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What do men want from antenatal screening? Findings from an interview study in England ☆

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ABSTRACT

Objective: in the UK, midwives are facing a policy-drive to include men in antenatal care, and men will soon receive paternity leave to enable their involvement. As a result, more men will be able to attend screening, support women and participate in decision-making. We therefore conducted a timely exploration of what being involved means for men and what they want from antenatal screening and midwives.

Design and setting: in-depth, semi-structured interviews with 12 men were carried out, mostly by telephone. Data were analysed using grounded theory.

Findings: we constructed three themes and showed that (1) in normal pregnancies, men knew little about screening, and were happy for midwives to take control during appointments, (2) in complicated pregnancies, men wanted to be more actively involved but some perceived that they faced suspicions of being coercive if voicing opinions, and (3) over time, men became more adept at communicating with midwives, but some disengaged from screening because of poor communication with midwives and/or a lack of faith in the benefits of screening.

Conclusion: findings build on other studies to highlight the multiplicity of roles men play during screening. For men and women to reap the benefits of men's involvement in antenatal screening, good communication is required between midwives and couples. Communication training could help to improve care delivery and the relationships between men, women and midwives.

Introduction

In the UK, antenatal screening for haemoglobinopathies and fetal anomalies (from here on referred to simply as antenatal screening) involves voluntary blood tests and ultrasound scans in the first and second trimesters, and antenatal diagnosis following a high-risk screen (see Table 1 for tests offered in England). The UK Royal College of Midwives (RCM) have agreed that midwives need to involve men in antenatal care (2011) and research reveals that women want men involved (Aune and Moller, 2012). Yet compared with research with women (e.g. Ahmed et al., 2012), there is scarce research about men's experiences of antenatal screening, and the meaning of 'involvement' for men has not been clarified. This issue is timely because from 2015, UK men will be permitted to take paternity leave for two antenatal appointments, meaning more men will be able to attend (Department of Business, Innovation and Skills (DBIS), 2011). The government's justification for this policy-change is that 'there is strong evidence that a father's attendance at ultrasound scans helps early bonding and increases his commitment to the pregnancy' (DBIS, 2011, p. 29). Yet the evidence for paternal antenatal bonding is limited, and a single, dated study is cited to back up this claim (Draper, 2002).

Secondly, they suggest that 'a father's attendance at ultrasound scans […] is strongly linked with positive engagement throughout childhood, including an increased likelihood to read to the child and to provide nurturing care' (p. 29). Along with Bronte-Tinkew et al. (2007), whom they cite, more recent research from the USA suggests that men's antenatal involvement can predict engaging and playing with the child and making health-related decisions, up to three years after birth (Cabrera et al., 2008; Zvara et al., 2013). However these findings might reflect, more simply, that men likely to attend antenatal

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Table 1
Antenatal screening and prenatal diagnosis in the NHS.

	Time point (weeks)	Type of test	Targets
Antenatal screening	8–10	Blood test	Haemoglobinopathies e.g. thalassaemia
	11–13	Blood test	Chromosomal anomalies e.g. Down syndrome
		Nuchal translucency ultrasound scan	
	15–20	Blood test	Chromosomal anomalies e.g. Edward syndrome
		Ultrasound scan	Structural anomalies e.g. spina bifida
Prenatal diagnosis	> 7	NIPD	X-linked conditions, e.g. Duchenne Muscular Dystrophy, and some single gene disorders
	< 10	CVS	To confirm screening result
	15–20	Amniocentesis	To confirm screening result

appointments are equally likely to engage with their children. There may be no causal relationship between the two factors.

Recent policy drives thus warrant some careful consideration rather than unconscientious adoption. The changes the new paternity leave policy might necessitate in antenatal service delivery, and the complexities that could arise from increased paternal involvement, as well as what being involved means for men, and what they want from midwives, requires exploration.

The existing literature only provides limited answers to these questions. Our systematic review and metasynthesis about men's screening experiences (redacted) showed that only two UK studies (Locock and Alexander, 2006; Reed, 2009a, 2011) have specifically explored men's involvement. In both, women outnumbered men. Moreover, Locock and Alexander (2006) focussed on fetal anomalies and Reed (2009a, 2011) on blood screening only. Nevertheless, the studies highlight some important findings. Locock and Alexander (2006) found that men played numerous roles in screening, including bystander, parent, supporter/protector, gatherer/guardian of facts and decider/enforcer. In short, their involvement consisted of providing women with emotional support, advocating for them, and sourcing information to help with decision-making. Reed (2009a, 2011) discovered that men generally felt less responsible for fetal health and for making screening decisions compared with women, but still wanted to be involved. These authors suggest that men need to be recognised by health care professionals (HCPs) as more than just women's supporters.

Studies conducted internationally have likewise shown that men want to be involved in decision-making (e.g. Wätterbjörk et al., 2012). They have indicated a tendency among men to seek technical and statistical information about screening to guide their partners' decisions, and to understand any complications (Sandelowski, 1994; Browner and Preloren, 1999; Markens et al., 2003; Gottfreðsdóttir et al., 2009a; Reed, 2009a). Other men feel uninformed about screening or overwhelmed with information (Ivry and Teman, 2008; Gottfreðsdóttir et al., 2009b; Pieters et al., 2011; Åhman et al., 2012). In complicated pregnancies, men feel anxious and under pressure to set aside their own worries to support their partners (Sjögren, 1992; Ekelin et al., 2008).

Across UK and international studies, men are reported to feel ignored by midwives (Ekelin et al., 2004; Locock and Alexander, 2006; Ivry and Teman, 2008; Reed, 2011). Men whose opinions about screening differ to their partners' additionally have misgivings that their views will be disregarded by HCPs (Markens et al., 2003). The impact of this perception has not been investigated in the current literature.

There is more to be understood about men's views and feelings about being involved in antenatal screening. By interviewing men about all types of screening, we aimed to build on UK studies by Locock and Alexander (2006) and Reed (2009a, 2011) and explore what men who attend antenatal appointments want from screening and from midwives, whether facing pregnancy anomalies or not.

Methods

Study design and sample

Data were collected in 2011. After receiving National Health Service (NHS) research ethics committee approval (10/H1207/38), we recruited men aged at least 18 whose partners had been offered a minimum of one screening test, and were prenatal or up to three years post partum. These broad inclusion criteria were used because the exploratory nature of the study meant no presumptions were made that any one demographic of men would have more valuable views than another. We recruited through an inner-city NHS antenatal department and antenatal class in the same location, and online parenting forums and mailing lists. To make potential participants aware that our study was about antenatal screening rather than ultrasound screening as a way of 'seeing the baby' (Draper, 2002, p. 771), we outlined on information sheets what antenatal screening involved (ultrasounds/blood tests) and what it could reveal. We are unsure how many men were invited to participate, because information was sent out by midwives and posted online.

Recruitment was ceased once we achieved theoretical saturation. Theoretical saturation occurs when themes have depth and variation, but new data stops shedding light on the central findings (Corbin and Strauss, 2008). We only sought saturation of the central (as opposed to all) findings because each man had an individual and nuanced experience, meaning it would be impossible to achieve saturation of every idea that surfaced. There is no set sample size necessary to achieve theoretical saturation. Rather, theoretical saturation will determine how many interviews are needed. Saturation in turn depends on a number of other factors, such as the richness of the interview data (Corbin and Strauss, 2008; Mason, 2010). To determine when saturation of the main topics occurred, we recorded newly arising concepts after each interview, and ceased interviewing soon after novel concepts stopped emerging (Guest et al., 2006). Saturation began to occur around the tenth interview and we stopped recruiting after 12 interviews.

Data collection and analysis

Our interviews were cross-sectional and semi-structured. To develop the interview schedule, we adapted the unanswered