fathers. Father groups have therefore often been organized alongside childbirth preparation courses and as father-children breakfasts. Fathers could also participate in other single training modules (about two hours) offered by VMG with cooperation partners.

Further description of participants: Exclusively men participated in the evaluation/workshops. Most participants (58 percent) were between 30 and 39 years old, and 16 percent were between 26 and 29 years old. The oldest participants (9 percent) were between 40 and 49 years old, and the youngest participants (4 percent) were 25 years old or younger. The target population was expectant fathers and fathers of children between zero and six years old at the time of the workshop. This explains why the majority of participants tended to be younger. The majority of participants (76 percent) came from Austria. However, there were also occasional participants from Afghanistan, Germany, Iran, Italy and Colombia. 95 percent of the participants were in a relationship and lived with their partner in one household. Only five percent of the participants were separated, divorced or did not live with their partner. 97 percent of the participants stated that they were or were going to be a biological father. Only one participant stated that he was or was going to be a patchwork father. About a quarter of them (25 percent) were becoming fathers for the first time, and the other 75 percent already had one or more children. This result shows that the (expectant) fathers who participated in the father workshops saw their father role as very active, involved and independent. At the same time, statements about traditional role models (man as breadwinner; no time for family because of work) received less approval. The workshop participants were already open-minded men and fathers. They did not reflect the majority of the Austrian population

in their attitudes and habits towards the role of fatherhood. While the majority of the Austrian population had a very traditional family structure, the workshop participants showed a tendency towards the equal-share system.

Evaluation results

Italy

The facilitators' assessment was very positive. The group of fathers involved showed right from the first meeting a desire and ability to get involved, sharing emotions, fears, doubts and aspirations as if they had known each other for a long time. The level of discussion, despite being limited by the time and conditions of distancing, was very high. The group talked about delicate and important things while maintaining a "light" and (self) ironic tone, which, in the opinion of the two hosts, was the preferred form of communication and sharing.

In general, fathers expressed appreciation for this course that allowed them to discuss and express the hardest things to share regarding their emotions. Some have suggested that fathers could bring their children to future meetings, as mothers do when they meet in the park or elsewhere. In general, all the participants expressed their desire to continue meeting every two weeks (2 meetings per month).

The expectation is that the group of fathers will meet up again even without the stimulus and external management of the project.

Lithuania

Due to the rather sudden restrictions because of the pandemic and the inability to find participants for online sessions, an evaluation of the training sessions is still pending.

Portugal

For impact assessment, monitoring and evaluation of the sessions, two online questionnaires (one pre- and one post-test) were given to each participant.

The main difficulties and challenges arose from the COVID-19 pandemic, which conditioned all of the following: the recruitment of fathers and their mobilization due to lack of time (work/life balance). These were overcome with mutual help by the Portuguese partners, the project disseminated with the academic and professional capacity of the teams of Portuguese partners and their consultants.

The fathers reported back that the topic of sexuality before, during and after birth is one that raises a lot of interest among fathers, as well as concerns about their children's futures and ways of caring for their baby/child. In the session where a guest couple talked about their experience as parents, the trainees showed a lot of interest and asked many questions afterwards. One important realization for educational groups was that a good atmosphere and trust between the participants must be created first, so that the participants will then open up about their thoughts and feelings, participate in the discussions and be open-minded. In the first session, participants should get to know each other, because these fathers' groups are based on more personal sharing and exchange at a later point.

In Portugal, the aim is for the Portuguese Program P to be reproduced and disseminated widely, not only by health professionals, who apply it in their fathers', mothers' and birth preparation groups, but also by other groups that have the same interests and goals.

Austria

More than 80 percent of the participants said that their expectations were (well) fulfilled. Only two people indicated that their expectations were met on average or not at all. Expectations of first-time fathers were more often very much met than those of participants who were already fathers. The positive exchange among fathers and the possibility to ask questions at any time were

highlighted. Among others, one participant who attended the workshop in the role of caregiver to a child (not as a father) also noted that the workshop was interesting for different men/male caregivers. When asked to what extent the (online) module was helpful for the participants, 66 percent responded with the answer “helpful” to “very helpful” (27 percent didn’t answer; 4 percent thought it was moderately helpful).

Probably the most mentioned positive feedback was the enthusiasm for and benefit from the exchange with other fathers. The exchange of experiences and tips, but also simply seeing and hearing how other fathers see and handle things, was particularly well received by the participants in Austria.

In Austria, the father workshops are planned to continue - whether online or face to face – for example as part of childbirth preparation courses or as events of the called Männerkaffee (men’s cafés), which are an open format for men to discuss various topics in which they are interested.

Facilitators’ feedback and conclusions

The Austrian trainers also noted - especially from their background as men’s counselors - that the father workshops were more likely to reach fathers who were already more motivated and fathers who were already active. Many of these participating fathers were very motivated, but felt very insecure in their role as father or they felt overwhelmed: how much love am I allowed to give my child without suffocating it? How and how intensely can I build a bond with my child? How do I deal with the new situation in my partnership? How can I continue to maintain the relationship with my partner - despite work, lack of sleep, and a partner who is overburdened by household chores and childcare? These were, for example, topics that concerned many of the participating fathers. The topics that most interested participating fathers were:

- How can I set limits for my child?
- How can I handle anger and resentment?
- Tips on breastfeeding preparation for expectant fathers.

The fathers' reports during the educational meetings in Austria showed that there were always cases in which fathers were not perceived, taken seriously and addressed as parents by the help system in the same way as mothers. Fathers were more often perceived by the help system (health professionals such as midwives or doctors, or social workers and youth welfare officers) only in their possibly dysfunctional role for the child's well-being.

From the trainers' point of view, the most important message that should be conveyed to fathers by the help system, by experts from the health and social sectors, is**: Fathers are just as important for children's well-being and fathers are just as competent and responsible for this as mothers.**

The participating fathers often lived in isolated nuclear families and were soon overwhelmed with the new situation. Many fathers were not even aware of support services such as family counseling and relief centers or did not even think of making use of them. Many fathers were not aware that they were as competent as mothers.

In view of these compatibility problems of many participating fathers, the goal of the father workshops is to support fathers in this situation, but not to overburden them in the process. The experience of the trainers through their ongoing practice in men's counselling gave them very helpful expertise in this regard.

The main goals that the trainers implemented in the father workshops were:

- Empowerment of fathers, giving them information and reinforcement in their role as fathers.
- Networking with other fathers - exchanging ideas with each other.
- Providing realistic ideas about birth and fatherhood.

In order to convey realistic and non-idealized ideas, the father workshops dealt with the question of what tasks and roles fathers can take on during birth and what they are not responsible for. Expectant fathers were encouraged to discuss their wishes and expectations with their partners and to ask themselves whether they, as fathers, would like to be present at the birth at all. From the trainers' point of view, this is important, even though in Austria it is now taken for granted that fathers will be present at the birth. This is because, from the feedback received in

the father workshop and the trainers' other counseling activities, there are always fathers who experience trauma during the birth. For example, one participating father whose partner had a caesarean section blamed himself and was afraid: "Did I fail as a father during the birth and am I therefore responsible?"

Photo: The Daddy-Child Breakfast at the Parent-Child Center Region Bad Radkersburg (Austria) was one of the Parent's father education formats. © VMG/ EKiZ Region Bad Radkersburg.

Educational training especially supported fathers to gain confidence and to know what they can do. One Austrian father-to-be who participated in three Parent educational training sessions showed this in his feedback to the Parent trainer:

> *"Since my life companion had a Caesarean section, I took over any services like changing diapers and cuddling right after the birth. And it worked very well, he is so calm, hardly ever cries and it is just wonderful to enjoy the time as a threesome. And for that I want to say thank you, for your many great tips and of course the experiences of the other expectant/extant fathers." (Austrian father who participated in Parent educational trainings)*

Reflections and Recommendations for educators and decision-makers

The training of the facilitators/trainers was regarded to be one of the crucial factors for the quality of such educational programs. Scambor & Theuretzbacher (2021, at press) recommend that facilitators/ trainers should have specific attitudes and should be trained with a capacity-building program including reflection on gender and violence and the use of an intersectional perspective.

The experiences of another international project called FOMEN led to recommendations for the implementation of a gender-sensitive and violence-preventive educational program for men with an international family history (Scambor & Theuretzbacher, in press 2021): The guideline should support multipliers (e.g. teachers, trainers, counselors) to prepare adequate conditions for the implementation of such educational programs with men. Scambor & Theuretzbacher recommend the following approaches in the education program: the groups should focus on education and intervention on these topics. Groups should have a culture-sensitive approach and should use an asset model, and the training should give "participants the opportunity and space to recognize their own needs." Participants should be encouraged "to become leaders/role models in their community."

Training sessions should be voluntary, they should be "brave (and safe) spaces" based on mutual respect and sensitivity. To create this environment, facilitators should establish specific ground rules with the group.

Pregnancy and birth preparation are the window of opportunity when fathers can be reached particularly well. Fathers should be directly addressed both during pregnancy and in childbirth preparation services, e.g. with special units for fathers-to-be only.

From the trainers' point of view, there is a need for offerings for men who became fathers unintentionally, for very young fathers (e.g. fathers who are not yet of age themselves) and for fathers with international family histories who also have translation needs, as well as for fathers after a separation.

What particularly prevented fathers who participated in the father workshops from being able to realize active fatherhood well were difficulties in reconciliation. Many fathers could not afford to reduce their working hours for financial reasons. Or this reduction or time off was not granted to them by their employers. This was a major hurdle for some fathers participating in the parenting training to balance active fatherhood, time to care for their partnership, and to work well. Many fathers who participated in the educational training would like to be more involved as active fathers, but got or will get only a very short time off around the birth. This would require a change to the legal framework and, from the trainers' point of view, there should be a legal entitlement to more time off around the birth and postpartum - similar to Scandinavian countries.

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CHAPTER 3

Active fatherhood as a strategy for the prevention of domestic violence: the role of social workers

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Introduction or why engage fathers?

Research on fathers' active involvement in childcare provides many examples of positive impact in the field of preventing domestic violence. Studies show that men who are engaged parents demonstrate less inclination towards domestic violence and rarely become perpetrators of partner violence (Esplen, 2006; de Keijzer, 2004; Shapiro, Krysik, & Pennar, 2011). The findings suggest more favorable attitudes towards gender equality and zero tolerance of violence among boys and young men whose fathers were active caregivers in their childhood. The experiences researched reveal that boys tend to support egalitarian attitudes and behaviors more frequently when they have grown up in an environment of equal relations between parents, where both parents participated equally in making decisions on family affairs and fathers regularly completed routine household tasks and took care of their children (Levtov et al., 2014). Boys who have nurturing fathers, involved in their upbringing, are less likely to use violence against female partners in adulthood (Shapiro, Krysik & Pennar, 2011; Barker & Verani, 2008; Foumbi & Lovich, 1997). There is some indication that sons of nurturing fathers will be more caring and gender equitable as fathers, and that daughters will have more flexible perspectives on gender and gender equal relationships (Greene, 2000; MenCare, 2011). Some researchers have suggested that young men who are more gender equitable often identify a father or other male figure who modelled gender-equitable roles (Barker, 2001).

While research underscores the benefits of positive father involvement, unhealthy paternal influences can have detrimental effects (For overview: Wells et al., 2013). Negative fathering has a complex impact on child development and affects children's future behavior, which may include low self-esteem, low self-confidence, and an inclination towards more frequent violent behavior (For overview: Wells et al., 2013). Witnessing or experiencing violence in the home

increases a child's likelihood of being in an abusive relationship in the future and creating an intergenerational effect For overview: Wells et al., 2013).

As mentioned above, research emphasizes the involvement of men and boys as a key violence-reduction strategy (For overview: Wells et al., 2013). Research findings suggest that a complex approach is required, including the engagement of men as role models, leaders and allies in working with other men and boys to promote healthy, positive constructs of masculinity (Katz, 1995; Kaufman, 2001). Underlying this perspective is the notion that it is critical to support and equip men to act as leaders or engaged bystanders for addressing and preventing violence within the environments where they worship, live, work and play (Wells et al., 2013).

Positively involving fathers – engaging them as key participants in family strengthening and support – can improve the lives of men, women and children (For overview: Wells et al., 2013). By increasing men's role in caring for children, traditional definitions of masculinity are replaced with a broader vision of men's capacity in family life and society in general). Research suggests that men's emotional well-being is improved when they spend more time caring for their children ( ). Caring for children and being engaged in the lives of young people can lead to an increase in men's capacity to express emotions and experience empathy (For overview: Wells et al., 2013). Increased positive father involvement is associated with lower levels of family conflict and violence, and increases the chance that children grow up in an emotionally and physically safe environment (For overview: Wells et al., 2013). Some research has also made the link between positive father involvement and a decrease in child maltreatment, including child sexual abuse (For overview: Wells et al., 2013).

The PARENT project– Promotion, Awareness Raising and Engagement of Men in Nurture Transformation aims to integrate these theoretical insights on active fatherhood into the practices of professionals. The overall objective is to equip them with knowledge and skills regarding caring masculinities in order to contribute to the prevention of domestic violence and violence against women. The project partnership involving Austria, Italy, Lithuania and Portugal presented different contexts in terms of the professional target groups. Partners from Portugal and Italy chose to work with healthcare personnel who have primary contact with young fathers during the pre-natal and post-natal phases. The rationale was that

these two countries have mainstream public health policies concerning gender and the prevention of domestic violence. In Austria and Lithuania, social care and social work play an important role in the prevention of domestic violence. These partners therefore chose to engage with social workers who are important actors in providing services for diverse families (families at social risk, refugee and/or migrant families, amongst others) in cases of domestic violence.

By suggesting a framework of active parenthood for the prevention of domestic violence, the project developed an innovative approach to training professionals and maximized their participation. This chapter of the manual will shed light on the training curriculum for social workers that proved to have an impact on transforming attitudes towards gender stereotypes, gender roles and gender norms.

Social workers as agents of change

Professionals working with families have an important role to play in changing gender stereotypes, perceptions about traditional gender roles and cultural norms about femininity and masculinity. Client meetings provide a unique opportunity to start a conversation about family issues, relationships within the family, the decision-making process, negotiation with a partner/spouse and their family's emotional state. Via engagement with an individual client or group of clients, social workers can identify any existing gender stereotypes and begin critical reflection together on outdated attitudes towards the role of men in family and society, normative masculinities and femininities, and how damaging these gender norms can be for both women and men. It also important to engage in constructing more egalitarian attitudes regarding mutual relations, partnership and caring within a family, so that both partners are willing to develop the necessary knowledge and skills.

Not all men are equally ready to accept these ideas. For some, rejection of outdated stereotypes can be alarming. Achieving positive results therefore requires a lot of consistent, focused, patient and complex work: the more often men hear the opinion of those around them that their active participation in children's lives is exactly what society expects from a "normal man", the more likely they will be to accept it. The more men engage in active parenthood, the

faster the transformation of traditional masculine norms will be, and the sooner aspects of caring will be embedded in men's self-perception.

Social workers are the active agents who engage in everyday conversations, services, shared experiences and many other activities which affect shaping and reshaping the attitudes of their clients and consequently their behavior. For example, by discussing the role of a client in the family, a social worker can integrate issues of an involved and responsible father and the benefits thereof for the man and his whole family when men engage more actively in sharing household burdens and childcare responsibilities, deepening emotional intelligence, taking care of one's health and the well-being of others. These changes are particularly important in laying a sustainable foundation for the prevention of domestic violence: a man who views a woman as an equal partner and a father who takes responsibility for the well-being of his children without domestic violence.

Whilst mapping of the needs of social workers in Lithuania, the team of project implementers from the Center for Equality Advancement (CEA) identified that social workers and case managers who interact and work with families on a daily basis are highly interested in training. Four interviews and six focus groups were organized with the potential target group to be engaged in the project and planned training sessions. The key issues addressed in the focus group proposed the topics for the upcoming sessions: 1. fathers' motivation to engage in childcare, 2. teaching fathers how to engage, 3. changing masculine norms, 4. changing gender stereotypes about gender roles and expectations. The social workers interviewed reflected on the need to establish standards of caring masculinity that deconstruct normative masculine domination. They expressed the belief that promoting norms on caring for others opens up the possibility for a qualitatively new coexistence in both the family and the community. In their work with families, social work professionals have a unique opportunity to address the damage caused by gender hierarchies and gender role stereotypes on intimate partner relationships. These illustrate how domination, control and the use of force affect both the partner and child's emotional and physical wellbeing. Such professionals, however, can provide the floor for discussion of equal partnership, caring and support experiences and their benefits for the family.

This mapping exercise helped to identify local partners. Local communication and engagement with potential target groups facilitated further work on a local level.

In spite of the willingness shown by social workers to collaborate in the project and participate in training, the analysis also revealed social workers' biases. In interviews and focus groups they openly expressed certain gender stereotypes and prejudices about gender norms and victim-blaming attitudes in the field of domestic violence. For example, in one focus group the participants discussed that they truly understand that any kind of violence and act of violent against a woman is detrimental, but sometimes there are situations that women provoke by not remaining silent on certain things or simply leaving their husband in the kitchen and going to another room. A woman continued to complain and nag her husband, so he lost his patience and hit her. Reflecting on this situation, some observed that even social workers find the reasons to justify a man's behavior and focus on a woman's wrongdoing (Focus group, 17-06-2019). These findings suggest the need for self-reflection among professionals concerning gender norms, roles and stereotypes.

Nevertheless, analysis of focus groups and interviews revealed that restrictive gender stereotypes have a negative impact on boys' safe spaces to express their emotions, build trusting relationships and seek help. The dominating norms of masculinity prevail, and young men and boys are trapped in an environment where they are expected to be powerful, cool and strong.

Therefore, the PARENT project training for social workers was designed both for educational reflection on and deconstruction of individual prejudices and gender stereotypes; and to obtain the professional knowledge and skills required to engage men in active fatherhood and deconstruct gender stereotypes and prejudices.

Conceptual and methodological approach

The Lithuanian team from the Center for Equality Advancement was inspired by the conceptual model on gender transformative approaches to engaging men in gender-based violence prevention elaborated by Casey, Carlson, Bulls and Yeager (2018), on which they built their methodological approach to training social workers in Lithuania. This conceptual model includes three interconnected domains. The first domain covers engaging men and boys in prevention work, which in this project we consider the steps of engaging young men in active

parenting. The second domain presents the possibility for intervention to change the attitudes and behaviors of young men. In this project we consider how social workers can intervene though the provision of social services, community events, discussions and other activities where issues of hegemonic masculinity can be challenged, and caring masculinities promoted. Finally, the third domain is fostering activism and integration into larger GBV prevention efforts and gender equality in general. This final step, as academic research shows (Casey et al., 2018), is important for engaging bystanders and men previously not engaged in any social activities.

The rationale for focusing on men's engagement as a component of the broader goal of preventing gender-based violence became the framework for the training design for social workers. In their work they have already drawn up certain strategies to reach out to young men via services for families on various issues including protecting against and preventing domestic violence, building skills for childcare and support, or other community services. Social workers therefore need to improve their knowledge and skills to address and challenge stereotypes about social gender roles. By reflecting on and deconstructing their own gender biases, they will be equipped with the theoretical and practical insights to intervene with their clients and gradually dismantle stereotypes, gender prejudices and rigid masculinity norms. Thus, training aimed to achieve two main goals. On the one hand, the training was tasked with preparing social workers to address issues surrounding childcare as a man's job (caring masculinities) and gradually transform gender stereotypes. On the other hand, it sought to provide a safe space for social workers to reflect on and critically assess their own gender biases and change their own attitudes towards social gender roles and cultural norms.

Training participants

125 individuals from different regions of Lithuania participated in the training sessions. Six training groups were held in December 2019 and January 2020. Then participants had homework to complete and continued their training in February – March 2020, just before the first lockdown.

Demographic Profile

The youngest participant in the first questionnaire was 22 years old, the oldest

66. The average age in the first questionnaire was 40.48 years. In the second questionnaire the youngest participant was 21 years old, the oldest 68. Average age in the second questionnaire was 43.03.

87.1% of participants in the first workshop and 96% of participants in the second workshop held a university degree. 5.2% of respondents in the first workshop held a professional degree and 2.6% held a high-school degree. Meanwhile, in the second workshop 1.3% held a professional degree and a high-school degree.

63.2% of participants in the first workshop and 62% in the second answered that they are social workers, the most common career among respondents in both workshops. Answers with over five percent in both workshops also included health office professional, education worker and psychologist.

In addition, 43.5% of those questioned in the first workshop and 51.4% in the second indicated that they have been working in their area for more than 5 years. Over 20% of respondents indicated that they have been working in their area for 3-5 years and 1-3 years in both questionnaires.

Diving into the learning process

This chapter presents a 3-day (24 academic hours) training program, including one day (12 academic hours) of homework. Its structure combines 2 days of face-to-face activities and independent deepening of participants' competencies which contribute to developing awareness of gender stereotypes in everyday life and motivating the promotion of the idea of active parenting as a prevention of domestic violence. In between those two days, there is time dedicated for homework that participants should complete and provide their insights, observations and reflections.

Modules I – V of the training are designed for group mobilization (participants' acquaintance, reflection on joint work, creation of preconditions by sharing insights), acquaintance with the main training topics (gender stereotypes, masculinity norms, the concept of parenthood, opportunities for preventing domestic violence).

Homework is then given for the participants to complete in the period between the face-to-face training sessions. Time for homework is integrated into the training as an important part devoted to independent work, which can be structured according to a specific group's motivation and capacity, depending on the circumstances. Participants are encouraged to take time to observe the environment more closely in order to identify both gender stereotypes and their potential for change. They will need to remember their observations to be presented later in the final part of the training.

The final part of the training, Modules VI – VIII, is devoted to a deeper analysis of the impact of stereotypical gender roles and the search for possible solutions to implement inclusive parenting.

Module	Duration
I. Basic working principles and group mobilization	30 min.
II. Childhood Memories	60 min.
III. Norms of Masculinity and Paternity	90 min.
IV. Domestic Violence: Abuse of Control and Power	90 min.
V. Equal Partnership as Prevention of Domestic Violence	90 min.
VI. Gender Stereotypes and Everyday Life	120 min.
Reflection on proposed methods	15 min
VII. Responsibility Cake	120 min.
Reflection on proposed methods	15 min
VIII. Summary of Training	90 min.

MODULE 1.

Basic Working Principles and Group Mobilization

Description of methods

1. Introduction (5')

Process: Participants are welcomed to the training and introduced to the working methods. It should be clarified that the aim of this training is to motivate professionals working with families to encourage men to become more actively involved in parenting:

- Strengthen awareness of gender stereotypes and the harm they cause;
- Raise awareness of the benefits of inclusive parenting;
- Provide for the prevention of domestic violence;
- Motivate them to be more actively involved in promoting norms of caring masculinity.

2. General Working Principles (5')

Process: In order for participants to feel comfortable and the group to become more cohesive, it is important to discuss the basic principles of the work at the beginning. Encourage participants to identify what they need to feel comfortable and safe. Facilitators should discuss all the proposed principles of the workshop (what exactly they mean) and write them down on a large flipchart sheet. Upon completion of the work, facilitators should highlight that these are general working rules.

Note: Participants may forget some important principles of working together. In this case facilitators should suggest them, explaining why they are is important. For example, respect for others' opinions, taking turns to talk, listening, confidentiality, active participation, punctuality, phones off or on silent. It is also important to offer a "STOP rule" - the possibility to withdraw from a discussion or group work at any time if uncomfortable.

3. Getting to Know the Group (20')

Participants can get to know each other in a variety of ways, so facilitators are encouraged to choose the one that works best for them. We propose the "Gift for a friend" method.

Process: Facilitators should explain to the participants that their task is to greet everyone in the room with a slight nod or eye contact and to "give a gift", i.e. their name after a greeting (e.g., "Hello, I am Martha"). Once the name is given to the partner, the participant who hears it no longer has his / her own name, but the partner's name. So, when she / he goes to greet another participant, the name gained during the previous greeting is "given". The process of exchanging names continues until their real name is "recovered". That participant can then sit down. The exercise ends when everyone has returned to their seat.

Note: It often happens that some names "get lost" and others "multiply". Then facilitator should simply let the participants sit in their seats. To conclude, it could be noted that this situation arose because we can lack attention while listening to others. It is important to pay attention to this aspect, because when discussing sensitive topics, it is especially important to hear what others are saying.

4. Motivation to Participate in Training (5')

Process: Participants are invited to remind others of their name again (now hearing the whole group) and to express their motivation (or lack thereof) to participate in the training freely.

MODULE 2

Childhood Memories

The aim of the module is to create preconditions for reflection based on childhood memories and to prepare participants for discussions about stereotypes that affect perceptions of gender roles in society. By completing the module tasks, participants are also encouraged to understand both the commonality and uniqueness of personal experiences.

Description of methods

1. Childhood Memories (40')

Process: Participants are asked to think back to their childhood, to remember notes, sayings and instructions heard by boys and girls, and to write them down on a piece of paper. We don't necessarily appreciate whether these memories are positive or negative, and yet we probably remember which gender was being addressed. This is individual work. The facilitator should ask participants first to remember messages addressed to their gender and then to children of the opposite sex (3-4 messages each). If the group is mixed gender, ask the women to remember what was said to girls and the men to remember what was said to boys. In the second step, reverse roles for women to remember boys' messages and men to remember girls'. (5')

In small groups of 3-4 people, the facilitator should ask participants to share their memories and nominate one person to present the overall results of the group: one list for girls; another list for boys. Encourage the inclusion of memories that were not recorded on the sheets but that arose from sharing memories. (10')

Gather a "harvest" of insights. First about girls, then about boys. Ask the representative(s) from each group to share what was discussed in the groups. Explain that some memories will be repeated, and this is very important, so these memories need to be re-named. Form two columns on the flipchart sheet: one for memories of girls, the other for boys. List the memories in two

lists (highlighting stereotypes on a large flipchart sheet with different colored markers). This part should take about 15 minutes.

When participants have finished their work, the facilitator should discuss the results with the participants: what are the noticeable trends? Ask them to imagine they're talking about a specific girl and boy who grew up hearing only the messages written on the flipchart sheet and followed the instructions carefully. What kind of adults did they become? Ask them to describe the psychological portraits of this woman and man. What personalities developed out of these messages? What impact did they have on shaping their priorities and attitudes towards childcare? (10')

2. Insight Analysis (20')

Process: It is important to take time to summarize participants 'insights. Note how their work is a simulation of socially constructed gender, helping us to understand how expectations, attitudes, behaviors and roles are formed from an early age, putting girls and boys, women and men into gender 'boxes', creating two distinct types of individual. The social construction approach allows us to understand the strong impact that our identity-shaping environment has on our self-awareness and perception of norms. It sends two important messages: on the one hand, what has been constructed can also be redesigned - changes in the human brain take place throughout life, and generations of children do not fully replicate their parents' and grandparents; attitudes towards gender. However, changing unconscious norms and those established during childhood is not easy, which is why gender stereotypes have such a strong impact on our lives.

In summarizing this work with childhood memories, it is important to pay attention to both the possibilities for changing attitudes and the challenges posed by this process. Empathetically ask how participants feel when they see these two lists. What thoughts, doubts and anxieties would they like to share? It is important to accept any opinion openly, recognizing that changes in attitude related to gender are a time-consuming process that can be worrying.

MODULE 3

Norms of Masculinity and Parenting

The aim of the module is to discuss the norms of masculinity inherent in our culture and their impact on men's quality of life, their ability to build and maintain deep interpersonal relationships and to be actively involved in the lives of their children. By completing the tasks in this module, participants are encouraged to reconsider critically the traditional image of a man and to open up to the idea of caring masculinity.

Description of methods

1. Real Man (35')

Process: Writing about "men in general". The facilitator hands out paper and pens to all participants and asks them to number the two sides of the paper with 1 (front) and 2 (reverse). The participants should then think about societal ideas about and expectations of men and write them down on page 1. "How do we picture men in general, what does society think about men? What is the dominant conception of masculinity? What are its typical characteristics? Please describe this on the first page." (5')

Writing about a man I like. The facilitator asks the participants to think about a male person they like and to describe this person on page 2. "Now please think of a male person from your group of friends, family or work, or anywhere else, whom you like very much. Please describe on page 2 why you like him." (5').

Reading each other's ideas. The facilitator asks the participants to take their paper, scrunch it into a ball and throw it to someone else to catch and read it. This way, participants can read each other's ideas (5').

Talking about conceptions of masculinity in pairs (10'). The facilitator asks the participants to find a partner (ideally someone they do not know very well) and discuss following questions:

- Are the characteristics we listed on page 1 the same that we listed on page 2?
- Where are they similar, where do they differ?
- What can it mean when they are different?

Full group discussion. Ask participants to share what they have learned from writing, reading and discussing their ideas about "men in general" and "a man I like". (15')

During the discussion, you could talk about:

- "Typical" vs. real-life masculinity (embodying societal concepts, costs for men of attempting to adhere closely to dominant expectations of masculine ideology)
- Changing ideas of masculinity over time and differences in different societies
- Hegemonic masculinity vs. devalued forms of masculinities (masculinity that is most dominant at any given time, few men are able to live up to the "ideal")
- Diversity within masculinities (e.g. in relation to social class, age, family status, ethnic identity, immigration status)
- Caring masculinities (self-concepts & societal structures that make it possible/impossible for men to embrace and enact values of care in their private and working lives)
- Masculinities and vulnerability

This method should always finish with reflection on what people have experienced and how they felt about it. Do not end the method without closing clearly (asking participants to leave their role) and checking how people feel.

2. Masculinity Norms (20')

After completing the Real Man method, the facilitator could take a few minutes to make a brief theoretical summary.

Process: The facilitator should point out that narrowly perceived norms of masculinity shape everyday practices that do a lot of damage not only to women (domestic violence, unequal distribution of resources, devaluation of work) but also to men. Not all of them can and want to fit the narrow framework of a certain conception of masculinity, usually based on competition, demonstration of aggressive behavior and egocentricity, therefore running the risk of social sanctions: bullying, rejection and violence.

It is important to emphasize that elevating a man's identity and everything related to masculinity above women and femininity (this is called cultural sexism) does great harm not only to girls and women. This attitude is also conversely harmful to men: for fear of feminization (being described as "girly"), they avoid talking about their problems or asking for help, thereby paying a high price in (mental) health and sometimes even their lives.

To prepare for the lecture, you can use the material in *Boys* in Care: Strengthening boys to pursue care occupations*. 2019 p. 31-33

3. My Father's Legacy (35')[7]

Process: Ask participants to remember their dad: what was he like, how did they spend time together? Then invite couples to share these memories. (15').

As participants gather in a general group, the facilitator could ask them to share insights: How did you feel about this task? What emotions accompanied those memories? What pattern(s) of behavior would you like to adopt from your dad, and what would you change? Ask them to name at least one trait they would like and one they would not want to bring over into their relationships with their own children.

The facilitator should encourage participants to reflect on the impact traditional masculinity has on a child's upbringing, and the socialization of girls and boys. What should we do to rid ourselves of harmful practices and build partnerships? Might we become parents who foster partnership and gender equality in relationships? How can these insights be applied when working with families?

7 Adopted from PROMUNDO. 2013. *Program P: A Manual for Engaging Men in Fatherhood, Caregiving and Maternal and Child Health*.

MODULE 4

Domestic Violence: Abuse of Control and Power

The aim of this module is to introduce participants to coercive control practices in the context of intimate partner violence and to help them understand how cultural gender norms support it or go unnoticed.

Description of methods

1. Power and Control Wheel (30')

Procedure: The facilitator should prepare a slide with a Power and Control Wheel (Annex 1) and use it to briefly review the strategies that perpetrators use to manipulate victims. Note to participants that, contrary to popular belief, systemic domestic violence does not necessarily have to be associated with physical abuse. The abuser resorts to these actions only when he doubts whether psychological measures will be enough to impose their will. This is why domestic violence often remains invisible and can occur unhindered.

It is also important to note that when violence reaches the level of physical abuse, the likelihood of a woman experiencing sexual violence is greatly increased: this is in order to further humiliate her, increase her sense of shame and force her to remain silent.

Note: To strengthen the arguments against toxic violent behavior, the facilitator could also use the Children's Domestic Abuse Wheel (Annex 2).

2. Gender Stereotypes - a Forge of Violence (30')

Process: The facilitator should assemble the participants into groups of 4-5 people, leave the slide of the Power and Control Wheel on display, ask the groups to choose several strategies for violent behavior from it, and examine which gender stereotypes that are prevalent in society facilitate said behavior.

To evoke gender stereotypes that affect perceptions or expectations of femininity and masculinity norms, the facilitator can encourage participants to recall the insights gained from the Childhood Memories exercise: what behaviors does gender-segregated socialization normalize and make unnoticeable?

To make group work more structured, the facilitator can ask participants to complete a table on gender stereotypes in society that support violent behavior:

Strategy of violent behavior	Gender stereotypes in society that support violent behavior
1.	
2.	
3.	

When the tables are completed, the facilitator should ask the groups to present their insights (15')

3. Structured Discussion (30')

Process: The facilitator invites participants to sit in a closed circle without leaving empty chairs and to recall the insights of Modules II, III, IV to summarize the connections they see between gender stereotypes, norms of masculinity and domestic violence. Let them discuss in pairs or groups of 3 (10') and then continue the discussion as a group:

- How did you manage to link gender stereotypes to domestic violence?
- Were there any findings that you hadn't thought about before?
- What are the most obvious gender stereotypes that favor domestic violence?

Note: If participants do not provide examples of child manipulation, economic violence, abuse of male privilege, the facilitator should suggest discussing these coercive control strategies and the cultural contexts that support them.

MODULE 5

Equal Partnership - Prevention of Domestic Violence

The aim of this module is to discuss strategies for changing gender stereotypes and behavior in order to ensure the sustainable prevention of domestic violence with a special focus on inclusive fatherhood.

Description of methods

1. Partnership and Equality Strategies (45')

Procedure: The facilitator should leave the slide with the Power and Control Wheel on the screen, divide the participants into four groups and give them the task of choosing two power and control strategies (marked on the Wheel) and deciding, in consultation with each other, which behavioral norms should be embedded for men to foster relationships based on the principles of equality, partnership and active participation in the lives of children. The groups should work with different power and control strategies so that they can all be explored during the training. (20')

Next, facilitators should ask the groups to present their insights and comment on how they have managed to look for attitudes that could help shape alternatives to controlling behavior. The other groups should be encouraged to listen carefully and add their own insights. (20').

At the end, the facilitator could show the slide with the Equality Wheel (Annex 3) and draw participants' attention to any aspects that have not been discovered by the groups, emphasizing the importance of gender equality provisions for the effective prevention of domestic violence. (5')

2. Equal Partnership: Men Can Do it (15')

Process: The facilitator opens up opportunities for joint discussion between participants, asking them to recall and provide examples that show that men are able and willing to take care of children, sharing household duties and responsibilities.

Note: It is important to make sure that the discussion does not turn into criticism or regret that men do not want to look after children. The aim of this exercise is to encourage positive change in society and to strengthen the belief that targeted efforts can change gender stereotypes and encourage men to become more involved in raising children, while at the same time refusing violence against both partners and children.

3. Homework Assignment (5')

Process: While assigning homework, the facilitator should encourage participants to observe their environment and fill in a "gender diary", that is, to make a note of all cases that could be related to the manifestation of gender stereotypes in their daily lives: work, advertising, family, in the street... Also, don't miss those examples that participants would consider breaking or changing gender stereotypes. Participants should be informed that this information will be needed for group work in the next session.

4. Group Reflection (25')

Procedure: Ask participants to sit in a closed circle so that there are no empty chairs or gaps, to take a deep breath and exhale several times, to "ground", to return to the work done during the day and to answer three questions:

- What emotion am I feeling now?
- What insights will I take from the workshop?
- What would I like to change?

Note: Before starting the day's reflection, it is helpful to remind participants that this action ends the day, so the opinions of other colleagues can only be heard and not commented on. The issues participants want to discuss will be addressed at the next meeting, and it is now important to end today's process.

Also, don't forget to recall that the topics covered can "catch up" with the participants and cause strong emotions even a few days after the training. It is important not to deny them, but to try to understand their origin and, if possible, to discuss emerging feelings and thoughts.

MODULE 6

Gender Stereotypes and Everyday Life

The aim of the module is to direct the participants' attention towards manifestations of gender stereotypes in everyday life, to deepen understanding of their origins and sources of reproduction, and to form critical thinking in relation to gender stereotypes.

Description of methods

1. Group Mobilization (30')

Process: Although within Module VI the facilitator will be working with the same participants as Modules I - V, it is important at the beginning to take the time to gather the group and "get to know each other" again. It is not easy to work together emotionally after a break, but a warm, safe, benevolent environment is important for becoming aware of your feelings, thoughts and behaviors.

Therefore, time should be taken to discuss the general working rules, to become acquainted with and express the expectations for the day (similar to what was done in Module I).

2. Gender Diary Entries (30')

Process: This method is used to discuss participants' observations (homework). volunteers could be encouraged to share insights and observations as a group. The following questions could be used to facilitate the discussion:

- How did you fill in the "gender diary"?
- In what environments was it easiest to find examples? Gender stereotyping? Denying gender stereotypes? What more in our environment?
- What was the most unexpected?
- Who confirmed your expectations?

- How did you feel when you noticed the stereotype?
- What was the effect of the stereotypical behavior you observed?

At the end of the discussion, it might be pointed out that gender stereotypes are difficult to avoid. They are changing, but the process is quite slow and does not take place without our effort and persistent, purposeful work.

Note: Examples of gender stereotypes provided by participants can be used in the *Gender Stereotypes Method: Benefit or Harm?* The links between the analysis carried out and the participants' observations and experiences could provide deeper insights.

3. Gender Stereotypes: Benefit or Harm? (60')

Procedure: Draw two columns on a flipchart sheet: one for writing stereotypes related to the norms of femininity, the other for the norms of masculinity. Participants should be asked to provide examples. Gender Diary posts should not be forgotten (5').

Participants should work in groups of 4 to 5 to choose one stereotype for women and one for men (different stereotypes in different groups) and examine them by completing a table:

Stereotype for women		**Stereotype for men**	
Harm	**Benefit**	**Harm**	**Benefit**
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.

When filling in the table, the same stereotype (for example, related to femininity: "a woman must be gentle") should be examined from the perspective of both sexes. In doing so, participants must answer the following questions:

- How does the existence of such a stereotype associated with femininity benefit women?
- What harm does the existence of such a stereotype associated with femininity cause women?
- How does the existence of such a stereotype associated with femininity benefit men?
- What harm does the existence of such a stereotype associated with femininity cause men?

A similar process must be performed with a masculine stereotype (for example, "a man must be physically strong"). In this case, participants must find answers to the questions:

- What are the benefits for men of having such a stereotype associated with masculinity?
- What harm does the existence of such a stereotype associated with masculinity cause men?
- How does a woman benefit from the existence of such a stereotype associated with masculinity?
- What harm does the existence of such a stereotype associated with masculinity cause women?

While searching for stereotypes' "benefits" and "harms", it is important to look at people's lives more broadly: not only in the field of interpersonal and family relationships, but also in the work environment, personal security issues, and opportunities for self-realization (35').

After completing the work in small groups, participants are invited to present their insights (20'). The questions below could be used to initiate the discussion:

- How did you do the task?
- Which pros or cons of stereotypes were easier to decide on?
- What general conclusion could you draw from this task?

Note: It is important to point out to participants that gender stereotypes are seldom clearly negative. On the contrary, it is extremely difficult to give them up precisely because each of them promises a certain "benefit". However, it should be remembered that everyone also has their own negative side, which limits the expression and opportunities of both women and men. Encourage reflection on what happens to those who cannot or do not want to conform to an existing stereotype: unrealized gender stereotypes can lead to dissatisfaction with deep, hard-to-resolve internal and external conflicts.

Reflection on proposed methods to deal with the issues of gender stereotypes in everyday life.

MODULE 7

Responsibility Cake

The aim of this module is to stress the importance of sharing household and childcare responsibilities in terms of both inclusive parenting and the prevention of domestic violence.

Description of methods

1. Family Story (60')

Procedure: Groups of 3-4 people should be given the Family Story handout (Annex 4). Participants should be asked to read it and discuss the barriers that prevented the young couple from sharing caring responsibilities evenly (15').

When the groups are ready, ask them to share their insights on the "target" drawn on a flip chart (Annex 5) marking a point with a colored marker in the concentric circle that best fits the obstacle category: individual level, pair relationship, extended family/friends, work environment, services/laws.

Groups are invited to do this work in turn by adding insights and providing their reasoning for the position chosen. The other participant might agree, disagree or add specific comments to what was already said (30').

Once all the groups have marked their insights on the "target", open the space for a summary discussion:

- Which obstacle category scored the most "points"?
- Which obstacles are the hardest / easiest to remove? Why?
- On which category of barriers do participants feel they can have the greatest impact? What specifically could be done?

2. Time Share (60')

Procedure: Divide the participants into groups of 3-4 people and distribute a "Family Story" to each of them (see Appendix 6). Ask them to read it and discuss

the barriers that prevented the young couple from sharing caring responsibilities evenly. Allocate 15' for this work.

3. Use of time (60')

Procedure: The facilitator should divide the participants into groups of 4-5 people (try to have different groups than in the previous task) and ask them to define the family whose experiences will be covered in the exercise: how many family members are there - adults and children, age, gender, occupation, what does their working day look like? (2-3'). After groups have decided, they should calculate how much time each member of their invented family spends on paid or unpaid work, their own needs, and leisure/hobbies.

The groups should be encouraged to complete the table (Annex 5) and then summarize its data. The numbers should be plotted on a graph that clearly shows each family member's time spent on different areas (35').

The results could be discussed with a view to answering the following:

- What are the noticeable trends in time use?
- Do all adult family members spend equal time on paid or unpaid work, their own needs and leisure/hobbies?
- Are there any trends that could be linked to traditional gender roles?
- What challenges may arise from the observed distribution of time?

Note: Quite often, participants notice that women spend more time on unpaid work, although the hours of paid work do not necessarily differ significantly from men's, and they sleep less. It is important to address this in opening up the possibility to discuss not only women's health but also women's economic vulnerability or the likelihood of experiencing economic violence within the family context. It is important to conclude the group debate by making it clear that sharing the burden of unpaid work equally and equal opportunities for self-employment are important steps towards effective prevention of domestic violence and greater involvement of men in children's lives.

Reflection on proposed methods to discuss sharing care responsibilities as a couple.

MODULE 8

Summary of training

The aim of this module is to summarize learning insights, work with results and motivate participants to apply the acquired knowledge and competencies in their work with families.

Description of methods

1. Washing line (45')

Process: The participants are asked to choose a partner and recall the topics discussed during the training to find out what other questions they would like to deepen or discuss. These ideas (maximum two per pair) should be written on sticky notes (one per note) and affixed to the 'washing line' (5').

Participants are then invited to review all the sticky notes in pairs and, after reading them, choose one with a question they know the answer to, or one that poses the greatest difficulty (10').

After a short consultation, the pairs should be invited to share their insights with the whole group to encourage discussion (30').

2. Closing Reflection: Heart, Hand and Head (45')

Procedure: One participant is invited to stand in front of a large sheet of paper attached to the wall (this can be done by gluing together several sheets of flipchart paper) and have the outline of his/her silhouette drawn.

The facilitator should explain that learning takes place at the heart, hand and head levels: that is, personal, practical and intellectual/theoretical, and provide examples if necessary. The outline drawn on the paper is a collective group body that is empty for the time being, but will soon be filled with group learning insights.

The participants should be divided into pairs, with sticky notes in three colors (or

shapes) that symbolize the heart, hand and head, and should write the learning outcomes of all levels on the appropriate sticker (one insight at a time).

Once completed, the facilitator should invite each group to share their insights with everyone and stick a piece of paper in the appropriate place in the silhouette. Finally, the abundance and value of the results should be noted.

Results evaluation from training social workers: assessing changes in attitude towards men's involvement in parental and maternal health, caregiving and gender equality

Insights on trends in changes in attitude

Specialist Attitudes

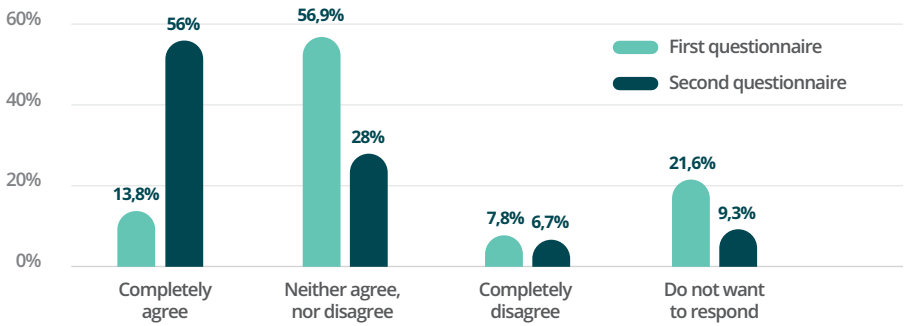
Participants' attitudes were assessed twice: after the first round of training and after the second. Assessment was based on the self-evaluation of a change in attitude. The questionnaire adopted GEM scale statements to assess the transformation of gender attitudes (Pulerwitz & Barker, 2008). In general, there are consistent notably positive changes in attitude between the first and second questionnaires with regards to the statements in this sub-section.

For instance, most of the respondents in both questionnaires disagreed that pregnancy consultations are only important for women. The positive changes in awareness of the importance of men's involvement in parental and maternal health may be reflected in the fact that the percentage of respondents holding this opinion increased from 78,4% to 90,7% in the second questionnaire. Simultaneously, the percentage of those questioned who agreed with the statement that pregnancy consultations are only important for women decreased from 7.8% to 2.7% in the second questionnaire.

This positive change in attitude is also reflected in the fact that the percentage of respondents who stated that they know how to encourage fathers to engage more actively in preparing for childbirth increased from 13.8% to 56% in the second questionnaire. This percentage increase may reflect an increase in professionals' expertise in helping engage with men in the health sector and promote active fatherhood as a result of the workshops. Meanwhile, the percentage of respondents who expressed a neutral opinion decreased from 56.9% to 28%.

It must also be noted, however, that the two questionnaires differ in sample size, which may affect the precision and interpretation of the results. Given the small sample sizes, this limitation is important.

I know how to encourage fathers to engage more actively in preparing for childbirth



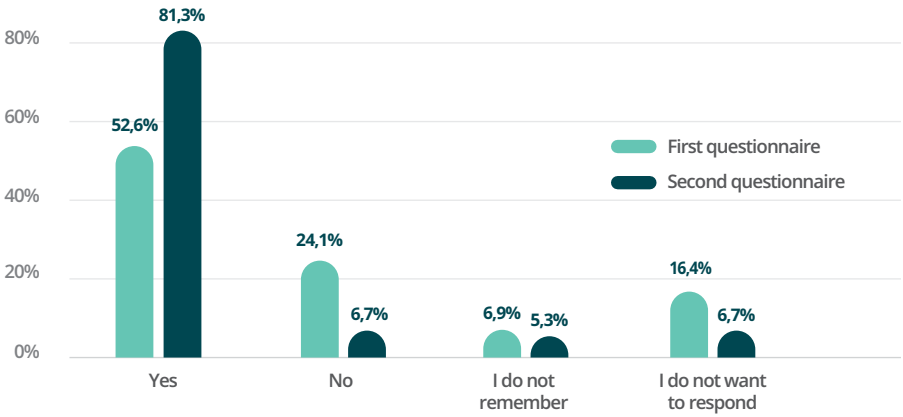
Specialist Practices

On the whole, positive changes in practices between the first and the second questionnaire are particularly notable in four of the seven questions in this sub-section.

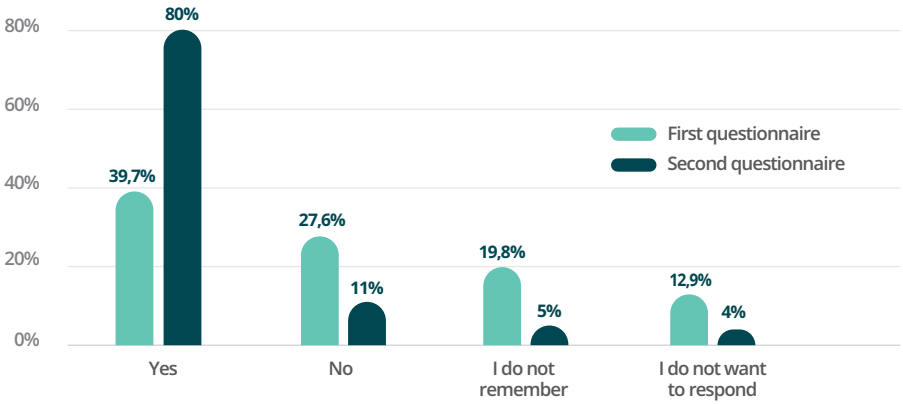
Here, the first three questions require the respondents to evaluate whether they encourage their co-workers to promote men's active participation in pregnancy consultations together with their partners, whether they personally encourage men to participate in pregnancy consultations, and whether they urge women to encourage their male partners to attend pregnancy consultations. While in the first questionnaire the answers to these questions are distributed quite evenly, in the second questionnaire there is a notable increase in affirmative responses: from 38.8% to 66.7%, from 52.6% to 81.3%, and from 39.7% to 80%, respectively. Meanwhile, the percentage of those questioned who indicated that they do not engage in the aforementioned practices fell from 19.8% to 10.7%, from 31% to 13,3% and from 24.1% to 6.7%, respectively.

These changes may suggest that, thanks to the educational workshops, more specialists have adopted practices that seek to engage men in preparing for childbirth.

I urge women to encourage their male partners to participate in pregnancy consultations



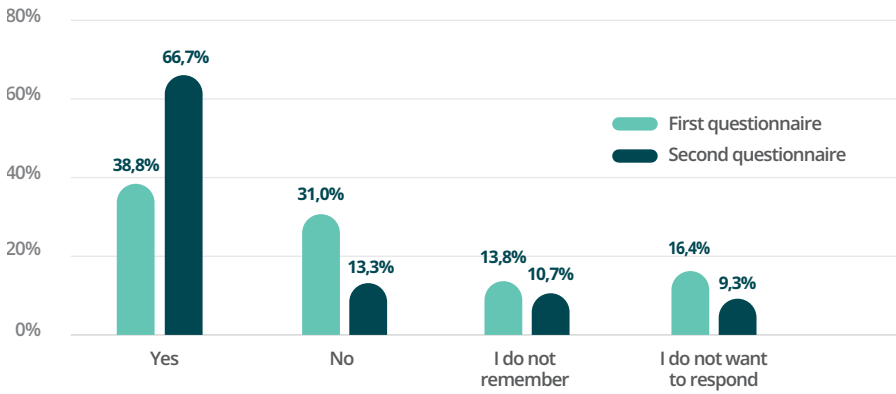
I urge co-workers to encourage fathers/men to participate in preganancy consultations with their partners



A similar effect is also notable in the question that asks respondents if they have participated in courses or workshops or have actively studied material related to parenting, masculine norms or gender equality in the past six months. Here, the

percentage of those who responded negatively decreased from 57% to 36% in the second questionnaire, while the percentage of those who responded positively increased from 30.7% to 60%.

I personally encourage fathers to participate in the pregnancy consultations together with their partner



In the other three questions in this section, the results suggest either a slight increase in positive practices by specialists between the first and second workshops or consistently positive practices.

Nevertheless, as before, the differing and small sample sizes in the two questionnaires may have affected the precision and interpretation of the results.

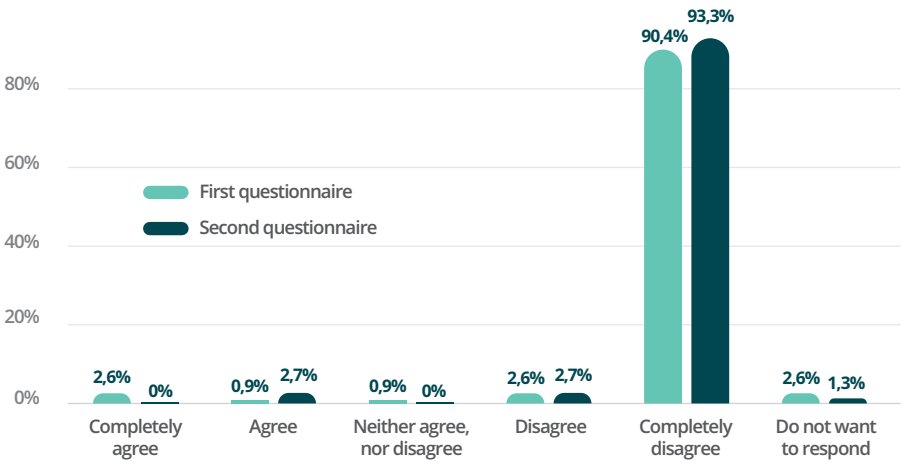
Childcare

With regard to the statements on childcare, there are no significant changes in attitude between the first and second questionnaires.

Most often, the responses in the second questionnaire uphold the results from the first questionnaire. This may suggest that the answers represent strong beliefs or values. For instance, in both questionnaires, the absolute majority of

people consistently expressed complete disapproval of physical punishment when disciplining a child. Similarly, the absolute majority of respondents in both questionnaires completely disagreed with the statement that children should not show their emotions. Most respondents in both questionnaires also completely disagreed that children should feel responsible for their parents' emotional wellbeing and should adapt to their parents' needs. Moreover, most of the specialists questioned in both questionnaires completely disagreed that good children must always obey their parents or that children should be taught always to obey their parents. Similar consistent responses reappear in numerous questions in this section.

It is not harmful when children are beaten with good intentions



Moreover, the answers chosen by a small percentage of respondents in the first questionnaire were often dropped in the second questionnaire. To illustrate this point, when asked to evaluate the statement whether it is enough for parents to use the phrase "because I said so" when explaining something to their children, in the first questionnaire 1.8% responded that they completely agreed, 1.8% that they agreed, 9.6% that they neither agreed, nor disagreed, and 3.5% that they preferred not to answer. Meanwhile, in the second questionnaire, these answers received 1.4%, 0%, 0%, and 2.7% of responses respectively. This may suggest that the workshops helped participants to form a more synchronized approach to responsible parenting and caregiving.

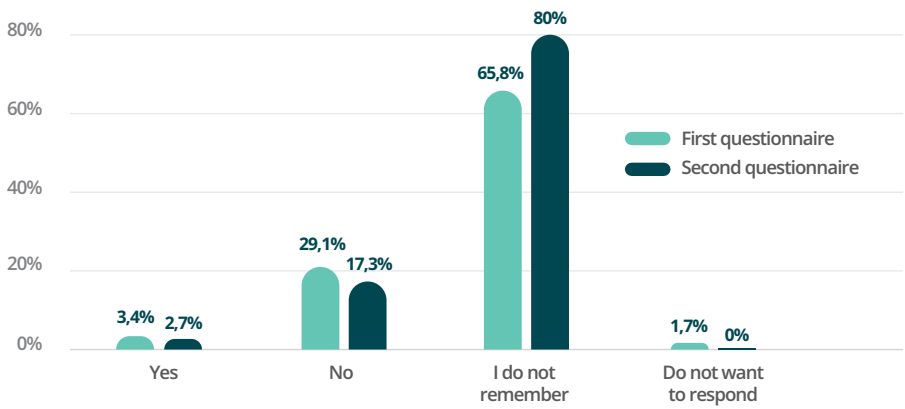
Attitudes Toward Gender Norms

Generally speaking, with regard to responses in this section, there were limited changes in attitudes between the first and the second questionnaires.

Positive change in attitude that contradicts the stereotypical view of gender norms is reflected in several questions in this section. For instance, the percentage of respondents who disagreed with the statement that women's most important role is caring for the family and home increased from 65.8% in the first questionnaire to 80% in the second one.

Similarly, the percentage of respondents who disagreed with the statement that men are always ready for sex increased from 32.8% to 54.7% in the second questionnaire. In addition, in the second questionnaire, 89.2% of those questioned disagreed that the woman is responsible for avoiding pregnancy, compared to 78.4% in the first questionnaire. However, it must be noted that the differing and small sample sizes in the two questionnaires may have affected both the precision and interpretation of the results.

A woman's most important role is caring for the family and home

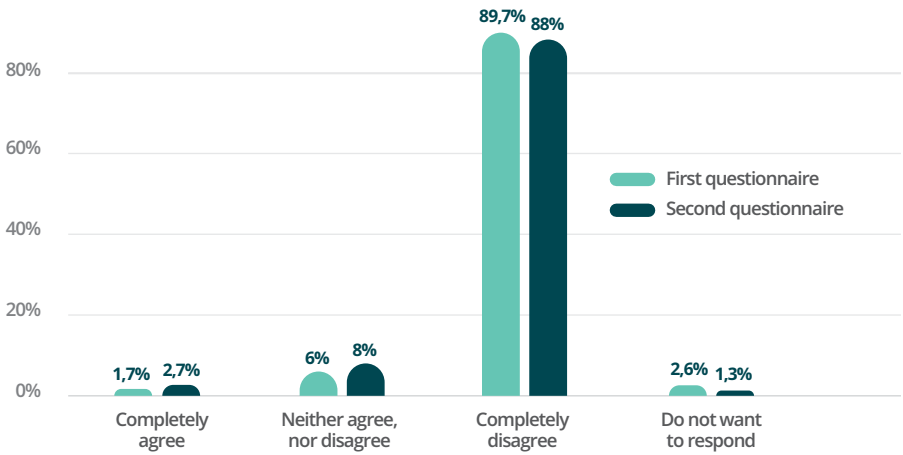


Moreover, similarly to the previous section, the responses to statements on gender norms in the second questionnaire often upheld the results from the first questionnaire. This may suggest that the answers represent strong

beliefs or values. For example, the absolute majority of respondents in both questionnaires completely disagreed with the statement that a real man should have multiple sexual partners. Likewise, the absolute majority of respondents in both questionnaires completely disagreed that a man is not responsible for housework. Also, most of the respondents in both questionnaires completely disagreed with the statement that a woman who requires her partner to use condoms is shameless.

Furthermore, the answers chosen by a small percentage of respondents in the first questionnaire were often dropped in the second questionnaire.

A woman who requires her partner to use condoms is shameless



Conclusions

On the basis of these findings, it appears that the two educational workshops had a limited positive effect on the attitudes of social workers towards men's involvement in parental and maternal health, caregiving, and gender equality. Whereas a significant positive change is visible in responses to questions

regarding men's involvement in parental and maternal health, either no positive change or a small change in attitude was observed in the rest of the responses.

These results may be explained by the fact that the initial attitudes of workshop participants towards men's active involvement in preparation for childbirth and childcare as well as gender equality were already positive or somewhat positive, as represented by their responses in the first questionnaire. Therefore, the two educational workshops on the participants' attitudes had a less significant positive effect they would have in the instances where participants' initial attitudes were negative or neutral. This could be particularly true given the fact that participation was voluntary, so the participants were probably already interested in these topics prior to the workshops.

Finally, these results are limited, as the sample sizes differed between the two questionnaires and both workshops included a small number of participants. Consequently, the results may not be accurate.

ANNEX 1.
Power and Control Wheel

The Power and Control Wheel is a visual representation of an abusive relationship based on the power that an abuser uses to maintain control over their victim. The abuser may use some of the methods within the wheel such as intimidation, emotional abuse, isolation, minimizing, denial, blame, using the children, male privilege, economic abuse, coercion and threats. If these methods do not fulfil the abuser's need for power and control over the victim, the abuser may resort to physical and/or sexual violence as shown on the outside of the wheel (A Safe Place, 2021).

This annex presents the Power and Control Wheel as an instrument to understand what it means to have an unhealthy/violent relationship between intimate partners, which can lead to domestic abuse, and physical and sexual violence. Because of the prevalence of domestic violence, many people unquestioningly accept foul and abusive behavior as normal. They are neither equipped nor prepared to expect and demand the characteristics of a healthy relationship. "All abusive behavior is designed to allow an abuser to achieve and maintain power and control. This wheel is helpful for understanding the overall pattern of abusive and violent behaviors, used by a batterer to establish and maintain control over his partner"(Understanding Power and Control, 2020).

Using intimidation: making him/her afraid; smashing things; destroying property; harming pets; displaying weapons; "binders".

Using emotional abuse: put downs; name calling; mind games, humiliation, making someone feel guilty.

Using isolation: controlling what s/he does, sees, reads, where s/he goes, limiting outside involvement, using jealousy to justify actions, "Normalizing".

Minimizing, denying, blaming: making light of abuse; saying it didn't happen; shifting responsibility; saying s/he caused it, mindgames.

DOMESTIC ABUSE INTERVENTION PROGRAMS
202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.theduluthmodel.org

Using Children: guilt-tripping about children; using them to relay messages; using visitation to harass her/him; threatening to take the kids away; a tie that binds.

Using male privilege: treating her/him like a servant; making all the big decisions; "Master of the Castle"; defining gender roles; Culture/ Religion.

Using economic abuse: preventing her/him from getting/ keeping a job; making her/ him ask for money; giving allowance/taking money; not allowing access to family income; Golden Rule.

Using Coercion and Threats: making and/or carrying out threats to hurt; threatening to leave; threatening suicide; reporting to "Welfare"; dropping charges; doing illegal things; maintenance behaviors.

Using Intoxication as an excuse: denying or minimizing the existence, severity, or impact of abusive behavior; blaming or otherwise shifting responsibility for abusive behavior; lying about, concealing, withholding or admitting information; situations to gain advantage; pretending to be a victim to gain sympathy, support, or allies.

Using Technology: sending unwanted text messages; breaking into someone's social networking profile, Emails or cellphone; pressuring someone to take, send, or look at sexual images (Griffit, 2017).

ANNEX 2
Children's Domestic Abuse Wheel

This example presents the consequences of domestic abuse between partners/spouses for a child. It is a visual representation of the negative effects on a child's health, emotional development, self-esteem and vulnerability. These negative consequences have a long-term impact on a person's life from childhood to adulthood.

Emotional Abuse: fear of doing the wrong thing; fear of expressing feelings; inability to learn at school; low self-esteem.

Physical & Mental Effects: feeling guilt and shame; thinking it's their fault; may regress to earlier stages of development.

Sexual Abuse: shame about their body; feeling threatened and fearful about their sexuality; access to pornography.

Using Children: being put in the middle of fights; being asked to take sides; parentification.

Threats: Learning manipulation; expressing anger through violence or not at all due to fear.

Sexual Stereotyping: copying abusive, dominant behavior; copying passive, submissive behavior.

Intimidation: fearing for physical safety.

Isolation: inability to develop social skills; can't have friends over to hide violence; keeping secrets; not trusting others (Griffit, 2017).

Adapted from the Domestic Abuse Intervention Centre, Duluth, Minnesota

ANNEX 3
Equality wheel

The Equality Wheel depicts the qualities involved in healthy relationships. It shows the changes needed for men to move from being abusive to having a non-violent partnership (Free Social Work Tool, 2021). It is applicable to all forms of relationships; with friends, dating partners, intimate partners, life partners, or family members. Each component of the wheel supports and reinforces the others, with equality always at the center. The Equality wheel can be used by anyone as a guide to maintaining healthy patterns in a relationship (The Equality Wheel, 2008). This type of relationship is characterized by kindness, strong communication, healthy boundaries, shared values, intimacy, vulnerability and respect (Free Social Work Tool, 2021).

The Center of the Wheel is Equality: Equality is the foundation of any healthy relationship.

Non-Threatening Behavior: talking and acting so that s/he feels safe and comfortable expressing her/himself and doing things.

Respect: listening to her/him nonjudgmentally; being emotionally affirmative; understanding and valuing opinions.

Trust and Support: supporting her/his goals; respecting her/his right to her/his own feelings, friends, activities and opinions.

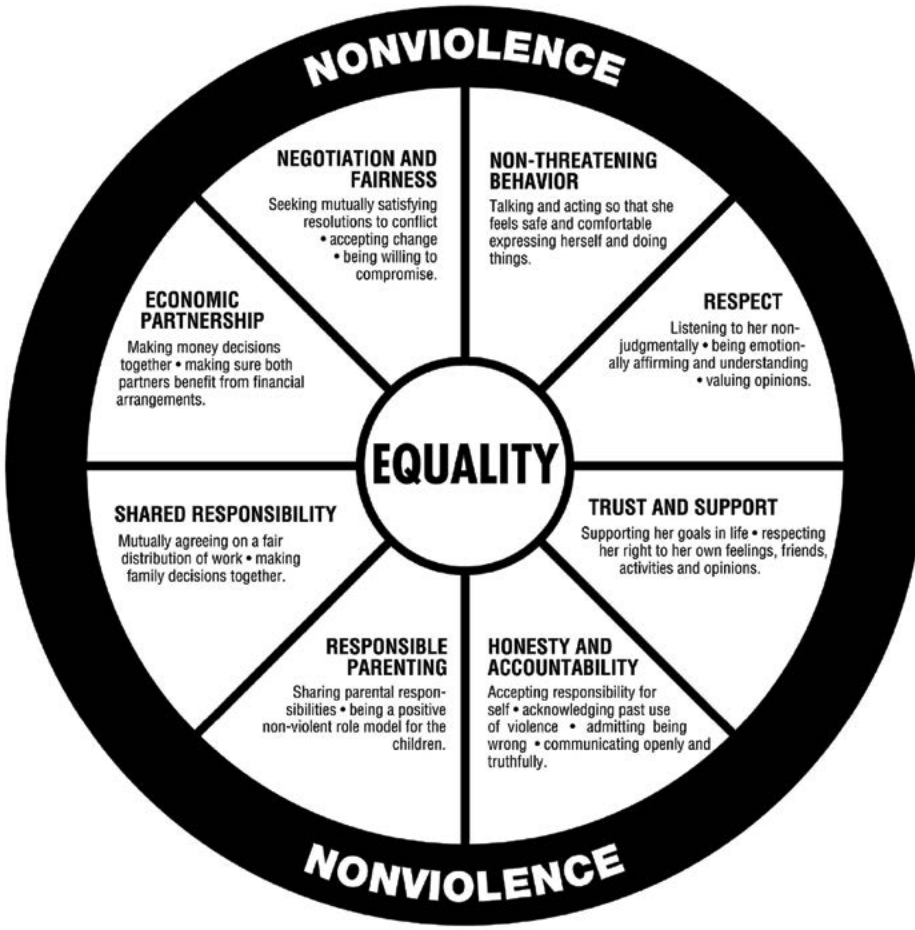
Honesty and Accountability: accepting responsibility for self; acknowledging past use of violence; admitting being wrong; communicating openly and truthfully.

Responsible Parenting: sharing parental responsibilities; being a positive non-violent role model for the children.

Shared Responsibility: mutually agreeing on a fair distribution of work; making family decisions together.

Economic Partnership: making financial decisions together; making sure both partners benefit from financial arrangements.

Negotiation and Fairness: seeking mutually satisfying resolutions to conflict; accepting change; being willing to compromise (Griffit, 2017)



ANNEX 4
A Family's Story

Before getting married, Edita and Robert were friends for seven years. They met while studying in the capital city, where both of them had come from small regional towns. While still studying, they settled down and, after completing their studies, began to plan for a shared future. It was not easy for young professionals to find jobs that would allow them to settle in the capital city - to buy a house and meet their other needs -so they both decided to go abroad.

Periodic commuting back and forth for seasonal work lasted five years. Their joint work yielded results: the couple bought a car, set up a shared home in the capital city and decided to settle in Lithuania more stably.

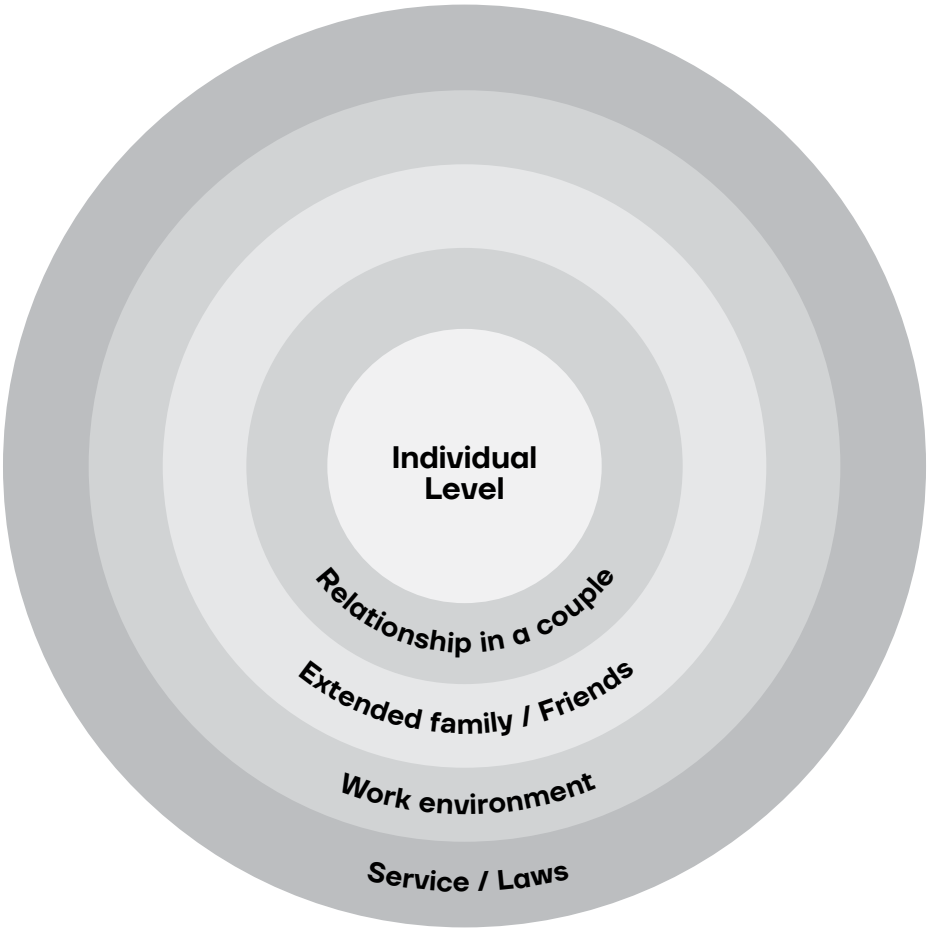
Edita easily found a job as a lawyer in an international company. Robert had a harder time. He tried to get a job with several companies, but the working conditions and were not satisfactory, so he decided to start a business related to production. It would have been too expensive to rent premises in the vicinity of the capital, so Robert moved the production process to his hometown around 200 km away and saved money on both the rented premises and labor costs. He spent most of the week in the small town and met Edita on the weekend when he came to the capital city.

The couple got married and soon had a daughter. Robert's friends joked that he would now be able to gain additional qualifications: how to change diapers, play and put the baby to sleep. However, he was focused on the business, leaving the entire burden of raising their baby to Edita. Edita could not expect any help or support from her own kin, so she decided to move closer to her husband and his parents. However, this did not change the situation drastically. Robert continued to work overtime and constantly returned home late. He always found an excuse about how time-consuming business was and how tough a world it was. He distanced himself from their daughter, did not want to change diapers, and was unwilling to hold their baby in his arms or engage in nurturing. e participated in bathing their daughter for the first time when she was six months old (standing alongside his wife). He refused to carry his daughter in the courtyard without Edita and was not prepared to feed her at mealtimes.

As the girl grew up, Edita searched for a kindergarten for when she was unable to look after their daughter. However, due to the unavailability of kindergartens, she had to search for a babysitter. Unfortunately, prices for such a service were very high and took up more than half of Edita's salary, so she started thinking about staying at home longer with their child and temporarily dropping out of the labor market. This decision seemed perfectly rational to her, knowing that her child could get sick and her job environment was not family-friendly. She could barely get days off for family reasons, much less flexible work arrangements or part-time work. She had to make the decision on her own, because Robert was not interested in her concerns.

Robert's agenda did not take childcare into account. "No one knows these issues better than you," he used to say.

ANNEX 5
The Target



ANNEX 6.
Time Division[8]

	Mother	Father	Son	Daughter	Family member X
6:00					
6:30					
7:00					
7:30					
8:00					
8:30					
9:00					
9:30					
10:00					
10:30					
11:00					
11:30					
12:00					
12:30					
13:00					
13:30					
14:00					
14:30					

8 This time use table can be adapted to different family constellations, also e.g. for single fathers, for patchwork families, for gay fathers

15:00					
15:30					
16:00					
16:30					
17:00					
17:30					
18:00					
18:30					
19:00					
19:30					
20:00					
20:30					
21:00					
21:30					
22:00					
22:30					
23:00					
Paid work					
Unpaid work					
Personal needs					
Leisure					

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CHAPTER 4

Early Childhood Development: The entry point to gender socialization and gender equity via fathers' engagement

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& Dr. Konstantina Rentzou

Introduction

Early childhood development refers to the cognitive, physical, language, motor, social and emotional development of children from conception to the age of eight years. The first years of a child´s life are the years of endless opportunities, but at the same time the years of great vulnerability. This is a time of rapid development, brain cell growth, and fast learning. During the early years, the foundations of life's productivity and overall wellbeing are built.

To fully develop and thrive children need nurturing care (UNICEF, et al., 2019), which includes an enabling environment created by parents and other caregivers that ensures children's good health and nutrition, protects them from threats, and gives young children opportunities for early learning, through interactions that are emotionally supportive and responsive (World Health Organization et al., 2018).

The primary responsibility for providing nurturing care to young children lies with parents or other primary caregivers, although this does not mean that they are the only ones responsible. And yet, parents and the family in general are according to the Convention on the Rights of the Child (UN General Assembly, 1989, p. 1) "the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children". Parents are so important that, according to research, parents' practices "are twice as predictive of a child's success in early learning as a family's socioeconomic status" (UNICEF, 2017, p. 3).

Parenting practices or parenting can be understood as interactions, behaviors, emotions, knowledge, beliefs, attitudes and practices associated with the provision of nurturing care (UNICEF, 2017, p. 3).

Given the multiplicity of roles and the importance of parenting practices, to be able to provide nurturing care to their children parents/caregivers and families have the right and need to be supported by empowered communities and services and by enabling policies.

Gender equity and gender socialization in early years and the role of parents

Although parenting practices refer to the practices adopted by both mothers and fathers, both in practice and in theory/research, parenting practice is primarily equated to the practices of mothers. The matrifocal view of parenting and caring neglects in most instances the role of the father. In addition, it contributes to sustaining gendered social norms as studies from a variety of disciplinary fields highlight that the early years are fundamental for a variety of "developmental outcomes relevant to gender equality, including the cognitive and affective formation of gender identity and stereotypes, and the range of skills learned by girls and boys through teacher-child interactions and gendered childhood play" (Chi, 2018, p. 4).

> **Gender equity:** this entails the provision of fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognizes that women and men have different needs and power and that these differences should be identified and addressed in a manner that rectifies the imbalances between the sexes. It is used to describe the processes that will be adopted to achieve gender equality (Women's Health East, 2017, p. 5).

Gender socialization starts at birth as children are taught from the moment they are born the stereotyped gender norms, attitudes and expectations of their community and society by parents/caregivers, educators and other influential

adults – through the way they model gender roles and relationships, respond to children's behavior and communicate with young children (Plan International, 2017). Gender is one of the first social categories that children are aware of: by age three, most children have formed a gender identity.

> **Gender socialization:** the process through which girls and boys learn about the gendered norms, attitudes and expectations of their community and society: how they are supposed to behave, what their future role will be, and how they are valued differently. Children learn these norms, attitudes and expectations right from birth, from parents/caregivers, educators and other adults – through the way these model different roles and behaviors for men and women; treat girls and boys differently; encourage specific activities for girls and boys; communicate different expectations as to how girls and boys should behave; and explicitly teach girls and boys different things in preparation for success in adult life (Nandyose et al., 2018, p. 3).

Given that parents are children's first educators and primary caregivers, they have a central role to play in children's gender equity and gender socialization right from birth. This is because parents influence children's gender development by role modeling and encouraging different behaviors and activities in their sons and daughters (Leaper, 2014).

Research data suggest that what parents do, rather than their gender ideology or attitudes, is most impactful in influencing how children form gender role attitudes (Nandyose et al., 2018). For example, preferences for a boy or girl can affect parents'/caregivers' interactions with babies right from birth (UNICEF, 2011). Thus, throughout their lives, parents, along with other adults and peers, impose gender beliefs and practices – whether conscientiously or unconscientiously - via their interactions with children and by promoting specific play styles and behaviors. Leaper (2014) maintains that gender-typed expectations may occur regarding personality traits (e.g., "boys are aggressive"), abilities (e.g., "girls are good at reading"), activities, and roles (e.g., "men are scientists").

According to UNICEF's (2011, p. 39) report, "this early socialization process sets a gendered trajectory for their development that shapes virtually all aspects of

life". Identifying with certain toys, activities and role models according to one's gender can therefore be very limiting to children's experiences and development (Women's Health East, 2017).

For a child, a strong parenting alliance is the first, most potent and continuously present model of gender-balanced togetherness, equality and interaction that respects both diversity and cooperation. A parenting alliance is an enriching relationship between parents, which is independent from their alliance as partners. It relates to agreements regarding how to raise the child, values, parenting style; how they are going to grow in their parental roles and support each other; how to divide home errands, etc. (ISSA&UNICEF ECARO, Module 18).

Fathers and other male caregivers in caring roles

Fathering and father involvement and its important role in early childhood development and gender equity has attracted research attention since the 1970s and has gone through several phases, from emphasis on the consequences of fathers' absence to emphasis on fathers' active involvement (Schoppe-Sullivan, McBride & Ringo Ho, 2004). This research has highlighted that the child-father relationship is not simply an imitation of the child-mother relationship, rather that men are also biologically wired to care for infants.

The term "father" carries several assumptions that may not be completely accurate given the changing family structure. In the AAP guideline on fathers, father is defined broadly as "the male or males identified as most involved in caregiving and committed to the well-being of the child, regardless of living situation, marital status, or biological relation." Along with the biological father, this definition includes foster fathers, stepfathers and grandfathers. (Yogman et al., 2016)

Fathering practices - the way and the extent to which fathers are involved in their children's care, education and upbringing - is ever changing as an emerging role and profile of fathers as true co-parents appears. In the past, the societal attitude

was that the father's main role in their family was to provide material support and income, while every other type of involvement in their children's care and education was somewhat discouraged (Fogarty and Evans 2009a). However, this societal attitude seems to have changed and "sociology has observed that patriarchal specialization tends to erode with the weakening of gender hierarchies in post-industrial societies" (Wood & Eagly, 2002, 717). Nowadays, fathers are becoming more and more involved in their children's care and education and they assume a wide variety of roles in their family. Yet fathers, and other males in caregiving roles, are still seen as the secondary caregiver, the "helper", if they are seen in their caregiving roles at all (Barker, Levtov & Heilman, 2018).

However, the "matrifocal" view of caring, as well as the matrifocal approach to programs, practices, data analysis and policies, limits our understanding of human caregiving and child development (Abraham & Feldman, 2018). Research data also highlight that "fathers' childcare involvement is negatively related to children's gender stereotyping and that through active involvement in childcare, fathers demonstrate that the adult male role may include nurturing as well as instrumental activities" (Leaper, 2014).

The multiplicity of fathers' roles

How parents and other adults can support children's gender development

- Exposing them to various types of feminine and masculine toys and activities and to counter-stereotypical models (e.g. policewomen, male nurses).
- Creating play environments well suited to both boys and girls.
- Avoiding gender-stereotyped comments and challenging children's biases and gender stereotypes.
- Making sure children have plenty of opportunities to interact with and learn from boys and girls through mixed-gender activities.

Mothers and fathers play different roles in the family system (Finley, Mira and Schwartz 2008). However, although maternal roles are well established, the roles fathers may assume and the concept of their involvement have long been debated (Schoppe-Sullivan, McBride & Ringo Ho, 2004). Thus, the differences in roles may be grounded in differences in cultural perspectives, whereas what constitutes a good father may be highly dependent on cultural, historical and familial ideologies (Lamb & Tamis-Lemonda 2004).

Many forms of paternal care and involvement have been documented throughout history, and anthropology has identified substantial variations in fathers' roles. Fathers' involvement can take many different forms such as:

1. **Engagement** (fathers' direct contact and shared interactions with the child in one-on-one activity such as playing, feeding, etc.)
2. **Accessibility** (fathers' potential availability for interaction: by virtue of being present or accessible to child, a parent is physically and psychologically available to the child, whether or not via direct interaction),
3. **Responsibility** (the role the father takes in ascertaining that the child is taken care of and arranging for resources to be available to the child)
4. Other qualities, such as paternal warmth, support, control/monitoring, and other cognitive and affective behavior, as well as economic support (Lamb et al., 1987; Pleck, 2007).

In general, fathers' involvement can be grouped into two broad categories (Torres et al., 2014, 188):

- **Indirect investment -** the provision of subsistence means and accumulation of capital
- **Direct investment -** proximal processes of interaction with the child

Pleck (2010) has discerned between two distinctive elements of direct involvement:

a. positive engagement activities and
b. dimensions of parenting quality.

According to McWayne et al. (2013), positive engagement activities focus on the time spent with the child during interactive activities which are most likely to facilitate learning and development (e.g., reading, playing outside, teaching). Dimensions of parenting quality, on the other hand, focus on how fathers engage with their children, and which parenting style they have (Authoritative, Authoritarian or Disciplinarian, Permissive or Indulgent, Neglectful or Uninvolved) according to Baumrind's (1967) parenting style framework (McWayne et al., 2013, 900).

Palkovitz (1997), acknowledging the need for a multidimensional approach to fathering, identified 15 major categories of parental involvement:

- Communication (talking, listening, expressing love),
- Teaching (role modeling, disciplining, encouraging interests and hobbies),
- Monitoring (looking after schoolwork, knowing who child's friends are),
- Thought processes (worrying, planning, praying),
- Errands (driving child someplace, picking up needed items),
- Caregiving (feeding, bathing, caring for a sick child),
- Child-related maintenance (cooking, laundry, repairs),
- Shared interests (reading together, developing expertise),
- Availability (attending/leading activities, spending time together),
- Planning (birthdays, vacations, saving for the future),
- Shared activities (shopping, playing together, working together),
- Providing (housing, clothing, food, healthcare),
- Affection (hugging, cuddling, tickling),
- Protection (monitoring child's safety, providing safe home environment and activities),
- Emotional support (encouraging the child, developing interests).

Fathers and other male caregivers should be involved from the beginning

Research shows that getting fathers involved early in their children's lives predicts their later involvement. Prenatal involvement by fathers, along with living with the mother, is the strongest predictor of their involvement by the time a child is 5 years old (Shannon et al., 2009). Fathers play an important role in supporting mothers during both the preparation for delivery and the delivery itself, and represent a source of support and comfort. According to the Fatherhood Institute, research findings generally indicate that men who understand the risk of pregnancy complications will support their partners' use of appropriate services, mothers who have a calm and supportive birth partner have better labors, and sharing the birth of their child can strengthen the parents' relationship. Some research shows how critical paternal involvement is just after a child is born: men who take 2 weeks or more to spend at home with a child after the birth are almost twice as likely to be involved in changing, feeding, cleaning, and caring for their baby at 9 months (ISSA/UNICEF, Module 5).

Benefits of fathers' and other male caregivers' engagement in ECD

Children's social, emotional, cognitive and behavioral development is boosted when fathers and other male caregivers are engaged. For example, playful interaction between fathers and children is associated with positive socio-emotional skills such as self-regulation and empathy with peers and others (UNICEF, 2017).

Additionally, research results highlight that fathers' involvement correlates to the following cognitive outcomes: children learn more; have better cognitive development and better school performance; show significant problem-solving skills (increased curiosity, greater resistance to stress and frustration, more willingness to try new things); and have enhanced cognitive skills (verbal skills, higher scores in tests of cognitive ability).

Researchers from the Murdoch Children's Research Institute, Australia, have found that when fathers read to their children at home, the child's language development increases with age. Children whose fathers read to them when they were two years old had better language development at age four. (source: https://www.firstfiveyears.org.au/early-learning/why-reading-with-dad-matters)

Fathers are reading models, especially for boys, preventing them from seeing reading as a feminine activity. (https://www.psychologytoday.com/us/blog/reading-minds/201906/fathers-roles-in-reading)

A father's involvement also plays an important role in a child's socio-emotional development. Children show healthier behaviors, have fewer behavioral problems, exhibit more empowered and improved social skills (more understanding, self-esteem and self-control and less impulsive behavior, higher resilience) and also appear to have more developed self-confidence and they manage their emotions better (Rentzou, 2017). Physical engagement, so called "rough and tumble" play in which fathers engage more than mothers, fosters resilience in children, promotes more risk-taking and strengthens decision-making skills in children from the earliest age (Fletcher et al., 2013).

Breaking down gender stereotypes from a young age helps to stop the negative consequences of inequality and discrimination as children grow into adults, and means that children aren't limited by expectations based on their sex. By providing children with environments that encourage non gendered norms and expectations, children can feel more accepted and celebrated for their individuality. They can broaden their aspirations and be more likely to reach their potential.

(Women's Health East, 2017, p. 15)

Studies show that when fathers are involved in their daughters' lives from a young age, they are at less risk for early puberty, early sexual experiences and teenage pregnancy. Additionally, fathers serve as role model and affect the way gender roles are perceived, for example, boys who have seen their own fathers engage in domestic work and caring for children are more likely to be involved in housework and caregiving. This "intergenerational transmission of care" can be a key factor in transforming gender relations and ending gender inequality, opening a wider range of future possibilities for both boys and girls (ISSA& UNICEF ECARO, Module 5).

Women's relationship satisfaction, general well-being and happiness are all improved. The strongest influence on a mother's adjustment to motherhood is her partner's adjustment to fatherhood. Supportiveness by fathers is linked to lower parenting stress and postpartum depression in mothers, a better birth and higher breastfeeding rates. Additionally, women with involved partners have a greater chance of employment and participating in society. In Sweden, where paternal leave is legally assured, it has been estimated that each additional month of parental leave taken by the father increases the mother's earnings by 6.7 % (Johansson, 2010).

Fathers'/men's overall satisfaction, health, and relationship satisfaction are improved, and the probability of conflict and violence is reduced. Research shows that caretaking causes cerebral and hormonal changes in men (as in women) that facilitate nurturing and bonding. Within 15 minutes of holding a baby, men experience raised levels of hormones associated with tolerance/trust (oxytocin), sensitivity to infants (cortisol) and brooding/lactation/bonding (prolactin) (ISSA&UNICEF, Module 5).

Society as a whole benefits from the creation of cycles of gender equality, from boys' acceptance of gender equality to girls' sense of autonomy. Engaged fatherhood can also help protect children from violence, abuse, exploitation, and neglect, and it can help ensure their access to health and education (Barker, Levtov & Heilman, 2018).

Barriers to male caregivers' involvement during the early years: What is missing?

Barriers to fathers' involvement in their children's care, education and upbringing as well as to services and programs that are addressed to parents fall under two main categories: those at the policy level and those in practice.

At the policy level, policies may tacitly or actively discourage fathers' engagement, for example, through the structure of social benefits, or through the provision of parental and paternity leave (Fletcher et al., 2014, p. 8).

For example, recent data on paid paternity leave highlight that:

- Out of 41 EU and OECD countries, 26 offer paid paternity leave;
- Paid paternity leave is shorter than maternity leave (usually 1–2 weeks);
- Paid paternity leave is often paid at a higher rate;
- 16 of the 26 countries guarantee 100% salary;
- The number of countries offering leave for fathers rises when parental leave, which follows paternity leave, is included;
- Out of 41 countries, 32 reserve paid leave for fathers through either paternity leave or parental leave (Chzhen, Gromada & Rees, 2019).

While paternity leave is available in many countries, uptake is low for many different reasons. The main reasons for low uptake of parental leave are of a financial nature or connected with breaking cultural norms at the workplace and society as a whole (van Belle, 2016).

In practice, a wide variety of organizational aspects influence fathers' decision to participate significantly, as well as practitioners' efforts to encourage or discourage father involvement. Specifically, as far as fathers' participation in social services and programs is concerned, Glynn and Dale (2016) suggest that the following influencing factors:

1. Organizational philosophy and goals: In many cases, programs and services do not address the family as a system, but rather target explicitly or implicitly only mothers. Thus, fathers' non-participation is not addressed as an issue. However, (social) services must intentionally and proactively target fathers and adopt inclusive strategies, informed by barriers they themselves have identified as preventing fathers' participation, in order to involve more fathers, as well as designing services that are relevant and accessible to fathers.

2. Characteristics of the program leader: Fathers are intimidated by professionals who do not understand and address their role and the challenges they may be facing. Research results highlight that fathers are more likely to participate in programs and services that are led by professionals who are helping, inclusive of males, and understand the importance of fathers' engagement.

3. The environment of the program: Programs and services addressing parents and children use largely matrifocal representations and messages. And yet the environment should be welcoming, comfortable and supportive for fathers (e.g. displays with fathers, information aimed at fathers, etc.).

4. Locations and times of parenting programs: Offering convenient and flexible hours and locations, such as planning program delivery for the evening or weekend and selecting father-friendly venues, such as parks, recreational sites or sports clubrooms, may encourage father participation.

5. Program content and delivery style: The content should be interesting and relevant to fathers and include topics which concern fathers directly. Fathers also seem to prefer more task-oriented rather than process-oriented programs.

6. Advertising the program: It is important for the program to be advertised in places where it is more likely to be seen by fathers. Other effective strategies include word of mouth and explicit invitations from the program leader.

7. 'Gatekeeping': Mothers' and professionals' attitudes may have an impact on fathers' participation in parenting programs.

In addition to the above barriers at the policy level and in practice, the extent to which fathers will be involved (if at all) and the ways they will do so are also associated with societal attitudes towards gender roles, as well as social and gender norms including fathers' unlikelihood to ask for support. Thus, a father's educational level and age have also been found to affect the extent to which they adopt a more gender balanced sharing of care work.

The effect of social attitudes on sharing care work is more than evident in time use. Existing research highlights that women spend 3 times as much time as men every day on caring for the home and for children, and that the younger the child, the more time woman spends on childcare. According to the results, even when paid parental leave is available for fathers, in many countries, fathers account for less than one in five of those taking parental leave. The share of men among parental leave users goes up to 40% or more in some Nordic countries and in Portugal, but is as low as one in fifty in Australia, the Czech Republic and Poland (OECD, 2016).

Fathers' engagement during Covid-19

- Fathers spend more time at home and this could be an opportunity for them to engage more in unpaid care and domestic work.
- The pandemic may contribute to a redistribution of care and domestic work but what this crisis confirms is that it is necessary to continue working on analyzing the factors which perpetuate gender roles (Belloso, 2020).
- The coronavirus pandemic has brought a new sense of urgency to many of the challenges women have faced for a long time.
- The care burden on women is higher due to the pay gap and social norms.
- The extra use of fathers does not automatically lead to fewer tasks for mothers (Yerkes, 2020).

According to a recent study:

- 22% of fathers say they care for their children relatively more than in the time before the coronavirus crisis.
- That care includes homeschooling and homework assistance.
- 17% of fathers say they do more around the house than their partner.
- The division of labor remains unevenly distributed.
- 65% of mothers still report doing more than fathers.
- Fathers (only the highly educated) have become relatively more concerned with their partners (Kreizer, 2020)
- Of all parents (especially those with an essential profession), 20% have started to worry less, with fathers and mothers hardly differing - especially parents with an essential profession, who are less concerned about their children than before the coronavirus crisis.

Source: https://www.nrc.nl/nieuws/2020/05/25/vaders-doen-sinds-coronacrisis-meer-in-huis-zeggen-ze-a4000711

Facilitating fathers' involvement through inclusive practices

Research highlights that, without deliberate measures to develop and incorporate father-inclusive practice into all aspects of service delivery, service providers will overwhelmingly concentrate their efforts on mother/child dyads (Fletcher, et al., 2014, p. 5).

Some of the strategies that can support fathers' involvement:

Welcoming fathers	Using inclusive language (Moms and Dads), images of fathers in brochures, posters, materials, messages etc.
Avoiding deficit model of fathering – promoting a strength-based approach	Instead of seeing fathers as incompetent, disinterested and uncommitted, their competences should be promoted, and they should be recognized as experts regarding their own children.
Involving more men in the workforce	The presence of men can send the message that men are w elcome, and male facilitators and fathers themselves can increase fathers' participation: they are usually trusted; and they can create a dialogue by sharing personal experiences.
Introducing male-friendly policies and practices	This can include creating male-friendly spaces, offering programs and activities outside of working hours, offering online services, utilizing spaces outside of the services, having more hands-on activities, peer discussions, informal gatherings etc.
Building on fathers' interests	Asking fathers what they want
Continuous professional development for staff on fathers' involvement.	Staff attitudes towards fathers' involvement are of utmost importance, so staff need adequate training and continuous professional development to develop positive attitudes and engage in working with fathers.

A small intervention with great impact:

In Grantham, Lincolnshire, in the UK (2009), two Home Visitors conducted a comparative study in which one continued to use the standard letter about the primary birth visit ("Dear parents") while the other used a new father-inclusive version ("Dear new mum and dad"). With the standard letter 3 out of 15 dads attended. With the father-inclusive letter 11/16 dads attended. (Module 5: Engaging Fathers, p. 18)

Facilitating gender equity at home and within public services

The ideas below, which are adopted from Women's Health East (2017) resource guide, can be used by both professionals working within ECD fields and as parents in order to assist them in breaking gender stereotypes.

Step 1. Self-reflection

As mentioned above, the first step towards promoting gender equity at home and in ECD services is to be aware of our own biases and values. Below a list of indicative questions, which can be answered by professionals in cooperation with their coworkers and/or by both parents.

1. What are some of my own biases, values and belief systems in relation to gender?
2. How might these gender values / beliefs influence the way I interact with (my) children? Do I engage differently with boys and girls?
3. How can I model a positive attitude towards gender equality in my everyday activities, actions and conversations with (my) children? What am I already doing?

4. How can I promote and strengthen gender equality in my (parenting) practice?

Step 2. Consider carefully the materials and displays available at home/public services

Materials and displays (e.g. posters, the color of the furniture, etc.) also transmit messages about gender expectations. Therefore, it is important to reconsider the messages conveyed by the materials we use with children in our everyday (parenting) practice. For example, when reading a book with children that presents gender stereotypes it is important to draw children's attention to that and discuss it with them so as to challenge those stereotypes. Similarly, children should be encouraged to use all toys while playing and not "gendered toys", and should also be encouraged to play in ways that aren't constricted by gender.

Step 3. Be a role model

Whenever possible, give examples of how you or people you know like to do things outside of gender stereotypes. For example, as a father tell your child(ren) how much you like to cook and cook for them frequently. If children relate colours, professions, etc. with gender, set the example by questioning them and offering counterexamples from your own knowledge or experience.

Concluding remarks

In order to achieve gender equity and for violence prevention through father involvement, all relevant stakeholders (starting from mothers and fathers themselves to international organizations, communities and countries) should "think bigger, commit to bold action, and set ambitious goals" (Heilman et al., 2017, p. 14). Moreover, this action should be taken up immediately, since father involvement may be characterized, according to Doucet (2011), as "a quiet revolution, a resilient problem, and one persistent puzzle". In fact, although fathers' involvement has increased in recent years and fathers assume new roles in their children's education, care and upbringing, "it is estimated that at the current rate of global progress, it will take 75 years to achieve equality in this work" (Heilman et al., 2017, p. 14).

In addition, research suggest that father involvement occurs along a continuum as fathers find different ways to become actively involved in their children's lives. This finding, combined with the fact that internationally fatherhood is "in the process of reconstruction and transformation" (O'Brien, 2004; as cited in Lero, Ashbourne and Whitehead, 2006, p. 5) calls for systematic efforts aimed at creating a clear international picture of fatherhood.

Fatherhood and father involvement are socially constructed concepts. In light of the changes and shifts in the role of women and men, of mothers and fathers, it is imperative to reconsider social constructions and representations and inform our nomenclature about the 'involved', 'good' father.

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APPENDIX 1.

Conceptual frameworks and tools

A vast number of frameworks and tools have been developed with the aim of supporting parents (including fathers) to get involved in their children's development and learning in a more nurturing way. Some of the frameworks presented below are addressed to parents in general whereas others have been created in an effort to increase father involvement.

Nurturing Care Framework[9]

The Framework builds upon state-of-the art evidence of how child development unfolds and of the effective policies and interventions that can improve early development. It outlines: why efforts to improve health and well-being must begin in the earliest years, from pregnancy to age 3; the major threats to early childhood development; how nurturing care protects young children from the worst effects of adversity and promotes physical, emotional and cognitive development; and what families and caregivers need to provide nurturing care for young children.

Standards for ECD Parenting Programs in Low- and Middle-Income Countries[10]

The aim of this document, published by UNICEF, is to guide practitioners interested in early childhood development through a set of recommended standards for parenting programs. The document addresses the challenge of implementing programs that do not have the expected outcomes, by presenting a set of program standards built to evidence. The standards cover a range of good practices that a program could offer to parents and highlight the importance of developing culture-specific content.

9 For more information see https://www.who.int/maternal_child_adolescent/child/nurturing-care-framework/en/

10 For more information see https://www.unicef.org/earlychildhood/files/UNICEF-Standards_for_Parenting_Programs_6-8-17_pg.pdf

Supporting families with nurturing care resource modules for home visitors[11]
These Resource Modules for Home Visitors, which have been developed by ISSA and UNICEF ECARO, are intended to better equip home visitors with the latest knowledge and tools to support and engage with the families of young children. The Modules are developed with a strengths-based, family-centered orientation towards practice, using evidence-informed approaches, developing both knowledge and skills in important areas relevant to home visits. Some of the modules in the package equip home visitors with new skills, others with new knowledge. The package also includes a Training Methodology handbook which can be used by Master Trainers to train home visitors. Module 5: Engaging Fathers and Module 18: Gender socialization and gender – Dynamics in families

ParentWorks[12]
ParentWorks is a free online program for Australian parents and caregivers of children aged 2 to 16. It provides evidence-based parenting strategies to improve parenting skills, confidence and child behavior. This means that the strategies in the program have been tested and found to work. Parents and caregivers may find this program helpful for:

- Managing challenging child behaviors such as tantrums, aggression, noncompliance, inattentive or hyperactive behavior, sibling conflict, getting ready for school and/or bed, and behaviors outside the home, such as problems in the supermarket
- Increasing their confidence in parenting
- Working as a team with their partner

The barbershop toolbox[13]

The Government of Iceland has developed the Barbershop concept with the aim to encourage men and boys to engage actively in promoting gender equality and to provide them with the tools they need in order to address inequality and become agents of change.

11 For more information see https://www.issa.nl/modules_home_visitors

12 For more information see https://parentworks.org.au/#/ and https://www.likefatherlikeson.com.au/for-fathers/

13 For more information see https://www.heforshe.org/en/barbershop

HeforShe[14]

This refers to the United Nations global solidarity movement for gender equality. It is an invitation to men and people of all genders to stand in solidarity with women to create a bold, visible and united force for gender equality.

Program P: A Manual for Engaging Men in Fatherhood, Caregiving, and Maternal and Child Health[15]

Program P ("P" for "padre" in Spanish and "pai" in Portuguese, meaning "father") provides concrete strategies for engaging men in active caregiving from their partner's pregnancy through their child's early years. It identifies best practices on engaging men in maternal and child health, caregiving, and preventing violence against women and children.

Strengthening CSO-Government Partnerships to Scale Up Approaches to Engaging Men and Boys for Gender Equality and SRHR: a tool for action[16]

This tool provides guidance on best practices to promote strong partnerships between civil society organizations and government representatives on engaging men and boys in gender equality and sexual and reproductive health and rights (SRHR). Its goal is to strengthen these relationships in order to enable the scaling up and/or institutionalization of evidence-based approaches.

State of the world's fathers action plan (Heilman et al., 2017)

At both a national and international level, the action plan suggested in the "State of the world's fathers" report can be used to promote action.

Engaging Fathers in Parenting Programs[17]

Engaging Fathers in Parenting Programs is a free, national training program for staff aiming to improve skills for engaging, working with, and retaining fathers in parenting services or interventions. The Best Practice Guidelines for Engaging

14 For more information see https://www.heforshe.org/en

15 For more information see https://promundoglobal.org/resources/program-p-a-manual-for-engaging-men-in-fatherhood-caregiving-and-maternal-and-child-health/

16 For more information see https://promundoglobal.org/resources/strengthening-cso-government-partnerships-engaging-men-boys/

17 For more information see https://www.likefatherlikeson.com.au/practitioner-training/

Fathers[18] has also been developed and constitutes a comprehensive resource to support this training program.

Father Support Program – ACEV

The program has been implemented in Turkey since 1996 and aims to encourage fathers to take responsibility in the care of their children, to establish a democratic relationship with their children and to support their development effectively. The educational program, which is updated in line with scientific developments and social needs, poses positive changes in fathers' attitudes towards child rearing, and significantly increases their knowledge of supporting the development of their children.

18 Available here https://www.likefatherlikeson.com.au/lfls/assets/File/Engaging%20Fathers%20Workbook%202017.pdf

CHAPTER 5
Monitoring and evaluation

Caroline Ferraz Ignacio

Introduction

The success of gender-synchronized programs can be measured in different ways, but it is important to seek to understand if your program works, why it works and how it can work better, as well as what types of intended and unintended consequences a project generates, in order to allow practitioners to reduce harm, promote benefits within the target communities and optimize scarce resources. Implementing a monitoring and evaluation (M&E) plan can help provide these insights.

This chapter is designed to help groups working on gender transformative programs to conduct M&E. By building on the example of PARENT, it aims to provide a real-world experience to highlight the basics of M&E, in addition to specific considerations that should be taken when conducting M&E of gender transformative programs. First, this chapter will introduce some of the key concepts of M&E. Then we'll dive further into the M&E process of PARENT.

A gender-synchronized results-based evaluation

Step 1: Understanding the program

When designing a results-based evaluation of a gender synchronized program, the first step is to get a clear idea of the problem the program wants to address and how your program will address it. In this context, PARENT – **P**romotion, **A**wareness **R**aising and **E**ngagement of men in **N**urture **T**ransformations – was a partnership to pilot a gender-synchronized approach aimed at promoting

gender-transformative and synchronized approaches by engaging men in co-responsible parenting and caregiving, and their participation in an equal share of unpaid care work in four European countries. By doing this, the project also aimed to contribute to preventing domestic and intra-familial GBV.

The **specific objectives** of the PARENT pilot were to:

1. Address the gaps in the EU related to engaging fathers in caregiving by providing the public health sector with tools and targeted training to promote greater involvement of both mothers and fathers in maternal and child health.
2. Increase awareness of GBV and the importance of engaging men in strategies to combat violence against women and children.
3. Increase gender equity in caregiving and promote engaged fatherhood.

The **expected results** of the PARENT pilot were:

- Increased **awareness** and **activities** regarding the importance of engaging men in active fatherhood and gender-equitable caregiving to promote the eradication of violence against women and children.
- Increased **engagement** of men as fathers, more **gender-equitable attitudes** and **behaviors** in caregiving and a decrease in violence against women and children.

To achieve these objectives, project implementing partners, together with local partners providing services directly to families, in Portugal (PT), Austria (AU), Italy (IT) and Lithuania (LT), designed and implemented context-specific adaptations of the Program P methodology developed by Promundo[19] through four (4) work packages, as summarized in Table 1.

19 More information on Program P is available at https://promundoglobal.org/programs/program-p/.

Table 1. Description of PARENT work packages (WP)

WP	WP Title	Lead Partner	Description
1	Management and Coordination	CES	General management and coordination of the project, communication and dissemination activities
2	Fatherhood in the Health Sector	CES	Promotion of health care professionals engaging men in the health sector and promoting active fatherhood. Focuses on interaction between health professionals and fathers from prenatal through to postnatal stages and how to encourage their participation in caregiving
3	Engaged Fatherhood	CES	Implementation of education groups for fathers and their partners, as well as other men engaged in care work
4	Mobilizing your community	CES	Implementation of national campaigns designed for health sector and education workers and activists who are interested in developing and implementing social-awareness-raising activities in their communities that promote the benefits of active fatherhood as a way to achieve gender equality, benefit children and improve the lives of men and women

This methodology recognized the need to work at multiple levels through a series of complementary activities, including: a) engagement directly with healthcare

workers to prepare them for involving men in the health sector and promoting active fatherhood, b) group education for fathers and their partners to question gender norms and challenge gender-inequitable attitudes and practices, and, c) community/ institutional mobilization and campaigns focused on promoting active fatherhood from an intersectional perspective, displaying the diversity of masculinities at the community level. This three-pronged approach utilizes a **socio-ecological model** to foster and sustain change in attitudes and behaviors at multiple levels (Figure 1) and catalyzes change by stimulating critical reflection on the status quo and by questioning gender stereotypes (Figure 2).

Figure 1. PARENT levels of intervention.

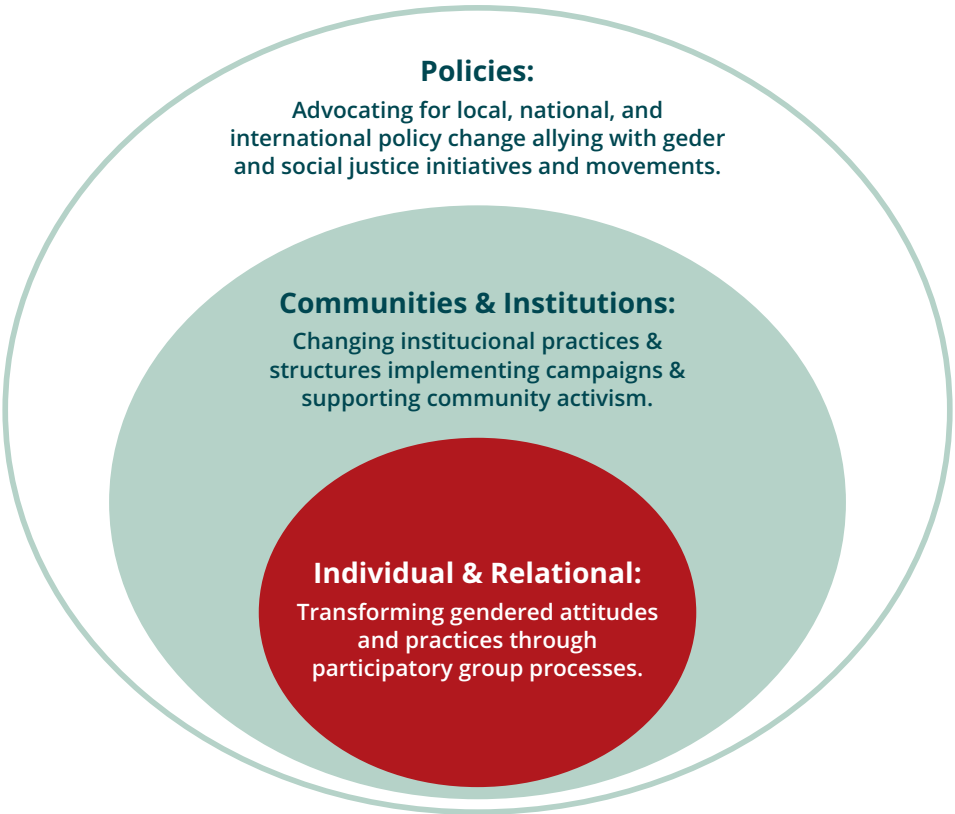
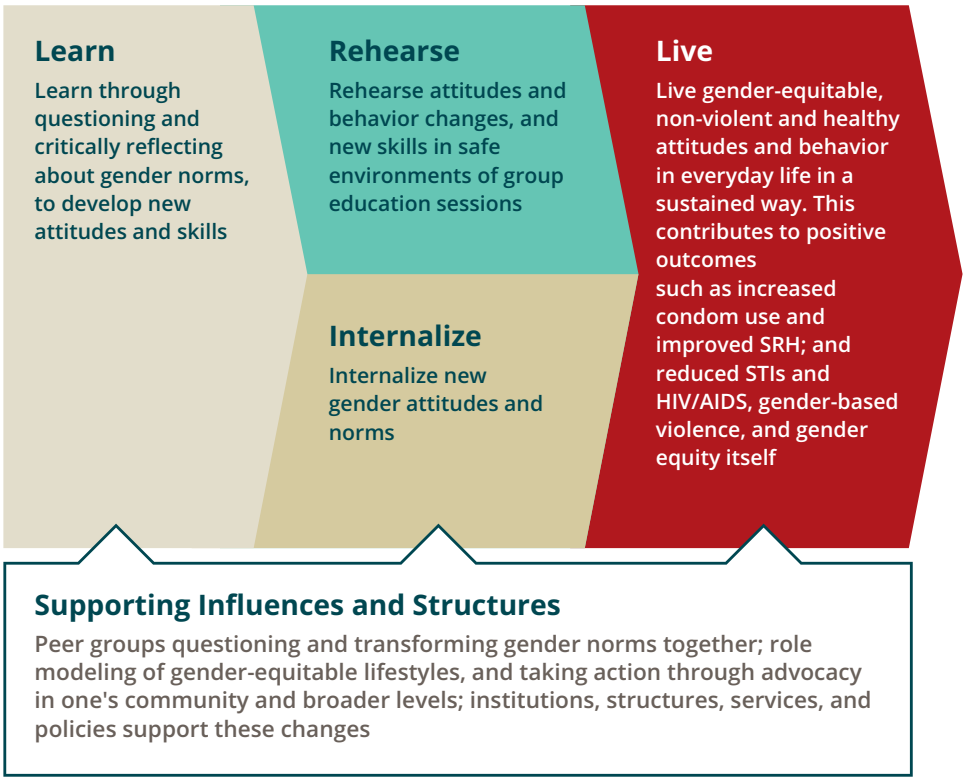


Figure 2. General change model of the Program P methodology.



The **key assumptions** underlying the project design were:

- Intersectionality is required to address different power relations and must always be present in the interventions addressing gender attitudes and roles.
- Everyone is affected by gender norms and attitudes. Gender norms are restrictive, narrow and unrealistic and most people fail to fulfil these requirements.
- Gender attitudes are an underlying cause of GBV and violence as a means of conflict resolution.
- Modifications of gender attitudes can result in modifications of gender norms and of behaviors.

- The health sector is an appropriate space for delivering the program and provides a productive space for participants to promote the participation of fathers in caregiving.
- Health professionals and men who participate in this intervention will apply these lessons to their daily interactions.
- Emancipative pedagogy, which allows for reflection on gender requirements, is preventive to violence.

Considering the aims of the project to promote more gender-equitable attitudes and behaviors between individuals and throughout communities, following an intersectional perspective, the project identified as main **target groups**: parents and caregivers, professionals who interact directly with these families, and institutions. The groups, shown in Figure 3, were chosen to gain a broad reach of actors engaged in the project who work in various areas of gender-based violence prevention and gender-equitable caregiving promotion and other related areas. It covered a wide range of healthcare professionals and those who work with refugees and children with disabilities. The implementing partners identified specific target beneficiaries from within each group that would be most relevant given their country contexts.

Figure 3. Primary beneficiaries of PARENT.

Parents/ Caregivers	Professionals	Institutions
• Adult men and women, including asylum seekers, refugees and migrants	• Prenatal health care professionals • Maternity professionals • Healthcare centre professionals • Special education professionals (working with children with disabilities) • Professionals working with asylum seekers, refugees and migrants	• Directorate-General of Health • Secretaries of State for equality • Representatives of ministries (e.g. Men's Department at the Ministry of Social Affairs in Austria) • Regional and local public authorities (e.g. Città metropolitana)

The selected **professionals** received training on themes related to gender, GBV prevention and the promotion of engaged fatherhood. The training was focused on preparing professionals to incorporate gender-synchronized approaches into their professional roles as they engage with parents/caregivers, their colleagues and the institutions to which they belong. Although WP 1 focused on health professionals, the parameters were broadened to allow the implementing teams to include special education professionals and those working with asylum seekers, refugees and migrants as deemed appropriate.

In addition to the work carried out with professionals, the project directly engaged **parents/caregivers**, as part of WP 3, in education and discussion groups.

Curriculum Development

At this stage, PARENT was a pilot program to develop and pilot adapted curricula based on the Program P methodology. The implementing partners received training on Program P and monitoring and evaluation. They were responsible for conducting needs assessments in their settings and then developing their program curriculum and implementation plan. This process allowed for the flexibility to develop a curriculum specifically designed to attend the needs related to the promotion of gender equality, engaged fatherhood and GBV prevention in each local context.

Program Delivery

The interventions were implemented according to context and each country's implementation of the pilot varied. It is important to note that every team had to adjust their program delivery significantly as a response to the COVID-19 pandemic by developing mitigation plans based on the specifics of the local context, which were submitted to and approved by the funders. For example, in **Austria** training courses for health professionals were developed in multiple formats: e-learning curriculum and tools (in case in-person training remained impossible due to COVID-19), or as face-to-face training of different lengths (short sessions of 1-2 hours or longer sessions of 2 to 3 days). In **Portugal,** due to the pandemic, all health and education services adopted strict measures that did not permit the implementation of in-person workshops and training – whether with health and education professionals or with fathers. As such, the team adapted the curriculum to be implemented via a virtual platform with all of the target groups.

Ethical Considerations

All appropriate measures were taken to follow the European Convention on Human Rights and preserve ethical principles of avoiding harm, maintaining confidentiality and preserving consent through voluntary participation.

Beneficence – The pilot dealt with sensitive themes relating to the private lives of families. The implementing partners also recognized that the healthcare setting itself carries considerations of vulnerability and power dynamics. To guarantee the principle of beneficence, critical reflection regarding the ethics of addressing gender, GBV prevention and caregiving took place among the implementing partners before and during designing the curricula.

Confidentiality - Confidentiality was a priority for evaluating the pilot. To ensure confidentiality, the implementing partners did not record the names or any other identifying information of participants when collecting data. All partners were trained on privacy and confidentiality. All forms with identifying information (e.g. attendance sheets, field diaries etc.) were kept separate from participants' questionnaire and interview responses.

Voluntary Participation – All participants invited to participate in the pilot program were informed that their participation was voluntary and that they would also be asked to participate in its evaluation by providing data through surveys/ questionnaires or individual / group interviews. Participants in WP 2 (i.e. health professionals) were informed that they would not be negatively impacted by their participation or non-participation with regard to supervisors or colleagues in their workplace. Participants in WP 3 (i.e. parents/caregivers) were informed that their quality of or access to healthcare or other services would not be impacted by their decision to participate or not participate in the pilot program.

However, due to the nature of the program as a pilot for new adaptations of a methodology and the creation of new training curricula among small groups of beneficiaries, not all partners submitted their pilots to ethical review boards.

Step 2: Planning the evaluation

The evaluation design needs to be based on the purpose of the evaluation and what is possible based on the program design, timeline, budget and evaluation questions. In general, evaluations occur at the end of the program or at benchmarks, usually specific transition points during the program such as between project phases, to determine if and how the program has achieved its objectives with a focus on the results and goals. There are different types of evaluations depending on the questions posed and when the evaluation was designed. Although important contributions come from implementation monitoring and theoretical evaluations, in this chapter we will focus on impact evaluations using specific examples from PARENT.

The results of a project are the changes that can be attributed to its activities, whereas the impacts are the long-term results. Typically, practitioners, funders and policy makers prioritize results-based evaluations as they speak directly to a project's effectiveness, or ability to achieve the intended results within the target population. In addition to effectiveness, results-based evaluations look at other domains, such as efficiency, sustainability and impact. The **purpose of the evaluation in the PARENT pilot** was for each PARENT pilot implementing partner to compile and analyze existing program data in order to understand the **effectiveness of the pilot in obtaining its expected results** and to guide future implementations or scale-up. As such, the evaluation focused on reach and effectiveness, or the extent to which the project achieved the desired results, and the key evaluation question was: *to what extent were the expected results obtained and how?*

To do this, the expected results were broken down into 5 specific research questions:

1. What changes can be identified in **awareness** among (health) professionals on the importance of engaging men in active fatherhood and gender-equitable caregiving to promote the eradication of violence against women and children?
2. To what extent were **activities** regarding the importance of engaging men in active fatherhood and gender-equitable caregiving to promote the eradication of violence against women and children implemented?

3. What changes can be identified in terms of the **engagement of men as fathers** in health services?

4. What changes can be identified in **men's gender attitudes**?

5. What changes can be identified in men's **behavior** in terms of caregiving and the use of violence against women and children?

Considering these guiding research questions for the evaluation, it focused on two groups of target beneficiaries: parents/caregivers and professionals. For this chapter, data was consolidated and synthesized from the implementing partners to highlight examples that answer the research questions.

The evaluation methodology can be determined based on the purpose of the evaluation. There are many types of indicators and evaluation designs that can be used. For more information, please refer to the recommendations in a previous gender-transformative program in the EU (EQUI-X).[20] Regardless of the types of indicators selected by the project team, indicators need to be **useful** for your project and meet the practical criteria associated with the timeline, budget, team and activities. You should be able to collect the required data for your indicator through reasonable and responsible use of resources. PARENT's evaluation strategy had to be implemented in light of the COVID-19 pandemic, which provided a perfect example of prioritizing the immediate context needs. For example, service providers and caregivers were experiencing extreme stress during this period, which meant that priorities and resources shifted in order to address essential and/or emergency services. This also meant that monitoring and evaluation strategies had to be adjusted to fit the context.

Step 3: Implementing the evaluation

In the PARENT pilot, all implementing partners utilized non-experimental designs to evaluate their pilot programs. The most common technique was the use of pre and post-test instruments. The country teams received training

20 The Engaging Youth in the Promotion of Non-Violent and Equitable Masculinities (EQUI-X) project manual includes a chapter exclusively focused on gender-transformative evaluations that provides further background on key terms and the theory behind results-based evaluations. The publication is available from: http://equixproject.eu/wp-content/uploads/2019/11/Guide-EU.pdf

on monitoring and evaluation tools, specifically on evaluating gender transformative programs. Overall, the training covered suggestions regarding research design, instrument construction and application, and analysis. It is important to emphasize that each country team had the flexibility to develop their own context-specific adaptation of the instruments and to design, implement and analyze the research. As such, evaluation methodologies varied between countries. For example, in **Austria**, only post-evaluations were used for e-learning training courses and for short training sessions of up to one day.

To support development of the evaluation tools, the Portuguese team shared their tools as models, emphasizing in particular the use of the Gender Equitable Men (GEM) Scale as a tool to assess gender attitudes. The GEM Scale was developed in 2001 by the Population Council/Horizons and Promundo based on qualitative research regarding gender norms in Rio de Janeiro, Brazil. Although developed in the context of 18-29-year-old Brazilian men, it has been successfully adapted to different age groups ranging from 10 to 59 years, including women and girls in schools and middle/high income communities in various countries. The Scale includes statements related to gender roles divided into five categories: home & child-care; sexual relationships; health and STI prevention; violence; and homophobia and relations with other men.[21]

As the global pandemic of COVID-19 altered the implementation of the curriculum, the **data collection** also had to be adapted accordingly. Considering this challenge, the change model is used to identify results that should be correlated with the implementation of the project, and the most **ethical**, **feasible** and **methodologically rigorous** strategy should be implemented to try to establish a causal relationship between the project and those results. Each team designed and implemented evaluation strategies to meet the needs of their contexts.

Quantitative instruments were used to assess the baseline and resultant

21 Pulerwitz J., Barker G. Measuring Attitudes toward Gender Norms among Young Men in Brazil: Development and Psychometric Evaluation of the GEM Scale. *Men and Masculinities*. 2008;10(3):322-338. doi:10.1177/1097184X06298778. Available from: https://promundoglobal.org/resources/measuring-attitudes-toward-gender-norms-among-young-men-in-brazil-development-and-psychometric-evaluation-of-the-gem-scale/

characteristics (knowledge, attitudes, and practices) of health professionals in Italy, Lithuania and Portugal. Overall, teams conducted the pre-test virtually with professionals and caregivers - direct beneficiaries - before beginning workshops, educational sessions, or any other intervention. The post-tests were conducted as early as possible – sometimes immediately - after workshops. Data analysis was also conducted by each implementation partner, who then developed their own databases, technical notes and country reports.

This publication combines each country's reports to extract contextual information, themes and key data. As such, one limitation of this document is that each implementation team's analysis of their data varied in terms of method and complexity, and this report will primarily present descriptive analysis of the common core items. This evaluation is summative in the analysis of the effectiveness of the interventions and formative in the production of knowledge to guide future iterations of similar programs.

Step 4: Understanding the data

Once the data has been collected, analysis should focus on answering the evaluation questions. Data below from Italy, Lithuania and Portugal have been used as examples of how to answer the evaluation questions. The examples contain a variety of data collection methods (Tables 2, 6 and 7) using both quantitative and qualitative techniques.

First, data from **Italy** is used to answer the evaluation questions focused on health professionals (Table 2). Table 2 shows the evaluation questions, the data sources and the questions used to gather data from health professionals.

Table 2. Example of PARENT evaluation question data sources related to health professionals from Italy

Evaluation Question	What changes can be identified in **awareness** among (health) professionals on the importance of engaging men in active fatherhood and gender-equitable caregiving to promote the eradication of violence against women and children?
Data source	Questionnaire to assess healthcare workers attitudes
Questions	Level of (dis)agreement with the following items: • The involvement of the father / partner during pregnancy visits is important • Written protocols promote the involvement of the father / partner during the birth process (pregnancy, childbirth, first years of life) • Healthcare facilities should organize meetings for fathers / partners and mothers on the birth path • The presence of the father / partner during labor and delivery is important • Healthcare facilities should provide specific educational material intended for fathers / partners • Healthcare facilities should allow free access to fathers / partners • Healthcare facilities should provide a changing table in the men's room • Healthcare professionals should encourage the presence of the father / partner during the child's health visits • Posters and pictures on the walls of health facilities should include pictures of fathers
	Gender attitudes: • It is ridiculous for a boy to play with dolls. • It is the woman's responsibility to avoid pregnancy. • The couple should decide together whether to have a child. • To be a man you need to be strong. • Women have the same right as men to work outside the home. • Changing diapers, bathing and feeding children are the mother's responsibility.
	Degree of "usefulness" of the following items: • childcare and domestic work are shared between father and mother

Evaluation Question	What changes can be identified in terms of the **engagement of men as fathers** in health services?
Data source	Questionnaire to assess healthcare workers' practices Questionnaire to identify the adoption of protocols within the health centres
Questions	Self-declared frequency of behaviors: • If the mother comes to the antenatal visit alone, I ask about the father / partner • When the father / partner is present, I provide information and guidance on how he can support the mother during pregnancy • I actively offer information to the father / partner on the [paternity and/or parental] leaflets available in Italy • I provide information directly to the father / partner on antenatal and postnatal care • I encourage the father / partner to be present during labor and delivery (after verifying the mother's consent) • I offer guidance on how the father / partner can provide support (physical and psychological) to the mother during labor and delivery • I explain to the father / partner how to register the boy or girl in the registry office • I talk to the father / partner about the possibility of registering the boy or girl with the surnames of both parents • When the father / partner is present I encourage his future participation • I record the presence or absence of the father / partner during labor and delivery • I provide the father / partner with information on how to support the mother during breastfeeding • I encourage skin-to-skin contact between the newborn and the father / partner, e.g. during the hospital stay, during hospitalization in the NICU or after returning home • I actively invite the father / partner to hold the infant or child in their arms • When the father / partner is present, I provide him with information and guidance on the child's health and development • I promote father / partner participation and fair division of all care and domestic activities

Protocols adopted by the health center

- Are there written protocols in your facility that involve the father / partner during antenatal visits?
- Are there written protocols in your facility that involve the father / partner during labor and delivery?
- Are there written protocols in your facility that involve the father / partner during child health visits?
- Is there screening for domestic violence during the birth process in your facility?
- Is there a treatment path in your facility for cases of domestic violence during pregnancy?

Open question: As a result of this training, have you or any others taken proactive action to involve fathers? (e.g. protocols, meetings, networks between services or with the territory, etc....)

In the Italian example, 129 he alth professionals ranging from 0 to 46 years of professional experience (average 20.6 years) answered the pre-test questionnaire. 91.5% (118) of the respondents were women and 7.0% (9) were male. 105 health professionals participated in the post-test. No statistically significant differences were detected among the demographic characteristics of the participants between the pre- and post-tests.

Table 3. Degree of (dis)agreement among health professionals in Italy with gender roles and attitudes (before and after)

Item	Level of (dis)agreement (n, %)				
	Pre-test (n= 129)		Post-test (n=105)		
	Agree or totally agree	Disagree or totally disagree	Agree or totally agree	Disagree or totally disagree	Percentage point change in agreement
The involvement of the father / partner during pregnancy visits is important.	124 (96.1)	3 (2.3)	103 (98.1)	1 (1.0)	+2.0
Written protocols promote the involvement of the father / partner during the birth process (pregnancy, childbirth, first years of life).	82 (63.6)	20 (15.5)	64 (61.0)	17 (16.2)	-2.6*
Healthcare facilities should organize meetings for fathers / partners and mothers on the birth path.	124 (96.1)	2 (1.6)	104 (99.0)	1 (1.0)	+2.9
The presence of the father / partner during labor and delivery is important.	119 (92.2)	3 (2.3)	104 (99.0)	1 (1.0)	+6.8
Healthcare facilities should provide specific educational material intended for fathers / partners.	121 (94.5)	2 (1.6)	103 (98.1)	1 (1.0)	+3.6
Healthcare facilities should allow free access to fathers / partners.	122 (94.6)	2 (1.6)	102 (97.1)	1 (1.0)	+2.5
Healthcare facilities should provide a changing table in the men's room.	108 (83.7)	3 (2.3)	97 (92.4)	0	+8.7
Healthcare professionals should encourage the presence of the father / partner during the child's health visits.	126 (97.7)	2 (1.6)	105 (100.0)	0	+2.3

Posters and pictures on the walls of health facilities should include pictures of fathers.	121 (93.8)	2 (1.6)	103 (98.1)	0	+4.3
It is ridiculous for a boy to play with dolls.	4 (3.1)	117 (90.7)	4 (3.8)	98 (93.3)	+0.7*
It is the woman's responsibility to avoid pregnancy.	3 (2.3)	123 (95.3)	2 (1.9)	101 (96.2)	-0.4
The couple should decide together whether to have a child.	124 (96.1)	2 (1.6)	104 (99.0)	1 (1.0)	+2.9
To be a man you need to be strong.	4 (3.1)	107 (82.9)	3 (3.0)	93 (88.6)	-0.1
Women have the same right as men to work outside the home.	121 (93.8)	4 (3.1)	101 (96.2)	3 (2.9)	+2.4
Changing diapers, bathing and feeding children are the mother's responsibility.	3 (2.3)	123 (95.3)	1 (1.0)	103 (98.1)	-1.3

Table 4. Self-declared frequency of behaviors of health professionals in Italy (before and after)

Item	Self-declared frequency of behaviors (n, %)				
	Pre-test (n= 129)		Post-test (n=105)		
	Always or often	Rarely or never	Always or often	Rarely or never	Percentage point change in "Always or often"
If the mother comes to the antenatal visit alone, I ask about the father / partner.	49 (38.0)	42 (32.5)	52 (49.5)	20 (19.0)	+11.5
When the father / partner is present, I provide information and guidance on how he can support the mother during pregnancy.	95 (73.6)	10 (7.8)	77 (73.3)	10 (9.5)	-0.3*

I actively offer information to the father / partner on the [paternity and/or parental] leaflets available in Italy.	48 (37.2)	57 (44.2)	49 (46.7)	44 (41.9)	+9.5
I provide information directly to the father / partner on antenatal and postnatal care.	71 (55.0)	38 (29.5)	83 (79.0)	14 (13.3)	+24.0
I encourage the father / partner to be present during labor and delivery (after verifying the mother's consent).	93 (72.1)	7 (5.4)	77 (73.3)	5 (4.8)	+1.2
I offer guidance on how the father / partner can provide support (physical and psychological) to the mother during labor and delivery.	95 (73.6)	8 (6.2)	74 (70.5)	8 (7.6)	-3.1*
I explain to the father / partner how to register the boy or girl in the registry office.	79 (61.2)	23 (17.8)	64 (61.0)	13 (12.4)	-0.2*
I talk to the father / partner about the possibility of registering the boy or girl with the surnames of both parents.	35 (27.1)	67 (51.9)	38 (36.2)	43 (41.0)	+9.1
When the father / partner is present I encourage his future participation.	102 (79.1)	15 (11.6)	94 (89.5)	5 (4.8)	+10.4
I record the presence or absence of the father / partner during labor and delivery.	28 (21.7)	42 (32.6)	22 (21.0)	33 (31.4)	-0.7*
I provide information to the father / partner on how to support the mother during breastfeeding.	96 (74.4)	23 (17.8)	83 (79.0)	18 (17.1)	+4.6
I encourage skin-to-skin contact between the newborn and the father / partner, e.g. during the hospital stay, during hospitalization in the NICU or after returning home.	90 (69.8)	17 (13.2)	70 (66.7)	14 (13.3)	-3.1
I actively invite the father / partner to hold the infant or child in their arms.	101 (78.3)	14 (10.9)	89 (84.8)	9 (8.6)	+6.5

When the father / partner is present, I provide him with information and guidance on the health and development of the child.	95 (73.6)	10 (7.7)	79 (75.2)	8 (7.6)	+1.6
I promote father / partner participation and fair division of all care and domestic activities.	101 (78.3)	15 (11.6)	83 (79.0)	14 (13.3)	+0.7

Table 5. Protocols in health centers as reported by health professionals in Italy (before and after)

Items	**Protocols adopted by the health center (n, %)**				
	Pre-test (n=129)		**Post-test (n=105)**		
	Yes	**No**	**Yes**	**No**	**Percentage point change in "Yes"**
Are there written protocols in your facility that involve the father / partner during antenatal visits?	12 (9.7)	102 (82.3)	9 (8.7)	57 (54.3)	-1.0*
Are there written protocols in your facility that involve the father / partner during labor and delivery?	26 (21.5)	89 (73.6)	27 (25.7)	38 (36.2)	+4.2
Are there written protocols in your facility that involve the father / partner during child health visits?	19 (15.4)	97 (78.9)	11 (10.5)	57 (54.3)	-4.9*
Is there screening for domestic violence during the birth process in your facility?	47 (36.4)	67 (51.9)	44 (41.9)	25 (23.8)	+5.5
Is there a treatment path in your facility for cases of domestic violence during pregnancy?	68 (52.7)	46 (35.7)	66 (62.9)	12 (11.4)	+10.2

The data from Italy (Tables 3, 4 and 5) show the greatest improvement in terms of health professionals' self-reported behaviors, especially those related to the provision of information on antenatal/postnatal care, parental leave, encouragement of his continued future participation, and registration of the child. This finding supports PARENT's first specific objective of supporting the public health sector with the tools needed for them to promote greater involvement of both fathers and mothers in maternal and child health. From the Italian data, suggested improvements in future iterations of PARENT could be greater attention to tools for fathers to support their female partners directly, such as information on family/paternity leave and emotional support.

In general, the health professionals presented generally equitable attitudes in the pre-test. At baseline, the least equitable attitudes were regarding the items: "Healthcare facilities should provide a changing table in the men's room" and "The presence of the father/partner during labor and delivery is important". Both items showed significant improvements in attitudes in the post-test.

The percentage point changes in tables 3 to 5 with an asterisk indicate change in an undesired direction. It should be noted that undesired changes were much smaller than the desired changes and are influenced by the small sample sizes. Health sector protocols faced particular challenges to desired changes because sanitary precautions related to the COVID-19 pandemic further limited opportunities for men to attend health centers with their partners. This contextual information is important considering that the greatest undesired change was in terms of protocols that involve the father in child healthcare visits. This example highlights the importance of not interpreting your data in isolation. In addition to the intervention itself, the results are influenced by the entire context in which the intervention was implemented. Both the intervention and context are likely to have influenced the large increase seen in the adoption of protocols for domestic violence as part of the birth path, since domestic violence concerns increased across the region during confinement.

The questionnaire applied to health professionals in Italy also included an open-ended question ("As a result of this training, have you or any others taken proactive action to involve fathers? (e.g. protocols, meetings, networks between services or with the territory, etc.)"). Of the respondents, 41.0% (43 people) provided positive responses, meaning that changes had already been applied or

a concrete plan put in place. 59.0% (62 people) responded that action had not yet been implemented. Of the respondents who reported no new proactive actions, reasons provided were related to limited time since the training for developing and implementing new processes, and biosecurity guidelines related to the pandemic.

Overall, the Italian findings suggest increased awareness and activity regarding the importance of engaging men in active fatherhood and gender-equitable caregiving to promote the eradication of violence against women and children. Support for protocols related to the promotion of fathers' involvement in maternal and child health, their creation and implementation should be the focus areas for continued work to further advance specific objective 1 of PARENT.

Next, data from **Lithuania** and **Austria** are used to answer the evaluation question focused on activity implementation (Table 6).

Table 6. Example of PARENT evaluation question data sources related to activity implementation in Lithuania

Evaluation Question	To what extent were **activities** regarding the importance of engaging men in active fatherhood and gender-equitable caregiving to promote the eradication of violence against women and children implemented?
Data source	Implementation records
Questions	What activities were implemented in terms of: • Service provider training • Fathers/male caregivers training • Communication campaigns

In **Lithuania**, the implementing team conducted 11 training sessions for social workers reaching 125 participants. The course load for these sessions was 24 hours of training: 16 hours of Synchronous learning and 8 hours of asynchronous, independent learning. The team also implemented educational groups with fathers: 2 separate groups and reaching 49 people. The course load for fathers' groups was 8 hours.

The team also conducted two cycles of training for trainers totaling 19 participants: one on 25 Nov 2019 with 10 trainers; and the second on 24 Feb 2020 with 9

participants. Additionally, the Lithuanian team conducted three meetings of the Technical Advisory Board.

As part of the communications campaigns, 11 leaflets[22] for parents, written in Lithuanian, were distributed at kindergartens to reach parents. Even in the context of the COVID lockdown, kindergarten directors reported that 714 families received the material during the period from April to June 2020. A National PARENT Fatherhood campaign was developed in a workshop with experts, pretested, and launched via the program website, social media, a podcast and written articles (blogs and newspapers). The national campaign included fathers' stories with pictures highlighting positive examples of engaged, caring fatherhood. Media monitoring was also used to analyze how the topic of fatherhood was portrayed across media channels during the initial national campaign. A second national campaign focused on debunking myths about childcare as the mother's mission in life, and highlighting the benefits of active fathers in the role of childcare for both children and men.

In **Austria**, 25 educational groups with 72 participants (fathers and fathers to be) were implemented either in person or virtually. The first 6 sessions were 12 structured modules, originally designed to be applied on 6 consecutive dates with two modules per 4-hour session. However, it was not possible to recruit enough fathers for a program of this level of intensity. Thus, the structure and duration of the fathers' workshops were adapted to a single session of up to 2 hours. Although the "low-intensity" sessions did not provide the in-depth training originally envisioned by the team, the implementers had to make strategic decisions based on the context and priorities of the action. The decision was made to prioritize spaces of initial reflection around masculinity and active fatherhood for a greater number of fathers, across more transformative spaces with a restricted number of participants. Among the results of the post-session survey, it was found that more than 80 percent of the participants were very satisfied with the session.

The activities implemented by the **Lithuanian** team show that activities on the importance of engaging men in active fatherhood and gender-equitable

22 The educational materials can be found at http://gap.lt/projektai/parent-vyriskumo-normu-kaita-isitraukiant-i-atsakinga-tevyste/

caregiving to promote the eradication of violence against women and children were implemented as expected. The **Austrian** data highlights that implementers need to be flexible to meet the context-specific demands and be prepared to use monitoring data to make changes.

Finally, data from **Portugal** are used to answer the evaluation questions focused on fathers. Table 7 shows the evaluation questions, data sources and questions used in gathering data from health professionals. These evaluation questions are focused on assessing the PARENT pilot's results related to increased engagement of men as fathers, andmore gender-equitable attitudes and behaviors in caregiving.

Table7. Example of PARENT evaluation question data sources related to fathers/male caregivers from Portugal

Evaluation Question	What changes can be identified in **men's gender attitudes**?
Data source	Questionnaire to assess fathers'/male caregivers' attitudes
Indicators	Level of (dis)agreement with the following items: • Men should defend their reputation even with force if necessary. • A gay man is not a real man. • A man who talks too much about his problems, fears or concerns does not deserve respect. • A man must always be willing to have sexual relations. • A real man should have as many sexual partners as he can. • A man shouldn't have to do domestic chores. • It is a woman's responsibility to avoid getting pregnant. • A woman's most important role is to take care of her home and cook for her family. • Changing diapers, bathing and feeding the children are the mother's responsibility. • It is important that a father is present in the lives of his children, even if he is no longer with the mother. • It is important to have a male friend that you can talk to about your problems. • Prenatal services are only for women. • Men's participation in prenatal services is unnecessary. • Men are not well received in prenatal services.

Evaluation Question	What changes can be identified in men's **behavior** in terms of caregiving and the use of violence against women and children
Data source	Questionnaire to assess men's intended behaviors
Indicators	Self-declared intended behaviors: • Take parental leave when the child is born • Take 15 days or more of parental leave when the child is born • Prepare my child's bottle or food (even if someone else is available to do so) • Change diapers (even if someone else is available to do so) • Give my child a bath (even if someone else is available to do so) • Change my child's clothes (even if someone else is available to do so) • Take care of my child's health (even if someone else is available to do so) • Take my child to medical appointments (even if someone else is available to do so) • Wash clothes (even if someone else is available to do so) • Play with my child (even if someone else is available to do so) • Sweep and do other chores (even if someone else is available to do so) • Prepare food for other adults (even if someone else is available to do so)

In the Portuguese implementation of PARENT, 23 fathers participated in the Portuguese pre-tests and 16 participated in the post-tests. Overall, the average age of fathers was 37.

Table 8. Level of (dis)agreement of fathers/male caregivers in Portugal with gender roles and attitudes (before and after)

Item	Level of (dis)agreement (n, %)				
	Pre-test (n= 23)		Post-test (n=16)		
	Agree or totally agree	Disagree or totally disagree	Agree or totally agree	Disagree or totally disagree	Percentage point change in Agreement
A real man should have as many sexual partners as he can.	0	23 (100.0)	0	15 (93.8)	0

A man who talks too much about his problems, fears or concerns does not deserve respect.	0	21 (91.3)	0	16 (100.0)	0
A man shouldn't have to do domestic chores.	0	23 (100.0)	0	16 (100.0)	0
Men should defend their honor/reputation even with force if necessary.	2 (8.7)	17 (73.9)	1 (6.3)	13 (81.3)	-2.4
A gay man is not a real man.	0	19 (82.6)	1 (6.3)	14 (87.5)	+6.3*
It is a woman's responsibility to avoid getting pregnant.	0	21 (91.3)	0	15 (93.8)	0
A woman's most important role is to take care of her home and cook for her family.	0	22 (95.7)	0	16 (100.0)	0
Changing diapers, bathing and feeding the children are the mother's responsibility.	0	23 (100.0)	0	16 (100.0)	0
It is important that a father is present in the lives of his children, even if he is no longer with the mother.	23 (100.0)	0	16 (100.0)	0	0
It is important to have a male friend that you can talk to about your problems.	19 (82.6)	0	13 (81.3)	1 (6.3)	-1.3*
A man must always be willing to have sexual relations.	1 (4.3)	13 (56.5)	0	12 (75.0)	-4.3
It's an outrage for a girlfriend to ask her boyfriend to use a condom.	1 (4.3)	22 (95.7)	0	16 (100.0)	-4.3
Prenatal services are only for women.	0	22 (95.7)	0	16 (100.0)	0
Men's participation in prenatal services is unnecessary.	0	22 (95.7)	0	15 (93.8)	0
Men are not well received in prenatal services.	1 (4.3)	13 (56.5)	0	15 (93.8)	-4.3

In general, the male participants in Portugal had very equitable gender attitudes. The items where participants exhibited less desirable gender attitudes at the pre-test were mostly related to attitudes around masculinity (what it means to be a real man and how real men should behave). Although the sample size was very small, it should be noted that items related to masculinity (specifically, around heteronormativity and the male relationships of "real men") saw percentage changes in an undesired direction. "Masculinity" refers to roles, behavioral patterns and features within a specific society considered to be characteristic of or desirable for men and related to the idea of being "a real man." The predominant view of the characteristics that "real men" should have varies according to time and place, and there are several "masculinities", or plural and dynamic ways that masculine norms, attitudes, identities, power dynamics and practices are lived.[23] Social understandings of masculinity significantly influence people's lives and current, hegemonic masculinity reinforces harmful stereotypes like hypersexuality, heteronormativity, acting tough and using violence, and rigid gender roles in the home. These rigid ideas of men's superiority and dominance are related to the use of violence (especially against women and girls), as violence in the traditional masculine model can be seen as an acceptable way of maintaining one's status.[24] Ideas on masculinity may also lead to intolerance and discriminatory practices; believing that sexist or intolerant actions or views are part of "being a man" can spark injustice and violence. These rigid attitudes are harmful to women, children and men themselves. Maternal and child health services should address gender attitudes directly related to women and children, but also masculinities in general, because rigid ideas around masculinity underlie and indirectly influence many negative behaviors addressed by health services.

Only slightly over half of the men questioned disagreed at the pre-test with the statement "men are not well received in prenatal service", but at the post-test 93.8% of the men disagreed. This suggests that it is possible to work with health service providers and with men to provide welcoming prenatal services that clearly include both women and men in their capacity as future and/or current parents.

23 Heilman, B., Barker, G., and Harrison, A., (2017). *The Man Box: A Study on Being a Young Man in the US, UK, and Mexico.* Washington, DC and London: Promundo-US and Unilever.

24 UN Women. (2016). *Self-learning booklet: Understanding masculinities and violence against women and girls*. https://trainingcentre.unwomen.org/RESOURCES_LIBRARY/Resources_Centre/masculinities%20booklet%20.pdf

Table 9. Self-declared intended behaviors of fathers/male caregivers in Portugal (before and after)

Behavior items	Self-declared intentions (n, %)				
	Pre-test (n=23)		Post-test		
	Yes	No	Yes	No	Percentage point change in "Yes"
Take parental leave when the child is born.	18 (78.3)	0	14 (87.5)	2 (12.6)	+9.2
Take 15 days or more of parental leave when the child is born.	7 (30.4)	-	6 (37.5)	-	+7.5
Prepare my child's bottle or food (even if someone else is available to do so)	21 (91.3)	2 (8.7)	15 (93.8)	1 (6.3)	+2.5
Change diapers (even if someone else is available to do so)	22 (95.7)	1 (4.3)	16 (100.0)	0	+4.3
Give my child a bath (even if someone else is available to do so)	22 (95.7)	1 (4.3)	15 (93.8)	1 (6.3)	-1.9*
Change my child's clothes (even if someone else is available to do so)	22 (95.7)	1 (4.3)	16 (100.0)	0	+4.3
Take care of my child's health (even if someone else is available to do so)	22 (95.7)	1 (4.3)	15 (93.8)	1 (6.3)	-1.9*
Take my child to medical appointments (even if someone else is available to do so)	21 (91.3)	2 (8.7)	15 (93.8)	1 (6.3)	+2.5
Wash clothes (even if someone else is available to do so)	15 (65.2)	8 (34.7)	12 (75.0)	4 (25.0)	+9.8
Play with my child (even if someone else is available to do so)	23 (100.0)	0	16 (100.0)	0	0

Sweep and do other chores (even if someone else is available to do so)	22 (95.7)	1 (4.3)	16 (100.0)	0	+4.3
Prepare food for other adults (even if someone else is available to do so)	18 (78.3)	5 (21.7)	14 (87.5)	2 (12.5)	+9.2

In terms of intended behaviors, most men intended to participate in childcare and domestic tasks even when someone else was available to do them. The activities with the lowest intended participation were related to general domestic tasks unrelated to childcare, such as washing clothes and preparing food for other adults. This finding suggests that gendered domestic roles may continue to exist even when men present gender equitable attitudes or behaviors related to caregiving. Fortunately, after the training, the tasks with the greatest increased intent were washing clothes and preparing food for other adults, suggesting that activities directed at fathers in the context of childcare can also address other gendered behaviors in the household. In the post-study, men also were more likely to intend to take parental leave and leave of 15 days or more.

Step 5: Identifying key lessons

When implementing gender-synchronized programming, one common barrier is the lack of understanding on the importance of using an intentional intersection of gender transformative efforts reaching beyond just women or just men. As such, programs often begin originally with one gender in mind and then realize that they need to develop creative and participatory strategies for expanding their work to become more responsive to both sexes. In PARENT, the need to include a synchronized approach was clear from the beginning, because maternal and child health services and interventions focused on caregiving in general have historically been directed towards women. This predominantly feminine approach ignores the roles that men can and should play in caregiving even from before conception. No one is born a 'specialist' in caregiving, and men are just as capable of providing the emotional and physical care needed by children. In addition to being capable of direct parenting, research shows that globally men also want to actively engage as caregivers: on average, 85% of fathers say that they would be willing to do anything to be highly involved in the early care of

their child and, among the participating countries in the region, that average was 91%.[25] And yet, the pressures men face from social norms limit their involvement as active caregivers.[26] These pressures can be related to perceptions of what men and women are expected to do, or injunctive norms, according to key members of their reference groups, which may be co-workers, family members, friends, or service providers.

Despite shared ability and desire to be actively engaged in their roles as parents, fathers still do not feel completely comfortable participating in prenatal services. Research shows that professionals may serve as gatekeepers to men's participation in caregiving by reinforcing mothers' traditional roles as the primary actors responsible for children through institutional practices, such as using the mother's name to identify the newborn in the maternity ward, and social cues used during interactions, such as predominantly directing discussions, questions and orientations towards the mother.[27] The PARENT pilot found an area for continued improvement to be in working with health professionals to recognize the importance of establishing gender equitable, inclusive protocols and following them within their institutions to promote the expectation that fathers be actively involved in the pre-conception, prenatal and postnatal phases, right into childhood.

The pilot program also shows that work with men to advance maternal and child health must adopt a transformative approach that reflects upon and questions underlying gender norms, specifically those related to masculinities, that perpetuate unequal caregiving practices and broader gender inequality. This key lesson can support future programs in advancing their strategies from gender-sensitive to gender-transformative and synchronized.

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