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Middle Managers' Views on Participation in a Home Visiting Program for First-Time Parents in Scania, Sweden

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Abstract

Family home visiting programs delivering early childhood services are supported by politicians and policy makers in many countries. This study focuses on a home visiting program for first-time parents in a county in Sweden. The program comprises six home visits conducted by interprofessional teams, including child healthcare nurses, midwives, social workers and dental hygienists, with the aim to increase accessibility to child healthcare and to promote more equal health in young children. Child healthcare, maternal care, social services and dental care organisations participated voluntarily in the program. This study explores how middle managers of the participating organisations view the program. Data were collected from semi-structured interviews with ten middle managers. The interviews were analysed using qualitative content analysis as a method. The results show that the middle managers saw the home visiting program as beneficial for society, parents and children, and the participating organisations and professionals. In other words, they expressed both altruistic goals and a self-interest in participating. The study is of importance as middle managers' decision to participate in a home visiting program might be grounded on their perceptions of the program.

Keywords: child health, early prevention, home visiting, interprofessional teams, middle managers' perspectives

1. Introduction

Family home visiting programs delivering early childhood services are viewed as beneficial for parent support and good child development by politicians and policy makers in many countries – for example, in the United States, the UK, Latin America, Japan, Australia, the Netherlands, Germany, Norway and Denmark – as showed in an overview of the history and theoretical bases, and of possible challenges to and benefits of home visiting programs (Finello, Terteryan & Riewerts, 2016). This positive view can be traced to studies showing evidence of home visiting having an impact on, for example, family functioning, parenting, and child outcomes (see overviews by Duggan, et al., 2018; Finello, Terteryan & Riewerts, 2016). In Sweden, home visits to parents with a new-born are well-established, with a standardized national child healthcare program that includes two visits by a child healthcare nurse. However, in order to meet the needs of children and their parents and to promote equal health, the government has allocated funds to the county councils to strengthen and develop home visiting programs and other interventions, with recommendations to raise collaboration between child healthcare and other actors (National Board of Health and Welfare, 2019).

Through the funding, an extended home visiting program is offered to first-time parents in Scania county, in the south of Sweden. The program comprises six home visits by interprofessional teams. This entails that child healthcare nurses conduct home visits together with midwives one to two weeks from birth, with social workers at one, four, six and fifteen months from birth, and with dental hygienists or dental nurses at eight months from birth. Politicians and civil servants at the county council level designed the program, having been inspired by a similar home visiting program in the municipality of Rinkeby, Stockholm, where child health nurses collaborated with social workers. The idea of including midwives and dental professionals was to ensure that families are given the right form of support (Swedish Association of Local Authorities and Regions, 2021). The program entails a change in the work practices of the participating professionals. Child healthcare nurses were expected to work in teams with professionals from other disciplines, not usually involved in home visits. However, social workers can be involved when there is need of child protection.

It was voluntary for child healthcare, dental care and social services organisations to participate in the program. Thus, middle managers' view on the program and their role as gate keepers are of significance for participation and, as a consequence, changing the work practices of the professionals expected to carry out the home visits. Consequently, this study focuses on middle managers' views on participation in the home visiting program. Another reason for this focus is that previous research primarily concerns the design and outcomes of home visiting programs.

In the following sections, we will briefly review relevant literature on home visiting programs and the role of middle managers regarding changes within organisations. Thereafter, we will describe the context of this study more in depth. Then, we will describe the methods and the analysis, and present the results. Finally, we will discuss the results and implications for the realization of the political aspiration to introduce the home visiting program.

2. Previous Research

2.1 Early Prevention and the Rationale for Home Visiting Programs

The general idea of early prevention programs is that there is substantial value, both human and economic, in preventing negative outcomes – such as marginalization, social exclusion, ill health and negative behaviour development – as early as possible (Nilsson & Wadeskog, 2008). Evidence from several interventions shows that intervening with the child and the family early in the developmental pathway can minimize future health, and educational, behavioural and anti-social problems, to mention some of the outcomes associated with early interventions (Farrington & Welsh, 2002).

Home visiting programs are examples of early prevention interventions. These programs usually entail collaboration between professionals from different disciplines, for example from healthcare and social services. The programs are considered as a valuable health promotion strategy to buffer possible effects of adverse early childhood experiences on individuals' lifelong health (Condon, 2019; Duffee, Mendelsohn, Kuo, Legano & Earls, 2017). The idea of home visiting programs originates from public health, early childhood education and antipoverty efforts (Duffee et al., 2017). They vary in goals and content, but in general they combine parenting and health care education that focus on children's well-being and healthy development. An advantage of home visiting programs is that professionals meet families in their own homes, which may increase families' sense of control and comfort (Peacock, Konrad, Watson, Nickel & Muhajarine, 2013). Another advantage is the professionals' opportunity to assess the development of the relationship between the parent and the child in their natural environment, which in turn allows the professionals to provide more tailored support and help when needed (Duffee et al., 2017; Peacock et al., 2013).

2.2 Universal or Targeted Approaches

Achieving good and equal health among people is of considerable interest in public health work. One essential question discussed in welfare interventions for promoting equal health is whether the intervention should be universal, that is offered to all in a society, or be targeted for selected groups (Carey, Crammond & De Leeuw, 2015). Early childhood home visiting programs often target families with young children (below the age of five) and with fewer socioeconomic resources because socioeconomic disadvantages can lead to poor developmental outcomes for children (Goldfeld, Price & Kemp, 2018). Many successful home visiting models are directed toward mothers and infants in high-risk groups, such as young or adolescent mothers, single-parent families, children with special needs, families living in poverty or immigrants (Duffee et al., 2017; Sweet & Applebaum, 2004).

Similar to previous research, most interventions focused on vulnerable families in deprived neighbourhoods. Families living in low socioeconomic neighbourhoods often experience high levels of stress, low access to recourses and minimal societal support: experiences that are associated with poor health and well-being (Balaji et al., 2007). Such results indicate that families living in deprived neighbourhoods may benefit from targeted support in handling difficulties that arise in their parenting strategies due to circumstances in their immediate environment (Nilsson, Ivert & Torstensson Levander, 2020).

Home visiting programs can be designed from the idea of proportionate universalism. This means that interventions should be universal and not targeted, but that the scale and intensity of the intervention should be proportionate to the level of need (e.g. Carey et al., 2015; Francis-Oliviero, Cambon, Marmot & Alla, 2020). An example of an intervention based on proportionate universalism is a Swedish extended postnatal home visiting program for first-time parents in Rinkeby, an area in Stockholm, where many families are exposed to social disadvantages. The home visits were carried out by child healthcare nurses and parental advisors from the social services (Burström, 2017).

Advocates of targeted interventions have argued that universal approaches may increase inequalities and lead to significant costs for society (Francis-Oliviero et al., 2020). Conversely, arguments in favour of universalism are that targeted interventions might miss individuals in need of support and lead to the stigmatization of individuals (Horton & Gregory, 2010; Marmot, 2010; Marmot, 2014).

2.3 Outcomes of Home Visiting Programs

Several areas for improving outcomes of home visiting programs have been identified regarding child development, parenting and parents' lives (Duffee et al., 2017; Sweet & Appelbaum, 2004). Home visiting programs have been shown to enhance parents' abilities to support their children's development, improve children's health and relationships within families, and reduce juvenile delinquency, family violence and crime reported to child protective services (e.g. Duffee et al., 2017). Home visiting has also been associated with less utilization of urgent medical care due to information on where and when to seek care (Burström, 2017; Raphael, Rueda, Lion & Giordano, 2013). Other outcomes are increased vaccination coverage among children, enhanced relationships between parents and children within the participating families, and better access for families to the wider early childhood service network, for example the open playschool (Barboza et al., 2018).

Home visiting programs can also contribute to a trustful relationship between the parents and the home visit professionals, thus making the parents more secure in their interactions and responses (Barboza et al., 2018). Trust is believed to be of importance for the success of welfare programs, and not only in terms of trust between parents and the professionals. If parents see the home visits as valuable, this can result in a positive attitude to welfare institutions in general and society at large (Franzén, Nilsson, Norberg & Peterson, 2020). However, this "spill-over effect" of trust may differ between countries and between social groups within a country. In Sweden, the proportion of citizens with social trust for other individuals is among the highest in the world, but the degree of trust can be lower among immigrants, the less educated, those in poor health and the unemployed (Holmberg & Rothstein, 2017).

2.4 Design of Home Visiting Programs

The design of programs differs between countries with regard to the frequency of home visits, the timing of visits before and after a child's birth, the length of a program, and the focus on expected outcomes. Programs can be designed to be preventive, to promote the relationship between parents and child, to promote a healthy and safe development of children, to prevent child abuse and juvenile criminal behaviour, or they can be designed in relation to the specific needs of a population (Finello et al., 2016; Nievar, van Egeren & Pollard, 2010). There can also be differences between programs within a country.

A common characteristic is collaboration between professionals from specific disciplines in interprofessional teams (Finello et al., 2016). Working in interprofessional teams is recommended in order to meet population needs and to deliver high quality health services (WHO, 2016). However, the cost of staffing and the availability of professionals in relation to the purpose of a program are factors that have to be considered in the design of programs (Finello et al., 2016). Such considerations are likely to be relevant for politicians, top managers and middle managers in their decision to launch a home visiting program.

2.5 Cost-effectiveness of Home Visiting Programs

It is important that intervention outcomes are routinely evaluated (Peacock et al., 2013). However, there are challenges associated with the evaluation of home visiting programs and drawing general conclusions because the context and the content of programs differ between countries. Benefits that are observed in one service system (for example a publicly funded healthcare setting) might not be applicable in countries with another service system and another population (Goldfeld et al., 2018). For example, in many European countries participation in home visiting is voluntary, and the program is embedded in a comprehensive parental and child health system (Finello et al., 2016). Another challenge is that decisions regarding the interventions are most often guided by a short-term perspective rather than by a long-term approach (Nilsson & Wadeskog, 2008). Furthermore, it can be difficult to affirm that improvements in people's health and changes in their behaviour are actual outcomes of the intervention. A lengthy period of time is required to distinguish environmental and individual behavioural changes as a result of the intervention (Ismail, 2017). However, home visiting programs have been shown to provide a foundation for improved child health and family well-being in many areas (Duffee et al., 2017), as described above.

Home visiting programs also have to be evaluated from a health economic perspective as public resources are limited. Because resources should be used effectively, politicians, civil servants and organisational managers have to prioritize certain health interventions. As a consequence, the use of cost-effectiveness analyses in the decision-making process has increased in recent decades (Davidson & Levin, 2010). Home visiting programs have been shown to be cost-effective in comparison to health care and social services, for example (Finello et al., 2016). In a study on the effectiveness of home visiting programs for the prevention of child maltreatment, it has been shown that the most cost-effective programs were those where multi-professional teams carried out the visits and when programs targeted high risk populations – especially young, low income, first-time mothers with multiple disadvantages (Dalziel & Segal, 2012).

In spite of the difficulties associated with economic evaluations, the need for calculating benefits and costs has been highlighted, as policy makers' decisions regarding resource allocation to home visiting programs and other family support programs are based on such evaluations (Cowan & Cowan, 2019). In addition, it has been argued that decision-makers need to be convinced that the delayed benefits will be worthwhile in the long run and that investing in public health interventions will be a sustainable use of the resources of the public sector (Ismail, 2017).

2.6 Managers' Role for Organisational Change

To initiate an extended home visiting program and to realise the needed changes regarding professionals' ways of working might be difficult, as is the case with other political proposals for organisational change that concern new ways of working. In change processes, managers play an important role (Hijal-Moghrabi, Sabharwal & Ramanathan, 2020), not least middle managers. Both how they value a political proposal and their motivation to drive change are considered as important conditions (Austin, Chreim & Grudniewicz, 2020). A bottom-up approach to change initiated by middle managers has been shown to be more successful than a top-down approach initiated by county council managers and healthcare politicians, for example to develop collaboration between caregivers (Ahgren & Axelsson, 2007). Further, a study on implementation of patient-centered care rather than disease-focused in healthcare organisations shows that change cannot be done only from top down. Also middle managers and the front line staff need to be engaged for success (Bokhour et al., 2018).

Managers, like employees, can interpret and make sense of changes differently, for example based on their personal interests, educational background and perceptions of what is fashionable (Alvesson & Sveningsson, 2016). A Canadian study in a healthcare context on middle managers' readiness for a governmental initiated change to achieve better coordination of healthcare providers and patient services revealed that managers' readiness depended on their evaluation of the benefits of the proposed change. Although assessed benefits may concern both themselves, patients and the health system, managers mainly focused on benefits for the health system. Those who pointed out benefits on more than one level perceived the change as more valuable (Austin et al., 2020).

2.7 Research Context

In Sweden, healthcare decisions are mainly decentralized amongst the 21 county councils and 290 municipalities. County councils are responsible for healthcare and for dental care up to the age of 23, and the municipalities are responsible for social services. Public services providers may be private actors. The overall goals and policies for the services are determined at national level (Anell, 2005). Swedish national guidelines recommend that the child healthcare service visit families with a new-born infant (National Board of Health and Welfare, 2014). The child healthcare service offers such parents a standardized program: one that includes two home visits by a child healthcare nurse – the first at one to two weeks after birth and the second at 8 months of age.

To promote equal health and increase the availability of child healthcare, the government financially supports county councils in the introduction or development of existing home visiting programs and other interventions (National Board of Health and Welfare, 2019). This paper concerns a home visiting program introduced in a county of Sweden in September 2019. The program is financed by grants from the Swedish government. It is temporary and will be concluded at the end of 2022 when governmental funding ends. Furthermore, the program necessitates that professionals from child healthcare, maternal care, social services and dental care work in interprofessional teams over a 15-month period and visit first-time parents. The project commenced in September 2019 with four teams, with additional teams joining thereafter. Participation was voluntary for healthcare, dental care and social services organisations.

The program is universal in its approach, cost-free and voluntary for first-time parents. Further, it comprises six home visits during a child's first 15 months. The home visits are carried out by a child healthcare nurse together with a midwife (1-2 weeks after birth), a dental hygienist or a dental nurse (8 months after birth), or a social worker (2-3 weeks, 4, 10 and 15 months after birth) (Mangrio, Hellström, Nilsson & Ivert, 2021).

To summarize, there is no single way to design and carry out home visiting programs to parents with young children. In the light of middle managers' role concerning the introduction of the extended home visiting program in question and their role as gate keepers for participation, this paper focuses on those middle managers who first participated in the program. The aim of this study is to examine their views on participating in the program.

3. Material and Methods

The empirical material is derived from semi-structured interviews with middle managers of the organisations that participated in the home visit program at the start of September 2019. The interviews are part of a larger qualitative study on middle managers and professionals of the four teams who carried out the home visits. The interviews were conducted by three researchers, two of whom are the authors of this paper.

A qualitative research approach was used as it is to prefer to examining individual's views and beliefs about a particular matter compared to a quantitative approach using questionnaires with prestructured, quantifiable categories (Alvesson & Deetz, 2000; Easterby-Smith, Thorpe & Lowe, 2002). This means that qualitative research can get insight about individuals' views and beliefs that quantitative research do not capture (Edmunds & Brown, 2012).

Each of the four maternal care, child health care and social service organisations was led by one middle manager, respectively. One of the dental care organisations was led by one middle manager and the other three were led by another one. The middle managers had similar professional backgrounds as the professionals who carried out the home visits. The data sources consisted of semi-structured interviews with 10 of the 14 middle managers: four managers of child healthcare, two managers of maternal care, two managers of dental care and two managers of social services. The managers were selected to obtain a mixture of represented organisations and professional disciplines. The number of managers may be seen small, which implies that this study has an explorative character.

The researchers emailed the middle managers a description of the aim of the study and an invitation to participate. Interviews were conducted individually by the research group between autumn 2019 and spring 2020: five were conducted face-to-face at the middle managers' workplaces and five digitally using Zoom because of the COVID-19 pandemic. The interviews lasted from 45 to 90 minutes, were recorded with the consent of each middle manager and then transcribed. Relevant questions for this paper concerned the middle managers' expectations of the extended home visiting program, participation in the program, and perceived opportunities and challenges of the program.

3.1 Analysis

In the analysis of the interviews, we followed the method of qualitative content analysis (Elo & Kyngäs, 2008; Erlingsson & Brysiewicz, 2017; Graneheim, Lindgren & Lundman, 2017). Firstly, we individually read the transcribed interviews thoroughly several times to get an overview of what the managers talked about and to identify statements that were relevant for the aim of this article. Secondly, we discussed our impressions of the texts and the statements we interpreted as relevant. Thereafter, still in discussion, we coded and grouped the statements into constructed categories. This process entails comparing the coded data and categorizing those that are interpreted to be related to each other (Elo & Kyngäs, 2007; Graneheim et al., 2017). These categories were then grouped into more overarching descriptive themes. A theme should be seen as a 'red thread', that is present in several categories (Graneheim et al., 2017). During the analytical process, we moved between the empirical material and the literature on home visiting programs. The themes are presented in the section below. The quotes that we present are used as illustrations of the content of the themes.

4. Results

The analysis of the interviews resulted in five themes denoting managers' views.

4.1 Good for Society

Amongst other reasons, managers participated in the home visiting program because they deemed its focus on parents with new-born children to be potentially *good for society* in the long run. Although they emphasized the implied increase in costs for the participating organisations, they saw societal benefits as decisive. This was briefly underlined by one manager:

We don't do this for our own sake or think it's good, but we do it for society in general. (M1)

Possible societal benefits that managers related were improved health among children, more school graduates and fewer children involved in criminality. These possible outcomes were explained as consequences of the preventive perspective of the program, which implies that parents in need of support could be identified early. Though the program is likely to necessitate more resources, this would be outweighed by the socio-economic benefits. One of the managers explained that the earlier preventive measures are implemented, the greater the future social and economic advantages:

The sooner we can get in, the sooner the preventive work can begin. I think we will save a lot of money in the long run, in ten, fifteen, twenty years from now, So, it might cost in terms of resources, but I think it is an investment in the future of our welfare. (M3)

Another manager emphasized the need for programs that facilitated early prevention, the identification of children in need of support, and the socio-economic gains:

In the beginning it will cost a lot of money, but I think that we will win from a socioeconomic perspective. (M8)

4.2 Support to Families

Managers highlighted that the program increased support to parents compared to the standardised child healthcare program, which includes home visits by a child-health nurse. This increase in support was a result of the collaboration

between the professionals who meet the families in their home environment, with this interprofessional collective support being described as significantly advantageous in preventing occurring problems.

Getting collective help from collective professionals is significant. I think the sooner we get in and the sooner we can help families that need some support, whether it be social services, dental care or whatever. I think that we, together, can help and have an effect. (M3)

The collaboration between the professionals from the different disciplines was further described as a safe basis for the families, as the professionals worked together as a unit for the best of the families, rather than working separately. With their different disciplinary expertise, the interprofessional teams were seen as contributing to a more holistic view of the families' living conditions and relationship with their children. One manager asserted how a holistic approach might materialise with regards food and nutrition:

The child healthcare nurse looks at if they [children] are eating, but the dental carer would look more at what they eat, and social worker on how they eat. (M8)

Visiting families in their homes was reported as superior to meetings at the professionals' workplaces. Home visits allowed professionals to observe aspects of children's living conditions that otherwise would be difficult to be notice:

The advantage of going home to patients is that you can observe things that might go unnoticed at our surgery. We can get a broader picture of the home situation. (M9)

In addition to the examples above, an expected benefit of the program was that the early prevention approach and support to families would avert future problems in the children's lives, and not only "here and now" in their early childhood.

4.3 Inclusion rather than Exclusion

When questioned about whether the extended home visiting program should be offered to everyone or just some selected families, the managers were generally positive to the former. They opined that all families might benefit from the program and that it determined who required extra support. One manager related:

This is something that everyone actually needs, regardless of where they live. Of course, we have a variety of ways of looking for information and at different backgrounds, but I still think it is important that everyone can has a chance. (M6)

Another managed concurred with this summation, adding that families' needs could vary and thus the support should be individualized:

Often we are *not aware which families are most in need. Therefore, I believe the program should be available to all. What is more, it is important to realise not everyone has the same needs. Then, what one offers can then be based on individual needs.* (M3)

Another argument to include all first-time parents was that it precludes professionals having to select families based on their socio-economic status, ethnicity or abode, thereby avoiding stigmatizing the parents as "bad" parents. Moreover, a common reflection was that the program should also be offered to families from other countries with a new-born child in Sweden and not only their very first child. The rationale behind this was that recently immigrated families with children might be need of support due to their current life circumstances.

It can be families that perhaps will give birth to their third child, but the first one in Sweden, where they might have social concerns, be a single parent, not speak Swedish, and not know how things work in Sweden, despite it being their third child. These aspects should be considered. (M2)

4.4 Building Trust to Professionals and Welfare System

The home visiting program was seen as a way to build trust between the parents and the participating professionals. As the professionals visit the families in teams of two, it was stressed that trust in one professional can lead to the development of trust in the other professionals. Furthermore, a notable strength of the program was the midwife establishing a relationship with the mother before the child was born, and thereafter conducting the first home visit with the child healthcare nurse. The mothers' trust in the midwife was believed to "move over" to the child healthcare nurse upon introduction:

If I have taken care of a women during pregnancy, she will be confident in me; and then, when I introduce the next profession, it will be a very trusting handover. (M2)

When we, the child healthcare worker and the midwife, do the first home visit, it feels like a handover. The person who [the mother] already has had a relationship with does the handing over and says that this is ok. So, it is a very fine handover. (M1)

Similarly, the child healthcare nurse may introduce the social service provider to the parents in a trustful way, thus helping to establish a relationship between them. However, one manager asserted that the time between visits by the social worker should be shorter to build stronger trust. Moreover, managers related that trust should not only transfer between the professionals but also to their respective organisations. Increased trust in welfare organisations was believed to be of importance, especially for immigrated parents without adequate knowledge of the Swedish welfare system. Such parents might not know where to get care when they or their child has minor ailment symptoms. One manager hoped the program would lead to greater trust in the welfare system, with parents opting to visit the child healthcare service rather than emergency care.

In addition, trust in the professionals contributed to parents seeking help from social services when necessary. For some parents, the social services might be seen as an authority liable to remove their children. However, the program and interactions with social service providers would dispel such fears; instead social services would be seen as a supportive authority for families:

Rather than seeing social services as something really frightening, you meet a rather nice person you are familiar with. Therefore, you have another picture of social services: as an authority that takes care of children. (M10)

Another manager added that the program could lead to 'confident parents who dare to turn to authorities when they need to' (M3). Not only would the program lead to improved relations with social services, but also with dental care. Dental professionals seldom participate in home visit programs to parents with young children. However, as one manager asserted, their participation in the project was a good opportunity to demonstrate the important role they play in aiding good dental health in the population:

We have to work a little bit more to be accepted and to be understood that we are part of the whole, but I think there is respect for what we do. This is a great opportunity to take part from the beginning. And even if we don't do so many home visits, we are an important part of this project. (M6)

4.5 Benefits for Managers and Professionals

The program was also seen in a positive light regarding the participating organisations and professionals. It was argued that an overall improved health amongst children would result in a reduction of organisational resources. The rationale behind this assertion was that healthcare and dental service treatments were costly. 'It costs a lot of money', as one manager remarked (M6).

Moreover, it was pointed out that home visits were more time consuming for healthcare and dental professionals compared to visits to clinics. This entailed the likelihood of recruiting more professionals to meet the demands – an aspect which managers had to consider in terms of their participation in the program. As one manager clarified:

We have to recruit competent staff on limited resources. And with a project of this kind, you have to decide whether it's feasible considering what we already have to do. It's not always the case that we can take on more work. We have an accumulation [of cases] as we don't have had enough times for appointments at the surgery. (M4)

However, the organisations' participation in the home visited project was something that could be capitalised upon in terms of recruitment of new staff. A manager related that she had highlighted the project in a recruitment process, rationalising that prospective employees might find it attractive to work in interprofessional teams and visit families in their homes:

In our employment advertisement, I wrote that we offer the opportunity to participate in a new project on extended home visits, thinking this could be something that seemed attractive. Working in a different way could be enticing, I think. To work more and faster doesn't function any longer. (M8)

Other managers also commented on the positive aspects of visiting parents in their homes for the professionals. These professional visits were most welcomed by parents, thereby heightening the professionals' joy in their work:

It promotes joy at work. You feel that you are very appreciated when you visit the families' homes and they offer you coffee. It feels very welcoming to come to their homes. It is something positive for their [the professionals'] working conditions. (M2)

Another positive aspect of the program, which a manager gave prominence to, was how the home visits would extend the professionals' working tasks and developed their competence (M7). The program was also viewed as a means for 'professional challenge and development and competence improvement' (M9).

5. Discussion

Home visiting programs to families are part of national child healthcare in many countries (e.g. Condon, 2019; Finello et al., 2016). In Sweden, there has been an expansion of home visiting programs to improve children's health as a means

to increase the availability of child healthcare. This is intended to contribute to more equal health – an intention supported and funded by the Swedish government (National Board of Health and Welfare, 2019; Swedish Association of Local Authorities and Regions, 2021). This article contributes to knowledge on middle managers' views on an extended home visiting program for first-time parents in Scania, Sweden. Regarding research on home visiting programs, there is, to the best of our knowledge, a lack of studies on a managerial perspective.

This study showed that the middle managers referred to additional aspects other than the political goal of the program of improved and more equal health. In addition to improved health among children as one possible outcome, the program was seen to contribute to the following: increased support to families, societal benefits as a consequence of the preventive approach, and heightened trust in both professionals and the welfare system. Moreover, benefits related to the respective professional organisations and their employees' working conditions were emphasised.

Managers saw the program as a means to create and strengthen trust in professionals, and in the welfare organisations and the Swedish welfare system, in general. It has been argued that the quality of welfare services has importance for peoples' trust in welfare institutions in general (Rothstein, 1998; 2005), thus implying that if parents value the program, it can have wider positive effects. Managers also emphasised the long-term beneficial outcomes for society when parents are more confident in their parenting and when the health of children is improved, which is in line with outcomes presented in previous research on home visiting programs (Finello et al., 2016). However, it is important to keep in mind the difficulty with evaluating the effects of interventions and establishing whether outcomes such as individuals' improved health and wellbeing are actual outcomes of an intervention as benefits often are delayed (Ismail, 2017).

The universal approach of the program was perceived positively. For example, child healthcare nurses not having to select parents for program participation was valued because of the difficulty associated with making a selection and ascertaining which families were most in need of extended support. Additionally, the managers stressed that a selection process may stigmatize families. These views on a universal program are in accordance with the literature, which underlined that it is possible to miss problems in targeted interventions and that this can lead to stigmatization of individuals (Horton & Gregory, 2010; Marmot, 2010; 2014). Middle managers in the present study also expressed a desire to extend the inclusion criteria of the program to include immigrated families with a first-born child in Sweden. They rationalised that immigrated parents might need to learn from the program professionals about the Swedish welfare system and how it can support them. They also pointed out the need for support to single parents and those who have poor living conditions. Managers' views on the program indicate the importance of considering families' backgrounds in the planning of home visiting programs. Thus a universal approach can identify families in need of support that otherwise would been missed, with the managers also identifying an excluded group that might benefit from participation in such programs.

Moreover, middle managers remarked on the benefits of the program for the participating organisations and the professionals. It was pointed out that although the program implied the use of more resources, it would likely be cost-effective in the long run due to improved health among children, and, as a consequence, fewer families having to turn to the healthcare, dental care and social services. Further, working in interprofessional teams and conducting home visits was believed to increase middle managers' possibilities to recruit new staff. Managers also pointed out that the way of working may contribute to working conditions for the professionals that will increase their work satisfaction and lead to professional development. Such working conditions may increase professionals' work engagement, their health and their well-being (Schaufeli & Taris, 2014).

Middle managers' views on and interpretation of the changes in professionals' ways of working, that is conducting home visits in interprofessional teams, are important as they are expected to lead such change. However, a managerial readiness and initiative to change might not be enough. Because professionals and other organisational members might be sceptical, change in work should not be controlled and organized by managers only. Rather, they have to engage the individuals concerned in the change process (Ahgren, 2014; Sveningsson & Sörgärde, 2020). In addition to greater possibilities to accomplish changes, active involvement of employees can contribute to increased trust and confidence in the managers who are driving the change (Sveningsson & Sörgärde, 2020).

The extended home visiting program in question is temporary and will be concluded at the end of 2022 when governmental funding ends. Thereafter, politicians at the county level will decide whether the program should be permanent. Should the program be made permanent, the findings from this study will be helpful in understanding middle managers' perceptions of opportunities and challenges of the program, which in turn will be helpful with the introduction of the program. Although the middle managers referred to several benefits of the program, they also suggested improvements. This should be taken into consideration. Moreover, it has been underlined that middle managers should be invited in the planning of a change project initiated by county politicians. Their knowledge and

experience are valuable for preparing for the change process. If middle managers are not ready for change, it will be difficult for them to manage a change process and to engage employees (Austin et al, 2020).

A limitation of the study is that it only concerns the middle managers of the organisations that took part of the program in its beginning. One important question for further research is how middle managers of the organisations that participated the program later on perceived it. The views of middle managers in this home visiting project cannot be generalized to such programs, but they will contribute to knowledge on middle managers' perceptions that probably are of interest in other contexts. Further research should also examine the involved professionals' views on participating in the program. Their roles and beliefs as 'workers on the floor' are of significance for the development of interprofessional teams and for the quality of the home visits.

6. Conclusions

The middle managers viewed the home visiting program as beneficial for society, parents, children, and the participating organisations and professionals. In other words, they expressed both altruistic goals and a self-interest in participating in the program. Their impressions of the universal approach indicate the need to consider families' backgrounds in the planning of home visiting programs in order to establish equal health. Middle managers' views are of interest to county politicians who should decide to make new home visiting permanent and in their subsequent design of the program. Because middle managers play a key role for participation and change processes, their views on a program and what they find attractive with it will influence the implementation of a permanent program. This study indicates that a successful introduction of home visiting programs will not only benefit young children and their parents but also involved middle managers and professionals.

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