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First-time fathers' experiences and needs during pregnancy and childbirth: A descriptive qualitative study

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ABSTRACT

Objectives: to explore first-time fathers' experiences and needs during their wives' pregnancy and childbirth in Singapore.
Design and setting: a descriptive qualitative was conducted. Participants were recruited from two obstetric wards in a tertiary hospital in Singapore from November to December 2012. Semi-structured, face-to-face interviews were used to collect data and themes from the interviews were generated using thematic analysis.
Participants: a purposive sample of 16 first-time fathers aged above 21 years who accompanied their wives throughout pregnancy and childbirth were recruited from the postnatal wards between one to three days after the birth of their children.
Findings: four themes emerged from 16 subthemes: (1) Emotional changes experienced; (2) Adaptive and supportive behaviours adopted; (3) Social support received and (4) Suggestions for improvement to the current maternity care. First-time fathers experienced a range of emotions from being happy and excited to feeling shocked and worried and to feeling calm. Adaptive and supportive behaviours were adopted to deal with the pregnancy changes and better support their wives. In the course of their transition to fatherhood, they also received support from their family, friends, workplaces and the health care professionals. Fathers suggested more information, timely, empathetic and professional care be given and a review to the current administrative/logistical policies.
Conclusions: all fathers modified their behaviours for the sake of protecting their wives and unborn children. Support from their family, friends, workplaces and the health care professionals was invaluable and greatly appreciated.
Implications for practice: health care professionals can guide and support fathers by providing them with more information and preparing them for the unknown changes. Future studies are needed to develop intervention programme for fathers to improve their experiences and adaptive behaviours.

Introduction

There has been an increasing global trend in the number of fathers involved in their partners' pregnancy and childbirth since the 1960s (Draper, 1997); currently, more than 90% of fathers in the United States participated in antenatal activities like seeing an ultrasound of their child and discussing the pregnancy with their partners whereas a similar percentage of fathers in the United Kingdom attended childbirth (Murphy, 2009; National Responsible Fatherhood Clearinghouse, 2010). Fathers' involvement during pregnancy had commonly been concluded to positively impact women as they offered women psychological, physical and moral support (Dudgeon and Inhorn, 2004). Additionally, when women were supported during childbirth, they generally had a more positive childbirth experience (Gungor and Beji, 2007; Kainz et al., 2010). Conversely, if they have a negative childbirth

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experience, their future reproductive decisions seemed to be adversely affected (Gottvall and Waldenström, 2002).

In earlier research on fathers' experiences, it was found that fathers experienced both positive and negative feelings and matured as they supported their partners through pregnancy and childbirth (Finnbogadóttir et al., 2003; Dolan and Coe, 2011; Widarsson et al., 2012). Although most of them experienced childbirth positively, some were emotionally scarred (Finnbogadóttir et al., 2003; White, 2007). Additionally, fathers also expressed the need for professional support both during their partners' pregnancy and childbirth. Yet, research has concluded that fathers often felt excluded and unsupported by the health care professionals during these periods (Dolan and Coe, 2011; Widarsson et al., 2012). It is only by knowing fathers' experiences and needs that health care professionals can aptly provide appropriate and culturally sensitive care for fathers during pregnancy and childbirth (Fenwick et al., 2012).

Additionally, though there have been previous studies looking at fathers' experiences and needs during pregnancy and childbirth, these works were largely conducted in Western countries. There are no published studies about fathers' experiences and needs during pregnancy and childbirth in Singapore though fathers here have also been encouraged to be involved during pregnancy and childbirth. Findings from previous research may not be transferable to Singapore because firstly, fathers in Singapore are not only influenced by Western cultures; Asian culture and their ethnicities also affect their beliefs and behaviours. Secondly, unlike most of the studies, pregnant women in Singapore are cared for mainly by an obstetrician supported by a team of midwives and nurses. As mentioned in Fenwick et al.'s (2012) study, differences in culture and the way maternity care services are organised and delivered may result in different experiences.

As first-time fathers are assumed to be more sensitive to all that happens and have greater needs than experienced fathers (Dolan and Coe, 2011; Hildingsson et al., 2011), the aim of this study was thus to explore first-time fathers' experiences and needs during their wives' pregnancy and childbirth in Singapore. This will contribute to a predominately westernised body of knowledge about fathers' experiences and needs. The results of the study will also provide evidence to improve perinatal care by involving fathers in the care.

Methods

Qualitative research allows us to understand naturally occurring social phenomena by exploring individuals' attitudes, the beliefs, meanings and values attributed and their experiences (Schneider et al., 2007). A descriptive qualitative design further summarises the facts of an event in everyday terms and 'is especially amenable to obtaining straight and largely unadorned answers to questions of special relevance to practitioners and policymakers' (Sandelowski, 2000, p. 337). Thus, a descriptive qualitative design was adopted as it allows first-time fathers to express their experiences and needs about these events (pregnancy and childbirth) in their own words. This study was conducted in a tertiary hospital in Singapore from November to December 2012. Semi-structured interviews were used to collect data. Thematic analysis was used to analyse the data.

Settings and study participants

The study was conducted in two obstetric wards (a private ward and a subsidised ward) in a public tertiary hospital in Singapore, which delivers an average of 2500 babies annually. Of this, around 25.5% are caesarean-sections, less than 1% are water births whereas the remaining are normal or instrumental vaginal childbirths (National University Hospital, 2010; Wee, 2011a; Wee, 2011b). A purposive sample of 16 fathers was recruited within three days after their wives' childbirth. The inclusion criteria were first-time fathers: (1) who speak English; (2) who were 21 years old and above; (3) who stayed with their wives during pregnancy and accompanied them during childbirth; (4) whose wives delivered via normal or instrumental vaginal births and were healthy; and (5) whose children were born at least at the 37th week of gestation and were healthy. The exclusion criteria were fathers who had any psychiatric problems or cognitive or speech impairments. Participants were purposively selected based on the ethnic proportion in Singapore. Data saturation was achieved at the 16th participant. A total of eight fathers refused to participate in this study with the reasons of 'lack of time' and 'not interested'.

Ethical considerations

The study was approved by a group ethics committee National Health Group Domain Specific Review Board (NHG DSRB) which the participating hospital is governed (Ref: 2012/00774). The study was explained to all fathers who were approached. After this, written informed consent was taken from all fathers who agreed to participate in the study and the audio-taping of interviews. Participation was voluntary and all fathers were assured that their refusal to participate or withdrawal during the study would not affect their wives' and children's care. Confidentiality was also maintained in that no identifiable information was tagged to any of the participants. Participant numbers were used in all the transcripts and data analysis sheets subsequently.

Data collection

The primary researcher first obtained relevant obstetric information on the women's parity, mode of childbirth, any intrapartum complications from an obstetric record book daily before recruitment to narrow down any potential participants. Both the women's and their husbands' names, the women's age, ethnicities and the ward and bed number in which they were transferred to postnatally were noted too. The primary researcher was then able to approach potential participants and invite them to participate in this study.

As preparation, a mock interview was carried out with another researcher in the study team before formal data collection. In addition, a pilot audio-taped interview with a father who fulfilled the inclusion and exclusion criteria was conducted but this was not included in the final data analysis. Thereafter, the primary researcher conducted all the interviews.

Semi-structured interviews were conducted in the hospital within three days post-childbirth. The researcher facilitated the participants in expressing freely about the topics in an interview guide, which was developed based on the study's aim and various issues raised by fathers in other studies (Kao and Long, 2004; Hildingsson et al., 2011; Fenwick et al., 2012). Instead of posing questions in a fixed order, the interviews unfolded based on participants' responses and new questions were asked to explore or clarify something relevant which the participants talked about. This would elicit further explanation and generate new discussion (Morse and Field, 1996). Most of the fathers were interviewed in a private room in the participating wards except for two fathers who were interviewed in their wives' rooms due to the lack of empty rooms at that time. Active listening was adopted and attention was paid to participants' expressions, non-verbal cues, hesitation in their responses and other observations not captured by the audio-taped recordings. The interview durations ranged from 22 to 54 minutes.

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