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Caring Masculinities at Work: Theoretical and Empirical Perspectives across Europe

Engaged fatherhood and new models of "nurturing care": Lessons learnt from Austria, Italy, Lithuania and Portugal

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Abstract

Research on gender-based violence highlights the need to engage men in prevention work through social change programs that present care as a powerful antidote to violence. Implementation of such programs worldwide provides many examples of how education and support for fathers and fathers-to-be can promote healthy masculinities and relationships with an intimate partner and their children. This article aims to explore the findings and lessons learned from the pilot of the European Union-funded Promotion, Awareness Raising and Engagement of men in Nurture Transformations (PARENT) project (PARENT) which sought to develop and pilot curricula adapted from the internationally tested Program P methodology. The PARENT pilot worked in four European countries to provide training activities for social, educational, and health professionals, as well as education groups for fathers and parents, with the overarching goal of preventing domestic violence through the promotion of engaged fatherhood. By

reporting the results from mixed-methods impact evaluations of pilot programs conducted with professionals and parents, this article discusses how gender-synchronous father-focused training can contribute to a shift toward increased positive engagement of fathers during the first 1000 days of a child's life. The article conveys the pilot's promising impact on the knowledge, attitudes, and behaviors of professionals and parents, and it examines some of the key contextual factors, limitations, and implementation approaches that plausibly contributed to the PARENT pilot outcomes, with the aim to formulate useful considerations for future scale-up efforts or the future implementation of similar programs to engage fathers in nurturing care and violence prevention.

KEYWORDS
fatherhood, nurturing care, PARENT, professionals

1 | INTRODUCTION

Over the past 2 decades, considerable interest and investment have been paid to the role of men's care in creating a more gender-equal world (Scambor et al., 2014). Traditional and prevalent conceptions of masculinity have disseminated the expectation for men to be aggressive, emotionally absent, and dominant over others, and these conceptions position masculinity and femininity as dichotomous and complementary cultural roles (Eisen & Yamashita, 2017). Given that the avoidance of care has been a traditional feature of 'being men', the efforts which individuals and systems have used to maintain men's distance from care work and dominion over women have contributed to women's disproportionate care work burden as well as high levels of men's violence within the family (Hearn, 2001). Global research has confirmed that gender inequitable norms and the need to assert masculine power shape men's interactions with their partners, families, and children on issues such as physical violence, distribution of care work and household work, and health-seeking behavior (Barker et al., 2007). Elliot (2016) proposed "caring masculinities," characterized by feminist ethics of care such as interdependence and relationality, as a key step toward reorienting the structures of care toward gender equality. Drawing on feminist considerations of gender equality and critical studies of men and masculinities, Elliot articulated a practice-based framework of caring masculinities, viewing the concept as a gender-equality intervention which incorporates the "values and practices of care and interdependence, traditionally though not inescapably associated with women, into masculine identities" (Elliot, 2016, 243).

This study is precisely based on the recognition of the problem of violence and on the premise that caring helps to reduce violence. For instance, high-quality childcare has positive outcomes, among others, language development and academic achievement, which are a preventing factor for youth violence World Health Organization (2015). Therefore, a comprehensive analysis of an intervention program that advocates the promotion of an engaged and caring fatherhood is proposed, whose data suggests the reinforcement of this basic premise.

This article aims to explore the findings and lessons learned from the pilot of the European Union (EU)-funded Promotion, Awareness Raising and Engagement of men in Nurture Transformations (PARENT) project (PARENT),

which developed and piloted curricula adapted from the Program P methodology in four European countries. The three main components of the PARENT pilot were (1) training professionals from various sectors who meet with parents between pregnancy and the first 4 years of a child's life (2) creating consciousness-raising education groups for fathers and their partners, and (3) implementing national campaigns to promote engaged fatherhood and gender-equitable caregiving. This article discusses how gender-synchronous father-focused training can contribute to a shift toward increased positive engagement of fathers during the first 1000 days of a child's life. Based on pretests, posttests, and post-intervention qualitative feedback from program participants, this article conveys the pilot's promising impact on the knowledge, attitudes, and behaviors of professionals and parents. Further, the present article examines some of the key contextual factors, limitations, and implementation approaches that plausibly contributed to the PARENT pilot outcomes.

1.1 | Theories and previous research on the relations between care, masculinities, and violence

Engaged fatherhood is a powerful entry-point for realizing caring masculinities. The term engaged fatherhood refers to the participation of fathers in work, childcare, and housework, and it opens opportunities to break out of traditional fatherhood models that centered on the role of provider or breadwinner (Moura, Cerdeira and Rolino, 2021; OECD, 2021). There is, by now, ample evidence to suggest that fathers' early involvement in care from the time of their partner's pregnancy is associated with improved maternal and birth outcomes (Tokhi et al., 2018), children's health outcomes (Moore et al., 2017), and children's cognitive, socio-emotional, behavioral, and psychological development (Redshaw & Henderson, 2013; Sarkadi et al., 2007). Engaged fatherhood is also linked with fathers' welfare and, by extension, healthy relationships (Greenhalg et al. cit. Redshaw & Henderson, 2013; Lee et al., 2018; Suto et al., 2016; Redshaw & Henderson, 2013). In addition, there is a growing body of research which points to an association between engaged fatherhood and lower risks of family conflict and domestic violence (Borter et al., 2007; Gärtner & Scambor, 2020, 22; Holter and Krzaklewsla, 2017; Swick, 2013).

These effects of caring masculinity upon family violence outcomes may be intergenerational, as there is research which posits 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, and that girls growing up in such households are also less likely to be subservient to men later in life (Fleming et al., 2015); however, more research is needed to understand the strength and pathways of this potential association.

Despite these varied and evidence-backed positive associations with engaged fatherhood, key barriers hinder men's actualization of engaged fatherhood and caring masculinities, as a result of their contact with the health sector. For example, men's interactions with health, social, and education professionals specializing in pregnancy, birth, and early childhood have been identified as promising opportunities to engage men as fathers (Frascarolo et al., 2016). However, research highlights that without deliberate measures to develop and incorporate father-inclusive practice into all aspects of service delivery, service providers will tend to concentrate their efforts exclusively or overwhelmingly on mother/child dyads, to the exclusion of men and fathers (Fletcher et al., 2014).

One promising approach to deliberately promote engaged fatherhood by educating health sector professionals, as well as fathers/couples, is the well-known and internationally evaluated Program P methodology. Developed as part of the global MenCare campaign coordinated by Promundo and Sonke Gender Justice, Program P ("P" for "padre" in Spanish and "pai" in Portuguese, meaning "father") is a gender-transformative program which provides concrete strategies for engaging men in active caregiving from their partner's pregnancy through their child's early years (Promundo, CulturaSalud, and REDMAS, 2013), encouraging health and social sector professionals, parent/couples themselves, and community members to challenge harmful social norms around gender power strongly linked to familial violence (e.g., notions of male authority and female subordination). The program aims to intervene

in gender equality within couple relationships by promoting equitable division of care work, equipping health sector professionals with strategies to promote greater involvement of fathers and mothers in maternal and child health, improving men's self-confidence and efficacy in caregiving, rejecting violence against women and children, and promoting positive parenting and healthy, happy relationships. The successes and lessons of Program P adaptations around the world, particularly around the effectiveness of health systems as an entry-point and the importance of dismantling structural barriers to men's care (Promundo, CulturaSalud, and REDMAS, 2013) have turned this transformative methodology into a strategic instrument for European countries to apply to promote engaged fatherhood and ultimately improve gender-based violence (GBV) and gender equality outcomes.

2 | METHODS

2.1 | Summary description of the PARENT intervention in four countries

The PARENT project was implemented in Austria, Italy, Lithuania, and Portugal between February 2019 and June 2021. These partners were gathered considering a shared research-action orientation among the organizations, and the potential for making an impact in these countries due to existing governmental and institutional interest in violence prevention and engaged fatherhood as an entry point. Further, contextual similarities among the PARENT countries indicated a need for increased active engagement in fatherhood by men. All four countries scored below the EU average (69.1) in the European Gender Equality Index subdomain concerned with gender gaps in the involvement of women and men in caring for their children, indicating that women in these four countries undertake a particularly high proportion of the total time spent on care activities by women and men (EIGE, Gender Equality Index 2021).

The pilot programs implemented in the four countries shared a common approach and similar activities for working with professionals and parents, in the design of curricula for professionals in all four countries to prepare participants to promote caring masculinities among families they encounter during their work and incorporate gender-synchronized approaches into their professional roles, while also providing a safe space for professionals to critically reflect upon and shift their own gender biases regarding men's caregiving role. All four PARENT country teams designed their professional training courses taking a multi-professional approach, in order to emphasize teamwork and coordination among different professionals involved at different moments in the pregnancy-birth-puerperium cycle. The content for father/couple groups were similarly aligned across the four PARENT partners; in all countries, father/couple groups focused on topics such as the transformation of social and gender norms, children's rights, pregnancy, parenting, paternity leave and public services for families, violence-free relationships, and sharing care work with a partner. For both professional and parent programming across all four PARENT countries, an emphasis on experiential learning and participatory methodologies was paramount.

Based upon needs assessments with parents, professionals, and expert stakeholders conducted prior to program implementation, the PARENT country teams identified different entry-points, thematic emphases, and target groups according to where they could expect the greatest impact in promoting gender equality, engaged fatherhood, and GBV prevention in each local context. Portugal and Italy recognized the opportunities presented by the mainstream public health policies concerning gender and domestic violence prevention already in place, and therefore chose to focus their work with professionals on healthcare personnel who have primary contact with couples/fathers during the pre-natal, natal, and post-natal phases. (e.g., gynecologists/obstetricians, pediatricians, nurse students, early child education professionals working), as well as pre-service training for future healthcare providers.

Additionally, Austrian and Lithuanian partners identified social care and social work as playing an important role in the prevention of domestic violence and promotion of caring masculinities. Thus, these partners engaged social workers who provide services for diverse families (families at social risk, refugee and/or migrant families,

TABLE 1 Parent program training format and participants.

		Austria	Italy	Lithuania	Portugal
Professionals	Health and education professionals and social workers	83			
	Health professionals undergraduate nursing students		130		100
	Social workers			125	
Parents	Nr. of parents	72 fathers	22 fathers	43 parents (19 fathers, 24 mothers)	25 fathers
	Workshops	23 workshops		Range between 2 and 25 sessions per course	
Nr. of training hours		From 2 to 4 h per worskhop		24 h (course)	30 h (course)
Format of training		Variable		Two rounds of 8-h synchronous hours 8 asynchronous hours	Ten 2-h synchronous sessions ten 10 asynchronous hours

amongst others) in cases of domestic violence, with Austria also including parent-child centers, and leaders of parent education groups.

Most professionals who participated in the programs were women, regardless of the different professions targeted by each respective intervention. In terms of the father/parent education groups, a main point of divergence among the four countries' methodologies was that some countries (Italy, Austria) focused solely or primarily on reaching men, while others (Portugal, Lithuania) reached couples which included both men and women, according to Table 1—Parent Program Training Format and Participants.

2.2 | Impact evaluation methods

The PARENT evaluation focused on measuring the reach and effectiveness of the project. Evaluation approaches were designed to identify changes in awareness among professionals on the importance of engaging men in active fatherhood and gender-equitable caregiving to promote the eradication of violence against women and children; professionals' behaviors related to promoting the engagement of men as fathers in health services; and men's gender attitudes and behaviors in terms of caregiving and the use of violence against women and children. All parents/caregivers and professionals who had participated in the PARENT pilot training sessions were targeted for evaluation (quantitative surveys and qualitative course feedback), although some of them did not complete endline evaluation due to drop-out and other difficulties related to the training sessions moving online after the onset of the pandemic.

While all implementing partners utilized similar mixed-methods, non-experimental designs to evaluate their pilot programs, each country team had the flexibility to develop their own context-specific impact evaluation instruments and approaches. For example, researchers in all four countries developed and administered Knowledge, Attitude, and Practices (KAP) surveys to professionals and parents participating in the PARENT pilot. These questionnaires were used to measure participants' awareness, beliefs, and behaviors related to father engagement. In all countries, these questionnaires were informed by the Gender Equitable Men Scale, which includes statements related to gender roles divided into five categories: home and child-care; sexual relationships; health and STI

prevention; violence; and homophobia and relations with other men (Pulerwitz & Barker, 2008). All country teams administered data collection activities online, for instance by sending a Google form link with those enrolled in the course. However, the content and length of survey instruments varied depending on the specific country context. For example, the Lithuanian team adapted the questionnaire to the professional specificities of social workers. Questions were adapted to assess the social workers' preparedness to engage with fathers on issues of caring for their child, emotional attachment, and gender equality, while the team removed health and STI questions which were not as relevant to the professional functions of social workers. Another example of methodological variation across the four countries was the timing of evaluation. Italy, Lithuania, and Portugal administered pre-and post-test evaluations at the beginning and end (or shortly after the end) of each program cycle to assess the baseline and endline characteristics of participants, while in Austria only post-evaluations were used.

3 | RESULTS

The PARENT pilot's training workshops with health professionals, social workers, education professionals, and undergraduate students had some—although limited—positive effects on participants' attitudes around gender equity and engaged fatherhood. Data from Italy, Lithuania, and Portugal are available to substantiate this claim, while data with professionals in Austria are not presented in this report due to the lack of a comparative baseline measurement. In general, the questionnaire items which showed the greatest positive shift in professionals' attitudes by the end of the interventions were related to perception of the importance of men's inclusion in maternal and child health settings.

In Italy, from baseline to endline, there was an increased proportion of health professionals who agreed with the statement "healthcare facilities should provide a changing table in the men's room", and an increase in agreement with the importance of the presence of the father/partner during labor and delivery. Lithuania saw larger positive changes in social workers' reported attitudes from baseline to endline, such as an increase of social workers supporting the notion that there is a need to involve men in parental and maternal health; a decrease in the percentage of social workers who agreed that pregnancy consultations are only important for women; and again an increase in the percentage who stated that they know how to encourage fathers to engage more actively in preparation for childbirth.

In Portugal, positive changes related more broadly to perceptions of the role of gender in participants' scope of work. For instance, an increase of health professionals and undergraduate students who disagreed with the statement "in my scope of work, gender and diversity are not important issues" from baseline to endline.

Although Italy, Lithuania, and Portugal saw positive changes in professionals' attitudes regarding men's involvement in pregnancy and family health, in all three countries there were questionnaire items (particularly those related to masculinity and gender norms) which showed either a very small positive change or a minor negative change from baseline to endline.

For example, in Italy the proportion of health professionals who agreed that "it is ridiculous for a boy to play with dolls" increased and, in Portugal, the proportion of health professionals and undergraduate students who agreed that "men need sex more than women" rose. However, given the not so big sample sizes across PARENT pilot programs with professionals, these shifts must be interpreted with caution, particularly because most participating professionals demonstrated high baseline levels of agreement with gender-equitable attitudes.

In addition to a somewhat limited positive impact on professionals' attitudes, there was also significant positive improvement in professionals' self-reported behaviors seen in the impact evaluation of programs in Italy, Lithuania, and Portugal. In Italy, the program appears to have led health professionals to undertake or increase their behaviors related to the provision of information on antenatal/postnatal care, parental leave, encouragement of his continued future participation, and registration of the child. For example, from baseline to endline evaluation there was an increase in the percentage of Italian health professionals in providing information directly to the father or

partner on antenatal and postnatal care and an increase in encouraging the father or partner's future participation when they are present.

Further, positive changes in practices of Lithuanian specialists were particularly notable. There were large increases in the proportion of social workers who encourage their co-workers to promote active men's participation in pregnancy consultation together with their partners, that they personally encourage men to participate in pregnancy consultations, and that they urge women to encourage their male partners to attend pregnancy consultations.

In Portugal, health professionals reported at endline that they believed they were more likely to take certain actions to engage fathers in health services. From baseline to endline there were increases in the proportion of participants who said it was "very likely" that they would "discuss in team ways to engage parents in the health service", "have protocols on how to engage fathers in prenatal care", "have education materials on fatherhood", and "invite fathers' participation in consultations".

Also, the PARENT pilot may plausibly have contributed to shifts in the attitudes and intended behaviors of men and fathers themselves. Impact evaluation results from Austria and Portugal are available to support this claim, while Lithuania's father groups did not complete an endline evaluation due to challenges related to the COVID-19 pandemic and online participant recruitment, and data from Italy's father circles are not available at present.

In both Portugal and Austria, the men participating in the father or father/couple groups had generally very equitable gender attitudes already at baseline. In Austria's father laboratories, because of the short training sessions, only postal evaluations were conducted, not baseline questionnaires. In these endline questionnaires few men said that they agreed with statements which affirmed traditional male roles (e.g., men are the primary breadwinner; men have no time for family because of work). Nevertheless, gender role attitudes of the participants became visible to the trainers already in the round of introduction of the participants. Austrian trainers noted in their reports that many workshop participants were already open-minded men at the beginning of the training and fathers whose tendency toward the equal-share system did not reflect the more traditional gender attitudes and fatherhood models favored by most of the Austrian population. Similarly, the male participants in Portugal father/couple groups built on their already very equitable gender attitudes by the end of the intervention. They demonstrated in their post-test results that they had made further improvements in their attitudes toward engaging as fathers in health services, their caregiving behaviors, and their endorsement of the use of violence against women and children. In the pretest, most men said that they intended to participate in various childcare and domestic tasks even when someone else was available to do them. The activities with the lowest intended participation at baseline saw the greatest increased intent after the training. These activities were washing clothes (65.2%–75%) and preparing food for other adults (78.3%–87.5%). In the post-study, men also said that they were more likely to intend to take parental leave and leave of 15 days or more (78.3%–87.5%). Further, men's endorsement of the use of violence decreased greatly by the end of the program. For example, the proportion of fathers' group participants who fully agreed with the statement "Men should defend their honor even with the use of force if necessary" decreased from 12.5% at pretest to 6.3% at posttest, and the proportion who disagreed increased from 62.5% to 81.3%. The items where participants exhibited less desirable gender attitudes at the pretest were mostly related to attitudes around masculinity (e.g., what it means to be a real man and how real men should behave). As was the case with health professionals in Italy and Portugal, fathers who participated in Portugal's father/couple groups demonstrated percentage changes in an undesired direction from baseline to endline on survey items related to masculinity and gender norms. It is possible that these negative shifts were influenced by the small sample size.

An interesting distinction between the Austria and Portugal father group outcomes emerges when comparing men's attitudes toward the health system after receiving the PARENT intervention. In Portugal, only slightly over half of the respondents 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 significant increase suggests that in the Portuguese context, the PARENT intervention was able to lead to an attitude change in which men felt that they were welcome in health

service spaces dedicated to preparing for childbirth. In contrast, fathers' reports during the fathers' laboratories in Austria showed that men felt they were not perceived, taken seriously, or addressed as parents by the health system in the same way as mothers, and that fathers felt that they were more often perceived by midwives, doctors, and social workers only in their possibly dysfunctional role for the child's well-being. Similarly, although data from Lithuanian parents' groups are not available on this topic, facilitators also observed the fathers' disappointment that healthcare professionals view fathers as, at best, assistants to help their spouse/partner in child nurturing. Some Lithuanian fathers pointed out that advice provided to couples by healthcare institutions as well as the popular literature on child care focuses almost exclusively on the mother's role while the father and his specific role are absent. These reports from Austrian and Lithuanian fathers suggest the importance of the overall context and specific institutional environments which men encounter as they prepare for fatherhood, as well as the ways in which educational curriculum with men is not sufficient to remove structural barriers to engaged fatherhood.

Reports from men who participated in PARENT's various father/parent groups in Austria, Italy, Lithuania, and Portugal, as well as assessments from facilitators of those groups, indicate that fathers and fathers-to-be were highly receptive to the intervention and felt that they benefited from the experience. Facilitators of Italy's fathers' circles noted that the group of fathers demonstrated from the first meeting a strong desire and ability to participate and share their emotions, fears, and hopes with each other. Despite time limitations and conditions of distancing, the Italian fathers' circles maintained a sophisticated, sensitive, and "light" or self-ironic conversational tone, which the facilitators felt contributed to excellent communication and sharing. Italian facilitators felt that the fathers expressed appreciation for the way the course invited them to discuss challenging emotions openly. For fathers in the Portugal parent groups, some of the highlights of the program identified in fathers' endline course evaluations were discussions about their children's futures, sessions which offered various approaches to caring for their baby, and sessions which covered the topic of sexuality before, during, and after birth. Facilitators in Portugal said that the fathers' open-minded discussion and willingness to participate were not only to the men's own high initial levels of motivation, but also to the atmosphere of trust established among the participants at the onset of the program, which encouraged the participants to get to know each other and become comfortable with more meaningful and vulnerable discussions throughout the program.

Fathers' willingness to attend the workshops in Lithuania, as facilitators noticed, was motivated by the expectations to learn from experiences of other fathers and share mutual concerns, diverse emotions and possible solutions for challenges of child care. Austrian facilitators observed that the most common positive feedback from workshop participants was enthusiasm for and benefit from the opportunity to exchange with other fathers by sharing experience, offering tips, and seeing and hearing how other fathers handle parenting challenges. Participants in Austria also reported their appreciation for being able to ask questions at any time, as well as the relevance of the program to different types of male caregivers of young children other than fathers. The Austrian trainers noted that men participating in the PARENT father workshops were more likely than the average Austrian population to be interested in engaged fatherhood, motivated to participate in the training, or already be active as fathers. However, many participating fathers also felt insecure in their role as father or overwhelmed by hurdles such as insufficient time off from their employers or inability to reduce working hours for financial reasons.

4 | DISCUSSION

The evaluative evidence presented above suggests that overall, the PARENT pilot led to some significant improvements in multiple outcomes in each of the four countries of implementation. Despite variation in target population, implementation context, program content, and evaluation approach across the PARENT countries, in all cases there are indications that the pilot programs made positive impacts on professionals and parents. Emergent pretest-posttest analysis from the PARENT programs in Italy, Lithuania, and Portugal indicate that awareness among health, education, and social work professionals about the importance of engaging men in active fatherhood

increased following the intervention, and there were also notable positive shifts in the practices of specialists to engage fathers and urge women to include their partners. Notably, impact evaluation data tentatively suggest that professionals' behaviors experienced larger positive shifts than their attitudes, which may be explained in part by professionals' high levels of initial agreement with gender equitable attitudes indicated in their pretest questionnaires. Across the PARENT programs, the data on the father/couple groups are more limited than the data on health professionals, due to smaller sample sizes and less rigorous evaluation approaches. Nevertheless, the available data suggest that fathers who participated in awareness groups also experienced positive shifts in their intended parenting behaviors and their agreement with gender norms, although feelings that men were not welcome in maternal and child health settings lingered in some contexts.

The findings from this study in the present paper add to the evidence for the effectiveness of gender-transformative parenting programs using the health sector as an entry-point to engage men in caring masculinities. These findings emphasize the potential usefulness of the health sector as an enabling environment for caring masculinity. For instance, Lithuania saw percentage increases in the proportion of social worker participants who said they know how to encourage fathers to participate more actively in childbirth, which reflects an expansion in expertise of the professionals on how to help engage with men and promote active fatherhood as a result of the training. From the perspective of fathers themselves, the results from Portugal which showed massive shifts in men's disagreement with the statement "men are not well received in prenatal service" (56.5%–93.8%) suggest 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. However, findings from Austria and Lithuania show that men's feelings of exclusion from the prenatal health environment can persist despite educational programming for fathers, particularly when existing institutional norms and legal structures do not support engaged fatherhood and instead pose barriers to men's involvement. The PARENT pilot also indicates that gender-transformative fatherhood programs can have impact beyond parenting. Notably, Portugal found that general domestic tasks unrelated to childcare (such as washing clothes and preparing food for other adults) had the lowest intended participation at baseline, suggesting that gendered domestic roles may continue to exist even when men present gender equitable attitudes and behaviors related to caregiving. Interestingly, these two activities saw the greatest increase in intent after the intervention suggesting that activities directed at fathers in the context of childcare can also address other gendered behaviors in the household.

Several additional themes emerged from extensive discussion with health, education, and social work personnel and with fathers/couples who received PARENT training. These topics include: the importance of contextual factors to mainstream engaged fatherhood in society, a summary of the most effective program contents and methods used in PARENT programming, and suggestions for scale-up.

4.1 | Contextual factors make a difference

The PARENT pilot intended to make engaged fatherhood more mainstream in society by influencing what we call the caring masculinities triangle (Messner, 2000), which encompasses changing individual attitudes, institutional practices, and public policies. Experiences from the PARENT pilot confirm that each of these three areas presents opportunities and constraints to using engaged fatherhood as an entry-point to caring masculinities.

Firstly, PARENT partners found that structural obstacles to engaged fatherhood at the institutional or public policy level often result from and reinforce the cultural stereotypes held by individuals regarding men's role in childcare. Some fathers participating in PARENT felt that they were excluded from the "caring space," while some mothers objected to men's "intrusion" and feared losing control. Within institutions, some individual health personnel held stereotypes about gender roles in parenting that affected their willingness to engage men in pregnancy and early childcare. For instance, men could be excluded due to the notion that men are potentially or inherently violent, while women could face loss of autonomy due to victim-blaming or attitudes about women's

autonomy at birth. Prevailing cultural norms around parenting also inform policy choices concerning welfare and Early Childhood Development (ECD) provisions. For example, in Lithuania there are very limited public ECD services before the age of two but there are generous parental leave provisions, used mainly by women. The belief that small children should receive care at home rather than in an ECD facility is intricately linked to the low rates of ECD provision in many EU countries. While these realities posed challenges for engaging men throughout PARENT, they also illustrate that there is an opportunity to shift policy and institutional practice by targeting individual attitude and belief change in parents and professionals.

Secondly, various institutional practices within the health system were identified by the PARENT pilot as barriers to engaged fatherhood. For instance, in Italy medical doctors were less likely than other health professionals to participate in PARENT for a variety of reasons, including time constraints and unavailability of replacements. In Lithuania, some medical personnel refused to engage in PARENT training, explaining that their functions relate only to maternal and child physical health and that conversations about the benefits of engaged fatherhood were not within their scope of practice. Across PARENT countries, we found that medical doctors tended to see active fatherhood as a personal matter decided within the couple, rather than as an opportunity for medical personnel to engage on this issue. Also, fathers' participation in maternal, newborn, and child health was, in some cases, 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. PARENT also found that the over-medicalization of childbirth constrained fathers' active involvement, particularly in the context of the COVID-19 pandemic. Research prior to the pandemic confirmed that 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, 2021). In the early days of the pandemic, when the mechanisms of infection were not yet well-researched, many health facilities embraced a risk-averse policy of separating fathers, partners, and accompanying companions from women during birth and at other moments along the birth path. As knowledge progressed and new guidance was issued by WHO and national/regional health authorities, some services made efforts to ensure parents could be together throughout childbirth. Regrettably, as we have seen and heard from professionals and parents throughout the PARENT project, some services and 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. The general sense observed in PARENT—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 well-established and recognized rights, given how easily they were overturned.

On the other hand, institutional practices also acted as opportunities or support systems for mainstreaming engaged fatherhood throughout the PARENT project. In Lithuania, municipal administrations supported the organization of the trainings and allowed its social workers to participate by releasing them from everyday tasks. Social workers equipped with tools and knowledge of mainstream gender-transformative approaches act as individual agents in both their work with young men and co-workers in their workplace. This contributes to ongoing social action in the field of prevention of GBV and connects domains of men's engagement as proposed by Casey et al. (2018).

Thirdly, some countries have progressive policies that support the mainstreaming of engaged fatherhood in society, but their implementation and uptake are varied. For instance, the extent to which fathers participate from birth is strongly correlated with national legal provisions for paternity leave or shared parental leave. This is not only because paid leave enables (some) fathers to take time off to be with the mother and child, but also because the existence and the extent of such provisions send a cultural message that such time is important for the family and society. The four countries involved in PARENT have different provisions, ranging from the lowest in Italy (10 days and only for private sector employees), to 3 weeks in Portugal and 1 month in Lithuania and Austria. Some countries in the EU, such as Lithuania, also have generous offers of parental leave that encourage parents, usually mothers, to stay at home for the first 2 years, thus affecting their employability and earning capacity. Similarly, use

by fathers as well as by mothers of work-life-family-balance provisions at work also varies. In most countries, such provisions are used mainly by mothers, a gender inequality that negatively affects women's employment status and career prospects while reinforcing traditionally distant roles for men in childcare. PARENT also found that the inadequate offer of Early Childhood Education (ECE) (0–3) facilities (e.g., in Lithuania, facilities are hardly publicly provided and are extremely scarce for children under age 2) also affects women's employment status, men's engagement as fathers, and the persistence of the breadwinner/caregiver stereotype.

4.2 | Most effective program contents and methods

Through implementing, monitoring, and evaluating the PARENT pilot, we can identify a suite of program characteristics which appear to be associated with effective engagement of participants and positive changes in attitudes, beliefs, behaviors, and institutional practices. Most centrally, we found that the objective of mainstreaming a father's perspective into the work of services and professionals, and of promoting co-parenting, should always be combined with a father-focused approach to enable men to gain confidence in their abilities as fathers. There must be a balance between mainstreaming (e.g., encouraging fathers' presence and active role in birth units by eschewing gender stereotypes) and focusing on the specificity of men's role and giving them space to exercise that role while respecting women's autonomy.

Additionally, the training of professionals on engaged fatherhood needs to be grounded on objectives that are more easily perceived by and of interest to them, such as child development and health, benefits for fathers themselves, and gender equality. For instance, service providers were drawn in by the notion that the early engagement (from pregnancy) of fathers was fundamental for the healthy psycho-social and even physical development of the child. Also, program facilitators noted that there is a growing desire among fathers to be involved in childcare from an early stage, and service providers who received PARENT training understood the necessity of responding to fathers' interest. Further, the notion that engaged fatherhood is necessary to ease women's burden, and to make progress toward gender equality, resonated with service providers across PARENT countries.

The PARENT project revealed several important considerations for talking about fathers and fatherhood during training, fathers' groups, and communication activities. First, the language used must be carefully adapted to the country of implementation. For instance, “engaged” or “active” fatherhood can mean different things in different contexts. It can range from simply “being there,” “doing stuff” to “help” mothers (in a still secondary and satellite logic) to a more intimate emotional as well as practical autonomous engagement. At one end it is less transformative, at the other it is more so. Second, it is important to keep in mind the pervasiveness of stereotypes concerning men and fathers (e.g., the male breadwinner and female care-giver model) among the general public and the (mainly female) professionals involved in early child education and health. Third, it is important to provide scientific evidence of how caring behavior changes men (e.g., in terms of higher levels of oxytocin vs. lower levels of testosterone and in terms of building a relation of trust and mutual respect with the child and the partner) to ground the objective of promoting caring masculinities, and to note that men's working skills improve when they become fathers as they learn new emotional and practical skills. Fourth, understanding the importance of caring behavior in men raises attention to the issue of having more men in the caring professions and early child education and in raising both boys and girls to care and do domestic work, breaking gender stereotypes. Finally, it is important to note that fatherhood is—for better or for worse—a social construct. The definition and promotion of new forms of fatherhood require complex forms of intervention that involve different actors and different dimensions (training of professionals, sharing groups, meetings, family counseling, communications projects, etc.).

PARENT has found that it is important to enable health provider trainees to self-reflect on entrenched stereotypes about gender, since these assumptions affect what and how they communicate to mothers and fathers. As a simple example, using the term ‘you’ in the plural (where required by the spoken language) when in the presence of the couple can be a way to make the father feel included in the conversation. Or, having heard from the mother, a

service provider can ask the father, "And what about you?" Among the most effective methods for deconstructing stereotypes and creating positive attitudes, the PARENT pilot found that active, participatory methods worked best. It is necessary to address/dismantle stereotypes regarding men and fathers (and institutional practices that "invisibilize" fathers) and raise awareness among prevalently female professionals about fatherhood as a social construct and the world of men's emotions and the cultural and practical constraints they face. Participatory training methodologies, group work, role plays, and testimonials of fathers are effective for these aims.

The overarching meta-goal of PARENT is to contribute to the prevention of GBV by promoting engaged fatherhood and thus caring masculinities. While implementing PARENT, a delicate balance has become clear regarding how the issue of violence is addressed during training with health staff:

> On the one hand, it is important to avoid strengthening the stereotype that all men are potentially violent. The training should focus on the more immediate reasons why engaged fatherhood is important (e.g., child development, maternal and child health, benefits for fathers, and gender equality) and take a positive approach to the possibility of engaging fathers in care. Scientific evidence that caring behavior is transformative for men, in terms of hormones/physiology and building mutually respectful relationships with children and partners, should also be emphasized. On the other hand, a brief discussion of the incidence of GBV during pregnancy and its short and long-term impacts should be part of the training, and training should stress the importance of developing effective male violence screening processes to identify signs of conflict during the pregnancy period. There also needs to be greater awareness about paternal depression, explaining symptoms which are different from those of women, and showing that it is not something to hide or be ashamed of. The link between engaged fatherhood and prevention of violence is neither intuitive nor widely recognized; it needs to be included as a topic in training events, bringing the available evidence.

Fundamental in terms of approach in training health professionals is the recognition of the autonomy of the mother in decision making regarding her own body, thus all that affects her physiology and physical as well as mental health. This has implications for the practices of health services and personnel, but also for the partner who is required to be supportive, respectful, and non-intrusive. Throughout the PARENT trainings, participating health personnel shared their own personal and professional doubts and thoughts about how to give space to men at the risk of them being intrusive, while recognizing that ultimately, when fathers are included and feel useful, the health and birth outcomes are better (as confirmed in literature: Tokhi et al., 2018, Moore et al., 2017, Redshaw & Henderson, 2013, Sarkadi et al., 2007). A frequent comment from PARENT trainees was that shared decisions by the couple regarding pregnancy and birth tend to work best and strengthen the mother's 'birth plan' vis a vis medical staff. This theme must be emphasized in programming with health professionals, fathers, and couples.

Lastly, based on PARENT experience it is possible to tentatively identify conditions that may encourage the participation of medical doctors, who were the most under-represented category of health professional across health personnel trainings. More medical doctors participated when they were mandated (or at least invited) to attend by the management of their respective services. In Italy, there was considerably higher attendance by medical doctors for shorter (3–-4 h) events/webinars co-organized with partner organizations. 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); and 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. However, the underlying causes of low motivation among medical doctors to attend are complex and require further study. Better ways need to be found to reach medical doctors such as making available and accessible scientific evidence, using training modules that are shorter, and offering flexible programming online.

4.3 | Upscaling and replication

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. Many programs begin with only 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 people of any gender. PARENT took a gender-synchronized approach from its inception, because maternal and child health services and interventions focused on caregiving have historically been directed toward women only. The PARENT pilot found an area for continued improvement 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, continuing 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.

Several additional recommendations have emerged from this PARENT pilot for future upscaling and replication. To avoid selection bias in future iterations of the program, fathers' groups can be self-selecting, although this approach does not address the issue of how to reach parents who are not already engaged and interested in caring masculinities topics. In terms of training, the program needs to influence pre-service training and curricula, not as a stand-alone but as a mainstreamed theme. Mainstreaming the concept of caring masculinity in pre-service training (e.g., by offering participants opportunities to engage in critical self-reflection about their own gender prejudices and understand their construction through the socialization process) might be important in promoting sustainable positive transformations in professionals' perspectives on gender norms, starting from the beginning of their careers. Finally, PARENT findings support the global evidence for men's growing interest in being involved as caregivers (Van der Gaag et al., 2019) and the role of professionals as "gatekeepers" to men's participation in caregiving by either reinforcing or challenging traditional gender roles through institutional practices (Frascarolo et al., 2016); therefore, there is an opportunity to continue to promote demand among service providers for gender-transformative training, as well as a need to continue to train program facilitators and trainers.

5 | LIMITATIONS

This exploratory study and research paper have several limitations. This paper combines each PARENT program's reports to extract contextual information, emergent themes, and salient data. However, the implementation teams in the four countries varied in the method and complexity of their respective study designs, data collection, and approaches to data analysis. Given these realities, the present paper is limited to a largely descriptive analysis of the common core items and only very limited comparisons across the KAP survey results for the four countries. Further, the overall lack of follow-up evaluations in the months following the intervention mean that this paper cannot speak to the long-term sustainability of the changes observed immediately following completion of the interventions.

Survey findings within each individual country must be interpreted with caution for several reasons. In all four countries, the health professions and ECE professions are highly feminized and participation of men in the PARENT pilot was scant, making it impossible to sex-disaggregate evaluation results. Since the findings are self-reported data, respondents may have given more socially acceptable rather than honest answers, may not have accurately assessed themselves, or may have misinterpreted the questions or rating scales. Drop out or non-response rates were rather high in some settings, and it is possible that the population who remained were no longer representative of the population we wished to study; for instance, those who were not able to complete the survey

may have held consistently higher or lower agreement with gender equitable attitudes than those who did complete the survey, skewing the results in one direction or the other. Problems also emerge due to the small sample sizes of the pilot groups. The relatively small sample sizes may not have had the statistical power needed to expose small but meaningful positive impacts of the program, or conversely may have led to overestimations of the program's impact. Further research on similar parenting programs would benefit from considering these limitations in their monitoring and evaluation plans.

In addition to these shared elements of program design, it is important to note that across all four countries, the COVID-19 pandemic and resultant prevention measures impacted the implementation of the project in similar ways, namely in its delivery approach, which transitioned from in-person sessions to an online format, and in the access to health professionals, who were at the frontline of the fight against COVID-19 and were no longer available to participate in an involved way in the project. It is essential to note that the onset of the pandemic and related safety measures undoubtedly impacted the implementation and outcomes of the PARENT pilot, namely in its delivery approach, which transitioned from in-person sessions to an online format, and in the access to health professionals, who were at the frontline of the fight against COVID-19 and were no longer available to participate in an involved way in the project.

While the programs in Austria, Italy, Lithuania, and Portugal shared a common integral approach and made several similar adaptations in response to the pandemic, each country's program curriculum and implementation plans were adapted to suit the specific situation in that country Shifting to online delivery of training (albeit maintaining small numbers and a high level of participants/trainer interaction) may have negatively influenced course assessments, as in our experience online training almost always obtains somewhat lower scores in terms of perceived effectiveness when compared to scores from in-person training, which most participants prefer. Roughly 25% of PARENT participants submitted only either the pre-test or post-test responses, a proportion which we believe was greatly elevated by the switch to administering surveys online. In our estimation, it is possible that the positive effect of PARENT could have been greater than indicated by our evaluations, as the participants who gave only partial responses were not included in the findings but may have positively influenced the outcomes. In addition, the pandemic prompted changes to health sector protocols which limited opportunities for men to attend health services and consultations with their partners. This contextual information that fathers were frequently excluded during the pandemic is important to consider when interpreting findings around protocols that involve the father in child healthcare visits. Additionally, 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 increased overall in the four countries during the pandemic across the region during confinement in response to pandemic-related increases in family tension. It is therefore difficult to discern the role of the PARENT intervention in increasing professionals' awareness of the importance of violence prevention during prenatal, natal, and postnatal periods.

6 | CONCLUSION

The PARENT project, adapted from the globally implemented and evaluated Program P curriculum, is an intervention to train health and early child education professionals and social workers on how to engage fathers in 'nurturing care' and contribute to the prevention of violence. The pilot of PARENT in Austria, Italy, Lithuania, and Portugal suggested that action research programs that apply gender-transformative methodologies may indeed have a decisive influence on a range of individual attitudes, with the potential for further influence on institutional practices and public policies. While the present study is exploratory, its findings suggest that the PARENT project resulted in more gender equitable attitudes and practices among service professionals, as well as increased awareness on the importance of engaging men in active fatherhood and gender-equitable caregiving to promote the eradication of violence against women and children, thus putting into practice the notion of engaged fatherhood and promoting "caring masculinities" (Elliot, 2016). Data from three PARENT countries offer somewhat more

limited evidence that fathers who participated in PARENT fathers' groups increased their engagement in child health services, their caregiving behaviors, and their disapproval of the use of violence.

Findings from this pilot build on existing evidence from other multi-sectoral male engagement interventions and contribute new knowledge about the possibility of implementing and scaling such programs across the EU. Program characteristics such as a gender-transformative and gender-synchronous approach, reflective and participatory methodologies, and attempts to transform institutional norms all impacted the intervention outcomes. This exploratory study offers promising insights and reference material for practitioners to consider integrating into their program and advocacy efforts, and for the PARENT program to heed in its next iterations. Future plans for PARENT include up-scaling the methodologies in each country (e.g., reaching a larger number of participants and mixing online and face-to-face sessions); strengthening partnerships with government institutions (namely ministries of health) to keep fatherhood and caregiving as a priority issue on their agendas; and promoting intersectoral approaches, such as working with the health sector and ECD professionals.

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DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions. The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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