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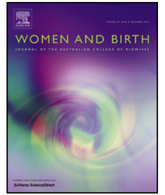

Intrapartum care could be improved according to Swedish fathers: Mode of birth matters for satisfaction

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ABSTRACT

Background: Intrapartum care is expected to be shaped by parents' need and preferences.
Aim: The aim was to explore Swedish fathers' intrapartum care quality experiences, with a specific focus on care deficiencies in relation to birth mode. A secondary aim was to explore which issues of quality that contributed most to dissatisfaction with the overall assessment of the care.
Methods: Cross-sectional design, part of a prospective longitudinal survey in Sweden. A quality of care index was developed, based on perceived reality and subjective importance of given intrapartum care. Two months after birth 827 fathers answered nine questions related to quality of care. Descriptive statistics and logistic regression analysis were used.
Results: Dissatisfaction with overall intrapartum care was related to deficiencies in partner's medical care (OR 5.6; 2.7–11.2), involvement in decision-making during childbirth (OR 2.6; 1.3–4.9), midwives presence in the labour room (OR 2.4; 1.2–4.7), and ability to discuss the birth afterwards (OR 2.0; 1.1–3.8). After emergency caesarean section 46% judged the partner's medical intrapartum care as most deficient (OR 1.73; 1.05–2.86), and after elective caesarean section 40% of the fathers judged involvement in decision-making as deficient (OR 4.07; 1.95–8.50). When the fathers had participated in a spontaneous vaginal birth they were dissatisfied with the presence of the midwife in the labour room (OR 1.72; 1.03–2.87).
Conclusions: Deficiencies existed in the intrapartum care and were judged differently depending on mode of birth. The fathers needed to feel secure about the women's medical care, and wanted to be involved and supported.
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1. Background

Fathers' involvement in pregnancy, childbirth and fatherhood has been found to be of relevance for their own health and wellbeing, and also for their partner's and children's health.[1] However, for most men the birth of their baby is an emotionally demanding experience,[2–4] which usually has a positive impact on them.[2] Significant memories include labour pain,[2,5] cutting the umbilical cord,[2,4] and about meeting the newborn baby.[2] Offering support to the woman[5–8] and sharing the birth experience[7] have been reasons for men being present during childbirth. Other reasons have been to create a close relationship to the baby and to fulfil social expectations from their partner and/or midwife.[2,7] However, men have sometimes been unprepared for the birth experience, leading to discomfort, worries and anxiety.[2,3,5] During labour and birth fathers have been supported when staff provided ongoing information about the labour process[9–11] and they had been able to ask questions.[9] The presence of a midwife in the labour room has been appreciated which in turn has reduced fathers' levels of anxiety.[9–11] Mode of birth has impact on fathers' birth experiences and those with a positive experience are more likely having participated in their partner's spontaneous vaginal birth. A less rewarding birth experience has been described in relation to instrumental and urgent surgical births. These situations often include limited time to give support to the fathers and may lead to feelings of anxiety and a loss of control.[10] Intrapartum care is expected to be shaped by parents' preferences;

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and satisfaction with given care has been pointed out as important.[12] Expectations of care are usually develop from conversations with friends and family, previous childbirth experiences, and more formal insights gained through antenatal classes and reading.[13] Parents' satisfaction with given care has been described as an indicator of care quality,[14] and may be used to improve healthcare. Dissatisfaction with given care has been related to professionals lacking skills, giving inadequate information, and professionals restricted in number. To increase satisfaction with given care, the care should be individualized.[14] The most important determinants for patient satisfaction, in general, have been related to respect for patient preferences, and giving emotional and physical support.[15]

Expectant fathers are concerned for their female partner when giving birth and want most likely her to receive high quality of intrapartum care. Evaluating professionals' care and support given during birth is important in order to learn which aspects could be improved. So, therefore our aim of the study was to explore Swedish fathers' intrapartum care quality experiences, with a specific focus on care deficiencies in relation to the birth mode. A secondary aim was to explore which issues of quality contributed most to dissatisfaction with the overall assessment of the care.

2. Methods

2.1. Design

A cross-sectional design as a part of a prospective longitudinal survey.

2.2. Participants and procedure

Recruitment for the prospective longitudinal survey took place during one year (2007) in Northern Sweden and included all three hospitals in this region with 2396 births in 2008.[16] Two weeks prior to the planned routine ultrasound screening examination, offered to all pregnant women in gestational weeks 17–19, information about the study was sent to all pregnant women and their partners. After the ultrasound screening, the midwife in charge of the examination asked the partners, whom were all male, if they wanted to participate in the study. In this paper, the study participants are called 'fathers'. Inclusion criteria were mastering of the Swedish language and a non-malformed foetus found at the ultrasound-screening. The fathers consented to participate in the study by signing an agreement form and were given the opportunity to complete the first questionnaire on site and put it in a sealed envelope, or at home and return it in a pre-stamped envelope. A reminder letter was sent to non-responders after two weeks and after four weeks a new questionnaire was sent out. The second questionnaire was delivered by mail two months after birth and included a prepaid envelope and a similar reminder process. To be included in the present study fathers who had answered the questions about the quality of intrapartum care two months after birth were identified. The background characteristics were collected in mid pregnancy, and data about the actual birth two months after birth. The included sample after two months after birth corresponds to 58% (827/1414) of those who originally consented to participate in mid pregnancy, and 74% (827/1112) of those who actually received the questionnaire two month after birth. After the first questionnaire in mid pregnancy eight fathers moved, 14 withdrew participation, five pregnancies ended in miscarriages and five in intrauterine deaths. These fathers did not receive the questionnaire two months after birth, nor did the fathers who did not return the questionnaires during pregnancy.

2.3. The questionnaires

The questionnaire delivered two months after birth included nine questions related to quality of intrapartum care. These questions were inspired of the 'Quality from the Patient's Perspective' (QPP) scale where two aspects of each question were assessed, perceived reality (PR) (actual care received) and subjective importance (SI) (how important the aspect was) of that particular item. Asking for study participants' PR and SI have previously been used for women's aspects of intrapartum,[17] and postnatal care;[18] and for fathers' experiences of antenatal care quality.[19] An example of the questions used in our study was worded: "*I was involved in decision-making during labour and birth*". The response categories for perceived reality were ranging from 'Do not agree at all' (=1) to 'Totally agree' (=4); and for the subjective importance 'Of little importance' (=1) to 'Of very great importance' (=4). Both of the response categories included 'Not applicable' which was excluded from the analyses.[18,20,21] An index was created by combining the answers for the questions about the quality of intrapartum care in relation to the SI and PR of each question, following the instructions from the creators.[20] '*Deficient care*' indicated aspects of care that are considered important by the respondents but were partially absent from the actual care, therefore perceived as less than good. '*Balanced care*' reflected the needs of the respondents and was described when the respondents rated high or low scores on both SI and PR. '*Excessive care*' was about aspects which were considered as not important but the care was beyond their expectations ('too much care'). According to the recommendations by the inventors of the QPP scale actions to improve the quality of care should be taken if >20% report 'Deficient care' for a specific issue.[20,21] The index was dichotomised into the categories deficient care (=1), and not deficient care (balanced and excessive care = 0). In the same questionnaire the overall assessment of the care was worded: "*What is your overall assessment with the intrapartum care?*". The question was answered on a five-point rating scale ranging from 'very satisfied' to 'very dissatisfied'. For the analysis, we dichotomised data into 'satisfied' (very satisfied and satisfied) and 'dissatisfied' (neither satisfied nor dissatisfied and dissatisfied and very dissatisfied). Furthermore, the variables used for the description of the study sample were socio-demographic background, actual mode of birth, self-reported complication during labour and birth such as bleeding and need for surgery, neonatal intensive care and birth experience. The questionnaires were tested in a Swedish context for face validity of 12 fathers; only minor wording was changed due to their comments. The reliability of the questions was assessed with the Cronbach's alpha coefficient, which was 0.83 for PR and 0.82 for SI[22] for intrapartum care.

2.4. Data analysis

Differences between first-time and repeat fathers were calculated using Chi-square test for independence. Paired samples *t*-test was calculated for the differences between PR and SI for each statement.[22] Differences between variables related to quality of care across mode of birth were assessed using one-way ANOVA. In order to find which statements most strongly associated with the mode of birth and dissatisfaction with intrapartum care logistic regression analysis was used.[23] The statistical analyses were conducted by using the Statistical Package for Social Sciences version 18.0.

2.5. Ethical considerations

This study was approved (17th January 2006) by the Regional Research and Ethics Committee at Umeå University, Swedenc

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