Received: 16 July 2021 | Revised: 30 August 2021 | Accepted: 6 October 2021

DOI: 10.1111/phn.12995

PHN PUBLIC HEALTH NURSING WILEY

PROGRAM EVALUATION

Norwegian fathers' experiences with a home visiting program

Beate Solberg RN, PHN, MScN, PhD candidate[1] | **Kari Glavin RN, PHN, PhD Professor**[1] | **Rigmor C. Berg PhD Professor**[2,3] | **Nina Olsvold RN, PhD Associate professor**[1]

[1] Faculty of Health, VID Specialized University, Oslo, Norway

[2] Norwegian Institute of Public Health, Oslo, Norway

[3] University of Tromsø, Tromsø, Norway

Correspondence
Beate Solberg, Faculty of Health, VID Specialized University, Theodor Dahls vei 10, 0370 Oslo, Norway.
Email: beate.solberg@vid.no

Funding information
Research Council of Norway, Grant/Award Number: 282167; VID Specialized University and the City of Oslo, Norway

Abstract

Objective: To explore fathers' experiences with a Norwegian home visiting program during the prenatal period and the first-year postpartum.

Design: Qualitative design with interpretive description (ID) as the methodological approach.

Sample: Individual interviews with fathers ($n = 13$) who received home visits by a public health nurse (PHN) within the New Families home visiting program.

Measures: Interviews were guided by a semi-structured interview-guide, which contained open-ended questions encouraging informants to reflect on their experiences with home visits. The analysis of the data was informed by content analysis.

Results: Two main themes that reflect the fathers' experiences emerged: (1) *The importance of being on their home ground* captures the fathers' experience of receiving home visits and building a trusting relationship with the PHN. (2) *Including fathers in the home visit* represents their thoughts about the content and focus of the home visits.

Conclusions: Fathers experienced the universal New Families home visiting program as an important contribution towards a more available and tailored service, with the home environment as a suitable arena for developing a trusting relationship with the PHN. However, the fathers often felt insufficiently included in the home visits, with only scant attention towards them as independent caregivers, their emotional reactions, roles, and family relationships. Pre-birth home visits might contribute to strengthening preparations for fatherhood and increase fathers' engagement in the Child Health Service.

KEYWORDS
child health service, fathers, home visit, public health nursing

1 | BACKGROUND

The transition to parenthood involves psychological changes, new roles, expectations, life focus, and change in one's relationship with one's partner (Baldwin et al., 2019; Condon et al., 2004; Darwin et al., 2017; Shorey & Chan, 2020). Studies have shown that fathers require support in this transition (Carlson et al., 2014; Hrybanova et al., 2019). Correspondingly, while the Child Health Services (CHS) have traditionally been aimed at supporting mothers and children, today's service providers are expected to have a family perspective

(Norwegian Directorate of Health, 2020). Nevertheless, many fathers do not feel fully included in the CHS, nor viewed as independent and equal caregivers (Carlson et al., 2014; Solberg & Glavin, 2018).

The CHS is part of Norway's municipal health services and is used by 98% of families (Statistics Norway, 2021). It is voluntary, universal, free, and focused on health promotion and primary prevention, aimed at pregnancy and families with newborns and children aged five and under (Norwegian Directorate of Health, 2020). The public health nurse (PHN) plays a key role in the service (Norwegian Directorate of Health, 2020).

In Norway, home visits are a common practice in public health nursing, with traditions dating back to the early 20th century (Hjälmhult, 2016). The CHS offers a child health program with 13 clinical consultations, which include monitoring of the child's growth and development, vaccinations, and parental guidance and support (Norwegian Directorate of Health, 2020). Home visits are offered to families after they leave the maternity ward, and can be part of an extended follow-up (Norwegian Directorate of Health, 2020). These visits provide an opportunity for tailored help and support, and are also an important means to identify children at risk (Jansson et al., 2001; Norwegian Directorate of Health, 2020).

The New Families home visiting program (NF) is a universal intervention, developed between 2013 and 2016 (Leirbakk et al., 2018, 2019; The City of Oslo, 2018). It is offered in the City of Oslo as a supplement to the ordinary CHS program, and targets couples expecting their first child together, couples having their first child in Norway and vulnerable multiparous parents. The parents are offered repeated home visits from late pregnancy until the child is two years old; the number and content of the home visits are determined by each family's needs. By establishing contact prenatally, the aim is to build an early relationship between the PHN and the new family. The home visits and regular CHS program are provided by the same PHN, in a primary nurse model (The City of Oslo, 2018). Home visits provide the PHN with valuable information about the families' living conditions and resources, which may aid in preventing and identifying child maltreatment (Norwegian Directorate of Health, 2020).

To facilitate active paternal involvement in childcare, Norway offers paternity leave of up to 15 weeks (Norwegian Labour & Welfare Administration, 2021). In the CHS's family-focused perspective, fathers are expected to be involved as active and equal caregivers (Norwegian Directorate of Health, 2020). However, fathers often report varying degrees of support from the service and a lack of information targeting fathers (Baldwin et al., 2019; Høgmo et al., 2021; Solberg & Glavin, 2018).

Further, despite the CHS's aim of being family-focused, most of the research in this field centers on mothers and motherhood. Even when research includes both parents, fathers' individual needs and perspectives are often overlooked (Hrybanova et al., 2019; Wells, 2016). Thus, when new family-centered programs are implemented in the CHS, they must be evaluated from both parents' perspectives. The aim of this study was therefore to explore fathers' experiences with the NF home visiting program, to better understand their perspectives.

This study is part of a larger ongoing research project studying the experiences and implications of the NF home visiting program (National Library of Medicine, 2019).

2 | METHODS

2.1 | Design

In this qualitative study, we used Thorne's (2016) interpretive description (ID) as a methodological approach. ID is an inductive research strategy within nursing and other fields of health research, designed to explore issues that arise in clinical practice through a disciplinary lens (Thorne et al., 1997, 2004). Seeking to generate knowledge relevant to clinical practice, the study's aim was to explore fathers' experiences with the NF home visiting program.

2.2 | Sample and recruitment

We conducted individual interviews with fathers participating in the NF research project (National Library of Medicine, 2019). Inclusion criteria were fathers participating in the ongoing NF study who had agreed to be contacted for follow-up studies, had received at least one NF home visit from a PHN, had a 1-year-old child and mastery of English or a Scandinavian language.

Based on methodological recommendations, a sample size of 10–20 informants was considered acceptable to generate clinically significant knowledge (Thorne, 2016). Twenty-five fathers met the inclusion criteria and were invited to participate. An information letter and consent form were sent by mail, and non-responders received reminders via text messages. Seven fathers did not respond, five declined, and 13 fathers who responded positively were recruited between August 2020 and February 2021.

2.3 | Data collection

For all interviews, we used a semi-structured interview guide, based on the study aim and our prior contextual understanding of the topic (Thorne, 2016). The guide contained open-ended, overarching questions that encouraged informants to reflect on their experiences with home visits from a PHN: namely, to describe the home visit, what they remembered in particular, what topics they discussed, how they experienced these topics and how the PHN supported them.

The first author conducted the interviews one-on-one, either digitally, using the Zoom platform, or by telephone. The fathers determined the method: six chose Zoom, and seven preferred telephone. Both approaches were audio-recorded only. The interviews lasted between 55 and 90 min (mean 66 min). The first author transcribed the interviews verbatim after each interview.

TABLE 1 Examples of condensed units, codes, sub-themes, and themes

Condensed units	Codes	Sub-themes	Themes
It isn't easier, but it is more relevant to talk about difficult subjects being in your own home. When you go to the clinic, you don't always remember everything and there are more strict timeframes. You have an appointment at a certain time, then the child shall be measured and get a vaccine. The home visit is more open. You can talk more freely, let the thoughts flow. You can't do that at a clinic in the same way, the home visits are more tailored (Informant 6).	Adapted for open conversations and reflections	Convenient and tailored to the fathers' needs	The importance of being on their home ground
It feels more like a friend being on a visit, then a doctor or a nurse (Informant 10).	Close and personal	Instilling trust through relationship building	
When they come to your house, they get the opportunity to see the child's home surroundings. That is a positive thing. Hopefully they can also uncover if things aren't good enough (Informant 11).	Control of home conditions	An opportunity to check the home	
When I visited the clinic there were almost only mothers being there, and the public health nurse commented: "And there comes the dad." It is funny to observer that they think only mothers can take care of these things, it isn't natural for them when the fathers show up, although it is as much our responsibility as the mothers' (Informant 12).	Not a natural part of the service	Feeling excluded from the maternal community	Including fathers in the home visit
I wanted more support and help, someone who could explain all my emotions and tell me how I should react or behave in this situation… for example when you are alone with the baby… (Informant 3)	Need for understanding own emotions	Recognizing and normalizing emotions	
The role of the father was not a topic at the home visit. I wish it was. I wanted to talk about it, discuss… how can a father contribute in the beginning when he is not breastfeeding? I have been frustrated not knowing what to do. It would have helped to talk about it in advance (Informant 4).	Clarifying father's role	The importance of understanding roles and relationships	

2.4 | Analytic strategy

The analysis was inspired by content analysis (Graneheim & Lundman, 2004); this method includes making the manifest and latent content of the empirical material available for interpretation through a inductive process. First, the interviews were read thoroughly and repeatedly to obtain an overview of the empirical material. Then qualitative meaning units about the fathers' experiences were extracted from all interviews. Each meaning unit was discussed by the authors until we agreed that it captured the essence of the specific data extract. The units were then condensed—shortened, but with the core meaning preserved—and labeled with a code. The codes were compared based on differences and similarities and sorted into sub-themes and then themes. Though this description of the analysis implies a linear process, the analysis itself was carried out in an iterative manner, making it a data-driven approach. The tentative themes and sub-themes were discussed and revised several times during the process, driven by the aim of the study (Thorne et al., 1997).

Examples of the analytic process are given in Table 1.

2.5 | Ethical considerations

The study was conducted in accordance with the Helsinki Declaration (World Medical Association, 2013) and was approved by the Regional committees for medical and health research ethics (reference no: 2018/1378), and the Norwegian Centre for Research Data (project number: 735207).

The informants received written and oral information about the study and its purpose. They were also informed that all participation was voluntary and that they could withdraw at any time without consequences.

Data were anonymized, treated confidentially, and stored in accordance with the Norwegian Personal Data and Health Research Acts using the Service for Sensitive Data platform (University of Oslo, 2016). We report in accordance with the COREQ checklist (Tong et al, 2007).

3 | RESULTS

Thirteen fathers as presented in Table 2, were interviewed. Twelve were first-time fathers and one had two children. All lived with the mother of their child(ren), were employed, and lived in an urban area. They were 26–45 years old (mean age 36). The children were 11–18 months at the time of the interviews (mean age 14 months). Three fathers had grown up in another European country, while the rest were Norwegians. All had received one NF home visit during their partner's pregnancy, at approximately week 30, and one home visit from the child health program after birth. None of the fathers had received more than

TABLE 2 Sample characteristics of informants participating in the study

Characteristics	*N* = 13
Fathers' age	26–45 years (mean age 36 y)
First-time fathers Father of two children	*n* = 12 *n* = 1
Living with the mother of the child	*n* = 13
Employed	*n* = 13
Living in an urban area	*n* = 13
Grown up in Norway Grown up in a European country	*n* = 10 *n* = 3
Completed paternity leave	*n* = 12
Children's age	11–18 months (mean age 14 m)
Premature birth Born to term	*n* = 1 *n* = 12
Number of NF home visit from a public health nurse during pregnancy (prepartum): one visit	*n* = 13
Number of home visit from a public health nurse within ten days after birth (postpartum): one visit	*n* = 13
Received both visits (pre- and post-partum) from the same public health nurse	*n* = 12
Attended the child health program at the child health service from birth to 12 months postpartum	*n* = 13

TABLE 3 Themes and sub-themes that emerged through the data analysis process

Themes	Sub-themes
The importance of being on their home ground	• Convenient and tailored to the fathers' needs • Instilling trust through relationship building • An opportunity to check the home
Including fathers in the home visit	• Feeling excluded from the maternal community • Recognizing and normalizing emotions • The importance of understanding roles and relationships

two home visits during the prenatal period and the first year postpartum. All the participants attended the child health program at the CHS in addition to the NF program.

From the analysis two themes and six sub-themes emerged, as presented in Table 3.

3.1 | The importance of being on their home ground

3.1.1 | Convenient and tailored to the fathers' needs

The fathers described the home visit as a convenient way to meet with the PHN. For one father, the informal character of the meeting was especially appreciated: "*The home visit was really nice - she came one morning before work, we drank coffee, talked. It was a good moment. It feels like a warm gesture from the community when they send someone to our home, wanting to get to know us, spend time and talk about what we are expecting. I really like the fact that they come to our home.*" (Informant 5). The service felt accessible and tailored to the fathers' needs. It required minimal effort and thus reduced stress, compared to an appointment at the clinic—especially after the birth. Further, the home provided a safe and informal arena, with what one father called "a good atmosphere." Being on their home ground made the fathers relaxed and more likely to be personally engaged during the visit. The clinic, in contrast, was described as a rather sterile environment.

Accordingly, fathers were more likely to attend a home visit. One of the fathers explained how being in his own home made him feel more in control when talking about difficult subjects, in contrast to meeting with the PHN in a small office: "*Being in a small office, you have no space of your own, no opportunities to retreat, so to speak. In your own home you can stand up, walk around, gain some physical distance, for a short while. So, I think it is a nice arena - the safety of being in your own home, being less formal, that's important to me.*" (Informant 1).

Although all the fathers agreed about the convenience and informality of a home visit, none had reflected on this need beforehand, especially not a prenatal visit. They were therefore surprised to learn that the CHS offered prenatal as well as postpartum support. Those who had limited support from family and social networks were most positive towards home visits.

Another aspect the fathers considered important was that home visits were universal, offered to all families, regardless of circumstances. The fathers felt that this reduced stigma that may be attached to visits based on an evaluation of needs.

The fathers also saw the home visits as a valuable source of information about the CHS in general, and the child health program in particular. Meeting their PHN early meant that they had a contact whom they could call; this in turn reduced barriers around contacting the service for help or advice. However, while it felt safe and convenient

to have visits in the home, the clinic represented an important social arena for the fathers. As such, the fathers thought that the optimal service would include both home and clinic visits, enabling them to socialize with other fathers.

3.1.2 | Instilling trust through relationship building

The home visits were considered important for the development of a trusting relationship with the family's PHN. The fathers also felt it to be a good platform for the PHN to tailor the follow-up to each family's situation. Having a contact person in the CHS contributed to the fathers' sense of security. As one father described: "*I think talking to our nurse, showing sincere interest for our child, feels good. Having that one person in the system, knowing our child and us, it feels safe.*" (Informant 11).

The fathers described the PHNs as "warm," "personal," "caring," and someone they felt close to—"a friend." The informal conversation between the fathers and the PHN contributed to a closer relationship, not one dictated by a strict agenda, but rather by the PHN wanting to get to know the family. The fathers also noted that having a good connection between the parents and the PHN was important for instilling their feeling of trust. The connection was described as good if the nurse understood the parents' situation, was sensitive towards their questions and acknowledged their thoughts and emotions. Fathers who lacked a good relationship with their PHN and fathers who received home visits by more than one PHN, felt more disconnected from the service.

The continuity of care from a PHN with whom the fathers had a good relationship, impacted whether they wanted to "open up" and talk about difficult subjects. One father explained this as follows: "*You need to develop a relationship with a person to talk about sensitive topics. Continuous contact with that one person would be of great help for the relationship.*" (Informant 7).

3.1.3 | An opportunity to check the home

The trust the fathers felt towards the PHN did not preclude them from reflecting on the purpose of the home visit. Besides getting to know the families and facilitating further follow-up, several fathers speculated as to whether there were additional objectives to the PHN visits: for example, to uncover a potentially unsuitable environment for children. The PHN did not state this purpose but the fathers wondered if it was part of a hidden agenda. One father asked frankly: *"They can see how your home is - I wonder if that's actually part of the intention with the visit, to see if everything is okay?"* (Informant 10). Nevertheless, the fathers felt confident that the PHN would recognize their home as a safe and suitable environment for their child. Moreover, they felt the PHNs' role in checking that environments in fact were suitable for children was a good thing, as was offering support to parents in at-risk homes. As one father pointed out: "*The nurse can see how our home is - that we have a good home, a home with resources. Others might not have that, and she can discover homes that are not as good and give advice to parents who don't live as they should.*" (Informant 4).

Two fathers expressed mixed feelings about the home visit and experienced it as an interference. They neither fully trusted the system, nor the PHN's intentions. They recalled having shared a sensitive story from their own childhood with the PHN and felt their trust had been challenged when their story was noted in the medical record in a negative way. One father explained: *"I don't trust the system. There is a lot of control for no reason. I feel stressed about this information written in the medical record, with no control over who reads it and what they do with the information."* (Informant 3). This aspect made both fathers question the true agenda of the home visit and challenged their trust in the system. They worried about the consequences for their family if the PHN found their home unsuitable.

3.2 | Including fathers in the home visit

3.2.1 | Feeling excluded from the maternal community

Most of the fathers described not feeling fully included during the home visits. Although both the mothers and the fathers partook, the fathers' role and experiences with fatherhood was only occasionally a topic of conversation. As one father noted: *"I wanted more understanding from the public health nurse, for her to give more attention to me as a father."* (Informant 5). They also often felt excluded from the relationship between the PHN and the mother, and this made them feel vulnerable. One father described this as a feeling of being unwanted: *"Being present and not being asked, not included, that's kind of okay and maybe to be expected as a father. But the feeling of being unwanted… I have had that feeling."* (Informant 7). In other words, while the fathers expected that the main focus would be on the mother and baby, they wished more attention could be directed towards them as fathers and as individuals, and on parenthood as a shared and equal undertaking. They described it as feeling excluded from a female community: *"The nurse and the mother, they enter a women's space, a place you don't understand as a father, making you an outside observer."* (Informant 2).

When the PHN showed a personal interest in them, however, it felt good, and made them feel important as fathers. As such, they wanted more attention towards fatherhood, and wanted to be given the opportunity to talk about their experiences independently, not only in conjunction with motherhood. The fathers felt that being present at the home visit was their signal to the PHN that they wanted to be involved. Moreover, the home visit felt like a more natural and inclusive arena than visits to the clinic: *"As a father, I felt lonelier and more like a stranger visiting the clinic than at the home visit."* (Informant 11).

3.2.2 | Recognizing and normalizing emotions

The fathers expressed being unprepared for their emotional reactions, especially in the postpartum period. They experienced feelings of uncertainty, stress, anxiety, jealousy, shame and fear combined with feelings of joy and expectations. One father described it as being on a roller-coaster of emotions: *"I was not prepared. I was prepared for less*

sleep, but I was not prepared for all these roller-coaster feelings. I don't know if you can really prepare for it - it hit me like a rock." (Informant 7).

Most fathers reported that it was the PHN who took the initiative to help them talk about and reflect on their emotions during the home visit. They appreciated this, although they were not always comfortable sharing their feelings. They found it helpful when the PHN introduced and normalized the wide range of emotions fathers might face. One father described his emotional struggle in the following manner: *"In the beginning, there is no space for dad's thoughts and feelings. If you struggle, it is difficult to talk about it. You are supposed to be on the side-line, and you can't expect someone to be aware of your emotions. But it would have been nice to hear what can be normal for fathers to feel, that it is normal, without having to share my real feelings."* (Informant 2).

When postpartum feelings had been normalized and discussed, the fathers described themselves as better prepared for dealing with them: "*We talked about normal mental reactions and feelings at the home visit - this made me more aware of my own reactions, more prepared."* (Informant 1). Further, being able to recognize their feelings as normal was important for understanding their reactions and developing security in their new role. The fathers also thought that discussing their emotional reactions with the PHN during the home visit made it easier to be supportive of their partner, and vice versa. It also lowered the threshold for contacting the PHN for support, if necessary.

However, not all fathers saw the home visit as a suitable context for talking about emotional challenges. Although many found the home a safe place in which to talk, others felt the homely surroundings made it difficult to break up the general bonhomie and begin talking about challenges.

3.2.3 | The importance of understanding roles and relationships

The prenatal home visit provided an arena for the fathers to begin preparing for their parental role, especially when the focus was on their role as fathers. Almost all the fathers had experienced challenges with this role after birth. In particular, they described being unprepared for the strong bond between mother and child, making them feel excluded, insecure, and side-lined. One father explained: *"It would have been nice if someone had told me that it is normal that the child is more attached to the mother than the father - that the father can feel left out and jealous."* (Informant 2). When this mother-child dyad was a topic in the conversations during the home visits, the fathers found it less challenging to find their place in the family unit afterwards. They highlighted the importance of receiving help in clarifying their role and preparing for the coming challenges: specifically, with regards to understanding their own reactions, and to their ability to be supportive towards the mother. As one father pointed out: "*It is important for the parental dynamics - mom needs dad, and dad needs to know that being there matters.*" (Informant 2). Moreover, when both parents were present at the prenatal home visit, it provided them with a common starting point for further reflection, enhancing awareness around their individual roles, expectations, and the shared parental role.

4 | DISCUSSION

The aim of this study was to explore fathers' experiences with the NF home visiting program.

The fathers felt that the home visits represented a form of follow-up care, which they wanted more of. They described the home visits as making it easier to contact the PHN, and a good opportunity to obtain information about the service and the child health program - information fathers often miss (Wells, 2016). They found the home visits easier to attend than appointments at the clinic. Indeed, prior research has shown that fathers participate in fewer clinic visits than mothers (Sandstrom et al., 2015). Prior to the prenatal home visit, the fathers were uncertain of the need for and purpose of the visit, but afterwards they described it as useful, starting a process of reflection. This finding is interesting in light of prior research showing that helping couples to reflect together as parents may increase their communication and shared thoughts regarding parenthood (Sandstrom et al., 2015).

In the interviews, the fathers stated that they wanted more attention on the fatherhood role, both individually and in relation to motherhood. This finding is supported by Hrybanova et al. (2019), who found that men often describe struggling with challenges and insecurity regarding their new role as a father; further, role strain and role conflicts can often be associated with negative mental health experiences (Shorey & Chan, 2020). Indeed, the fathers felt unprepared for the breadth of emotions they experienced related to fatherhood. They highlighted the importance of the PHN in terms of normalizing this experience and giving general information about the range of feelings that may arise—and how to cope with them. The fathers found talking about their emotions in the home visit to be a positive, if challenging, experience. These findings are supported by Wells' (2016) study, which showed that fathers who receive emotional support feel more secure regarding fatherhood.

It is important to note, however, that fathers may question the legitimacy of their own emotional challenges, often prioritizing the mothers' needs (Darwin et al., 2017). In addition, PHNs have described challenges around determining fathers' emotional states (Hammarlund et al., 2015). The fathers' need for emotional support—and the benefits of receiving this support from other fathers in similar situations (Darwin et al., 2017)—may explain why the fathers in this study wanted both home and clinic visits: namely, they wanted the opportunity to socialize with other fathers at the clinic. This highlights fathers' need to receive both formal and social support. Indeed, other studies emphasize the importance of giving fathers the opportunity to meet and share emotional experiences, as a complement to the formal support provided by the CHS (Åsenhed et al., 2013; Carlson et al., 2014; Darwin et al., 2017).

The fathers described the universal aspect of the home visit as reducing potential stigma around visits. Universalism is described as one of the strengths of public health nursing services, and is an important element in the NF program (Cowley et al., 2015; The City of Oslo, 2018). Offering visits to all parents enables PHNs to identify support needs and deliver services at a level proportionate to those needs—often referred to as "proportionate universalism" (Cowley et al., 2015; Macdonald et al., 2014). This approach, together with the possibility of

adapting the number of home visits, could better align the service with actual support needs (Carey et al., 2015).

Despite the universal framework of the NF program, however, the fathers reflected on what they perceived as a hidden agenda of the home visits. This can be described as a tension between care and control that is not always verbalized by the PHN's. Interestingly, while the fathers acknowledged this tension, they did not feel personally affected by it. Instead, they thought it was important that PHNs ensure that home environments are beneficial to children, describing this as a matter of trusting the service to do what was right. The NF manual describes the aim of home visits as building a trusting relationship, while also enabling the PHN to observe family behavior and interaction, living conditions and the suitability of the home for children (The City of Oslo, 2018).

To facilitate trust, the PHN must be able to recognize parents' vulnerability and have the professional and individual competence necessary to be trustworthy (Dinc & Gastmans, 2012). The issue of trust was highlighted by the fathers during the interviews: in relation both to the "control" aspect of the service, and to experiencing the home visit as interfering. Had the PHN clarified the purpose of the service, this may have increased trust. Moreover, a trusting relationship between PHNs and fathers has been shown to be essential for fathers' engagement in the service (Sandstrom et al., 2015). The majority of the fathers, however, did not feel fully included by the PHN. While the PHN's focus on mother and child was expected, the fathers also wanted to be included—both as independent caregivers and in relation to the mother. This duality is also described in other studies, which report fathers' experiences of inequality and being overlooked in female-focused arenas (Hrybanova et al., 2019; Høgmo et al., 2021; Solberg & Glavin, 2018; Wells, 2016). Family-centered programs often focus mainly on mothers and lack attention towards fathers, making them feel excluded and ignored (Wells, 2016).

In our study, the differences in the PHNs' approaches and attention towards the fathers impacted the degree to which the fathers felt included and would express their need for support. Many fathers find it difficult to seek help; they often question the legitimacy and importance of their own experiences, especially if they feel the service to be mother-oriented (Darwin et al., 2017). Some fathers even experience PHNs as gatekeepers, keeping the fathers' out of the female-centered CHS community, and making them feel like a secondary parent (Sandstrom et al., 2015; Wells, 2016). Nurses have reflected on their own gender role attitudes when meeting parents, noting their presumption that the mothers will automatically be present, but not the fathers: in fact, they often make a comment if the father is present (Hammarlund et al., 2015). As such, PHNs may benefit from changing their practice to overcome traditional gender role attitudes influencing their encounters with parents (Hammarlund et al., 2015). This may include viewing fathers as independent caregivers. In general, fathers receive less support from PHNs compared to mothers, and many nurses are ambivalent about fathers' caring abilities (Massoudi et al., 2010). Indeed, PHNs often describe themselves as more involved with mothers in their practice, and report a lack of routines and tools to assess fathers' health (Hammarlund et al., 2015).

The extent to which fathers feel supported, empowered and helped can be directly linked to their involvement in the CHS (Wells, 2016). PHNs have highlighted that their ability to make fathers feel welcome and important is crucial for fathers' engagement in the CHS (Massoudi et al., 2010). As fathers are more often present at the home visit, this may be a more suitable arena in which to involve fathers and include their perspective (Massoudi et al., 2010). Home visits focusing on building a one-on-one relationship between the PHN and the father—focusing on their personal needs, giving them attention—may increase fathers' engagement in the service (Stolz et al., 2020; Sandstrom et al., 2015). Some studies also indicate that fathers may require even more support from PHNs than mothers, because they often lack the mothers' supportive network (Jungmarker et al., 2010).

In this study, the fathers described the physical environment of the home as important for inclusion. The environment at the clinic, by contrast, has often been found to be female-dominated, potentially signaling that mothers belong there more than fathers (Engman & Wells, 2009; Wells, 2016). Home visits might therefore enhance fathers' feelings of inclusion and equality.

4.1 | Limitations

The study was conducted within and framed by the Norwegian health care system and traditions, which represents a potential limitation: the transferability of results regarding fathers' experiences and engagement with the service must be seen in this cultural context.

Another limitation is that the study was conducted by female researchers—a possible weakness given the study's focus on fathers. While the interviewer is a PHN, which may have influenced the interviews, she critically examined her own role, made concerted efforts to achieve neutrality and there was more than one analyst.

The sample size of this study was limited to 13 informants. This limits the transferability of the results, although they represent and reflect the experiences of the fathers in the current sample. Related, there may be some uncertainty in representativeness of the informants. They had relatively similar backgrounds and fathers who agree to participate in this type of study may be the ones who are the most positive, committed, and have high program expectations. They had also received a rather small number of home visits each from the PHN. However, the findings are strengthened by the participants' first-hand experiences. Use of an interview guide ensured a consistent approach, open questions increased the fathers' opportunities to reflect on their experiences.

4.2 | Implications for public health nursing

To increase the family-focused perspective of the CHS, PHNs need more focus on fathers as independent caregivers. Including fathers' perspectives might contribute to a more tailored service for both parents, thus realizing the goal of a family-oriented service. To reduce gender differences, further research is needed on the fathers' perspectives concerning the service's content and practices.

5 | CONCLUSION

Fathers reported positive experiences regarding the NF home visiting program. They reported that it made the CHS seem more accessible and supportive. That the program was offered to all families, reduced stigma and enabled the fathers' individual needs to be met. Additionally, the fathers found that the home was a suitable arena for developing personal and trusting relationships with the PHN. Related, they noted the importance of transparency about the aim of the service. Some fathers felt insufficiently included in the home visits and sensed a lack of attention towards themselves as independent caregivers. They found their emotional reactions, the paternal role, and the different roles and relationships in the family were scantily addressed. Finally, the fathers felt that pre-birth home visits might help fathers better prepare and may increase their engagement and participation in the CHS.

ACKNOWLEDGMENTS

We want to warmly thank the fathers who participated in the study, sharing their experiences and thoughts with us.

CONFLICTS OF INTEREST

We have no known conflict of interest to disclose.

ETHICS STATEMENT

The study was conducted in accordance with the Helsinki Declaration (World Medical Assosiation, 2013) and was approved by the Regional committees for medical and health research ethics (reference no: 2018/1378), and the Norwegian Centre for Research Data (project number: 735207).

The informants received written and oral information about the study and its purpose. They were also informed that all participation was voluntary, and that they could withdraw at any time without consequences.

Data were anonymized, treated confidentially, and stored in accordance with the Norwegian Personal Data and Health Research Acts using the Service for Sensitive Data platform (University of Oslo, 2016). We report in accordance with the COREQ checklist (Tong et al, 2007).

DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions.

ORCID

Beate Solberg RN, PHN, MScN, PhD candidate https://orcid.org/0000-0002-2220-1255
Kari Glavin RN, PHN, PhD https://orcid.org/0000-0002-6697-2764
Rigmor C. Berg PhD https://orcid.org/0000-0002-6915-0993
Nina Olsvold RN, PhD https://orcid.org/0000-0002-3297-6943

REFERENCES

Åsenhed, L., Kilstam, J., Alehagen, S., & Baggens, C. (2013). Becoming a father is an emotional roller coaster—An analysis of first-time fathers' blogs. *Journal of Clinical Nursing*, *23*, 1309–1317. https://doi.org/10.1111/jocn.12355

Baldwin, S., Malone, M., Sandall, J., & Bick, D. (2019). A qualitative exploratory study of UK first-time fathers' experiences, mental health and wellbeing needs during their transition to fatherhood. *BMJ Open*, *9*, e030792. https://doi.org/10.1136/bmjopen-2019-030792

Carey, G., Crammond, B., & Leeuw, E. D. (2015). Towards health equity: A framework for the application of proportionate universalism. *International Journal for Equity in Health*, *14*(81),. https://doi.org/10.1186/s12939-015-0207-6

Carlson, J., Edleson, J. L., & Kimball, E. (2014). First-time fathers' experiences of and desires for formal support: A multiple lens perspective. *Fathering*, *12*(3), 242–261. https://doi.org/10.3149/fth.1203.242

Condon, J. T., Boyce, P., & Corkindale, C. J. (2004). The First-Time Fathers Study: A prospective study of the mental health and wellbeing of men during the transition to parenthood. *Australian and New Zealand Journal of Psychiatry*, *38*(1-2), 56–64. https://doi.org/10.1177/000486740403800102

Cowley, S., Whittaker, K., Malone, M., Donetto, S., Grigulis, A., & Maben, J. (2015). Why health visiting? Examining the potential public health benefits from health visiting practice within a universal service: A narrative review of the literature. *International Journal of Nursing Studies*, *52*(1), 465–480. https://doi.org/10.1016/j.ijnurstu.2014.07.013

Darwin, Z., Galdas, P., Hinchliff, S., Littlewood, E., McMillan, D., McGowan, L., & Gilbody, S. (2017). Fathers' views and experiences of their own mental health during pregnancy and the first postnatal year: A qualitative interview study of men participating in the UK Born and Bred in Yorkshire (BaBY) cohort. *BMC Pregnancy and Childbirth*, *17*(45),. https://doi.org/10.1186%2Fs12884-017-1229-4

Dinc, L., & Gastmans, C. (2012). Trust and trustworthiness in nursing: An argument-based literature review. *Nursing Inquiry*, *19*(3), 223–237. https://doi.org/10.1111/j.1440-1800.2011.00582.x

Engman, J., & Wells, M. (2009). BVC ur ett genusperspektiv. In A. Sakadi (Ed.), *Föräldrastöd i Sverige i dag - vad, när och hur? [Parenting support in Sweden today—What, when and how?]*. Landstinget i Uppsala Län: Statens Folkhälsoinsitut.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*, 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Hammarlund, K., Andersson, E., Tenenbaum, H., & Sundler, A. J. (2015). We are also interested in how fathers feel: A qualitative exploration of child health center nurses' recognition of postnatal depression in fathers. *BMC Pregnancy and Childbirth*, *15*, 290. https://doi.org/10.1186/s12884-015-0726-6

Hjälmhult, E. (2016). Hjemmebesøk som metode [Home visit as a method]. In H. Holme, E. S. Olavesen, L. Valla, & M. B. Hansen (Eds.), *Helsestasjonstjenesten. Barns psykiske helse og utvikling [Child Health Services: Children's mental health and development]* (pp. 413–423). Gyldendal Akademisk.

Hrybanova, Y., Eksröm, A., & Thorstensson, S. (2019). First-time fathers' experiences of professional support from child health nurses. *Scandinavian Journal of Caring Sciences*, *33*(4), 921–930. https://doi.org/10.1111/scs.12690

Høgmo, B. K., Bondas, T., & Alstveit, M. (2021). Going blindly into the women's world: A reflective lifeworld research study of fathers' expectations of and experiences with municipal postnatal healthcare services. *International Journal of Qualitative Studies on Health and Well-being*, *16*(1), 1918887. https://doi.org/10.1080/17482631.2021.1918887

Jansson, A., Pettersson, K., & Uden, G. (2001). Nurses' first encounters with parents of new-born children—Public health nurses' views of a good meeting. *Journal of Clinical Nursing*, *10*, 140–151. https://doi.org/10.1046/j.1365-2702.2001.00456.x

Jungmarker, E. B., Lindgren, H., & Hildingsson, I. (2010). Playing second fiddle is okay–Swedish fathers' experiences of prenatal care. *Journal of Midwifery & Women's Health*, *55*(5), 421–429. https://doi.org/10.1016/j.jmwh.2010.03.007

Leirbakk, M. J., Torper, J., Engebretsen, E., Opsahl, J. N., Zeanah, P., & Magnus, J. H. (2018). Formative research in the development of a salutogenic early intervention home visiting program integrated in public child health service in a multiethnic population in Norway. *BMC Health Services Research*, *18*(1), 741. https://doi.org/10.1186/s12913-018-3544-5

Leirbakk, M. J., Magnus, J. H., Torper, J., & Zeanah, P. (2019). Look to Norway: Serving new families and infants in a multiethnic population. *Infant Mental Health Journal*, *40*(5), 659–672. https://doi.org/10.1002/imhj.21804

Macdonald, W., Beeston, C., & McCullough, S. (2014). *Proportionate universalism and health inequalities*. National Health Services Scotland. http://www.healthscotland.com/uploads/documents/24296-ProportionateUniversalismBriefing.pdf

Massoudi, P., Wickberg, B., & Hwang, P. (2010). Fathers' involvement in Swedish child health care—The role of nurses' practices and attitudes. *Acta Paediatrica*, *100*(3), 396–401. https://doi.org/10.1111/j.1651-2227.2010.02047.x

National Library of Medicine. (2019). *New Families—Innovation and development of the Child Health Services in Oslo (NF)* (Identifier NCT04162626). https://clinicaltrials.gov/ct2/show/NCT04162626?cond=New+Families&cntry=NO&draw=1&rank=1

Norwegian Directorate of Health. (2020). *Nasjonal faglig retningslinje for det helsefremmende og forebyggende arbeidet i helsestasjon, skolehelsetjeneste og helsestasjon for ungdom* [National guidelines for health clinics and school health services]. Retrieved from 17. June 2021: https://www.helsedirektoratet.no/retningslinjer/helsestasjons-og-skolehelsetjenesten

Norwegian Labour and Welfare Administration. (2021). *Parental benefit, lump-sum grant and pregnancy benefit*. Retrieved from 17. June 2021: https://familie.nav.no/

Sandstrom, H., Gearing, M., Peters, H. E., Heller, C., Healy, O., & Pratt, E. (2015). *Approaches to father engagement and fathers' experiences in home visiting programmes* (OPRE Report #2015-103). Office of Planning, Research and Evaluation. https://www.acf.hhs.gov/sites/default/files/documents/20151130_fahv_report_finalized_b508_0.pdf

Shorey, S., & Chan, V. (2020). Paternal mental health during the perinatal period: A qualitative systematic review. *Journal of Advanced Nursing*, *76*, 1307–1319. https://doi.org/10.1111/jan.14325

Solberg, B., & Glavin, K. (2018). Fathers want to play a more active role in pregnancy and maternity care and at the child health center. *Sykepleien Forskning*, *13*(72006),. https://doi.org/10.4220/Sykepleienf.2018.72006en

Statistics Norway (2021) *Municipal health care service*. Statistics Norway. Retrieved from 17. June 2021: https://www.ssb.no/en/helse/helsetjenester/statistikk/kommunehelsetenesta

Stolz, H. E., LeGraff, M. R., Mullican, K. N., Connor, L. A., Green, M. J., & Clouthier, S. (2020). Exploring fathers' engagement with home visiting: The Tennessee dad project. *Families in Society: The Journal of Contemporary Social Services*, *101*(4), 498–513. https://doi.org/10.1177%2F1044389420901640

The City of Oslo. (2018). New families—A good start in life. Training manual. The city councillor for child upbringing and knowledge, The City of Oslo.

Thorne, S. (2016). *Interpretive description: Qualitative research for applied practice* (2nd edn.). Routledge.

Thorne, S., Kirkham, S. R., & MacDonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health*, *20*, 169–177. https://doi.org/10.1002/(SICI)1098-240X(199704)20:2%3C169::AID-NUR9%3E3.0.CO;2-I

Thorne, S., Krikham, S. R., & O'Flynn-Magee, K. (2004). The analytic challenges in interpretive description. *International Journal of Qualitative Methods*, *3*(1), 1–11. https://doi.org/10.1177%2F160940690400300101

Tong, A., Sainsbury, P., & Craig, J. (2007) Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

University of Oslo. (2016). *Service for sensitive data*. https://www.uio.no/english/services/it/research/sensitive-data/about/introduction.html

Wells, M. B. (2016). Literature review shows that fathers are still not receiving the support they want and need from Swedish child health professionals. *Acta Paediatrica*, *105*, 1014–1023. https://doi.org/10.1111/apa.13501

World Medical Association. (2013). World Medical Association Declaration of Helsinki: Ethical principles for medical research involving human subjects. *Jama*, *310*(20), 2191–2194. https://doi.org/10.1001/jama.2013.281053

How to cite this article: Solberg, B., Glavin, K., Berg, R. C., & Olsvold, N. (2021). Norwegian fathers' experiences with a home visiting programme. *Public Health Nursing*, 1–9. https://doi.org/10.1111/phn.12995