Sexual & Reproductive Healthcare 8 (2016) 1–5

Contents lists available at ScienceDirect

Sexual & Reproductive Healthcare

journal homepage: www.srhcjournal.org

Partners' perspective on care-system support before, during and after childbirth in relation to parenting roles

Anna Vikström [a,*], Mia Barimani [b]

[a] Department of Neurobiology, Care Sciences and Society, Academic Primary Health Care Centre, Karolinska Institutet, SE-141 83 Huddinge, Sweden
[b] Department of Women's and Children's Health, Division of Reproductive Health, Karolinska Institutet, SE- 171 76 Solna, Sweden

ARTICLE INFO

Article history:
Received 30 April 2015
Revised 7 November 2015
Accepted 26 November 2015

Keywords:
Focus group study
Partner support
Pregnancy
Childbirth
The infant period

ABSTRACT

Objectives: To explore (i) ways in which partners experience support from care systems before, during, and after childbirth in relation to their parenting roles and (ii) ways in which support can improve.
Methods: Four focus group interviews (n = 17; median age = 35; age range = 24–46) and inductive content analysis.
Results: Analysis revealed the following three categories: (1) Care staff include or exclude in relation to partners' parenting role; (2) Care systems continuity; (3) Being a supportive partner. The latent content of the categories was formulated into a theme: being engaged and wanting to be included.
Conclusions: Because partners are engaged parents, who support the woman giving birth, they must feel included during pregnancy, birth, and postpartum care and during encounters within child health care units. This would require (i) information that directly targets partners before and after childbirth, (ii) specially adapted venues for parent education, and (iii) personal, partner-focused discussions with care staff.

Introduction

Increased acknowledgement exists regarding men's reproductive rights and their reproductive health needs – including partners' active, informed involvement in maternity, childbirth, and child care systems [1]. Fathers and partners want care systems to support them by preparing them for parenthood. As new parents, they want advice and support from the care systems as they enter their new roles [2–4].

Research shows that these expectations are not met. Partners perceive maternity care services as unwelcoming, and many partners feel excluded and fearful [5]. One study reports that ways in which midwives cared about and gave attention to them (throughout birthing) affected fathers' senses of security [2]. Deave reports that fathers expressed feelings of exclusion and of being bystanders during ante- and postpartum care [6]. Others report that postpartum care has limitations when it comes to involving partners [4,7]. In a prospective longitudinal study in Sweden, 21% of the fathers (N = 827) were dissatisfied with overall postpartum care [8]. The parents also need continuity that comes with connected, coherent care [9]. Continuity means that parents receive information that enables self-management, they are involved with planning for discharge, they are notified regarding various care pathways, and they develop a relationship with a trusted clinician [9,10].

Parents have expectations regarding antenatal parent education that prepares them for parenthood [11]. One study reports that low, education-session attendance (after the birth) was associated with daytime meetings [12].

Regarding care-system support associated with the parenting role, studies primarily focus on male partners – and have not included female partners and their perspectives on care-system support for them as parents. McKelvey reports that postpartum care was the area of least satisfaction for co-mothers [13]. Another study reports that lesbian co-mothers felt predominantly included and accepted by maternity service providers [14].

Research, which describes partners' perceptions of ways in which support might be realised across the care continuum in relation to their roles as expectant and new parents, has not been found. Consequently, this study's purpose was twofold: to explore (*i*) ways in which partners experience support from care systems before, during, and after childbirth in relation to their parenting roles and (*ii*) ways in which support can improve.

Methods

Care context for expectant and new parents in Sweden including the time of birth

Sweden's antenatal care system is responsible for pregnancy care; antenatal midwives in antenatal units are also responsible for

* Corresponding author. Department of Neurobiology, Care Sciences and Society, Academic Primary Health Care Centre, Karolinska Institutet, SE-141 83 Huddinge, Sweden. Tel.: +46708142236.
E-mail address: anna.vikstrom@sll.se (A. Vikström).

http://dx.doi.org/10.1016/j.srhc.2015.11.008
1877-5756/

postpartum check-ups within four months after childbirth. The system's mission (as stated in its antenatal care guidelines) is to prepare both parents for childbirth and parenthood; the guidelines emphasise the importance of sharing information and including the woman's partner in all meetings [15]. First-time parents are supposed to be invited to attend parent education sessions.

Intrapartum care units in hospitals are responsible for childbirth and for the mother and child up to one week after childbirth, which includes contact after the 2–3 days of hospital stay. Partners are invited to stay in the postpartum care (PC) unit. The maternity care concept includes care given in antenatal units and intrapartum units.

Child health care (CHC) units are responsible for child health care from age 0 to 6 years. About one week after childbirth, a CHC nurse meets the new parents and their child.

Setting and study participants

A large Swedish city constituted the study's setting. Data were collected via focus group interviews – a suitable method when a study's objectives are to (*i*) find out how a particular group views a phenomenon and to (*ii*) minimise interviewer's influence on conversations [16]. We used a semi-structured interview guide that was based on topics aligned with the purpose of this study. The guide aided gathering data on (*i*) perceived support from antenatal, postnatal, birth, and child-care units; (*ii*) experiences of care system continuity; (*iii*) descriptions of various types of support that might have led to participants feeling strengthened in their parenting role; and (*iv*) types of information participants wanted/needed.

Inclusion criteria were: (*i*) all parents had to have at least one child; (*ii*) their youngest child's age had to be one year or younger; (*iii*) all participants had to be able to read and speak Swedish; (*iv*) participants had to experience childbirth at different hospitals; (*v*) study participants had to be partners of mothers who had given birth (birth mothers).

The partners were fathers and co-mothers. Study participants were recruited from three antenatal units in the city and surrounding suburbs. The interviews were held in these units. To recruit participants, an antenatal team leader introduced the study's design to antenatal care staff. Most participants were recruited from parent education groups (during or after pregnancy) and were contacted again after delivery. A few participants were recruited from the antenatal clinics before or after birth. All participants received oral and written information, and they gave their informed consent to participate. Study participants could bring their children to the interview sessions.

Four focus group interviews were held with 17 partners (N = 17), fourteen (n = 14) fathers and three (n = 3) co-mothers; median age = 35; age range = 24–46. Three groups with fathers (one group with four participants and two groups with five participants) and one group with co-mothers (three participants) and four birth mothers (not included as participants). Five (n = 5) participants had more than one child; twelve (n = 12) had just had their first child. The volume of data sufficient for credibly responding to research questions varies – depending on phenomena complexity and data quality [17].

Data collection and data analysis

Focus group interviews were held between February and May 2014; the interviews took between 1.5 and 2 hours. Interviewers used a guide with semi-structured questions. During the interview period, the authors and two other researchers took turns assuming the non-participant observer role. The interviewers/authors were not involved in the study participants' care at that time.

Within the scope of the research objectives and without interviewer interference, study participants were given a high degree of freedom for speaking with each other about their experiences.

Each focus group interview was recorded and transcribed verbatim. The transcribed text was analysed in several steps using inductive content analysis [17,18]. Initially, each interview was read several times to get a sense of the whole. All study-objective-related data from the interviews were extracted and compiled into one document. Meaning units were identified, abstracted, and labelled with a code in an iterative procedure; both authors read and discussed the units. Codes were abstracted to categories that referred to a descriptive level of the content and an expression of the manifest content. Together, the two authors discussed and then revised the tentative categories. The underlying meaning, that is, the latent content of the categories, was formulated into a theme.

A university research ethics board (2013/1841-31) approved the research.

Results

Table 1 presents the theme, categories, and subcategories that emerged from the interview data. The theme indicates that study participants were involved as parents and partners and that during maternity and early child health care, they wanted care staff to make them feel included as parents and partners.

Care staff include or exclude

Care staff made the study participants feel visible and included when participants were asked questions or when care staff told participants what they could do in various care processes:

> … they also talk about what I can do. And they see – they also see the father and ask if I have any questions. For example, they don't assume that the conversation is over just because the mother has no questions. They see both of us, and I think that's rather nice. They actually see and talk about what I can do to participate – so it's not just about the mother and her child. I actually have a part in it, too.

Study participants felt that care staff encouraged them by saying that they have an important role to fulfil as a parent, for example, their roles during childbirth and parental leave:

> I think a little about the courses we had – particularly before the birth. And they emphasised the role of how important you are – during the birth, and so on. They push for taking out parental leave and that it's good for the baby, the relationship, and everything … so … I think that anyway, I got, I got a certain push in which … that I have an important role to play.

A sense of exclusion did not occur during the birth; it manifested in other care units. Despite a generally positive reception from care staff, study participants got the sense of being an appendage. While they felt satisfied with friendly receptions and various staffs' skills, first-time partners, in particular, did not feel as included as they would like to be. It was obvious to the study participants that

Table 1
Results of data analyses.

Theme	Category	Subcategory
Being engaged and wanting to be included	Care staff include or exclude in relation to partners' parenting role	Partner inclusion Partner exclusion
	Care systems continuity	Parent education
	Being a supportive partner	Support during breastfeeding Giving support as a partner Getting support as a partner