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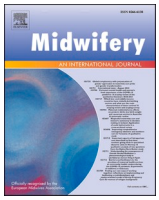

"I always felt like I wasn't supposed to be there". An international qualitative study of fathers' engagement in family healthcare during transition to fatherhood

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ABSTRACT

Objective: Engagement of fathers in family health services confers benefits for the health and wellbeing of the whole family. The childbirth continuum is traditionally considered a feminine event, however, commensurate with the changing paradigm of gender equity in family healthcare worldwide, the role of fathers is in transformation. The aim of the study is to explore father's perceptions and experiences of healthcare engagement during pregnancy and early infant care.

Design: Qualitative free-text questions were embedded in a large multi-country, cross-sectional survey, to explored fathers' attendance, participation, and experience of health care during appointments with their pregnant partner and/or baby.

Setting and participants: Expectant and new fathers were recruited through Prolific®, an international paid online survey platform.

Findings: Qualitative responses (n=889) were provided by fathers from 28 countries, with experiences of a range of contexts and models of care; 46.8% of whose partners were pregnant and 53.2% had given birth since 2020. The findings suggest that although most fathers wanted to attend and participate in maternity and early parenting-related healthcare, multiple barriers were identified at the individual father, organisational context, and societal levels. Fathers reported negative social factors such as gender bias and restrictive gender norms as barriers to their healthcare engagement. In contrast, factors that enabled fathers to overcome barriers included the fathers' feelings of confidence in their partner's autonomy and decision-making skills, trusted professional relationships with clinicians, and clinicians with good interpersonal skills.

Key conclusions: Multiple barriers restrict the participation of fathers in healthcare for childbearing and early parenting. Knowledge of these barriers can inform healthcare redesign to include more successful engagement strategies for fathers, to benefit fathers, mothers, and infants alike.

Implications for practice: Health professionals consulting with the mother, father and infant triad are ideally placed to address the healthcare needs of both parents. Early engagement of fathers in family health care by use of inclusive interpersonal skills and the development of a trusted relationship has potential to improve paternal mental health, and may be associated with benefits for the health, wellbeing and safety of the whole family.

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Introduction

Pregnancy and early infant care have traditionally been considered feminine events, and women have historically assumed responsibility as "gatekeepers" (Hemard et al., 1998, p. 56) for family healthcare. Women have also historically been reported to perform between three to ten times the amount of unpaid care and domestic work than men (Addati et al., 2018). In contrast, the masculine gender role of the father in Western society has traditionally been described as the "breadwinner" (Hildingsson et al., 2011, p. 129), characterised by earning money to provide for their family, and by adoption of more physically demanding jobs than traditionally assigned to females (Heise et al., 2019). Historical, cultural, social and familial ideologies and norms have influenced and even restricted the traditional roles and amounts of time fathers spend with their children, the activities they share with them, and potentially the quality of the father-child relationship (Heise et al., 2019; Schoppe-Sullivan et al., 2021).

Yet, the role of fatherhood is in transition as more fathers' are adopting a greater physical and emotional presence for nurturing roles in childcare and homelife (Baldwin et al., 2018; Volling & Palkovitz, 2021), and their expectations for participation in family health services is becoming more commonplace (Andersson et al., 2016; Baldwin et al., 2019; Wright & Geraghty, 2017). Many fathers are taking on a more central caregiving role within the family (Carlson et al., 2015), and fathers are increasingly recognised in society as active members of the parenting team making a vital and unique contribution to early child development (Brown et al., 2018; Freiband & Barker, 2022).

Distinct from the positive impact of mothers, children who receive the positive involvement of their fathers are found to have better short- and long-term outcomes socially, emotionally, and academically (Bateson et al., 2017; Cabrera et al., 2018; Fletcher et al., 2014). Furthermore, engagement of fathers in maternity care has been shown to provide positive benefits for the mother and baby, through facilitation of practical and emotional support, (Aune et al., 2015; Barimani & Vikström, 2015; deMontigny et al., 2018; Feenstra et al., 2018; Plantin et al., 2011; Vieira & Saraiva Aguiar, 2021), and support for breastfeeding (Bich et al., 2014; Fisher et al., 2018; Shorey et al., 2016) and may provide protection against postnatal depression in women (Saligheh et al., 2014).

While equal involvement and parenting partnerships may be an aspiration of both the mother and father (Andersson et al., 2016; Widarsson et al., 2015), it is argued that gender norms and gendered social expectations may continue to shape men's fathering and consequently their involvement in programs that seek to engage men as fathers (Kaufman, 2018; Pfitzner et al., 2018). Gender norms are the 'unspoken rules' that govern behaviours considered to be acceptable for men, women and gender minorities in society (Heise et al., 2019), and are powerful determinants of health and wellbeing (Gupta et al., 2019).

When choosing to engage with family healthcare, some fathers have reported feeling restricted, excluded, invisible, or insecure during engagement in maternity services (Ampim et al., 2021; Baldwin et al., 2019; Elmir & Schmied, 2022; Hodgson et al., 2021; Venning et al., 2021). New fathers have described feeling like a "spare part" (Roberts & Spiby, 2020, p. 494) during the birth, and experiencing limited professional support to prepare psychologically for "rollercoaster of feelings" associated with their "new identity" as a father (Baldwin et al., 2019, p. 5) and their fatherhood role (Elmir & Schmied, 2022); which may be associated with perceptions that their "partner's needs being greater than theirs" (Baldwin et al., 2019, p. 8).

Compared to many other life stages, the transition to fatherhood and the early years of childrearing are periods in which men are at increased risk of experiencing psychological distress (Price-Robinson, 2015), anxiety (Leach et al., 2016), and depression (Cameron et al., 2016) and are particularly vulnerable antenatally, during and after the birth of a baby (Baldwin et al., 2018; Philpott, 2016; Philpott et al., 2017; Price-Robinson, 2015). Poor paternal perinatal mental health may be exacerbated by the challenges with engagement of men at this life stage in healthcare (Venning et al., 2021; Wells, 2016). Fathers often do not seek help for themselves (Schuppan et al., 2019), either because they prefer to keep the focus on their partners and infants (Fletcher et al., 2014), they experience barriers toward access paid parental leave (Kaufman, 2018) or because they perceive antenatal and early childhood health services as maternal-centric (Macdonald et al., 2022; Pfitzner et al., 2018; Venning et al., 2021; Wells, 2016).

Studies suggest that deterioration in the mental health of new fathers is linked to a cumulation of pressures such as financial responsibilities, sleep disruptions or reduced social activities (Garfield et al., 2018; Macdonald et al., 2021; Wynter et al., 2020). Systematic reviews of international studies have concluded that in the early years of parenting, the prevalence of paternal anxiety is estimated to be 18% (Leach et al., 2016) and depression 8.4% (Cameron et al., 2016), of which common symptoms may include feelings of excessive anger or irritability (Macdonald et al., 2020). Indeed, symptoms of depression and a perceived lack of paternal social support have been associated with a higher likelihood of wanting to express the emotion of anger physically, such as breaking or banging objects and to "kicking," "hitting" and "pounding" a person which is a potential risk to family safety (Macdonald et al., 2020). It may be argued therefore that positive engagement of fathers in family health care and actively responding to the needs of new fathers may present opportunities to improve safety from violence within the family unit (Cowan et al., 2022; Hegarty et al., 2020).

Significant family health service provision challenges to engagement with fathers have been identified (Macdonald et al., 2022). At a health policy level, there is evidence of categorical thinking or stereotyping by gender norms or even restrictive gendered expectations by differences in biological gender at birth (Connell, 2012). For example, most antenatal, maternity and child-health services have been designed to centre around the needs of the cis-woman and child. Ostensibly for practical reasons, most if not all clinical documentation in maternity care pertains to the mother and baby (DOH, 2015; NHS, 2020) and fathers' mental health and wellbeing is not routinely included in the medical record as part of the mother, father and infant triad. There is also a paucity of funding models or guidelines to provide for the father's specific healthcare needs that can be accessed by maternity care providers, (Bateson et al., 2017; DOH, 2019, 2021). Referral pathways are often limited to suggestions to visit the father's own general practitioner (GP) or access to a local social service provider. Unsurprisingly, evidence suggests that family health services are often not successful at engaging fathers (Baldwin et al., 2018; Wells, 2016), despite recommendations to include fathers in health care during this transformative life event (World Health Organization, 2015).

From a maternity service provider perspective, midwives have reported that they lack training and confidence with engaging fathers, particularly when responding to fathers with mental health concerns, or in circumstances of suspected family violence (Wynter et al., 2021). Male violence against women during pregnancy and childbearing is of real concern during the provision of maternity care (Baird et al., 2021; Campo, 2015; ICM, 2014). In Australia, thirteen per cent of women experience violence when they are pregnant, compared to 5.3 per cent of the broader population (KPMG, 2016). This creates a unique dilemma for midwives when trying to achieve father-inclusive practices without disempowering women or increasing the risk of family violence (Wynter et al., 2021).

Health professionals consulting with the mother, father and infant triad are ideally placed to address the healthcare needs of both parents. As new parents' needs and motivation to seek support to adapt to parenthood are substantial, large benefits may be achieved for both parents and children, and new families have considerable contact with the health service (Johnston et al., 2015). Currently, there is limited research on strategies to improve engagement of fathers in family health care, such as strategies for service redesign and interventions to support communication with fathers as part of the maternity triad (Varga et al., 2021).

Table 1
Inclusion and exclusion criteria of participants

Inclusion criteria	Exclusion criteria
Male (sex assigned at birth) participants registered with the Prolific® research recruitment platform who either have a partner who is currently pregnant, or whose partner gave birth in 2020 or 2021	Female (sex assigned at birth) partners of women currently pregnant or recently given birth.

The aims of this study are 1) to explore expectant and new fathers' perceptions and general experiences of attendance and/or engagement with family health services, 2) to understand low levels of engagement or interaction with the professionals and family health services, and 3) to identify enablers and opportunities to improve engagement of fathers in family health services for the mother, father and infant triad.

Methods

Design

The qualitative component was embedded in a large multi-country, cross-sectional survey, including aspects of paternal health literacy and experiences of engagement in maternity and early infancy care (family healthcare henceforth) (Wynter et al., 2023). The qualitative data was extracted from three open-ended questions: (i) 'You have indicated that you did not always attend health services with your partner and/or baby. Please tell us why'. (ii) 'You have indicated that you have not always participated actively in conversations with healthcare professionals during appointments with your partner and/or baby. Please tell us why', and (iii) 'Please provide any further comments on your experience of health care in pregnancy or since you had your baby (as appropriate)'.

Online qualitative surveys may confer benefits over other qualitative data collection methods, which is the ability to capture a wide range of rich and complex accounts related to the perspectives, opinions and experiences from a large population, which is especially useful when researching under-researched areas (Braun et al., 2021). To provide context for interpretation of the results, sociodemographic data were also collected from respondents. These data included age, country of birth and residence, language spoken at home, highest level of education attained, perceived socio-economic status and model of care accessed by the respondent's partner.

Setting

Given that fathers are not routinely engaged in health services during the transition to fatherhood (Leach et al., 2019), it can sometimes be difficult to recruit fathers to research studies. Therefore, we chose to recruit via Prolific® (www.prolific.co/). Prolific® is an online research recruitment platform based in the United Kingdom but open to participants from all over the world. Participants are paid for completing surveys, based on time taken to complete (at or above UK minimum wage). Data collection occurred between 22 August and 18 September 2021. In this time period, most countries were experiencing restrictions associated with the global COVID-19 pandemic emergency, and some participants may have experienced limitations to access to family healthcare.

Participants

The Prolific® platform allows a variety of custom screening tools for potential study participants registered onto the platform. The custom screening tools to be applied in the inclusion criteria specified through Prolific® included male sex assigned at birth, and year of birth or youngest child 2020-2021; or male sex assigned at birth and pregnancy (partners). (Table 1).

Low-risk ethical approval was granted by the Deakin University Human Research Advisory group (reference HEAG-H 107_2021).

Procedure

Members of the general population around the world may choose to interact with Prolific® in order to participate in research studies. Potential participants choose to enter their personal information into the Prolific® platform, which is used by the platform to screen potential participants against the eligibility criteria of current research studies registered with the platform for recruitment of potential participants. Potential participants opt-in to participate in studies that they are interested in, and review the informed consent statements, and complete further screening questions if they choose to participate in the study. In this study, eligible men were notified by Prolific®, and provided with the survey link, should they wish to participate. A link to the Plain Language Statement was included in the introduction to the survey; this could be downloaded by participants. Eligibility was assessed by a number of screening questions and consent to participate was confirmed by an additional question, at the beginning of the online survey.

Data sources

The survey was hosted on Qualtrics, an online survey platform (Qualtrics, 2021).

Data analysis

Data analysis utilised reflexive inductive thematic analysis techniques as described by Braun and Clarke (Braun & Clarke, 2022). Responses to each question were analysed by reading the response line-by-line, and inductive coding and grouping into themes was conducted by researcher VW. A meeting was held with members of the research team (VW, KW, JM, SK, SH, BR, and HTM) to present, discuss and reflect upon the preliminary findings from each question and then to consider the findings as a whole to identify the major themes and subthemes that emerged from synthesis of the whole qualitative dataset. The diverse backgrounds of the research team which included nursing and midwifery (VW and BR), psychology (KW and JM), public health (SK and SH), and health promotion (HTM), supported reflexivity in the inductive thematic analysis process.

The survey was completed by a sample of fathers (n=889) residing in 28 countries, with diverse ethnic heritages and socioeconomic backgrounds (Table 2).

Fathers indicated their transition to fatherhood at time of completion of the survey, 46.8% of whose partners were pregnant and 53.2% had given birth since 2020; and their family healthcare provider (Table 3). Multiple models of family healthcare were represented in the sample, including hospital, community-based, remote area, public and private maternity, paediatric and family healthcare services.

Findings

The central theme that resonated through the responses from the global sample of fathers was that they would like to be actively engaged in their fatherhood role with family health services to provide care for their families. However, many fathers experienced barriers to doing so. A total of 1329 free-text responses to the three qualitative questions were recorded in the survey. Of these, 356 responses provided information why the father did not attend family healthcare; 296 responses provided reasons why fathers did not actively participate in family health care; and 677 responses provided information pertaining to the

Table 2
Socio-demographic variables of participants

Variable	n (%)	Variable	n (%)
Country of birth (n=880)		Country of residence (n=887)	
USA	259 (29.5)	USA	274 (30.9)
UK	203 (23.1)	UK	239 (27.0)
South Africa	139 (15.8)	South Africa	155 (17.5)
Poland	36 (4.1)	Poland	33 (3.7)
Portugal	21 (2.4)	Canada	26 (2.9)
Canada	18 (2.0)	Spain	24 (2.7)
Italy	17 (1.9)	Portugal	21 (2.4)
Spain	16 (1.8)	Germany	18 (2.0)
Zimbabwe	15 (1.7)	Mexico	14 (1.6)
Other[1]	165 (18.8)	Other[2]	85 (9.6)
Language spoken at home (n=887)		Highest completed level of education (n=889)	
English	761 (85.8)	Primary / elementary school	3 (0.3)
Other	126 (14.2)	Secondary school	126 (14.2)
Age in years (n=888)		Trade school/ apprenticeship/ diploma	125 (14.1)
Mean (SD)	32.5 (6.0)	Undergraduate degree	319 (35.9)
Median (IQR)	32 (28-36)	Postgraduate degree	316 (35.5)
Minimum, maximum	18,57	Relationship status (n=888)	
Self-reported social standing[3] (n=885)		Not currently in a relationship	11 (1.2)
Mean (SD)	5.9 (1.5)	In a relationship, not living together	103 (11.6)
Median (IQR)	6 (5 – 7)	De facto	162 (18.2)
Minimum, maximum	1, 10	Married	612 (68.9)
Self-reported physical health (n=886)		Self-reported mental health (n=886)	
Good, very good or excellent	816 (91.9)	Good, very good or excellent	738 (83.3)
Poor or fair	72 (8.1)	Poor or fair	148 (16.7)

[1] Including Germany, Mexico, Nigeria, Australia, France, Greece, Pakistan, India, The Netherlands, Belgium, Estonia, Sweden, Northern Ireland, Philippines, Bangladesh, Chile, Cuba, Ghana, Hong Kong, Hungary, Israel, Latvia, New Zealand, Romania, Saudi Arabia, South Korea, Turkey, Vietnam, Argentina, Bosnia, Botswana, Brazil, Bulgaria, China, Colombia, Croatia, Czech Republic, Democratic Republic of Congo, Egypt, Ethiopia, Finland, Indonesia, Kenya, Kosovo, Lesotho, Lithuania, Malaysia, Norway, Russia, Serbia, Slovenia, Uzbekistan, Yemen

[2] Including Australia, Italy, France, Greece, Belgium, Japan, Estonia, Hungary, Northern Ireland, The Netherlands, Israel, Latvia, New Zealand, Chile, Czech Republic, Finland, Korea, Slovenia, Switzerland

[3] 0 suggests the lowest level of self-reported social standing, and 10 the highest.

Table 3
Transition to fatherhood and family healthcare provider

Variable	n (%)
Partner pregnant or already given birth (n=889)	
Pregnant	416 (46.8)
First pregnancy	*132 (31.7)*
Subsequent pregnancy	*284 (68.2)*
Already given birth	473 (53.2)
First baby	*239 (50.5)*
Subsequent baby	*234 (49.5)*
Antenatal care provider (n=881)	
Public Hospital Maternity care - mostly Midwives	241 (27.4)
Public Hospital Maternity care - mostly Doctors	172 (19.5)
Private Obstetrician	153 (17.4)
GP Shared Care (between the hospital and a General Practitioner (GP))	110 (12.5)
Privately Practising Midwife (planned home or hospital birth)	71 (8.1)
GP Obstetrician care	47 (5.3)
Team Midwifery care	30 (3.4)
Private Obstetrician and Privately Practising Midwife joint care	30 (3.4)
Midwifery Group Practice (MGP) caseload care	14 (1.6)
Other[4]	7 (0.8)

[4] Including no antenatal care, remote area maternity care and care from a family member)

father's overall experience of family health care. The concept of *Fathers' Experiences and Perspectives* was influenced by three major themes: *Individual father factors, Organisational context*, and *Gender roles and/or Restrictive gender norms* (Fig. 1).

The major theme Individual father factors comprised three subthemes: Personality traits and psychological factors, Health literacy, family and socio-economic factors, and Personal beliefs and preferences (Table 4).

Individual personality traits and psychological factors were identified as a barrier to engagement in family health services. In particular, participants identified having an introverted personality, feelings of shyness or having a pre-existing mental health condition as negative reasons why they did not attend and/or actively participate in conversations with health care professionals during family healthcare. Conversely, the choice for active engagement in family healthcare was described as a "*beautiful experience and one you will never have the opportunity to relive*' (Father 379, USA, Private Obstetrician). Fathers identified other intrinsic factors that impeded them from attendance and/or active participation in family healthcare. Navigation of conflicting priorities at the personal level such as work, study and child and family commitments were also identified; compounded by poor health literacy, socio-economic challenges or geographical distance.

The major theme *Organisational context* comprised three subthemes: *Clinician interpersonal skills, Service design,* and *Clinical priorities* (Table 5). Clinician interpersonal skills were identified as positive for fathers' engagement and their overall experience of care, whereas inadequate clinician interpersonal skills were identified as a major barrier to father's participation in family healthcare. Service design that hindered fathers from participation in family healthcare was noted in the pre-COVID-19 context. In the context of the COVID-19 global pandemic, clinical priorities that led to access restrictions were described as a 'wrecking ball' toward aspirations of father participation in maternity care. Continuity of carer and the ability to build a relationship with a trusted family healthcare provider were commonly identified with a positive experience of engagement in family healthcare. In contrast, participants identified receiving conflicting advice from different clinicians as disempowering, and the perception of a lack of support available postnatally was identified as less favourable.

The major theme gender roles/ restrictive gender norms comprised of three subthemes: *Woman's presiding role, Perceptions of 'women's work',* and *'Father-unfriendly or hostile environment'* (Table 6). Respect for the presiding role of the woman in childbearing and her capability to actively lead maternity care was framed positively by fathers. In particular, fathers' identified their personal beliefs of respect for the woman's autonomy and privacy as influential factors upon their level of engagement in family healthcare. However, perceptions of 'women's work' indicated a preference for a passive role or even non-engagement of fathers in healthcare, based upon the father's perceptions of gender role, or restrictive gender norms associated with a lack of paid paternity leave at the macro (government policy)-level. The responses of several fathers also indicated the role of restrictive gender norms through their experiences of exclusion from family healthcare, either through passive measures such as being ignored, or active exclusion or perceived hostility toward fathers when they tried to engage with healthcare professionals.

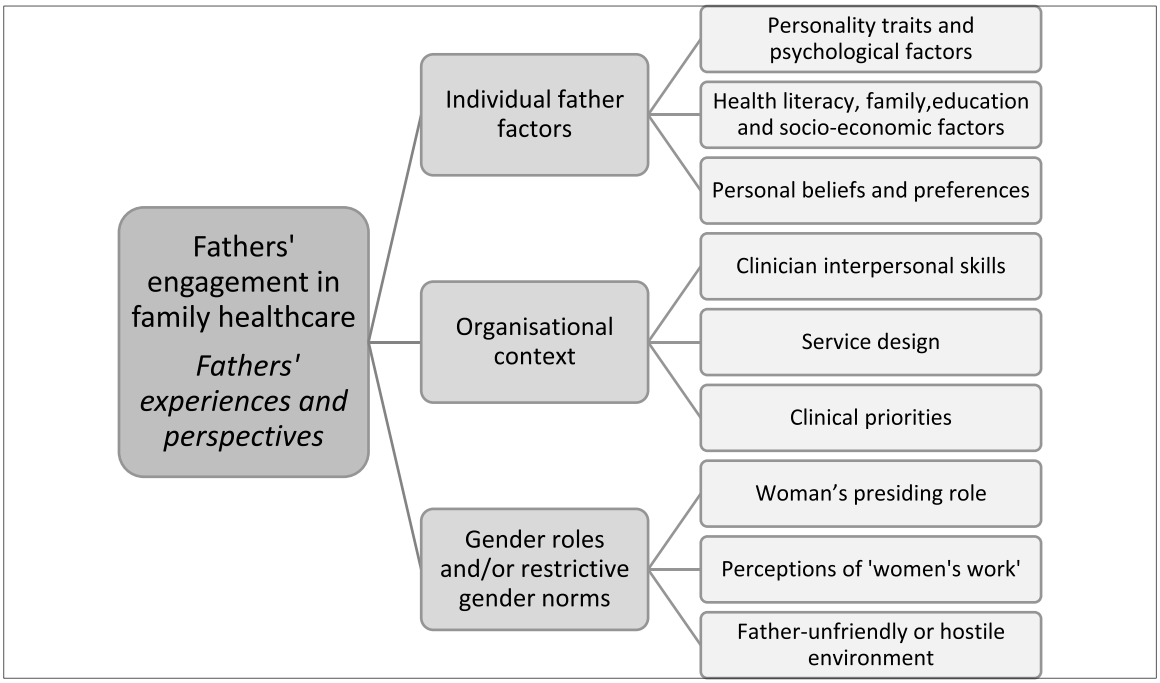

Fig. 1. Influences upon fathers' engagement in health care during pregnancy and early infancy

Some fathers expressed negative impacts following their interactions with family health care services. For example, one father stated his belief that "*Hospitals and prenatal care are brutally uncaring when it comes to the fathers"* Father 316 (USA, Privately Practising Midwife, planned hospital birth). Another stated the opinion that "*Father's health (both mental and physical) is neglected"* Father 393 (Portugal, Private Obstetrician) when engaging in family health services. Others indicated that negative experiences of family health care were associated with harm to their own health and wellbeing. One father stated, *"I felt helpless and vulnerable many times"* Father 336 (Hungary, Public Hospital - Doctors). Another revealed *"I suffered with postnatal depression with my second, I wasn't aware this was a thing for males, and that I had someone I could talk to until my partner asked. I do believe this should be spoken about more"* Father 75 (UK, Team Midwifery).

Discussion

Aside from the devastating impact of the COVID-19 global pandemic emergency upon healthcare provision, many of the fathers that participated in our study told us that they experienced challenges toward attending and participating in family healthcare. Fathers' desire to actively engage and participate in family health care is consistent with the findings of several other studies (Nash, 2018; Rominov et al., 2017; Xue et al., 2018), however at the individual father level, socio-economic factors such as conflicting priorities and work commitments were a common finding. Indeed, many survey respondents identified financial concerns and the need to work as a major barrier to engagement in family health services and very few identified that they had accessed paid paternity leave.

Other individual father-level factors including fear of hospitals, introverted personality traits or the presence of a mental health condition were also identified as negative factors that impacted fathers' experience of engagement with family health services. This finding is consistent with other studies in which new fathers describe challenges in accessing support for their own mental health during transition to fatherhood due to perceived lack of service provision and/or health care professional staff training in the perinatal mental health of fathers, or through perceived stigma of paternal mental health problems or inability to cope with the paternal role (Baldwin et al., 2019; Shorey & Chan, 2020). This is despite evidence that transition to fatherhood is associated with feelings of stress for which fathers may use unhealthy denial or escape activities, such as smoking or working longer hours, as coping techniques (Baldwin et al., 2018; Shorey & Chan, 2020).

Key themes of gender bias, socio-economic, and geographical barriers to fathers' participation were identified at the macro- (healthcare government and policy), meso- (organisational) and micro- (frontline clinician) levels of healthcare to enable equitable access and engagement of fathers in family health services. It is well known that many countries worldwide have poor or non-existent provision for maternity, paternity, and shared parental leave. Yet, studies have shown that even in countries such as the UK where paid parental leave is available for eligible fathers, there may be low-uptake due to poor policy communication and/or perceived policy complexity, and societal gendered expectations (Birkett & Forbes, 2019; Kaufman, 2018). In a qualitative study, new fathers identified financial costs, gendered expectations, perceived workplace resistance, and policy restrictions as key barriers to their uptake of paid paternity leave (Kaufman, 2018). In another study factors such as the couple's educational background and workplace culture influenced the uptake of shared parental leave, with professional couples more likely to take shared parental leave, particularly where the mother earned more or the father's company endorsed Shared Parental Pay (Birkett & Forbes, 2019).

Restrictive gender norms associated with maternal-centric family healthcare services design was another key barrier to fathers' engagement in family healthcare. Father-unfriendly service design based upon restrictive gender norms was a common finding, with services being perceived as not inclusive of fathers. Perceptions of gendered health inequities were evident in the survey responses of fathers, who described a range of negative experiences from being passively ignored or ill-considered through to active exclusion and perceived hostility. As achieving gender equity and "transforming restrictive gender norms is crucial to achieving global aspirations for good health, as embodied in the Sustainable Development Goals (SDGs)" (Heise et al., 2019, p. 1), these barriers must be addressed and resolved as a matter of urgency.

Previous studies have acknowledged clinicians' concerns associated with the importance of screening for and identification of gender-based

Table 4
Individual father factors subthemes and illustrative quotes

Subtheme	Illustrative quote
Personality traits and psychological factors	*I blame this on school, I've always been afraid to speak up in front of others.* Father 77 (USA, GP Shared Care) *I tend to be the shy type and hardly talk* Father 2 (USA, Privately Practising Midwife, planned hospital birth) *I am an introvert* Father 413 (South Africa, GP Shared Care) *My wife is a much better parent than I as well. I've been working on it. I've been seeing a counsellor for mental health. I am involved with the decision making in our house regarding the healthcare of my children, but my wife is much better at communicating with the healthcare professionals and is stronger mentally than I* Father 404 (USA, GP Obstetrician) *I don't like asking questions – I felt helpless and vulnerable many times.* Father 336 (Hungary, Public Hospital – Doctors)
Health literacy, family, education and socio-economic factors	*Some of the terminology I did not understand* Father 207 (South Africa, Public Hospital -Midwives) *Sometimes I feel like I don't know enough to comment.* Father 164 (USA, Private Obstetrician) *I have been working and otherwise required to stay home to take care of our other child* Father 381 (Canada, Team Midwifery) *It's because sometimes I'm in class at school, if I attend them I skipped my classes for studying* Father 354 (South Africa, Public Hospital - Doctors) *My sister assisted while I got caught up with work* Father 405 (South Africa, Public Hospital- Midwives) *Sometimes I had to be at the farm to check up on things that needed my attention* Father 887 (South Africa, informal AN care provided by family member) *Money, and the Mexican health services are expensive and bad* Father 139 (Mexico, Public Hospital- Doctors)
Personal beliefs and preferences	*It feels awkward since it's not my body we're there to discuss* Father 159 (USA, Private Obstetrician) *It felt like I'm intruding* Father 224 (South Africa, Public Hospital - Midwives) *While my wife was pregnant, she didn't ask me to join her at her appointments, so I didn't want to intrude. Currently I'm a stay-at-home dad so I take my child to every appointment.* Father 77 (USA, GP Shared Care) *My wife got the attention and since she was the one carrying the baby I didn't want to interrupt.* Father 44 (Spain, Public Hospital - Midwives) *I just prefer to listen, take notes, and if any question bothers me, then I ask* Father 230 (Poland, Privately Practising Midwife, planned hospital birth) *I felt it was important for both me and my wife that I attended all appointments prior to and post-delivery to fully appreciate the process, actively assist my wife (whether that was just emotional support or to have a second set of ears), and to feel as engaged (as possible) during pregnancy itself. I would strongly encourage all fathers to take an active role during pregnancy and post-delivery care, it's truly a beautiful experience and one you will never have the opportunity to relive.* Father 379 (USA, Private Obstetrician)

Table 5
Organisational context subthemes and illustrative quotes

Subtheme	Illustrative quote
Clinician interpersonal skills	*I always felt like the doctor didn't care about what I had to say … like I wasn't supposed to be there whenever I went to appointments with my wife. The doctors and nurses always made me feel out of place.* Father 24 (USA, Private Obstetrician) *The health care practitioner would not give us time of day to ask questions* Father 184 (South Africa, Public Hospital - Doctors) *The quality of care in the hospital varied wildly between individuals. Some were a lot more attentive and understanding than others* Father 69 (UK, Public Hospital - Midwives) *Despite their workload being huge, I still feel like we were treated with patience and respect* Father 235 (Belgium, Public Hospital - Doctors) *I feel very positive about the way my wife and I were treated, and my wife had excellent support. The support received as a father was significantly less, although I am aware I did not ask for any support so it may be available if requested* Father 195 (UK Public Hospital- Midwives)
Service design	*… I felt as though little thought had been given to the partner's attendance during these conversations* Father 390 (UK, Team Midwifery) *The platform to [participate] was not provided* Father 256 (South Africa, Public Hospital - Midwives) *Maternity was heavily focused on the mother. I did not have something very comfortable to sleep on, I was not proposed any meal, etc…* Father 434 (France, Privately Practising Midwife, planned hospital birth) *The experience was good. The health care provider was always there wherever we needed him even after the baby was born* Father 187 (South Africa, GP Shared Care) *Using a midwife guru was the best decision we made for both of our children* Father 37 (USA, Team Midwifery) *My wife found it very difficult because she was always seeing different midwives, she also felt that check-ups were few and far between and was confused about why the GP was the point of contact for her but was not involved in the pregnancy in any other way.* Father 520 (UK, Remote Area Maternity Care) *During pregnancy the healthcare and midwifery team were good, although there was a lot of being passed from person to person with the midwives. After we're had little to no contact with any healthcare provider for regular check-ups, only if we've initiated contact ourselves.* Father 79, UK, Team Midwifery *I was rarely asked how I felt during the process. There is plenty of much needed support and care offered to the mother, but in my experience, I don't think a single person ever asked me how I was doing or if I needed anything.* Father 381 (Canada, Team Midwifery) *Most health care is aimed at baby and mother. Fathers are often disregarded or shunned.* Father 385 (The Netherlands, Public Hospital- Midwives)
Clinical priorities	*My [baby] daughter's mother is the one who monopolized all the doctor's attention with her doubts during the pregnancy, since it was a high-risk pregnancy* Father 327 (Mexico, Private Obstetrician) *Because of COVID it restricted what we could do. I couldn't even be with my wife during pregnancy until she was giving birth and then I had to leave straight away after birth* Father 123 (UK, Team Midwifery) *Covid prevented me from going to most OB [obstetrician] appointments, but I always brought my wife and waited in the car. I was allowed in for ultrasounds* Father 16 (USA, Private Obstetrician) *Our provider began limiting visits to one parent due to COVID so I wasn't able to attend.* Father 8 (USA, Private Obstetrician)

family violence, particularly during antenatal care (Andreu-Pejó et al., 2022; Baird et al., 2021; Callander et al., 2021; Chaves et al., 2019; Hegarty et al., 2021). Nevertheless, it is also argued that efforts toward achieving greater equity and social justice by the contemporary practices of 'calling out' hegemonic masculinity should be balanced with healthy, connected, equitable and caring ideas of manhood by focusing upon men's capacity to give care, such as the practice of fatherhood (Freiband & Barker, 2022). Indeed, the principle of early engagement of fathers in family health care has been proposed as a preventative strategy to address domestic abuse and family violence (Hegarty et al., 2020). Further research in this area is imperative to improve the safety and wellbeing of families.

A central theme recognised in a previous study was the use of social networks to facilitate understanding for fathers about how to prepare for childbirth and parenthood (Bäckström et al., 2021) provides insight for further research into alternative models of care that may support

Table 6
Gender roles / restrictive gender norms

Subtheme	Illustrative quote
Woman's presiding role	*Some conversations that took place did not require my active involvement. My partner is capable of having those conversations without needing my input* Father 66 (UK, Private Obstetrician) *Sometimes I didn't have questions to ask or felt like my wife had the conversation under control* Father 59 (USA, Private Obstetrician) *Sometimes it made my wife more comfortable if I was a passive observer* Father 270 (USA, Private Obstetrician) *There are some topics (especially during pregnancy) where my wife should make her own decisions.* Father 33 (Germany, Privately Practising Midwife, planned hospital birth) *My girlfriend said she can/wants to go alone* Father 198 (Germany, Private Obstetrician)
Perceptions of 'women's work'	*They just needed to talk to my wife, and it didn't apply to me. No input needed.* Father 232 (USA, GP Obstetrician) *Wife was attending alone. This is how it goes in my country* Father 303 (Estonia, Public Hospital - Doctors) *The staff talked about how to deal with pain and discomfort which did not concern me* Father 214 (Poland, Public Hospital- Doctors) *Work schedule kept me from being able to attend all the time and I was unable to get adequate time off. [The] United States does a very poor job of allowing fathers the time they need.* Father 147 (USA, Public Hospital- Doctors)
Father-unfriendly or hostile environment	*There are some health workers who understood my role as a father and the connection I had with my child, yet there were some who thought this wasn't for men but women*. Father 18 (South Africa, Public Hospital Midwives) *It happened several times that, although I was present, the healthcare professionals only addressed my partner* Father 167 (Italy, Privately Practising Midwife, planned hospital birth) *My name is almost never learned, I'm just referred to as "dad"* Father 738 (USA, Private Obstetrician) *Never an extended invitation to be involved during pregnancy, and the rare time I would ask, it was answered very dismissively* Father 245 (USA, GP Obstetrician) *They asked me to hold my questions because the mother was most important* Father 171 (USA, Private Obstetrician) *Some appointments such as breastfeeding antenatal classes male partners were expressly told not to attend. However same sex couples could have their partners attend* Father 390 (UK, Team Midwifery) *Often the midwives (etc) were almost hostile towards me being there. Many occasions me and my partner laughed at how hostile the staff where towards me even being present … I think the majority of staff where unhappy with my presence as a male. My opinion was disregarded and whenever my partner needed me to be her voice when she couldn't (i.e during Induction) I was met with eye rolling and a harsh tone (I'm a REALLY personable guy and had to really be diplomatic with them)* Father 365 (UK, Public Hospital – Midwives) *I have generally [participated in conversations with family healthcare providers] but I have to be proactive. Nothing is addressed specifically towards me …* *Interesting - I have noted just how sexist the childbirth process is* Father 67 (UK, Public Hospital – Midwives)

engagement of fathers in family healthcare in a meaningful way. An increasingly popular alternative "group" model of maternity care (Catling et al., 2015; Wiggins et al., 2020) may provide new opportunities to support engagement in facility healthcare as well as the development of social networks for new fathers. In this model of maternity care, instead of traditional one-to-one appointments, health professionals facilitate groups and provide continuity of care (usually with a midwife) to around 8–12 pregnant families with similar estimated due dates, providing an opportunity for families to build social support during transition to parenting (Catling et al., 2015; Lazar et al., 2021; Wiggins et al., 2020). Engagement with social networks has been shown to be beneficial for intimate partner relationship quality (Marabel--Whitburn et al., 2023) and generally protective toward men's mental health (Mansour et al., 2023). Further research is required on the impact of group family healthcare upon the development of a support network for fathers and for possible improvements fathers' perinatal mental health.

Enablers of fathers' engagement included good clinician interpersonal skills, and the development of a trusted relationship with the family healthcare provider. Conversely, a lack of continuity of care or the opportunity to build a relationship with a healthcare professional was associated with a disjointed experience of care by some fathers, hindering their ability to feel included in discussions around family healthcare. In studies of childbearing women, continuous and personalised care provided by a known midwife has been associated with active involvement in decision-making (Allen et al., 2019), the highest level of satisfaction with maternity care (Allen et al., 2017; Macpherson et al., 2016) and is beneficial to the psychological and physiological recovery of the woman (Macpherson et al., 2016). Current evidence on fathers' experiences of continuity of midwifery carer is limited; however, in a recent study conducted in Denmark, male partners identified feeling "… involved and included by the midwife … the midwives remembered and recognized the couple's stories" (Jepsen et al., 2017, p. 64). Further research is required to ascertain the impact of relational continuity of midwifery models of care on the engagement of fathers in their family's health.

Strengths of this study include the qualitative survey study design that facilitated a rich source of data from a large sample of fathers from multiple countries, and a wide range of models of family health care. This enables confidence in the reliability of the research findings, and offsets the potential limitations associated with a qualitative survey. However, some limitations to this study should be considered. Firstly, the timing of the global COVID-19 pandemic emergency which was in progress during some of the data collection. However, important insights into the impact of the COVID-19 pandemic upon fathers' engagement in family health care were gained.

Secondly, the qualitative survey design with the potential to achieve depth in the responses, combined with a lack of ability to go back and ask further questions or confirm details as conferred with the qualitative interview technique. However, this limitation is balanced with the ability to recruit a large sample of participants with diverse ethnic, socio-economic, educational backgrounds. Thirdly, despite a recruitment strategy that included financial renumeration for participants, it is still possible that the views of some groups of fathers from hard-to-reach or underserved communities are not represented in this study.

Conclusion

Our research has identified multiple macro, macro and micro-level barriers that currently present barriers to the participation of fathers in healthcare for childbearing and early parenting. Knowledge of these barriers can inform healthcare redesign to include more successful engagement strategies for fathers, to benefit fathers, mothers and infants alike. Individual family health care providers such as (but not limited to) obstetricians, GPs, midwives, health visitors, paediatricians and maternal and child health nurses should reflect upon their knowledge and practice toward father-inclusive practices. Family health services designed to facilitate the needs of the mother alone are outmoded and may actively cause harm to families by precluding fathers from engagement in healthcare for mother, father and infant triads.

Ethical approval

Ethical approval (low risk) was granted by Deakin University Human Ethics Advisory Group for the study HEAG-H 107_2021: *Health literacy and engagement in health services among expectant and new fathers: a cross sectional study.*

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CRediT authorship contribution statement

Vanessa Watkins: . Shane A Kavanagh: . Jacqui A Macdonald: . Bodil Rasmussen: Conceptualization, Formal analysis, Funding acquisition, Methodology, Writing – review & editing. **Helle Terkildsen Maindal: . Sarah Hosking:** Conceptualization, Formal analysis, Methodology, Writing – review & editing. **Karen Wynter:** Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Writing – review & editing, Writing – original draft.

Declaration of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

Dr Karen Wynter reports financial support was provided by Deakin University Institute for Health Transformation 2021 Seed Grant. All other authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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