Fathers' integration in Quebec's perinatal and early childhood public policies

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ABSTRACT

Mothers' physical and mental health, as well as their socio-economic status, are currently acknowledged as determining factors in the health and development of young children in Quebec. It is thus not surprising to find that the majority of government perinatal and early childhood initiatives are directed toward mothers. Yet, fathers today are increasingly involved in the care and education of their children, and scientific studies have shown that their involvement is just as crucial as that of mothers. It is recognized that a father's involvement optimizes the physical, cognitive, affective and social development of his children. The purpose of this text is to examine how fathers are taken into account in two public perinatal and early childhood policies. It has been found that fathers are virtually absent from Quebec government's objectives and orientations, and when they do appear, no concrete means are offered to reach them. Considering that health care workers have difficulty offering truly inclusive services to fathers, recommendations with regard to inclusion of fathers in public policies are necessary in order to optimize the health of children and their families.

KEY WORDS: Father involvement; children; health policy; health services; Quebec

La traduction du résumé se trouve à la fin de l'article.

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In Quebec, it is recognized that, in addition to individual characteristics, the characteristics of the environment, of the various systems and of the general context in which a person lives influence his or her state of health.¹ Children's health is no exception to this point of view, and the role played by the family environment's influence during the perinatal and early childhood periods is in fact more powerful than during other stages of life. As primary caregivers and educators, parents thus contribute greatly to the development of young children. Hence, it is not surprising that the majority of the various health care policies concerning preschool age children target their parents.^{2,3}

Yet it is curious to see that these policies seem to target mothers much more than fathers. Great importance is placed on the mother's age, level of education, state of health and lifestyle habits because these health determinants relate directly to the outcome of pregnancy, and thus to the health of the child to be born and his or her later overall development.^{2,3} Moreover, mothers' decision to breast-feed promotes optimal overall growth, since breast-feeding is a non-negligible factor protecting the health of the child all the way to adulthood.³ The pre-, peri- and postnatal periods are thus times when the focus of health care policy implementation priorities is directly on the mother since her actions determine the health of her child.

Despite this, the benefits produced specifically by paternal involvement to children's development, adaptation and social integration no longer need to be proven. Through his

involvement, the father, like the mother, influences the child's physical and psychosocial health by enabling, or not, the child to develop various personal and social competencies, healthy lifestyle habits, and appropriate forms of behaviour.¹ More specifically, involved fathers play direct and indirect roles in the quality of the child's physical,^{4,5} cognitive,^{6,7} linguistic,⁷ affective^{7,8} and social⁹ development. How does Quebec's public policy support paternal involvement in young families today? This article looks specifically at the role given to fathers in Quebec's 2003-2012 National Public Health Program and the 2008-2018 Perinatal Health Care Policy.

2003-2012 National Public Health Program

Non-gender-based analysis of the National Health Program² highlights the various activities to be deployed specifically towards parents and future parents of young children so that the family environment will be most conducive to the development, adaptation and social integration of the latter. However, it can be

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noted that, with respect to both the objectives and the recommended action strategies, only mothers and future mothers are directly mentioned (Table 1). Fathers are represented generically as “parents” or “family members,” but no goal or action is specifically aimed at them concerning their paternal roles (Table 2).

The 1997-2002 National Public Health priorities used to include, as an expected outcome, that perinatal and early childhood programs would systematically value fathers’ role and actively promote their involvement.¹⁰ In the third assessment of the program, it was noted that certain structuring actions had occurred in the majority of Quebec’s regions.¹¹ It has to be said that raising the status of fatherhood and paternal involvement remained more a concern than a real intervention target integrated into professional practices at the national level since the activities that were established were rather local, occasional and isolated. It is thus surprising to see that the *Ministère de la Santé et des Services sociaux* chose to withdraw this objective when the next national program was developed.

2008-2018 Perinatal Health Care Policy

Since its goals include supporting mothers and fathers in their perinatal experiences, and, more specifically, development of parenting skills, the Perinatal Health Care Policy proposes that the *Ministère de la Santé et des Services sociaux* adapt its services to today’s needs so as to ensure access, diversity, quality and continuity.³ This document recognizes the following: “Certain periods prove to be more critical for ‘paternal dropout,’ namely, the arrival of the child and if the couple separates. The age of the child at the time of the separation and the strength of the attachment bond established at birth are determining factors in the maintenance or weakening of the father–child relationship after separation. Health care workers have to show greater openness to fathers so that perinatal services make them feel just as crucial as mothers. The involvement of fathers throughout the entire perinatal period must not only be desired, but recognized, favoured and actively supported.” (3, p.12 [our translation])

This document’s tenets include the necessity for paternal involvement’s support, but such support is vaguely translated into guidelines. There is a suggestion to “establish or consolidate a systematic follow-up program offering all women the following services after postnatal discharge from the place of birth: a phone call within 24 hours of discharge from the place of birth and a systematic visit within 24-72 hours. An effort should be made to perform the visit when the father is present, while ensuring the deadlines are met.” (3, p.60 [our translation])

While here it is stated that the father’s presence during the unique postnatal visit is desired, nothing tells nurses to pay attention to his experiences or needs, or even less to offer him specific support. The other guideline concerning fathers suggests more generally “adapting practices, interventions and services offered in the health care and social services network so as to welcome and promote fathers’ involvement with their young children.” (3, p.63 [our translation])

Yet, various studies have shown that, even today, social and health care workers have trouble offering fathers truly inclusive services, and that the main difficulty stems from a lack of knowledge of fathers’ needs and unfamiliarity with specific ways

Table 1. Objectives and preventive clinical practices to support mothers and expecting mothers

Objectives
<ul style="list-style-type: none">• Reduce the proportion of children who are born a) prematurely to under 7.8%; b) with an intra-uterine growth delay to under 8%; c) with a neural tube anomaly to under 5.1 per 10,000; and d) with foetal alcohol syndrome.• Increase the rate and duration of breast-feeding and of exclusive breast-feeding.• Reduce to zero the incidence of indigenous rubella during pregnancy as well as that of congenital rubella.• Maintain at less than 2 per year the number of children born in Quebec who are infected with HIV through mother-to-child transmission.• Reduce the incidence of unfavourable pregnancy outcomes attributable to the workplace (premature birth, abortion, stillbirth), as well as growth delays and physical health problems in the unborn child.
Activities and action strategies
<ul style="list-style-type: none">• Recommendation that women of reproductive age take folic acid.• Screening of and counselling for pregnant women with respect to alcohol and tobacco consumption.• Counselling with respect to breast-feeding.• Screening of adults for depression, especially pregnant women and women in the postnatal period, and referral to diagnostic, treatment and follow-up services.• Screening of pregnant women for rubella.• Screening of pregnant women for HIV, syphilis, hepatitis B and other STDs.• Identification, evaluation and documentation of pregnant or breast-feeding women’s jobs and recommendations for attending physicians.

Table 2. Objectives and preventive clinical practices to support parents and expecting parents

Objectives
<ul style="list-style-type: none">• Reduce the pregnancy rate to under 18 per 1000 adolescent girls aged 14-17, and to under 65 per 1000 young women aged 18-19.• Reduce the proportion of children and adolescents aged 0-17 who suffer physical and psychological abuse, sexual abuse and negligence.
Activities and action strategies
<ul style="list-style-type: none">• Counselling of sexually active adolescents concerning sexual activity and contraception methods.• Dissemination of prenatal and postnatal information (for example, the guide “From Tiny Tot to Toddler”) to future and new parents.• Recommendations for underprivileged families to take advantage of integrated perinatal and early childhood services.

to approach fathers.^{12,13} Putting the task of adapting practices, interventions and services in the hands of health care professionals and managers without giving them means or concrete objectives makes it relatively improbable that this guideline will be transferred into clinical practice.

Public policies’ impact on the availability of father-inclusive services

First, let us note that Quebec’s health care system is organized around nine program-services that encompass sets of social and health care activities and services designed to meet the needs of the general population as well as specific groups of individuals. Owing to the emphasis it places on prevention, the 2003-2012 National Public Health Program thus forms the basic outline of the Public Health program-service, but it is also at the base of all the other program-services.² The content of the National Public Health Program is of crucial importance for the development, establishment and maintenance of services and activities in the health care and social services network, as is that of the Perinatal Health Care Policy with respect to pre-, peri- and postnatal services.

It seems vital to ask questions about the impact that these policies have on the various social and health care services. Virtually all of these documents refer to the mother as the principal determining factor in the health of young children, and

thus orient the action priorities in accordance with the health, needs and services to be offered to the mother-child dyad. Just as in the Ontario's Family Health Program Standards – Healthy Babies, Healthy Children Protocol,¹⁴ the father is described in these documents more as a partner, a secondary parent or a family member, but rarely as an individual having to adapt to a transition: despite there being a desire for it, no institutional response has been defined with respect to his needs for support or skill strengthening. Yet, fathers are also at risk, just like mothers with respect to developing different problems that could impact on their relationships with their children, like depression during the postnatal period.¹⁵

New fathers may be less present than mothers in perinatal services owing to the constraints of their jobs, but it is nonetheless the case that they want to be involved with their children, that some will need support to succeed in doing so, and that in the end it is their children, their family and society as a whole who will benefit if we support them better in their parental roles. For this, we believe it is urgent to: a) integrate paternal realities into the next National Public Health Program; b) adapt the strategies of the National Public Health Program to fathers' specific issues so that the mother is no longer considered the sole primary parent; c) set up concrete action priorities fostering implementation of the Perinatal Health Care Policy orientation to support fathers' involvement, like specific training and support for health care professionals; and d) allow equity in the health care services delivery by compiling data about both mothers and fathers, for example. Other Canadian provinces are also invited to reflect on fathers' integration in their perinatal and early childhood policies so that all fathers can benefit from effective professional support through their transition to parenthood.

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RÉSUMÉ

La santé physique et mentale ainsi que le statut socio-économique des mères sont actuellement reconnus comme étant déterminants dans la santé et le développement des jeunes enfants du Québec. Il n'est donc pas surprenant de constater qu'elles constituent la majorité des cibles d'actions gouvernementales en périnatalité et petite enfance. Pourtant, les pères d'aujourd'hui sont de plus en plus impliqués dans les soins et l'éducation de leurs enfants et les écrits scientifiques démontrent que leur engagement est aussi crucial que celui des mères. Il est reconnu que l'engagement du père optimise le développement physique, cognitif, affectif et social de ses enfants. Ce texte vise à examiner l'espace qui leur est accordé dans les différentes politiques publiques de périnatalité et de petite enfance. Il apparaît que le père est à peu près absent des objectifs et orientations gouvernementales et lorsqu'il s'y retrouve, aucun moyen concret n'est proposé pour les atteindre. Alors qu'il est connu que les intervenants ont de la difficulté à offrir des services véritablement inclusifs des pères, il semble pertinent, voire urgent, de se questionner à propos d'un tel constat si l'on souhaite optimiser la santé des enfants et de leur famille.

MOTS CLÉS : engagement paternel; enfant; politique de santé; service de santé; Québec