Father involvement in perinatal and paediatric care: evidence, barriers and challenges

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Recibido para publicación: 25-02-2026. Versión corregida: 25-02-2026. Aprobado para publicación: 25-02-2026.

Modelo de citación:

Pérez Anaya O., Macías Lara L.M., Orozco Morales L. **Father involvement in perinatal and paediatric care: evidence, barriers and challenges**. Arch Med (Manizales). 2026;26(1). https://doi.org/10.30554/archmed.26.1.5607.2026

Dear Editor,

For decades, perinatal and paediatric care has been based on a model focused almost exclusively on the mother and the mother-child dyad. While this approach has been fundamental to improving maternal and child health indicators, it has also inadvertently contributed to the systematic exclusion of fathers from the processes of care, support and decision-making surrounding birth and early childhood. In a context where shared parental responsibility is recognized as a key determinant of family well-being, it is pertinent to critically question this model and review fatherhood in health services.

Paternal involvement is no longer understood solely as financial provision but as a multidimensional construct that includes direct commitment, emotional accessibility, and responsibility for child welfare [1,2]. The accumulated evidence consistently shows that greater father involvement is associated with better outcomes in children's cognitive, socio-emotional, and behavioral development, as well as indirect benefits in maternal mental health and the quality of the couple's relationship [3,4]. These positive effects are observed even in the context of chronic childhood illness and

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situations of psychosocial vulnerability, reinforcing the importance of the father as an active participant in family health.

Despite these findings, many men's experiences during pregnancy, childbirth, and the postpartum period continue to be marked by ambiguity and narrow margins of participation, as various qualitative studies have documented how fathers, even when invited to be present, tend to occupy a secondary role, perceived as companions, helpers, or even spectators within health services [5,6]. This exclusion is often implicitly manifested through clinical practices, professional language, and care devices designed primarily for women, in which the emotional, informational, and educational needs of fathers are neglected.

From a sociocultural perspective, this situation is linked to the tensions inherent in contemporary fatherhood, in which the figure of the 'present father' coexists with traditional norms of masculinity that privilege self-sufficiency, emotional control, and the role of economic provider [7,8]. In this sense, many men experience pregnancy and childbirth as 'disembodied' processes, lacking biological markers that facilitate the transition to fatherhood, which can lead to delayed or fragmented involvement [8]. Institutional structures do not always create conditions necessary for meaningful participation.

Barriers to paternal inclusion are not homogeneous and are modulated by cultural, normative, and public policy factors, as evidenced by parental leave policies, the organization of paid work, and gender expectations, which directly influence the time and quality of paternal participation in various regions [6,9]. Even in contexts where paternity leave exists, it may be insufficient to promote real shared responsibility for caregiving, perpetuating the idea that the father's involvement is optional or secondary.

Early father involvement is consistently associated with specific benefits in children's social-emotional development, as father-child interactions, characterized by differentiated play styles, greater exploratory stimulation, and risk regulation, complement maternal care and promote early social and emotional skills [4,10]. Similarly, warmth, emotional sensitivity, and active participation by fathers are linked to more secure attachment bonds and better emotional regulation in childhood [11].

In recent years, some experiences have begun to highlight more inclusive alternatives, such as comprehensive birth care models, antenatal preparation programs aimed at men, and fatherhood groups, which have shown promising results in terms of satisfaction, strengthening the father-child bond, and shared responsibility for care [12,13]. These spaces allow men to express doubts, emotions, and fears, as well as acquire practical skills

and psycho-emotional support, aspects that have traditionally been absent from perinatal care.

The implementation of these strategies remains limited and depends largely on the training and practices of health professionals, particularly the role played by midwives, nurses, and medical staff in the inclusion or exclusion of fathers through clinical communication, role assignment, and recognition of their presence as legitimate in care processes. This highlights that moving towards more equitable models requires transformations that transcend regulatory changes and incorporate sustained cultural changes in health systems [5,6].

In this context, it is essential to rethink fatherhood as a central dimension of family health and not as an accessory element of maternal care. This implies recognizing the father as a subject of care and advancing the design of policies, clinical practices, and training devices aimed at promoting active, informed, and emotionally supported participation, in line with the available scientific evidence on the benefits of parental co-responsibility for mothers, children, and families.

The question is no longer whether fathers should be included in perinatal and pediatric care, but how to ensure that this inclusion is effective, sustained, and meaningful, a step that represents a challenge for health systems and, at the same time, an opportunity to move towards more comprehensive and humane models of care that are consistent with contemporary family realities.

Conflict of interest: The authors declare no conflicts of interest.

Funding: Self-funded.

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