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An Unequal Chance to Parent

*Examples on Support Fathers Receive from the
Swedish Child Health Field*

MICHAEL B. WELLS



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Abstract

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Father involvement benefits children, mothers, and themselves in a number of ways. Swedish legislation and Swedish society have promoted father involvement. At the same time, the Swedish child health field has also unequivocally states that both parents should feel welcomed and supported within that sphere. Despite these statements and policies, fathers feel neglected and invisible within and throughout the Swedish child health field, which includes prenatal clinics, birth and labor wards, postnatal clinics, child health centers, and parent support programs. Less is known however about the factors that influence father involvement in the child health centers, especially from the child health nurses' perspective and the influence of the built environment. Additionally, parent support programs are another way through which parents receive support regarding their young child's mental health, but very little research has focused on why fathers participate or the thoughts parents have regarding their participation, especially within a Swedish context.

The overall aim of this dissertation was to better understand some of the barriers fathers have when trying to participate in the female-dominated world of the Swedish child health field, especially during the child's preschool years. In Study I, 17 child health nurses were interviewed regarding their thoughts on fathers, and in Study II, 31 child health centers' built environments were assessed to see how inclusive they were of fathers. In Study III, a parent support program was assessed to see if mothers and fathers had different background characteristics for participating, and Study IV sought to understand the extent to which parents appreciated and used the information from the program.

These studies showed that child health nurses welcomed fathers, but did not actively invite them to participate. In addition, 75% of the child health centers did not have representations of fathers, but most child health centers had representations of mothers and/or children. Paternal behaviors positively changed if they were in an environment with either explicit paternal representations or only child representations. Mothers participated in the parent support program for several reasons, including if their child had perceived behavior problems, while fathers participated if they were stressed and perceived their child as having emotional problems. Parents believed the information they learned in the parent support program was valuable, and they continued using some strategies a year after the intervention.

Swedish family policies can affect parental involvement within the child health field, but the child health field is less inclusive of fathers than mothers, and it fails to meet the needs of fathers, which can then, in turn, negatively affect maternal, paternal, and child outcomes. Therefore, the Swedish child health field needs to continue working on improving their practices of treating both parents equally.

Keywords: Sweden, gender equality, father involvement, child health field, nurses, midwives, parental leave, family policy

Michael B. Wells, Department of Women's and Children's Health, Akademiska sjukhuset, Uppsala University, SE-75185 Uppsala, Sweden.

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*A person needs to think that you care,
before they care what you think.*

Wes Moore
Author and U.S. Army veteran

List of Papers

This dissertation is based on four original research articles, which are referred to in the text by their Roman numerals.

- I **Wells, M.B.**, Varga, G., Kerstis, B., & Sarkadi, A. (2013). Swedish child health nurses' views of early father involvement: A qualitative study. *Acta Paediatrica*, 102(7), 755-761.
- II **Wells, M.B.**, Engman, J., & Sarkadi, A. Gender equality in Swedish child health centres: An analysis of their physical environments and parental behaviours. Accepted for publication in *Semiotica: Journal of the International Association for Semiotic Studies*.
- III **Wells, M.B.**, Sarkadi, A., & Salari, R. Mothers' and Fathers' Participation in a Community-Based Universally Offered Parenting Program. *Under Review*.
- IV Rahmqvist, J., **Wells, M.B.**, & Sarkadi, A. (2013). Conscious parenting: A qualitative study on Swedish parents' motives to participate in a parenting program. *Journal of Child and Family Studies*. April 2013.

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Terms and Definitions

Father involvement	Relates to fathers' accessibility, engagement, and taking responsibility. Accessibility refers to being around the child and responding to them. Engagement refers to listening to and interacting with children, especially in relation to their needs and interests. Taking responsibility relates to thinking, planning, organizing, and managing a child's needs.
Gender equality	Relates to men and women having the same rights, responsibilities, and opportunities with respect to daily living.
Parent Support	Consists of a wide range of actions that parents are offered to take part in, especially in relation to promoting children's health and mental health.

Preface

I worked for Head Start for three years prior to becoming a PhD student in Women's and Children's Health at Uppsala University. Head Start is an American government-funded national preschool program for low-income children, children with disabilities, and their families. Here, children not only receive an education, but more appropriately, a comprehensive early childhood education, including nutrition, medical, dental, and mental health services. Seeing parents as important contributors to the child, Head Start also provides social services and parental support [1].

Every year parents drop-off their 3, 4, and 5 year old children, with backpacks and bright smiles. Some even bring their babies into Early Head Start. While greeting parents, I continuously heard them exclaim that they are so excited to see their children could go through such a great program! A program that many of them said they formerly went through.

Upon hearing these exclamations, I pondered—*Is this the goal of Head Start?*

Head Start exists to help lift families *out* of poverty. And yet, year after year, generation after generation, many Head Start families continue living *in* poverty.

I once met a former Head Start mother. She came to enroll her child. Before filling out paperwork, we briefly talked about her life situation; that she came from an impoverished family; that she's a 28 year old, single, African-American mother who needs to work to pay her bills and put food on the table for her family. And most importantly she said that she's very concerned about young children being able to receive a high-quality education.

I asked, "How old is your child that you want to enroll into Head Start?"

"Oh sweetie," she replied, "it's not my child; it's my grandchild. Her mother is in middle school, and she don't have no time to come here to sign my grandbaby up for school."

Head Start had failed this family. Not once, but twice. This family had not risen out of poverty. But was it Head Start's fault?

While earning my master's degree in Human Development and Family Science from Ohio State University, I had learned that Sweden was not as equal as their reputation. Under Dr. Sarah Schoppe-Sullivan's tutelage about the importance of mother and father involvement, parent-child attachments, and the transition to parenthood, I began to read about the unequal treatment of women and mothers, and how that treatment affected familial and young child outcomes. I later read Åsa Lundqvist's book, *Family policy paradoxes: Gender equality and labour market regulation in Sweden, 1930-2010*, which cogently details, amongst other important policy matters, the struggle of the 20th century woman in the Swedish workplace.

As I read about the struggles women went through when entering the workplace: the harassment, being underpaid, being passed over for promotions—I wondered—*why is it taking so many decades for women to be treated equally within this predominantly male-oriented environment?*

At the same time, I wondered who looked after the children—Was childcare providing the bulk of parental nurturing? Did fathers take over the child caring responsibilities? Since Swedish fathers were granted the right to use parental leave in 1974, surely they have, by 2015, taken their fair share of childcare duties...unless there were obstacles in their way.

I began to think—if women and mothers were (are) treated unequally within a predominantly male-oriented environment, would men and fathers be treated unequally within a predominantly female-oriented environment? If women are paid less than men in the workplace, are fathers denied certain benefits within the realm of childcare? If it has taken an entire century to try to change workplace behaviors regarding women, how long will it take to change childcare behaviors regarding fathers? How much legislation will it take?

The Swedish child health field provides an ample opportunity to explore the role of men and fathers within a female-dominated world, as the child health field has mainly consisted of women, mothers, and children, until recently. In fact, those in charge of providing the child health services, such as the midwives and child health nurses, are also mostly women and mothers.

But, do Swedish fathers want to be more involved in their child's health? Will Sweden be able to encourage, support, and convince fathers to take part in their child's health lives? Can fathers' participation in childcare rival women's participation in the workplace? Or will the limitations of involving fathers be too great?

Maybe it wasn't Head Start's fault that a 28-year-old grandma needed to enroll her grandchild into the preschool program. Surely there are other external (and internal) forces that affect someone's poverty status. But those working for Head Start often wonder—*Could we have done anything more to help this family from having to watch another generation be enrolled in Head Start?*

The Swedish child health field may want to ask a similar question. In fact, regardless of any limitations or barriers, the ultimate question becomes: Is there anything more that the Swedish child health field can do to improve child outcomes? Or in the words of the famous American poet Walt Whitman, “the powerful play goes on, and you may contribute a verse.” What verse will the Swedish child health professionals contribute to the father-child relationship?

To help answer these questions, I have written the following dissertation. My dissertation, however, isn't meant to persuade people, especially those in the child health field, to change their behavior. My dissertation is meant to *provoke a conversation*. To provoke a dialogue about terms like “women's and children's health” and terms like “gender equality”—what do these symbolic and actual terms mean? It's also meant to provoke conversations around how we respond to fathers and the ramifications, the implications, of those actions. We have to ask: Do we hold mothers back, because of how we treat fathers?... Do we hold fathers back?... Do we hold children back?... And if so, are we holding society back?

Throughout my dissertation, I argue that fathers are beneficial to the whole family, and that the Swedish child health field can do more to support and meet the needs of fathers. With that said, this dissertation is both descriptive and analytical regarding previous research findings. Hopefully the information will be found useful.

The introduction and background is composed of four parts: I first detail the ways fathers benefit children's, mothers' and fathers' health. Then I review

family policies aimed at including fathers. Next, I explore the role child health professionals play in encouraging and supporting fathers. Finally, I delve into the implementation realm of how family policies and child health professionals go about trying to create an environment of equality, all in the name of benefitting the child.

The second section is composed of the four studies composing this dissertation. These four studies collectively look at the personnel and the environment when distributing early childhood health services to see how inclusive they are of fathers. Study I chronicles the child health nurses views on involving fathers, while Study II discusses the gender biases within the built environment of the child health centers. Study III shifts focus over to the parents, focusing on their background characteristics for participating in a parent support program, and Study IV highlights what parents like and do not like about participating in this program. I then discuss these four studies in relation to their methodological considerations.

The third section is a discussion of the Swedish child health field. After placing the field within the context of Swedish society and family policy, I discuss how family policies are both directly and indirectly influencing family outcomes. I further delve into Lipsky's bottom-up perspective by focusing on how Swedish child health professionals, as well as other barriers, limit the implementation of public policies. The overall conclusions are then stated, along with future research and the clinical implications of these findings.

Ok, this preface has been *in utero* long enough; let's get to the delivery.

Introduction

While having a job and maybe being at the same hospital when the mother gave birth constituted involved fathering in the 1950s, by the 1960s and 1970s, fathers in Sweden were seen as supporters to maternal health; taking on more roles, such as helping expectant mothers reduce their stress, by reassuring her and providing her with comfort during childbirth. From the 1980s through the present however, there has been an on-going shift regarding father involvement in maternal and child health, where fathers can be seen as important actors, whose involvement benefits all members of the family [2-5].

This dissertation will explore the ways in which fathers benefit the health outcomes of children, mothers, and themselves, the extent to which the Swedish government and the Swedish child health field independently encourage father involvement in childcare, and how implementation theory can be used to explain the progress that has been made regarding involving fathers in the child health field.

Overall, this dissertation explores how easy it is for a man to be accepted in a woman's world, as the definitions and pressures of good fathering shift to a more egalitarian model.

Fathers Benefit the Whole Family's Health

While the child health field is rife with support for expectant and new mothers, as well as for the child, only relatively recently have their been advances into the important roles fathers play regarding improved maternal and child health [5]. But should the child health field include fathers? Does father involvement bring about positive outcomes for the mother and child? Do fathers themselves benefit from being involved? To answer these questions, the World Health Organization [3], and later again in Plantin et al. [5], conducted a literature review of the ways European fathers provide health benefits to mothers, children, and themselves. A brief summary of their findings pertaining to the benefits of fathers' involvement will be noted here:

Benefitting mothers. Fathers play an important supporting role, both during and after pregnancy, for mothers. In fact, mothers see fathers as vital to their motherhood identity, where women feel more positive regarding their own transition to motherhood when their partner provides emotional support and sensitivity, as well as physically helps in childcare. In broader terms, fathers' involvement in child health is associated with psychological, emotional, and moral support for the mother. There are also positive physical effects from receiving these types of support, which include a reduction in pain, panic, and exhaustion during delivery for the mother. Subsequently, some studies, but not all, have found that mothers spend less time in labor and reduce their incidences of using epidurals if fathers are present. However, all studies point to mothers having more positive experiences in childbirth when their partner is present. Mothers also want to share the birthing experience with the father, seeing it as a way to develop and heighten their relationship.

Benefitting children. Father involvement in child health also benefits the child, such as reduces preterm births, low infant birth rates, and fetal harm. In fact, the reviews continue noting that father involvement may even save the mother's and child's life, as the more prepared fathers are, especially in the case of obstetric emergencies, the more likely they are to reduce maternal and child mortality. In addition, if fathers have a premature or low birth-weight baby, father involvement in providing care to mothers and the child is also associated with improved child outcomes. Attachment theory, as well as research in the field further argues that the earlier a father can involve himself with his child, the stronger his attachment will be to his baby. And since father involvement is related to several positive child outcomes, such as the child's social, emotional, behavioral, psychological, language, cognitive, and academic abilities [6], involving fathers early in the pregnancy is important for children.

Benefitting fathers. When fathers are included early in the pregnancy, they start to better understand and feel a stronger connection to their changing roles, which can encourage fathers to be more involved in their child's life. For example, men start to identify as fathers when they see their unborn baby during the ultrasound visits, as seeing their child confirms their new parenting role. Not only do nearly all men see the delivery as a positive experience, but fathers who participated in giving birth also feel as though they have matured into fatherhood, which again connects fathers to their children. When the medical staff recognizes fathers as parents, especially by giving them emotional support, then fathers tend to have better overall physical and mental health. And if fathers are involved in the child health field, they feel more connected to their partner and their child, which increases their psychological health.

Parental Health Matters

Upon reviewing the literature, it is clear to see that ensuring the parent's health, that is their physical, psychological, and socio-emotional health, is vital to positive outcomes for all members of the family (i.e. children, mothers, and fathers), as parents may not be able to contribute to the family if they are not healthy. To provide one example of this, let us look at the influence of depression.

Both maternal and paternal depression can influence family outcomes. For example, if mothers or fathers are depressed, then children are more likely to have adverse outcomes [7]. About 10 percent of fathers [8, 9], as well as mothers, develop depressive symptoms in the postnatal period [10]. However, depressive symptoms seem to manifest themselves differently between the genders. For example, although both parents have mild-to-moderate depressive symptoms [11], more severe forms of depression seem to affect mothers more than fathers [12], while depressed men experience more irritability and anger compared to women [13]. The outcomes of paternal depression are that it can affect his ability to parent [14], establish an attachment relationship with his baby [13], and have negative affects on children's behavioral, cognitive, and emotional development [15]. Currently in Sweden, there is routine screening for postnatal depression for mothers, but not for fathers, even though the Edinburgh Postnatal Depression Scale is validated for major depression in fathers [16]; therefore paternal symptoms may go on untreated for longer periods of time, with the consequence of negatively affecting the child's, mother's, and their own outcomes.

Even though involved fathering benefits the whole family in a myriad of ways [6, 17-19], fathers are not as involved as mothers in caring for their child. Doherty, Kouneski, & Erickson [20] argue that this is because fathers, more than mothers, are affected by contextual factors, such as maternal and societal expectations, economic factors, and institutional practices. In fact, if fathers are viewed by society as secondary parents, whose relationship with their child is less important than the maternal-child relationship [21], then fathers may not be as involved in their child's life. This has led researchers to conclude that both *public policies* and *professionals* need to re-examine how they support fathers [19].

In knowing this, what lessons have been learned in Sweden? Do Swedish fathers now receive the same support as mothers? Are Swedish fathers equally encouraged to participate in parenting and childcare? Does the Swedish government promote legislation that supports paternal involvement? To find out, Sweden's public policies, especially those related to the family, need to be assessed.

Background

Swedish Family Policies

To further understand the role Swedish public policies play with respect to father involvement, it is important to look at the public policies that have had the biggest and most direct impact on encouraging fathers to be involved in childcare, namely Sweden's family policies. The prevalence of parental usage of these family policies will help shed light on the extent to which equality in childcare has been achieved, as well as on how the welfare state's policies impact men's views of fatherhood [5]. This is important, as father involvement is associated with positive outcomes for the whole family [5, 6, 19, 22].

Swedish Family Policies and Father Involvement

Sweden is one of the most gender equal countries in the world [23]. To help accomplish this, Sweden has created a social welfare state [24, 25] marked by encouraging a relatively low gender-wage gap [26], full employment, economic and gender equality, and cradle-to-grave welfare benefits, as well as having a low child poverty rate [27]. Within this framework, Sweden has created family policies that aim to support the individual in order to generate a more gender-equal society [28-30]. In fact, Swedish government reports state that family policy should not discriminate between men and women based on their biological differences, among other things [31]. A gender-equal society is achieved, in the simplest of terms, when two goals are accomplished: 1) both genders work to the same extent and 2) both genders complete household and childcare work to the same extent.

Parents of young children in Sweden are privy to five family policies that encourage them to balance their employment and childcare duties: 1) the right to take parental leave; 2) the right to care for their sick child; 3) the right to reduce their working hours; 4) the right to have subsidized child care; and 5) the right to receive home care allowance. The first three policies facilitate both parents to be employed and to complete household/childcare work; therefore, they can also be referred to as *father-friendly* policies. The last two policies do not mainly concern fathers, as public childcare mostly enables mothers to work, and the home care allowance mostly employs

mothers to provide childcare for their children; therefore, only the first three policies will be discussed further [for in-depth analysis on these policies see 25, 28] (see Figure 1).

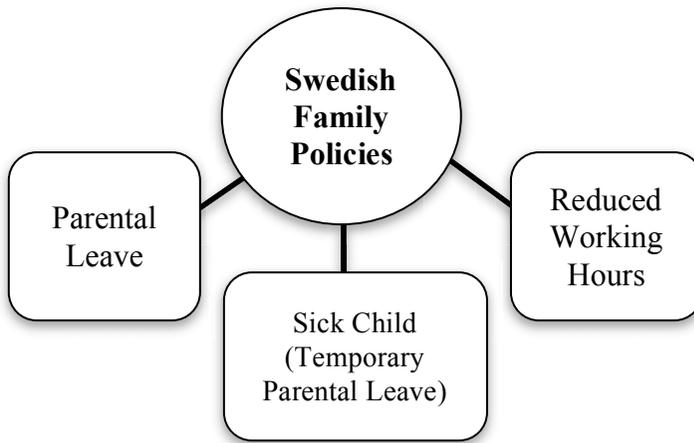


Figure 1: Three father-friendly Swedish family policies

Parental Leave. The most famous Swedish family policy, its flagship, is the parental leave (i.e. parental allowance) policy, which is viewed as the pinnacle of promoting equal parenting in Sweden [32-35], as it both symbolically and actually recognizes both parents as equal partners in caring for their young child [36, 37]. Also, by allowing parents time off from work to raise their child, Sweden expands individual freedoms and balances the family-work paradox [36, 37]. Today, parents receive 480 days off from work, with the first 390 days at 80 percent of their pay (capped around \$53,000 annually), and for the last 90 days receiving a low flat rate of around \$26 to \$54 per day [38, 39]. Parental leave is also extremely flexible, allowing parents to use their leave in increments as little as one hour [40].

Sweden has led the European Union in encouraging fathers to use parental leave [35] by developing several policies aimed at fathers. For example, 1) paternity leave is granted for the first 10 working days after the child's birth; 2) each parent is guaranteed two months of parental leave for themselves, while being able to split the remaining days however the parents see fit; 3) the gender equity bonus monetarily rewards parents for using parental leave equally; and 4) it allows both parents to use parental leave at the same time (up to 30 days).

These policy changes seem to affect paternal uptake of parental leave. For example, obviously fathers could not use parental leave before 1974, and therefore any fathers who used parental leave during and after 1974 was a

significant increase. In 1995, when the first *daddy-month* was created, 55 percent of fathers were not using any parental leave, while *one year* after the introduction of the daddy-month, this number was reduced to only 25 percent of fathers not taking any parental leave by the time the child was two years old. These numbers of not using parental leave were further reduced again in 2002, when fathers were granted two months of parental leave that only they could use [26]. For example, for those children born after 2002, fathers used 22 days more, on average, than the fathers of children born in 2001, while in contrast, fathers of children born in 2001 only used three more days than fathers of children born in 2000, by the child’s eight birthday [39]. However, the gender equity bonus that was introduced in 2008 is said to be a failure at increasing paternal uptake of parental leave, suggesting that receiving a low monetary incentive does not convince parents to change their behaviors regarding parental leave uptake. This may be because many parents have already agreed with their workplace to receive additional compensation above the government’s compensation limits (e.g. an additional 10 percent of their salary), and thus, the 2008 gender equity bonus ultimately may have mainly subsidized the companies payments to parents [39]. With that said, today, fathers are taking more leave than ever before, with around 90 percent of fathers taking some parental leave, and fathers are taking 25 percent of the total parental leave days [26].

With respect to taking parental leave, gender equality has not been fully realized, despite several changes to the policy to promote father involvement (see Figure 2).

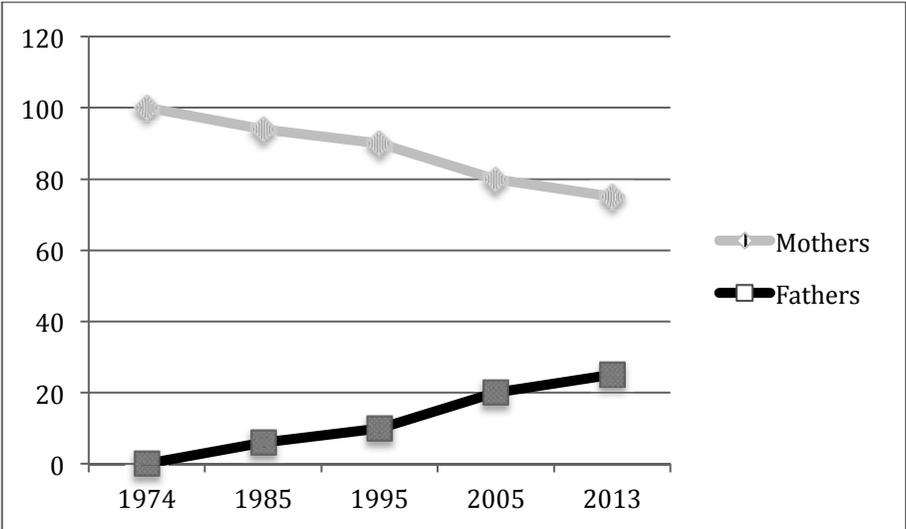


Figure 2: Mothers’ and fathers’ percentage of parental leave uptake from 1974-2013

Sick child. This is also called *temporary parental leave*, and is an additional right to the aforementioned parental leave policy. Both parents have the right to take time off of work to care for their sick child or to be off from work if the child’s caregiver is sick [41]. Parents are permitted to utilize this benefit for up to 120 days per year for each child under the age of 12 [40] and be compensated at the same rate as taking parental leave (80 percent), although the cap for taking temporary parental leave is set at a lower annual salary; around \$40,000. In addition, parents can receive extended leave if their child is sick for prolonged periods of time (e.g. cancer).

When it comes to taking time off from work to care for a sick child, most families do not use this benefit [27]. However, of those who do use it, mothers use this option almost twice as often as fathers. In fact, these gender differences have been roughly equivalent since 1974 [26] (see Figure 3).

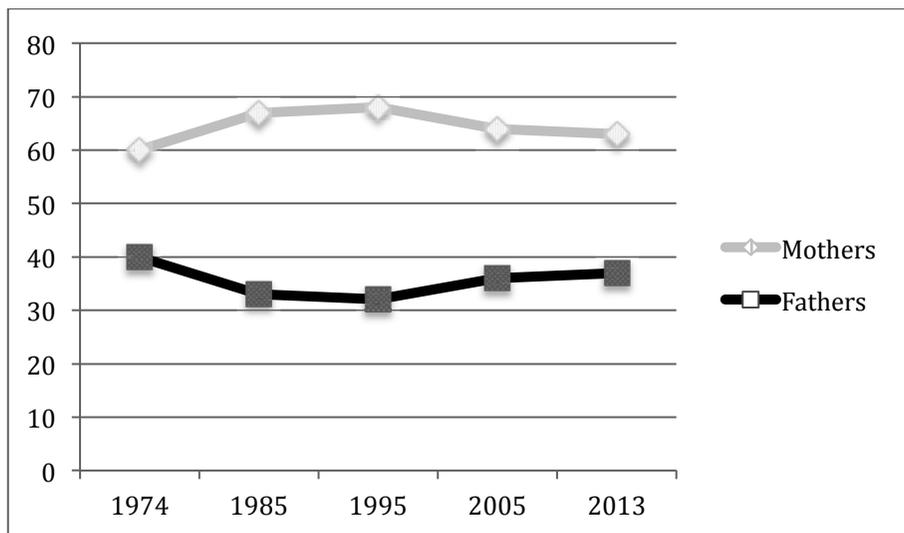


Figure 3: Mothers’ and fathers’ percentage of child sick leave uptake from 1974 to 2013.

Reduced working hours. The parents have a right to reduce the percentage that they work when they have young children; albeit without pay compensation [40]. Since 1979, parents in Sweden have been entitled to have one of the two parents decrease their work by up to 25 percent until their child is 8 years old, with that parent receiving compensation for their reduced work hours through the National Insurance Agency (Försäkringskassan). This reform is supposed to help parents balance the duties of their work-life and their home-life.

Statistics on who uses this right, that is, which parents specifically lower their working hours because of having children, appear to not be kept [40]. However, there is data on the percentage of mothers and fathers who have young children and work part-time, which provides an indication of which parents may reduce their working hours because of having young children (see Figure 4 below). Today, a little under half of the mothers of preschool-aged children work part-time, while around 9 percent of fathers work part-time; therefore, we can still see a gender difference despite the program being open to both parents [26]. Similarly, in looking at all workers, almost three-quarters of fathers work full time (73 percent), while only a little over half of mothers work full-time (54 percent) [26]. Therefore, there is a gender-bias in working status (greater levels of fathers) and for parents working part-time when children are young (greater levels of mothers).

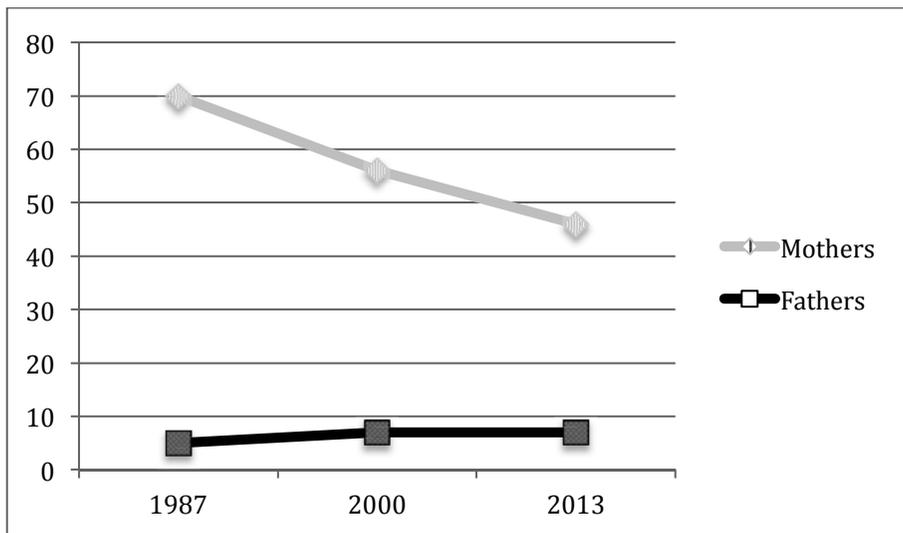


Figure 4: Mothers’ and fathers’ percentage of working part-time between 1987-2013 for parents who have two children, where the youngest is 3-5 years old.

To sum up, although these father-friendly policies allow and even encourage both genders to utilize them, fathers are not using the family policies to the same extent as mothers. It should be no surprise then that recent reports still state that fathers are working more than mothers, and that mothers are completing more household and childcare work compared to fathers [26]. For example, the report states that women perform around 3.5 hours of unpaid housework during the weekday, while men perform 2.5 hours. These numbers have been edging toward equality, as women have a 1-hour reduction in unpaid household work since 1990, while men have increased their unpaid work by 8 minutes. Overall though, gender equality has not yet been fully achieved.

While family policies seem to have their limitations, can others encourage fathers to take more responsibility for child rearing? This dissertation will explore the specific role the child health field plays in encouraging both mothers and fathers to participate equally in their child’s health and care. To do this, first *the professionals* who work in the child health field and second, the extent to which those professionals *implement* gender equal policies will be examined.

The Professionals in the Child Health Field

The term *child health professional* refers to any worker in the field who provides health and development information to parents and works in the child health field. This includes, but is not limited to, physicians, midwives, nurses, and other practitioners, like preschool teachers. The current analysis consists of a literature review on father involvement in five professional child health fields: prenatal clinics, labor and birth wards, postnatal clinics, child health centers, and parent support programs. The first four fields are more responsible for the child’s physical health (among other things), while the parent support programs are more responsible for the child’s mental health, although both fields overlap on providing health services and support to children and their parents (Figure 5).

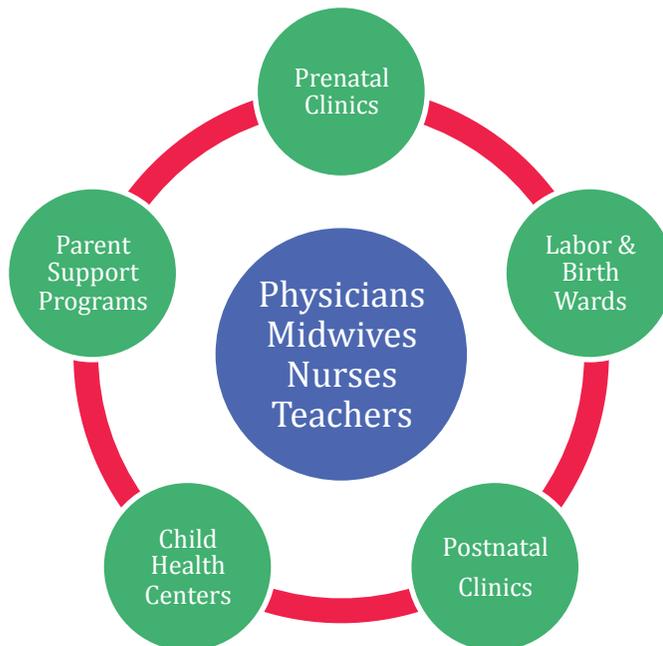


Figure 5: The different arenas child health professionals work in.

The Swedish Child Health Field

Nearly all public health care in Sweden, including throughout the child health field, is financed through taxes, allowing people, regardless of their economic status, access to high quality health care. The Swedish child health field is responsible for children's health from pregnancy through preschool-age, working toward achieving the same goal—promoting the care and development of the young child. To achieve this goal, they also provide support and advice to parents, as parents benefit child outcomes [42-44]. Below is a brief summary about each arena and the extent to which that arena provides encouragement and support to fathers in Sweden.

Fathers in the Swedish Child Health Field

Since the 1970s, Sweden has actively worked toward involving fathers in their children's lives [28, 34, 45]. The child health field is no exception to this, as the *parental perspective* in medical care took hold during the same time period [46]. In the context of this analysis, the parental perspective highlights the importance of focusing on the couple and on both parents as individuals, while they traverse the transition to parenthood [47]. So today, nearly half a century after the introduction of taking the parental perspective, have fathers become a part of the fabric of the Swedish child health field? Has the shift from providing care, support, and advice to women and children extended to men? To find out, I will conduct a literature review, focusing on the research findings from the 21st Century in the Swedish prenatal clinics, labor and birth wards, postnatal clinics, child health centers, and parent support programs.

Prenatal Period. Within the child health field, most parents see a midwife before, during and after giving birth, as the midwives are the ones responsible for providing medical care to expectant mothers and fathers during a normal pregnancy and birth. For routine pregnancies, expectant mothers and fathers will see the midwife eight to nine times, as well as have at least one ultrasound, normally in the 17th-19th week of gestation, while an obstetrician is either never seen or only seen once. Prenatal parent education courses are also offered during this time period, and a few places have *father groups*; that is, parent groups consisting only of expectant fathers.

While expectant fathers [48], much like expectant mothers [49], view the expectant mothers' medical and emotional care as the most important aspect of pregnancy, expectant fathers see themselves as half of the new parenting couple starting early on in the prenatal period [50, 51], and therefore also want and need advice about the transition to parenthood [51]. Fathers show this by expressing their desire to play an active role in pregnancy-related

events, such as attending medical exams and participating in childbirth classes [50]. However, expectant fathers sometimes view the pregnancy with ambivalent feelings in the early stages of pregnancy, because fathers lack tangible evidence of their unborn child, the changing roles of their couple relationship, and their changing identity from partner to parent; thus this prenatal period is viewed by fathers as the most stressful time during their transition to parenthood [50]. The Swedish prenatal clinics promote expectant fathers by encouraging them to come to the ultrasound visits [52]. At the ultrasound visits, expectant fathers can tangibly see for the first time that they will be fathers, and therefore, at this time, they may start to feel like they are becoming a parent [53].

Fathers are also invited to participate in prenatal parent education programs, where they can learn about the delivery and the transition to parenthood. In looking at parental attendance rates, 72.1 percent of mothers and 66.5 percent of fathers attended at least one session [54]. It is important to engage expectant fathers in these courses so that they have less stress and anxiety around birth and in so doing, may also improve the expectant mothers' pregnancy and birthing experiences [55]. Special invitations may be warranted to teenage fathers, as they are even less likely to attend prenatal parent education courses [56].

Despite the current systems efforts to include expectant fathers, about one in five feel like they do not have *any* support network [57]. Fathers feeling this way is associated with having previous children, not attending prenatal parent education classes, not feeling involved by the prenatal midwife, and not having the chance to attend a father group [57]. Other research has also documented that the midwives [58] and the prenatal parent education classes [51, 52] do not involve fathers. Expectant fathers feel like midwives rarely focus on paternal needs [59], and they further express that they feel they can be seen, but not heard [48, 60]. A similar finding was echoed by Olsson and Jansson [58], where they found that expectant fathers are seldomly approached by the midwives. This may be because midwives and child health nurses are not used to merging fathers with pregnancy care [59], which contributes to fathers feeling excluded and ignored [58, 61] and therefore, they struggle with forming a positive relationship with the midwife [48]. Since fathers feel neglected when attending prenatal parent education classes [62], fathers can perceive this to mean that they do not need to take greater responsibility in parenthood [51].

Expectant mothers also want their partners to be involved in prenatal care [61, 63], but state that midwives do not actively involve their partners, nor do they meet their partners' needs [64]. One way of including fathers more,

as suggested from both mothers [49] and fathers [48], is to change the hours of operation so that working parents can more easily attend the prenatal visits. These reasons may be why one study found that only 18 percent of first time fathers (and 11 percent of fathers with previous children) had strongly agreed that the midwife made him feel involved and that only 23 percent of fathers reported being “very satisfied” with their overall prenatal care [48].

In summary, while both mothers and fathers have struggled with ensuring that the fathers’ needs are met, midwives continue to see fathers as an ancillary parent [59]. Despite researchers acknowledging that the expectant fathers’ needs are as important as the expectant mothers’ needs [65], relatively little research has focused on which types of support may best meet paternal needs during this time period [50] or on how midwives see their roles in relation to involving fathers.

Labor and Birth. Expectant mothers typically give birth in a hospital setting with a midwife. Mothers and fathers normally have a hospital midwife perform the labor and birth procedures. This midwife is almost always a different midwife than their prenatal one [66], and the midwife will most likely be caring for more than one couple, although fathers are almost always present at the time of birth [67]. Obstetricians typically only become involved if complications arise, such as needing a caesarean section. Swedish birthrates are relatively high for western industrial countries, with families averaging 1.9 births. Sweden is also known for its low infant and maternal mortality rates.

Both parents find it fulfilling if the father has high involvement in the childbirth process, is supportive and caring towards his partner, and when the father cooperates with the midwife [68]. Fathers view this time period with a sense of pride and pleasure [50], and mothers see the fathers as the most important person after giving birth [69]. In fact, mothers see fathers as more important than others, like child health professionals, since they can help mothers maintain social contacts, care for the baby, support the mothers’ psychological and physical adjustment, and support breastfeeding [69]. Fathers acknowledge that they receive positive support from child health professionals when they can ask questions during labor, when they can interact with the mothers and the midwife, and when they can choose to be more or less involved in the overall process, while fathers do not like feeling helpless, especially during labor [70]. In fact, when midwives provide support and information, as well as are present during delivery, then fathers feel like they have had a positive birthing experience [66], while if

these factors are not present, then fathers do not have a positive birth experience [71].

Although many fathers want to participate in their partners' labor and birth, simultaneously, they are also fearful and sometimes want to leave the delivery room [50]. Around 13 percent of fathers have fear regarding the overall birthing process in Sweden [55, 72], with first-time fathers and non-native fathers experiencing the most fear [55]. Fathers are primarily fearful of the child's health status, their partners' health status, the labor and birth process, and their own ability to parent [73, 74]. More generally speaking, fathers are fearful when they feel out of place and unprepared, especially in relation to the demandingness of the labor, and therefore, they can be in need of psychological support [50]. In fact, when looking at four variables—communication difficulties, exposedness and inferiority, insecurity and danger, and norms of harmony—Eriksson et al.'s [72] model explained 52 percent of the fear in fathers, with communication difficulties with the child health professionals being the single largest fear-barrier for fathers. Since fathers are often fearful of the birthing process, they may push for caesarian sections, as doing so takes the burden off of the mother and themselves and places it on the child health professionals [75]. In other words, the fear fathers feel is often coupled with their feelings of insecurity, which can hardly facilitate a positive transition to parenthood [59].

Postnatal. The postnatal period is the period directly after giving birth, but before leaving the hospital. During this time period, mothers can recover from giving birth, both mothers and fathers can bond with their new child and each other, and they can receive information about the birth and the next steps after leaving the postnatal clinic. In Sweden, new mothers normally share a room with other new mothers, although some hospitals have a family unit, where the partner can sleep overnight [76]. Over the past two decades, postpartum care has gone through significant changes, with the length of the hospital stay being dramatically reduced from 6 days in 1973 to 2 days currently. In fact, 75 percent of mothers stay less than 48 hours if they had a vaginal birth [77]; and women from larger cities are often encouraged to be discharged within 24 hours after giving birth [76]. This has the added consequence of parents needing to take on more responsibility once they leave the hospitals [78].

The postnatal period marks a change in fathers, as they transition from men to parents. Fathers often talk about the bonding that occurs between them and their child [79], leading to identity changes. However, fathers are heavily negatively influenced by environmental factors during this time period, as they start to have misgivings regarding their new parental roles,

such as feelings of lacking basic infant care capabilities, especially in relation to their partners' capabilities, their lack of fatherhood role models, their reduced free time, and adjusting to their new sexual lives [50]. In fact, mothers are twice as likely to have a parental role model as fathers [80]. Fathers want to be involved and learn about caring for their new child from the child health professionals [81]. Fathers can seek additional support from their partners [47], as well as from attending parenting classes and receiving social support, including from the fathers' place of employment [50]. Despite these possibilities for support, fathers are overlooked, forgotten, and viewed as merely a visitor in the postnatal clinics [81, 82].

The main reasons mothers [76] and fathers [83] have for being unsatisfied are because of the unfriendly and unhelpful staff, lack of support, lack of medical check-ups, and not allowing the new fathers to spend the night in the hospital with the mother and his baby. Other research has found similar results citing that fathers feel overlooked, not treated nicely, and provided with insufficient support [81], and because of this lack of support and information provided to fathers, they were not confident in taking care of their infant [83]. Fathers were further dissatisfied with the environment, the visiting hours, the rules regarding sleeping over with the mother and their new child [83], and if they did not receive information about breast-feeding and childcare [76]. In addition to this, before leaving the maternity wards, most first-time fathers want to talk about the delivery and the next steps after leaving the wards; however, 40 percent of new fathers never had a postpartum discussion compared with only 25 percent of mothers who never had a postpartum discussion [84]. In order to provide parents with a sense of security before they leave the postnatal clinics, midwives should empower both parents, have a positive working relationship with both parents, provide both parents with their own sense of autonomy and control, and to have both parents leave the clinical setting feeling healthy and believing that their newborn child is also healthy [85].

Fathers in more vulnerable groups may require even more support. For example, when mothers have postnatal depression, fathers are more likely to perceive their child as having a difficult temperament, and are stressed and dissatisfied with parenting [86], which could lead to negative child outcomes [86]. Fathers may also require more support if they have a premature baby, as they feel concerned, stressed, and helpless, and focus their attention only on their partners' and infants' well-being, with little regard for their own well-being [87]. The good news is that the fathers' feelings can change if they are supported, provided with a sense of security, and are happy, leading them to feel like they can handle their situation [87]. This is very important for the whole family, as mothers see the fathers' support as invaluable,

especially during this time period [88]; therefore, midwives and nurses need to pay special attention to these fathers and ensure that they have been provided with all of the relevant information and are supported [87, 89], which may mean communicating messages more than once [89]. Non-native fathers can also use additional support. In fact, non-native fathers enjoy being invited and are open to receiving information around their partner's pregnancy, as well as on their child's birth, and childrearing [90].

In the end, fathers want to be given the opportunity to participate and take responsibility, be assured about the mothers' and baby's health status, be able to ask questions and receive competent answers, and to be met as their own person, not just as an extension of the mother [91]. These findings have led researchers to conclude that midwives need to view fathers as important participants during the birthing process, and that they should provide fathers with more support [68]. Since the postnatal visits are relatively short, under 2 days for most parents, it is difficult for these clinics to meet their goals of providing family-centered care; therefore either home-based postnatal care is needed [92] or the child health centers will need to provide parents with the support and information that they want, so that the parents can raise their babies in healthy and developmentally appropriate ways [47].

Child Health Centers. In Sweden, around 98 percent of families with children ages 0 to 6 visit the child health centers, indicating that families in Sweden see the child health centers as beneficial [93]. Child health nurses are typically referred to as district nurses, having an additional year of pediatric or public health education. They usually work independently, focusing on reducing infant mortality and morbidity, preventing or detecting childhood disabilities, promoting child health and safety, as well as providing parents with parent group meetings, typically while the child is under 12 months of age [34]. These parent group meetings meet six to eight times during the infants' first year [94], while the child health nurses expect to see infants at the child health centers 11 to 13 times over the first year of life [95].

Both fathers [59] and child health nurses [96] view fathers as equal parents, which is important, since an integral part of the Swedish child health nurses' job is to offer and provide support to both mothers and fathers [46, 96, 97]. In fact, nearly all child health nurses have positive thoughts about working with fathers [7]. Despite this, paternal needs are not being met [34].

Fathers can feel unwelcomed at the child health centers, because of the overwhelming number of mothers (and lack of fathers), the conversations often revolve around breastfeeding, they typically only hold normal office hours, and fathers can feel ignored or treated as secondary parents [34, 98].

Additionally, when fathers try asking the child health nurse a question, they feel like either she is incompetent or would only answer their questions vaguely [98]. This may be because mothers and fathers ask different types of questions, with fathers asking more direct questions compared to mothers [96], which child health nurses may not be used to or prepared for when trying to answer the parents' questions.

Overall, these factors can lead fathers to believe that child health nurses have a stronger relationship to the mother and that they communicate more effectively with mothers compared to fathers [94]. In fact, although both fathers and child health nurses see fathers as important, both fathers [59] and child health nurses [7, 44] see fathers as secondary parents. For example, only one-third of child health nurses believe that fathers are as sensitive as mothers regarding the infants' needs, and two-thirds of child health nurses believe that mothers are instinctively better at caring for infants than fathers [7], leading child health nurses to lack expectations of the fathers' caring abilities, and give most of their attention to mothers [94].

The conversations at the child health centers are so dominated by the child health nurses, that parents may not feel comfortable raising personal parenting issues [99]. Child health nurses further admit to not involving fathers to the same extent as mothers, especially during their conversations with parents [96]. For example, child health nurses may not give as much eye contact to fathers, and they do not encourage father participation if the mother wants to control the visit [96]. Mothers can also be gatekeepers during this time period by not encouraging or even allowing fathers to take care of the child for the entire day [59].

Fathers believe that a trustful relationship, as well as receiving important parenting and child health information from the child health nurse is achieved through having regular encounters with each other [94]. However, only 70 percent of fathers stated that they had ever visited the child health center, and only 38 percent said they regularly or quite often visited [98]. In fact, fathers were only more likely to visit the child health centers if the child was ill and therefore had a doctor's visit [98].

Regarding parent group meetings, around 80 percent of mothers participate [7], while fathers typically participate in low numbers, ranging from two to 28 percent [see 7, 98, 100-102]. Of those attending, mothers averaged 5.7 sessions (nearly all sessions), while fathers averaged 2.8 sessions (only around half of the sessions) [101]. Father participation in the parent groups may be limited because they typically take place during normal working hours and during the infants' first year [103], when mothers are mainly

utilizing parental leave [34]. Although it is not normally offered, fathers like the idea of and actually use parental groups more if they are exclusively for fathers [7]. Therefore, fathers may appreciate and use the parent groups to a greater extent if they were offered during non-office hours, and if they were led by a male [94].

Despite nearly all child health nurses thinking that fathers are important and that they welcome fathers into the child health centers, child health nurses still hold several traditional views on parental competencies, especially for older child health nurses [7]. Nearly 90 percent of child health nurses stated that they rarely realized that a father could be distressed. At the same time, only a little over one-quarter of child health nurses said that they had ever attempted to identify distressed fathers, while 66 percent of child health nurses tried to identify distressed mothers [7]. And less than one in five child health nurses had offered, let alone provided, *any* father with supportive counseling during the previous *year* [7], while nearly 90 percent of child health nurses provided mothers with supportive counseling [104].

Both mothers and fathers make lifestyle changes to promote a healthy environment for their child, but not necessarily for themselves, which is why child health centers should not only focus on the child, but also on the parents' lifestyle, especially in relation to fathers, in order to help ensure health benefits for the whole family [105]. While fathers' self-rated physical and emotional health is stable during pregnancy and in the postnatal period, fathers' physical and emotional health decreases after their child is one year old [42]. This may be due to mothers re-entering the workplace, while fathers start to take their parental leave [42]; therefore, child health centers need to develop a separate curriculum for fathers [96] and more research is needed on finding new ways to increase father participation at the child health centers [98].

Limitations to the Child Health Centers' Research. After reviewing the literature [34], previous studies have mainly focused on paternal involvement from either a parental perspective or have interviewed child health nurses about maternal involvement. Massoudi, Wickberg, & Hwang [7] used quantitative survey questionnaires and found that child health nurses provided less support to fathers, and in fact were more ambivalent regarding the fathers' caring abilities. However, little is known about why child health nurses may respond this way toward fathers; therefore, more qualitative research is needed on this topic. Study I focuses on child health nurses views on fathers, especially on the extent to which they try to involve fathers. Additionally, beyond the staff, it is also important to see how the built environment of the child health centers affects parental behavior, as the

environment has been shown to affect patient perceptions of care [106], as well as their quality of care [107]; therefore Study II delves into the built environment of the child health centers to see how inclusive they are of mothers, fathers, and children, and to explore the effects of parental behaviors based on the child health centers' inclusiveness of the different members of the family.

Parent Support Programs. In recent years, Sweden has invested in parent support programs to prevent child mental ill-health [108], as they are the most effective approach for reducing externalizing problems in young children [109]. The programs aim to change the behavior in children by bolstering parenting via enhancing parental knowledge, confidence, and skills [109]. Mental health professionals, caseworkers, and family counselors typically instruct the parent support programs, although sometimes psychologists and teachers have also been known to lead them. The programs can range in both length and in intensity, with more severe child behavior problems receiving more amounts of one-on-one counseling, while parents with few or minor problems participate in seminars, lectures, and discussion groups. Although several literature reviews and meta-analyses show the effectiveness of parent support programs [110-117], and Swedish studies show that their parenting is related to child behavior problems [118], understanding the motivation behind why parents participate in prevention programs is difficult to study [119, 120]. Identifying factors that contribute to participation in these programs will help to develop more effective recruitment strategies [121].

Limitations to the Parent Support Programs' Research. Relatively little research has been conducted on parental participation in parent support programs [122, 123]. So far there has been some research completed on the factors that encourage *parents* [119, 124-126], as well as *maternal* participation [122, 127-129], but to my knowledge, no studies have yet been published on the reasons why fathers participate. Fathers should participate, as they need to understand the important role they play in their child's life (i.e. empowerment reasons) [130], especially regarding the positive influence they can have on child outcomes, such as reducing child behavior problems [131]. Therefore, Study III will see if there are different background factors in the mothers and fathers who do participate compared to those who do not participate in a parent support program.

In addition to this, little research has been completed on parental thoughts about the parent support program. This is important, especially when the same parent support program is offered in multiple countries, as cultural norms may differentiate parental acceptance and therefore use the programs information to a greater or lesser extent. Study IV will therefore examine

parental perceptions on a parent support program to see the extent to which Swedish parents appreciate an Australian-based parent support program, the Positive Parenting Program—Triple P.

After reviewing the literature on the child health field, it is evident that fathers are treated like secondary parents. Or worse, as invisible [132]. So why do fathers feel like they do not belong in the child health field despite explicit gender-equity promoting public policies in Sweden?? An exploration into implementation theory may yield some possible directions into further understanding the role of the child health professional.

Implementing Father-friendly Policies from the Bottom-up

Public service workers (often referred to as front line workers) are people who directly work with citizens, such as police officers, teachers, welfare workers, health care workers, and other public employees. Michael Lipsky [133] refers to these people as street-level bureaucrats who have a considerable amount of discretion when they perform their routine job duties; therefore, whether knowingly or unknowingly, their employment is constantly balancing the legislative demands with their workload. Since front line workers interact with the public, have little direct oversight, and yield considerable discretion, they exercise influence beyond their formal job responsibilities, and therefore, in effect, *produce* public policy as the population experiences it [133]. As principal-agency theory points out, the front line workers' influence is so vast and crucial to the success of the implementation of public policies, that the front line workers can either promote or undermine the goals of elected officials. Therefore, the role child health professionals play regarding encouraging and involving fathers is critical to implementing certain public policies.

Rational for this Dissertation

The aforementioned literature review highlights that involving fathers in the Swedish child health field is important, as they provide positive health outcomes for children, mothers, and themselves [3, 5]. Furthermore, Sweden has developed a list of father-friendly family policies to encourage both parents to be involved in their young child's life. Despite this, fathers are still not taking an equal share of the childcare responsibilities [26]. The question then arises: why are fathers not taking an equal share of childcare responsibilities? And, is there something that child health professionals can do to increase father involvement in those settings? Answering these questions fully cannot be completed in this dissertation. However, a thorough review of the limitations placed on fathers from the child health field has been stated, with the major finding that fathers often feel like, and actually are treated, as secondary parents, which then has implications regarding gender equality.

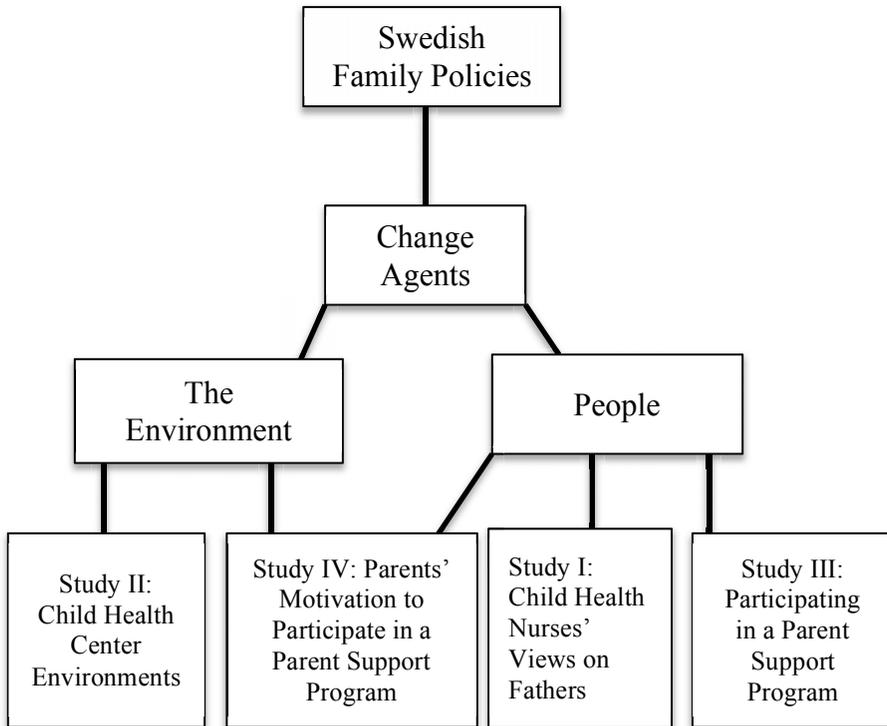
While more research has been completed on prenatal, labor and birth, and postnatal clinics, relatively little research has been completed on father involvement when children are young (i.e. 0-6 year olds). There are two main areas where young children receive health services: the child health centers and parent support programs. While the literature has focused on maternal and paternal perspectives regarding father involvement at the child health centers, there has not been much attention on father involvement from the child health nurses' perspective; a view that may convince fathers to visit or refrain from visiting the child health centers. Additionally, to my knowledge, no research has been completed on how the child health centers' built environments influence paternal (and maternal) behavior. Similarly, little is known about father involvement in parent support programs, especially in relation to why they choose to participate, and if parents enjoy, as well as learn and use the strategies taught in the parent support program.

Overall and Specific Aims

The overall aim of the studies constituting this PhD dissertation is to better understand some of the factors that influence early father involvement within the Swedish child health field; specifically within the child health centers and a parent support program.

This dissertation seeks to answer the following questions:

1. To what extent do the child health nurses include fathers when providing parenting advice on young children's health and development? (Study I)
2. Do the child health centers create an environment that both symbolically and physically represents mothers, fathers, and children? And do the different environments influence parental behavior? (Study II)
3. Which background characteristics encourage mothers and fathers to participate in a parent support program? (Study III)
4. Do parents like participating in a parent support program and do they use techniques taught in that program? (Study IV)



Study I: Child Health Nurses' Views on Father Involvement

The purpose of Study I was to explore Swedish child health nurses' views on their role of involving fathers at the child health centers, employing two research questions: 1) do they want fathers to be involved at the child health centers? and 2) to what extent are child health nurses inclusive of fathers?

Methods

Design

Child health centers were preselected to represent different geographical areas of Sweden. There were 17 interviews conducted with the child health nurses based on a pre-set 8-question interview guide. Additional questions were asked in order to clarify, prompt, or expand on child health nurses' statements.

Sampling

Each child health center had between two and six child health nurses, and the child health nurse who greeted the researcher at the door was asked to participate in the study. All 17 of the child health nurses stated that they would like to participate, although two said that they had little free time to complete the interview; therefore their interviews were shorter in length.

Interviews

All of the child health nurses understood and stated that they were comfortable participating in an English-speaking interview using a semi-structured interview guide.

The interviews averaged 28 minutes in length. Although the interviews were shorter than what would be typical in qualitative interview studies, four qualitative researchers determined that the material was rich in details of child health nurses' descriptions of both their thoughts and experiences (actions), while there was variation in the kinds of experiences described.

The transcripts were analyzed using Systematic Text Condensation according to Malterud [134] (Table 1).

Table 1. The simplified four steps of the analysis process in systematic text condensation

Steps in data analysis	An example from Wanting More Father Involvement
<p>Total impression of the data:</p> <p>→ Finding Themes</p>	<p>The child health nurses say they like it when fathers visit the child health centers, that they see fathers more often, and they would like more fathers to come to the child health centers.</p> <p>Preliminary Theme: Perceptions of Fathers</p>
<p>Identify and sorting relevant text units – meaning units</p> <p>→ from Themes to Codes by grouping meaning units to create code groups</p>	<p><i>“I think more fathers would definitely come or rather any working parents would definitely come if we had non-office hours, like working until 5 or 6 in the evening or even a Saturday morning.</i></p> <p>Code group: Thinking and Trying to Include Fathers</p>
<p>Condense the meaning in each code group as if it were a story told by one nurse</p> <p>→ from code to meaning through abstraction</p>	<p>I would like the child health centers to stay open later during the week or even to work half a day on Saturday so that working parents, especially fathers, would be able to attend to an easier extent.</p> <p>Abstraction: Longer hours of operation will help and encourage working parents, especially fathers, to visit the child health centers.</p>
<p>Summarize the essence of each code group - Synthesizing</p> <p>→ Validate the result by re-reading transcripts. Use quotations to draw out the point of that code group.</p>	<p>Essence: Child health nurses develop ways to actively involve fathers.</p> <p>The original transcripts were re-read to see if the themes and code groups had a goodness-of-fit. Add a quotation from the interviews into the code group.</p>

Results

Themes

Four themes resulted from the analysis: 1) the nurse’s own agenda, 2) nurse’s opinion about the fathers’ role, 3) nurse’s gatekeeping, and 4) wanting more father involvement. Follow systematic text condensations recommendations [134], the first two themes will not be presented here as previous research has identified and discussed these topics, while the third and fourth themes will be highlighted to a greater extent, as they tease out new information on child health nurses’ perceptions of how they involve fathers (see Table 2).

Table 2: The Themes and Categories

Themes	Categories
THE NURSE’S OWN AGENDA	<ul style="list-style-type: none">• The infant’s advocate• Supporting parents and co-parenting
CHILD HEALTH NURSE’S OPINION ABOUT THE FATHERS’ ROLE	<ul style="list-style-type: none">• The fathering role has changed• Fathers are attending the child health centers more than before• Perceived differences between fathers and mothers
NURSE’S GATEKEEPING	<ul style="list-style-type: none">• Mothers are our priority• The gate is closed, but not locked
WANTING MORE FATHER INVOLVEMENT	<ul style="list-style-type: none">• Fathers are worthy of change• Active in involving fathers

Nurse’s gatekeeping

Mothers are our priority

The 5th interviewed child health nurse explained that since the mother takes care of the infant during the first year, she knows how the child health centers are run, and therefore continues to come, while the father is increasingly less knowledgeable about the procedures at the child health centers and therefore feels less welcome. Child health nurses stated that they believe the fathers feel they are entering a female world, emphasizing the amount of conversations on breastfeeding.

I think that many fathers feel that they are coming into a very female dominated world. So maybe they don't feel like they belong here, when all of the conversations are about, you know, about breastfeeding.

Child health nurse Interview 6

The gate is closed, but not locked

Although fathers are welcome to participate in parent group meetings, the main reason child health nurses gave for fathers not attending was that the meetings were held in the early afternoon. Child health nurses understood that it was not possible for fathers to come in the early afternoon, because they work during that time period, but they further stated that it would be impossible for the child health centers to change the time the parent group meeting were held.

I think it's up to them [the parents] to decide who comes to the child health centers. But of course I will ask the mother, if she always comes, if she communicates everything to the father. But I don't say anything else.

Child health nurse Interview 13

Wanting more father involvement

Fathers are worthy of change

Child health nurses thought that they would have to actively work to encourage greater father involvement, but lacked the skills to do so. A reflection by one child health nurse exemplifies this:

Often the father feels like he's on the outside, and if I had been a little more experienced, I could have said 'but I really would like you to hear this too, because I would like to meet both of you,' and I would say that now, but not when I started.

Child health nurse Interview 2

Active in involving fathers

Child health nurses either contemplated or had taken action toward involving fathers to greater extents. These child health nurses usually noted that their hours of operation needed to change.

I think more fathers would definitely come or rather any working parents would definitely come if we had non-office hours, like working until 5 or 6 in the evening or even a Saturday morning.

Brief Discussion

Child health nurses were comfortable speaking about their role as a child health nurse, as well as elaborating on the importance of fathers within the family. However, while they accepted fathers at the child health centers, the child health nurses typically did not see themselves as active agents in involving fathers, but rather saw the proverbial gate as being unlocked to fathers, but not actively inviting them in, as they do for mothers. Some child health nurses noticed this trend at their child health center and have either thought about, tried to, or have started to institute changes to further encourage fathers to be more involved in the child health centers; thus living up to their own policies of equally including both parents.

Wells, M.B., Varga, G., Kerstis, B., & Sarkadi, A. (2013). Swedish child health nurses' views of early father involvement: A qualitative study. *Acta Paediatrica*, *102*(7), 755-761.

Study II: Child Health Centers' Waiting Rooms and Father Involvement

The aim of Study II was to investigate if child health centers' waiting rooms address all family members through their built environment (i.e. the waiting room) and to see if that environment affects parental behaviors.

Methods

Sampling and data collection

A total of 43 child health centers throughout Sweden, based on their geographical diversity and on the socioeconomics of the area served, were asked to participate: 34 child health centers (80 %) accepted. Only 31 out of 34 child health centers were visited because the data was sufficient in order to conduct the semiotic analysis.

The waiting rooms in the 31 child health centers were photographed thoroughly, magazine names were written down, and all pamphlets were sampled.

In 25 of the 31 child health centers, observations of parental behaviors were completed. Observations of the remaining 6 child health centers did not take place because those child health centers did not have patients at the time when the researchers were able to visit their location. Observations of parental and child behaviors were also completed at the child health centers and placed into one of four categories: 1) *parental interaction* is when parents are playing or reading with their child, 2) *parental reading* is when parents read magazines, brochures, and/or the bulletin board, 3) *parental conversation* with adults (their partner, other parents, or nurses walking through the waiting room), and 4) *parents had no interaction* with respect to the environment and/or their child/partner (e.g. interacted only with their cell phone or just sat patiently waiting).

Semiotic visual analysis

In performing semiotic visual analysis, the meanings of images are described on two levels: denotative (manifest) and connotative (latent) [135]. The manifest analysis describes the picture exactly as it is (i.e. facts that could be corroborated). The latent analysis involved a subjective interpretation of the pictures of the waiting room that were based on the findings from the manifest analyses, allowing the analysts to quantitatively develop an overall feeling for whom the waiting room was signifying; the father, mother, child, or any combination thereof.

Definitions of the environments were created to make the latent analysis less subjective (see Table 3).

Table 3: Definition of Environments

Different Environments
<hr/> Family Centered Family centered environments addressed fathers, mothers, and children. All members of the family were represented on the posters, brochures, billboards, and magazines. At least one quarter (25%) of the posters, brochures, billboards, and magazines had to involve fathers, mothers, or children. Additionally, these environments also offered more gross motor toys compared to the other environments.
Child-Mother Centered Child-Mother centered environments exhibited a clear child and mother emphasis. That is, fewer than 25% of the posters, brochures, billboards, and magazines represented fathers. Also, there were distinct areas for children to play in, with several toys and/or books for children.
Child Centered Child centered environments were areas that were filled with toys and/or books, but lacked representations of mothers and fathers. That is the posters, brochures, billboards, and magazines were mainly only representing children (under 25% of the materials had representations of mothers and under 25% of the materials had representations of fathers).
Neutral There was little representation of fathers, mothers, or children, as these child health centers had few posters, brochures, billboards, and magazines. There were few to no toys or books for children.
Women Centered Women centered environments were focused on the woman's needs. These waiting areas tended to have posters, brochures, billboards, and magazines directed only towards mothers/women (fewer than 25% of the materials represented fathers and fewer than 25% of the materials represented children). There were few toys or books for children.

Three analysts independently reviewed the pictures of the waiting rooms and independently coded the manifest and latent analyses and then met to compare their findings.

Results

Who do waiting rooms appeal to?

Of the 31 child health center waiting rooms, 12 were Mother-Child Centered, 6 Child-Centered, 2 Women-Centered, and only 8 were Family-Centered. Three child health centers did not have more than 10 items for the mother, father, or child, and were therefore not appealing to any member of the family. These environments were termed Neutral environments. The data did not indicate any Father-Centered, Mother-Father Centered, or Father-Child Centered environments (see Table 1 for definitions of the child health center waiting room categories).

Behavioral observations at the child health centers

Of the 31 child health centers with environmental data, 25 waiting rooms had parental observations. A total of 281 parental observations were completed: 82 observations were completed on fathers and 199 were completed on mothers. Observations were completed on the day that the researchers took pictures and collected data on the environments, but before the waiting rooms were assigned to whom they appealed.

To conduct the statistical analysis, the data was re-categorized into two environmental categories: Mother targeted and Non-Mother targeted Environments. Mother targeted consisted of Mother-Child Environments and Women Environments, while Non-Mother targeted included Family Environments, Child Environments, and Neutral Environments.

The relationship within and between environments and parents' behavior

Within Environments: Fathers played significantly more with their children than *mothers* in Non-Mother targeted environments (Fisher's exact test = .000). However, fathers were approaching, but did not reach significance with respect to playing with their children in mother-targeted environments compared to *mothers* (Fisher's exact test = .093). There were no significant differences between mothers and fathers with respect to Parental Reading when parents were in Non-Mother or Mother targeted environments.

Between Environments: Fathers played significantly more with their children in Non-Mother targeted environments compared to *fathers* in Mother-

targeted environments (Fisher's exact test = .020). Fathers also read brochures and magazines significantly more in Non-Mother targeted environments compared to *fathers* in Mother-targeted environments (Fisher's exact test = .050). There were no differences between the behaviors of mothers in the different environments.

Brief Discussion

The most common environment is the Mother-Child Centered environment (38%), while only a quarter of environments were designated as Family Centered. Thus, only 25% of the examined child health centers met the national guidelines for being inclusive to all family members, at least as far as the physical environment is concerned. Moreover, although mothers did not differentiate their behaviors in either environment, fathers were more engaged with their children and with the medical information in Non-Mother targeted environments.

Wells, M.B., Engman, J., & Sarkadi, A. Gender equality in Swedish child health centers: An analysis of their physical environments and parental behaviours. Accepted for publication in *Semiotica: Journal of the International Association for Semiotic Studies*.

Study III: Parent Support Programs and Mother and Father Involvement

The aim of Study III was to examine the characteristics of both mothers and fathers who did and did not participate in a universally offered practitioner-led parent support program in a non-high-risk community, to see if mothers and fathers have different background characteristics for participating.

Methods

Measures

We collected information on several demographic variables of the family, including child's age and gender, as well as on the parents' age, level of education, marital status, country of birth, and number of children in the family.

We also collected several subject variables; those are variables that apply to the participants' background beyond basic demographic information and they include: 1) An abbreviated version of the Eyberg Child Behavior Inventory [136] was used to measure the child's externalizing problems; 2) The Strengths and Difficulties Questionnaire [SDQ; 137] emotional symptoms subscale was used to measure children's psychosomatic and anxiety-related symptoms; 3) The Parenting Sense of Competence Scale [PSOC; Gilbaud-Wallston & Wanderson, 1978; as cited in 138] was used to measure parental satisfaction and efficacy; 4) The Parenting Scale [139] was used to measure parents' disciplinary practices; 5) The Dyadic Adjustment Scale-4 [DAS-4; 140] was used to measure the couples' relationships, and 6) the Depression Anxiety Stress Scales-21 [DASS-21; 141] was used to assess the parents' perceived stress and depression levels.

Intervention

The Positive Parenting Program - Triple P is a multilevel parent support program that aims to reduce behavioral and emotional problems in young children by providing parents with parenting information and teaching them

new skills to utilize [109]. Triple P is used in many countries and is shown to be effective at reducing child behavior problems [109, 114, 116].

In the current study, levels 2 and 3 were universally offered to all parents in the participating intervention preschools, although parents could choose to or not to participate. For the purpose of this study, we only focused on participation in level 2 of Triple P, since this level focuses more on every day issues, and therefore appeals to a greater number of parents. Level 2 of Triple P consists of three 90-minute seminars for parents seeking general parenting information or for those seeking advice about a specific behavior problem.

Maternal and paternal data were analyzed separately. Chi-square tests were run for categorical variables and analysis of variance tests were run for continuous variables. Logistic regression analysis was then performed to see if the variables in the model could predict participation rates for mothers and fathers, respectively. All analyses were performed using SPSS 20.

Results

During the first six months that the intervention was offered, 49 mothers (23% of the total 213) and 18 fathers (12% of the total 150) participated in at least one of the three Triple P seminar sessions. In the total sample, mothers were more likely than fathers to participate: $\chi^2(1, N = 363) = 7.08, p < .01$.

Factors Related to Participation

Participants and non-participants were compared on several demographic and subject variables using chi-square and *t*-tests, respectively.

Three demographic variables were related to maternal participation: being born in Sweden, if they had three or more years of higher education, and if their children were male. None of the demographic variables were related to participation in the program for fathers.

For subject variables, mothers were more likely to participate if they had reported greater levels of problem behavior in their children (ECBI), and if they had reported being more overreactive when responding to their child's misbehavior (PS Overreactivity). Fathers were more likely to participate if they had reported their child to have more emotional problems (SDQ Emotional Symptoms), and if they perceived themselves to have more stress (DASS Stress).

Independently Related to Participation

For mothers, the logistic regression model was run with the five significant variables. The model was statistically significant, $\chi^2(5, N = 210) = 33.67$, $p < .001$, and explained 22.5% (Nagelkerke R squared) of the variance in participating, and correctly classified 78.1% of the cases. As shown in Table 3, only three of the independent variables made a unique statistically significant contribution to the model: child gender ($p < .04$), maternal education ($p < .001$), and EBCI problems ($p < .02$), while being born in Sweden and parental overreactivity were trends ($p < .10$). Mothers' odds of participating were 2 times higher if she had a boy or had a higher education, after controlling for all other factors in the model.

For fathers, the logistic regression model was run using the two significant variables. The fathers' model was also statistically significant, $\chi^2(2, N = 150) = 8.74$, $p < .01$, and explained 10.9% (Nagelkerke R squared) of the variance in participation. However, this model classified all the fathers as non-participants, and only one independent variable made a unique statistically significant contribution to the model: SDQ emotion symptoms ($p < .03$). Fathers' odds of participating were 1.4 times higher if they perceived their child to have emotional problems.

Brief Discussion

The objective of this study was to see if mothers and fathers participating in a practitioner-led universally offered parent support program had different background characters. While mothers were more likely to participate if they perceived their child as having behavioral problems, for example, fathers were more likely to participate if they perceived their child as having emotional problems; therefore, mothers and fathers participate for different reasons. Because of this, parents should be marketed to participate in different and more individualized ways.

Wells, M.B., Salari, R., & Sarkadi, A. Who participates in a Swedish parenting intervention: A look at mothers and fathers self-selection to participate in Triple P. *Under review.*

Study IV: Parental Motivations for Participating in a Parent Support Program

The Positive Parenting Program or Triple P has been used around the world as a parent support program designed to help bolster parenting practices. While there has been plenty of research conducted on the effectiveness of the program [110, 114, 115], little research has been completed on what parents like and do not like about the program. The aim of this study was to find out why parents of preschool children chose to participate in Triple P in Sweden, what they thought of the Triple P curriculum, and how the program related to their parenting philosophy in general.

Methods

A year after receiving Triple P, parents were recruited to participate in this qualitative study. Semi-structured interviews were used and saturation was reached after interviewing 10 parents, including seven mothers and three fathers. The interviews were transcribed verbatim and were analyzed using Systematic Text Condensation [134].

Results

The analysis yielded three themes: 1) Triple P meets parents' needs; 2) A well-organized toolkit; and 3) Conscious parenting.

Triple P meets parents' needs

Parents chose to participate in Triple P because they wanted to learn more about the intervention, they had specific problems that they sought help for, and they felt encouraged to participate due to advertisements and recommendations from friends.

I was hoping to get some advice on how to handle small problems in everyday life, so that I would improve as a parent and be able to handle different situations better.

–Mother of four, 38 years old

A well-organized toolkit

Parents expressed their interest in the built environment of the intervention: 1) they liked the location of the intervention, which was at their child's preschool; 2) they enjoyed learning about the parenting strategies from someone they already knew and respected, the preschool teacher; and 3) parents appreciated having access to free childcare during the seminars.

She [the preschool teacher] knows my child [...] I mean, she knows him and how he is at the preschool. She can see if there are any differences in his behavior or mood. [...] It would feel strange if I was to talk about problems with my son to a complete stranger; a person I had never met.

–Father of two, 34 years old

On the Triple P curriculum, the participants especially enjoyed the “directed discussion” technique, the positive reinforcement sections, and the instructions on how to communicate effectively with their child by staying calm, close, and maintaining eye contact.

Conscious parenting

It was important for many of the parents to feel validated and respected, and they liked having discussions with the preschool teacher rather than from a person they did not previously know.

I think they've been reasoning with me rather than giving straight orders. They usually asked me 'Have you tried anything else?' or 'Do you think there could be another way of looking at this problem?' Instead of just saying 'do this.' That makes you start thinking for yourself, and gives you the feeling of solving the problem yourself.

–Mother of three, 33 years old

Brief Discussion

Parents in this Swedish sample generally liked and selectively used the strategies they learned from participating in Triple P, depending on how well these fit with their own parenting experiences and philosophy. They appreciated the location of the intervention, as well as enjoyed learning from a trusted practitioner, their child's preschool teacher. Swedish practitioners can use this practical information when providing other interventions.

Rahmqvist, J., **Wells, M.B.**, & Sarkadi, A. (2013). Conscious parenting: A qualitative study on Swedish parents' motives to participate in a parenting program. *Journal of Child and Family Studies*. April 2013. DoI: 10.1007/s10826-013-9750-1

Methodological Considerations

Data collection and analyses

In two studies (Study I & IV) data was gathered using semi-structured interviews, while Study II used observational qualitative and quantitative methods, and Study IV used quantitative methods.

Both Study I and IV used systematic text condensation [134]. While systematic text condensation is based in Giorgi's phenomenological approach [142], Giorgi's approach tries to subscribe a deeper meaning to the participants' experience – looking for its essence – whereas systematic text condensation only seeks a description of the event as expressed by the interviewee. This approach was important for Study I, as the interviews were conducted in English with native Swedish-speaking participants; therefore an analysis at a deeper level may have led to misinterpretations of what the participants were really trying to say. In Study IV, a novice medical student who was just learning qualitative methods conducted the interviews and led the analysis. Since systematic text condensation was created for ease-of-use, especially with respect to new qualitative researchers, the method was considered appropriate.

Within qualitative research, the terms credibility, dependability, and transferability are used to control for quality: 1) credibility refers to the amount of confidence or believability one has with respect to the truth of the data in relation to the research question; 2) dependability refers to the stability of the data within a changing context and describes the extent to which results can be corroborated or confirmed by others; and 3) transferability refers to the extent to which the findings can be transferred to other settings or contexts [143]. These concepts are used here when discussing methodological issues concerning the three qualitative studies included in this dissertation.

Credibility. Several measures to improve credibility were employed: triangulation, using an interview guide, peer debriefing, and a form of member checking.

Triangulation is generally regarded as improving credibility. In studies I, II, and IV of this dissertation, several forms of triangulation were used. For example, *investigator triangulation* was used in all three studies, where two or more researchers analyzed and interpreted the data.

Method triangulation was used in Study II, as behavioral observation was combined with photographing the waiting rooms, and investigating the readership of the magazines found in the waiting rooms. In addition, space triangulation was used. *Space triangulation* refers to collecting data on the same phenomena at multiple sites. For example, six different counties, consisting of 17 and 31 sites were visited in Sweden for Study I and II, respectively.

A special form of method triangulation occurs when individual studies examine the same phenomenon. For example, when combining Study I and II, a better understanding of the extent to which fathers can feel involved at the child health centers is employed. This is completed through interviews, assessing the waiting room environments, and parental and child observations within those waiting rooms. Study III and IV also combine to use method triangulation, whereby Study III quantitatively focused on the background factors mothers and fathers had for participating in a parent support program, and Study IV had findings that merged with Study III, by explaining the extent to which participating parents enjoyed the parent support program (i.e. the extent to which the program met their needs).

To ensure the quality of data collection for Study I and IV, the researchers drafted an *interview guide*, which helped the interviewer concentrate on the research topic. However, probing questions were employed beyond the interview guide, allowing the interviewee to respond in greater depth.

Peer debriefing is when sessions are conducted with peers for reviewing and exploring different aspects of the research. In all four studies, the design and analyses were discussed in multiple research team meetings, as well as at conferences, and with specific experts. For example, for Study I, Kirsti Malterud, a known qualitative researcher, independently went through the interview guide, the methodology used, and the results from the analysis, before providing feedback.

A type of member checking was employed for Studies I and II. Member checking refers to the researchers providing feedback to the study participants. Doing so can provide important feedback regarding credibility. Study I and II were shared with multiple Swedish child health nurses who were *not* participants. These child health nurses, overall, agreed with the

findings, and provided information that later evolved into the creation of a waiting room checklist, where child health nurses could work on including different types of people, including fathers, throughout their built environment. This was not completed on other parents, like in Study IV, because the interviews took place a year after the parents participated in the parent support program, and therefore non-participating parents were not as accessible as non-participating child health nurses.

Dependability. Several measures to improve dependability were employed: employing one or more co-analysts, researcher reflexivity, and leaving a clear decision trail.

In Studies I and IV, several researchers independently analyzed the interviews. In Study II, three researchers independently analyzed the photographs from the waiting rooms based on the pre-set definitions of what constituted a mothers, father, and/or child environment. By utilizing investigator triangulation, the researchers could blend their skills and expertise, providing a fuller understanding of the data. For example, in all three studies, researchers from both sexes were represented and they had 1) different professions such as being physicians, nurses, and psychologists; 2) they came from different cultures like Sweden, Hungary, and the USA, and 3) they were in different life stages: single, living with a partner, and having children. Having a diverse group of researchers analyze the same topic (*employing co-analysts*), but arrive at similar conclusions, helps to add dependability to the studies.

When researching, it is important to be aware of and acknowledge the researchers' preconceptions, also referred to as *researcher reflexivity*. By being open and honest, the study's trustworthiness is further strengthened. I learned about Sweden's gender equality policies, while living and researching in America. Understanding different cultural variations on gender equality can be both helpful and a hindrance, as these preconceptions led me to think that Sweden was quickly approaching gender equality. However, after starting my Swedish research, I found that Sweden's reputation for gender equality seemed to be ahead of its actual practices, at least with respect to father-friendly policies in the Swedish child health field. This led me to further assess and therefore scrutinize the ways in which gender equality had not yet been achieved in Sweden, again paying particular attention to the Swedish child health field and Swedish family policies. Having additional researchers collaborate with me on these four studies has helped to keep the research grounded, both in terms of the methods and analyses used, as well as with respect to the conclusions ascertained from the analyses.

One of the advantages of using systematic text condensation is that the method can be followed step-wise. This allows the qualitative researcher to have a *clear decision trail* (see Table 1 in Study I). The condensation step is one of the most crucial steps within systematic text condensation. At this stage, meaning units are re-described in story form as told by one person. This creates a narrative with the data, allowing the researcher to see both similarities and differences within the code groups. By doing this, the researcher can then determine if the code groups have enough recurring material to be considered as a theme, which again contributes to the overall dependability.

Transferability. Several measures to improve transferability were employed: a thorough description of the sampling procedure, ensuring a thick description of the phenomena studied and negative case analysis.

A thorough description of the sampling procedure was completed by providing the geographic locations of the sites and the demographic information of the participants in studies I, II, and IV. Thus, other researchers could judge if their population is similar or not to those in these four studies, allowing them to draw conclusions regarding the transferability of the findings.

The term *sample selection* refers to content in the interviews that provides in-depth experiences rather than politically correct comments and/or platitudes. By using trained interviewers, we ensured that *thick descriptions* were obtained from the participants. After the first pilot interviews, these were transcribed and an experienced qualitative researcher reviewed the transcripts with the interviewer. Possibilities to enhance descriptions through techniques such as probes, mirroring, and summarizing were discussed and practiced before the interviewing process continued. During the analysis, meaning units providing thick descriptions were chosen.

In addition, the two interview studies (Study I & IV) described both typical and atypical views - *negative case analysis* - expressed by the participants. Although it is possible that the results could vary depending on the prevailing routines of other child health clinics and parent support programs, this was at least minimized in Study I, where the child health nurses were interviewed from multiple different sites across Sweden. However, Study IV may be limited in its generalizability, since it is only from one parent support program (Triple P), and there is an overrepresentation of university-educated parents.

Validity and reliability. In quantitative research, it is important that the instruments used are both valid and reliable. Validity refers to the degree to which the instrument measures what it is intended to measure, leading to accurate inferences of the findings, while reliability is the degree to which an assessment tool provides consistent and stable results.

All of the measurements used are valid and reliable: an abbreviated version of the Eyberg Child Behavior Inventory [136, 144], Strengths and Difficulties Questionnaire [145], Parenting Sense of Competence Scale [146], laxness and overreactivity in the Parenting Scale [139], and the Depression Anxiety Stress Scales-21 [147, 148]. In addition, the findings were either congruent with previous findings or theoretically sound. For example, although no research has actually analyzed fathers' participation in a parent support program, previous research had surveyed and interviewed fathers to understand why they would not participate [149]. Our results also showed similar findings, but with the actual actions of fathers.

Main Strengths and Limitations Per Article

The main strengths and limitations to each study will be discussed here (please see full articles for a more detailed discussion).

In Study I, the main strength was that the data researched an understudied aspect, the child health nurses' perspective, which shed light on two important themes: nurses gatekeeping and wanting more father involvement. The main limitation was that the interviews were completed in the child health nurses' non-native language (i.e. English). This limitation was minimized, as each child health nurse who agreed to participate was made aware of this potential language issue prior to conducting the interview. Additionally, all child health nurses agreed to participate, despite this potential limitation. Child health nurses were also allowed to speak in their native language (Swedish) if they did not know how to fully express themselves in English. Moreover, the detail that the child health nurses gave during their interviews was deemed by four qualitative researchers to yield sufficient information on the topic.

Study II was a subjective interpretation of a waiting room environment based on semiotic visual analysis. Semiotic visual analysis usually assesses single rather than multiple pictures at the same time, and therefore, a strength of this research was that methodologically, this was the first time this technique was used to assess the manifest and latent meaning of an entire waiting room. Since this could also be a limitation, we attempted to overcome any

biases by using definitions of what constituted a different environment. Additionally, three researchers independently assessed the data, using the standardized definitions, and came to the same overall conclusions on all of the waiting room environments.

In Study III, a main strength is that this is the first study to examine maternal and paternal participation independently, allowing for practitioners to better meet the needs of both parents. The main limitations were the sample sizes and the number of participation factors. The sample sizes were small, especially for fathers ($n = 18$ for those who participated). Additionally, data on all of the participation factors found in the literature were not collected in the present study. Nevertheless, to my knowledge, this is the first study distinguishing between participants and non-participants in parent support programs that looks specifically at *paternal* data.

Study IV was a subjective analysis of parental thoughts on a parent support program in Sweden. While previous research has sought to understand if a non-Swedish based parent support program could be transferred into a Swedish context via an evaluation of that programs effects [150], the main strength of this study was that it is the first study completed in Sweden on the parents' thoughts regarding the appropriateness and use of a parent support program. Knowing this information is beneficial, as parents are not likely to affect changes in their child if they do not enjoy and use the programs information. However, a limitation to this data is that it consisted of only ten parents; therefore, the data could not be aggregated into either mother/father, native/non-native, single-child/multi-child data.

Overall Limitations of these Four Studies

The overall limitation to the four studies that constitute this dissertation is that they do not assess if fathers will actually involve themselves more in their child's health lives if the field removes the paternal barriers. However, as the Swedish government promotes through utilizing policy changes [28, 45], the child health field encourages through their policies [151, 152], and the Parent Support Programs endorse through their rhetoric [149]—both parents should be encouraged and supported to participate equally; therefore, these systems should do everything in their power to try to encourage, promote, and involve both mothers and fathers for the sake of the child.

Discussion

Sweden strives to create a gender equal society, both in the workplace and at home [28, 45]. Within the child health field, policies also exist to support parents regardless of their gender [151, 152]. Additionally, child health professionals, such as physicians, midwives, nurses, psychologists, and mental health practitioners are ideally placed to encourage and engage fathers; therefore, they play important roles in supporting men's transition to fatherhood [50]. Family policies and the child health field should work together to enable and encourage father involvement, especially since it is unlikely that fathers will be involved in childcare if they are not educated, prepared, or included at the beginning of their child's life [47].

Although Sweden is consistently considered to be one of the most gender equal countries in the world [23], Sweden's family policies are limited in their scope of including fathers [28, 34], and both researchers [40, 153], and Swedish government reports [26] claim that gender equality has only been partially realized, commonly citing that fathers are not as involved in childcare as mothers. Although, men are completing more unpaid work than ever before, and women are doing less housework [26], women are still consistently completing more hours of housework and childcare compared to men.

Part of these results may be due to father-friendly family policies being more symbolic, rather than actually encouraging of father involvement [154], especially since fathers have several obstacles to overcome before utilizing those policies [34]. In addition, despite the numerous positive effects fathers have on children's, mother's, and their own health [3, 5], the studies included in this dissertation, as well as in the Swedish child health literature review, further highlight that father involvement is mainly advertised symbolically, rather than trying to actually encourage and promote father involvement in the child health field. This is shown in both the child health professionals' words [155] and actions (Study III), as well as in the built environment [156]. If the child health field wants fathers to be involved to a greater extent, then child health professionals need to make changes to both how they interact with fathers and to how they build their environment. As seen in the aforementioned literature review, not meeting paternal needs is a

systemic issue, encompassing prenatal clinics, labor and birth wards, postnatal clinics, and child health centers, similar to previous findings [157]. As seen in Study III and other studies [111, 149, 158], it also looks like parent support programs are not highly successful at involving fathers or meeting their needs. Child health professionals should work on further encouraging fathers to actively participate in all aspects of family life, including caring for and spending time with their new child [50], as well as with building and strengthening the couple and the coparental relationship. In doing so, greater positive child, mother, and father outcomes can be achieved [159].

Promoting Equal Treatment

For decades, pregnancy-related matters focused primarily on maternal experiences [46]. When paternal experiences were finally brought to the forefront, fathers were seen as *supporters* to mothers, rather than having their *own* needs [46]. This creates a paradox for expectant fathers, where they are fully expected and even encouraged to participate in the pregnancy and delivery of their child, but must do so while hiding their own feelings of anxiety, anger, sadness, and fear, especially if those feelings might upset the mother [160, 161]. But expectant fathers *do* experience psychological, social, emotional, and physical changes during the transition to fatherhood [162], and therefore their need for support and encouragement during pregnancy is as relevant as that given to expectant mothers [65]. In fact, fathers may require even more support than mothers, since they, more than their partners, lack a support network [48]. In addition to that, fathers may also require more support as, according to child health nurses, fathers are not as instinctively able to care for infants, nor as naturally sensitive to infants' needs compared to mothers [7]. However, instead of providing greater levels of support for fathers, child health professionals place a greater emphasis on supporting mothers. This has the logical consequence that mothers may become either solely or at least, more responsible for their child's health, as they become the expert on their child's health and have established relationships with the child health professionals. This illustration results in a real life example of how gender roles are socially constructed [163].

Childbirth and early parenthood has been described by fathers as a vulnerable period; therefore, there is a need to treat fathers sensitively and with respect [82], and for child health professionals to show their confidence in fathers [81, 82]. Although father involvement with the child health field must not be considered to be relative to father involvement with their child in general [94], communicating directly with fathers is essential for ensuring

paternal involvement [96]; therefore, both mothers and fathers need and deserve to be actively invited into the child health field [98].

Benefits to father involvement in the Swedish child health field. One reason expectant fathers should be involved in prenatal care is so that they can actually visualize the baby during the ultrasound, which can help them better connect to their future role as a parent [164]. In fact, having men attend the ultrasound with their partner helps to encourage equality, as now men have access to the female world of pregnancy [165] by being able to feel the fetal movements and listen to their child's heartbeat [166]. Another reason to include expectant fathers in prenatal care is to test them for sexually transmitted infections, which can yield negative health effects not only for the man, but also for the expectant mother and child [167]. A third reason is so that expectant fathers can understand and help plan the prenatal care, as currently, medical information about planning the prenatal care is primarily divulged to expectant mothers [161]. Understanding prenatal care can even prove to be vitally important, as fathers who are more prepared for obstetric emergencies are more likely to save the expectant mother's and child's life [5]. Lastly, expectant fathers also need to be informed about what the transition to fatherhood looks like and to further support their partner [168]. When expectant fathers are not informed, they are then weakly involved in decision-making, weakly attached to their future child [169], and feel more insecure about being able to support their partner [161].

Obstacles to father involvement in Swedish child health. Fathers face another paradox after the child is born, since fathers are expected to be involved in childcare, but mothers typically utilize the parental leave during this time period [103]. During the infants' first year, parents are encouraged to visit the child health centers 11-13 times [95]. That amounts to one visit per month! Since mothers are utilizing the parental leave, typically only the mother can attend the child health check-ups. The consequence of this is that the mother, and not the father, has a chance to form a close relationship to the child health nurse, while at the same time, become an expert on their child's health and development, and on different age-related parenting issues [95, 103], as well as form parenting networks by meeting and socializing with other new mothers. This places new mothers in the primary parenting role, with support from both child health professionals and mothers, while fathers need to continue working, and thus take on a secondary parenting role from the very beginning of their child's life.

In fact, father involvement is limited by the child health centers' routine procedures in no less than four ways. First, the child health centers pose limits to father involvement by mainly being open during normal business

hours [94, 155] and thus limit any working parents' ability to participate. Second, when fathers do come to the child health centers, they see many mothers and few fathers, and therefore fathers might not feel welcome [156, 170]. Third, according to fathers, the child health nurses inadvertently discourage father involvement by limiting conversations, especially during the child's first year, to topics around breastfeeding [94, 155], leading fathers to feel secondary and without their own parenting role [59]. In fact, child health nurses have even directly stated that they see the mother as the primary parent and the father as a secondary parent [7, 44]. Fourth, father involvement may be limited [171] in attending the parenting groups, because they are only held during the infant's first year [103] and typically on weekdays in the early afternoons [172], when fathers are still working. Mothers, on the other hand, who are on parental leave, are better able to and do attend [103, 173], thus further increasing their parental knowledge. Although fathers think of themselves as equally important for their child, they also view the mother as the main parent [94]. This may be because mothers are provided with greater amounts of support, not just from the child health field, but from other parents, the culture, and the society, as well as are encouraged to use parental leave immediately after the child's birth, while fathers do not start taking parental leave until the child is six to nine months old, since, until 2014, only one parent could use parental leave at a time.

Some of these barriers are reduced for parent support programs, such as having sessions in the evenings or weekends, having childcare options, hosting the program in a convenient location, and being taught by a person the parent already knows and respects [174]. Although these logistical barriers are helpful at garnering parental participation, they do not specifically target fathers, as such. Father involvement may be limited by the advertisements used to market to parents, the topics discussed within the program, and the amount of mothers who participate in the program [Study III; 149, 158]. Therefore, fathers may be less willing to attend and participate, since the marketing for and topics discussed do not necessarily appeal to fathers as much as they do to mothers (Study III). Fathers are more willing to participate if they hear about other fathers participating, as well as having the advertisements and other recruiting efforts be specifically directed at them [175]. Two ways to specifically target fathers is to use the term *fathers*, rather than the generic term *parents* [158], and invite them to a male-only, or at least, male-led group [149].

Meeting Paternal Needs via Implementing Father-friendly Policies

To meet paternal needs, father-friendly family policies need to be implemented by both the policy makers and by the front line workers. To understand how father-friendly family policies impact father involvement, it is important to look at both the direct and indirect pathways by which these policies reach their intended goal (e.g. greater levels of father involvement in childcare).

Directly Influential. A top-down perspective could help to explain the direct impact of a policy. However, a complete top-down analysis is beyond the scope of this dissertation, and therefore, only one example is provided.

Sabatier [176] argues that a top-down perspective is best used when policy areas are dominated by one piece of legislation. Since Sweden's parental leave often dominates gender equality debates, it will suffice as an appropriate example of analyzing from a down-down perspective. As has been stated in the introduction, the years 1974, 1995, 2002, and 2008 were all pivotal years regarding Swedish parental leave specifically targeting fathers, often with the result of increasing paternal leave usage. But three main questions still arise: 1) Why do fathers not take an equal amount of parental leave? 2) Why is paternal leave usage only slowly increasing? and 3) Are there policy changes that could occur to further encourage paternal uptake of parental leave, and therefore help to further gender equality?

To help answer these questions, it can be helpful to create a diagram of what the goals of taking parental leave are, as well as the rules associated with taking parental leave. After doing so, a theoretical analysis can be performed.

The goal of Swedish parental leave is two-fold: to encourage both genders (mainly mothers) to join the labor force and to encourage both genders (mainly fathers) to take a greater share of childcare responsibilities. In fact, it can be argued that the primary reason for creating *parental* leave was for mothers to join the workforce [28 p. 73].

Beyond the importance of being employed, there are at least four rules that govern who takes parental leave: 1) parental leave pays parents 80 percent of their salary; 2) the salary limit has a cap; 3) of the 480 parental leave days, 390 days are paid at the 80 percent level; 4) until 2012, only one parent could take parental leave at a time, while after 2012, both parents could take parental leave at the same time, up to 30 days.

Below I argue that these rules create obstacles regarding paternal uptake of parental leave. If these obstacles limit fathers from using parental leave, then this can impact the mother-father-child relationship, as well as place the mother as the primary parent. If the policy encourages mothers to take the first six to nine months of parental leave, without permitting fathers to also take leave during that time period, then she is encouraged, via the parental leave policy, to be the primary parent, as she spends significantly more time with the baby compared to the father (who is typically at work during this time period), and as such, mothers also have access to other parenting resources, such as the child health centers and a greater parenting network (mainly mothers). Thus, the parental leave policy is potentially aiding in shaping gendered parenting, as mothers are encouraged to be the main parent during the child's early life, and they are provided with more resources to become better experts on their child's development. This may affect the whole family system, especially with respect to co-parenting and father-child relationships, as established routines and practices may have already taken hold by the time fathers start to inherit full-time childcare duties via parental leave.

There are at least four ways in which fathers' use of parental leave is limited by the current policy (see Figure 6).

Limit 1: Parental leave only pays up to 80 percent of a person's salary. Some families may struggle with this substantial pay decrease, which could encourage them to continue working. Since men historically and currently still perceive their roles as breadwinners, they (and indeed their whole family) may put more pressure on the men to continue working. Some companies have tried to encourage parental leave by offering parents an additional ten percent (i.e. for a total of 90 percent of their normal salary). Either way, families may need to rely on receiving their full salary, especially if they have adjusted their lifestyle to their current salaries and cannot afford to take a reduction in pay due to taking parental leave; therefore, fathers are more likely to continue working compared to their partners, because their 20 percent normally equates to more family money lost than if their partners took parental leave, as fathers, on the whole, earn more than mothers [26, 177].

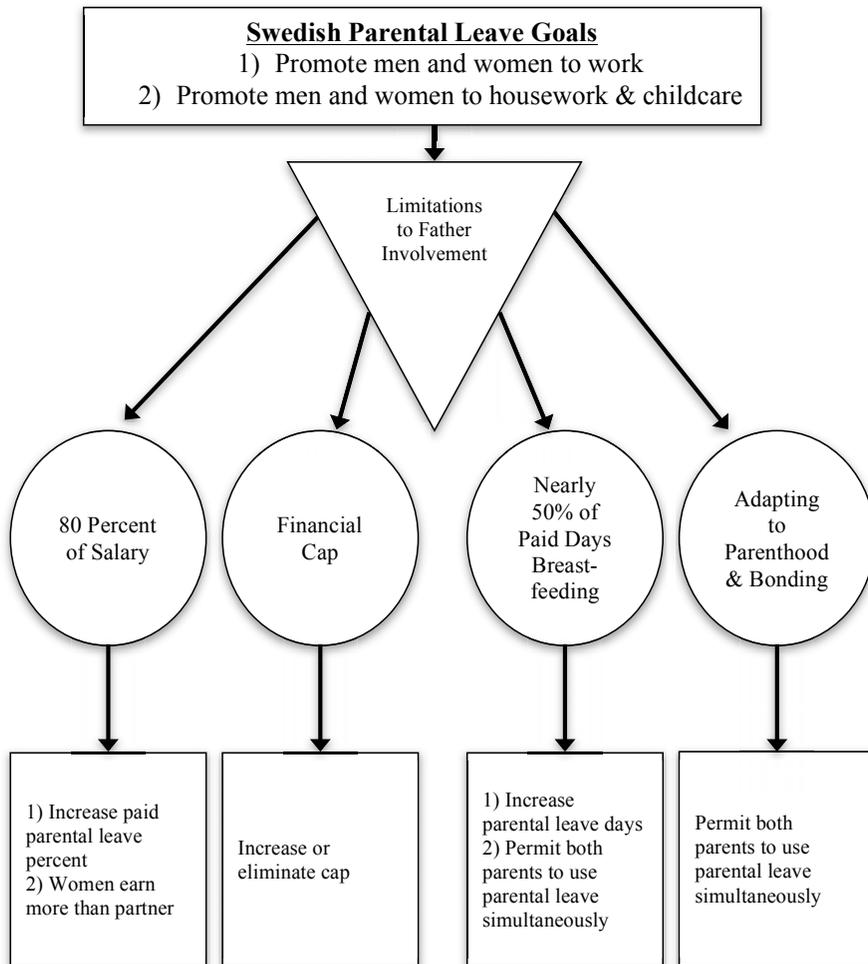


Figure 6: Swedish parental leave and its limitations and solutions to paternal uptake.

Limit 2: A similar, but disparate flaw in the parental leave policy is placing a cap on the amount of money parents can receive when taking parental leave. A family can maximize their income if the parent who earns more continues working. For example, even if both parents cap out (earn more than around \$53,000 annually), the family is still financially better off if the parent earning more money continues working, while the parent making less money takes parental leave. Since fathers are more likely to earn more than their partners, it again makes financial sense for fathers to continue working and thus not use parental leave.

Limit 3: Part A. Only 390 days out of the 480 parental leave days are paid at 80 percent. For these last 90 days, the financial rates drop significantly

(around \$26-\$54 per day); therefore there is a huge financial difference in parental leave benefits between the first 390 days and the last 90 days. **Part B.** Once breaking down the financial part of the parental leave days, parents are left with around 13 months to split their parental leave equally, as the Swedish government rhetorically promotes them to do. At the same time, breastfeeding is strongly promoted in Sweden, and there is substantial evidence to support these breastfeeding initiatives, as they directly benefit both the child and the mother in several ways, such as an increased immune system and improvements in children's cognitive and academic abilities. Because of the benefits of breastfeeding, the World Health Organization states that the mother should breastfeed for at least the first 6 months of life, and suggests benefits up to the first year of life. The majority of Swedish parents follow this guideline, with 65 percent of parents solely providing their child with breastmilk (either through the breast or from pumping) at six months [103, 178], and about half of the mothers in Sweden continue providing solely breastmilk past 9 months [179]. This translates to mothers, for biological reasons, being encouraged to use a significant portion of the parental leave days (at 80 percent pay) before fathers start using parental leave; thus, mothers take the primary parenting role from the beginning of the newborns life and by association, fathers can more easily become secondary parents.

Limit 4: **Part A.** Many parents talk about the struggles of adapting to parenthood, as the first year of a child's life is a transitional period, where parents are often struggling to find their new roles and responsibilities. Each child is undoubtedly different, and therefore, parents may struggle more with raising their child at one time point than at another; therefore it could benefit sleepy, exhausted, and stressed parents to have both parents at home via permitting simultaneous use of parental leave benefits. This would help in raising the child, while providing relief to the other parent. But also, this could improve the couples' relationship, as their relationship is more likely to be at odds when one or both parents are lacking sleep, irritable and stressed, which could lead to further destruction of their co-parenting relationship and negatively affecting child outcomes. **Part B.** Connecting to this is the issue of breastfeeding. Mothers are strongly encouraged to be the first parent to use parental leave, so that they have time to recover from giving birth and to breastfeed. Since historically only one parent could utilize parental leave at a time, aside from the first 10 working days after the infant is born, fathers can miss out on bonding with their newborn in the same way as mothers, as they need to continue working. This means that Sweden's parental leave policy, from nearly the moment of birth, places the mother as the primary parent and the father as a secondary parent. Although fathers may and still do bond with their young child, it is reasonable to assume that spending more time with the infant would allow for a deeper

relationship to occur (e.g. understanding the child's needs to a greater extent, developing daily routines and practices). Since fathers do not (and nearly always *cannot*) start taking parental leave until the mother's leave is over, they may already start to feel more distant to their child and the new family structure compared to the mother. For example, mothers may already have started to create common practices and routines for the child, which may create tensions between parents once fathers start taking parental leave, as fathers may want to have different practices and routines for the child.

Conclusions of the Top-down Analysis. Swedish parental leave does not yet encourage mothers and fathers to parent equally. Although parental leave has been continuously updated, reregulated, and modernized, it still fails in four unique ways to encourage paternal uptake, while at the same time, encourages maternal uptake, especially when the infant is a newborn. The parental leave policy in its current form thus further promotes mothers to take the lion's share of paid parental leave. This can have the consequence of mothers becoming and possibly staying the primary parent, as fathers are not provided with an equal chance to parent their infant, nor to fully participate in the restructuring of the family, at least not to the same extent as compared to parents who could take parental leave together.

Starting in 2012, both parents could take parental leave at the same time, up to 30 days [26]. Two main limitations to this are that: 1) parents still need to notify their work in advance of actually using that parental leave (unlike the amount of advanced warning that they need to inform work if they have a sick child). This advanced notice does not help parents who may be struggling on a particular day and needing the other parent; and 2) parents may not be able to financially afford to use parental leave at the same time. Nevertheless, it will be substantially important to follow if and when parents utilize the newly established 30 simultaneous parental leave days to see if this increases paternal usage, and to check for other outcomes, such as improved family and marital relations.

Indirectly Influential. While a top-down analysis looks at potential problems in implementing the policy, starting with the makers of the policy and the policy itself, a bottom-up perspective looks at the front line workers, also referred to as street-level bureaucrats, to see how they interpret and implement the policy—termed indirect influence [133].

Although front line workers are not the sole facilitator or denier of policy outcomes, they do play an important and crucial role in the delivery of public policies (i.e. the implementation), and therefore their *attitudes* and *actions* are of importance to policy makers. However, there are dynamic

interactions where front line workers both make and are controlled by various rules within their workplace. For example, they are often torn between the legislative demands, their managers and clients, and their high workload [180]. This has led implementation researchers to note that front line workers typically fall into one of three categories: as cogs within a system, as experts lacking resources, or as gatekeepers [181].

Sometimes front line workers are viewed as *cogs within a system*. That is, they are trying to help clients, while wading through red tape [181]. In order to manage their workload, they may develop coping mechanisms, such as rationing services, discriminating against those who receive services, and rationalizing program objectives (Lipsky 1980). This may lead to front line workers providing inconsistent treatment to similar clients and/or routinized treatment to dissimilar clients, which then distort the purpose of the original policy. For example, when being discharged from the postnatal clinics, midwives can discuss with parents how their birth went and what to expect after leaving the clinics. Midwives, though, can be seen as rationing these services, and in effect, providing preferential treatment to mothers [84].

Front line workers can also be seen as *experts* and therefore knowledgeable about how to help clients. Despite this, they may still fail to deliver policy goals, because they lack resources, the power to execute change, and/or the technical abilities to complete those goals. Therefore, an assessment of their needs, as well as their current capabilities should be established in order to provide them with needed support. For example, I interviewed child health nurses on their views of involving fathers [155]. While they thought fathers were important, some child health nurses did not know how to meet paternal needs, while others noted barriers that they ran into when trying to further involve fathers; thus, fathers continue to be excluded, albeit for reasons beyond the child health nurses control.

Front line workers can further be viewed as *gatekeepers*, by possessing a right to “decide” what the client needs. Therefore, they may either encourage “positive discrimination,” where they assist those people they consider the most deserving or most in need of their services, or they may discriminate against those they do not want to provide services to, such as hard-to-handle clients, demanding clients, and those they do not like for other reasons. Managers and the organization may have accountability and formal directives in place in order to suppress these types of discriminations. However, these only have had limited influence over front line workers, in part because they often work alone; that is, without managers overseeing their actions. For example, positive discrimination can be seen when child health nurses are asked about how parents parent. Massoudi, Wickberg [7]

exposed that two-thirds of child health nurses believe mothers are instinctively better at caring for infants compared to fathers, suggesting a positive discrimination towards mothers and unconscious gatekeeping against fathers.

Moving Beyond Lipsky

In taking a bottom-up perspective, Lipsky [133] considered front line workers, like child health professionals, to be indispensable actors in the implementation of public policies. Although this is absolutely true, I posit that many other domains also influence the implementation of public policies. For example, maternal gatekeeping, the workplace, the child health field's hours of operation, and the built environment all dynamically influence the outcomes of these father-friendly goals.

Mothers as gatekeepers. While front line workers, like physicians, midwives, and nurses, are known for being gatekeepers, and therefore potentially limiting the implementation of the policy [182], mothers may also limit the implementation of father-friendly policies, often through subtle and implicit negotiations [154]. For example, mothers can control who uses parental leave [154, 183], which may help to explain why fathers feel less satisfied than mothers, when mothers take a longer amount of parental leave [30]. In fact, mothers in Sweden may feel obligated to gatekeep, as mothers who relinquish their parenting role in lieu of work too early are viewed negatively by their colleagues and society [154, 184].

The workplace: The culture of the workplace is a substantial actor in implementing father-friendly policies [154, 185-187]. This result may partially be explained by the fact that more fathers tend to work in the private sector, while more mothers tend to work in the public sector [26]. While fathers may have more barriers compared to mothers in taking parental leave [183], this is especially true from within the private sector. Four reasons why the private workplace may limit fathers from taking parental leave are that fathers: 1) are less likely to receive information about their parental rights; 2) are less likely to receive wage-replacement (i.e. receiving 90 percent or 100 percent of their pay while utilizing parental leave [while the public sector is more likely to offer this benefit]); 3) may be burdened by the income ceiling for payment benefits; and 4) work in more male dominated environments and therefore, there is a greater emphasis on continuing to work [40].

The hours of operation. Wells et al. [155] posits that fathers may be limited in their ability to visit the child health centers, because of their hours of operation. This has the implication that the child health nurse does not inform fathers about their child's health or about resolving various parenting problems, since fathers cannot visit. Although some child health nurses have talked about the need to book appointments for working parents in the evenings or on the weekends, child health centers have failed to readjust their overall hours of operation, thus limiting father participation. Not only have child health nurses realized this limitation, but mothers [49] and fathers [48] have also voiced their concerns over the child health centers hours of operation. Other research has also discussed this issue [94, 188]

The built environment. The built environment affects patient perceptions of care [106], and their quality of care [107]. As emphasized in Wells et al. [156], 75 percent of the Swedish child health center waiting rooms were not inclusive of fathers. However, when the environments were inclusive of fathers, or at least did not place their emphasis on the mother, then fathers were more likely to read information and play with their child. These types of environments can lead to fathers being more knowledgeable about different local events and encourage father-child bonding through play. Other research has also shown that the built environment affects who uses that space [189, 190]; therefore, the design and layout of the waiting rooms, offices, hallways, and atriums send messages to parents that can influence who utilizes that space and how they utilize it.

Rahmqvist et al. [174] also looked at the built environment, albeit in a non-gendered format. In this study parents stated that they appreciated having the intervention take place at their child's preschool, as it was both in a convenient location and a familiar place that they trusted. In addition, some of the preschools had free childcare options for parents, which also improved the built environment, especially when both parents wanted to participate in the parent support program.

Therefore, while front line workers can and do influence the implementation of public and workplace policies, other facets also affect policy implementation. These barriers to father involvement limit the Swedish goals of achieving gender equality, as fathers may have a harder time taking parental leave and participating in child health services. These limitations on fathers not only affect the gender dynamics within the household, as the mother subsequently takes on a larger burden of the parenting responsibilities, but the consequences also reverberate into other parent and child outcomes, the co-parenting relationship, and the mothers' flexibility of participating in the workforce.

Conclusions

This dissertation explored the factors that influence early father involvement within the Swedish child health field. Both the child health nurses and the parent support program designed their parental interactions around maternal more than paternal needs. For example, the child health nurses were seen as gatekeepers who openly encouraged maternal, but not paternal involvement, while the parent support program focused on providing support to parents with child behavior problems; an issue linked to maternal, but not paternal needs, as fathers wanted support regarding their child's emotional problems. However, those parents who participated in the parent support program, overall, enjoyed the program. In addition to the personnel, the built environment was also seen as an important construct. At the child health centers, the built environment was aimed more at mothers and children than at fathers, while the built environment of the preschools was seen as welcoming and beneficial according to the participants in the parent support program. Overall, Swedish family policies, especially parental leave, as well as Swedish child health professionals provide inadequate support to fathers. Fathers can and do interpret this lack of support as not needing to be as involved in childcare as mothers, thus contributing to a gendered society. Since Sweden strives to create gender equal policies, and more importantly, because involved fathers improve outcomes for children, mothers, and themselves, changes need to be made within the child health field, as well as within public policies, to further promote gender equality.

Future Research

Future research should focus on four broad, albeit not mutually exclusive, areas:

- 1) Ways to change child health professionals' views and actions regarding father involvement.
- 2) Conducting qualitative and quantitative research on child health professionals, especially in relation to any implementation difficulties of willingness to increase paternal involvement.
- 3) Other ways that work on increasing father involvement within the child health field.
- 4) Learning more about child, mother, and father outcomes derived from increasing paternal involvement within the child health field, especially after controlling for other known influences, such as maternal involvement.

Public Policy & Clinical Implications

Although Sweden has made numerous strides to create gender equality, both in the workplace and at home, especially through public policies, fathers still do not take-up household and childcare duties to the same extent as mothers [26]. The paradox is that in Sweden, fathers are expected to take more control over childrearing responsibilities, while at the same time, not receiving the same amount of support as mothers, and therefore not having their parental needs met, leading to several consequences, such as mothers continuing to complete more childcare work.

Enacting laws does shift people's behavior; however, it is slow and not fully effective [191]. In fact, as Wells and Sarkadi [34] argue that simply having father-friendly policies does not, in and of itself, lead to father-friendly child-rearing practices, and therefore, Sweden still seeks out ways to increase paternal uptake of parental leave [45]. Implementing father-friendly policies would occur faster if there were greater support from those who work with parents, such as front-line workers, as well as from multiple other arenas, such as from society, the culture, the workplace, and Sweden's public policies.

At the same time, if the child health field aims to include both genders, then their gender bias needs to be acknowledged, and methods for involving fathers must be improved. Child health professionals working with parenting issues need to think about how they will recruit and retain fathers, as well as provide them with father-specific advice. That is, in order to increase father involvement, programs should not simply adopt the same methodologies and strategies they use to gain maternal involvement, but rather, they should employ strategies and techniques that are central to paternal needs. When programs start targeting and marketing to fathers, fathers will at least be given an equal opportunity to participate.

To further highlight the importance of every member of the family, and to align with the different parenting structures (i.e. same-sex parents, adoptive parents, step-parents), I propose that the names of university departments and services be revisited to become more inclusive of all members of all possible family types. One example is my own alma mater, the Department

of Women's and Children's Health at Uppsala University. The department conducts research and health care within gynecology, reproductive medicine, obstetrics, perinatal medicine, and pediatrics. Within many of these fields, all members of the family are included, something that is not mirrored in the current name. For example, fathers are also seen as important figures in the neonatal, perinatal, and pediatrics fields. The women's and children's health title is not appropriate, both symbolically and literally, as the title implies that medical services (and research) are only provided to pregnant women, biological mothers, and children. All parents, regardless of their biological connectedness, including non-biological same-sex couples, adoptive, and step-parents, are an integral part of their child's life, from pregnancy onward, in both direct and indirect ways, and therefore deserve a full seat at the table. The rights of all parents are inhibited when they are not included, and therefore, one change to acknowledge their importance is to change the name of my, and other similar departments.

Practical Implications

- Future child health professionals should receive information about fathers while earning their degrees
- Child health professionals should recognize the important contributions fathers have to the family
- Child health professionals should explain to both mothers and fathers about the fathers' important role
- Child health professionals should reconsider their office hours
- The built environment should equally represent mothers, fathers, and children, as well as different types of families
- Child health professionals should welcome and actively encourage father involvement
- Child health professionals should deliberately focus on fathers and advocate for the father when they are not present
- A checklist of topics to discuss with fathers should be created
- The child health field should re-organize its policies, on-going trainings, and professional standards to be more father-inclusive
- Targeting fathers during transition times is helpful at promoting and encourage father involvement (e.g. ultrasound visit, prenatal parent education courses, after the birth of the child)
- The earlier the child health professional forms a relationship with the father, the better
- The child health field should work on providing greater amounts of stability by having the same professionals work with the family from pregnancy through preschool-age

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