A process evaluation of Promotional Guides used by health visitors to support men's transition to fatherhood: a qualitative study

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Background

Health visitors in England, who are specialist public health nurses, are responsible for leading and delivering the national Healthy Child Programme (HCP) (PHE, 2021). They work with families from late in the antenatal period and following birth until the child reaches five years of age. This means that every family with a child under the age of five will have routine access to a health visitor. Through the delivery of the HCP health visitors play a crucial role in ensuring that every child has the 'best start in life', which is viewed as a fundamental to improve health and reduce health inequalities (NHS, 2021). The HCP includes a minimum of five contacts with every new family: antenatal health promoting visit, new baby review, six to eight week assessment, one year assessment, and two to two-and-a-half-year review (PHE, 2021). Through these contacts, health visitors can support new parents in their transition to parenthood, promote child development, improve child health outcomes and ensure families at risk are identified at the earliest opportunity (PHE, 2018). The first three of the five contacts provide opportunities to conduct comprehensive and holistic assessments of the expectant/ new mother's and father's needs. The Department of Health for England stated that the six to eight week health visitor visit "is crucial for assessing the baby's growth and wellbeing alongside the health of the parent, particularly looking for signs of postnatal depression" (DH, 2015, p-17). Health visitors are therefore in an ideal position to identify and address fathers' mental health and wellbeing needs as well as mothers.

Many health visiting services use the Promotional Guide system with both parents during their routine antenatal and postnatal six to eight week assessment. The

Promotional Guide system originated from the European Early Promotion Project (EEPP) in 2000 which was a primary health promotion and prevention programme provided by health visitors and other community health nurses across five European countries - the United Kingdom, Finland, Greece, Serbia and Cyprus (Puura et al., 2002). The Promotional Guide system is underpinned by the Family Partnership Model (FPM) (Davis and Day, 2010), which was designed to support parents' transition to parenthood and comprises Antenatal and Postnatal Guides to be used with parents by health visitors who have undergone relevant training (Day et al, 2014). The guides aim to support parental health and wellbeing; promote early fetal and infant development; and inform accurate, well-informed decisions about family needs, health behaviours and early intervention (Barlow and Day, 2016). The Promotional Guide system is a licensed programme that requires the professionals administering the guides to be appropriately trained and in receipt of regular supervision. The theoretical framework underlying the FPM emphasises the need for highly skilled professional communication. Training and supervision are essential for the effective and consistent delivery of this programme, as well as a face-to-face contact between the health professional and parents. The key components of this intervention are summarised in Figure - 1.

Figure 1: Key Intervention Components of the Promotional Guide System (Day et al., 2014)

Intervention Components
Staff training (skills) & supervision (quality)
Antenatal and Postnatal face-to-face contacts with mother and father
Antenatal and Postnatal Promotional Guides
Antenatal and Postnatal Topic Cards
Strengths and Needs Assessment
Partnership approach between parents and professionals

Although during the time of this study (June 2018 – June 2019), eighty-five NHS trusts across England were reported to use the Promotional Guides, little was known about health visitors' views of the use of these, how they were used in practice or barriers to effective implementation with fathers.

The feasibility of using the Promotional Guide system with fathers, including their engagement with, and acceptability of the intervention, and impact on their mental health and wellbeing was explored as part of the New Dad Study (NEST) which is reported elsewhere (Baldwin et al, 2021, under peer review). This paper reports the process evaluation undertaken, which explored health visitors' views of using Promotional Guides with fathers. Data collated included exploration of their level of engagement with and acceptability of the intervention, fidelity of delivery and reported impact on first-time fathers' mental health and wellbeing. Barriers and facilitators to delivery of the intervention are also discussed.

Aims & Objectives

The study aimed to explore:

1) health visitors' use of Promotional Guides with fathers

2) health visitors' assessment of father's mental health and wellbeing

3) facilitators and barriers to using Promotional Guides in practice

Method

A process evaluation, informed by the Medical Research Council guidance (Moore et al., 2015) was chosen to provide a logical approach to evaluating the intervention, providing a better undertaking on the context. Data capture using interviews and observation of practice enabled a better understanding of how Promotional Guides were used in practice. Interviews with health visitors provided in-depth perceptions of their use of Promotional Guides and undertaking observations enabled the researcher to understand what happened in practice with their use, providing a range of perspectives and better understanding of implementation of this complex intervention (Bowling, 2002; Ritchie et al., 2014). Verbal consent was obtained from parents, permitting the researcher to be present during their consultation with the health visitor and written consent obtained from all fathers and health visitors for interviews.

Questions were developed to inform each stage of the evaluation process to ensure appropriate, in-depth data capture to meet study aims (Table - 1).

Table 1: Questions relating to the process evaluation of the Promotional Guide system, based on guidance from Moore et al. (2015).

Process Evaluation Steps	Possible questions	Context
1. Fidelity	- To what extent was the intervention implemented consistently with the underlying theory and philosophy?	- Was it consistent with the principles of the Family Partnership Model – did the health visitors use partnership, strength based, parent-led approaches?
2. Dose delivered	- Were all intervention components delivered? - To what extent were all of the intended components of the intervention provided to the participants? - To what extent were all materials designed for use in the intervention used? - To what extent was all of the intended content covered? - To what extent were all of the intended methods, strategies, and/or activities used? - Was the intervention materials and advice well received by the providers?	- Were both the antenatal and postnatal Promotional Guides delivered? - Were all five core themes of the Promotional Guides covered in the discussions? - Did health visitors use the Promotional Guide topic cards to generate discussion? - Was there sufficient time to cover the required content? - Did health visitors allow parents to choose the topic guides for discussion? Did they use the family strengths/ needs framework? - What are health visitors' views of the Promotional Guides? Do they find it useful and acceptable?
3. Dose received	- To what extent were fathers present at intervention activities?	- Were all fathers present at this intervention, in line with the universal family offer in the UK?

	- To what extent were fathers engaged in the activities? - How did participants perceive the intervention? - To what extent did participants engage in follow-up? - To what extent did participants engage in recommended follow-up behaviour? - Was the intervention materials and advice well received by the participants?	- Where fathers were present with their partners, how engaged or involved did they feel? - Was it inclusive of fathers? Did they feel it addressed their needs? - Did fathers participate in both the antenatal and postnatal Promotional Guide contact? - Did fathers act on/ make any changes following the discussions taken place/ advice given during the Promotional Guide visits? - Did fathers find the Promotional Guides to be useful and acceptable?
4. Reach	- What proportion of the priority target fathers attended each session? How many participated in at least one session?	- This is a universal offer and therefore the target should be 100% attendance
5. Recruitment	- What procedures were used to invite/ attract fathers to participate in the intervention? - What were the barriers to involving fathers in the Promotional Guide contacts? - What planned and actual procedures were used to encourage continued involvement of fathers in the antenatal and postnatal Promotional Guide contact?	- Were fathers exclusively invited to take part in the Promotional Guide contacts – antenatally and postnatally? - Were fathers informed by the health visitors that the Promotional Guides were aimed at fathers as well as mothers? - Are health visitors guided by organisational policies to involve fathers in the Promotional Guide contacts?

	- What were the barriers to maintaining father involvement?	- Did health visitors face any barriers to maintaining engagement with fathers from the antenatal Promotional Guide contact through to the postnatal Promotional Guide contact?
6. Context	- What other barriers and facilitators influenced delivery of the Promotional Guide System to fathers?	- What factors in the organization, community, social/political context, or other situational issues could potentially affect either intervention implementation or the intervention outcome?

Study setting

Four London boroughs/administrative districts (two inner and two outer cities) whose population healthcare needs are served by two National Health Service (NHS) organisations were selected as study sites to support the recruitment of a diverse group of participants. Each site served a diverse socio-economic and cultural population, with minority ethnic groups representing 44%–69% of the overall total population of the borough selected (ONS, 2011).

Recruitment

Health visitors were recruited from the participating NHS sites. The researcher liaised with the managers of the health visiting teams at both organisations and asked them to disseminate information about the study amongst their teams. Participation was on a voluntary basis and those interested in participating were given a participant information sheet and asked to sign a consent form. Only qualified health visitors who were trained and experienced in use of the Promotional Guides were included.

Data Collection

A purposive sample of 11 health visitors across both study sites, who had the relevant experience, were interviewed to assess their perceptions of delivering this intervention to fathers. Participants were offered the option of face-to-face or telephone interviews. Of the 11, six were telephone interviews and five face-to-face. An interview topic guide (Appendix – A) was developed based on the process evaluation questions in Table 1 and piloted during the first two interviews. A fidelity checklist (Appendix – B) was also used for all interviews to ascertain whether the intervention was implemented consistently with the underlying theory and philosophy of the Promotional Guide system. The interviews were audio-recorded and transcribed using an approved transcription service. Participants were offered an opportunity to check their interview transcript for accuracy prior to analysis. The duration of the interviews varied between 11 and 32 minutes, with the average being 21 minutes. After completing eight interviews, the researcher noted that no new themes or codes were emerging from the interviews, however a further three interviews were carried out which confirmed that the content domain of the construct had been adequately populated. This ensured that data saturation was reached, which according to Guest et al (2020) can typically happen after 6–7 interviews in a homogenous sample. Field notes were written after each interview to record aspects of the interview not captured on the recording such as environment, context, general observations and thoughts.

Seven additional health visitors were observed using the Promotional Guides in practice. It was decided not to observe the same health visitors who were interviewed, to obtain a wider perspective on Promotional Guide use across the sites. The observations were informed by a checklist, also based on the process evaluation questions in Table 1 and the fidelity checklist (Appendix – C). The researcher (SB) attended Promotional Guide visits with the participating health visitors for which parental consent was obtained (by the health visitor) prior to each visit by telephone. Following introductions and a brief explanation of the study, the researcher positioned herself out of the health visitor and parents' eyeline to maintain a non-participant stance. In addition to the observation checklist, detailed fieldnotes were taken by the researcher at each interview, including descriptions of the setting, interactions and people present, as well as the researcher's own understanding and interpretation of what was happening. Although the researcher was a health visitor by background, she did not take an active part in any of the discussions between the health visitor and the parents.

The initial plan was to conduct five qualitative interviews and five observations at each site. This was achieved in one site, however at the other site six interviews and only two observations were completed due to the lack of Promotional Guide use during antenatal and postnatal contacts. This is considered further in the findings and discussion sections of this paper.

Data Analysis

Data were analysed by the first author (SB) using framework analysis and the five steps of data management for thematic analysis as described by Ritchie et al. (2014) to include familiarisation; constructing an initial thematic framework; indexing and sorting;

reviewing data extracts; and data summary and display. Framework analysis was chosen over other qualitative approaches due to its ability to answer specific research questions (Ward et al., 2013), in this case questions relating to the use of Promotional Guides with fathers in practice. It allowed the categories and themes identified in the data to be explicitly and systematically considered, while facilitating sufficient flexibility to detect and characterise new themes emerging from the data (Dixon-Woods, 2011). The findings were discussed amongst the research team (all four authors) at each stage before agreement was reached about the final themes. The computer software package NVivo (version 11) was used to facilitate this process.

Data from the observation of health visitors were incorporated into the initial thematic framework constructed from the health visitor interviews. This involved explicitly and systematically considering the observation data against the initial categories and themes identified from the interviews. Although this was a predominantly deductive process, the framework facilitated enough flexibility to detect and characterise any new themes which emerged. The focus of the observations was on the content and delivery method of the Promotional Guide system. The data obtained aligned well into the existing themes and subthemes of the initial framework with no new themes emerging.

Ethical Considerations

The study adhered to the Research Governance Framework for Health and Social Care and Good Clinical Practice (GCP). All methods were carried out in accordance with

relevant guidelines and regulations. Study participation was voluntary and written consent obtained from all participants. The interviews were transcribed with the principle of anonymity in mind and a confidentiality agreement was in place for the approved transcribing service used. Approval was obtained from the Health Research Authority (HRA) and given favourable opinion by London - Fulham Research Ethics Committee (IRAS no: 203629).

Results

In total 18 health visitors participated from the two NHS sites. Eleven participated in interviews and seven in observations of their use of Promotional Guides in practice. Participants' ages ranged from 25 to over 60; length of qualification as a health visitor ranged from under two years to over 20 years; and the majority worked full-time (n=13). Health visitors also came from various ethnic backgrounds: 44% described themselves as Black (including African, Caribbean and British), 44% as White (including English, Irish and other), 6% as Asian (other), and 6% as Mixed (White and Black African). Most health visitors (n=15) had received their Promotional Guide training in the past three years, with only three reporting to have been trained more than three years prior to this study. All health visitors reported to receive some form of supervision, the majority being in receipt of two to three different types from a range of supervision, to include preceptorship, restorative (an evidence-based model of reflective supervision used within health visiting), clinical, safeguarding, managerial, and peer supervision. See Table 2 for full participant characteristics.

Five main themes were identified from interview and observational data:

1. Inquiry into fathers' mental health
2. Promotional Guides in Practice
3. Health visitors' perceptions of the Promotional Guides System
4. Barriers to using promotional guides with fathers
5. Facilitators and recommendations for using Promotional Guides with fathers

1. Inquiry into fathers' mental health

Health visitors practice around asking fathers about their mental health and wellbeing varied. One participant described inquiring about the father's wellbeing before the mother:

"*It's always about asking about them first thing you enter the house, asking about their wellbeing before the woman. Usually that always helps because nobody's asking them*" (HV10).

Some health visitors did not pay as much attention to fathers' mental health as they did with mothers. Instead, they asked about fathers' general health rather than asking them specific questions on mental health.

"*I haven't really asked about mental health as such, but I ask how they - how do they feel about becoming parents, and do they understand how their life's going to change and how long have they been waiting for the baby?"* (HV2)

Only one health visitor mentioned assessing paternal mental health using the Whooley questions if the father was present during the visit (these questions (Whooley et al., 1997) are recommended in NICE guidance on Antenatal and Postnatal Mental Health (NICE, 2018) and include two questions on low mood and loss of interest or pleasure.

During the **observations**, most health visitors made general enquiries about how the father was feeling and discussed some of the changes they may experience following the birth of their baby. In two observations, health visitors asked fathers direct questions about their mental health; in two observation episodes, health visitors did not discuss paternal mental health at all.

2. Promotional Guides in Practice

Health Visitor involvement with Promotional Guides

Health visitors' involvement with use of Promotional Guides varied between the study sites. In one trust, the Promotional Guides were only used antenatally on a targeted basis. Although there were management expectations that Promotional Guides would be used universally at every antenatal contact, in practice they were only used on more vulnerable families (those with identified additional needs such as safeguarding, mental health, domestic violence etc):

"…*at the moment it's changed and we're only doing targeted families. So this is just families that, you know, there's concern*" (HV9)

"…. we are only doing antenatal contact for vulnerable clients" (HV8)

In the other trust, health visitors were expected to use the Promotional Guides antenatally and postnatally, however use varied between practitioners. Some used them routinely with all parents, some only antenatally, and some only when time allowed or when they felt it was necessary.

Six of the seven observations of Promotional Guides used in practice were of antenatal contacts and only one was a postnatal contact.

One health visitor considered it was easier to use the guide postnatally "*because with postnatal, you go to people's home and you have a control over your time …"* (HV1)

However, this view was not shared by all, with different expectations placed on the health visitors in the two trusts around the tools they should use to carry out the postnatal assessment. One health visitor explained the difficulties relating to this, *"….we have about three different tools that we use for assessing postnatal care and given an hour and a half in which to complete them. So, using the postnatal guidance as well as the assessment tools from the trust has become quite a chore, you know, to try and complete that within the hour and a half."* (HV10)

How Promotional Guides were used by health visitors (Fidelity)

Promotional Guide topic cards are designed to facilitate parental leadership of the conversation, by allowing the parent to choose a topic card of their choice. All health visitors described using the Promotional Guide topic cards as prompts to allow parents

to take the lead and choose the topics that they wanted to discuss. If fathers were present during these contacts, they were included in the discussions:

"*When a card is presented, we usually space it out so that whatever they want to talk about they pick it up and talk about it. So they have the autonomy to choose what … they take the lead, it might be the man or the woman*" (HV7)

Some health visitors found it difficult to find a balance between offering health promotion advice (as required by their organisation) and letting the parents lead the conversations, as HV8 explained: "*The problem is that you want to give this advice and give this information but if you are using the promotional guide, it's not an advice-giving session, it's led by the client. So I guess it's a bit of a compromise between letting them set the agenda, but also wanting to maximise the impact of the visit from a health promotion point of view. I also feel that the promotional guides that I'm balancing those two bits, and I have to kind of hold back a little bit on the amount of health promotion I would usually give*". (HV8)

Inviting fathers

There was variable practice with regards to inviting fathers to attend the Promotional Guide contacts. Health visitors reported not having a system in place for specifically inviting fathers, with invitation letters usually addressed to 'parents' or 'parent to be'.

"*Never. There's just no system in place to do that*". (HV1)

"*I've never known a contact where the father's been exclusively invited*" (HV4)

Some were more proactive in following up the invitation letter with a phone call to invite fathers. In cases where fathers were not invited but present during the contact, they were included in the Promotional Guide discussions.

"…*they present themselves, they come with the mothers to antenatal. So, that's up to them, they weren't invited. So, if they present themselves, then I will always engage them in the process*". (HV1)

Steps to engage with mothers and fathers

All health visitors discussed the approach they used to introduce the Promotional Guides to the women. This was done through the Promotional Guide topic cards, allowing women to choose the topics that they wanted to discuss, which helped to engage women with the Promotional Guide conversations (Observation, HV12, HV18).

Most health visitors did not take any additional or specific steps to engage with fathers. When the father was present, they ensured that they were included in the discussions and informed about the important role they played as a parent. One health visitor explained: "*I haven't had to do anything different from, you know, the times that I've used them. I find that the dads are as keen as the mums are. So I've not had to do anything different or say anything different to the dads that I've not said to the mums*" (HV9). This practice was also noted during the observations.

Managing time between both parents

Health visitors talked about prioritising their time for the person who needed it more, which generally tended to be the mother: "*More time seems to go towards the mother, normally, because they've got more questions*" (HV4).

When fathers were less vocal than their partner, health visitors encouraged them to participate and ask questions to ensure that they felt involved, an approach seen in most of the observations. Sometimes health visitors found it challenging when the mother and father had a lot to discuss, given the timeframe of the visit, and had to prioritise the most important topics for discussion.

"*I think the difficult when you've got mum and dad is that they can be that they want to talk about everything. Or more things than you've got time for. So a lot of it is trying to narrow it down to be specific about what we can do in the timeframe*". (HV5)

Health visitors also used their professional judgement when prioritising the needs of the mother and father, and whether it was appropriate to have certain discussions with both parents together, for example if domestic violence was a potential issue.

"*You have to mostly use your professional judgement. If there are sensitive issues like domestic violence, you really don't want to do it together*". (HV7)

Follow up and changes

Some health visitors described lacking the opportunity to follow up families after the initial Promotional Guide contact either due to the lack of continuity of care, with follow up not carried out by the same practitioner, or because they had to provide a 'targeted' offer, rather than follow-up all families.

Where health visitors saw changes in fathers following the Promotional Guide contacts, they were mainly in the context of the father's level of involvement with their child and partner.

"*I think mostly it's around their engagement with the child. So, we speak to them about dads' clubs, and …… about mental health*". (HV10)

One health visitor talked about improvement seen in other health behaviours such as smoking, where a father took positive steps to stop smoking following a discussion with the health visitor about passive smoking during the antenatal Promotional Guide contact.

3. Health visitors' perception of the Promotional Guide System

Benefits of the Promotional Guide contact

All health visitors viewed the Promotional Guides as father inclusive, "….*because some of the pictures. Like the recent and the past experience, I like the fact that it's got a picture of the father in it*" (HV6). The promotional guides were described as a useful tool because it "*sparks that conversation and gets you into knowing a little bit more about*

the family than you would otherwise. It's not a tick box exercise so it makes you relate to the family" (HV10).

Health visitors discussed the beneficial aspects of the Promotional Guide contact with fathers, "*They have found it useful, beneficial and educating because it raises more awareness, so it goes beyond what they expected about antenatal, because it's quite detailed and there is no limit to how far they can discuss*" (HV7).

Feedback from fathers following Promotional Guide visits suggested that they felt enabled to have better dialogues with their partner as a consequence. One health visitor said: "*I could see the dad's behaviour and the dad and mum were having this dialogue much better than if I were to ask mum about things and dad was sitting there like, you know, non-participant observer*". (HV1)

Health visitors described the topic cards as "*user-friendly and when you lay them out, I like the colours of them. They're very nice bright colours, which I'm always a keen fan of*" (HV3). The topic cards could be prompts to enable parents to talk about topics they may not have considered otherwise: "*Some will point to a card and say they haven't really thought about it, so it is a prompter, it's a good prompt*" (HV4). One health visitor, who had recently qualified found the topic cards particularly helpful: "*Just as a prompt and as a prompt with the little key questions on the back of the cards, even for me as well. So, being newly qualified as well, it's just - it does help"* (HV4). During the observations the Promotional Guide topic cards were handed to parents, who were asked to choose a few together for discussion. This seemed to encourage the father to raise queries and concerns he had, which were then discussed further (Observation, HV16).

Overall, the health visitors spoke positively about the Promotional Guide system. They valued its partnership approach, which enabled them to explore parents' feelings more effectively than being guided by their own or organisational priorities.

Benefits of involving fathers

All health visitors interviewed referred to the benefits of involving the father in Promotional Guide contacts. Fathers being involved would "*give them a better awareness of what is going to happen, and just to give them an idea of the changes that are going to happen to both their lives. And even discussing things like feeding and how you can get them involved in skin-to-skin and even if there's breastfeeding, how they can be involved in the baby's life"* (HV4).

Having the father involved benefited the mother, as fathers would be able to provide more support to their partners during the perinatal period, and develop better bonding with their babies. Involving the fathers for these contacts was also perceived to enhance the health visiting assessment of the family situation, identifying any strengths and weaknesses they may have. "*I think it's a helpful thing, it's a positive thing in …. a lot of many ways, albeit like I said if it is to tease out if there is any domestic violence, or if it is just to cement the different things that they may have held in tradition of what the man is supposed to be doing or not doing, what is expected of them from a professional. All of those things*." (HV10)

Having fathers involved was also discussed in relation to mental health and the important role fathers can play in supporting maternal and infant mental health.

The topic guides enabled the health visitor to discuss the importance of skin-to-skin contact with the dad and how he could get involved once the baby was born (Observation, HV16).

When health visitors used the Promotional Guides with both parents together, they occasionally faced challenges arising from the couple's relationship, however benefits of using the Promotional Guides were reported to far outweigh the negative aspects.

"*Well the obvious ones are things, if the relationship isn't particularly good. Or if there's a domestic violence in the relationship. Or there are things that mum wants to talk about that she doesn't want to talk about in front of the dad. Or vice versa I suppose. And that's the only negatives I can see". Otherwise I think that the positives outweigh the negatives*." (HV5)

4. Barriers to using Promotional Guides with fathers

Capacity and duration of Promotional Guide contacts

One of the main challenges was the lack of capacity. Although they valued the Promotional Guides and found them a useful intervention, health visitors often did not have the capacity to use them routinely in practice.

"*I feel that as professionals we've been trained for it. You have the, you know, capability of using it. The only trouble is sometimes, you know, there's no capacity and it's a time management issue, and then the staff are not able to use it"* (HV9)

Many struggled with the demands of the service and found it difficult to balance their time between facilitating the Promotional Guide conversation and delivering key health promotion messages as directed by their NHS trust. This health visitor summed up the difficulties: *"..we understand the values of the promotional guide in terms of exploring parents' feelings about the pregnancy, their hopes and fears for the baby, but we also have to come back to the office and tick boxes to say that we've discussed smoking and drinking, we've discussed breastfeeding, we've discussed accident prevention, we've discussed immunisations, and it is that balance which is tricky*". (HV8)

The lack of capacity also meant that many health visitors were not using the Promotional Guides with fathers.

In one NHS trust, health visitors allowed an hour and a half for the Promotional Guide contact, however some found that it often took longer to complete especially when couples had a lot to discuss. Additionally, there was a view that the dad in the conversations would take up more time as *"… if you've got dad as well you don't know the extent to which dad wants to explore things*" (HV9).

In the other NHS trust only half an hour was allocated for the antenatal contacts, leaving the health visitors worried and reluctant to start up a conversation that they may not be able to finish.

"*You know we don't have very much allocated time. They can open up a huge can of worms sometimes because of the nature of the topics. And also because it's led by them*". (HV5)

Access to fathers

Gaining access to fathers was a main barrier. Fathers were often not present during visits: "*With fathers I find they're mostly not in contact. I'd say if I did ten new birth visits I'll probably have one occasion that a father was at home*" (HV6).

Another health visitor explained that the timing of these contacts being at 6-8 weeks postnatally meant "*they are hardly ever there at the six to eight weeks for follow-up check*". (HV6)

Many health visitors stated that fathers were unable to attend these appointments due to not being able to take time off work. Of the seven observations carried out, although the father was invited by the health visitor, none were present during the antenatal Promotional Guide visit due to work commitments.

Language and culture

Language and cultural differences were another barrier. Health visitors described difficulties of using the guides through an interpreter, with concerns that discussions were not as effective due to being misinterpreted or misunderstood.

"*And even if you use interpreters it's not going to mean the same when you're going through somebody else who interprets that. So that will be the barrier*". (HV11)

Some were also concerned about not having access to an interpreter:

Health visitors described an individual's cultural background as a barrier to involving men with the Promotional Guide contact. They perceived that men from different cultures viewed this contact to be related to childbearing and childcare, and "*having babies is, like, women's work*" (HV2); "*a lot of Asian families … tend to honestly just leave it for the woman to do baby care than having to kind of maybe talk about their feelings…"(*HV10).

5. Facilitators and recommendations for using Promotional Guides with fathers

Systems and processes

Health visitors identified several facilitators for using the Promotional Guide System in practice. They felt that if parents were informed that the Promotional Guide contacts were aimed at both parents and if the invitations reflected this, it would encourage more fathers to attend appointments, especially if given advanced notice of the appointment date.

"*I mean in an ideal world before we did an antenatal contact, we would send out a letter addressed to both parents saying 'we warmly invite you both to this home visit. The health visitor is coming to learn more about you both and your family' and put it like that. …and that letter would go out about a month and a half in advance so that dad can book some time off work if he needed to and that sort of thing".* (HV8)

Health visitors also felt that the venue in which the contact took place was important. For example, the home setting was seen as ideal as it offered privacy and would allow parents to feel more relaxed (HV3).

When a contact was undertaken in a clinic setting one health visitor talked about displaying the Promotional Guide topic cards on the desk so that "*if you've got the fathers sitting there and you've got a desk with the guides all spread out, they're drawn to it. Their eyes are drawn to it, so they can see it."* (HV4)

Being allowed to dedicate adequate time to use the Promotional Guides viewed as essential, as one health visitor explained: "*if you want to have a meaningful conversation that means that they're going to go away with something, then you can't really do it in less than half an hour"* (HV5)

Although continuity of care was problematic as referred to earlier, having the same practitioner facilitating the Promotional Guide contacts could better facilitate the process.

Of the one postnatal observation carried out, the health visitor undertaking the visit was not the same practitioner who carried out the antenatal contact for this family. In this case, it was clear she had not had the chance to build any rapport with these parents (Observation, HV12).

Training and supervision

Health visitors were complementary about their initial Promotional Guide training and had health visitor champions within their workplace. However, they raised concerns about the lack of routine use and refresher training or updates: "*And the less that you are using, you know, a certain skill that you've been trained to do, the more you are at*

risk of losing that skill……Because for a year now I don't think there's been any updates or any refresher training on the use of the promotional guides." (HV9)

Having good opportunities for clinical supervision was seen as a facilitator to the implementation of Promotional Guides to both mothers and fathers, "*I think the clinical supervision is quite good, and the team ones are quite helpful as well"* (HV9).

A lack of support networks for fathers, was a challenge as health visitors did not know where to sign post fathers who requested for more support.

Management and organisational support

There was a general view that more commitment and support from senior managers was needed to implement the Promotional Guides in an effective manner as health visitors considered that Promotional Guides were not a priority for the organisation: "*there is always shifting priorities anyway, and use of the Promotional Guide used to be a priority when they're investing in the training. I think it has now gone off the burner*" (HV8).

Although as one health visitor described *"the expectation is that the contact will be undertaken. The organisation would like us to use to the Promotional Guide antenatally. The organisation would like us to be engaged better with fathers*" (HV8), there were no systems in place to enable this or monitor its use. The uptake of Promotional Guide contacts were not routinely collated by their organisations, and systems did not enable the recording of contacts with fathers: "*it's not like it's accounted for in our own*

assessment tool…..we've got a separate assessment, our own assessment tools on our computer screens is actually about the mother and the baby". (HV10)

To enable better facilitation of the Promotional Guide system with fathers "*it would be good if there was more systems in place like a number …I mean, we've no idea who's using it, who's not using it, and how many Practitioners use it. It might be useful to have a record of how often they're using it. I mean, we receive the training, but really, there hasn't been follow-ups since then and what discussion/supervision, in relation to scenarios that came up during their usage*". (HV3)

A fidelity questionnaire was used for the interviews and observations (see summary in Table 3). All 18 health visitors used the Promotional Guide topic cards to form the basis of contacts. Through the discussions of the topics chosen by the parents, health visitors identified or reported to identify specific priorities for parents, and the necessary resources (to include family members, friends and other social supports) needed to achieve their goals. However, no health visitor encouraged parents to keep a written record of their priorities, goals, and improvements. The completion of the 'family strengths and needs summary' was variable, with reports/observations of 67% (n=12) not to completing it at all, 22% (n=4) using it to inform their assessment without actually completing or recording it, and only 11% (n=2) fully completing it (manually completing and recording it).

An additional question was included in the study questionnaire about the 'Family Map', which was introduced by the Centre for Parent and Child Support (CPCS) in 2016, for

use following a Promotional Guide contact. The Family Map enables parents to use a visual format to identify their goals and the resources needed to achieve them. It also helps them to make a written record of the plans made to meet their goals. None of the health visitors interviewed in this study were aware of the Family Map and those observed did not use it during their Promotional Guide consultations.

Table 2: Fidelity checklist summary from interviews and observations with health visitors

Part No.	Use of PG Guide materials	Identified main priorities with parents	Encouraged parents to records priorities	Identification of resources for goal achievement	Completed Strengths & Needs summary	Used Family Map
HV1.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Completed fully	No
HV2.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Not completed	No
HV3.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Use to inform assessment but not completed	No
HV4.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Not completed	No
HV5.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Not completed	No
HV6.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Not completed	No
HV7.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Use to inform assessment but not completed	No
HV8.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Not completed	No
HV9.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Complete fully	No

HV10.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Use to inform assessment but not completed	No
HV11.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Use to inform assessment but not completed	No
HV12.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Not completed	No
HV13.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Not completed	No
HV14.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Not completed	No
HV15.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Not completed	No
HV16.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Not completed	No
HV17.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Not completed	No
HV18.	Use the PG topic cards as the basis of contact	Yes	No	Yes	Not completed	No

Discussion

This process evaluation was carried out as part of the New Dad Study (NEST), which focussed on first-time fathers' mental health and wellbeing. Other parts of this study have been previously reported (Baldwin et al, 2018; 2019; 2021 under review). This paper reports the process evaluation exploring health visitors' views of using Promotional Guides with fathers, their level of engagement with and acceptability of the intervention, fidelity of delivery and reported impact on first-time fathers' mental health and wellbeing.

Health visitors' practice around asking fathers about their mental health and wellbeing varied. A few health visitors asked fathers direct questions about their mental health, most asking general questions about the fathers' wellbeing if he was present at the contact. Some health visitors reported to prioritise maternal mental health over paternal, a finding consistent with fathers' accounts of not being asked direct questions about their mental health (Baldwin et al, 2021). This suggests that enquiring about paternal mental health is not part of routine health visiting practice and further work is needed which includes staff training, organisational support and commitment.

All health visitors were trained in the Promotional Guide system and in receipt of at least two to three types of supervision in practice, which were key to delivering the intervention. Despite this, the health visitors' involvement with Promotional Guides varied between the two study sites. In both, the Promotional Guides system was

implemented and offered in two of the five Universal contacts: antenatal health promoting visit and six to eight week assessment (PHE, 2018), however in practice this did not happen. In one site, only the Antenatal Promotional Guide was used by health visitors on a targeted basis for families with additional needs, with intervention use based on the individual health visitor's professional judgement. In the other site, health visitors used the Antenatal and Postnatal Promotional Guides, but practice was reported to be ad hoc varied considerably between practitioners. Some used them with all parents, while others only used them antenatally when time allowed or when they felt it was necessary. This practice was also confirmed by the observations carried out, six of which were for antenatal contacts and only one for postnatal.

In both study sites, some invitation letters for the Promotional Guide appointments were addressed to 'parents' or 'parents-to-be' but neither site had a system for explicitly inviting fathers. A few health visitors used their own initiative to invite fathers by phone or letter, but this was not routine practice. This explains the previous findings reported by fathers, where only a small number of men were invited to attend the antenatal and postnatal health visitor appointment with their partner (Baldwin et al, 2021).

When health visitors did use the Promotional Guide system, they used the topic cards as a basis of their conversation, offering parents the choice of topic that they wanted to discuss, as intended by the programme. If fathers were present, they were included in the discussions and encouraged to participate. When both the mother and father was

present, health visitors used their professional skills to manage the time between both parents, prioritising their time for the person who needed it more. They also made assessments of the appropriateness of talking to both parents together and where necessary arranged separate appointments (such as in cases of domestic abuse). When fathers were less vocal than their partner, health visitors encouraged them to participate and ask questions to ensure that they felt involved, which was also observed by the researcher during the observations. The findings suggest that health visitors used their 'professional skills' and a 'partnership approach' to using the Promotional Guides as outlined by the programme.

Health visitors also considered the intervention to be inclusive of fathers, due to the way in which the topic cards were designed for 'our baby and us' and included pictures of fathers as well as mothers and babies. Health visitors recognised the importance of involving fathers in these visits and the positive impact it could have on the whole family. While health visitors valued the Promotional Guide system, they often experienced challenges of using them routinely due to time constraints and the increased demands of the services, at both study sites. This also resulted in the intervention not being used with fathers.

Other barriers included not being able to access fathers due to their work commitments, and language and cultural differences. Some health visitors held the view that fathers from certain cultures perceived childbirth and childrearing to be related to the mother

only, and highlighted this as a barrier to men engaging or getting involving in the antenatal and postnatal health visitor appointment. Interestingly, men in this study also highlighted this view held by health professionals, which they felt acted as a barrier to involving fathers in contacts during the perinatal period (Baldwin et al, 2021, under peer review). This suggests that health professionals may be holding on to the more traditional 'breadwinner role' of fathers, which could be preventing them from engaging effectively with men from certain cultures during this period.

Facilitators for using the Promotional Guides system included informing fathers that the intervention was aimed at both parents; explicitly inviting fathers along with mothers; sending them appointments in advance; being able to offer the appointment in home settings, being allowed to dedicate adequate time to deliver the intervention and to have continuity of care (the same health visitor delivering the antenatal and postnatal visit). While wider changes in organisational and social culture are necessary for health professionals to effectively engage with fathers, small changes by individual health visiting teams such as these could have a great impact (Bateson et al, 2017).

Health visitors identified a lack of management support and organisation policy or guidance for the use of the Promotional Guide system and a lack of monitoring of uptake or impact. This was considered a huge gap in the implementation process of the intervention. According to Day et al. (2014), co-ordinated action is required by service managers for the use of Promotional Guides to be effective and sustainable, which should include having clear operational guidance as well as guidance for systems for monitoring routine use and impact of the Guide. This was also highlighted in a UK

based qualitative study of nine health visitors, which identified factors affecting the implementation of the Promotional Guide in practice (Morton and Wigley, 2014). Similar to the findings of the current study, Morton and Wigley (2014) reported that health visitors favoured the partnership approach used as part of the Promotional Guide practice, which enhanced their practice, similar to those also reported by Barlow and Coe (2013) in their evaluation study of the level of implementation and stakeholder perceptions. However, implementation was affected by the lack of integration of client needs with organisational agenda, lack of organisational compliance, and lack of appropriate recording and monitoring systems for Promotional Guides (Morton and Wigley, 2014). As these issues were identified as factors affecting implementation in the current study, a clear implementation strategy and operational guidance that explains "*how the content, timing and duration of Promotional Guide contacts and resulting family strengths and needs analysis and assessment should be recorded*" (Day et al., 2014, pg-.667) should be included in practice.

While all health visitors had received the initial Promotional Guide training, no refresher courses were offered, with concerns raised that the lack of routine use would de-skill their practice. Participants raised concerns about not being able to offer fathers with support if they required it, due to a lack of knowledge about what was available to them. Ensuring health visitors are aware of support services available to fathers in their local area, either through training or supervision sessions, could facilitate better support being offered to fathers.

Information obtained from the fidelity checklist showed that the completion of the 'family strengths and needs summary' by health visitors, identified as an essential component of the intervention, was variable. Two thirds of the health visitors did not complete the 'family strengths and needs summary' at all, while some used it to inform their assessment without actually completing or recording it, and only 2 health visitors reported to fully complete it for each promotional Guide visit. Furthermore, none of the health visitors were aware of the 'Family Map', which was introduced to the Promotional Guide programme in 2016, which reflects the lack of ongoing training or refresher courses relating to the intervention highlighted by the health visitors.

The lack of routine use of the Promotional Guide system by health visitors in this study is probably reflective of the national picture where health visiting numbers have declined drastically over the past four years. The reduced health visiting workforce having to prioritise working with the most vulnerable families, resulting in a universal health visiting service not being provided to all families as set out in Public Health England's Commissioning Guidance (IHV, 2019a).

The finding from this study suggests there were two main factors that prevented effective implementation of this intervention in the two study sites. They relate to organisational, community and public policy level rather than individual or interpersonal. In other words, it was the lack of organisational support, investment in and commitment to the intervention that has led to inconsistency in staff training and support (no refresher courses, no policies or guidelines to inform practice), which resulted in inconsistent practice in relation to the way in which the intervention is offered (targeted

offer, some only offered antenatally etc.) and delivered (inadequate time allocated to visit, inconsistent use of resources).

The organisation operates in the context of the national picture. Health visiting provision in England is locally commissioned (in contrast to the devolved nations of Wales and Scotland), leaving vital decisions to local government members. According to the Institute of Health Visiting (IHV), "*whilst there have been some examples of good commissioning in recent years, even senior Directors of Public Health recognise that commissioning in some areas is not as good as it could be*" (IHV, 2019b, pg-11). This means that the key performance indicators (KPIs) set by the local commissioners and the quality of support that families receive could vary significantly. The most common health visiting KPIs tend to be numerically driven based on the number of contacts undertaken, breastfeeding rates and child health reviews, rather than the emotional and psychosocial aspects of parenting that the Promotional Guides focus on, which are more difficult to measure numerically.

The health visitors in this study often worried about meeting the KPIs set by their local commissioners and adjusted their practice accordingly. By prioritising KPIs over providing a 'meaningful service' increases the risk of simply "*ticking the box, but missing the point*" as highlighted in the Position Statement issued by IHV in July 2019 (IHV, 2019a). In order for the Promotional Guides system to be implemented properly and its benefits to be assessed, senior health visiting managers and leaders need to have a better understanding of the intervention and how it may have the potential to support both the mother and father's transition to parenthood. "*When the contribution of Promotional Guide practice is unclear to senior managers, there is a risk that resources*

and investment will be directed elsewhere and the achievements and impact of practitioners using the Guides will be undervalued and overlooked" (Day et al., 2014, pg- 665). Senior managers and leaders need to ensure that the use of Promotional Guides is aligned to the commissioning priorities so that local policies and guidance can be developed to support health visitors in practice. It is also essential that adequate monitoring systems are in place so that the intervention fidelity and impact can be evaluated. This is likely to make the delivery of the Promotional Guide system more meaningful to both practitioners and parents, rather than the inconsistent way in which it is currently being delivered in the two study sites.

Strengths and Limitations

There are several strengths associated with this study. Health visitors found being involved in the study was acceptable and study aims were important. They spoke positively about the Promotional Guide programme and considered it to be a useful and suitable intervention for supporting fathers. The identified facilitators and barriers to using this intervention with fathers can inform future practice and research.

As health visitors' participation in the interviews and observations were voluntary, a limitation could be that the views and practices of the participants may not be representative of all health visitors in the two NHS organisations. It is possible that only those who were more proactive and/or confident in using the Promotional Guides volunteered to take part. Furthermore, it is acknowledged that there are some limitations associated with the non-participant observation approach used in this study. Health

visitors being observed by the researcher (who is also a trained health visitor), may have led the participants to behave differently, a phenomenon referred to as the Hawthorne effect. In this case it is possible that health visitors used the Promotional Guides comprehensively to the best of their ability during the observation, when that may not be their usual practice. However, health visitors not using the 'Family Strengths and Needs Summary' or the 'Family Map' during the observations (which were identified as key intervention components), suggests that health visitors were unaware of these resources, as discussed previously.

Recommendations for Practice & Research

Fathers should be explicitly invited to antenatal and postnatal appointments with the health visitor and informed that the appointment is for the father as well as the mother. Health visitors should enquire about fathers' mental health and wellbeing, and ask direct questions as they do with mothers. Men are then more likely to express their own needs and engage more. A consistent approach to the delivery of the Promotional Guide system is required. For this to happen improvements need to be made at organisational, policy level and practitioner level. Health visitors using the Promotional Guide system with fathers (and mothers) should inform them about the intervention and that it is designed for the mother and father, which is likely to increase engagement. When using the Promotional Guide system, health visitors need to ensure that they use all materials designed for use in the intervention. Organisational policies should clarify expectations around Promotional Guide use with fathers; its content, duration and timing; and have robust recording and monitoring systems in place. Regular staff training, updates and

supervision for the Promotional Guide system needs to be embedded in practice, to include the use of ‘Family Strengths and Needs’ summary and ‘Family Map’. Health visiting leaders and managers need to ensure that data is collected on Promotional Guide use and outcomes reviewed. These should be reported to commissioners to inform future commissioning priorities and decisions.

Further research is needed to assess the effectiveness of the Promotional Guide system used by health visitors with mothers and fathers. For this to happen the implementation gaps identified in this study and in the report by Baldwin et al (2021, under peer review) need to be addressed first.

Conclusions

This study considered the acceptability, feasibility and fidelity of using the Promotional Guide programme with fathers from the health visitor’s perspective. The findings provided an insight into health visitors’ experiences of working with fathers, inquiring about men’s mental health needs and their use of the Promotional Guides with men during the perinatal period. Triangulation of data collection was achieved through interviews with health visitors and observation of health visitors using the intervention in practice. Feedback from health visitors and the observation findings were consistent in relation to engagement and involvement, mental health enquiry and promotional guide use. This study identified a number of barriers and facilitators to the use of Promotional Guides with fathers. Recommendations were made for improving services for first-time

fathers, implementing the Promotional Guide system with fathers, highlighting areas for future research.

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Contributions

The research team consisted of the first author (SB), who undertook all aspects of this study (including recruitment, data collection, data analysis and writing the first draft of the paper), with support from three members of her research team (DB, JS, MM). The findings of the study were discussed amongst the research team at each stage and there were several iterations of this process, before the final results were developed and agreed by all authors. All authors reviewed the manuscript.

Competing interests

The authors declare no conflict of interest

Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request**.**

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