

Barriers and opportunities for health service access among fathers: A review of empirical evidence

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Abstract

Issue Addressed: Engagement with health supports benefits the whole family, yet few health services report successful engagement of fathers. Our aim was to describe available evidence on barriers and opportunities relevant to health system access for fathers.

Methods: Scoping reviews were conducted seeking empirical evidence from (1) Australian studies and (2) international literature reviews.

Results: A total of 52 Australian studies and 44 international reviews were included. The most commonly reported barriers were at the health service level, related to an exclusionary health service focus on mothers. These included both 'surface' factors (e.g., appointment times limited to traditional employment hours) and 'deep' factors, in which health service policies perpetuate traditional gender norms of mothers as 'caregivers' and fathers as 'supporters' or 'providers'. Such barriers were reported consistently, including but not limited to fathers from First Nations or culturally diverse backgrounds, those at risk of poor mental health, experiencing perinatal loss or other adverse pregnancy and birth events, and caring for children with illness, neurodevelopmental or behavioural problems. Opportunities for father engagement include offering father-specific resources and support, facilitating health professionals' confidence and training in working with fathers, and 'gateway consultations', including engaging fathers via appointments for mothers or infants. Ideally, top-down policies should support fathers as infant caregivers in a family-based approach.

Conclusions: Although barriers and opportunities exist at individual and cultural levels, health services hold the key to improved engagement of fathers.

So What? Evidence-based, innovative strategies, informed by fathers' needs and healthy masculinities, are needed to engage fathers in health services.

KEYWORDS

fathers, health services accessibility, men's health, parents, perinatal care

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1 | INTRODUCTION

Poor health among fathers is associated with negative consequences not only for themselves but also for their partners and children.^{1–4} This is particularly evident during pregnancy and after the birth of a baby when, compared to other life stages, men are at heightened risk of poorer physical health^{5,6} and are more vulnerable to symptoms of depression,⁷ stress⁸ and anxiety.⁹

Australia has identified the need to improve supports for fathers as positive role models in their families and communities.^{10–12} Here, there is potential for substantially improved health outcomes via engagement of men in preconception planning for parenthood¹³ and by providing fathers with ongoing support post-birth for physical and mental health.¹⁴ In support, the Australian National Men's Health Strategy 2020–2030 recommends expanding the maternal and child health infrastructure to include fathers.¹² Internationally, the World Health Organisation strongly recommends interventions to promote male partners' involvement in maternal and newborn health.¹⁰

Despite these recommendations and the evidence that fathers are vulnerable to poorer physical and mental health during pregnancy and after the birth of a baby, fathers may not access health services for themselves during pregnancy and early parenthood.¹⁵ Indeed, across the lifespan, men are less likely than women to access non-emergency health services regularly and in a timely way.¹⁶ Health system access includes an individual's opportunity to identify their personal health care needs; identify health care services suitable for meeting their needs; reach health care relevant to their needs; receive effective care that addresses their health care needs; and adhere to health care advice or treatment in accordance with their needs.^{17–20} Thus, health system access can be facilitated or impeded at various levels of the health system as well as within the individual or groups of health system users.

The aims of this review were to:

1. Synthesise the evidence on barriers to health system access for men during pregnancy and the postnatal period ('fathers'), and
2. Identify evidence-based opportunities to effectively engage fathers within the health system.

Specifically, the focus was on evidence for barriers and opportunities for fathers within Australia; however, we also conducted an umbrella review of international literature from high income countries.

2 | METHODS

This review formed part of an extensive literature review commissioned by the Australian Department of Health and Aged Care on men's and boys' barriers and enablers to health system access. This broader review incorporated the nine priority population groups identified in the Australian National Men's Health Strategy,¹² which also

identifies the transition to fatherhood and the role of fathers as encompassing specific health risks and opportunities.

The commissioned report including the sub-section on fathers was delivered to the Australian Department of Health and Aged Care in March 2020, just as the COVID-19 pandemic emerged as a global health priority. The report was subsequently not released until August 2023.²¹ Owing to the delay, we undertook to update the search, this time specifically for fathers. Thus, the search strategy and screening are described in two parts below, for the original search and search update, respectively.

2.1 | Search strategy

The search strategy followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA).²² We conducted four searches: we searched separately for articles that reported on barriers to and opportunities for access to health services, reporting on Australian studies. We also searched for relevant international reviews on barriers and opportunities.

The searches for the *original* review were conducted on 21 October 2019, incorporating 18 databases (Table 1). We included only articles published since 2000 in English language, reporting on human participants. See the primary review for additional detail and search strategies.²¹

For the *updated* search, conducted on 26 April 2023, the same search was run; however, because our aim was not to capture all priority health groups, we narrowed the "Male" concept, to specifically target fathers, searching for (Father* OR patern* OR dad*) OR (("Parent*") AND (Male or Men or Man or "gender differ*" or "sex differ*")). We further limited the timeframe by including only records since the original search. For the search update, databases were narrowed to those that commonly index father-focused research: Medline Complete; PsycINFO; CINAHL Complete; ERIC; Global Health and Health Policy Review Center.

Reference lists of all included articles (original and updated searches) were scanned for relevant titles. Additionally, members of an advisory group consisting of experts on fathers' access to health systems, were consulted and asked to indicate key literature expected to meet the inclusion and exclusion criteria.

2.2 | Article screening

For the *original* review of all male priority health groups, screening was conducted in Covidence, the Cochrane Collaboration's online screening software. Titles and abstracts were screened first. Double screening of records was not possible owing to the sheer volume of records (almost 30 000). However, to assist with consistency, the first 6.3% of titles and abstracts were double-screened, at which point 95% consensus was being recorded. After this, single screening was applied. Screeners tagged references according to relevant subgroups of men or boys, including 'fathers'. For the purposes of the review reported in this paper, we include only those relevant to this subgroup.

TABLE 1 Search strategy with examples of search terms for each search concept, separated by Boolean operators 'OR' and 'AND'.

| Concept | Search for barriers | | Search for opportunities | |
|--|--|---|--|---|
| | Search 1 Australia | Search 2 International | Search 3 Australia | Search 4 International |
| Male | E.g., male* OR men OR man OR boy* OR father* | | | |
| AND | | | | |
| System provider OR type of care OR place of care | E.g., nurs* OR oncolog* OR GP OR clinician* OR therap* OR counsel* OR screen* OR diagnos* OR intervention* OR hospital* OR clinic* OR rehab* OR "medical cent**" | | | |
| AND | | | | |
| Barriers | E.g., barrier* OR enabl* OR access* OR embarrass* OR humiliat* OR guilt* OR phobia* OR obstacle* OR challenge* OR stigma* OR avoid* | | x | x |
| Opportunities | x | x | E.g., (evaluat* OR effect* or efficac*) N4 (intervent* OR program* OR RCT* OR trial* OR pilot* OR randomi* ed*) OR Participat* OR Adhere* OR Engag* OR Attend* | |
| AND | | | | |
| Australia | Australia* | x | Australia* | x |
| Review | x | E.g., "systemati* review" OR "literature review" OR "rapid review" "narrative review" | x | E.g., "systemati* review" OR "literature review" OR "rapid review" "narrative review" |

Note: Databases searched: Embase; Via EBSCO and searched separately: Medline Complete; PsycINFO; CINAHL Complete; ERIC; Global Health; Health Policy Review Center; Via Informit and searched together: Australasian Medical Index (AMI); Australian Public Affairs Information Service (APAIS) – Health; Aboriginal and Torres Strait Islander (ATSI) Health Bibliography; AUSPORT – Australian Sport Database; AusportMed; Health Issues in Criminal Justice (CINCH-Health); DRUG; Health & Society; HIVA; Health Collection; Rural and Remote Health Database (RURAL). "**" indicates a word has been truncated to capture all possible endings.

Screening of the *updated* search results was conducted in the Living Review System (LRS),²³ a cloud-based web platform that utilises machine learning to expedite the review process by elevating the most relevant articles to the top of the screening list. This is done using active learning, a technique whereby a machine algorithm adapts its understanding of inclusion and exclusion criteria with each reviewer's determination of reference relevance. Ten percent of titles and abstracts were double screened by authors with an agreement rate of 95%. Given the high interrater reliability, articles were then single screened. The system has a stop rule which is activated when there is less than 30% chance of relevance and 40 consecutive 'no' votes;²³ however, while the system is finalising independent validation, we screened all abstracts.

For both the original review and the search update, all articles were double-screened at the full-text screening stage. Reviewers resolved conflicts by consensus; a third reviewer resolved conflicts where required.

2.3 | Inclusion and exclusion criteria

To be eligible for inclusion, studies had to report evidence for barriers or opportunities relevant to accessing health systems, support or resources. These included factors that impeded or enhanced men's: knowledge and understanding of their health care needs; knowledge and understanding of available services and resources; and

participation and retention in services or programs. We included both qualitative and quantitative studies.

Studies reporting on data from both women and men were included only if results were reported separately for men, or at least 70% of the total sample was male.

International reviews were included only if they reported on data from high-income countries.²⁴

2.4 | Data extraction

Data were extracted into three tables capturing separately the Australian quantitative and qualitative (or mixed methods) studies and the international reviews. For each table, information on barriers and opportunities was captured in separate columns. See the primary review for additional information about data extracted.²¹

2.5 | Data analysis

In the original review, a number of reviewers identified emergent themes within their extractions for the various priority groups. This was an iterative process; with each new study, themes were added, modified to ensure consistent language and classified into a hierarchical structure. There was a substantial crossover within themes and a

designated set of these was selected to be reported on within all groupings.²¹ For the updated review, any additional themes that emerged were noted and consensus was arrived on these among co-authors. As there was considerable overlap in the codes representing barriers and opportunities, with these often representing two opposite ends of a spectrum, the codes were synthesised into combined themes and sub-themes. Illustrative quotes from qualitative studies are provided where available.

3 | RESULTS

3.1 | Study characteristics

The number of Australian and international studies yielded in each search is summarised in Figure 1. In total, 96 papers were included. Please see Supplementary File 1 (<https://osf.io/gk9r3>) for details of each study.

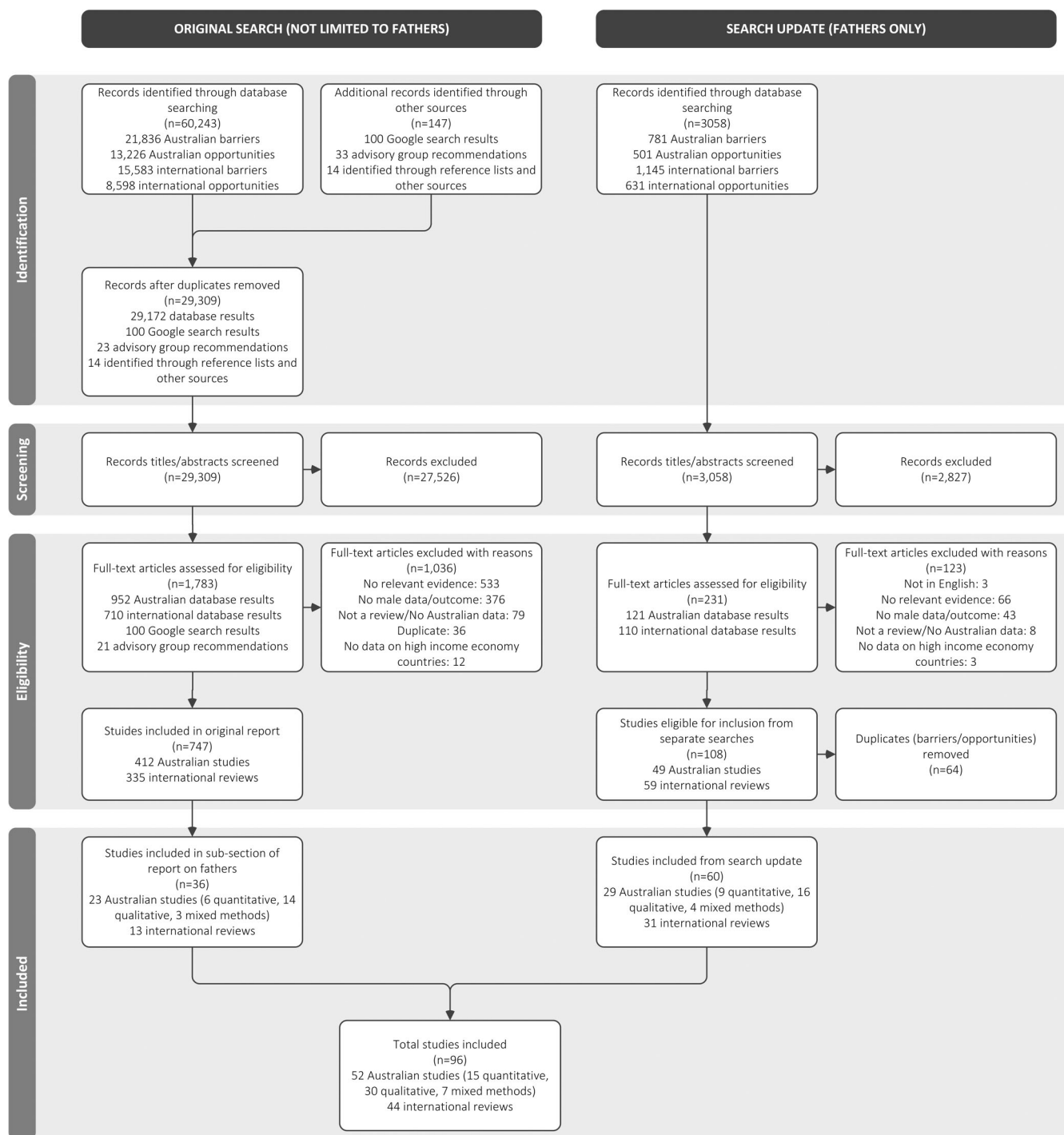


FIGURE 1 PRISMA flowchart including original and updated searches.

Among the 52 Australian papers, 32% included data collected during pregnancy. Among those reporting data collected after the birth, child age ranged from early infancy up to 10 years old. Where reported, the average age of men varied from 19 to 45 years old; the youngest reported participant was 20, while the oldest was 66 years. Data were collected from men ($n = 43$ articles, a total of at least 7069 men), pregnant women or mothers ($n = 9$ articles) and health professionals ($n = 15$ articles), including midwives, maternal and child health nurses, GPs, obstetricians, family service practitioners, men's group facilitators, intervention program facilitators, and clinicians and managers from Early Parenting Services. In the studies that sampled father participants, recruitment settings included antenatal clinics, family and child health services, childbirth education classes, postnatal wards, paediatric or neonatal hospital services, outpatient clinics, community groups, support services and online.

Only two Australian studies^{25,26} used validated instruments to assess among fathers barriers to help seeking and factors impacting engagement, respectively.

Most of the studies (74%) used convenience samples, with probable selection bias. Among the 14 quantitative studies, two reported samples with fewer than 50 participants, and many did not report sampling frame details including the number of participants who were eligible or the associated response fraction.

Of the 44 reviews, 42% were systematic; two completed meta-analyses but these were not specific to engagement in health services. Twenty percent of reviews focused on fathers' mental health; the remaining reviews examined fathers' experiences more broadly. More than 1214 studies were included in the reviews.

Fifty-nine percent of the Australian studies and 48% of the reviews focused on vulnerable or specific subgroups of fathers (see Table 2).

3.2 | Summary of findings

Within a broad conceptualisation of health system access,¹⁷⁻²⁰ barriers and opportunities are designated within three levels, namely *individual* (Ind), *health system* (HS), and *cultural* (Cult). As barriers and opportunities often represented two ends of the same spectrum, results of the separate searches have been combined in Tables 3, 4 and 5 to indicate this.

3.2.1 | Individual level barriers and opportunities

At the *individual* level (Ind), specific demographic and reproductive factors can represent both barriers and opportunities for health service access (Ind1). A perceived need among some men to conform to restricted, narrow views of masculinity can present a barrier to accessing services (Ind2): the need to be strong and stoic, discomfort talking about emotions, a tendency to minimise problems, stigma associated with seeking help and a perception that caregiving is women's work. On the other hand, reframed masculinities representing fathers as

TABLE 2 Focus on subgroups among fathers.

| Father subgroup | Australian studies | International reviews | Total ^a |
|---|--------------------|-----------------------|--------------------|
| First-time | 3 | 2 | 5 |
| Young | — | 1 | 1 |
| Single/separated | 1 | 1 | 2 |
| CALD/refugee | 5 | 1 | 6 |
| Aboriginal and Torres Strait Islander | 5 | 1 | 6 |
| With a disability | 1 | — | 1 |
| Risk of alcohol/violence | 2 | 1 | 3 |
| Risk of depression | 1 | — | 1 |
| NICU/premature | 2 | 6 | 8 |
| Perinatal loss | 5 | 1 | 6 |
| Adverse events during pregnancy/birth | 2 | — | 2 |
| Child sleep problem | 1 | — | 1 |
| Child neurodevelopmental or behavioural problems | 3 | 3 | 6 |
| Child illness, disability, developmental problems | 1 | 4 | 5 |

^aSome studies include more than one subgroup.

caring and actively involved in infant care can change fathers' perceived roles and improve access to services (Ind2). A commonly-reported barrier to attending health services, is fathers' lack of time and other commitments especially paid work (Ind3); on the other hand, workplaces can facilitate fathers attending appointments by allowing them time off or flexibility in work arrangements (Ind3). Despite conflicting demands, fathers are highly motivated to attend services with their partners and babies (Ind4). Fathers prioritising others' needs (for example, their partners') above their own can be barrier to their accessing services, but on the other hand the transition to fatherhood represents a time when they are often motivated to seek help for mental health concerns (Ind5). Finally, distrust of health professionals can be a barrier to accessing health services (Ind6) (Table 3).

3.2.2 | Health service level barriers and opportunities

At the *health service* (HS) level, many of the barriers arise from the predominant health service focus on mothers such that fathers, including but not limited to those from specific subgroups or caring for children with specific needs, report feeling marginalised and excluded (HS1). On the other hand, there is evidence that father-inclusive policy can support inclusion of fathers at a high level, and that more father-inclusive health service environments may facilitate engagement of fathers (HS1). Father-specific resources, services and support are lacking or fathers have trouble identifying which of these

TABLE 3 Individual barriers to, and opportunities for, fathers' health service access.

| Over-arching category | Barriers | Australian studies; International studies | Opportunities | Australian studies; International reviews |
|-----------------------|---|---|---|---|
| Ind1 | <p>Demographic, reproductive factors</p> <ul style="list-style-type: none"> Lower levels of education, socio-economic disadvantage, lower literacy, rurality Unexpected pregnancy. | 46,79,115; 72,83 | <p>Among fathers, number of GP visits increases over time/with age</p> <ul style="list-style-type: none"> Primiparous fathers more likely to engage in health services | 79,112,116; N/A |
| Ind2 | <p>Masculinities and roles</p> <ul style="list-style-type: none"> Beliefs associated with rigid, restricted views of masculinity Perceived need for control, strength, stoicism and self-reliance in managing one's own problems. 'You gotta be the bloke and hold the family up' Father⁴⁷ Lack of awareness of, and inability/ discomfort associated with talking about, emotions. Perceived tendency to downplay or minimise problems. '...they had like a father's group thing but ... they cancelled it because there was only two people that said yes, and they just, like I don't know - don't know if it's a cultural thing [or] like a masculinity thing that you know, we'll just grin and bear it or they've got other kids other responsibilities to work or whatever'. Father⁵³ Stigma associated with seeking help for mental health problems, may feel it is a sign of weakness/ vulnerability/ poor parenting. 'I guess people maybe [laughing] might have that fear of shit, what is [the screening instrument] going to reveal about me, what are they going to, what are they going to think of me' Father⁴⁷ Caregiving perceived as women's work, while men's role is providing income, support, strength and protection for their partners. Men, women and health professionals | <p>27,28,47,49,53,82,101,104,117; 33,72,74,94,95,99</p> <p>25,28,47,53,115,117; 33,57,72,74,94,99,118</p> <p>25,53,117; 57</p> <p>(39,47,55,101,103); (33,74,77,94,95,99)</p> <p>(28,29,47,49,66,91,101); (72,74,91,94,97,99)</p> | <p>Broad, societal shift in perceived roles of fathers, resulting in reframed masculinities.</p> | <p>27,28; 59,60,77,91,95,99</p> <p>(27,28); (59,60,77,91,95,99)</p> |

TABLE 3 (Continued)

| Over-arching category | Barriers | Australian studies; International studies | Opportunities | Australian studies; International reviews |
|-----------------------|--|--|---|---|
| Ind3 | <p>Balancing demands of work and other responsibilities</p> <p>may lack confidence in men's ability to care for children. <i>'Like there's not a lot of support... it's slowly changing but again it's no you're the dad you've gotta be at work'. Father⁶⁶</i></p> <ul style="list-style-type: none"> Demands of caring for other children and work/ searching for work, especially if limited support networks. <i>'Once parental leave period is over, which might only be a couple of weeks, you're pretty well back at it supporting the family, being at work and all that stuff. Your brain capacity to look up these things and engage yourself in things outside of the daily grind becomes a little bit more difficult'. Father⁸²</i> | (36,37,82,115,116); (74) | <p>Some workplaces facilitate fathers attending appointments or engaging in services.</p> | 70; 59,95 |
| Ind4 | Fathers' desire to be engaged | | <ul style="list-style-type: none"> Fathers are motivated to attend services with partners and babies. They want to be included and involved in decision-making, and believe that their involvement in health service consultations is important for their attachment with the baby and relationship with the partner. <i>'I take care of the other children at home and of my job, but I also need to be here – I want to be here, as well'. Father⁵⁸</i> | 28,36,40,43,51,58,82,101,116; 60,64,74,78,83,91,97,98,118,119 |
| Ind5 | Prioritising other people's needs over their own well-being | <ul style="list-style-type: none"> Reluctance to seek support as they do not wish to take the attention/support away from their partners and infants. May perceive support or resources are for more 'legitimate' users (e.g., mothers, fathers facing specific challenges, parents of children with serious problems) | <ul style="list-style-type: none"> Fathers are motivated to address their mental health or poor health behaviours. The transition to fatherhood prompts reflection on responsibilities to children and family – can lead to help-seeking, to reduce impact partner or child. <i>'... reframing the whole thing as, by getting help for yourself is a way of helping your baby might be a good way of going about it'. Father¹⁰¹</i> | 34,43,47,101; 48,85 |

(Continues)

TABLE 3 (Continued)

| Over-arching category | Barriers | Australian studies; International studies | Opportunities | Australian studies; International reviews |
|-----------------------|----------------------------------|--|------------------|--|
| Ind6 | Distrust of health professionals | <ul style="list-style-type: none"> Distrust of medical practitioners, for example, after negative previous experiences. | (39); (72,74,91) | <p>'I was telling myself, 'I've got to stop doing this and be a better Dad' ... The last visit, I made the decision to go to the rehab...and that was 2 years ago when I started setting hard goals for myself'. Father³⁴</p> |

are appropriate (HS2). Engagement of fathers can be improved by offering them practical, tailored, parenting-focused, flexible resources and support (HS2). Fathers are not usually asked about their health and appropriate screening tools and referral pathways are lacking (HS3); however, screening of fathers for mental health problems may provide fathers with an opportunity to start a conversation with a health professional on this topic (HS3). Fathers and health professionals suggest that extra or separate consultation time would assist engagement of fathers to address their health care needs (HS3). Fathers attending services with their partners means that fathers and mothers are not always provided with separate private spaces to discuss their health concerns with health professionals (HS4). However, when fathers attend appointments with their partners and infants, health professionals have the opportunity to 'incidentally' engage fathers as they attend appointments with the mother and infant ('gateway consultations', HS4). Fathers are more likely to attend and participate in health services if they are specifically invited and engaged (HS4). Health professionals lack training, awareness and confidence about working with fathers, although some organisations provide such training (HS5). Health care professionals sometimes perpetuate unhelpful stereotypes in their communication with families; however, health professionals' positive attitudes and communication with fathers can greatly improve engagement of fathers in health services (HS6). Female-only staff can represent a barrier to fathers' accessing services; specific practitioner characteristics (for example, male) can facilitate engagement of fathers (HS7). Services are sometimes inaccessible to fathers, for example when health service consultation hours conflict with traditional paid work hours, when services do not physically accommodate fathers or when services are not conveniently located (HS8). Access to services and support can be improved through convenient and flexible locations and services hours, and by promoting father services in non-health settings where men attend (HS8). There is also preliminary evidence for engagement of fathers via technology such as SMS messaging and websites (HS8). Some fathers may not feel comfortable attending parenting groups (mixed-gender or fathers only), while others value father-specific groups (HS9). Mothers often encourage fathers to access services (HS10) and consultation with fathers should inform services and support relevant to them (HS11) (Table 4).

3.2.3 | Cultural level barriers and opportunities

At the *cultural* level (Cult), fathers from culturally and linguistically diverse (CALD) backgrounds may experience a conflict between expectations of being involved in Australia and traditions in their country of origin, and barriers associated with speaking a language other than English (Cult1). Access to health professionals from similar backgrounds and to interpreters may improve engagement with services among fathers from CALD or First Nations backgrounds (Cult1). Health professionals may lack cultural sensitivity or may demonstrate racial bias (Cult2); cultural competence training and consultation with communities may help to overcome these barriers (Cult2) (Table 5).

4 | DISCUSSION

This review summarises the barriers experienced by fathers in accessing health services and opportunities through which engagement of fathers in health services may be facilitated. The exponential increase in studies eligible for inclusion published during the past 4 years underlines increasing recognition of the importance of this topic.¹⁵ This review has yielded barriers and opportunities reported by fathers in general as well as: first-time fathers,^{27–31} young fathers,³² single³³ or separated³⁴ fathers, fathers with disabilities,³⁵ fathers from CALD,^{36–40} refugee⁴¹ or First Nations^{32,42–46} backgrounds, those at risk of depression,⁴⁷ alcohol abuse⁴⁸ or family neglect or abuse,^{49,50} those experiencing adverse events^{51,52} or loss during the perinatal period,^{39,53–57} or fathering children admitted to a NICU,^{58–63} premature,^{60,64,65} or with sleep,⁶⁶ health/disability/developmental,^{38,67–70} neurodevelopmental^{60,71,72} or behavioural^{71,73,74} challenges. Given the relatively consistent barriers reported by fathers in general in a large number of Australian studies and international reviews, we argue that *all* fathers are in fact ‘vulnerable’ in that they report difficulties in identifying their health care needs, identifying or accessing relevant, specific, helpful resources or support, or receiving or adhering to effective care that addresses their health care needs at this crucial junction in their lives.

In addition to the barriers reported consistently across Australian studies and international reviews, specific barriers faced by First Nations fathers were highlighted in Australian studies, including negative experiences with health care professionals who lack cultural competency and sensitivity.^{43,46} Cultural responsiveness training for staff and consultation with First Nations communities and elders when developing services or programs may improve engagement of First Nations fathers.^{40,42,44,46,75,76} In general, First Nations men in Australia report improved engagement with health services that provide holistic, ‘one-stop’ health care for their physical, emotional, social and spiritual wellbeing.²¹

A large number of studies reported barriers and opportunities at the health service level, mostly associated with a service-level focus on mothers. Fathers commonly report feeling excluded and marginalised by health services during pregnancy and after the birth of a child.^{77,78} The emphasis on health service factors is encouraging in that such factors are potentially modifiable; however, many of these factors require attention at a policy or systems level,^{37,66,77–79} and are beyond the efforts of individual health care professionals. Without appropriate training, health professionals are unlikely to have the opportunity to change the care that they provide for new families,⁶⁶ even if they believe that fathers are important decision-makers and should be included in the current model of care.^{37,79,80}

Resnicow et al.⁸¹ categorise public health cultural sensitivity into ‘surface’ and ‘deep’ dimensions. Surface structure involves matching resources, messages and support to observable characteristics of the target population. To improve engagement of fathers, health services could offer male staff^{46,54} and engage interpreters^{37,79} and First Nations workers.⁴³ There is clear need to also address structural

barriers which could include more convenient locations or assistance with transport and parking costs,^{74,82} taking supports to where men are,^{83,84} offering appointment times outside of traditional employment hours,^{74,85} and adopting father-inclusive language^{29,39,74,82} and environments.^{58,79} Identifying the format and settings of services, resources and support for fathers requires input from fathers to ensure that these are appropriate.⁸¹ Thoughtful input from health care professionals and mothers is also required to ensure that private opportunities to discuss sensitive matters, including risk of domestic violence, are provided to all mothers.^{37,79}

Deep structure involves incorporating the cultural, social, historical, environmental and psychological forces that influence the target health behaviours in the target population, namely fathers.⁸¹ This would involve changing the existing culture to one in which fathers are recognised, included and sensitively engaged as equal parenting partners with an important role to play.^{29,86} One such example of ‘sensitive enquiry’ could be asking men about their sleep rather than symptoms of depression or anxiety; poor sleep is significantly associated with depression and anxiety symptoms among fathers^{87,88} and fathers may be more comfortable starting a conversation with a health professional about their sleep than about their mental health.⁸⁷ Education is needed to improve health professionals’ gender sensitivity and confidence with providing care for fathers,^{66,80,88,89} challenge stereotypes and unconscious biases they may inadvertently perpetuate in their daily work^{28,77,90} and enable positive and father-inclusive communication with fathers.^{66,91} A specific resource to support father-inclusive language among health professionals has been developed in Australia.⁹²

The deep structure factors to improve engagement of fathers go beyond health service level opportunities; it is necessary to address gender norms at a broader societal level. Thus, the distinction between individual, health services and cultural factors is inevitably blurred. The same social norms that underpin health services’ focus on mothers as the ‘caregivers’, implying that fathers are the ‘supporters’ or ‘providers’,^{29,46,77,78} may drive some men, at an individual level, to conform to narrow views of masculinity that restrict help-seeking.^{27,28,33,53,93,94} New understandings of ‘masculinities’ provide an opportunity for health services to reflect on and champion a change toward fathers being regarded as physically and emotionally ‘involved’ in a parenting team which shares infant care.^{14,95–98} Organisational and policy support informed by reframed masculinities may facilitate changes at an individual level, among those who *use* as well as those who *provide* health care services. Changes in policy must accommodate acknowledgment of fathers within administrative systems,^{37,66} specific requirements and invitations for fathers to be present in at least some consultations,^{74,79,83,91} routine screening and appropriate referral pathways for fathers’ mental health problems,^{14,47,99} extra or father-specific consultation time,^{42,79,95,99,100} and investment in easily accessible, evidence-based resources and support for fathers.^{30,77,82,90,101} The development of screening, resources and support for fathers needs to be done in consultation with fathers to ensure their needs are understood and met.^{14,37,66} These shifts align with the values that underpin the

TABLE 4 Health service barriers to, and opportunities for, fathers' health service access.

| Over-arching category | Barriers | Australian studies; International reviews | Opportunities | Australian studies; International reviews |
|-----------------------------------|---|--|---|--|
| HS1 Health service environment | <ul style="list-style-type: none"> Service-level focus on mothers 'The mums' group, the mums' walk, the mums' this, the mums' bloody everything and there's no parent there' Father.²⁹ Fathers feel marginalised, unwelcome, excluded, as if no role in decision making 'The community nurse was good, but it seemed that the only time they're interested in talking to you or, having anything to do with you is just by accident because I was at home on annual leave... but it was really good because they did like a domestic violence assessment... that's the only time they took an interest in partners it's like, you know is he abusing you? And the rest of it was you know... back to just, mum's business'. Father⁶⁶ Fathers experience lack of understanding, support and validation of fathers' needs, and minimisation of fathers' experiences. | <p>26,29,37,39,41–43,46, 47,49,51–56,58,61,64,66,69,70,80,90, 100,101,104,116,117,120,121; 30,31, 48,57,63,65,67,68,72, 74,77,78,91,95,97–99,118,122–126</p> | <ul style="list-style-type: none"> Some organisations have father-inclusive policies, and administrative systems that 'capture' fathers as well as mothers and children. Father-inclusive environment: Posters and resources with images of men Father-inclusive name for the service Extra beds on postnatal wards Within NICUs, comfortable chairs and single rooms, ward rounds scheduled when they can be present | <p>37,66; N/A</p> <p>37,79; 48,58–60,77</p> |
| HS2 Resources and programs | <ul style="list-style-type: none"> Father-specific resources lacking, fathers not aware of these, they are confusing, they are only available in English, or do not meet fathers' needs Too many resources, hard to identify which resources are reputable, or which advice to follow if conflicting information. 'There are just so many things out there, which is a good thing, but also there is so much out there that you are like, 'Which ones do I go to? Which ones are reputable?' For a first-time parent, it can be a little bit overwhelming'. Father¹⁰¹ | <p>35,39–41,43,44,47,49,51,53,54, 66,79,82,90,101,116,120,121; 30,31,33,57,60,65,72, 74,77,126,127</p> | <ul style="list-style-type: none"> Preferred content, messaging and format of resources, programs and support for fathers: <ul style="list-style-type: none"> Informational, technical, practical, timely, comprehensive, relevant content Focus on parenting, father's positive role in child development or the parent-child relationship Evidence-based Benefits of participation are clear (e.g., for child development) Personal, tailored to specific needs Father-inclusive, non-academic language Active engagement of fathers Diverse formats to meet varying needs Reimbursement of travel expenses, incentives Lower/shorter attendance requirements for fathers | <p>27,28,34,37,53,54,58,90,101; 57,63,65,71,72,74,77, 83,85,97,118,122,125–127</p> |

TABLE 4 (Continued)

| Over-arching category | Barriers | Australian studies; International reviews | Opportunities | Australian studies; International reviews |
|---|--|--|---|--|
| HS3 Health screening and support for fathers | <ul style="list-style-type: none"> Fathers rarely asked about their own wellbeing. <i>'...it would help if somebody asked me a few questions like 'How are you? How do you feel about it?' ... they know I'm dad but that's about it, but they don't talk to me much at all. It's as if I am not there.'</i> Father⁹⁷ No routine, consistent mental health assessment/screening. No clear referral pathways. <i>'Whereas for women you can refer them to [helpline] or a psychologist...but for dads there's none of that network... he'd have to go and find his own solution...his own GP and get a referral, but nah I wouldn't say I know how to refer a dad...'</i> Midwife⁷⁹ Long waiting periods to access services for mental health concerns. | <p>37,41,47,50,52,54,55,70,79, 90,100,104,116,117,121; 57,83,97,99,119,124</p> | <ul style="list-style-type: none"> Screening raises awareness of symptoms, can provide structure for conversation with a health professional helps reduce stigma associated with mental health problems (normalisation). Intention and possible outcomes of screening are clear, framed in a way that appeals to men's roles as fathers. Shorter screening tools require less time and cognitive/affective load. Longer consultations to address fathers' health care needs, or Separate consultations for fathers. <i>'Probably a separate [appointment] and maybe have a pamphlet or maybe a follow up call from someone to say, look if you, you know, want anything, maybe come in for a yarn or something like that, I don't know, that could be a good thing and do the test what they do, whatever that test is, the check for that depression or whatever'</i> Father⁴² | <p>47; 99</p> <p>42,79,100; 95,99</p> |
| HS4 Fathers attending with their partners | <ul style="list-style-type: none"> When mothers and fathers attend together, there is no opportunity for each to speak to health professionals privately. Men may prefer not to share/disclose mental health symptoms in front of partners, especially if there is parenting conflict. Health professionals also need time alone with women to ask about sensitive matters, for example, mental health and domestic violence. <i>'...it makes it tricky when we need to ask about domestic violence,</i> | <p>37,79; 74,91,98,99</p> | <ul style="list-style-type: none"> Health professionals encounter fathers 'incidentally' as they attend with the mother and infant, for example, antenatal appointments, antenatal education, ultrasound appointments, early parenting services ('gateway consultations') Men from CALD backgrounds may attend appointments as they provide transport/interpret for their partners. Home visiting and continuity-of-care models of care associated with better engagement. <i>'Yeah, they're [fathers are] always at home...because most of them take time off</i> | <p>35-37,40,42,43,49-52,58, 66,79,103,104,121; 48,83,85,91,119,124,125,128-130</p> |

(Continues)

TABLE 4 (Continued)

| Over-arching category | Barriers | Australian studies; International reviews | Opportunities | Australian studies; International reviews |
|-----------------------|---|--|--|--|
| | because we can't ask with the partners there and it's very hard often to get some women on their own' Family and Child Health Nurse ³⁷ | | work, I usually find they're really supportive...and they're not scared to ask questions as well...they really do participate in the home visits'. Midwife ⁷⁹ | |
| HS5 | Health care professionals' training and confidence | <ul style="list-style-type: none"> Health professionals lack awareness, confidence and training in working with fathers. 'In my 3 years at University I don't think I was taught a single thing about dads. [...] Even just one lesson on what challenges dads face and how to help them would have been useful' Midwife⁸⁰ | <ul style="list-style-type: none"> Specific, targeted invitation to fathers attend services and participate Some organisations include father-inclusive staff training and resources in their strategic planning and policy. | 79; 74,83,91 37,66; N/A |
| HS6 | Health care professionals' attitudes and communication | <ul style="list-style-type: none"> Health care professionals sometimes use negative language, express gendered expectations (e.g., assume that only mothers wish to participate) or convey unhelpful stereotypes about fathers. 'The [antenatal class for fathers] was horrendous. It was gendered—they were sort of the idea there that, "Guys, you're going to have to put the beer down and not watch the footy for sort of a few days" type of thing, and I thought they were condescending...toward males, well, toward me' Father.²⁸ | <ul style="list-style-type: none"> Positive, calm, non-dismissive, clear, sensitive, honest, emotionally intelligent, non-judgmental communication with health professionals Health professionals treat fathers as if they have a valued role in decision making. 'She has really addressed us both, not just one, but both of us, so that we have something together. This makes participation much, much more [apparent]' Father⁹⁷ Midwives use specific strategies to promote father-inclusiveness and facilitate father involvement, for example, asking them questions and giving them tasks to do. Health professionals, for example, midwives, believe that engaging fathers is part of their role, and see it as important for transforming harmful gender norms. | 28,37,52,53,70,90,119; 74,77,119 26,36,37,41,51,53,58, 62,66,69,70,79,101,116; 57,59,60,63– 65,68,72,74,77,78,83,96, 97,111,118,119, 123–125,131 37,79,80,132; 83 |
| HS7 | Health care professional characteristics | <ul style="list-style-type: none"> Health care professionals are mostly female. Health professional job advertisements may not | <ul style="list-style-type: none"> Some fathers prefer to engage with male health professionals Some prefer general practitioners (GPs) rather than psychologists, maternal child | (25,36,43,49); (99) |

TABLE 4 (Continued)

| Over-arching category | Barriers | Australian studies; International reviews | Opportunities | Australian studies; International reviews |
|-----------------------|---|--|--|---|
| HS8 | <p>Access to services</p> <p>specifically encourage male applicants.</p> <ul style="list-style-type: none"> Health services' hours conflict with men's paid work commitments. Appointments often run late – requires fathers to take a substantial amount of time off paid work. Limited physical facilitates to accommodate fathers, for example, in postnatal ward, NICU. <p><i>'[You're] in...cramped and confined, often shared, sleeping arrangements. When you're, uh, trying to sleep on an office chair... there's no privacy in the place, you're always on display'. Father⁷⁰</i></p> <ul style="list-style-type: none"> Distance between health services and home/work, lack of transport options | <p>26,29,36,37,42,52,79,80,101,104,117; 31,64,71,74,77,78,83,95,99</p> <p>53,70,116; 57,65,67,91,118,123</p> | <p>health nurses, or early parenting services. (In the hospital setting midwives experienced as kinder and less rushed than doctors)</p> <ul style="list-style-type: none"> Flexible, convenient timing of services or programs. Convenient location with access to parking, transport. Services and support promoted or offered in non-health settings where men attend, for example, recreational activities outside of business hours. Health professionals' home visits scheduled while men are available. | <p>41,45,79,82,84; 71, 74,77,83,85,91,127</p> <p>25,27,44,59,83,87–90; 105–108; 48,74,119,126</p> |

(Continues)

TABLE 4 (Continued)

| Over-arching category | Barriers | Australian studies; International reviews | Opportunities | Australian studies; International reviews |
|---|---|---|--|---|
| HS9 Group forums | <ul style="list-style-type: none"> Fathers may not be comfortable opening up in mixed-gender parenting groups. Male-specific groups may make men uncomfortable, for example, if required to discuss feelings <p><i>'Seeing people sitting in a circle can be a little bit confronting because it then makes you feel like you're going to have to stand up and talk to people about something that's incredibly personal. And I don't know that that's something that men are particularly good at'</i> Father⁵⁴</p> | 27,28,54,82,86; 48,72,77,119 | <ul style="list-style-type: none"> Father-specific groups <p><i>'Really good, because the blokes would open up when the ladies were not around, so that was really good. Interesting to hear them saying things that they probably would not say in front of their partners'. Father⁸⁶</i></p> | 53,58,66,82,86; 33,72,74,77,83,91,97,126 |
| HS10 Partner support and encouragement | | | <ul style="list-style-type: none"> Mothers encourage fathers to attend or access information. <p><i>'[Wife] was good, she pushed me to go, because she knew it was better for us as a family'. Father⁸²</i></p> | 29,73,82,90,101; 48,74,85,97 |
| HS11 Consultation with fathers | | | <ul style="list-style-type: none"> Consultation with fathers about services relevant to them. | 37,66; N/A |

TABLE 5 Cultural barriers to, and opportunities for, fathers' health service access.

| Over-arching category | Barriers | Australian studies; International reviews | Opportunities | Australian studies; International reviews |
|--|---|---|---|--|
| Cult1 Experiences specific to fathers from culturally and linguistically diverse (CALD) or First Nations backgrounds | <ul style="list-style-type: none"> Expectations of being involved in Australia are different to traditions in some fathers' country of origin. Pregnancy and caring for an infant seen as 'women's work'. <i>'Actually, here all the time I was with my wife but in Afghanistan, my family, my father, mother and other relatives would take care of my wife and child, but here I play a hundred roles during pregnancy and appointments'</i> Afghan father¹²⁵ Women may be reluctant to involve male partners, as it could be perceived as disrespectful to men's role. Health professionals may be concerned about offending fathers because of their culture, religion or personal beliefs. Speaking a language other than English. | 36,37,39–41,52,79,80,116; 38,77,91,99,125,129 | <ul style="list-style-type: none"> Health professionals from similar backgrounds to them, or if support workers (e.g., First Nations health workers) are present. <i>'I don't feel comfortable talking to a White person. I'm comfortable with Black talking to one of my mob. ... I feel uncomfortable when I talk to him [White worker]. He's alright but, I don't know, because we just talk with each other. If I talk to a Black fella we have long conversations'</i>. Father⁴³ Availability of interpreters. | 37,40,42,43,79; N/A |
| Cult2 Cultural sensitivity of staff | <ul style="list-style-type: none"> Lack of understanding and cultural competency (including training) among health care professionals. Fathers experience bias and racial stereotypes. | 36,37,43,46,52; N/A | <ul style="list-style-type: none"> Cultural competence/sensitivity training for health care professionals. Consultation with First Nations communities and elders can ensure cultural relevance and sensitivity of programs and services. | 37,44–46,76; N/A |

Australian Government's development of a strategy to achieve gender equality in both health care and parenting.¹⁰²

Opportunities also exist to engage fathers through alternative, innovative strategies without major system-level changes in health service structures. One example is 'gateway consultations' in which fathers are engaged when families seek help for mother and infant, for example at antenatal or early child wellness consultations, early parenting services, ultrasound appointments, antenatal education classes and home visits; these opportunities can facilitate conversations with fathers, to assess and address their own health needs.^{35,103,104} Another opportunity is reaching fathers through web or smartphone technologies, thus overcoming any conflict between health service hours and men's paid work

commitments.^{82,83} Preliminary evidence exists that fathers' help-seeking and engagement in support may be facilitated via an initial contact through these technologies.^{25,44,105–108}

In summary, there is a unique opportunity during pregnancy and in the early years of parenting when men, with partners and children, may encounter health services at a higher frequency compared to earlier life stages.¹⁰⁹ However, if the experience of engagement is not a positive one, it may negatively impact future willingness to trust and engage with services during times of critical need.^{16,74,91} Recent evidence from Australia suggests that poor experiences are linked to high dropout rates from mental health care among men, particularly those experiencing depression and suicidal ideation.¹¹⁰

4.1 | Limitations of the included studies

Studies including fathers often do not report and analyse mother and father data separately, precluding efforts to assess factors that may contribute to engagement and positive outcomes for fathers. Fathers' perspectives are often provided by others.^{60,71,72,111}

The majority of the Australian studies were qualitative. Quantitative studies were fewer in number and hampered by convenience and/or small samples, low response rates, and lack of diversity among participants; findings may not be generalisable to a more representative sample. No robust data exist from randomised controlled trials demonstrating increased engagement of fathers compared to usual models of care. No studies reported any cost-effectiveness analysis relevant to health system access for fathers.

Finally, almost all the evidence related to barriers to and opportunities for engagement in services for mental health and wellbeing. Only a small number of papers reported on evidence about fathers engaging with GPs more generally¹¹² and interventions for improving fathers' physical health.^{82,84} Considering that the transition to fatherhood represents a time when men are at risk of lower levels of physical activity, unhealthy eating habits and poor sleep,^{5,6} this is a considerable gap in the literature.

4.2 | Limitations of this review

The current search originated within a broader review which included but was not limited to fathers. This necessitated a two-stage methodology where variation, particularly changes in male/father search terms, may have influenced the final set of included studies. Owing to time and funding constraints, we did not search for grey literature when conducting the search update.

The focus of this review was on barriers and opportunities relevant to health service access; hence, studies reporting on barriers and opportunities relevant to fathers' access to parenting programs that are not based within or accessed through the health care system, were not included.

As noted in the original review,²¹ non-cisgender men were not excluded; however, we did not find any studies related to non-cisgender men that met all inclusion criteria. We note there is a small body of emerging literature reporting challenges for this population in engaging with reproductive care^{113,114} and that fatherinclusive health care strategies should be mindful of this.

5 | CONCLUSION

Adequate provision of health care support for men in preparation for fatherhood and across the key parenting years has the potential for far-reaching individual and intergenerational benefits. The perinatal period in particular represents an opportunity to improve health care access. During pregnancy and after the birth of a child, men are at risk of poorer physical and mental health, but also often have

considerable contact with health services and are motivated to improve their health and behaviours. However, this review demonstrates that fathers experience multiple barriers to accessing health services, with most included studies focused on early parenthood. Top-down health service restructuring to support fathers as part of a parenting team is required to ensure fathers' health needs are recognised and addressed. When this occurs, it will be critical that data are collected and disseminated to quantify the impacts of change for fathers, mothers and children.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are openly available in Open Science Framework at (<https://osf.io/gk9r3>).

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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