Double exclusion: How to engage with and support gay fathers

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Most of the research conducted in the last 40 years suggests positive outcomes for children growing up with lesbian or gay parents. How many gay fathers are there in the UK and elsewhere and who are they? How do educators, midwives and early years' practitioners engage with them? What information do they want and how might services better meet their needs?
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Researchers have been studying families headed by lesbian, gay, bisexual and transgender (LGBT) parents since the late 1970s and despite four decades of research since then - most of it suggesting positive outcomes for children growing up with gay or lesbian parents - many countries, including the UK, still prohibit same-sex couples' access to alternative routes to parenting (Takács et al., 2016; Fedewa et al., 2015).

However, many routes exist through which gay (and bisexual) men can and do become fathers. Some do so via heterosexual relationships; some become stepfathers, partnering with men who already have children; some enter 'co-parenting' arrangements – either singly or as a couple, with single women or female couples who wish to become mothers via artificial insemination; some act as 'donor dads' with little or no subsequent involvement, although since 2005 children in the UK have the right, when they reach 18, to find out who they are (Human Fertilisation and Embryo Authority, HFEA, 2019); some adopt or foster – either singly or as a couple; some use surrogacy – again, either singly or as a couple, and with differing levels of ongoing involvement from the surrogate and/or egg donors; there are also transgender fathers who give birth to their children.

There are no definitive statistics for how many gay fathers there are in the UK, but the Fatherhood Institute estimates that there could be around 16,000 (see Box 'How many gay fathers are there in the UK?').

How many gay fathers are there in the UK? According to official estimates (Office of National Statistics, ONS, 2017), there were 18,000 same sex couple families with dependent children in the UK in 2017 (the most recent date for which detailed figures are available). These were made up as follows: 8,000 civil partner couple families, 6,000 married couple families and 4,000 cohabiting couple families.

Evidence from the US suggests that male-male households are half as likely as female-female, to have children (Burgoyne, 2012). If we were to assume the same pattern in the UK, that would suggest a third of the 18,000 families (6,000) were male-male and two-thirds (12,000) were female-female. This would give us a total of 12,000 gay fathers (two per couple).

This figure does not include single gay fathers with dependent children. We know that in total, there were 1.8 million 'lone parent families with dependent children' (ONS, 2017), and of these roughly 10% (180,000) were headed by men. Assuming that, in line with the general population, around 2% of these men identified as gay (for estimates of self-identified sexual orientation, see Office of National Statistics, ONS, 2017b), that could add another 3,600, bringing the total to 15,600.

These figures will include biological, adoptive and 'social' fathers. We cannot quantify these categories in detail, but indications are that adoptive fathers make up a fairly small proportion of the whole – even if a growing proportion of adopted children are placed with same-sex couples. In 2018, 450 out of 3,820 adoptions (12%) involved same-sex couples – up from 10% in 2016 and 8% in 2015. Out of all adoptions, 11% were to single people but data on their sexual identity is not recorded (Besanville, 2018).

On top of the 15,600 gay fathers estimated above, there will be other gay fathers and father-figures who have dependent children and may be substantially involved in their lives, but who are not recorded in official statistics because their children live primarily (or spend an equal amount of time)

with their mother(s). We have no way of counting these men but numbers could be significant.

Added to the list of 'invisible fathers' we should add 'trans-dads' - female-to-male transgender people who give birth. The UK doesn't hold data on this, but Australia (whose population is less than half that of the UK) does, and has recorded 228 such births in the last decade (Quinn, 2019). A recent court case confirmed that for now at least, such fathers are, legally speaking, mothers (Booth, 2019).

For more on the problems of official data failing to record men's fatherhood, see the Fatherhood Institute's 'Where's the Daddy?' report (Goldman & Burgess, 2017).

To give a sense of how small the UK population of gay fathers is, in 2017 there were 4.9 million heterosexual married couple families with dependent children, and 1.2 million heterosexual cohabiting couple families with dependent children. So same-sex married couple-with-dependent-children families made up 0.1% of the total number of married couple-with-dependent-children families, and same-sex cohabiting couple-with-dependent-children families made up 0.3% of the total number of cohabiting couple-with-dependent-children families. These percentages are much lower than the overall percentage of the population identifying as lesbian, gay or bisexual, which was 2% in 2017.

The proportion of couple families who have dependent children is much lower among same-sex couple families, than among heterosexual couple families. Almost two-fifths (39%) of heterosexual married couple families, and the same percentage of heterosexual cohabiting couples, have dependent children; among same-sex married couple families the figure is 18% and among same-sex cohabitees, it is 4%; 15% of civil partner couple families (who under current legislation are all same-sex couples) have dependent children. It is interesting to note that these percentages are broadly similar to those in the US (see Burgoyne, 2012).

WHO ARE GAY FATHERS?

The varied 'types' of gay father (see Box 'Different 'types' of gay fathers' for more information) mean there is no such thing as a 'typical' one. In some cases, for example where a single gay man has adopted a child or children, one may encounter a gay father who is a child's only parent. In others, for example where a gay couple has used surrogacy arrangements to create their family, two fathers may present as a co-parenting family unit. Often a gay father (or fathers) will be part of a bigger parenting team involving one or more mothers.

Different 'types' of gay father

Thanks to their differing routes to fatherhood (see Riggs & Due, 2014, for a useful review), gay (and bisexual) fathers will present to health services in diverse ways. Many may, if anything, be less visible to services than their heterosexual counterparts – but this should not absolve you from seeking to engage with them, because of their significant potential impact on their children's lives, health and developmental outcomes.

Primary care, maternity, health visitor and other community-based services in larger cities, where there will be larger concentrations of LGBT people - and especially in historically 'gay-friendly' places like Manchester and Brighton in the UK – are likely to be relatively accustomed to dealing with LGBT families with children. Awareness of, and responsiveness to, lesbian couples becoming mothers via artificial insemination – probably the most common family 'type' - may actually reinforce a service's 'women only' focus though, with the unintended consequence that gay fathers and father-figures (within these families and more generally) remain unseen or viewed as an afterthought.

In some cases donor fathers have little or no involvement in 'their' child's life. However, it is also relatively common for gay men (singly or in couples) to cooperate closely with lesbians (again, singly or in couples) and even straight women (see for example Erera & Segal-Engelchin, 2014), to create 'co-parenting' families. Even if the 'main' parents in these families are female, a biological father and sometimes another father-figure too, may be somewhere in the picture: such dads may or may not appear at scans, as birth partners or at home visits, but they may still be highly involved as hands-on parents. And in some cases they will be very much present, as an integral part of the 'parenting team' around the newborn baby. Either way, they may be just as much in need of information and support as any other parent.

Increasingly, female-to-male transgender people are giving birth, adding a layer of complexity to the challenge for health professionals of looking beyond first impressions when meeting parents, even if the law has yet to accept that a person who gives birth to a child could be its father (Booth, 2019).

What about gay fathers using a surrogate mother? There is a growing international surrogacy market, and while the act of surrogacy itself is not illegal in the UK (although advertising and paying for a surrogate (apart from their expenses) is), it is not impossible that you might encounter such a case. The family in question may appear to be 'standard': mum, dad and soon-to-be-born bump; or the birth-mother might appear with two fathers – and it may not be clear (including to the people involved, not just yourself) which one is the biological dad; indeed, it could even be that both men are, if it is a gestational surrogacy and each partner's sperm has fertilised one of two successfully implanted embryos!

Studies of gay father surrogacy families are in their infancy, but they so far suggest that the dads try to establish positive ongoing relationships with surrogates and, where possible, with egg donors (Blake et al., 2016); that genetic and

non-genetic fathers are just as likely to want to become parents, and share similar motivations for choosing surrogacy (Blake et al., 2017), and that they may also be more open about their route to parenthood than heterosexual surrogacy families, when dealing with healthcare and education providers (Sydsjö et al., 2019).

Levels of parenting stress among gay-father-surrogacy families seem to be similar to those of lesbian-mother families formed through donor insemination and heterosexual-parent families formed using IVF (Van Rijn, 2018). It is not known if/how UK health services respond to gay father surrogacy families; a recent US study reports that in the state of Rhode Island, 'intended parents' can, if they have the right paperwork, make medical decisions about the newborn baby, and hospital staff will teach them about newborn care; it also describes in detail how postnatal support might best be provided to such fathers (Salera-Vieira, 2019).

Gay adopters and foster fathers may not typically make use of maternity services because they are taking on older babies or children – but they, along with all the other 'types' of gay father described, will come into contact with primary care and other community-based services, and they are almost certainly growing in number (see Box 'How many gay fathers are there in the UK?' for more information about numbers). Adoptive parents generally experience higher parenting stress than other parents, and it is important that adoption agencies bear this in mind when placing children; LGBT adopters' parenting stress seems to be no higher than heterosexual adopters' (Wingfield, 2017).

Adoptive dads should, like any other parent, expect to receive appropriate information and support without feeling like they need to justify themselves or accept negative comments or attitudes. This should pose no particular challenge for services: if your focus is child health, it should be considered absolutely normal, after all, for a father (gay, straight or otherwise) to accompany his child to appointments and be the one to give and receive relevant information.

What about 'social fathers' including stepfathers or fathers' boyfriends – who may not have any legal status in respect of the child, but may well show up to appointments or be present during home visits? Such men may seem less important but they can be hugely significant in a child's life – especially if supported to carve out their own relationship with the child in an often crowded parenting team. So in the same way that one should view a man accompanying a mother to appointments as a potential father-figure - someone to approach as a potential resource (as well as a potential risk) the same ought to be true if he comes along with a father.

Some of the challenges faced by gay fathers (and we should include bisexual fathers in our thinking, too) will differ in line with their diverse routes to fatherhood. But no matter how they became fathers, these men – like all fathers – need high quality information and support that is relevant to their specific needs, timely, addressed directly to them, and focused on supporting them to:

- become confident and competent hands-on caregivers;
- develop happy, positive relationships with their children; and
- create a healthy, supportive environment in which their children can thrive.

Much of the exclusion gay fathers experience when accessing health services will have its origins not in homophobia, but in deeply ingrained beliefs about gender. The idea that women are better, more committed and more 'natural' parents is widespread in UK society, although science does not support it (Brooks, 2014). It is promulgated by films, TV and the advertising industry, and it is supported by government policy – for example the UK has the widest gap anywhere in the developed world between mothers' and fathers' parenting leave entitlements (Burgess & Davies, 2017:12-15).

This, combined with the very understandable focus of maternity services on women's health, and exaggerated beliefs about the prevalence of intimate partner violence perpetrated by men during pregnancy (Burgess & Goldman, 2018:23-25), conspires to create services which view men - any men (regardless of their sexual identity) - as superfluous and even unwelcome 'intruders' in a female space, rather than as figures central to the achievement of successful child (and maternal) outcomes.

A recent Fatherhood Institute (2018) survey of 1,873 men who had become fathers in the preceding five years provided an insight into how this 'dyadic' (mother-child) focus is experienced by new dads. Despite 94% of those surveyed having attended at least one antenatal appointment, 99% ultrasound scans, 98% labour/birth (91% from start to finish), and 94% at least one postnatal home visit, large numbers felt ignored before, during, and after delivery - even though their involvement is central to infant and maternal well-being, and is desired by mothers.

Two-thirds (65%) of the fathers said the healthcare professionals had rarely or never discussed fathers' roles. More than half (56%) said they had rarely or never been addressed by name. Fewer than a quarter had been asked about their physical health (22%) or diet and exercise (18%). And even though a father's mental health is closely correlated with a mother's, only 18% had been questioned about it. Around half (48%) had not been asked about smoking, despite the risks of passive smoking to babies, and fathers' key role in supporting pregnant mums to give up. NHS staff visiting after the birth never or rarely spoke about fathers' roles, according to nearly half the respondents, even though dads influence infant feeding and

are key to spotting maternal depression.

Although it is not known how many of the fathers who responded to this survey (if any) were gay, it seems unlikely that maternity services would be any more 'male friendly' towards gay fathers per se.

Indeed, it may be that a sample of gay fathers would report having received an even rougher deal from services, because they are in a unique double bind. Firstly, they are stereotyped and oppressed by negative beliefs about lesbians and gay men that call into question their capacities or skills (McLeod et al., 1999) and even their 'right' to be parents, and, at the same time, they are, as men (regardless of sexual identity) rearing children without the presence of a woman, seen as contravening traditional masculine gender expectations (Berkowitz & Marsiglio, 2007). All of this can result in discriminatory behaviours and negative attitudes, ranging from unconscious biases to deliberate exclusion.

Heteronormative culture and a lack of education about LGBTQ health among health professionals may underpin inadequate care (Stewart & O'Reilly, 2017). This matters because studies have found associations between exposure to homophobic discrimination and stigmatization and negative psychosocial/ behavioural outcomes in lesbian and gay parents and their children (Short et al., 2007; Tasker, 2005).

So one might say that gay fathers are fundamentally similar to heterosexual ones – but even more in need of special efforts to 'bring them in'.

HOW TO ENGAGE WITH GAY FATHERS

If you want to engage with a gay father, you should (as with any other father) focus first on the basics: it is important to establish trust. Look him straight in the eyes (Montague et al., 2013), smile and call him by his name. This can allow you to open a dialogue where your goal is to find out how he is feeling, whether he needs some help to do a good job of being a father, and to talk to him about his child as you would with a mother. Sometimes you may not instantly receive a warm reaction, but don't give up: men accessing maternity, parenting and child-focused services are generally out of their comfort zone, and gay men perhaps even more so - so you may need to give him time to get over the shock of being addressed directly and viewed as a valid parent!

Keep your focus on the whole team around the child, and that means not just thinking about the mother (or mothers). Parents often complain about strict hospital visiting policies which exclude dads beyond certain fixed hours (only 17% of those in the Fatherhood Institute survey (2018) were allowed to stay overnight, for example). It is worth noting that almost half of the NHS negligence bill is accounted for by claims relating to poor maternity services; yet when two units piloted overnights for fathers, complaints plummeted and midwives were freed up to give direct care (Higgs, 2010).

In a family where the baby has two mums and a highly involved dad, where would he stand in the pecking order for visits, and for the kind of supportive, informative conversations with midwives and educators that might ideally be on offer? And what if his partner is part of the parenting team too – would he be welcome too?

WHAT INFORMATION DO GAY FATHERS NEED?

Like other fathers, gay fathers need information that speaks to them directly and focuses on how they can best support their children's health, happiness and developmental outcomes.

Stonewall's 'Guide for Gay Dads' (Stonewall, 2015) contains lots of useful information, and you could recommend it to gay fathers you come across – but it focuses on legal matters and making decisions about how to become a father, rather than the practicalities of baby-care, child development, healthy behaviours and so on.

If money were no object, it would be great if services could produce targeted information aimed at every conceivable sub-group of fathers and mothers. But realistically, very few services even produce information targeted at fathers generally. So the chances are that if you have the opportunity to create a new resource, you should make it your goal to produce really good, practical information, focused on how to do the best job of looking after small children – and to make this work for ALL dads.

How do you bathe a tiny baby? What are the best ways to soothe her? Should I read to my baby or is that a waste of time? How much Calpol can we give him? These are the kinds of questions all parents need answers to, and gay fathers are no different. You don't need to give all the answers, but raising key issues and signposting to recommended sources can be really helpful.

An obvious way to make such a resource more universal, and to make gay fathers feel 'seen', would be to include some relevant images of gay couples (and single men) with children and to make clear in the wording that you are there to help them too. LGBT people, like heterosexual people, are culturally and ethnically diverse; some have disabilities; and they can become fathers at many different stages in life. So the more diverse the representation, the better.

'Standard' perinatal information usually includes content aimed at supporting heterosexual parents to keep their relationship as a couple happy, and may offer advice about sex during pregnancy, after the baby arrives and so on. While this is clearly not relevant to gay fathers, it is obviously important for most dads, so rather than take it out, make clear in the design of your information that this element of the information is aimed at fathers in heterosexual couples.

If you had space for information targeted specifically at gay dads, it could focus on things like: how to make a success of 'team parenting' with lesbian mums, how to handle the legalities of

REDESIGNING SERVICES TO BE INCLUSIVE OF FATHERS (INCLUDING GAY FATHERS)

Below are some recommendations for how services could make fathers welcome throughout pregnancy, birth and early infancy, valuing the role they play not just as supportive partners but also as independent parents with a unique connection to their baby. These are adapted from the Fatherhood Institute's 'Who's the Bloke in the Room?' research review (Burgess & Goldman, 2018).

1: Change NHS terminology to refer to fathers
At the time of the birth, 95% of parents are in a couple relationship, and 95% register the birth together. For a heterosexual woman to have a new partner at this stage is almost unheard of. Only one birth in a thousand is registered to two women, and even in such cases, the couple may wish the biological father and/or social fathers to also be highly involved in the child's life. Yet despite the overwhelming presence of biological fathers in antenatal services, the term 'woman's partner' or 'mother's partner' (rather than 'father') is commonly used. This defines the baby's father solely as a support-person and does not recognise his unique connections (both genetic and social) to his infant. The term 'woman's partner' should be widely replaced by 'father/ woman's partner'.

2: Invite, enrol and engage with expectant dads
Employed fathers in Britain have, since 2015, had a statutory right to time off to attend two antenatal appointments. But there is no guideline stating that NHS services should extend a direct invitation to fathers to attend such appointments. This should be rectified, to make clear to professionals, fathers and mothers that he is being acknowledged as a parent as well as a support-person, and to provide a pathway to welcoming, educating and informing him, identifying strengths and challenges associated with him, and referring him to relevant services (e.g. to smoking cessation). In the meantime, individual services should pilot ways of reaching out to, and inviting, fathers directly.

3: Deliver woman-focused, family-centred services
Fathers' and father-figures' impact on child (and maternal) outcomes is well established by research. Maternity services should be formulated as 'woman-focused and family-centred' meaning that, while the obstetrics focus remains on the pregnant woman, the father (or, where relevant, woman's partner and other key supporters) are actively encouraged to become an integral part of all aspects of maternal and newborn care. Hospitals should collect information from both/ all parents about their experiences of family-centred care, as part of the NHS Friends and Family Test. Working groups in each of the four countries in the UK should be established to define family-centred care during pregnancy, at the birth and in neonatal care, and to explore strategies, objectives and targets for implementation – including providing facilities for fathers/partners to stay overnight after the birth. In the meantime, individual services should pilot such approaches.

4: 'Father-proof' maternity staff training
The term 'midwife' means 'with woman' and most practitioners in maternity and neonatal care services are not trained to engage effectively with men or to work in a 'partnership of care' with families. When guidelines for maternal and neonatal care are drawn up, these should include the evidence on the impacts of fathers' characteristics and behaviours on mother and infant, impacts of couple relationship functioning, and impacts of fatherhood on men. Pre- and post-registration training curricula should be revised to include the 'whys' and 'hows' of engaging with fathers and families. When core competencies are time-tabled for revision, relevant new competencies should be drafted and included. Existing training modules should be revised to equip healthcare practitioners to engage with both parents, rather than only with the pregnant/labouring woman.

5: 'Father-proof' information for expectant and new parents
Pre-natal health education and information should be directed at men as well as women, and maternity services should be required to provide information directly to the father/ woman's partner, rather than relying on the 'woman as educator'. To counter unconscious bias against men/ fathers as competent caregivers, the content should include the neurobiology of active fathering, co-operative caregiving (the 'parenting team') and the impacts of father involvement and couple functioning on the infant's health and development. 'Father-proofing' guidelines to equip authors of new resources (and of resources that are being revised) to address both parents effectively should be developed and made available to commissioners, authors and editors, with the requirement that these be applied and utilized as part of the Gender Equality Impact Assessment.

6: Collect better data on expectant and new dads
We recommend that any future 'birth' cohort study should collect data in pregnancy from both the father/ woman's partner and the mother (cohabiting or living separately), with a phase of testing for approaches to recruitment. Where we have identified gaps in primary research and/or in secondary analyses of data already collected, consideration should be given to commissioning primary research or secondary analysis of existing cohort data. At birth registration, the father should be asked whether the infant being registered is his first child. Analysis of the data collected will then be able to establish fathers' age at birth of first child and men's fertility rates in Britain.

whose name goes on the birth certificate, how to negotiate a parenting agreement, when and how to disclose your sexuality to your children, and how to access relevant specialist support locally.

Having said all this, there is no correct answer to what information gay fathers need; the best way to find out is to consult directly with them. Ask about what information they think they might need, and how they would prefer to access it – via printed publications, online or via text messages. This can be a good way to establish a meaningful connect with them; it is also a great 'way in' to gaining permission to take suitable family photos!

And remember that sometimes, a 5-minute chat and mini-demonstration ('Do you want to come and help me bathe her, so I can show you my brilliant technique?') will be much more powerful than endless pieces of paper.

For more ideas about how to make your services more father-inclusive, see Box 'Redesigning services to be inclusive of fathers (including gay fathers').

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