MANCHESTER
1824
The University of Manchester

The University of Manchester Research

Fathers' roles matter too: an ethnographic study examining fathers' roles and the influences on their roles during labour and birth

Document Version
Accepted author manuscript

Link to publication record in Manchester Research Explorer

Citation for published version (APA):
Longworth, M., Kirk, S., & Furber, C. (2021). Fathers' roles matter too: an ethnographic study examining fathers' roles and the influences on their roles during labour and birth. *Midwifery*, Article 102857.

Published in:
Midwifery

Citing this paper
Please note that where the full-text provided on Manchester Research Explorer is the Author Accepted Manuscript or Proof version this may differ from the final Published version. If citing, it is advised that you check and use the publisher's definitive version.

General rights
Copyright and moral rights for the publications made accessible in the Research Explorer are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

Takedown policy
If you believe that this document breaches copyright please refer to the University of Manchester's Takedown Procedures [http://man.ac.uk/04Y6Bo] or contact uml.scholarlycommunications@manchester.ac.uk providing relevant details, so we can investigate your claim.

Download date:02. Dec. 2023

Fathers' roles matter too: an ethnographic study examining fathers' roles and the influences on their roles during labour and birth

Mary K. Longworth, PhD[1], Susan Kirk, PhD[2], Christine Furber, PhD[2]

[1] School of Health Sciences, Bangor University

[2] School of Health Sciences, University of Manchester

Corresponding Author: Dr Mary K. Longworth, PhD, School of Health Sciences, Bangor University

Abstract:

Background: A narrative review of the literature on fathers' involvement during labour and birth found that two themes were identified: the roles adopted by fathers, and the barriers and facilitators to their involvement during labour and birth.

Aims of the research study: The aims of this study were to understand why fathers adopted a particular role, how much variation there was in fathers' roles and to discover the influences on the roles they adopted during labour and birth.

Methodology and methods: The study adopted an ethnographic approach. Fathers accompanying a woman during labour were recruited via the labour ward and midwifery-led unit of one hospital. Data were collected using non-participant observation and in-depth interviews. A staged approach to ethnographic analysis was used, and the patterns of thought and action repeated in various situations, with different participants, were explored.

Results: While fathers appeared to adopt a variety of roles, their overarching role was 'protecting' the woman. Fathers adopted different roles in order to achieve their goal of protecting. While couples had expectations of fathers' roles, they did not always discuss them prior to labour and birth. A number of influences on fathers' roles were identified, including midwives, which appeared to change their roles or how they were enacted.

Discussion: This study has found that fathers adopted a number of roles during labour and birth; however, these roles were not static and fixed, but were dynamic and changed in response to the changing context of the labour room during the course of labour.

Conclusion: A number of recommendations for practice, research and policy have been outlined, which could contribute to encouraging fathers' role adoption during labour and birth. In practice, this study has the potential to initiate discussions on strategies that can be used by midwives to enhance fathers' roles during labour and birth.

Introduction and background

In most Western societies fathers are expected to have an active role in labour and birth; However, Cross-cultural studies indicate that in 60% of cultures, fathers are not always allowed to attend the birth of their child (Behruzi et al, 2013). In 40% of cultures fathers are permitted to attend but may only be allowed to have a minimal role (Hewlett & Macfarlan, 2010). Indeed in some African cultures, women prefer the company of other women rather than their partners (Madi et al., 1999.

In the United Kingdom (UK), fathers' involvement during labour and birth has increased over the last 40 years, with evidence indicating better outcomes for women and babies with reductions in analgesia and caesarean section rates and greater likelihood of a normal birth reported (Chan & Paterson-Brown, 2002; Gungor & Beji, 2007; Hodnett, et al 2011; Ip, 2000; Somers-Smith, 1999). Father's presence has been found to deepen the relationship between couples, and to be an important part of the process of becoming a father (Logsdon *et al.*, 1994; Vehviläinen-Julkunen & Liukkonen, 1998; Lwanga et al 2017) and associated with closer infant-father relationships (Brandao & Figueiredo, 2012; Grossmann *et al.*, 2002).

Research suggests that fathers adopt passive or active roles during labour and birth. The more passive role of observer or witness was found to be adopted when fathers viewed themselves principally as companions, providing emotional and moral support (Chapman, 1992; Chandler and Field, 1997; Johnson, 2002). Studies suggest that fathers may not want to adopt an active coaching role, preferring to 'sit back and watch' (Chandler & Field, 1997; Chapman, 1992; Johnson, 2002; Kunjappy-Clifton, 2008; Longworth & Kingdon, 2011). However, other studies have identified that fathers may adopt active roles during labour which vary from providing practical and psychological support to acting as an advocate for their partner (Backstrom & Hertfelt Wahn, 2011; Chapman, 1992; Gungor & Beji, 2007; Lindgren & Erlandsson, 2011; Nichols, 1993; Sansiriphun et al., 2015; Sapkota, Kobayashi, & Takase, 2012; Steen et al., 2012; Kuliukas et al., 2014). A limited number of studies have examined fathers' involvement in decision making during labour (Dejoy, 2011; Martin, 2003; Poh et al., 2014). A number of facilitators and barriers to fathers' involvement during labour and birth are identified in the literature. The facilitators included fathers' attendance at antenatal education classes (Fletcher et al., 2004; Kao et al., 2004; Longworth & Kingdon, 2011; Wockel et al., 2007; Roberts & Spiby, 2019), support from midwives in accentuating fathers' roles (Backstrom & Hertfelt Wahn, 2011; Hildingsson et al., 2011; Ledenfors, 2016) and the use of technology such as the cardiotocograph (CTG) monitor (Williams & Umberson, 1999). The barriers included poor communication with health care professionals (Dellmann, 2004; Eggermont et al., 2016; Messner,

2010; Sengane & Nolte, 2012) and the use of medication during labour (Waldenstrom, 1999; Williams & Umberson, 1999).

While the literature has identified the different active and passive roles that fathers adopt during labour and birth, these studies do not explain why fathers adopted a particular role, if there was any variation in performing this role depending on the context,. The aims of this study were to understand why fathers in the UK adopted a particular role, how much variation there was in fathers' roles and to discover the influences on the roles they adopted during labour and birth.

Methods

To understand the roles fathers adopt and the influences on their roles, a qualitative approach was the most appropriate, as it seeks to answer questions about how or why a particular phenomenon occurs (Creswell, 2013). an ethnographic approach was utilised as it was important to study human interactions in the context of a culture, so as to uncover its rules, values and norms (Hammersley & Atkinson, 2007). Ethnography allowed ML to study participants' interactions in the labour room through observations and then to further explore their perceptions and interactions using interviews in order to gain greater understanding of the labour room context (Reeves *et al*., 2008). The ethnographic approach chosen was focused, as the study concentrated on fathers' roles during labour and birth. Focused ethnography is typified by a specific research question, short or even no field visits and a researcher with background knowledge of the cultural group (Cruz & Higginbottom 2013). In this study, ML is an academic with a background in midwifery. In the field, therefore, she met both insider and outsider roles and found herself at different points along the continuum at different times. Through reflexive positionality, the first author examined how her social position and personal values and beliefs might affect her data collection and analysis of the data.

Sampling and recruitment

A maternity service in the UK which provided obstetric-led and midwifery-led maternity services was the setting.

A range of fathers were purposively selected to obtain variation in age, numbers of existing children, or participants from different ethnic groups. Participants were recruited into the study during fixed data collection periods on the labour ward until data saturation occurred.

The inclusion criteria were fathers who were assumed to be the biological parent of the fetus, who intended to accompany the woman throughout labour and birth,and conversed in English with the woman. The exclusion criteria were fathers or women under the age of 18, fathers in families where

there were safeguarding issues, and fathers whose partner was carrying a fetus with a congenital impairment or unlikely to be alive at birth.

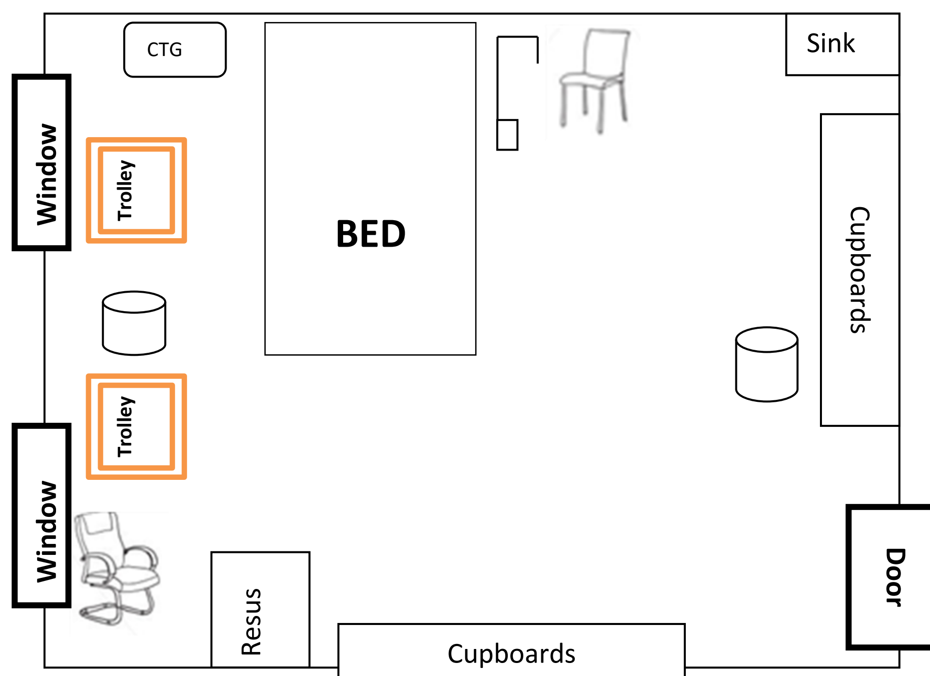
Couples who met the inclusion criteria were provided with study flyers y from 32 weeks of gestation by the community midwives. During data generation periods, potential participants were identified from either labour ward or MLU by the senior midwife, in consultation with ML to ensure that they met the inclusion criteria and to enable purposive sampling. If there were several couples who met the inclusion criteria, then MLs decision on who to approach was based on ensuring variation in the sample in terms of participants 'characteristics. This decision was based on aiming to include different ethnic backgrounds and women receiving different models of care in the sample.

ML asked the midwife's permission for her to observe the couple in the labour room during labour and birth. Once permission was gained, the midwife provided the couple with verbal information about the study and a participant information sheet (PIS). each couple had at least 30 minutes to decide whether they were interested in participating. Couples who were interested, met with ML for further information. If they agreed to participate, written consent was obtained prior to the observations.

Data collection

Data collection included observations and interviews. The aim of the observations was to observe the interactions and activities of the father whilst he accompanied the woman during labour and birth. It included those interactions between the father and the woman, the father and the midwife and/or doctor, and the father and couples' relatives. ML maintained a discreet distance between the participants and herself, and out of the main line of view, so as not to interfere with events (Figure 1). ML focused on observing and recording fathers' roles in supporting women, as well as what appeared to be influencing the roles they adopted. A structured schedule was not used to guide and record the observations. ML made detailed written field notes recording the behaviours, actions and interactions of the participants in the labour room. In addition, ML audio-recorded her observations using an encrypted digital audio recording device, ifollowing each observation period.

Figure 1: Floor plan of a labour room on labour ward



ML maintained a discreet distance between the participants, wherever possible and sat out of the main line of view of the participants. To minimise participant reactivity (Waltz et al., 2016), ML limited her observations by spending intervals of time looking away, so that participants did not feel they were being constantly watched. Each observation was no longer than three hours before having a break, unless ML was asked by the woman, midwife or the father to leave at any point before this. The total length of observations ranged from 2 to 9 hours 15 minutes (including breaks). Permission to remain during labour and birth was only renegotiated once, when the woman requested that ML leave during her vaginal examination. .

Within six weeks following the birth, in-depth, face-to-face, semi-structured interviews were conducted with 12 couples in their own home. Before the interviews began, ML requested to interview the couples separately if circumstances allowed. In most cases the father and the woman were interviewed separately; however, three couples were interviewed jointly for part or all of the time due to circumstances related to care of the newborn or other children in the house. A topic guide, one for the father (Table 1) and one for the woman, was used to explore feelings, beliefs and values about the participants' experiences (Creswell, 2013). All interviews were digitally recorded.

Data Analysis

In order to ensure robustness of the data analysis process, Fetterman's (2010) phased approach to ethnographic analysis and interpretation guided the development of the analysis. This started after

the first observations and proceeded throughout the data generation and interpretation process. The field notes and digital recordings from the observations were transcribed into one document and the interactions and activities from the observation findings were used to inform the interviews.

After listening to the recordings, they were transcribed verbatim and uploaded to NVivo for data coding. Throughout analysis, transcripts were discussed with the co-authors to ensure consistency and rigour. This included data interpretation and the development of codes, subthemes and themes from both the observational and interview data in order to understand the participants' actions and activities and to try to understand their perspectives (Fetterman, 2010).

The observations and interviews were analysed separately, exploring patterns of thoughts and actions within the data sets, repeated in various situations and with different participants. After further analysis of the observations and interviews, links were made between the codes through NVivo and gradually a number of subthemes arose. As analysis progressed the subthemes from the interviews were gradually merged with those of the observations and associations between the two were identified (Ritchie *et al.,* 2013). The meanings of the subthemes from the observations and interviews were then identified in terms of either fathers' roles or the influences on fathers' roles during labour.

Ethical Issues

Ethical approval was obtained from the University Ethics Committee and the Health Board Ethics Committee. Before the observations and interviews commenced, written consent was obtained after providing each couple with verbal and written information (Green & Thorogood, 2013). To protect anonymity, participants were assigned pseudonyms and staff were unnamed and subtle details about them were altered (O'Leary, 2013). Steps were planned to manage any distress or safeguarding issues that may have occurred during the observations and interviews.

Rigour

Rigour was enhanced through reflexivity where ML reflected on her personal position and her influence on the research question, methods and findings. She recognised that her presence may have influenced the behaviour of the couples, particularly the fathers and the staff, and how this may have prevented her from observing all dimensions of the experience. Triangulation was used in the study through different data-collection methods, observations and interviews, to evaluate the extent to which all evidence converges. Triangulation was also used through consulting different researchers to provide multiple perspectives (Brender 2006) when the transcriptions were read by the co -authors. To ensure robustness of the data analysis, the analysis process was conducted

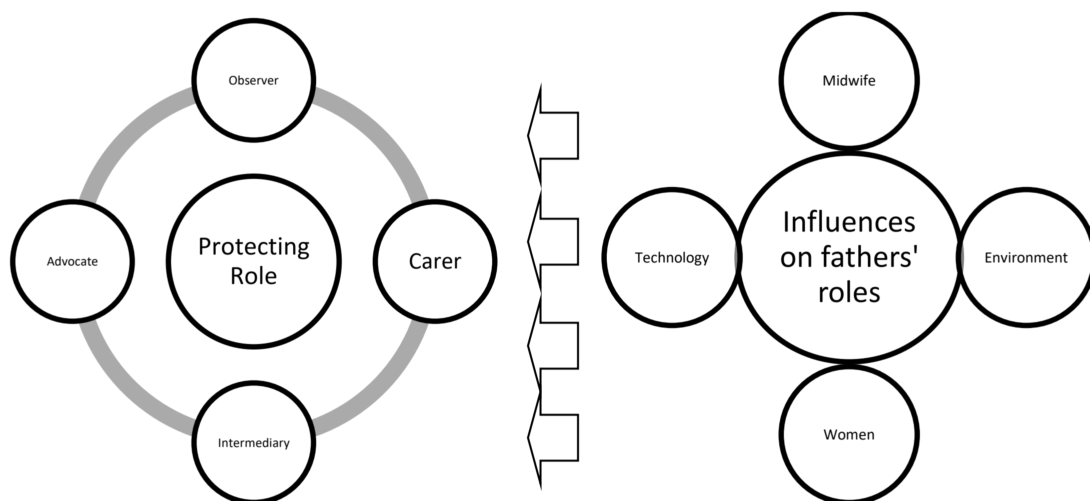
transparently and systematically and was enhanced by Fetterman's (2010) phased approach to ethnographic analysis and interpretation. Rigour was further enhanced with the use of the software package NVivo.

Findings

Nineteen couples were approached to participate. Four couples declined, and a further couple consented to participate, but subsequently this woman's labour did not establish. Fourteen couples (28 participants) were observed. Only twelve couples were interviewed after the birth; one couple declined without a reason and the father of the other couple was working away from home.

The participants' ages ranged from 20 to 59 years. The ethnic origin for the majority of participants was White British. There was variation in length of time together, whether couples were married or cohabiting and how the number of previous children (Table 2 supplementary files). The data from the observations and interviews suggested that fathers adopted different roles in order to achieve their goal of 'protecting' the woman, and that these roles were not static but were adopted in response to the dynamic nature of the context within which labour and birth occurred (Figure 2) . There were a number of influences which appeared to change fathers' roles or how they were enacted.

Figure 2: Fathers' roles and the influences on their roles



Fathers' roles

The overarching goal that arose was fathers' role of 'protecting' the woman. In this study the term 'protecting' was used to convey fathers' aim of caring and watching over the woman to ensure her needs and wishes are met and respected, as fathers perceived that a woman in labour is vulnerable Fathers appeared to adopt different roles in order to achieve their goal of protecting the woman, and these included observer, carer, intermediary, and advocate.

Observer role

All fathers appeared to be observers at some stage during labour and birth, but would move from an observer role to different roles depending on contextual triggers. There appeared to be two different types of observer roles which fathers adopted: passive and active roles.

Passive observers maintained their goal of protecting the woman but were not fully focused on the individuals and activities within the environment, and did not engage with the context. However, they were still a part of the labour room context and were subject to its influences. This role appeared to manifest as distancing, when fathers were disengaged emotionally or physically Mick appeared disinterested and distant focusing on his own thoughts, and was distracted with his personal technology.

> *13.30 Mick was sat a couple of metres away from Jane, at the end of the bed on Jane's right facing Jane and said very little. He was listening to music with one headphone in his ear, looking most of the time at his MP3 player rather than Jane.* [Obs. 3 Mick & Jane]

In contrast, active observers appeared to closely watch the woman and appeared to be alert to any activity in the room. Active observers maintained different types of vigilance, namely professional, machine and partner vigilance, similar to the types first reported by Gungor and Beji (2007). Fathers adopted professional vigilance when they closely observed the actions of healthcare professionals (HCP), machine vigilance when they closely watch the CTG machine in order to monitor the fetus and the woman's contractions and partner vigilance when they watched the woman, closely monitoring to see if she was in pain or in distress.

The carer role

All fathers adopted the carer role at some stage. Indeed, fathers would adopt multiple carer roles in response to the women's needs during labour, as well as move from a carer role to an observer, intermediary, or advocate. There appeared to be two main aims to the carer role: to make the woman comfortable and to support her emotionally. Josh's actions were directed at making Gail

comfortable by supporting her physically, assisting her in changing her position or supporting her with pain relief:

> *9.52 Josh notices that Gail looks uncomfortable on the stool. He says to her 'Where do you want to move?' Gail replies 'I don't know'. Josh says to her 'Do you want to stand?'... Gail nods her head, Josh helps Gail to stand up but as she stands she has a contraction so he fetches the Entonox for her which she has put on the couch and she starts to breathe it. He then holds her as she breathes the Entonox.* [Obs.10 Josh & Gail]

Fathers also supported the woman through massaging her back or fetching items such as a glass of water or personal belongings from her bag.

Father supported the women emotionally by providing encouragement or expressions of concern and compassion and in order to raise the woman's spirits. Alan used humour to raise Helen's spirits:

> *12.43 …He [Alan] then looks at Helen and says 'Are you okay?' He smiles and says 'Wouldn't it be good if we could just magic this baby out with a click of a finger?' (He clicks his fingers). 'And another click for placenta.' He clicks his fingers again.* [Obs. 11 Alan & Helen]

Intermediary role

As an intermediary, fathers passively facilitated the exchange of information between the woman and those within and outside the labour room. Sion was observed intermediating between the woman and the midwife:

> *14.25 Sion … asks Glenda 'Are you okay?' Glenda replies 'They are getting stronger now… I'm not comfy here'. Sion looks towards the midwife who doesn't seem to have heard Glenda so he says to the midwife 'Glenda is asking if she can move.' The midwife says to Glenda 'Do you want to get off the couch and sit on the ball?'* [Obs. 14 Sion & Glenda]

Fathers also intermediated between the woman and the 'outside world'. to protect them from disturbance from friends and relatives.

Advocate role

Fathers actively spoke out to ensure that the woman's needs and concerns were met. Fathers were observed assisting the woman to translate her expressed desires into an acceptable plan of care, aiming to steer the HCPs in a direction preferred by the woman. The advocacy role was enacted firstly by fathers acting as the woman's voice by representing their perception of her needs and concerns, when acute events developed during labour and secondly, by advocating specifically for the choices and decisions that the woman (or couple) had made antenatally. Fathers advocated for a woman's wishes when HCPs imposed different choices or obstetrical demands, which were different

to the decisions in a woman's birth plan. In the extract below Glyn was aware of Molly's wishes not to go to theatre for a caesarean section and he described how he felt he had influenced Molly's decision in preventing this:

> *So I asked the doctor just to stop what he was doing and we ... we just had a couple of minutes, and we just had a chat, 'Is this what you really want? We make the decision now. And the doctor's telling us ten more minutes and the baby will be born in here, what do you want to do?' And then Molly decided she's going to give it a go, just for ... that further ten minutes. And that's when ... that's when he was born.* [Int. 8 Glyn & Molly]

Influences on fathers' roles

A number of influences on the roles impact on fathers' roles adopted during labour and birth. These included technology, transfer to another environment, the midwives' presence and women themselves.

Technology

Technology appeared to influence fathers' roles through increasing their attentiveness or causing distraction. Fathers would press the boost button on the TENS machine when they observed the start of a contraction on the CTG monitor, in order to attempt to relieve their partner's discomfort. Observing uterine contractions on the CTG monitor was another way of promoting comfort. When fathers saw the start of a contraction needle beginning to rise, they advised their partner to start inhaling Entonox to maximize its effects. Fathers also closely watched the fetal heart rate, as described in the fieldnotes below:

> *12.00 Glyn … notices that the FH is only 82 and looks worried. He glances at the midwife and back to the machine and the midwife readjusts the transducer again. Glyn says to the midwife 'Is that the pulse?' The midwife says 'Yes it was probably'. The FH then recovers up to a normal baseline. Glyn leans back in his chair but remains fixated on the FHR recording next to him.* [Obs. 8 Glyn & Molly]

Conversely, some fathers appeared to become detached in the presence of technology in the labour room, and became distant, distracted and less focused on the needs of the woman. It was apparent that personal devices such as mobile phones or tablets could hinder father's supportive roles. When fathers used these devices, they seemed more distracted and remained in a passive observer role and were not focused on the needs of the woman. Technology was also a physical barrier to fathers adopting a carer role, preventing them moving close to their partner.

Transfer to another environment

Transfer to another environment appeared to change fathers' roles. When couples were transferred from the 'homelike' environment of the MLU to the medicalised environment of the delivery suite, fathers appeared to be unsure about which roles to adopt. They stepped back from the woman as if sensing that they needed to stay out of the way. Josh explained how uncertain of the role he would play when they were transferred from the MLU to the delivery suite,:

> *You know, when you're there it's all low risk and you're chilled out… but once they transferred us and … you realise it's not straightforward, I kind of thought … I not sure what I can do you now… I should fade into the background and let these … experts tell her what to do. [Int. 10 Josh & Gail]*

However, the observer role was only transitory until fathers had adjusted to the new environment, when they then resumed the roles of carer and advocate.

Midwives' presence

Midwives and how they interacted with couples appeared to be a significant influence on fathers' roles. Building relationships with couples, providing them with information, removing barriers and working in partnership with fathers, appeared to influence the roles that fathers adopted and how these roles were performed.

Midwives built relationships with fathers through concern and awareness of fathers' needs and through the use of humour or 'making light of the situation'. Midwives were observed building relationships with fathers by showing them concern and awareness of their needs during labour which enhanced the way their roles were enacted during labour.

When midwives provided information for fathers and purposefully directed information exclusively towards fathers, their role changed, and they would move from a passive to a more active role. The midwife was observed instructing Ben how to massage Sian's back:

> *17.03 … The midwife asks Ben 'Will you massage Sian's back again?' He replies 'Yes I will' and the midwife then shows Ben how to deeply massage Sian's back at the base of the spine during contractions. She demonstrates to him first as he watches and then he does it as she watches him.* [Obs. 2 Ben & Sian]

Midwives encouraged fathers to work in partnership with them in supportive and practical tasks, requesting fathers' help through cues, which influenced a father's role or affected how his roles were enacted. Midwives removed barriers in the labour room in order to enhance a couple's intimacy and allowing them space and privacy. They did this through considering fathers' physical position in relation to a woman, the physical position of a midwife or interruptions from other staff. However, when midwives did not engage with fathers, encourage fathers to work with them,

remove barriers or provide fathers with information to enable them to perform their role, fathers adopted a less active role.

Women

The women themselves were an important influence on fathers' roles and how they were performed through their prior expectations they held about fathers' roles and the encouragement they provided. Women with higher expectations adopted a more demanding attitude and expected fathers to adopt active roles. Women adopted a 'laissez-faire' attitude when they had low expectations of fathers' roles and they did not necessarily want them to do anything other than be present during labour. Fathers' presence offered a sense of comfort through knowing they were there if they needed them. For example, Ceri admitted that she had few expectations of Charles' role and she described his role as being dependent on what she wanted him to do:

> *I don't think, with Charles ... he thinks that he's going to be … a certain way or anything, I think he just goes with the flow. I think if I needed him more he'd have been there more, if I'd needed him less he'd have been there less with me. And I think … what he did on the day I think was just going off how I was reacting and how I was feeling ....'* [Int. 7 Charles & Ceri]

Women influenced fathers' roles by how much they encouraged them to adopt more active roles. Women's encouragement was either 'explicit' or 'implicit'. It was explicit when they made a direct request for fathers' support, or was implicit when their actions indicated that they needed assistance.

Discussion

This study has identified that fathers adopt four roles during labour in response to contextual influences in order to achieve their overall goal of 'protecting' the woman. Similarly, Bedwell et al (2011) found that when decisions are made in pregnancy around place of birth, fathers' rationale for wanting a hospital birth was to protect their partner. Although the protecting role could be interpreted as gender based power, with men exercising authority, positioning women as vulnerable and passive, the notion of protecting could have been used as a means of hiding men's own vulnerability and uncertainly (Bedwell et al., 2011).

Fathers adopted an observer role when they watched the woman, either as passive or active observers. Other studies have found that the observer role was a common role adopted by fathers and some fathers did not want to adopt an active coaching role and preferred to 'sit back' and watch (Chapman, 1992; Chandler & Field, 1997; Johnson, 2002; Longworth & Kingdon, 2010). However, Longworth and Kingdon (2010) found that some fathers were not merely passively observing, but

were closely monitoring HCPs and the CTG monitor. Fathers suggested that their motivation to observe the woman, as part of their protecting role, was their perception that a woman in labour is vulnerable due to pain from contractions, the sedative effects of the pain relieving drugs, and unanticipated interventions or procedures not included in the birth plan, although it may also have indicated their mistrust of staff looking after their partner.

Multiple carer roles were adopted when fathers provided both physical and emotional support in order to safeguard a woman's comfort and well-being. Similarly, other studies found that fathers adopted a number of carer roles in the form of practical and psychological support for the woman during labour and birth (Chapman, 1992; Nichols, 1993; Gungor and Beji, 2007; Sengane, 2009; Backstrom & Wahn 2011; Lindgren & Erlandsson, 2011; Sapkota et al, 2012; Sansiriphun et al, 2015). However, contrary to the findings in this study, these other studies did not indicate whether carer activities were performed separately or simultaneously, or to varying degrees according to the context.

An intermediary role was adopted by fathers with the intention of facilitating communication exchange between the woman and the HCP or family and friends or acting as a buffer against unwanted visitors. Similarly, other studies have shown that men speak on behalf of a woman in circumstances when they are unable to speak for themselves. Women trust their partner to look after their interests and speak for them (Kainz et al., 2010; Eggermont et al., 2016) or act as a buffering process between their partner and their friends and relatives. In this study fathers acted as a 'buffer' as part of their protecting role, ensuring that a woman was not disturbed from trying to communicate with HCPs, or by ensuring she was not disturbed by unwanted visitors during labour.

Fathers acted as an advocate, with the purpose of assisting a woman to translate her expressed desires into an acceptable plan of care for both the woman and the HCPs, aiming to steer the HCPs in a direction preferred by the woman. Fathers adopted the role of decision enabler, advocating specifically for the choices and decisions that a woman (or couple) had made antenatally or before she was pregnant. Other studies have identified how men act as advocates for their partner in interactions with care providers, during labour and when women have a chronic medical condition, screening information and 'speaking up' for the woman's wishes, particularly when HCP's impose different choices or demands on women (Backlar,1996; Gungor & Beji, 2007; Kainz et al., 2010; Premberg et al 2011; Kululanga et al., 2012). In this study fathers advocated for a woman's wishes, or enabled her decisions made antenatally as part of their protecting role, when HCPs imposed

different choices or obstetrical demands, which were different to the decisions in a woman's birth plan.

There are, however, limits to the extent to which fathers can become involved during labour in terms of decision-making as they have very little authority or control over the events of labour (Dolan & Coe, 2011). The ethical principles underpinning professional practice, of maternal autonomy, bodily integrity, confidentiality, and the legitimate nature of 'advocacy', may limit the extent to which fathers can legitimately adopt the role of decision maker in a medical setting (Draper & Ives, 2013).

There is a fine line between a man acting as a woman's advocate or decision enabler and the risks of gender based power and male dominance, and their threat to women's autonomy and woman-centred care. This also needs to be considered in terms of fathers' roles and increasing their involvement during labour. Draper and Ives (2013) emphasised that when a father acts as a women's advocate, then it would be inappropriate if he expressed his own opinions, anxieties and fears, or sought information for his own needs. They highlighted the importance of fathers reflecting the views of a woman rather than their own.

These findings indicate there were a number of influences on the roles fathers adopted during labour and birth and how these roles were performed. These influences included technology, transfer to another environment, midwives' presence and women themselves.

Technology influenced fathers' roles and how they were enacted. Technology increased their attentiveness through watching the fetal heart rate and the uterine contractions on the CTG monitor. Similarly, Hasman *et al.* (2014) found that in the high-risk environment fathers felt more in control from actively performing concrete tasks, such as watching the pumps and the CTG monitor. Conversely, the findings from this study suggest that some fathers appeared to become detached in the presence of technology in the labour room, where they became distant, distracted and less focused on the needs of the woman. Technology was also a barrier to the provision of support for a woman when it became a distraction or was a physical barrier. Almerud, et al (2007) also found that technology was a barrier to intimacy and closeness, and compromised a caregiver's role in the ICU context.

Fathers' roles were influenced when couples were transferred to a more medicalised environment such as labour ward or the operating theatre. Transfer appeared to create a sense of uncertainty for fathers about which roles to adopt, which lead them to become less active and involved. Similarly, other studies have found that fathers experience feelings of helplessness and they feel their role

decreases in value when they are transferred to a medicalised environment (Chandler & Field 1997; Somers-Smith 1999; Backstrom & Hertfelt Wahn 2011). However, an earlier study by Westreich et al. (1991) found that fathers were more involved with coaching and verbal encouragement in a medicalised setting compared to a birthing unit. Johansson et al., (2012) found that when women are transferred to the operating theatre, fathers feel overwhelmed and excluded and the unfamiliar environment induces anxiety, particularly when they are not given sufficient information.

The midwife's ability to work in partnership, provide information and build relationships with fathers appeared to influence their roles and how they were enacted. Similarly, other studies have found that partnership is encouraged when midwives involve fathers by asking them to help them with tasks. This in turn leads to feelings of involvement and control. Fathers appear to wait for a cue or permission from midwives to actively support a woman (Longworth & Kingdon 2011; Premberg et al. 2011). Information provision, assurance and support from midwives increases fathers' security and confidence, making them better able to support their partner (Hildingsson et al., 2011; Longworth & Kingdon, 2011). Conversely, when fathers are ignored by midwives and they withhold information, they become disconnected, which can lead to distress and frustration, and they are more likely to disengage from active support of the woman and to adopt a spectator role (Johnson, 2002; Hallgren et al. 2005; Backstrom & Hertfelt Wahn, 2011; Longworth & Kingdon, 2011; Johansson et al., 2012). However, Longworth and Kingdon (2011) argue that it is fathers who deliberately limit the information they decide to take into account, in order to distance themselves from pregnancy and childbirth.

Women's expectations of fathers' roles were demonstrated through a laissez faire or a demanding attitude, which influenced their expectations and how they encouraged fathers' roles. This variation is supported by other studies. Johnson (2002) found that women's prior perceptions of their partner's knowledge led them to have high expectations of the support they would provide. In addition, Somers-Smith (1999) found that women's expectations were also influenced by whether the labour was progressing normally or not. If labour complications were present, then their expectations of fathers' roles were lower.

Strengths and limitations

The strengths to this study are the ethnographic methodological approach. The observations, interviews and reflexive diary generated in depth understanding of fathers' roles. These methods also enabled triangulation that contributed to the trustworthiness of the data.

The limitations relate to the setting and understanding of the labour room culture. There were only a small number of observations conducted on a MLU, the interviews did not explore the views of the midwives after the birth, and ML did not always have the opportunity to observe couples during the earlier stages of labour and was not always present during the birth, which could have potentially limited the data generated.

Conclusions

The study findings revealed new insights into fathers' roles during labour and birth, through identifying the dynamic nature of their roles and how role adoption is influenced by the changing nature of the context over the course of a woman's labour. Father's roles were not fixed, and were contextual in that they varied depending on the changing nature of the context during the course of labour. There were a number of influences which changed their roles or how they were enacted. These findings provide valuable insights into how the labour room context and individual values influence role adoption.

These data provide a basis to develop strategies that can be used by midwives to enhance fathers' roles during labour and birth. These strategies could include educating fathers' on how to support women, supporting fathers in the transition from one environment to another, familiarising fathers with the technology in the labour room, and providing fathers with information and communicating with them when complications arise during labour.

In light of policy recommendations that care should be provided by the same midwife or group of midwives and should be personalised to the needs of the woman and her partner (NHS England, 2016), it is important to continue to gain further understanding of fathers' roles during labour and birth.

References

Almerud, S., Alapack, R. J., Fridlund, B., & Ekebergh, M. (2007). Caught in an artificial split: A phenomenological study of being a caregiver in the technologically intense environment. *Intensive and Critical Care Nursing*, 24(2), 130-136. https://doi.org/10.1016/j.iccn.2007.08.003

Backlar, P. B. (1996). Ethics in community mental health care: Confidentiality and common sense. Community Mental Health Journal, 32, 513-518. https://doi.org/10.1007/BF02249747

Backstrom, C. & Hertfelt Wahn, E. (2011) Support during labour: first time fathers description of requested and received support during birth of their child. *Midwifery,* 27, 67-73. DOI: https://doi.org/10.1016/j.midw.2009.07.001

Bedwell, C., Houghton, G., Richens, Y., & Lavender, T. (2011). 'She can choose, as long as I'm happy with it': A qualitative study of expectant fathers' views of birthplace. *Sexual and Reproductive Healthcare*, 2(2), 71-75. doi10.1016/j.srhc.2010.12.001

Behruzi, R., Hatem, M., Goulet, L., Fraser, W., & Misago, C. (2013). Understanding childbirth practices as an organizational cultural phenomenon: A conceptual framework. *BMC Pregnancy Childbirth*, 13, 205. https://dx.doi.org/10.1186%2F1471-2393-13-205.

Bondas-Salonen, T. (1998). How women experience the presence of their partners at the births of their babies. *Qualitative Health Research*, 8(6), 784-800.

Brandao, S., & Figueiredo, B. (2012). Father's emotional involvement with the neonate: Impact of childbirth experience. *Journal of Advanced Nursing*, 68(12), 2730-9. DOI: 10.1111/j.1365-2648.2012.05978.x.

Brender, J. (2006) Handbook of Evaluation Methods for Health Informatics

Chan, K. L., & Paterson-Brown, S. (2002). How do fathers feel after accompanying their partners in labour and delivery? *Journal of Obstetrics & Gynaecology*, 22(1), 11-15.

Chandler, S. & Field, P. A. (1997). Becoming a father: First-time fathers' experience of labor and delivery. *Journal of Nurse-Midwifery,42*(1), 17-24. doi:10.1016/S0091-2182(96)00067-5

Chapman L.L. (1991) Searching: expectant father's experiences during labour and birth. *Journal of Perinatal and Neonatal Nursing,* 4(4), 21-29

Creswell, J. (2013). Research design: Qualitative & quantitative approaches. Thousand Oaks, CA: Sage Publications.Cruz, E.V. & Higginbottom, G. (2013) The use of focused ethnography in nursing research. *Nurse Researcher* 20(4) 36-43. DOI: 10.7748/nr2013.03.20.4.36.e305

Dellmann, T. (2004). "The best moment of my life": A literature review of fathers' experience of childbirth. *Australian Midwifery*, 17(3), 20-26. https://doi.org/10.1016/S1448-8272(04)80014-2

Dejoy, S. (2011) *The Role of Male Partners in Childbirth Decision Making: A Qualitative Exploration with First-Time Parenting Couples* (PhD thesis). University of South Florida, United States. Graduate School Theses and Dissertations. Retrieved from http://scholarcommons.usf.edu/etd/3720

Dolan, A., & Coe, C. (2011). Men, masculine identities and childbirth. *Sociology of Health and Illness*. 33, 1019-1034. https://doi.org/10.1111/j.1467-9566.2011.01349.x

Draper, H., & Ives, J. (2013). Men's involvement in antenatal care and labour: Rethinking a medical model. *Midwifery, 29*(7), 723-729. doi:10.1016/j.midw.2013.02.007

Eggermont, K., Beeckman, D., Van Hecke, A., Delbaere, I., & Verhaeghe, S. (2016). Needs of fathers during labour and childbirth: A cross-sectional study. *Women and Birth*, 30(4), e188-e197. http://dx.doi.org/10.1016/j.wombi.2016.12.001

Fetterman, D. M. (2010). *Ethnography: Step by step*. London, United Kingdom: Sage Publications.

Finnbogadóttir, H., Crang Svalenius, E., & Persson, E. K. (2003). Expectant first-time fathers' experiences of pregnancy. *Midwifery*, 19(2), 96-105. doi:10.1016/S0266-6138(03)00003-2

Fletcher, F., Silberberg, S., & Galloway, D. (2004). New fathers' postbirth views of antenatal classes: Satisfaction, benefits, and knowledge of family services. *Journal of Perinatal Education,* 13(3), 18-26. https://dx.doi.org/10.1624%2F105812404X1734

Friesen, B., & Stephens, B. (1998). Expanding family roles in the system of care: Research and practice. In M. H. Epstein, K. Kutash, & A. Duchnowski (Eds.), Outcomes for children and youth with behavioral and emotional disorders and their families (pp. 231-259). Austin, TX: PRO-ED.

Green, J., & Thorogood, N. (2013). *Qualitative methods for health research*. (3rd ed.). London, United Kingdom: Sage Publications.

Grossmann, K., Grossmann, K. E., Fremmer-Bombik, E., Kindler, H., Scheuerer-Englisch, H., & Zimmermann, A. P. (2002). The uniqueness of the child? Father attachment relationship: Fathers sensitive and challenging play as a pivotal variable in a 16-year longitudinal study. *Social Development*, 11(3), 301-337. https://doi.org/10.1111/1467-9507.00202

Gungor, I., & Beji, N. K. (2007). Effects of fathers' attendance to labor and delivery on the experience of childbirth in Turkey. *Western Journal of Nursing Research*, 29(2), 213-231. Hammersley & Atkinson, 2007).

Hallgren, A., Kihlgren, M., Forslin, L., & Norberg, A. (1999). Swedish fathers' involvement in and experiences of childbirth preparation and childbirth. *Midwifery*, 15(1), 6-15. https://doi.org/10.1016/S0266-6138(99)90032-3

Hallgren, A., Kihlgren, M., & Olsson, P. (2005). Ways of relating during childbirth: An ethical responsibility and challenge for midwives. *Nursing Ethics*, 12(6), 606-621. doi:10.1191/0969733005ne831oa

Hasman, K., KjaergaardKjaergaard, H., & Esbensend, B. A. (2014). Fathers' experience of childbirth when non-progressive labour occurs and augmentation is established: A qualitative study. *Sexual & Reproductive Healthcare,* 5(2), 69-73. https://doi.org/10.1016/j.srhc.2014.02.001

Hewlett, B. S., & MacFarlan S. J. (2010). Fathers' roles in hunter-gatherer and other small-scale cultures. In M. Lamb (Ed.). The role of the father in child development. (5th ed.) (pp. 413-435). New Jersey, NJ; John Wiley and Sons.

Hildingsson, I., Cederlöf, L., & Widén, S. (2011). Fathers' birth experience in relation to midwifery care. *Women and Birth*, 24(3), 129-136. http://dx.doi.org/10.1016/j.wombi.2010.12.003

Hodnett, E. D., Gates, S., Hofmeyr, J. G., Sakala, C., & Weston, J. (2011). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*, 16(2): CD003766. doi:10.1002/14651858.CD003766.pub3.

Ip, W. Y. (2000). Relationships between partner's support during labour and maternal outcomes. Journal of Clinical Nursing, 9(2), 265-272.

Johnson, M. P. (2002). An exploration of men's experience and role at childbirth. The Journal of Men's Studies. 10(2), 165-182. https://doi.org/10.3149%2Fjms.1002.165

Kainz, G., Eliasson, M., & von Post, I. (2010). The child's father, an important person for the mother's well-being during the childbirth: A hermeneutic study. Health Care for Women International, 31(7), 621-635. doi:10.1080/07399331003725499

Kao, B., Gau, M., Wu, S., Kuo, B., & Lee, T. (2004) A comparative study of expectant parents' childbirth expectations. The Journal of Nursing Research, 12(3), 191. doi:10.1097/01.JNR.0000387503.21749.0d

Knoblauch, H. (2005). Focused ethnography. Forum: Qualitative Sozialforschung / Forum: Qualitative Social Research, 6(3), Art. 44, Retrieved from http://nbn-resolving.de/urn:nbn:de:0114-fqs0503440

Kuliukas, L., Hauck, Y., Duggan, R., & Lewis, L. (2014). The phenomenon of intrapartum transfer from a western Australian birth centre to a tertiary maternity hospital: The overall experiences of partners*. Midwifery, 31*(2015), 87-93. http://dx.doi.org/10.1016/j.midw.2015.01.010

Kululanga, L., Sundby, J., Malata, A., & Chirwa, E. (2012). Male involvement in maternity health care in Malawi. African Journal of Reproductive Health, 16(1), 1-45. Retrieved from http://www.jstor.org/stable/23317042

Kunjappy-Clifton, A. (2008). And father came too... A study exploring the role of first time fathers during the birth process and to explore the meaning of the experience for these men: Part two. MIDIRS Midwifery Digest, 18(1), 57-66.

Ledenfors, A. (2016). First time fathers' experiences of normal childbirth. Midwifery, 40, 26-31. doi:10.1016/j.midw.2016.05.013

Lindgren, H., & Erlandsson, K. (2011). She leads, he follows – fathers' experiences of a planned home birth. A Swedish interview study. Sexual & Reproductive Healthcare, 2(2), 65-70. doi:10.1016/j.srhc.2010.12.002

Logsdon, M. C., McBride, A. B., & Birkimer, J. (1994). Social support and postpartum depression. Research in Nursing and Health, 17, 449-457.

Longworth, H. L., & Kingdon, C. (2011). Fathers in the birth room: What are they expecting and experiencing? A phenomenological study. Midwifery, 27(1), 67-73. doi:10.1016/j.midw.2010.06.013

Lwanga, H., Atuyambe, L., Sempewo, H., Lumala A.& Byaruhanga R. N. B. (2017). An exploratory study of men's companionship, perceptions and experiences during pregnancy and delivery in Uganda. *BMC Pregnancy Childbirth*, 17, 196. https://doi.org/10.1186/s12884-017-1385-6

Madi, B. C. J., Sandall, J., Bennett, R., & MacLeod C. (1999). Effects of female relative support in labor: A randomized controlled trial. *Birth,* 26, 4–8. https://doi.org/10.1046/j.1523-536x.1999.00004.x

Martin, K. A. (2003). Giving birth like a girl. *Gender & Society*, 17(1), 54-72. doi:/10.1177/0891243202238978

Mays N., & Pope, C. (1995). Qualitative research: Rigour and qualitative research. *British Medical Journal,* 311, 109 http://dx.doi.org/10.1136/bmj.311.6997.109

Mauthner, N. S., & Doucet, A. (1998). Reflections on a voice-centred relational method of data analysis: Analysing maternal and domestic voices. In J. Ribbens & R. Edwards (Eds.), Feminist dilemmas in qualitative research: Private lives and public texts (pp. 119–144). London, UK: Sage.

Nicholas, D. B. (2017). Examining the roles and experiences of fathers of children with chronic kidney disease. *Global Qualitative Nursing Research*. 4, 1-8. doi:10.1177/2333393617705035

NHS England. (2016) National Maternity Review: Better Births – Improving outcomes of maternity services in England – A five year forward view for maternity care. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

O'Leary, Z. (2013*). The essential guide to doing research*. London, United Kingdom: Sage Publications

Poh, H. L., Koh, S. S. L., Seow, H. C. L., & He, H. (2014). First-time fathers' experiences and needs during pregnancy and childbirth: A descriptive qualitative study. *Midwifery*, 30, 779-787. https://doi.org/10.1016/j.midw.2013.10.002

Premberg, A., Carlsson, G., Hellström, A., & Berg, M. (2011). First-time fathers' experiences of childbirth – A phenomenological study. *Midwifery*, 27(6), 848-853. doi:10.1016/j.midw.2010.09.002

Reeves, S., Peller, J., Goldman, J., & Kitto, S. (2013). Ethnography in qualitative educational research: AMEE guide no. 80. *Medical Teacher*, 35(8), e1365-e1379. doi:10.3109/0142159X.2013.804977

Ritchie, J., Lewis, J., Elam, G., Tennant, R., & Rahim, N. (2013). Designing and selecting samples. In J. Ritchie, J. Lewis, C. McNaughton Nicholls, & R. Ormston (Eds.). (2013). Qualitative research practice. A guide for social science students and researchers. (pp. 111-142). London, United Kingdom: Sage Publications.

Roberts, J., & Spiby, H. (2019). 'The calm before the storm': A qualitative study of fathers' experiences of early labour. *Women and Birth.* https://doi.org/10.1016/j.wombi.2019.11.002

Sansiriphun, N., Kantaruksa, K., Klunklin, A., Baosuang, C., & Liamtrirat, S. (2015). The journey into fatherhood: A grounded theory study. *Nursing and Health Sciences*, 17(4), 460-466. doi:10.1111/nhs.12216

Sapkota, S., Kobayashi, T., & Takase, M. (2012). Husbands' experiences of supporting their wives during childbirth in Nepal. *Midwifery,* 28, 45-51. doi:10.1016/j.midw.2010.10.010.

Sengane, M. (2009). The experience of black fathers concerning support for their wives/ partners during labour. *Curationis*, 32(1), 67-73.

Schwalbe, M. (2005). *Identity stakes, manhood acts, and the dynamics of accountability. Studies in Symbolic Interaction* (pp. 65-81) Emerald Group Publishing Limited. doi:10.1016/S0163-2396(04)28010-3

Soderberg, S., Strand, M., Haapala, M., & Lundman, B. (2003). Living with a woman with fibromyalgia from the perspective of the husband, *Journal of Advanced Nursing*, 42(2), 143-150. https://doi.org/10.1046/j.1365-2648.2003.02597.x

O'Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic masculinity: Rethinking the concept. *Gender & Society*, 19(6), 829-859. doi: 10.1177/0891243205278639

Somers-Smith, M. J. (1999). A place for the partner? Expectations and experiences of support during childbirth. *Midwifery*, 15(2), 101-108. Wockel *et al*. (2007).

Vehviläinen-Julkunen, K., & Liukkonen, A. (1998). Fathers' experiences of childbirth. *Midwifery*, 14(1), 10-17.

Vindrola-Padros, C. & Vindrola-Padros, B. (2017). Quick and dirty? A systematic review of the use of rapid ethnographies in healthcare organisation and delivery. *BMJ Quality and Safety*, 321-329. doi:10.1136/bmjqs-2017-007226

Waltz, C., Strickland, O. L., & Lenz, E. R. (2016). *Measurement in nursing and health research.* (5th ed.). New York, NY: Springer Publisher Company.

Westreich, R., Spector-Dunsky, L., Klein, M., Papageorgiou, A., Kramer, M., & Gelfand, M. (1991). The influence of birth setting on the father's behavior toward his partner and infant. *Birth*, 18(4), 198-202.

Williams, K., & Umberson, D. (1999). Medical technology and childbirth: Experiences of expectant mothers and fathers. *Sex Roles*, 41(3-4), 147-168. https://doi.org/10.1023/A:1018898027379

Wockel, A., Schafer, E., Beggel, A., & Abou-Dakn, M., (2007). Getting ready for birth: Impending fatherhood. *British Journal of Midwifery*, *15*(6), 344-348. https://doi.org/10.12968/bjom.2007.15.6.23673