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Where Fathers Fit in Quebec's Perinatal Health Care Services System and What They Need

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Research has shown that the transition to paternity can be a source of stress and anxiety for fathers who receive little support during the perinatal period. Fathers' feeling of exclusion with respect to perinatal care is documented, but we know very little about fathers' needs in terms of services during the perinatal period. This qualitative study explored the place fathers occupy in Quebec's perinatal services—that is, where they fit among the concerns, objectives, strategies, and actions of health care providers or institutions—and their resulting needs. We analyzed information from 2 sources: (a) semistructured interviews with 34 parents who were either expecting a child or had a child under 2 years old about their perinatal care experiences, and (b) 50 institutional documents pertaining to perinatal care in health and social services centers in Quebec (Canada). The findings describe fathers' position within the couple, in interactions with health care providers, and in services offered in the perinatal period. Fathers' experiences of contact with health care providers are described along the continuum of the need for recognition. Some feel welcomed and supported, whereas others feel excluded and invisible. They are invited to get involved during the perinatal period, but are relegated to a set place that limits their experiences and the expression of their needs. Fathers mainly need space—both in the sense of physical space to be present, and especially room in their interactions with health care providers—where they can speak about their experiences and needs. Recommendations are discussed for developing father-friendly practices and services.

Keywords: fathers, needs, professional practices, services, perinatal period

The past two decades have seen a growing social movement in Quebec encouraging paternal involvement, which is generally defined in Quebec as the biological or substitute father's ongoing participation in and concern for his child's physical, psychological, and social development (Forget, 2009). This social movement has been fueled by rapid changes in family structures and dynamics over recent decades (Deslauriers, Gaudet, & Bizot, 2009) as well as by research interest in fathers' specific contribution to child development (Marsiglio, Day, & Lamb, 2000; Pleck, 2012). The fundamental aim of this movement is to redress the relative invisibility of fathers in family law, parent support initiatives, and programs for children, youth, and families (Ball & Daly, 2012). Not only is paternal involvement a matter of concern for families and the scientific community, but it has also progressively become a political concern (Conseil de la famille et de l'enfance, 2008; Ministère de la Santé et des Services sociaux [MSSS], 2008). Even

so, the fact remains that, in Quebec, no implementation strategy for public policy around perinatal health and early childhood specifically targets fathers (St-Arneault, de Montigny, & Villeneuve, 2014). We know that how society defines paternity—and the attendant rights, responsibilities, and roles—will influence the community services and institutional practices that fathers encounter (Lero, Ashbourne, & Whitehead, 2006). As such, it is not surprising to find that Quebec fathers have difficulty seeing where they fit in the health and social services they use (de Montigny & Lacharité, 2004; de Montigny et al., 2007; Lacharité, 2009). The objective of this exploratory study was to explore fathers' needs during the perinatal period, focusing especially on the place they occupy in perinatal health care providers and services' concerns, objectives, strategies, and actions.

Transition to Paternity

Becoming a father is a significant event in a man's life. Men report being deeply moved and proud by the child's arrival in their lives (Genesoni & Tallandini, 2009). Feelings of amazement, love and great responsibility, surprise, and confusion are described by new fathers (Deave & Johnson, 2008). While many men find becoming a father enjoyable and meaningful, some experience particular challenges. Many men feel pressure to satisfy the new social expectations of them as fathers and have difficulty adapting to the rapid personal, conjugal, family, and professional changes

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related to the transition to paternity (Chin, Hall, & Daiches, 2011). Some experience a high level of stress and anxiety (de Montigny, Girard, Lacharité, Dubeau, & Devault, 2013; de Montigny & Lacharité, 2008).

Their partner's pregnancy can be an especially stressful period for fathers. Some feel incompetent, inadequate, and anxious (Finnbogadóttir, Crang Svalenius, & Persson, 2003). During the birth, some fathers are unsure about their place and role with respect to their partner. They experience high stress related to the unfamiliarity of the situation and their lack of knowledge about hospital environments (Deave & Johnson, 2008). In the weeks following the birth, many fathers say they lack the skills, knowledge, and experience to take care of their newborn (Goodman, 2005). They experience many difficulties in finding a balance between the need to assume their role as providers and their desire to be present for their child (Genesoni & Tallandini, 2009). They have difficulty adapting to the situation and describe themselves as "overwhelmed" (Fäger skiöld, 2008; St John, Cameron, & McVeigh, 2005). They report experiencing distress, disappointment, and frustration during their adjustment to paternity (Goodman, 2005).

Father Involvement

One of the challenges in transitioning to paternity is developing involvement with the child. The father-child relationship develops in a specific context in which both personal and contextual characteristics, such as health and social services or policies, have a determining influence (Ministère des Familles et des Aînés [MFA], 2011). Characteristics such as the objectives of programs and services, the education and attitudes of health and social services providers, or even opening hours of services, have the power to facilitate or restrict fathers' involvement in their child's care. Paternal involvement also depends on fathers' own needs (personal characteristics) being met. In fact, fathers who receive support during their partner's pregnancy and whose experiences as fathers are acknowledged have been shown to be in better physical and psychological health (Plantin, Olukoya, & Ny, 2011).

Services for Fathers During the Perinatal Period

Despite the challenges involved in the transition to paternity and the known impact of contextual characteristics on fathers' involvement and well-being, fathers in Quebec (de Montigny, Gervais, & Tremblay, 2015; de Montigny & Lacharité, 2004) and elsewhere in the world (Bäckström & Hertfelt Wahn, 2011; Halle et al., 2008; Premberg, Hellström, & Berg, 2008) receive very little support during the period surrounding the birth of their child. Even though the transition to parenthood is a good time to intervene with fathers and help them to become more involved with their child (Doherty, Erickson, & LaRossa, 2006), there are few activities and services designed specifically for fathers in Quebec (Conseil de la famille et de l'enfance, 2008). A recent inventory of services that are offered to men or families in this Canadian province showed that only 13% of the organizations contacted ($N = 78/613$) offered support modalities specifically designed for fathers (Dubeau & Villeneuve, 2011).

Most family organizations now use the term "parent" in an effort to make their services more father-inclusive, but this term still represents and speaks more to mothers than to fathers (Dubeau

& Coutu, 2012). This idea persists because there is a much greater body of knowledge about mothers than about fathers; mothers continue to be seen as the primary parents of young children and some researchers who have involved mostly mothers in their samples use the broader term "parent" in their writings, thereby generalizing their findings incorrectly to include fathers (for examples, see Archibald, Caine, Ali, Hartling, & Scott, 2015 [M: 20, F: 1]; Blood & Cacciatore, 2014 [M: 102, F: 1]; Eronen, Pincombe, & Calabretto, 2007 [M: 27, F: 1]; Tétréault et al., 2014 [M: 49, F: 5]). All of this perpetuates the belief that fathers are identical to mothers in what they need, how they act, and their influence on child development, with the result that services supposedly implemented for parents are, in reality, designed to meet the needs of mothers (Dubeau & Coutu, 2012). It is therefore not surprising to observe that, in fathers' encounters with perinatal health care providers, they often report feeling sidelined or excluded from the providers' relationship with their family. In the days following the birth of a child, fathers perceive that health care providers' interventions mostly address mothers and are designed to meet their needs (Montigny & Lacharité, 2004). Fathers say that, throughout the perinatal period, they are rarely perceived by health care providers as parents in their own right, but rather as sources of support for the mother (Lacharité, 2009), and they say they do not know where they fit in the services offered (Lacharité et al., 2005). A recent study revealed that social services and health care professionals are not comfortable with vulnerable fathers being present during consultations (St-Arneault, 2013). Some professionals seem to have a negative perception of fathers and prefer to interact with mothers, whom they consider to be more interested in the child's well-being (Lacharité et al., 2005).

In Quebec, perinatal services are offered by health and social services centers (CSSSs) (MSSS, 2014). Each CSSS has local community service centers (CLSCs) (MSSS, 2014), long-term care facilities, and usually a hospital. The hospital delivers short-term care, mainly at the time of birth, whereas CLSCs are mandated to improve the health and social conditions of individuals and the community through a comprehensive (multidisciplinary) community approach. In particular, they are responsible for prenatal visits and postnatal follow-up for new families, as well as support programs for at-risk families. Each CSSS has partnership arrangements with other institutions and agencies, such as a child and youth protection agency that provides social services for young people with developmental, behavioral, or social adjustment problems (abuse, negligence, delinquency, etc.) and community organizations that offer services for families (MSSS, 2008). The present study looked at parents' perceptions of services received from the hospital, CLSCs, and community organizations that are partners with the CSSS. It was a study of a single case, that of Quebec, where society is undergoing transition with respect to fathers' place in perinatal services.

Research Objective and Questions

The poor fit between Quebec's health and social services system and fathers' needs during the perinatal period suggests that it is imperative to explore fathers' place in perinatal services. The objective of the present study was thus to answer two research questions:

- Where do fathers fit within the observations, concerns, and actions of perinatal health care providers, according to parents' perceptions and the analysis of institutional documents?
- What are fathers' needs in terms of services and formal support during the perinatal period?

Method

This study was part of a broader research program aimed at developing an initiative to improve practices and care for fathers during the perinatal period. Both qualitative and exploratory, its purpose was to describe fathers' current situation with regard to services in order to determine their needs. Two sources of data were used: interviews with parents and institutional documents.

Part 1: Parent Interviews

The first source of data was 17 couples who were new or expectant parents. Since the idea that fathers have a place in perinatal care is relatively recent, interviews were used so that the interviewer could support fathers in their reflection, explore the study's themes in depth, and obtain rich and detailed information on the links between fathers and services. We deliberately adopted a systemic approach that involved interviewing couples rather than fathers alone, in order to better understand the mother's perception of the father's place within the couple, in interactions with health care providers, and in services offered during the perinatal period. Indeed, mother and child are the main focus of health care providers' attention in the perinatal period, and providers' relationship with the father is mainly influenced by what the mother says about him and the extent to which she invites him, or not, to take part in consultations. Including the mother in the interviews was also a practical way of accessing the history of the family's perinatal services use, since most fathers were not present at every appointment due to their work schedule. Since the characteristics of the population studied were relatively well circumscribed, meeting 17 couples provided a good variety in terms of family structure, type of services, and place of residence in the study region.

Part 2: Institutional Documents

The second data source consisted of institutional documents used in the hospital's maternity unit and in the CLSCs that provided front-line health care and social services. These documents were analyzed with respect to both structure and content. The data from the two sources were processed in a complementary manner in order to support and capture the subtleties of the themes discussed by the parents.

Study Procedure

The study was approved by the research ethics committees of the Université du Québec en Outaouais and the Université du Québec à Trois-Rivières and by the ethics committee of the participating CSSS. The data in Part 1 were gathered from 17 couples who were either expecting a child or had a child under two years old and had received perinatal services in the preceding six months. They were recruited by key informants in the target communities, who invited them to take part in the study. The

parents who agreed to participate were contacted by the researcher. Before making an appointment with them, she explained the research objectives and procedure to them again. The selection criteria for parents were that they: were over 18 years old; were expecting a child or had one or more children under 2 years old; had received services for the pregnancy or for the child from at least one organization in the region within the preceding 6 months; were able to speak, read, and understand French; and agreed to participate in an interview as a couple. An effort was made to obtain a sample of parents representing a variety of family situations in terms of number of children, parents' ages, socioeconomic status, and type of service received by the family (Tables 1–3).

The parents were met in their homes by either the lead researcher or a research officer for a couple's interview lasting between 60 and 90 min. The semistructured interviews explored the links between the couple, in particular, the father, and the services and health care providers involved with the family during the perinatal period. The interview focused on the father's needs during the perinatal period, the practices established by health care providers to support the father's involvement, and the couple's satisfaction with the services received. The parents also filled out a short sociodemographic questionnaire. The interviews were audiorecorded and then transcribed verbatim. In each visit, both parents signed a consent form for the interview and the audio-recording.

To gather the data for Part 2 of the study concerning institutional documents, health care providers and managers were asked to provide the lead researcher with all the written documents that structured family services and practices. These documents not only defined the family services' goals and objectives and the strategies health professionals should use to attain them, but also identified what the professionals should pay attention to while supporting families—hence, how to consider (or not) fathers' needs in their interventions. Twenty such documents were received and analyzed, including information documents, clinical pathways, evaluation forms, nursing documents, and data collection forms.

Next, the nurses' notes in 30 patients' records were analyzed: 16 records from the maternity ward and 14 from the CLSC. Around half of the families had received preventive services and were participating in programs for at-risk clients¹, while the other half had received general services. Several professionals were involved in the selected records, including nurses, doctors, psychologists, social workers, and nutritionists.

Before the nursing notes were collected, permission was obtained from the medical records service. Next, the researcher met with a medical records employee, who explained the principles underlying the writing of notes in patients' records and their utility. The employee next randomly identified 30 records of families that had received perinatal services in the last 6 months. The researcher analyzed the files using a grid designed for the purpose that had been validated by a committee of experts. That grid captured the father's presence or absence when interventions were carried out and recorded in detail the number and nature of observations and interventions noted with respect to the mother, the father, and the

¹ Vulnerability criteria in Quebec include income below the poverty threshold, mother's young age (less than 20 years), low education level (secondary school not completed), or recent immigration.

Table 1
Sociodemographic Characteristics of the Family

	Mean	Variance
Age of father (years)	34	22–46
Age of mother (years)	32.2	18–40
Union duration	5.7 years	9 months to 11 years
Number of children	2.29	1–5
Age of youngest child	9.5 months	Prenatal to 24 months

family. In this context, maintaining records is considered a significant professional activity that makes it possible to track services delivered to families, thereby ensuring the accountability and responsibility of health care providers. The notes made in the record reveal the principles that underlie services for families.

Data Analysis

Thematic analysis is designed to transpose a corpus of data into a certain number of themes to capture the personal experiences described by the participants (Paillé & Mucchielli, 2012). As a first step in the thematic analysis, five randomly chosen transcripts were read to get an overview of the material that had been collected. Next, all of the transcripts were read and annotated in order to identify central themes in the participants' accounts while paying attention to recurring themes and possible ways to group them. As suggested by Paillé and Mucchielli (2012), a third reading of five randomly chosen transcripts was then done to refine the division and grouping of the themes. These themes were then discussed by the team to define them more clearly and reach consensus. Finally, a fourth reading of all of the transcripts was performed to check the accuracy of the themes and to group them along thematic lines and into a coding tree chart illustrating the complexity of the place the father occupies during the perinatal period.

The institutional documents were analyzed from two angles. First, the structure and content of the 20 institutional documents were analyzed to determine the degree to which those documents encouraged health care providers to pay attention to fathers. Second, the content of the notes in the patient records was transcribed and studied to analyze what place fathers occupied in health care providers' observations, concerns, and actions. These analyses were done, not to evaluate the professional actions or practices of the health care providers, but to understand the institutional framework that governs such practices.

To compare different views on fathers' place in perinatal services and to identify the resulting needs, the findings from the

Table 2
Services Used by the Family During the Preceding 6 Months

Organization	Proportion of family using services (%)
Community health services centers	83 ($N = 15$)
Hospital services related to pregnancy or birth	56 ($N = 10$)
Community organizations	61 ($N = 11$)
Child and youth protection services	6 ($N = 1$)
Rehabilitation services	6 ($N = 1$)

Table 3
Socio-Economic Profile of Respondents

Education level	Proportion of families (%)	Annual income (Canadian dollars)	Proportion of families (%)
Six years	5.8 ($N = 1$)	Less than \$30,000 ^a	35 ($N = 6$)
Twelve years	53 ($N = 9$)	\$30,000–\$79,000	41 ($N = 7$)
College or vocational diploma	17.6 ($N = 3$)	\$80,000 or more	23 ($N = 4$)
University degree	23.5 ($N = 4$)		

^a The low-income threshold is the income level below which a family is likely to devote a greater proportion of its income (around 63%) to food, housing, and clothing than the average family. In Canada, the low-income threshold for a family of four has been set at \$43,544 CDN/year before taxes for the year 2010 (Statistics Canada, 2012).

analysis of the interviews with the parents and from the analysis of the institutional documents were cross-referenced. The analysis of the interviews was used as the primary material, and the findings from the documentary analysis were used to complement or gain a better understanding of the parents' remarks, thereby forming an overall picture of fathers' place in perinatal services.

Results

Analysis of the data highlighted different views of fathers' place in perinatal services, which, when combined, provided insight into fathers' resulting needs. The themes identified emerged mainly from interviews with parents. We have specified and explained points where the analysis of institutional documents echoed the themes raised by parents. First, we will describe fathers' place in the conjugal relationship with the help of subthemes related to different roles and needs. Next, fathers' place in relation to health care providers will be presented as a continuum ranging from fathers who feel welcomed to those who feel excluded. Finally, fathers' place in services will be described through the subtheme of perinatal services geared exclusively toward mothers. Figure 1 presents the themes in the form of a coding tree chart.

Fathers' Place in the Conjugal Relationship

The objective of this study was to examine fathers' place in perinatal services. However, the mothers' testimonies revealed that it is difficult to focus on fathers in the perinatal context and that their place in services cannot be discussed without looking at their place in the couple. The mothers clearly expressed their own expectations about their partner.

A limited paternal role. The interviews revealed a perceived dynamic in which the father has a duty to support his partner. This dynamic, which we can only hypothesize already existed in the couple, was reinforced by services delivered to the couple in the prenatal period:

Me, I had the impression that the father was defined as supporting the mother. I found that during the delivery he was essentially told: "Be the wall that everything is going to lean on, be the support." So it was important for him to be there [during the prenatal classes] to receive the information. (Megan)

Prepare the couple for the birth . . . What she expects me to do . . . And me, what should I expect, when she gives birth . . . What is my

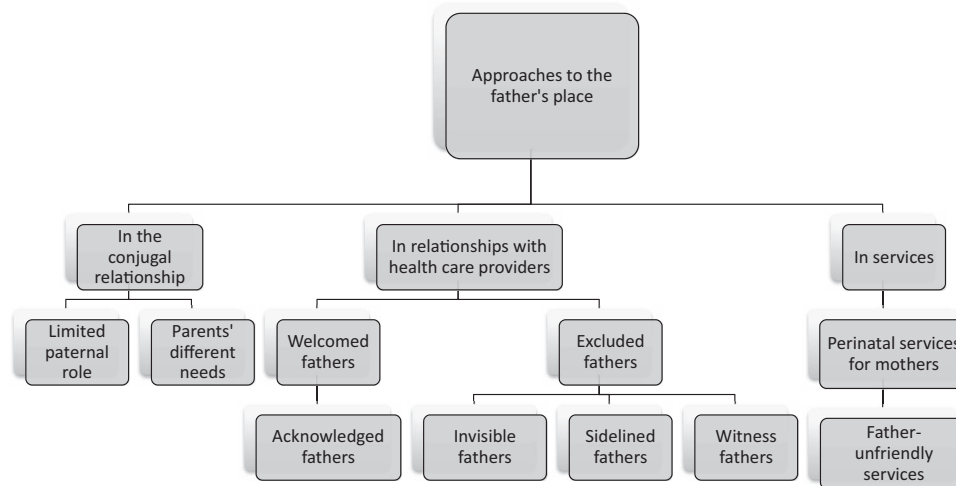


Figure 1. Coding tree for thematic analysis.

place there? Where is the line I should not cross, what should I do, and what shouldn't I do [for her]? (David)

These remarks illustrate the little space that their partners gave fathers and that fathers gave themselves with respect to the birth. The mothers expected their partner to be the wall on which they could lean, and the fathers, worried about playing their supporting role poorly, were eager for information concerning that role. The way fathers are portrayed in health care providers' practices, such as being a wall to lean on during birth, influences the couple's relationship and changes the attention and support that the partners give each other.

Different needs. During the perinatal period, several fathers had doubts about the legitimacy of their experiences and needs. These fathers felt they were not entitled to receive services from professionals since they considered that their partners' needs had priority:

[Mothers] have concerns; they are the ones we really want to reassure [in prenatal classes]. We can ask questions, but if all the guys asked too many questions, when would the professional take the time to reassure the mothers? He [the doctor] has no time to waste. You can see that the office is full. You can feel it. You do not want to waste his time. And Lucie, given what she is experiencing, I want him to take care of her needs. Me. . . (Louis)

These fathers thought that if they expressed their needs, they would compromise the health care providers' response to the needs of their partner. They thus stepped aside so their partner would receive the attention she needed. At the same time, the mothers expressed the wish that someone else would take care of the fathers, invite them to appointments, and relieve them of the responsibility of persuading the father to get involved:

As a mother or future mother, it is always hard to include the father by saying: "I'd really like you to be there." We know he has things to do. It's the health care provider herself who has to show and convince the father that it would be really good if he were there. (Cate)

Some mothers were more aware of their partner's needs for support during the perinatal period and regretted that health care providers hardly responded to those needs.

Having someone who is there to listen to the dads, to try to see where there are problems for them . . . You know, reassure them . . . To have help for the dads who are maybe less comfortable. It's important, the first-time dads who need support. . . (Nadia)

When health care providers did not offer resources for fathers, mothers said they had to support fathers themselves at a time when they often did not have the availability, energy, or state of mind to do so, as Nadia explained: "The result is that we end up with two needs. A dad who needs help and a mom who needs air. . ."

Fathers' Place in Relation to Health Care Providers

The participants' accounts of the relationship between fathers and health care providers revealed many subtle points. The fathers' experiences of contact with health care providers were described along a continuum of need for recognition. At one end of the continuum, some fathers felt welcomed and supported, whereas, at the other, they felt excluded from relationships with health care providers, invisible, as if they were not experiencing anything and were simply witnesses to the events.

Welcomed fathers. The fathers were especially sensitive to health care providers' attitudes and energy. For many, the success of their relationship with a health care provider was not related to a specific practice, but rather to the provider's personal characteristics: "Well, she was just super, super nice. Really kind. Her energy . . . A great smile, super sweet. A calm little voice. She was not aggressive." (Theo)

When the family perceived the appointment with the health care provider as a success, the father expressed ease in taking a legitimate place and including himself in the relationship. He had the impression that the health care provider cared about him, that his presence was desired, and that he could ask questions:

The openness, the availability, the understanding [of the health care provider]. The least question, she was also available to answer you. That's what I remember. If you are a family, the health care providers are there for the whole family. (Charles)

The fact they were acknowledged in visits with the health care provider and were included in the discussions was significant for

these fathers. They often remembered it as an important time during which they felt they “existed” in the relationship between the health care provider and the new family.

Acknowledged fathers. The interventions that made the greatest impression on fathers were those in which the health care provider gave them information that concerned them, those in which their specific attributes as fathers were acknowledged:

[In the prenatal classes], they talked about what the guy was going to experience in relation to the mother, psychologically and also emotionally. Me, I think it's good that the mother is there to hear what the guy is going to experience. (Peter)

The fathers also appreciated being asked to help personally. They liked feeling useful, whether with respect to their partner or their child. Adam's remarks concerning his participation in his newborn's first bath is a good illustration of this feeling:

She explained to me what she was doing. There was a dialogue there. I was not just there for show. It was we [the fathers] who undressed, dressed. You hold his little foot . . . It makes you feel a little more useful because, otherwise, you're there and you wait. It doesn't take very long at all, but during that short time, I was taking part in the story. After that you can say that, once he's born, we're still a couple. (Adam)

Each instance of direct interaction with a health care provider was important for the fathers, who appreciated being questioned, reassured, and informed. On those occasions, the fathers felt their presence and expertise recognized, and they felt supported in their role.

Excluded fathers. While couples described many exemplary practices, other fathers had much less pleasant experiences in which they felt invisible or excluded by health care providers and in which there was no place for their experiences or feelings as fathers.

Invisible fathers. In some of the events that were described, the fathers said they felt transparent or invisible. Far from being noticed, their presence was denied by the attitudes and remarks of health care providers, who did not look at or speak to them.

The father, they do not look at him . . . if you do not ask them any questions, they will not speak to you. (Richard)

Sidelined fathers. Several fathers made more nuanced observations. In their relationships with health care providers, they felt they were welcome, but that their opportunities to discuss their paternity or worries were very limited.

You go to the doctor. It's more for the mother and that's normal. Except that you still ask general questions that concern the couple, but still it's more the mother who is considered, since she's the one who is pregnant. It's not so much that we're shunted to the side, but for sure they do not ask any questions about the father! (Xavier)

While the health care providers seemed happy that they were there, few asked the fathers about themselves or how they were experiencing fatherhood. Some fathers mentioned the gap between the public discourse, which promotes fathers' involvement during the perinatal period and in caring for and educating children, and the little attention they actually received from health care providers during those events. For some, it was the health care

providers' attitudes that a priori excluded fathers' own experiences of the events related to pregnancy and birth:

The health care providers weren't there to play at being psychologists. They were really there for the mother. They didn't really ask me how I was doing, how I was taking it. (Nick)

For some parents, it was not only the fathers' needs for support and recognition that were not acknowledged, but also their basic physical needs, as Rose described:

He had been awake for 48 hours. At one point I was worried about him. I was thinking: “This is no time for you to get sick again, I want you to get some rest. I'm going to need you at home, too.” I told him: “You have to get some sleep.” He went to sleep, and he had been sleeping for maybe half an hour or an hour. I was in my bubble with Maud. But then a nurse came into the room and woke him up. “Hey,” she said, “you're not the one who needs rest, she is!” (Rose)

Witness fathers. Some of the fathers' remarks expressed a feeling of existing in parallel to the relationships established between their partner and the health care providers. They witnessed the relationships as outside observers, but were never really part of them. A number of fathers thus experienced contradictory emotions, because while everyone was emphasizing the importance of their role in supporting their partners during the perinatal period, health care providers neglected to inform them about and prepare them for that role. The fathers thus did not really feel equipped to support their partner, and the feeling of incompetence or failure was hard on them:

For sure, we have a background role. The mother is primordial and that's normal. But we still have a supporting role, and sometimes I think we do not do a very good job of it. (Nick)

Examination of the nursing notes in the patient records confirmed the fathers' second-class rank. The records contained around twice as many observations on mothers as on fathers, and noted four times more interventions with mothers than with fathers. Given the large number of observations that revealed problems related to fathers (substance abuse, conjugal violence, little involvement in family life), it was surprising to see how few interventions were carried out with them. According to the records, direct interventions with fathers occurred more often among fathers who were regular patients. They involved either highlighting and encouraging the beautiful relationship between the father and the child, or encouraging the father to support his partner following the delivery, whether with respect to breastfeeding or to the children's education. There were no records of interventions with fathers experiencing problems with substance abuse, anger management, or violence. In some cases, health care providers noted that they had given documents to the mother to give to the father.

Fathers' Place in Services

The parents' perceptions that there was little space for fathers in services were much more consistent and revealed another continuum of perceptions, ranging from a vision of services as being only for mothers to an impression that services were unfriendly to fathers.

Perinatal services only for mothers. According to the participants, perinatal services that are supposed to be “family-centered” are, in fact, geared toward mothers and children. When fathers use these services, they rarely feel at home:

The classes are for mothers. They're not for dads. They're welcome, but . . . she isn't speaking for dads, there. It's not really geared toward dads, that, it's really for the moms and babies. (Sam)

However, a number of fathers nonetheless felt it was important to attend appointments and activities with their partner. It was surprising to see that services had adapted very little to this new reality and had failed to make room for such fathers:

About 20% of the interventions included me . . . In reality, it was a lot less than that because, in the end . . . I was the one who asked questions, but they didn't come to me and ask me anything. If they had any questions, it was more for paperwork, registration . . . that's all. (Charles)

According to the fathers, the discussion topics, information provided, and nature of the activities were clearly intended for women. When the fathers attended, they felt the activities did not really concern them and provided little benefit. Some fathers saw it as normal for the focus to be on the mother and her needs, but others concluded from this that the services were not for them and were unrelated to their needs, which reinforced the feeling of exclusion mentioned above, especially since no agency or institution in the area offered services or activities specifically for fathers.

The perception that perinatal services were geared only to mothers was confirmed by the institutional documents. In them, we found very little encouragement to pay attention to fathers or take care of them. The only times the father was mentioned were in reference to the role he could play in supporting his partner. For example, it was in the needs identification procedure of the SIPPE program² that we found the most information on fathers, who are discussed under the heading “mother's support network.” The father is perceived as having a peripheral role, on the same level as friends and the extended family, rather than as an actor in his own family.

Father-unfriendly services. Even more striking than the evidence from the documentary content is the fact that the father's presence is complicated by the environment in which services and activities are carried out. For example, several fathers were offended by the absence of a bed for them if they wanted to stay with their partner in the maternity unit. Some fathers went home to sleep because the only alternative was to sleep on the floor in the hospital, an unacceptable option.

For years, men were criticized for not being present. I'm present, but I find that the system isn't made for that. At the hospital, the nurses, the doctors, they talk to the mother. Everything is focused on the mother, and that's great because she's the one who needs support. But it would be a good idea to consider that maybe the father might want to sleep in the room after the delivery, too. He might not feel like going home. He wants to be there with his wife and child. Would it be possible to consider having a folding bed? (Peter)

They also complained that the maternity unit provided meals for the mother only, requiring fathers to leave the unit to eat:

After the delivery, you're exhausted. You manage to sleep one or two hours. Then you wake up because they come with breakfast. No, no, no. They do not come with breakfast for both of us, they come in with a breakfast for the mother. You, take care of yourself! (Peter)

In such an environment, it is difficult for fathers to feel their presence is desired. The schedule of services and activities is also an obstacle to fathers' participation because it generally conflicts with their work hours, reinforcing the message that the services are for mothers and the father's presence is accessory.

I was working a lot, so I was not there. I went to only one appointment. The others were during the week, during my work hours. (Gabriel)

From our examination of the structure of the maternity unit records, there appeared to be little incentive for health care providers to pay attention to the father, which, in turn, may have contributed to a father-unfriendly environment. Indeed, the father's presence in postpartum was not noted, and from the files it is not possible to know whether the father received postnatal lessons, or only the mother. Fathers' second-rate position is well illustrated in the document entitled “*Cheminement clinique du nouveau-né*” [The newborn's clinical pathway], which recommends encouraging skin-on-skin contact between the father and the newborn, but only in cases where skin-on-skin contact between mother and newborn is impossible following a birth by caesarean.

Discussion

Fathers' Needs in the Perinatal Period

The objectives of this study were to explore where fathers fit within the observations, concerns, and interventions of perinatal services professionals and to identify fathers' needs during the perinatal period. The place fathers report occupying in their conjugal relationships, in their relationships with practitioners, and in services provides insight into fathers' needs. Here we discuss those needs and offer recommendations for clinical practice and research regarding fathers.

Despite the fact that fathers' needs were the central theme of the interviews, few needs were specified by the fathers. Cross-referencing the two sources of data helped explain the silence surrounding fathers' needs.

First, the characteristics of masculinity may make it difficult for men to discuss their support needs during their transition to fatherhood (Summers, Boller, & Raikes, 2004). For many men, requesting or accepting support is perceived as a failure or evidence of incompetence. Admitting a need for support is incompatible with the masculine characteristics they have internalized, such as independence, competence, self-confidence, courage, au-

² The objectives of the SIPPE program (*services intégrés en périnatalité et de la petite enfance* [integrated perinatal and early childhood services]) are to maximize the health potential of children, mothers, and fathers, to optimize children's development, and to improve the conditions of families living in vulnerable situations. SIPPE families are followed, primarily in the home, by an interdisciplinary team of nurses, nutritionists, psychoeducators, and social workers. This follow-up begins in the prenatal period and continues until the first child followed by the program starts school (MSSS, 2004).

tonomy, and aggressiveness (Dulac, 2002; Tremblay, Cloutier, Antcil, Bergeron, & Lapointe-Goupil, 2006).

Second, their partners' attitudes contributed to the fathers' silence about their needs. The mothers' remarks and the interactions between the parents during the interviews revealed that, at that point in their lives, the mothers were not very available to think about the fathers' roles and needs. Their narrative was constructed around their own experiences. They expected their partner to support them during the perinatal period, but they neither expected to nor knew how to help their partner adapt. Indeed, a birth holds many unknowns for mothers; men being asked to be a 'wall' could be the only language a woman has to anticipate an experience she has yet to encounter.

Next, health care providers, who are professionally trained and encouraged by their institutions to focus on mothers and their needs, convey this concern to fathers through their actions. Fathers are thus encouraged to be more concerned about their partner's needs than their own. Many feel they are not allowed to consider the services in terms of what would be helpful for themselves. They thus find themselves isolated in three ways: by health care providers, who consider them only as sources of support for the mother; by their partner, who is not available to consider their needs; and by their own perception of the perinatal period, oriented toward meeting the needs of their partner (de Montigny, Lacharité, & Amyot, 2006). These findings call for further exploration of fathers' needs during the perinatal period. In particular, research with fathers in focus groups could provide a more detailed description of fathers' experiences and needs during the perinatal period (Vreeswijk, Maas, Rijk, & van Bakel, 2014).

The mother's relationship with the health care provider also determines the practices that health care providers establish with respect to fathers (Fleming & King, 2010). There is a three-way dynamic among the mother, the health care provider, and the father, in which a father who is not represented or described as "ideal" by the mother will find himself left out of the health care providers' concerns and interventions (Dubowitz, Lane, Greif, Lamb, & Jensen, 2006). This dynamic might explain the gap between the large number of observations of problems concerning fathers recorded by health care providers in the patient records and the low number of interventions carried out with them.

Finally, analysis of the documents revealed that very little provision is made, at the institutional level, for any consideration of fathers' needs. When the father's importance and positive contribution to the child's well-being are not clearly acknowledged, this sends a message that the father is not important or has a negative effect on the family (Clapton, 2009). This image of fathers colors the relationships between health care providers and families, to the detriment of the providers, parents, and children. The lack of institutional incentive to pay attention to fathers, combined with the fact that health care providers have little training with respect to paternity and working with men (de Montigny et al., 2009), results in an environment where fathers may feel tolerated, but rarely welcomed. The findings highlight the value of using an ethnographic approach to explore in depth the link between an organization's institutional documents and the practices adopted by its health care providers. Adopting an ethnographic approach would have enriched the study, positioning the researcher inside the institutions rather than as an outside observer. From this vantage point, the researcher would have been able to

develop an overall picture of how the care providers used their institutional documentation and the progress notes in patients' records to construct their practices. This ethnographic approach would have promoted a more comprehensive understanding of how health care providers interact with fathers in terms of existing relationships and institutional knowledge, values, and relationships (Bourassa, Miron, & Lacharité, 2011). The results of such research would highlight the importance of ensuring that programs to encourage paternal involvement include not only health care providers, but also managers.

Together, the factors discussed here explain why it is difficult for fathers to express their needs. They are living in a context that limits their perception of their own experiences and expression of their feelings. Exploring fathers' needs calls for an atypical method for analyzing needs. Rather than having them answer a questionnaire on their needs or their satisfaction with services, the study looked at fathers' relational needs and highlighted the ways in which fathers' needs are seen (or not) in service organizations that are centered on mothers and children.

Looking at fathers' inclusion through the lens of institutional documents sheds light on the interface between services and parents and helps to uncover fathers' needs. Considering fathers within the services context, in fact, reveals a number of limitations currently inherent in health and social services: little contact between fathers and care providers, interactions between fathers and care providers being influenced by the mother, and interactions being limited to matters related to the mother and child.

Limitations

This study has certain limitations. The parent recruitment method was biased, since the health care providers most certainly targeted parents with whom they had good relationships. Another limitation lies in the bias introduced by the methodological choice to meet the parents together instead of separately. In some couples, the spouse's presence inhibited the interviewer's ability to obtain the father's perspective on his needs. However, interviewing couples helped to enrich the description of the fathers' experiences, while also illustrating the power of women's talking about the perinatal period in relation to men, thereby contributing to the understanding of fathers' needs. The analysis of the institutional documents was also a limitation for this study. As mentioned above, it would have been relevant to perform an ethnographic, rather than a formal, analysis of the documents. Finally, these results cannot be generalized to all types of fathers (adoptive, same sex, etc.). For these men, becoming a father is not embedded in a biological perspective and the generative fathering framework (Hawkins & Dollahite, 1997) would probably be a better-suited approach than the involved fatherhood one to understand their specific needs.

Implications

The findings of this analysis suggest that we need to differentiate between "making room for fathers" and "making room for the experiences of fathers," the latter being apparently much more difficult to integrate into practices. Increasingly, health care institutions and providers want fathers to be present. They invite them in, but then pay very little attention to them, as if their objective

were achieved simply by the fathers' physical presence. Fathers are welcome in services, but they occupy a set and limited space there, whereas emotionally and psychologically they are in constant motion as they experience fatherhood. Fathers' primary need is thus for space—physical space so that they can be present, but also, and above all, space to speak about their experiences, where they are acknowledged as parents in their own right.

From a clinical standpoint, these results also highlight the need for health professionals to anticipate fathers' needs, intervene proactively, and find different ways to invite fathers to take their place in the relationship being established between care providers and the new family (Hayes, Jones, Silverstein, & Auerbach, 2010). Such invitations might take the form of telephone calls to encourage fathers to attend appointments, or asking fathers about their experiences, their opinions on the situation, and their needs and expectations. For fathers to want to take an active role in relationships with their children and care providers, there needs to be formal recognition of the importance of their presence in the lives of their children and spouses and in interactions with care providers (Fagan & Palkovitz, 2011).

The findings also lead us to propose a suitable solution for those needs. Rather than responding directly to some of the identified needs, this analysis suggests undertaking a process of reflection on the space allotted to fathers in services, in their interactions with the health care providers they encounter, and in their relationship as a parent couple. The findings highlight the need for health professionals to develop father-friendly attitudes, knowledge, and practices (Kiselica & Kiselica, 2014). While many programs supporting paternal involvement aim to change fathers' behavior, increase their knowledge, and change their perceptions of themselves as fathers (Magill-Evans, Harrison, Rempel, & Slater, 2006), the findings of this study suggest instead setting up an initiative to change health care and services so that they become more accessible and useful to fathers, include them from the beginning, and meet their specific needs more effectively (Hoffman, 2009; Premberg et al., 2008), rather than establishing a series of predetermined, standardized interventions for new fathers.

Conclusion

For health care managers and providers, as well as for members of fathers' social networks, this means working as a team around them to accompany and support them as they develop their involvement with their child. To achieve this, health care providers and institutions need to be supported so that Quebec's social movement toward greater recognition of fathers can permeate health care services, and so that those services will be part of a system that acknowledges fathers' specific characteristics and makes room for the wealth of their experience.

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