

How do midwives and fathers communicate during labour and birth?

An ethnographic study in the North West of England

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Abstract

This ethnographic study explores midwife-father communications during childbirth. Fathers are relative newcomers to the world of birth. Existent research has focused on their roles, needs, feelings and behaviours and has identified midwives as ideally placed to engage fathers during childbirth. However, a scoping review of 34 key studies found that, to date, there has been little focus on midwife-father communication.

The aim of this research was to investigate midwife-father communications, to gain a deeper understanding of the complex relationships involved, with a view to enhancing the experiences of the central birth triad: mother, father and midwife. Direct observations during childbirth in four different birth environments and semi-structured postnatal interviews involved 11 couples and 16 midwives.

Thematic analysis was employed to analyse the data. The five key findings are: 1. the midwife-father relationship currently relies largely on non-verbal communications, guesswork and assumption; 2. midwives' familiarity with the childbirth landscape can blunt their awareness of the father's perspective; 3. birth environment (place and people) has a clear effect on midwife-father communications; 4. there are considerable variations in parents' expectations of the father's role, which remain un-explored; 5. there is great potential for all three central players to learn from each other during childbirth: including opportunities for the father to learn about birth from the mother and the midwife, and for the midwife to learn about the woman from the father.

This study recommends the development of approaches to facilitate verbal midwife-father communications. Its insights into the father's perspective of the childbirth landscape point to ways in which the midwife can help him habituate. Discoveries about the impact of birth environment on midwife-father communication and on fathers' behaviours highlight the need to 're-frame' the father's role: to provide support and appropriate spaces in hospital to take a break; to move away from the current emphasis on 'busyness' and to articulate the fundamental importance of 'presence'.

Table of Contents

List of tables.....	x
List of figures	xi
List of appendices	xii
Glossary	xiii
Transcription of fieldnotes and interviews.....	xvi
List of abbreviations.....	xvii
Structure of thesis	xviii
Chapter 1 Midwives, fathers and birth: the historical context	1
1.1 Introduction.....	1
1.1.1 Birth as a rite of passage	1
1.1.2 Human childbirth: a social event and ‘women’s work’	1
1.1.3 The involvement of fathers in childbirth.....	2
1.2 Place of birth	3
1.2.1 Maternity service policy and place of birth	3
1.2.2 Birth moves from the private to the public domain	4
1.3 Who is present during childbirth?	5
1.3.1 Mapping fathers’ attendance.....	6
1.3.2 Why did fathers start to attend?	8
1.3.3 The ‘medicalisation’ of childbirth	10
1.4 Other factors impacting on fathers’ involvement.....	10
1.4.1 Consumer pressure groups.....	11
1.4.2 Second wave feminism	12
1.4.3 Policy drivers.....	12
1.4.4 Evidence-based care	13
1.5 Conclusion.....	13
1.6 Summary box	14
Chapter 2 Scoping review of the literature	15
2.1 Introduction.....	15
2.2 Rationale for choosing a Scoping Review	16
2.2.1 Overall aim.....	17
2.3 Methods	17
2.3.1 Search strategy.....	17
2.3.2 Eligibility criteria	18
2.3.3 Information sources.....	18
2.3.4 Selecting and charting of evidence	20

2.3.5	Analysis of included studies	21
2.4	Results	21
2.4.1	Research focus of the 34 included studies.....	21
2.4.2	Characteristics of included studies.....	23
2.4.3	Thematic synthesis of results.....	27
2.5	Discussion	33
2.5.1	Strengths and limitations.....	35
2.6	Conclusion.....	35
2.7	Summary box	36
Chapter 3	Methodology	37
3.1	Introduction.....	37
3.2	Research question, aims and objectives	37
3.3	Applied health research.....	37
3.3.1	This study's fit within the AHR paradigm.....	38
3.3.2	The biopsychosocial model of childbearing.....	38
3.4	Philosophical framework for the study	38
3.4.1	Social constructivism.....	38
3.4.2	Ontology, epistemology, axiology and methodology	39
3.5	Qualitative research.....	42
3.5.1	Characteristics of qualitative research: its 'fit' for this study ..	42
3.5.2	Qualitative research - influencing practice in health care	43
3.5.3	Rationale for rejecting a mixed-methods approach	43
3.5.4	Qualitative approaches considered and rejected	44
3.6	Ethnography	45
3.6.1	The development of ethnography.....	45
3.6.2	Ethnography and midwifery research.....	46
3.6.3	Definition and rationale for employing this approach.....	46
3.6.4	The study in relation to different ethnographic 'schools'	46
3.6.5	Framing and developing the research question	47
3.6.6	Research participants.....	48
3.6.7	Data collection and analysis.....	49
3.6.8	Challenges and limitations of an ethnographic approach.....	51
3.7	Quality and rigour in qualitative research	51
3.7.1	Reflexivity.....	53
3.8	Summary box	54

Chapter 4 Methods	55
4.1 Introduction.....	55
4.2 Study design.....	55
4.3 Setting.....	55
4.3.1 Demographics.....	55
4.3.2 Maternity services.....	56
4.4 Sampling strategy.....	56
4.4.1 Parent participants.....	56
4.4.2 Midwives.....	57
4.5 Ethical issues.....	58
4.5.1 Ethical and governance approvals.....	58
4.5.2 Service user involvement.....	58
4.5.3 Gaining access.....	58
4.5.4 Informed consent.....	59
4.5.5 Burden on participants and measures taken to minimise.....	59
4.5.6 Study Distress Policy.....	60
4.5.7 Researcher's role: emergency / 'poor practice' situations.....	60
4.5.8 Data management.....	61
4.5.9 Burden on the researcher and supervisory team.....	61
4.5.10 The 'green light' to proceed.....	61
4.6 Publicising the study.....	62
4.6.1 Midwives and the wider maternity team.....	62
4.6.2 Publicising the study to parents.....	65
4.7 Recruitment and informed consent process.....	66
4.7.1 Recruitment: parents.....	66
4.7.2 First face-to-face meeting with potential participants.....	67
4.7.3 Written informed consent process: parents.....	68
4.7.4 Parent participant profiles.....	69
4.7.5 The couples who declined to take part.....	71
4.7.6 Recruitment and informed consent: midwives.....	72
4.7.7 Midwife participant profiles.....	72
4.8 Data collection and preliminary analysis.....	72
4.8.1 Data collection Phase 1 - observations.....	73
4.8.2 Data collection: birth environments.....	73
4.8.3 Data collection Phase 2 - semi-structured interviews.....	77
4.9 Data analysis.....	80

4.9.1	Stages 1 and 2: transcription / reading and familiarising, taking note of items of potential interest	81
4.9.2	Stages 3 and 4: coding across entire dataset and searching for themes	83
4.9.3	Stage 5: reviewing themes and producing a thematic map, with themes and sub-themes.....	84
4.9.4	Stage 6: defining and naming themes.....	84
4.9.5	Stage 7 Writing – final analysis	84
4.10	Summary box	85
Chapter 5 Findings 1: Spaces.....		86
5.1	Introduction.....	86
5.2	Theme 1 Spaces, domains and territories	86
5.2.1	Homebirth: midwives' and fathers' perspectives	87
5.2.2	Hospital triage: fathers 'handing over' to midwives	95
5.2.3	Birth centre.....	97
5.2.4	Delivery suite.....	97
5.2.5	'Transfer' in labour and midwife-father communications	101
5.2.6	Maternity theatre	102
5.3	Theme 2 Circles of intimacy: people create the birth space	107
5.3.1	The couple	107
5.3.2	Triadic mother-father-midwife relationship	111
5.3.3	A Greek chorus	116
5.4	Summary box	120
Chapter 6 Findings 2: Teams		121
6.1	Introduction.....	121
6.2	Theme 3 Who's in the team?.....	121
6.2.1	The midwife's approach	121
6.2.2	The midwife's assessment of the couple.....	124
6.2.3	Fathers as team members	125
6.3	Theme 4 Types of talk and tools of communication.....	129
6.3.1	Factors influencing communications	130
6.3.2	Building rapport.....	132
6.3.3	Dyadic communications	137
6.3.4	Types of talk and communication between midwives and fathers	143
6.4	Summary box	145

Chapter 7 Findings 3: Navigation and socialisation	146
7.1 Introduction.....	146
7.1.1 Theme 5: navigation and socialisation	146
7.2 Midwives and childbirth: on familiar terrain.....	146
7.2.1 Midwives' socialisation into childbirth	146
7.2.2 Midwife's expectations of the father	150
7.2.3 Fathers being busy and involved	152
7.2.4 Fathers being close and involved.....	153
7.2.5 Midwives assess the father's performance	153
7.2.6 Cutting the cord.....	155
7.3 Fathers and childbirth: learning to navigate unfamiliar terrain	159
7.3.1 How fathers prepared themselves.....	160
7.3.2 How fathers used their past experience of birth	162
7.3.3 Fathers drawing on wider life experience to navigate	164
7.3.4 Fathers subjugate their feelings	167
7.3.5 Fathers working out how to 'be' during childbirth	170
7.4 Summary box	173
Chapter 8 Synthesis of findings	174
8.1 Introduction.....	174
8.2 Key findings about the midwife-father relationship	174
8.2.1 Midwives and fathers: the nature of their communications..	174
8.2.2 Non-verbal communications are central to the relationship.	174
8.2.3 A relationship based on guesswork.....	174
8.3 The childbirth landscape: midwives' and fathers' experiences	175
8.3.1 Birth as a 'social event'	175
8.3.2 How midwives can help fathers to navigate	175
8.4 The midwife-father relationship in different birth environments	176
8.4.1 Fathers confined	176
8.4.2 Freedom and autonomy	176
8.4.3 Fathers and maternity theatre	176
8.5 Midwives' and fathers' expectations	176
8.5.1 Midwives and the 'ideal' birth partner	177
8.5.2 Fathers' expectations	177
8.6 The birth triad: its potential for knowledge-sharing	177
8.7 Summary box	178

Chapter 9 Discussion and conclusions	179
9.1 Introduction.....	179
9.2 The study’s original contribution to knowledge	180
9.2.1 What was revealed through the lens of ethnography?	181
9.3 Key findings situated in relation to existent literature.....	182
9.3.1 The midwife-father relationship: characterised by non-verbal communication	182
9.3.2 Experiences of the childbirth landscape	186
9.3.3 Midwife-father relationship: different birth environments	189
9.3.4 Midwives’ and fathers’ expectations	192
9.3.5 The birth triad: its potential for knowledge-sharing.....	194
9.3.6 Synthesis of findings in relation to social constructivism	197
9.4 Strengths and limitations	198
9.5 Recommendations: education, practice, research, policy.....	200
9.5.1 Education and practice.....	200
9.5.2 Policy.....	201
9.5.3 Research.....	202
9.6 Final summary.....	203
References.....	205
Appendices.....	227

List of tables

Table 1	PEO Framework, based on Bettany-Saltikov (2016)	17
Table 2	Definition of key concepts employed in literature search	17
Table 3	Types of literature identified	19
Table 4	Research focus of the 34 studies	22
Table 5	'Source' of 13 recruited couple participants	67
Table 6	Parent participant profiles	70
Table 7	Place of birth	73
Table 8	Length of observations	76
Table 9	Integrating preliminary themes from 3 data sets 19.05.22	84
Table 10	Five themes re-ordered and integrated into 3 Findings chapters	85
Table 11	Differences between home and hospital for the father	86
Table 12	Summary of preliminary themes from the three data sets; V1.1, 2018.11.28	287

List of figures

Figure 1 Modified PRISMA flow diagram (Moher et al, 2009)	20
Figure 2 Participant-observer continuum (adapted from Gold, 1958) ..	50
Figure 3 Ethnicity of borough's population (ONS, 2012).....	55
Figure 4 Timeline: engagement with study site to ethics / governance approvals.....	62
Figure 5 Timeline: publicising study, recruitment and data collection ..	63
Figure 6 Recruitment and informed consent: midwife participants	65
Figure 7 Recruitment and informed consent: parent participants	66
Figure 8 Fieldnotes Lou and Donal N18, sketch 4.....	91
Figure 9 Fieldnotes Jo and Ricky N23, sketch 2	94
Figure 10 Fieldnotes Lou and Donal N18, sketch 5.....	95
Figure 11 Fieldnotes Ayesha and Hamid, N22 sketch 3	99
Figure 12 Fieldnotes Jill and Mick N21, sketch 1	112
Figure 13 Fieldnotes Rae and Will, sketch 3.....	112
Figure 14 Fieldnotes Hazel and Ben N25, sketch 3.....	113
Figure 15 Fieldnotes Rosa and Dan N20, sketch 2.....	117
Figure 16 Factors influencing midwife-father communications	130
Figure 17 Types of talk during initial assessment in labour	133

List of appendices

Appendix A: Key concepts and variants employed in literature searching	227
Appendix B: Key studies for Scoping Review	228
Appendix C: ScR key studies: development of Thematic Analysis	241
Appendix D: Reflexive account	242
Appendix E: Taylor’s 8 ‘big-tent’ criteria for excellent qualitative research	246
Appendix F: Ethics and HRA approvals	248
Appendix H: Participant Information Sheet – Parents.....	251
Appendix I: Written Informed Consent Process – Parents	257
Appendix J: Study distress policy	263
Appendix K: Participant Information Sheet - Midwives.....	266
Appendix L: Flyer - Study summary information and publicity for staff	272
Appendix M: Written update for staff.....	273
Appendix N: Written Informed Consent Process - midwives.....	274
Appendix O: Flyer for parents – publicity for the study	276
Appendix P: Contacting the researcher when labour is established ..	277
Appendix Q: ‘Thank you letter’ to parents not included in the study .	278
Appendix R: Observation guide, informed by Spradley’s 9-dimension framework for ethnographic observation.....	279
Appendix S: Example of fieldnotes	280
Appendix T: example of fieldnote sketch	281
Appendix U: Semi-structured interview guide	282
Appendix V: Summary and illustration of Thematic Analysis	284
Appendix W: Dissemination plan	289
Appendix X: Recommendations for education and practice	290

Glossary

Active birth	Approach to childbirth encouraging woman to remain mobile; emphasises partner's support role; sessions offered by NHS / private providers
Antenatal classes	Preparation for childbirth / early parenting offered by NHS / private providers
Assisted birth	Use of ventouse or forceps (see below) to expedite baby's birth
Birth	'the emergence of a baby from the body of its mother' (OED, 2020) employed as noun and verb to denote mother's active role in childbirth
Birth centre	Birth environment for healthy 'low risk' women; 'midwife-led' care; 'homely' environment; on separate floor to Delivery Suite at study site
Birth plan	Preferences recorded by (some) parents, specifying wishes for care during childbirth / immediately afterwards; discussed with midwife during pregnancy or labour
Birth-space	Physical birth environment + the people within it
Cardiotocograph monitor	Electronic method of recording baby's heart and mother's uterine contractions
Childbirth	Process of woman giving birth to a child. Includes all three stages of labour; spontaneous / assisted vaginal birth and by Caesarean Section
Childbirth continuum	Pregnancy, labour, birth, postnatal period (up to six weeks)
Community midwife	Provides antenatal / postnatal care in community plus intrapartum care at homebirths
Consultant-led care	Care by obstetrician for women with complications during childbirth continuum or serious co-morbidities/ health conditions unrelated to pregnancy
Delivery suite	Or 'labour ward'. Hospital birth environment; 'consultant-led' care for women with health issues; also available by woman's choice; anaesthetist-administered pain relief options (e.g. epidural). Midwives provide care in liaison with medical colleagues

Doula	Lay woman employed to provide support during childbearing
Established labour	Woman has regular uterine contractions, getting longer, stronger, closer together; cervix typically at 3 – 4 cm dilated, though labour may have ‘established’ before or after this stage
Father	Male parent
First stage of labour	Progressive effacement and dilatation of the woman’s cervix to ‘full dilatation’ (10 cm) and downward movement of baby towards the vagina
Forceps	Surgical instrument used by doctor to expedite baby’s birth due to concern about mother’s or baby’s wellbeing
High risk woman	Woman with certain pre-existing medical conditions / who develops problems at any stage of childbearing continuum; care led by obstetrician; midwives also involved
Homebirth	Woman giving birth at home. Legal option in UK; national policy states should be offered to all ‘low risk’ women
Hypnobirthing	Method of preparation for childbirth: combines visualisation, relaxation, deep breathing; woman + birth companion attend sessions; emphasises ‘coaching’ / reminders during labour from partner
Intrapartum	Timespan of childbirth, from start of contractions to end of 3rd stage
Level 3 NHS facility	Maternity hospital incorporating midwifery, obstetric anaesthetic and all 3 levels of neonatal care (‘special’, high dependency, intensive)
Low risk woman	Childbearing woman who is fit, well, free from obstetric problems; suitable for ‘midwife led care’ throughout childbirth continuum
Maternity theatre	Operating theatre on delivery suite for assisted / Caesarean / other surgical obstetric procedures
Mayes’ Midwifery	One of two standard midwifery text books ¹ accessed by majority of UK midwives during training and beyond

¹ Alternative is: Marshall, J. and Raynor, M. eds. 2020. *Myles Textbook for Midwives*, 17th ed. London: Elsevier

Medical model	Childbearing viewed as potentially pathological, safe only in retrospect; strong preference for hospital birth, technological screening / monitoring; medical intervention to correct deviations from anticipated 'norms' e.g. rate of progress in labour
Midwife-led care	Midwife is lead health-care professional throughout childbirth continuum; refers to medical colleagues if problems arise
Multiparous	Used in study to refer to mother / father / couple having second or subsequent baby
NHS Foundation Trust	Organisational unit within NHS in England; manages hospital and community-based services
One Born Every Minute	British observational documentary series about childbirth; screened on Channel 4; available from: https://www.channel4.com/programmes/one-born-every-minute/on-demand/47242-001
One-to-one midwifery care	Provision of continuous midwifery care to woman in 'established labour'
Parentcraft	Term used from 1970s; replaced 'mothercraft' to reflect inclusion of fathers. Used interchangeably with 'antenatal classes'.
Primiparous	Used in study to refer to mother / father / couples having 1st baby
Remi / remifentanyl	Short-acting, synthetic opioid analgesic drug; used in labour; administered by anaesthetist on delivery suite
Second stage of labour	Period from cervix 'fully dilated' until baby's birth
Singleton pregnancy	Mother pregnant with one baby
Social model	Views childbearing as largely physiological, normal social event, not necessarily requiring medical intervention / hospital birth. Emphasises use of preventative measures / simple remedies e.g. for slow progress in labour
Supervisor of midwives	Element of UK midwifery's governance structure at time of planning study; replaced (2017) by 'Professional Midwifery Advocates' (England) https://www.nmc.org.uk/standards/midwifery/changes-to-midwifery-supervision

Third stage of labour	Period from birth up to and including delivery of the placenta and control of bleeding
Triage	Maternity hospital admission department, staffed by midwives; 'first point of contact' for parents
Ventouse	Or 'vacuum cup'; suction device; used (usually by obstetrician, sometimes by trained midwife) in second stage of labour to expedite birth

Transcription of fieldnotes and interviews

In fieldnote transcripts, the following abbreviations are used:

♀	woman / mother
♂	man / father
ctn	uterine contraction
MA	midwifery assistant
MW	midwife
StMW	student midwife

In interview transcripts, participants' utterances were recorded verbatim and have not been altered to standard English. The rationale for this is given in the Methods chapter (section 4.9.1) Typographical emphases are used to reflect the speaker's tone (*italics* / **bold** / underline); comments and observations (made by the researcher during interviews) are included when the speaker displayed particular emotions; an ellipsis denotes a hesitation or short pause.

List of abbreviations

GP	General practitioner; community-based family doctor, access point for general health needs / referral to specialist services
HoM	Head of Midwifery
HRA	Health Research Authority; approvals process for research in NHS organisations (England)
IRAS	Integrated Research Application System; single system for ethics approvals' applications for research in health and social care organisations (UK)
MSLC	Maternity Services Liaison Committee; statutory body of commissioners, providers and users of services for planning, monitoring and improvement of local services (NCT 2013). Functions taken over (2016) by National Maternity Voices (https://nationalmaternityvoices.org.uk)
NHS	National Health Service
NMC	Nursing and Midwifery Council; UK body regulating all aspects of midwives' practice
ONS	Office for National Statistics
REC	Research Ethics Committee; group appointed to review research proposals for formal assessment of conformity to recognised ethical standards, e.g. respecting participants' dignity, rights, safety and well-being Governance of RECs falls within remit of UK health departments
UNICEF 'Baby Friendly' award	Evidence-based programme of education and training regarding infant feeding and care

Structure of thesis

This thesis consists of nine chapters. The first explores the cultural and historical context of fathers' involvement in childbirth in the UK; the second is a scoping review of relevant literature. The third chapter opens with a statement of the research question, aims and objectives; it then sets the study within its methodological context and explains why ethnography was chosen as the most appropriate methodology to meet the study's aims. Methods are described in chapter four. The following three chapters present the findings. These are summarised in chapter eight, which provides a 'bridge' to the final chapter. Chapter nine, the discussion, concludes with recommendations for education, practice, research and policy. A summary of the thesis structure is given below.

	Chapter
I. Introduction and research context	1. Background and historical context 2. Scoping review of the literature
II. Research strategy	3. Methodology 4. Methods
III. Empirical work	5. Findings 1 Spaces 6. Findings 2 Teams 7. Findings 3 Navigation and socialisation 8. Synthesis of findings
IV. Discussion	9. Discussion and conclusion

Chapter 1 Midwives, fathers and birth: the historical context

1.1 Introduction

Childbirth is a universal event, which involves 'only two obligatory characters...the mother and the baby' (Odent, 2008, p.131). The participation of other people in childbirth depends on the cultural context. 'Culture' is defined as 'the way of life of a group, the learnt patterns of behaviour that are socially constructed and transmitted' (Holloway and Todres, 2010, p.166). The cultural context for childbirth includes its settings, people, language, customs, rituals, beliefs, attitudes, behaviours and actions which inform the practices adopted and the care provided. All these factors are relevant to this study.

1.1.1 Birth as a rite of passage

All cultures recognise birth as a rite of passage (Blackshaw, 2003). For a woman, childbirth clearly represents the rite of passage to motherhood. Her physical and social status are unequivocally transformed, her embodied experience an important component of this transition (Draper, 2003). Since records began, 'every culture has had a system of midwifery' (Cassidy, 2007, p.27). The care offered to a mother varies in nature and in name, according to the society's cultural norms; notwithstanding these variations, the woman in labour is the midwife's central focus.

The father's rite of passage during childbirth is more ambiguous, since he does not have the embodied experience. Historically, a range of socially-sanctioned rituals have marked his transition, for example *couvade*, the father undergoing fasting and purification rituals during the woman's labour. In some religious traditions, the father offers prayers for the mother's wellbeing (Kitzinger, 2000). In the recent past, UK rituals for the 'absent' father included supplying the midwife with boiling water during homebirths (Odent, 1999), and participating in the public ceremony of 'wetting the baby's head' after the birth (Draper, 2003). Such rituals have rarely involved the father being physically present in labour. His attendance therefore represents a radical cultural change in practice. This study is concerned with what happens when he is present in the birth environment: how the midwife-father relationship develops in this space which in the past was occupied almost exclusively by women.

1.1.2 Human childbirth: a social event and 'women's work'

Women have laboured and given birth in the presence of other people, almost always women (Cassidy, 2007), since before records began. In their evolutionary analysis of the birth process, Rosenberg and Trevathan hypothesise that:

The practice of midwifery might have appeared as early as five million years ago, when the advent of bipedalism first constricted the size and shape of the pelvis and birth canal.

(Rosenberg and Trevathan, 2001, p.79)

Compared to other mammals, human babies' brains and skulls are relatively large; labour therefore tends to be prolonged (Saxbe, 2017), especially for first babies. The baby usually emerges facing away from the mother: should s/he require assistance, the unsupported mother may be unable to provide this (Trevathan and McKenna, 1994). At birth, the baby is helpless, unable to crawl and manoeuvre towards the mother's breast. Thus there are physiological benefits to birthing women being accompanied by other people.

Human birth has been described as 'an inherently social event' (Trevathan and McKenna, 1994, p.91); humans differ from other mammals, who tend to seek solitude as birth approaches and usually labour alone. For humans, the company of others provides companionship and support (Fourer, 2008). This helps protect the woman's privacy, encouraging oxytocin production and the smooth progress of labour (Parratt, 2008; Taylor et al, 2000).

There are rare examples of societies where women have laboured alone or in the company of male lay supporters. The women of the indigenous people of the Mexican state of Chihuahua customarily give birth alone (Chopel, 2014); Cassidy (2007) cites a small South Pacific island where the father has traditionally been the usual birth attendant. These are the exception. Birth has been conceptualised as 'women's business', 'from time immemorial' (Willis, 1989, p.94). 'Woman-to-woman help in childbirth' (Kitzinger, 2000, p.99) has been the universal norm, with women giving birth close to their mother or 'mother substitute', in the context of their family and community (Odent, 2008). The father is therefore a relative newcomer to this female world. This study explores how midwives and fathers are working to establish his role within it.

1.1.3 The involvement of fathers in childbirth

The inclusion of men in the childbirth environment was considered culturally unacceptable in the UK as recently as the 1970s (Walton, 2001). Fathers from particular ethnic and religious groups are still less likely to be present (Burgess and Goldman, 2018; King, 2016). Men's active involvement in childbirth continues to be taboo in some parts of the world today (Aygare et al, 2018).

These variations noted, over the past 60 years, there has been a significant paradigm shift in the UK away from birth as exclusively 'women's business'. Until the 1950s and 1960s, fathers were usually actively excluded. In 1967, 'Mayes' Handbook of Midwifery' advised the midwife attending a planned homebirth to ensure the mother had arranged for 'a suitable woman' to assist the midwife during labour and 'to inquire about the accommodation available for children and the husband during labour and the lying-in period' (da Cruz, 1967, p.367). This implies 'the husband' would be separated from his wife during childbirth and the following 10 days.

Over subsequent years, fathers' involvement increased. Only twenty years later, it had become socially acceptable - and furthermore expected - for fathers to be present (Dragonas et al, 1992; Kitzinger, 2000). This shift from childbirth as 'women's business' represents a significant change over a relatively brief period of time. However, scant attention has been paid to investigating what actually occurs within the dynamics of this new situation - how the three central players navigate the father's presence and roles.

Three inter-related paradigm shifts in the culture of childbirth occurred over the course of the 20th century:

- Place of birth
- Who is present during childbirth
- 'Medicalisation' and the use of technology (Wagner, 1994).

All three – and wider societal issues - impact on fathers' involvement. Advice to midwives regarding this involvement is traced by reference to successive editions of 'Mayes' Midwifery'. These span 50 years from the first to mention fathers (da Cruz, 1967), to the most recent edition (Macdonald and Johnson, 2017).

1.2 Place of birth

Until the early years of the 20th century, a majority of babies (77% in 1923) were born at home (McIntosh, 2014). Most working-class women birthed at home (Leap and Hunter, 1993); women from wealthy families were more likely to give birth in a 'maternity home'. From 1948, the NHS provided universal maternity care, based on a domiciliary midwifery service for homebirths, plus maternity hospitals for birth and postpartum care. By 1958, the homebirth rate had fallen to 36% (Tew, 1990).

1.2.1 Maternity service policy and place of birth

Two policy directives resulted in further falls in homebirths. The Cranbrook Report (HMSO, 1959) made provision for 70% of babies to be born in hospital; by 1970, the homebirth rate had declined to 13% (Tew, 1990). The Peel Report (HMSO, 1970) centralised maternity services into large acute trusts and provided a clear directive

that 100% of babies should be born in hospital. Further re-organisation of maternity services in 1976 moved midwives' employment from local authorities to hospital trusts (Cronk, 2000), changing midwives' primary focus from community to institutional settings. It has been argued that this process 'uproot[ed] them from the essential concept of the meaning of the word [midwife] to be 'with women' to being 'with institution'" (Page, 2008, p.117). The downward trend continued; by the 1980s, less than 1% of women were giving birth at home (Tew, 1990).

The concept of 'choice' within maternity services' policy

Policy from the early 1990s changed focus from centralist principles, espousing instead those of individual choice (DH, 1993; DH, 2007; NHS, 2016). Evidence about efficacy and safety, including on place of birth, was prioritised. This included support for healthy women to give birth at home. Despite these policies encouraging homebirth where appropriate, rates have remained at around 2% since 2000 (Office for National Statistics, 2017).

1.2.2 Birth moves from the private to the public domain

Policy change was the driver for the move in place of birth from the private to the public domain. Fathers' presence at birth, a shift in cultural practice of similar significance, was not driven by policy change, although The Cranbrook Report acknowledges that the labouring woman may feel isolated in hospital, suggesting 'her husband or relation should be allowed to stay with her...at least during the first stage of labour' (Ministry of Health, 1959, p.16). The 1967 edition of 'Mayes' Midwifery' afforded the father potential 'visitor status', to mitigate the mother's boredom and loneliness in hospital:

In early labour she can sew, knit, read, watch television, chat with other patients, or have her own visitors, notably her husband and her mother.

(da Cruz, 1962, p.184).

Birth therefore moved from the familiar, private environment of home, in the presence of female companions likely to be known to the woman, to large institutions in the presence of strangers, involving men and including the father. The complex relationship between place of birth and involvement of fathers is explored in the following section.

1.3 Who is present during childbirth?

A system of supporting and assisting women through childbirth is an integral part of cultures throughout the world (Odent, 2008; Tew, 1990). These birth attendants have traditionally been women (Kitzinger, 2000).

The role of the midwife

Women have been assisted by 'midwives', trained and untrained, for centuries. The word, derived from the Middle English 'mid' (with) and 'wif' (woman), describes the function of accompanying a woman during childbirth. In the past, this often included informal support from female family members (Mander, 2004). All middle-high income countries (World Bank, 2020) now have a formal system for the education and regulation of midwives (ICM, 2021). In some low-to-middle-income countries, women may (by necessity or choice) continue to receive care from informal networks of 'traditional birth attendants' (Sarker et al, 2016), who have not had formal midwifery training.

Place of birth: involvement of different players

When predominant place of birth moved to hospital, midwives continued to be the main caregivers for most women. Midwifery remains an almost exclusively female profession; a recent study (Hasana et al, 2019) found that men make up approximately 0.63% of the international midwifery workforce. In the UK, men were barred from training until 1983; at the time of writing, less than 0.3% of midwives identify as male (NMC, 2018) and in some countries, men are still not admitted into midwifery training programmes (Hasana et al, 2019). However, the move of birth to hospitals led to an associated increase in the involvement of other health professionals, including obstetricians, anaesthetists and paediatricians. Initially, these were likely to have been predominantly male (Jefferson et al, 2015). The increased involvement of men in a professional capacity is one of the key consequences of the paradigm shift away from home.

Involvement of men in childbirth

In industrialised societies, men's involvement in birth was limited to a small number of 'man midwives' from the 17th century; during the 18th and 19th centuries, the establishment of 'lying-in' hospitals for destitute women was used as an opportunity to train male doctors. The medical specialism of obstetrics developed (Tew, 1990); involvement of male physicians and surgeons increased (Odent, 2008). However, the participation of men in childbirth was confined mainly to health professionals until the 1960s, when fathers started to attend.

1.3.1 Mapping fathers' attendance

It is challenging to establish a reliable timeline tracing fathers' involvement during childbirth and a realistic picture of how many fathers attend. In the past, the father's presence was not usually registered in the mother's records (Blackshaw, 2003; King, 2016). This situation persists, despite the introduction of electronic record-keeping systems which should facilitate such recording and auditing. However, this information is not systematically documented, possibly implying that midwives' practice has not caught up with the shift towards the father's attendance, that his contribution to the birth is not worthy of record, his presence not deemed sufficiently significant to note, or that it is now so commonplace that it is 'taken for granted'.

In her 2016 review tracing fathers' involvement in childbirth, King identified a slow shift towards attendance from the 1950s onwards. In 1958, approximately 13% of fathers were present during homebirth. The following 20 years were a period of rapid change; the percentage increased from 39% (1974) to 69% in 1979 (King, 2016). The upward trend continued: Singh and Newburn's 2000 study found that 94% of women surveyed (n = 790) had their partner present during labour. The gender of the partner is not specified in this study, but the authors differentiated between support from 'partner' and 'female companion', implying the partner was assumed to be male. Fathers' presence has come to represent the 'status quo'; midwives, family and friends usually assume he will be there, unless the parents explicitly state otherwise.

Rules and regulations regarding fathers' attendance

Institutional rules applied to fathers' presence date back to the early days of their attendance (Kitzinger, 1962) and continued into the 1970s and 1980s. Fathers were often excluded during certain clinical 'procedures': admission to hospital; vaginal examination; instrumental and operative births (King, 2016; Kirkham, 1987). Such routine exclusion represents 'a very clear symbolic statement' from hospital policy-makers: the locus of control remained firmly with the institution (Davis-Floyd, 2003, p.81).

These policies gradually relaxed; by the end of the 1980s, 'Mayes' Midwifery' advised that it is usual 'for the partner to remain during admissions procedures if the couple wish this' (Sweet, 1988, p.186). However, rules excluding fathers in certain circumstances persisted into the 1990s; on occasion fathers were 'barred' during Caesarean birth (King, 2016), even when local anaesthesia was used, meaning the mother was conscious. Currently, hospital policy in most maternity units excludes the father if his partner is having a Caesarean under general anaesthetic.

Reasons for excluding fathers included reducing the risk of cross-infection (Blackshaw, 2003). It was also suggested that witnessing childbirth could negatively impact on the couple's future sexual relationship (Blackshaw, 2003; Jackson, 2012); some evidence supports this theory (Delicate et al, 2018).

Health professionals' views on fathers' attendance

There were variations in fathers' attendance depending on region, hospital and health professionals' views. Some London-based 'teaching hospitals' (providing training, education and research activity for medical staff) encouraged their attendance; as early as 1953, an un-named obstetrician at University College London (UCL) advocated for this:

We...feel that this is a combined operation...we encourage fathers if they want to come...and their wives want them there...most of them stand up to it very well...on the whole it's a terrific and exciting experience for both expectant father and mother...

(BBC, circa 1953)

The phrase, 'most of them stand up to it very well', suggests it was seen as an ordeal or test, albeit 'a terrific and exciting experience'. Unusually for the time, fathers' presence was recorded at UCL and Charing Cross hospitals; in 1964, approximately 50% of fathers were noted to be present (Blackshaw, 2003).

Throughout the 1960s and 1970s, discrepancies persisted. Midwives' views were mixed; some advocated for fathers' presence (King, 2016), others displayed antipathy. A midwife training during the late 1970s was shocked to witness the antagonism displayed by some midwives (Walton, 2001).

Historically, health professionals were the 'gatekeepers', barring or permitting the father. Although the father's presence is now expected and accepted, there continue to be restrictions placed on the number of birth companions who are 'allowed' to accompany a woman birthing in hospital. Most units put an upper limit of two, thus the 'gatekeeping' persists.

The father's inclusion brings complexities and challenges to the inter-personal dynamics of the birth environment. It was 'a practical mechanism for avoiding the complex psychodynamics involved in having to relate to both parents' (Blackshaw, 2003, p.219). This has been suggested as an unrecorded reason for his exclusion and underlines the importance of this study.

Dissenting voices

French obstetrician Michel Odent has been a consistent voice of dissent regarding fathers' presence at childbirth (Odent, 1984; 1999; 2008; 2015). Describing fathers as 'invading' the birth territory (Odent, 2008, p.140); he suggests their presence can inhibit women's physiological processes.

Other commentators also sound a note of caution, advising that it is 'the midwife's responsibility to ensure that the couple realise the importance and enormity of the decision' (Jackson, 2012, p.160). There has recently been an increase in debate which challenges the widely-held assumption that fathers 'should' be present. Discussions in both academic midwifery circles (Jomeen, 2017; Watkins 2018) and on social media (Family Included, 2015) encourage parents and midwives not to make assumptions, but to consider the options.

1.3.2 Why did fathers start to attend?

A number of possible reasons stimulated the movement towards fathers' attendance. The labouring woman's need for company and support was highlighted in the mid-20th century by early and influential childbirth author, general practitioner Dick-Read:

No greater curse can fall upon a young woman whose first labour has commenced, than the crime of enforced loneliness.

(Dick-Read, 1942, p.180)

Other reasons include change in birth-place; to 'complement' midwifery care; to support the mother – all combined with growing recognition that the father could also be present 'in his own right', to experience his baby's birth and mark his transition to fatherhood.

Change in place of birth

The shift in place of birth from home to hospital has been cited as 'the most important variable in determining partners' involvement' (King, 2016, p.398). In hospital, the potential for isolation was increased for the woman, separated from her family in an unfamiliar environment. The father's presence could alleviate her 'loneliness, pain and uncertainty' (Blackshaw, 2003, p.226). It was also assumed (by midwives and mothers) to help the labouring woman to relax in hospital (Barbour, 1990; Odent, 2008).

To 'complement' midwifery care

Fathers' increased involvement in childbirth stimulated debate in the 1970s about whether their presence constituted extra work for the midwife, or an extra pair of hands (King, 2016). The 1982 edition of 'Maye's Midwifery' advised strongly against using the 'husband' as a substitute for midwifery care, suggesting that, for the father, being left alone with 'the patient' could be a frightening experience (Sweet, 1982). However, an early guide to evidence-based care, suggests that the father was 'expected to fill in gaps in [midwifery] care' (Enkin et al., 1995, p.194), by offering practical and emotional support to his partner. The authors caution that no evidence base supported this assertion, adding the father's emotional involvement could diminish his ability to offer support.

'Being useful'

As fathers' attendance increased, the strongest rationale for their 'admission' was to fulfil a role in supporting the mother:

The fact that a father might wish to be present on his own account alone was not considered reason enough... the father had to be of use.

(Blackshaw, 2003, p.219)

The emphasis on 'being useful' was influenced by the work of US obstetrician Bradley (1962), like Dick-Read in the UK, a proponent of 'natural childbirth' (Moscucci, 2002). This challenged the practice in the 1930s and 1940s of giving the mother light sedation for the birth of the baby (Enkin et al, 1995; Moscucci, 2002). Bradley developed 'husband-coached childbirth' in the 1940s. Couples were encouraged to aspire for an un-medicated birth by attending antenatal instruction classes, taught by Bradley and colleagues. During labour, the husband, garbed in gown and mask, replaced the anaesthetist and adopted the role of 'coach', using a series of pre-taught prompts to support the mother through labour and birth. Bradley believed men would be able to relate to the concept of 'coaching', with its sporting associations. His review of 4,000 'husband-coached' births (Bradley, 1962) claimed that he and his colleague-obstetricians had both re-defined their own role and created a role for the father. Bradley states: 'We do not deliver babies, we train husbands how to teach their wives to give birth to their babies' [emphasis in original] (1962, p. 475).

This approach is echoed in the 1972 edition of 'Mayes' Midwifery', which recommends that 'parentcraft' should include a 'fathers' evening' co-facilitated by a midwife and doctor, with two discussion groups. The doctor facilitated the fathers'

group, because 'the presence of a doctor often helps the father to verbalise his problems.' (Bailey, 1972, p.166). As with Bradley's approach, the father and obstetrician (who was usually male) are aligned. This constitutes a major paradigm shift from the conceptualisation of childbirth as 'women's business, taking place in women's space...choreographed by women' (Kitzinger, 2012, p.301).

Fathers' presence: more than a 'support-role'

As fathers' attendance became more accepted, there was a growing awareness of fathers' own 'psychological or other needs' (Blackshaw, 2003, p.227), which were at risk of neglect if fathers were perceived purely as 'supporters'. This role also 'fails to acknowledge his unique connections (both biological and social) to his infant' (Burgess and Goldman, 2018, p.17). Early seminal work (Greenberg and Morris, 1974) suggested that fathers' presence promoted a stronger sense of connection, compared with those who first met their baby after the birth. The growing body of literature on mother-infant relationships during the 1970s, including on bonding and attachment, may have led to a concomitant focus on father-infant relationships (Palkovitz, 1985; Blackshaw, 2003). There was increasing recognition of the significance for the father of witnessing the birth and welcoming his baby into the world (Bedford and Johnson, 1988; Draper, 1997; King, 2016).

1.3.3 The 'medicalisation' of childbirth

The rapid institutionalisation of birth and development of a biomedical model from the 1950s and 1960s, led to 'the rise of a medicalised scientific discourse' (Blackshaw, 2003, p.213) concerning birth. The move to hospital birth brought an increasing emphasis on the physical needs and safety of the mother, a reliance on technology, concurrent medicalisation of childbirth, and the potential for women's 'emotional isolation' (Tew, 1993, p.141).

The midwife-mother relationship remained 'the medium through which the [maternity] service is provided' (Kirkham, 2000, p.227), but the move to institutions brought fundamental changes in this relationship (Page, 2008). It was now surrounded by layers of complexity, involving a range of relationships with other health professionals during childbirth - obstetricians, anaesthetists and paediatricians. As fathers became increasingly involved, the complexity of these relationships extended to include the midwife's interactions with the woman's partner.

1.4 Other factors impacting on fathers' involvement

Broader social and cultural changes impacted on fathers' increased involvement: issues of social class, gender norms and roles and alterations in work patterns (Blackshaw, 2003). It was also linked to greater geographical and social mobility:

women were less likely to live near their own mothers, who in the past had offered the support now expected of the woman's partner (Bailey, 1972). Changing work patterns in the 1960s and 1970s included the evolution of new social roles for men (Bedford and Johnson, 1988; Blackshaw, 2003); these encompassed the conceptualisation of the 'good father' as being one who was actively involved with all aspects of his child's development (Miller, 2011), beginning during pregnancy and birth.

1.4.1 Consumer pressure groups

The institutionalisation and medicalisation of childbirth contributed to the rise of an increasingly confident, vocal 'consumer movement'. From the mid-1950s, lay organisations campaigned for personalised approaches, the humane treatment of women in childbirth and their right to exercise choice over where and how they gave birth and who accompanied them. The National Childbirth Trust (NCT) campaigned for the inclusion of fathers at all stages of the childbearing trajectory. The Association for Improvements in the Maternity Services (AIMS) lobbied for the rights of women labouring alone in hospital to have a companion with them (Walton, 2001, p.107).

The NCT's antenatal classes led by lay childbirth educators were seen as a direct challenge to the growing medical domination of childbirth (Kitzinger, 1990). From the early 1960s, fathers were encouraged to attend NCT classes (Women's International Network News, 1986). The establishment of NCT couples' courses influenced the later provision of such classes within the NHS. By the 1990s, these were recommended as NHS 'best practice' (Deane-Gray, 1997), marking another step towards normalising fathers' involvement.

The active consumer groups which were campaigning for the inclusion of fathers were predominantly middle-class in membership, but had a wider impact for all parents (Oakley 1977). The influence of these organisations helped to shift the balance of power between health professionals and parents (King, 2016), and has been linked to the growth of health consumerism and the 'choice' agenda (Greener, 2003). This in turn relates to the inclusion of fathers in childbirth.

The formation of fathers' pressure groups was a later development. For example, the Fatherhood Institute (www.fatherhoodinstitute.org), established in 1999, includes a commitment to lobby for father-inclusive services at all stages of the childbearing continuum. The increased involvement of fathers has been seen as a factor in shifting childbirth away from the 'medical model' and towards a biopsychosocial paradigm (Saxbe, 2017), acknowledging the psychological, social and cultural aspects of childbirth for fathers.

1.4.2 Second wave feminism

The growth of second-wave feminism in the 1960s and 1970s and the development of increasingly vocal consumer groups with their emphasis on 'natural childbirth' (Bates, 2004; Walton, 2001) were well-aligned; they had a direct impact on fathers' increasing involvement (Palkovitz, 1985; Dellmann, 2004). The natural childbirth movement was witnessed in several industrialised nations. Developed in the 1930s and 1940s, it offered an alternative to the practice of sedating women in the second stage of labour. Proponents included physiologist Pavlov in Russia, general practitioner Dick-Read in Britain (Arney and Neill, 1982) and obstetrician Bradley in the United States (Bradley, 1962). The UK 'natural childbirth' movement used a blend of the preparation-for-childbirth approaches championed by these advocates. They all aligned well with feminist principles: they were founded on a woman's rights to choose where and how she gave birth, and belief in her ability to birth with minimal assistance. They also shared an inclusive approach to fathers, often allocating him a 'coaching' role.

Women who participated in these social movements were reacting against what they perceived as 'regimes of industrialised birth' (Parrat, 2008, p.40). Midwives concerned about increasing medicalisation formed their own pressure group in 1976. The Association of Radical Midwives (ARM) (<https://www.midwifery.org.uk/about-us/history/>) and lay consumer organisations worked together, campaigning for women's childbearing rights.

1.4.3 Policy drivers

In the early 1990s, the publication of two key reports ('Winterton' (HMSO, 1992); 'Changing Childbirth' (DH, 1993)), marked a change in policy, philosophy and language (McIntosh, 2013). The increased emphasis on the psycho-social aspects of childbearing acknowledged the father's role, (DH, 1993, p.31) although short on detail as to how he should be included.

Subsequent policy has emphasised the key importance of fathers' active involvement in the lives of their children (DfES, 2004; DH, 2007; DH 2011, NHS England, 2016) in terms of positive impact on children's long term outcomes: health, well-being, educational attainment, social stability and economic achievement.

Fathers' own health outcomes, as well as those of their partners and children, also benefit from their increased involvement (Plantin et al, 2011). However, there is a growing body of evidence that fathers may experience a range of mental health problems in the first year after the baby's birth (Bradley and Slade, 2011; Darwin et al, 2017). These problems can include post-traumatic stress disorder, depression and anxiety (Inglis et al, 2016; White, 2007). They may impact on the father and on

other relationships, including with his partner and baby (Etheridge and Slade, 2017; White, 2007). Further stress arises for fathers who feel unprepared for complications in labour (Lindberg and Engstrom, 2013); those whose needs for information and involvement in decision-making were unfulfilled (Elmir and Schmied, 2016; Kuliukas et al, 2017), or who feel that they had failed to give their partners the support they needed (Thies-Lagegren and Johansson, 2019). Such evidence underlines the need for the current study.

1.4.4 Evidence-based care

The content of standard midwifery textbooks has tended to follow rather than lead the trend concerning fathers' presence. The current edition of 'Mayes Midwifery' acknowledges the shift in practice towards fathers' involvement was not evidence-based, highlighting that the impact of his presence on the progress of labour is unknown (Jackson, 2017).

Evidence-based care in midwifery was introduced in the late 1980s (Walsh, 2007), illustrated for example by the publication of a series of 'research-based approach' midwifery texts (Alexander, Levy and Roch, 1990). The first Cochrane review group focussed on pregnancy and childbirth (<https://pregnancy.cochrane.org/welcome>); it was established in 1989, around the same time. However, by this time, fathers' presence during childbirth had become the norm; as with many other aspects of childbearing, there was lack of evidence about the efficacy and impact of this practice.

Recent guidance from the Royal College of Midwives makes specific recommendations about including the woman's partner during labour, by offering information, advice and the opportunity to explore his own expectations (RCM, 2018). This demonstrates the evolution of the midwife's role from being 'with woman' to including her partner. The lack of research focussed on the complex dynamics involved in this new triadic relationship highlights this study's contribution.

1.5 Conclusion

The father's current role during childbirth is complex. He is present both as a support person and in his own right, as he undergoes the transition to fatherhood. His status remains ambivalent: he is 'neither patient nor visitor' (Steen et al., 2012, p.430). His presence has become the norm; but perceived pressure to participate may lead to feelings of helplessness and anxiety (King, 2016). The following chapter, a scoping review of the literature, explores these and other key issues and demonstrates the problem that this study seeks to address.

1.6 Summary box

- Childbirth has traditionally been 'women's business'
- The involvement of fathers constitutes a significant paradigm shift
- This shift took place over a short period, approximately 20 years, in the context of broader societal changes
- It is linked to other changes in childbearing practice, particularly place of birth and increasing use of technology
- Fathers' presence during childbirth is now accepted in the UK, to the point that it is assumed he will be present

Chapter 2 Scoping review of the literature

2.1 Introduction

The previous chapter conveyed how childbirth has been conceptualised as ‘women’s business’ since records began. Human birth is a social event, which has almost invariably involved the woman in labour being supported by a female companion – a ‘midwife’. Historical and contextual literature were employed to explore the reasons and timeline for the father’s involvement. It was established that the introduction of the father – a male lay-person - into this previously female domain denotes a significant shift in practice which has occurred over a relatively short time span. Driven neither by policy or evidence, this change has come about through a range of social and cultural factors. The midwife-mother dyad has been supplanted by a triadic mother / father / midwife relationship.

The researcher’s initial curiosity about this ‘new phenomenon’ was kindled during a period of 30 years (1980 – 2010) spent working with childbearing parents, during which time she observed changing attitudes to fathers’ presence. Listening to parents’ birth stories and reading about the evolution of different cultural childbirth practices led her to focus in particular on fathers’ experiences within this previously female domain. This interest crystallised into the decision to explore the area further and subsequently to undertake research into midwife-father communications.

The literature informing the development of this research was gathered over a six-year period. It began with a background literature search and review in 2014, soon after commencing doctoral studies. This was updated in 2016, and throughout the course of this study has been supplemented by weekly alerts from Ovid Medline; visits to the British Library, Boston Spa and Royal College of Nursing Library, London; a search of the grey literature and re-run of the original literature search to develop a scoping review in 2020.

The original research question included two parts: an exploration of midwife-father communication and the ways in which it impacted on birth experiences for mother, father and midwife. However, the findings of the initial literature search (2014) contributed to the researcher’s decision to focus on the specific area of midwife-father communication. The 2014 search identified a range of literature which explored aspects of fathers’ experiences during childbirth. Fathers’ feelings of helplessness and exclusion have been well-documented (Waldenstrom, 1999; White, 2007; Inglis et al, 2017; Thies-Lagegren and Johansson, 2019). The potential for the midwife to play a pivotal role in including and engaging the father was highlighted in these studies. However, the search revealed a dearth of literature which focussed on the topic of midwife-father communications. Since the midwife does not provide

clinical care to the father, her relationship with him is based solely on communication. The ways in which the midwife interacts with the father during childbirth constitute a key element in encouraging his engagement. This was therefore identified as an area ripe for study; the research question was simplified to focus on the area of midwife-father communications.

2.2 Rationale for choosing a Scoping Review

Fathers' presence during childbirth has been established as a relatively new development. The background literature search had identified a paucity of literature about midwife-father communications; this is therefore an under-studied area. The scoping review (ScR) has been described as a useful approach to 'mapping' existing knowledge in an area where there is currently a paucity of research; it is particularly appropriate for areas of 'emerging evidence' (Levac et al, 2010; Munn et al, 2018; Peters et al, 2015). The decision to conduct an ScR was therefore informed by the 2014 search. This is congruent with the iterative nature of ScRs, which may involve repetition of steps to ensure a comprehensive review (Arksey and O'Malley, 2005).

The choice of an ScR enabled the inclusion of both qualitative and quantitative studies (Arksey and O'Malley, 2005). This guided the choice of approach; alternatives such as a metasynthesis would have excluded quantitative studies, thus limiting the scope of the review. It was a better fit for this study than a systematic review, used where a substantial body of literature already exists and whose purpose has been defined as to address the effectiveness of a particular practice or treatment (Munn et al, 2018).

An ScR is employed to map the breadth and depth of existing literature (Levac et al, 2010) and to identify gaps in knowledge (Arksey and O'Malley, 2005). The ScR aligns with other approaches to reviewing the literature, provided it is carried out in a systematic, replicable, transparent and rigorous manner (O'Brien et al, 2016). It differs from approaches in which rigorous assessment of quality is an essential stage of the review. Arksey and O'Malley's original 2005 guidance on the conduct of ScRs stated that quality assessment of included studies did not form part of the process; later commentators have endorsed this view (Armstrong et al, 2011; Tricco et al, 2016). A pragmatic approach to quality appraisal was taken (Downe, 2008), whereby studies were not necessarily excluded for quality issues. However, if identified, these were noted. The structure of the chapter is guided by the systematic approach cited in the 'Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping (PRISMA-ScR) Reviews Checklist' (Tricco et al, 2018).

2.2.1 Overall aim

The aim of this review was to scope existing literature related to the research question: 'How do midwives and fathers communicate during labour and birth?'

2.3 Methods

The first stage of the ScR was completed in 2016, taking a thorough and systematic approach, as described below. The process was repeated and the review updated in 2020. When the second search was undertaken, the volume of literature relating to fathers and childbirth was noted to have grown considerably in the intervening years.

2.3.1 Search strategy

The Population / Exposure / Outcome (PEO) framework was employed to design the search strategy, identified as valuable in formulating an answerable research question and defining its key concepts (Bettany-Saltikov, 2016). Table 1 (below) identifies these concepts:

Population	Exposure	Outcome
Midwives and fathers	Childbirth	Communication

Table 1 PEO Framework, based on Bettany-Saltikov (2016)

Defining key concepts

For clarity, brief definitions of the four key concepts (midwives / fathers / childbirth / communications) are provided in Table 2:

Concept	Definition
Midwife	A person trained to assist a woman in childbirth
Father	Male parent
Childbirth	The process of a woman giving birth to a baby; includes all three stages of labour; vaginal birth - spontaneous or assisted by forceps or ventouse; birth by Caesarean Section
Communicate	'To share information with others by speaking, writing, moving your body, or using other signals...to talk about your thoughts and feelings, and help other people to understand them'. Cambridge English Dictionary, 2020.

Table 2 Definition of key concepts employed in literature search

Synonyms, truncations and wildcards were employed that were appropriate to each database (Appendix A). Synonyms for 'communication' were expanded to include concepts with the potential to inform understanding of communications, for example 'relationships'; 'roles' and 'support'. Each database was searched separately and

systematically, using the Boolean Operators, with keywords for individual concepts entered and then combined using 'OR', the resultant sets combined using 'AND'.

2.3.2 Eligibility criteria

The criteria for inclusion were studies which related to the topic of midwife-father relationships during childbirth. A broad interpretation was taken of this concept; there are very few studies with the specific focus of midwife-father communication, which both necessitated adopting this approach, and underlined the need for the current study. Included were studies which explored the specific topic of midwife-father communications in the antenatal period, because this relates to the preparation of the father for birth; also included were studies which reported on aspects of fathers' birth experiences and considered the impact of interactions with midwives, as were those which considered the range of roles that fathers play, since father-midwife communication constitutes an important element of this issue.

Inclusion criteria for the ScR were as follows - studies which were:

1. Reporting primary research
2. Published in peer-reviewed journals
3. Written in or translated into English
4. Set in high-income countries (World Bank, 2020) where fathers' attendance during childbirth was widely accepted as the norm

One exception was made to the final criterion of study setting, with the inclusion of a randomised controlled trial (RCT) based in a high to middle-income country (World Bank, 2020). This study (Gungor and Beji, 2004) was conducted in Turkey, where fathers' attendance during birth was not the norm. The rationale for its inclusion is given in Section 2.4.2.2.

Eligibility was unrestricted by date or by nature of the father's relationship to the mother (i.e. marital / relationship status) or baby (i.e. biological connectedness). Several historical studies provided useful background to the research but did not meet the inclusion criteria above. They were therefore included in the historical background chapter rather than the ScR. Policy documents were also excluded from the ScR and included in the previous chapter. The search of grey literature did not identify any relevant studies for the ScR.

2.3.3 Information sources

Six key health and social science electronic databases were searched to ensure identification of literature from a broad range of medical, nursing, midwifery, psychology and social science disciplines: EMBASE/ Classic; CINAHL (Cumulative Index to Nursing and Allied Health); MEDLINE; Maternal and Infant Care; PsycInfo

and ASSIA (Applied Social Sciences Index and Abstracts). Grey literature was searched using three databases: OpenGrey, ProQuest and Zetoc. The timescale was from the inception of each database searched to 2020. Finally, the search was extended to websites of relevant organisations, including the NCT, Royal College of Midwives and The Fatherhood Institute.

A large number of articles was identified in the first wave of searching (n = 12,988). At this stage, the researcher made a ‘novice error’: she scanned all records identified for relevance by title and abstract, without first removing duplicates. She thus created a considerable amount of extra work for herself and learnt from this mistake.

Screening of the titles and abstracts yielded 732 potentially relevant hits, which reduced to 272 after removing duplicates. These were divided into the following categories, displayed in Table 3:

Type of literature	Number
Primary research: qualitative / quantitative / mixed methods	167
Secondary research: systematic reviews /evidence syntheses	27
Policy documents	0
Practice / service development	21
Historic	23
Grey literature	34
Total	272

Table 3 Types of literature identified

The search process which led to the eventual selection of studies for inclusion is summarised in the modified PRISMA flow diagram (Moher et al. 2009), see Figure 1:



PRISMA 2009 Flow Diagram

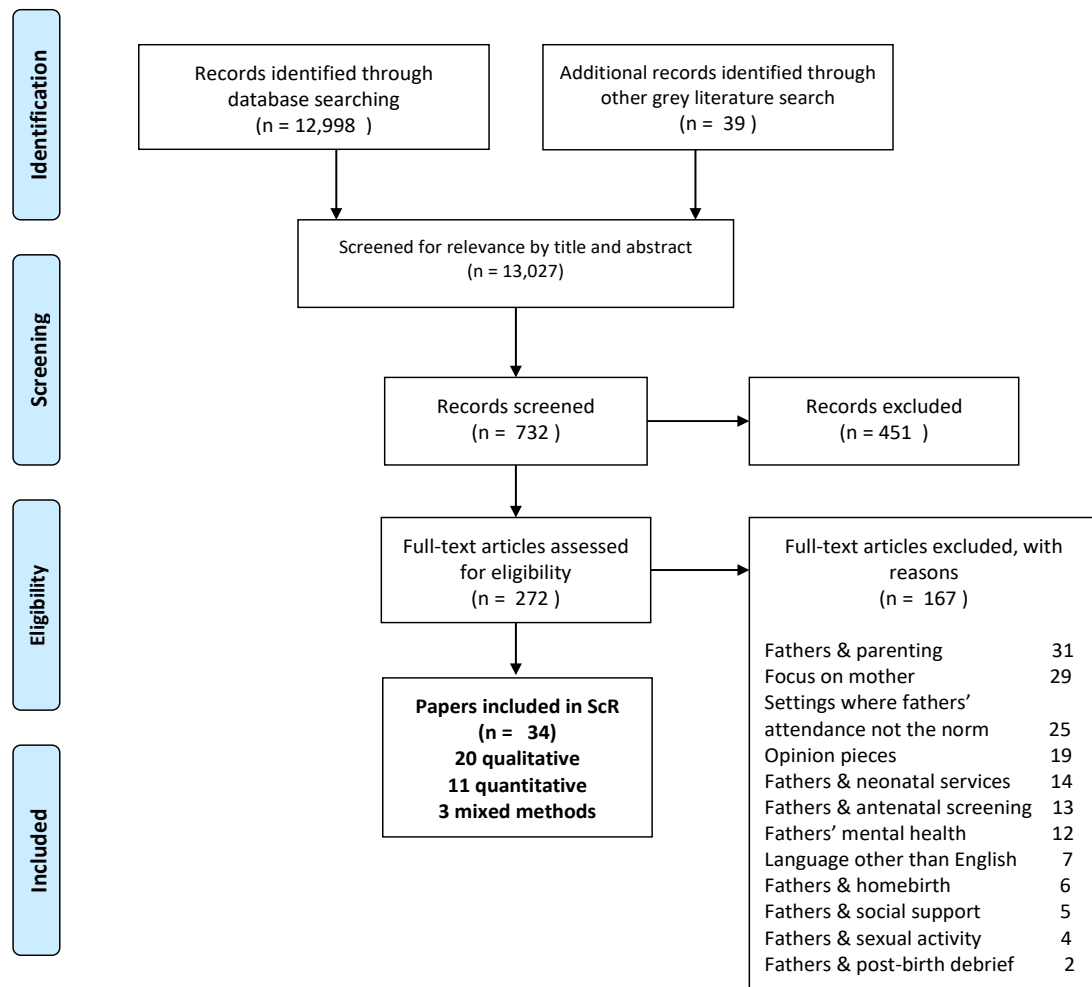


Figure 1 Modified PRISMA flow diagram (Moher et al, 2009)

2.3.4 Selecting and charting of evidence

After reading through the 167 primary research studies, 34 were identified to relate directly to the PEO Framework outlined above. The types of studies included: 20 qualitative, 11 quantitative and 3 mixed methods.

Details of the 34 included studies were tabulated (Appendix B). The following information was recorded: primary author/s, year and country of publication, title; study type; participants - recruitment and description of sample; data collection - mode and timing; type of analysis employed; summary of findings and comments. The final column in the table maps each study according to the thematic synthesis of results (Section 2.4.3 below).

2.3.5 Analysis of included studies

Included studies (N=34) were synthesised using thematic analysis (TA) (Braun and Clarke, 2013). This has been demonstrated to be a pragmatic, appropriate approach to analysis involving both qualitative and quantitative data (Lucas et al, 2007) and has been previously employed in ScRs (Greenfield and Darwin, 2020). The first of the seven stages of TA was omitted as not relevant; numbers 2 – 7 were followed:

1. Transcription
2. Reading and familiarising, taking note of items of potential interest
3. Coding across entire dataset
4. Searching for themes
5. Reviewing themes and producing a thematic map
6. Defining and naming themes
7. Writing – final analysis

(Braun and Clarke, 2013, p.202)

The stages in this TA involved reading and re-reading the studies, taking note of words, phrases and concepts relevant to the review. Linkages between studies were highlighted, along with areas of agreement and difference. Themes were developed and reviewed and a thematic map produced (Appendix C). The findings were charted into the table of studies (Appendix B) and an analytical account of the findings was developed. Discussion with the supervisory team to reach consensus about exclusion and inclusion of studies was an important part of the process.

2.4 Results

Key characteristics of the studies included in the ScR are now given. Qualitative, quantitative and mixed methods studies are presented in three separate sections for clarity and then combined in the ‘synthesis’ (Section 2.4.3).

2.4.1 Research focus of the 34 included studies

The studies covered a broad range of aspects of fathers’ involvement in childbirth. They were grouped into six categories to describe the focus of the research in each (Table 4): fathers’ experiences, perceptions and perspectives during childbirth (n = 20; of these, 13 focussed on normal and 7 on complicated childbirth); the midwife’s role in involving and supporting fathers (n = 7); the mother’s perception of partner support (n = 3); the father’s support needs in labour (n = 3); the father’s contribution to decision-making and supporting the woman (n = 2); fathers’ supportive activities during labour (n = 1). One study (Somers-Smith, 1999) fitted into more than one group; therefore, the ‘research focus’ column in Table 4 enumerates 35 studies.

Research focus	Studies	Study type
1. Fathers' experiences, perceptions and perspectives during childbirth (n = 20)	<p><u>During normal childbirth (n = 13)</u> Chandler and Field, 1997; Chapman, 1991; Ledenfors and Bertero, 2016; Longworth and Kingdon, 2011; Porrett et al, 2012; Premberg et al, 2011; Premberg et al, 2012; Roberts and Spiby, 2019; Symon et al, 2011; Tarlazzi, 2015; Thies-Lagegren and Johansson, 2019; Vehrolainen-Julk and Luikkonen, 1998; Waldenstrom, 1999.</p> <p><u>Where there are complications (n = 7)</u> Chapman, 2000; Eriksson et al, 2006; Inglis et al, 2016; Johansson and Hildingsson, 2013; Kuliakas et al, 2017; Lindberg and Engstrom, 2013, White, 2007.</p>	Qualitative 6 Quantitative 4 Mixed methods 2 Qualitative 5 Quantitative 2
2. The midwife's role in involving and supporting fathers (n = 7)	Backstrom et al, 2017; Brown et al, 2009; Dallas, 2009; Deave and Johnson, 2008; Hildingsson et al, 2011; Jepsen et al, 2017; Rominov et al, 2017.	Qualitative 5 Quantitative 1 Mixed methods 1
3. The mother's perceptions of her partner's support (n = 3)	Gungor and Beji, 2004; Kainz et al, 2010; Somers-Smith, 1999.	Qualitative 2 Quantitative 1
4. The father's support needs in labour (n = 3)	Backstrom and Herflet Wahn, 2011; Eggermont et al, 2017; Hollins Martin, 2009.	Qualitative 1 Quantitative 2
5. The father's contribution to decision-making and supporting the woman (n = 1)	Somers-Smith, 1999.	Qualitative 1
6. Supportive activities undertaken by the father during labour (n = 1)	Bertsch et al, 1990	Quantitative 1

Table 4 Research focus of the 34 studies

2.4.2 Characteristics of included studies

Characteristics of the qualitative, quantitative and mixed methods studies are summarised in turn below.

2.4.2.1 Qualitative studies

Location and timing

Six studies were undertaken in Sweden, four in the UK, three in the USA, two in Canada and in Australia, one in Denmark, Italy and New Zealand respectively. Three studies were published between 1990 and 1999, five between 2000 and 2009 and 12 between 2010 and 2019.

Participants

Most studies involved fathers ($n = 12$) or couples ($n = 7$). One recruited mothers alone (Kainz, G. et al, 2010) and explored their views on partners' presence. One, in addition to recruiting couples, also included midwife participants, (Kuliukas et al, 2017). Nine studies focussed on first-time fathers and eight on those whose partner was expecting a subsequent baby. For two studies the fathers' parenting status was not provided.

Fathers' attendance at antenatal classes was not stated for the majority of studies. Where this was recorded, the proportion participating was high; for example, Longworth and Kingdon (2011), Longworth (2000) and Ledenfors and Bertero (2016) reported antenatal class attendance of 100%, 95% and 75% respectively. This was linked to the recruitment approach employed, as antenatal classes offer a practical source of potential participants for research into many aspects of maternity care. Attendance at antenatal classes is recorded because it involves the possibility of selection bias. As noted by the authors of one study (Longworth and Kingdon, 2011), fathers attending antenatal classes are more likely to be in professional socio-economic groups. They have had some preparation for childbirth and may be better equipped for events that occur. Conversely, they may have formed clear hopes and expectations of the experience, which if not met, may be reflected in research findings.

Data collection

Nineteen of the 20 studies used semi-structured interviews for data collection. The majority of these were face-to-face. Telephone interviews were employed in two studies. Backstrom et al (2017) used telephone interview alone for all 14 fathers in their study; in Kuliukas et al's 2017 study, 43 of the 45 participants were interviewed face-to-face and the remaining two by telephone.

Two studies employed observations plus interviews: Chapman, 1991; Jepsen et al, 2017, with the latter describing the 'type' of observation used as 'participant'. Chapman

(1991) did not specify the observational stance adopted. In each study, a proportion of the participants was observed during labour, rather than the entire cohort. Chapman's (1991) study included observations for nine out of 20 couples; Jepsen et al's (2017), six out of ten (2017). A single study (White, 2007) collected data via a narrative method with fathers submitting their story in written or audio-recorded form, plus interviews for an unspecified proportion of fathers. Inglis et al (2016) collected data via responses to a qualitative survey, in addition to interviews; two of the five interviews in this study were conducted via Skype.

Data collection for seven studies was from both mothers and fathers; three of these involved dyadic interviews and in four the parents were interviewed separately.

Kuliukas et al's 2017 study involved separate interviews with mothers, fathers and midwives – the only study to seek perspectives from all members of the birth triad.

The timing of data collection varied. One study collected data in pregnancy; five were longitudinal, defined as collection of data via both pre- and post-birth interviews. In 14, data were collected post-birth. A majority of these specified a time frame, ranging from the first week post-birth to within four and 26 weeks of birth. The timing for others varied greatly, from immediately after birth to 10 years later (Brown et al, 2009). The longest variation was in White's 2007 investigation of fathers' experiences of post-birth trauma, where their babies had been born between one and 27 years previously.

These variations are noted because the length of time that has elapsed is likely to affect participants' recall and perceptions of the experience (Levine and Safer, 2002). Additionally, significant changes in the culture of maternity care and midwifery practices occurred over the longer time frames in Brown's (2009) and White's (2007) studies. These may have been relevant to the fathers' experiences.

2.4.2.2 Quantitative studies

Location and timing

Five studies were undertaken in Sweden, two in the UK and one in Australia, Belgium, Turkey and the USA respectively. Except for Turkey, these met the inclusion criteria of high-income Westernised countries where fathers' attendance during childbirth was the norm. Turkey's cultural practices around birth differed in that, at the time of the study, it was usual practice to exclude fathers. Gungor and Beji's (2004) RCT is included because it has direct relevance to the current research; it is also a rare example of an RCT conducted in this field. This reflects ethical considerations, which would preclude replication of this study in countries where women's choice is a central tenet of care and fathers' presence during childbirth has become the norm.

As with the qualitative studies, the number of studies has grown exponentially over the past 30 years. Two were published between 1990 and 1990, four during the following decade and five between 2010 and 2019.

Participants

Six of the 11 studies involved fathers; couples were recruited to the remaining five. One study, which compared fathers' behaviours in relation to doulas', recruited mothers, fathers and doulas (Bertsch, 1990).

It was not always possible to discern the 'parenting status' (whether they had other children) of the fathers who participated, as in several studies this was not stated. For example, Bertsch's study (1990) involved only primiparous women, but the father's parenting status was not provided. The parity of the mother was identified, with the implication that if the woman was expecting her first baby, the same would apply for the father. This assumption highlights the absence of mechanisms to record fathers' details within the childbirth arena. Two of the six father-only studies involved first-time fathers; three involved both first-time and subsequent fathers; for the remaining study, no parenting status was given. Of the five studies which recruited couples, in some cases, parenting status was assumed from the mother's parity. Two stated that couples expecting first babies were recruited; one that participants were drawn from parents of both first and subsequent babies. For the remainder, parenting status was not clear.

Data collection

The 11 quantitative studies all collected data via questionnaire. Two studies collected data via observations during labour and questionnaires post-birth. These studies both involved 'ranking' fathers' behaviours against a pre-determined scale. The observation phase of Bertsch et al's (1990) study involved the researcher sitting 'off to the side' of the birth environment, the implication being that she was out of sight. This study compared fathers' and doulas' activities during labour. In contrast, Gungor and Beji's (2004) RCT was designed to determine the effectiveness of fathers' presence, their behaviours and support during labour; during observations the researcher describes 'participating' in supporting the father. The results must therefore be treated with caution. In this study, fathers' roles were categorised according to their participation style, based on Chapman's earlier research (1991) into fathers' roles during childbirth which identified the role of coach, team-mate and witness. In both studies, a post-birth questionnaire was used to amplify the observational data.

Two studies (Bertsch, 1990; Gungor and Beji, 2004) were RCTs. Gungor and Beji's (2004) study, which explored the impact of fathers' presence during labour on childbirth experience, included 25 women in the experimental and control groups respectively. The study recruited potential participants at 36 weeks' gestation or beyond. Inclusion

criteria were: women with low risk pregnancies, who anticipated a vaginal birth at the study site hospital and who wished their husband [sic] to be present. When labour began, the recruited participant contacted the researcher by telephone. The first 25 to do so were allocated to the experimental group and the following 25 to the control group. For the former, husbands were 'allowed' to be present during childbirth. Data were collected via observation, which 'ranked' fathers' behaviours, plus questionnaires.

Waldenstrom's (1999) study exploring the effects of birth centre care on fathers' experiences of birth was part of a broader RCT of parents' satisfaction with birth centre care. Data were collected via questionnaire. Birth centre care involved continuity of midwifery carer from early pregnancy to the postnatal period, a homelike birth environment and 'family-centred' approach with fathers invited to stay overnight following the birth. During pregnancy, the parents were randomly allocated to birth centre (n = 576) and 'standard maternity care' (n = 567) respectively, choosing an envelope containing a slip of paper specifying 'birth centre' or 'standard' care. The study sample was self-selecting, in that all the parents had decided in pregnancy that they wished to access birth centre rather than standard maternity care. The author acknowledges that those allocated to 'standard care' may have been disappointed not to have the option of their chosen preference of birth centre care.

The timing of data collection varied significantly. Apart from one, all studies collected post-birth data only. Hollins Martin's (2009) project, whose aim was to design a tool for measuring father's attitudes and needs in relation to birth participation, used two questionnaires, the first administered pre- and the second post-birth. Four studies collected data in the immediate post-birth period of up to seven days; one in the two weeks following birth; one in the two / three months afterwards, two within six to twelve months; one when the child was aged between one and four years and for two studies, the time period was not stated. As with the qualitative studies, these time differences are noted because participants' recall and memory of events are likely to vary according to the length of time that has elapsed.

2.4.2.3 Mixed methods studies

Location and timing

The three studies were conducted in Australia, Finland and Sweden. One was published in 1998 and two post-2010, previously noted as a period of considerable growth in research about all aspects of fathers' involvement in maternity care.

Participants

One study (Vehrolainen-Julk and Luikkonen, 1998) recruited fathers and collected data within three days of birth; one (Premberg et al, 2012) at between two- and three-

months post-birth. One (Rominov et al., 2017), exploring midwives' experiences of engaging fathers in maternity services, recruited midwives. For this study, timing in relation to birth was not relevant.

Data collection

Of the three mixed-methods studies, one (Premberg et al, 2012) employed qualitative interviews to develop a questionnaire to validate an instrument for assessing fathers' experiences of childbirth. Their study reports the results of the questionnaire. The second (Rominov et al, 2017) employed an initial online survey followed by semi-structured interviews with a sub-group of participants. Vehrolainen-Julk and Luikkonen's (1998) study used a postal survey with a combination of Likert scale and open-ended, qualitative questions.

2.4.3 Thematic synthesis of results

In the 6th and 7th stages of the thematic analysis process (Braun and Clarke, 2013), a thematic map was developed (Appendix C) and the findings of the 34 studies were synthesised into five main themes:

1. Fathers' needs
2. Fathers' roles
3. Fathers' feelings
4. Fathers' behaviours
5. Midwives' attitudes towards fathers

The five themes are discussed below; overlaps and interconnections between themes were noted throughout.

2.4.3.1 Fathers' needs

There is a dearth of research that focuses specifically on fathers' needs during childbirth (Eggermont et al, 2017; Hollins Martin, 2009). This section examines the range of needs identified in the key studies.

Information

The primary need identified was for information (Backstrom et al, 2017; Deave and Johnson, 2008; Eggermont et al, 2017; Gungor and Beji, 2004; Hildingsson et al, 2011; Johansson and Hildingsson, 2013; Ledenfors and Bertero, 2016; Premberg et al, 2012). Within this overall finding, specific information-needs were identified: regarding procedures, equipment and the processes of childbirth (Eggermont et al, 2017); ways in which the father could support his partner and be actively involved (Eggermont et al, 2017; Gungor and Beji, 2004) and the teaching of strategies on how to comfort the woman in labour (Backstrom et al, 2017; Johansson and Hildingsson, 2013; Roberts and Spiby). Two studies identified that the father looked to his partner to give him

guidance as to how to support her, but found that when she was focussing on her labour, she was unable to offer this guidance (Chapman, 1991; Somers-Smith, 1999). The midwife's guidance (Premberg et al, 2012) was therefore essential in the provision of 'father specific' information (Rominov et al., 2017).

Inclusion and emotional support

Information-giving involved more than conveying facts: how information was imparted was important. Approaches that engaged the father on an emotional level, for example by creating an atmosphere which encouraged him to ask questions and to participate in decision-making, enabled him to fulfil a support role more effectively (Backstrom et al, 2017). The father's right to ask questions was also highlighted by Johansson and Hildingsson (2013), with the onus falling on the midwife to enable this (Backstrom and Herflet Wahn 2011). It was important to fathers that midwives were aware of their emotional needs during childbirth and went further than sharing of practical tips (Backstrom and Herflet Wahn 2011; Johansson and Hildingsson, 2013). It is interesting to reflect on this expectation in the context of Rominov et al's (2017) study. This study found that midwives' priority in relation to fathers involved focussed on the sharing of practical tips with fathers as a key part of their role. They prioritised such practical approaches over attending to the father's emotional wellbeing.

During labour, fathers were found to be wary of expressing their own emotions (Inglis et al, 2016), suppressing them in order to protect their partner (Eggermont et al, 2017; Lindberg and Engstrom, 2013; Premberg et al, 2011; Tarlazzi et al, 2015; Waldenstrom, 1999). Premberg et al (2011) also suggested that displaying emotions such as distress and anxiety does not conform with gendered expectations of 'manly' behaviour. Suppression of emotions during labour has been associated with fathers feeling helpless, ashamed and humiliated (White, 2007). Midwives sometimes fail to acknowledge that fathers have emotional needs (Chandler and Field, 1997). When the midwife does recognise these needs, however, she is well-placed to offer the comfort and security he requires (Vehrolainen-Julk and Luikkonen, 1998). Midwife-behaviours that provided the father the with support he sought, included offering him the opportunity to express his emotional needs (Eggermont et al, 2017) and being continuously present in the room. Her presence confers a sense of security which he values; conversely, when she is absent, his anxiety levels rise (Hildingsson et al, 2011; Thies-Lagegren and Johansson, 2019).

Being recognised as an individual and also as part of a couple

How midwives perceived and interacted with fathers was an area of concern for fathers. Analysis of these studies' findings suggests that there were two – potentially contradictory - aspects to fathers' needs: wanting to be seen as an individual

(Premberg et al, 2011; Rominov et al, 2017; Vehrolainen-Julk and Luikkonen, 1998; White 2007), but also to be viewed as part of couple (Backstrom and Herflet-Wahn, 2011; Backstrom et al, 2017; Chandler and Field, 1997; Ledenfors and Bertero, 2016; White, 2007).

The importance of being seen by the midwife as a couple, and being affirmed and supported as such, was a strong recurring theme (Backstrom and Herflet Wahn, 2011; Backstrom et al, 2017; Brown, 2009; Chandler and Field, 1997; Ledenfors and Bertero, 2016; Premberg et al, 2011; Waldenstrom, 1999). Chandler and Field (1991) and Chapman (2000) describe the father's perception of himself as that of 'co-labourer' with the woman, suggesting that the midwife did not share this perception. Other studies cited examples of midwives providing care for the 'labouring couple': helping them to assess and express their own needs, involving them in care-planning (Brown, 2009) and shared decision-making (Johansson and Hildingsson, 2013).

For the father, being seen as an individual was symbolised by the midwife recognising that he had discreet needs that were different from the woman's; she was then able to tailor her support to suit these needs (Backstrom and Herflet Wahn, 2011; Backstrom et al, 2017; Kuliukas et al, 2017). Chapman (1991) and White (2007) suggested that midwives should not assume he wished to be present, but proposed a discussion about options as to whether to remain with his partner throughout labour and birth. White (2007) went further in suggesting that the current perceived pressure on the father to be present instilled a sense of shame in those who chose not to be.

Practical needs

The father's basic, practical needs were identified as an area which has been neglected. There was a failure to provide toilets, drinks, food and comfortable seating (Symon et al., 2011) in a situation and environment which is unfamiliar to most fathers and furthermore uncomfortably warm, because it is designed to meet the baby's needs at birth. In order to meet his own practical needs, it was likely that he would have to leave the room and – if in hospital - the delivery suite or birth centre where the birthing rooms are situated. To regain access, he had to press a bell – in effect seeking permission from the midwife to re-enter (Symon et al, 2011). Despite this temporary 'exclusion' from the birth environment, Tarlazzi (2015) found that fathers would have welcomed the midwife recognising that they needed to leave the room for a break and valued her giving this 'permission' to do so.

2.4.3.2 Fathers' roles

Bertsch et al's 1990 study comparing fathers' behaviours during labour with doulas', identified that at this relatively early stage of fathers being present, all the central players – parents and health professionals – were unsure about fathers' roles during

childbirth. This lack of a secure, defined role was borne out in Steen et al's (2012) later metasynthesis 'Not-patient and not-visitor', which highlighted fathers' ambivalent status within maternity services. When a midwife offered support tailored to meet the father's needs as an individual, an explicit discussion about the roles he can play (Hollins Martin, 2009) was valuable in exploring the options. The message is clear: the midwife should not make assumptions, but rather should ask, negotiate with the father and the couple and offer suggestions (Backstrom and Herflet Wahn, 2011; Hollins Martin, 2009).

A key influential study exploring fathers' roles (Chapman, 1991) identified that fathers were 'searching for place' (p.27) during childbirth. Chapman employed grounded theory to identify three distinct roles for fathers: coach, team-mate and witness. Varying degrees of physical and emotional engagement are linked to these three roles: the 'coach' takes the lead and directs, the 'team-mate' helps and follows the lead of the mother and health professional and the 'witness' plays the role of observer and companion (Chapman, 1991). The 'coach' and team-mate' roles, which involved close engagement, matched well with midwives' expectations of fathers being visibly and actively involved (Rominov et al., 2017). However, the role of 'witness' is less tangible and more complex. An understanding of this illuminates the root cause of some of the distress fathers experience during childbirth.

The act of 'being present' fulfils a role that is important to the woman in labour (Bertsch et al, 1990; Kainz et al, 2010; Somers-Smith, 1999; Thies-Lagegren and Johansson, 2019). The father's presence, company and familiarity increase her confidence and give her strength to carry on. She values his emotional and psychological support and the fact that he can communicate with the midwife when she is unable to do so. Also important is the sense of 'shared endeavour' which culminates in becoming parents (Eggermont et al, 2017, Kainz et al, 2010; Roberts and Spiby, 2019; Tarlazzi et al 2015; Thies-Lagegren and Johansson, 2019). The evidence clearly demonstrates that women feel supported by fathers' presence and that the act of 'being there' and being witness are key roles. However, fathers' feelings of helplessness and inadequacy, identified by Waldenstrom in 1999, continue to be reported (Thies-Lagegren and Johansson, 2019).

The father's sense of being on the periphery during childbirth (Longworth and Kingdon, 2011) is a recurring theme. Deave and Johnson (2008) conceptualised this role as being a 'bystander'. When he was assigned a 'spectator' role, he was left 'standing on the side-line' (Inglis et al, 2017, p127). The resultant feelings of helplessness and exclusion were exacerbated when complications arose during labour (Inglis et al, 2017). A study of fathers who experienced post-traumatic stress following childbirth suggested that when fathers were assigned the roles of spectator, supporter and fetcher-carrier, rather than participant, the feelings of alienation that arise can result in

long-lasting trauma (White, 2007). In White's study, the role of 'witness' rather than participant was conceptualised as problematic for the father, for whom being present during childbirth can be a peak life experience (Vehrolainen-Julk and Luikkonen, 1998) which marks his transition to fatherhood. Midwives may fail to recognise the significance of this role for the father (Dallas, 2009; Longworth and Kingdon, 2011) and in doing so, also fail to acknowledge the transformative nature (Ledenfors and Bertero, 2016) of the experience.

2.4.3.3 Fathers' feelings

Fathers experienced a conflicting range of strong emotions during childbirth: euphoria and agony (Premberg, 2011), joy and elation (Ledenfors and Bertero, 2016), anxiety and helplessness (Chapman, 2000). As previously identified, their distress may be heightened by perceived pressure to hide their emotions, both because they feel it is unacceptable for men to express anxiety and vulnerability (Chandler, 1997) and also to protect the woman in labour from their own distress.

The father's feelings of protectiveness towards his partner are powerful during labour (Kuliukas et al, 2017). This desire to protect has been linked to his concern for her safety and well-being. This is his priority; during labour he tends to be more anxious about the mother's health than the baby's (Thies-Lagegren and Johansson, 2019), although there is also evidence that he worries equally about the mother and the baby (Premberg et al, 2012). He may also be anxious about his own capabilities, whether he will be able to withstand the sights and odours that accompany birth (Tarlazzi et al, 2015), and be adequate to the task of supporting his partner (Thies-Lagegren and Johansson, 2019; Waldenstrom, 1999). When fathers conceptualised childbirth as intrinsically risky and stressful (Thies-Lagegren and Johansson, 2019), their feelings of vulnerability and anxiety were heightened, as were their protective feelings towards their partner (Symon et al, 2011).

Currently, there is scant evidence about the benefits to fathers of having continuity of midwifery carer. However, recent studies have started to address this issue. Rominov et al (2017) demonstrate the benefits to the father, as well as the midwife, of having built a pre-labour rapport. The father's sense of 'being known' by the midwife was a significant factor in easing his anxieties (Jepsen et al, 2017; Rominov et al., 2017). It increased the father's sense of trust, normalised the experience for him, and provided links with the world outside the birth environment (Jepsen et al, 2017). The midwife's approach may help reduce the father's feelings of fear and helplessness in other ways, explored in *'Midwives' attitudes to fathers'* below.

2.4.3.4 Fathers' behaviours

Fathers' more active involvement (using practical support strategies like massage), which may be welcomed by women in early labour, were perceived as less helpful as

labour progressed and intensified (Chandler, 1997; Chapman, 2000). Fathers experienced increasing stress levels as labour progressed compared with early labour when women welcomed these more active physical-support approaches (Chandler, 1997; Ledenfors and Bertero, 2016). They were not prepared for the changes in the woman's behaviour that they witnessed as labour grew more intense (Chapman, 2000; Jepsen et al, 2017; Tarlazzi et al, 2015). The woman's withdrawal from social communication, her growing 'inward focus', which may be perceived as 'distancing' (Roberts and Spiby, 2019), and the rising intensity of her pain led to the father feeling increasingly anxious, frustrated and helpless. These feelings increased as labour progressed (Roberts and Spiby, 2019), especially if it was prolonged (Chandler, 1997, Chapman, 2000) or when the comfort measures (such as massage) used in early labour became unacceptable to the woman (Chapman, 2000). A grounded theory study of 17 couples explored the impact on the father of the mother having an epidural in labour (Chapman, 2000), describing how the father felt he was 'losing her' as labour became more intense and 'getting her back' when the epidural had been sited.

2.4.3.5 Midwives' attitudes towards fathers

One paper in this ScR reported the results of a longitudinal study, starting in pregnancy and continuing until the child's second birthday, which involved 25 adolescent, black, unmarried [sic] fathers. It was the only study identified which specifically explored interactions between fathers and healthcare professionals (HCPs). It focussed on the father's perspectives (Dallas, 2009). This study has valuable findings that may be transferable to fathers from various communities. Dallas identified three 'categories' of HCP-father interaction:

- Supportive: giving information and emotional and material support
- Distancing: actively negating / denigrating the father's role
- Neutralising: failing to affirm the father's support role / his own transition to fatherhood

These categories are reflected in other studies in this ScR. Midwives have been identified as the 'gatekeepers of information' (Inglis et al, 2017). When they spontaneously offered information to the father, this signified inclusion and increased his sense of involvement and control (Johansson and Hildingsson, 2013). Lack of communication about the birth process and the woman's progress in labour increased the father's distress (Backstrom et al, 2017; Inglis et al, 2017).

Fathers sometimes report feeling 'side-lined' by the midwife (Eggermont et al, 2017). When not included and treated with respect by the midwife, their feelings of anxiety and loss of control increase (Eriksson et al, 2006 Thies-Lagegren and Johansson, 2019); conversely, when the midwife is inclusive in her approach, these feelings are reduced (Backstrom and Herflet Wahn 2011) and the father helped to support his partner

(Gungor and Beji, 2004). In addition to their need to be accepted and included by the midwife (Premberg et al, 2012), fathers valued both having their relationship as a couple acknowledged and also their 'insider knowledge' of the woman recognised. Kuliukas et al's (2017) study found this knowledge was often ignored. There is a significant relationship between the midwife's attitude to the father's presence, as demonstrated by her behaviours towards him, and the father's experience of childbirth (Porrett et al, 2012). When the midwife adopts supportive practices, such as informing, involving and supporting the father, his overall experience is enhanced. Midwives' attitudes towards fathers are therefore pivotal in influencing their experience of childbirth.

2.5 Discussion

This ScR sought to map existing literature relating to aspects of fathers' experiences during childbirth and midwives' roles in including and engaging them. The country with the highest proportion of studies (n = 12) conducted was Sweden. Long-established legislation, practices and goals of gender equality have led to clear policies of including fathers in child health services (Eriksson et al., 2006; Hildingsson et al., 2011; Wells, 2016). Most fathers attend antenatal classes (Thies-Lagergren and Johansson, 2019). This is noted because the culture of inclusion and family-centred care is further advanced than in other included countries.

Fathers' experiences of birth have received growing interest and have been examined using a range of methodological approaches, building a body of research examining their needs, roles, feelings and behaviours and midwives' attitudes towards their presence in the birth space, as identified in the thematic synthesis. However, the overview also revealed a dearth of literature which focussed on the topic of midwife-father communications. Only one (Dallas, 2009) has as its focus this key area of health professional-father communication.

It is clear from the ScR's studies' 'conclusions and recommendations for practice', that the father wants more than 'practical tips' from the midwife; he seeks recognition as an individual with needs that are distinct from the mother's and it is the midwife who is best placed to help fathers to find and establish their place during childbirth (Backstrom and Herflet Wahn, 2011; Backstrom et al, 2017; Brown, 2009; Chandler and Field, 1997; Chapman, 1991; Chapman, 2000; Kainz et al, 2010; Kuliukas et al, 2017; Porrett et al, 2012). However, as previously demonstrated, midwives emphasise the teaching of practical comfort measures to fathers as the key approach to involving them (Rominov et al, 2017). For the mother, the father's simple presence may be his contribution that she values most highly (Bertsch, 1990). Yet this is one of the most challenging roles for fathers, giving rise to feelings of anxiety and helplessness, as

described above (Waldenstrom, 1999; White, 2007; Inglis et al, 2017; Thies-Lagegren and Johansson, 2019).

Several tensions therefore exist within this set of expectations and experiences: the mother's, father's and midwife's. Midwives' emphasis on 'practical tips' can be traced to the conceptualisation of the father as 'childbirth coach' (Bradley, 1962). This had a powerful and enduring influence on the expectations of all the players involved in childbirth, perpetuated by the adoption of a 'coaching approach' by antenatal education organisations, including the NCT, Lamaze and the NHS. All have advocated 'training for childbirth' and taught fathers support strategies with which to 'coach' the woman: help with breathing techniques, back massage and verbal encouragement. As demonstrated in this ScR, if fathers anticipate fulfilling an active supporting role, these expectations may be disappointed when faced with the realities of labour; they may be unprepared for the ways in which women's behaviours and needs change during the course of labour. This ScR has also highlighted the scope for midwives to reflect an understanding that fathers are not a homogeneous group, but individuals who have different needs and behaviours. As such, they will experience labour differently according to several factors, including whether it is a first or subsequent baby (Vehrolainen-Julk and Luikkonen, 1998).

The findings of three of the ScR's studies are of particular relevance because they foreground the interconnected nature of relationships between the three central players - mother, father and midwife. Rominov et al's (2017) study, which explored midwives' perceptions and experiences of engaging fathers, found that the 106 midwives surveyed were unanimous in agreeing that doing so was part of the midwife's role. It also established, however, that 83% of these midwives had received no formal training in how to do this. These findings have clear implications for midwifery research, training and practice. Symon et al's (2011) exploration of how couples (N=500) experienced the 'built birth environment' (buildings constructed specifically for birth), concluded that whilst partners were invited to be present and to fulfil an interactive role during childbirth, appropriate facilities were not provided to support this inclusion and involvement. Each member of the birth triad has different needs, but those of the father were not taken into consideration. The 'triadic' perspective of Symon et al's (2011) work is echoed in Kuliukas et al's (2017) study investigating experiences of intrapartum transfer, from the perspectives of mothers, fathers and midwives. Kuliukas et al identified that each member of the triad shared some aspects of the experience but viewed it through a different lens. The richness of the findings of these three studies demonstrate the levels of interconnection between the central players in childbirth. They highlight the potential for the midwife to address some of the challenges that fathers experience at this time.

2.5.1 Strengths and limitations

Whilst several literature reviews have examined fathers' experiences (Elmir and Schmied, 2016; Evans, 2015; Longworth et al, 2015; Steen et al, 2012; Werner-Bierwisch et al, 2018; Xue et al, 2018), this is the first to examine midwife-father communication during childbirth. The review was conducted following recognised methods (Levac et al, 2010; Moher et al. 2009; Peters et al, 2015; Tricco et al, 2018) and this included the 'consultation' exercise recommended by Lucas et al, 2007, through use of supervisory discussions. While this helps to address some of the limitations concerning analysis/interpretation that arise when using a sole reviewer, nonetheless there will have been implications for the screening and selection of articles for inclusion.

The principle limitation of this ScR is that a sole researcher was involved in screening and selecting articles for inclusion, rather than the minimum of two reviewers (Micah et al, 2015) or a team approach (Levac et al, 2010; Tricco et al, 2016) recommended as best practice in the conduct of ScRs. This, along with limitations on the sensitivity of the search (for example, including only studies published in English) increases the potential for some important and relevant studies to have been missed. However, during supervision discussions, the author's analysis, interpretations and syntheses were challenged, constituting the 'consultation' exercise recommended by Arksey and O'Malley (2005) as the penultimate stage of the ScR.

The very large volume of 'hits' (12,988) identified during the electronic search meant that the process of screening via title and abstract was very time-consuming. Despite undertaking this with a systematic and committed approach, human error may have resulted in some studies being overlooked. It is hoped that the breadth of background reading undertaken throughout the research process and incorporated into other chapters of the work, will help to mitigate against this limitation. Importantly, the procedures Tricco et al (2018) laid out earlier in the chapter were systematically and carefully followed.

2.6 Conclusion

The research examined in this ScR highlights that mothers and fathers have distinct and different needs during childbirth and the midwife is best placed to engage the father. However, since father-midwife communication has not to date been examined explicitly, this is clearly a gap in the existing literature. The findings of the ScR add strength and support to the rationale for conducting this current research. The following 'Methodology' chapter opens with a statement of the research question, aims and objectives.

2.7 Summary box

- Sixty years after fathers were first admitted during labour, their status within the birth environment remains unclear.
- Fathers play a number of roles during childbirth, but midwives prioritise the father's role in offering practical support to the mother over the benefits the mother feels from his presence, or addressing the father's emotional needs.
- The father's feelings of anxiety and exclusion during childbirth are mitigated when the midwife offers information and reassurance about what is happening.
- Currently, few opportunities are created for dialogue and negotiation between midwife and father about the types of involvement the couple wants him to have and the roles he may play.
- The role of the midwife, which has in the past been clearly defined as being 'with woman', is changing to include an expectation that she is now caring not only for the woman, but also her partner and for the parents as a couple. This forms a triadic relationship. The complex dynamics involved are founded on effective communication.

Chapter 3 Methodology

3.1 Introduction

This chapter starts with a statement of the research question, aims and objectives. It then sets the study within its methodological context of applied health research, outlines the philosophical framework, describes the rationale for adopting a qualitative approach, explains why ethnography was chosen as the most appropriate methodology, explores the issues of quality and rigour in qualitative research and situates the researcher in relation to the research, through the process of 'reflexivity.'

3.2 Research question, aims and objectives

Research question

'How do midwives and fathers communicate during labour and birth?'

Aim

This ethnographic study focuses on communications between fathers and midwives during childbirth. During childbirth, the midwife provides direct care to the mother, but also interacts with the father. The mother and father's on-going couple relationship brings a further dynamic into the room. How midwives and fathers communicate is therefore set within the context of the triadic mother / father / midwife relationship. This will be explored, to gain a deeper understanding of the complex set of relationships involved and enhance the experiences of the three central players.

Objectives

To explore

1. The views, experiences and needs of fathers in relation to being present during childbirth and of mothers in relation to their (male) partner being present
2. the views and experiences of midwives in relation to fathers being present

To identify

3. how midwives perceive and respond to fathers' needs
4. the approaches used by midwives to engage and involve fathers
5. the approaches used by midwives to engage with the mother/father couple-unit

3.3 Applied health research

Applied health research (AHR) is the scientific study of any factors that impact on aspects of health and health care. Its scope ranges from investigation into professional and clinical practice and service user experience, to research into health service processes, structures and systems (Bowling, 2014). By contrast, bio-medical research involves the investigation and treatment of specific disease and conditions, both physical and mental (OECD, 2001). The scope of AHR encompasses a range of

disciplines including philosophy, psychology, sociology, anthropology, economics, management and leadership theory, as well as all fields of health care. Midwifery has a broad knowledge base which draws on all these disciplines; AHR is therefore an appropriate paradigm for midwifery research. In AHR, research findings are used to influence clinical practice (Gerrish and Lacey, 2010), aiming to generate knowledge that is useful, practical and 'has immediate application' (Given, 2008).

3.3.1 This study's fit within the AHR paradigm

ARH includes the study of 'patient care' in the broadest sense, including investigation of the psychological and emotional well-being of patients and service users, and also their families and other members of their social networks. This study's focus is on the midwife-father dyad, in the context of the triadic mother-father-midwife relationship and interactions with other people who are involved. This complex set of relationships is outlined to demonstrate the study's fit within the AHR paradigm.

3.3.2 The biopsychosocial model of childbearing

The biopsychosocial model (Suls and Rothman, 2004; Saxbe, 2017) highlights that the physiological dimension of childbearing constitutes but one element within the entire experience, which is 'very much embedded in a social and cultural setting' (van Teijlingen, 2003, p.120). Within the biopsychosocial model, the inclusion of the woman's partner is integral to the provision of high-quality care; it recognises 'the various biological, psychological and social dimensions that apply' (Edozien, 2015, p.902). This research focusses on psychosocial aspects of childbirth and therefore fits with this biopsychosocial conceptualisation.

3.4 Philosophical framework for the study

The following section opens by outlining the principles of social constructivism as the study's interpretive framework; it then makes explicit the ontological, epistemological, axiological and methodological assumptions that underpin the study. The rationale for aligning the study with these philosophical assumptions is explored, with mention of other approaches that were considered and rejected.

3.4.1 Social constructivism

The terms 'constructivism', 'constructionism' and 'interpretivism' are often employed interchangeably. All are concerned with the ways in which human beings construct meaning and are based on the assumption that 'meaning is not discovered but constructed' (Crotty, 1998, p.42). Some commentators elaborate further. For example, Braun and Clarke suggest that 'constructivism' is 'more individualistically and psychologically orientated than 'constructionism' (2013, p.239); Crotty (1998) emphasises that constructionism recognises the powerful influences exerted by the cultures within which people live. Others use the terms 'interpretivism' and

'constructionism' interchangeably (Ormston et al, 2014, p.12) or state that 'social constructivism...is often described as interpretivism' (Creswell, 2013, p.24). There is therefore ambivalence about the precise meanings of these terms. Semantics apart, they all stress the importance of context: 'understanding people's lived experiences' (Ormston et al 2014, p.13) in the context of their social, cultural and historical situations (Braun and Clarke, 2013) and work to understand how people construct 'subjective meanings of their experiences...[which are] varied and multiple' (Creswell, 2013, p.24).

The social constructivist framework for this study is based on Vygotsky's sociocultural theory of human development (Hopwood, 2013; McLeod, 2018). Developed in relation to human learning and education, this theory of social constructivism stresses 'the fundamental role of social interaction' (McCleod, 2018) as one of its three central tenets. This emphasis on social interaction is the key rationale for adopting social constructivism as the theoretical framework for this study, whose focus is communications. Vygotsky's other two core themes, the 'more knowledgeable other' and 'zone of proximal development' (David, 2014), are also explored and related to the study's findings in the Discussion chapter.

3.4.2 Ontology, epistemology, axiology and methodology

3.4.2.1 Ontological perspective

Ontology is concerned with the nature of reality and its characteristics (Creswell, 2013; Ormston et al, 2014). A relativist ontological stance assumes the existence of multiple realities (Denzin and Lincoln, 2018) and rejects realism, which is based on the premise that there is an external reality existing independently of human consciousness (Levers, 2013) or people's beliefs or understanding of it (Lincoln, Lynham and Guba, 2018) and 'only accessible through the perceptions and interpretations of individuals' (Ormston et al, 2014, p.21). The researcher's assumptions about the nature of the world and reality determined both the topic area she chose to focus on and the approaches she adopted to understand it (Saunders et al, 2019).

Social constructivism in relation to ontological perspective

The social constructivist approach adopted for this study is based on the relativist ontological belief that there is no single reality or truth: reality is constructed through a range of social processes, including language, actions and behaviours (Braun and Clarke, 2013). This ontological stance is appropriate because each of the central players has a different experience of childbirth. These experiences also differ depending on the context - whether it is a first or subsequent baby (for either parent), the place of birth, the stage and speed of labour and other people present. In order to gain insight about these different perspectives, the researcher must find ways to access and comprehend these varying experiences.

3.4.2.2 Epistemological perspective

Epistemology is concerned with what constitutes valid and legitimate knowledge (Creswell 2013; Saunders et al, 2019) and how best to acquire knowledge about the phenomena under study, thus guiding the choice of methods employed to address the research question. This study takes the epistemological stance of interpretivism: the premise that the social world, unlike the natural world, is not governed by a set of immutable laws. Rather, knowledge about the social world is built through finding out about, understanding and interpreting the perspectives of its participants (Ormston et al 2014, p.24).

Social constructivism in relation to epistemological perspective

In relation to her epistemological stance and employment of a social constructivist framework, the researcher adopts the definition offered by Crotty, that knowledge is constructed through the study of people's interactions with each other, within their social contexts (Crotty, 1998). In epistemological terms, social constructivism is an appropriate interpretive framework for this study because it seeks to understand participants' perspectives 'in the context and circumstances of their lives' (Ormston et al, 2014, p.22). It is an exploration of a social world which explores the interactions within it, in their 'real life' context.

3.4.2.3 Axiological perspective

Axiology is concerned with the role of values and ethics within the research process: the ways in which the researcher deals with her own and the participants' values (Saunders et al, 2019).

Social constructivism in relation to axiological perspective

In choosing to gather data via observation and face-to-face interview, the researcher placed a high value on data obtained through social interaction, rather than through other means – for example 'an anonymous questionnaire' (Saunders et al, 2019, p.134). She recognises and respects the values and beliefs of others, including when they differ from her own; this is a personal core value. She maintained a respectful stance in relation to the study participants (Creswell, 2013, p.37); she aimed to represent the participants' voices (Killam, 2013), befitting the adoption of the social constructivist approach.

As a midwife undertaking research in maternity settings (Hunt and Symonds, 1995, p.40), her acclimatisation to the world of childbirth was an issue she identified as giving her an emic ('insider') perspective. This was in contrast to the fathers', whose own perspectives were at the heart of the study. Even those fathers who had been present at previous births were relative outsiders in the world of birth. It was therefore important that the researcher should strive to become a 'cultural stranger' (Holloway and Todres,

2010, p.167), seeking to understand the 'etic' perspective. She consciously worked to be aware of and to pursue this 'outsider' perspective and to be mindful of her own values and beliefs and the ways in which they could impact data collection and analysis. Throughout the course of the research she engaged actively in a process of reflexivity, through self-questioning and introspection (Francis, 2013, p.69), reflective journaling (Okyere, 2016) and discussions in supervision. Her own values and beliefs in relation to the area of study and her motivations for undertaking this research are made explicit in the 'Reflexivity' section of this chapter and Appendix D. In holding this awareness of her own values and perceptions, she acknowledged that qualitative research cannot be 'value free' (Creswell, 2013, p.20).

3.4.2.4 Methodological perspective

A qualitative methodology is appropriate for this study because it focuses on human experiences and seeks to understand the *meanings* of these experiences within a social and psychological context (Braun and Clarke, 2013). The philosophical foundations upon which quantitative research is based – the positivist notion of one absolute truth (Taylor, 2013a, p.16); that the world is ordered and predictable (Topping, 2010, p.129) and that the methods employed in quantitative research – for example, hypothesis-testing, control of variable numerical analysis, emphasis on statistical significance (Taylor, 2013a, p.17) - are inappropriate for this study.

Social constructivism in relation to methodological perspective

Social constructivism recognises the complexity of the social world (Creswell, 2013), acknowledging that events, objects and interactions have different meanings for different people. In doing so, it rejects the notion of knowledge as 'an objective...reflection of reality' (Braun and Clarke, 2013, p.30) and also the 'positivist approach to investigating the social and natural world...based on the assumption that social life, like natural sciences, can be studied as facts' (Topping 2010, p.131). It has been described as 'the strongest contrasting paradigm to positivism' (Killam, 2013).

Childbirth is a universal phenomenon, but the meanings of the events that unfold during labour and birth – the intentions, beliefs, values, motives and rules - are not based on universal laws and cannot be understood in terms of simple causal relationships (Hammersley and Atkinson, 2007, p.7). The meanings ascribed to events will be different in different societies and within a society; they will vary for each couple, midwife, birth and birth setting.

The central players during childbirth each have very different perceptions and understandings of the experience. Social constructivism recognises complexity: that individuals' interpretations of events are shaped by context and backgrounds (Creswell, 2013, p.24). This also makes this interpretive approach a good 'fit' for this study, in

which parent participants had varied backgrounds and expectations (including previous experience of childbirth) and data were collected in four different birth environments.

The researcher actively sought this complexity and worked to construct knowledge of the social world through different discourses and 'systems of meaning' (Braun and Clarke, 2013, p.30). Social constructivism is thus an appropriate interpretive framework, particularly as it adopts a critical stance to 'perceived truths and taken-for-granted knowledge' (Braun and Clarke, 2013, p.30). In doing so, it fulfils one of the study's objectives, of stimulating discussion around the issue of fathers' involvement in childbirth.

Social constructivism in relation to an inductive approach

The inductive approach to knowledge acquisition in this study is congruent with social constructivism. The researcher espoused the belief that 'truth is revealed through observation and...verification' (Braun and Clarke, 2013, p.330). She collected data to explore the area of midwife-father communication, which she then used to build patterns and themes, moving from the specific to the general in the development of concepts (Saunders et al, 2019). These patterns of meaning were generated inductively, from the 'bottom up' (Creswell, 2013, p.45). She acknowledges, however, that this was an iterative process, and that 'pure induction' cannot exist since the researcher is central to the collection and analysis of data (Ormston et al, 2014). Therefore, elements of deduction were also involved, due to the iterative nature of the investigation. This highlights the importance of the high degree of reflection, reflexivity and discussion which were key elements of the process of concept development.

3.5 Qualitative research

A qualitative methodological approach is appropriate for this research because it is a study about human experience. The focus is not on the clinical care of the mother by the midwife, but rather on how the interactions between the key 'players' involved unfold during labour and birth, describing, explaining and exploring the meanings of this experience (Gerrish and Lacey, 2010), with a focus on individuals' perceptions, beliefs and attitudes.

3.5.1 Characteristics of qualitative research: its 'fit' for this study

The central tenet of qualitative research is 'that it deals with, and is interested in *meaning*' [authors' emphasis] (Braun and Clarke, 2013, p.20). It is characterised by the collection of rich data (Braun and Clarke, 2013), in 'natural' settings which are 'sensitive to the people and places under study' (Creswell, 2013, p.44). It involves studying and reporting on multiple perspectives and realities and uses multiple forms of evidence to capture these different perspectives (Creswell, 2013) including semi-structured interviews, direct observations and focus groups. Data analysis often

proceeds concurrently with data collection (Lathlean, 2010) and although essentially inductive, also includes elements of deduction in the development of themes and patterns. All of these characteristics of qualitative research are congruent with the study's philosophical framework outlined above.

This research involves an in-depth study of what actually happens in terms of communication and interaction during childbirth, within the environments where labour takes place. This study aims to get as close as possible to 'the action' – to be present during labour and birth to observe directly what happens and then to explore in more depth these data collected 'in the real world' by interviewing the 'players' involved. The nature of labour and birth - a process that unfolds over time and within different contexts – encompasses a wide range of experiences and emotions for each of these players

3.5.2 Qualitative research - influencing practice in health care

The introduction of evidence-based maternity care in the late 1980s (Walsh, 2007) was rooted in the development of 'evidence-based practice' in all fields of medicine (Sackett et al 1996). In the past, the 'gold standard' evidence for influencing change in health care has been the randomised controlled trial (Reed, 2010). However, there is now clear recognition that qualitative research findings have the potential to influence care provision (Cluett and Bluff, 2006) where research questions cannot be successfully investigated by such positivist approaches. This is of particular relevance where the focus of the research is to deepen understanding of the relational aspects of healthcare – the interactions between health professionals and service users during the provision of care (Gerrish and Lacey, 2010). Through investigating '...the meaning of human experiences...[it] creates the possibilities of change through raised awareness and purposeful action' (Taylor, 2013a, p.3). The qualitative paradigm is therefore a good 'fit' for this study.

3.5.3 Rationale for rejecting a mixed-methods approach

A quantitative approach was rejected as too deductive for this study. Aspects of the research topic could have been explored using mixed-methods; employing (in addition to a qualitative method), a quantitative approach such as testing a hypothesis (for example, *'Midwives' communication styles have a direct correlation with paternal birth satisfaction'*); investigating the father's presence in relation to the mother's use of analgesia or mode of delivery; undertaking a 'satisfaction survey' of fathers' experiences; using questionnaires to generate data on midwives' views of fathers' presence. A concern was that such approaches to data collection which relied heavily on 'self-report' would raise questions about the validity of responses, due to 'social desirability' and 'response biases' (Demetriou et al, 2015). This study aims to build

knowledge through exploration of social phenomena; these quantitative approaches were therefore deemed too restrictive for this.

3.5.4 Qualitative approaches considered and rejected

Qualitative research is recognised as ‘a very broad church’ with a wide range of approaches to choose from (Ormston et al, 2014, p.3). This section summarises the options that were considered and rejected.

Grounded theory

Grounded theory constructs theory from data (Charmaz et al, 2018), often aiming to deepen understanding of social processes (Braun and Clarke, 2013). It usually employs interviewing as its primary data collection tool (Creswell 2013) and conducts analysis either by creating a taxonomy of inter-related codes (Glaser and Strauss, 1967) or, more recently, via constructivist approaches (Charmaz et al, 2018). This study did not aim to generate theory; grounded theory was therefore deemed inappropriate.

Phenomenology

Phenomenology aims to describe ‘...the common meaning for several individuals of their **lived experience** of a...phenomenon’ [author’s emphasis] (Creswell, 2013, p.76), with the phenomenon under study, ‘...phrased in terms of a single concept or idea’ (Creswell, 2013, p.78). Initially, phenomenology was considered as an attractive approach for this study, particularly as the essence of phenomenology is a desire to understand people’s subjective experiences (Braun and Clarke, 2013). It was rejected firstly for its emphasis on ‘a single concept or idea’; this study has a broad focus, exploring complex interactions within different social contexts. Secondly, the emphasis in some phenomenological approaches on ‘bracketing’ (Taylor, 2013b), was felt to be an unrealistic expectation for the researcher, with her long experience of working in the field. Although other approaches (for example, Interpretative Phenomenological Analysis) recognise that ‘bracketing’ is unachievable, after careful consideration, phenomenology was rejected because it places greater emphasis on psychological rather than ‘socio-cultural’ interpretations (Braun and Clarke, 2013, p.103) which are central to this study.

Narrative research

Narrative research, with its reliance on participants’ stories about their experiences (Freshwater and Holloway, 2010, p.188) was considered briefly, but rejected for two reasons. One: during the preliminary literature search, the dearth of childbirth studies which employed observation for data collection was noted and prompted the decision to use an approach which has observation as its primary data collection tool. Two:

given the aim of exploring the interactions between fathers and midwives, in the context of the couple relationship and within the birth environment; narrative research was deemed an inappropriate methodology for capturing such complexities.

Case study

The 'case study' approach was also considered. Described as an in-depth enquiry into a phenomenon (the 'case') in its 'real-world context' (Yin, 2014, p.16), it shares this and other 'defining features' with ethnography, for example the use of multiple data collection approaches (Creswell, 2013). It is considered a valuable approach for health researchers who are familiar with their research settings; a 'pre-understanding' (Clarke and Reed, 2010, p.239) of the issues they plan to study is helpful in formulating research questions. Although case study research can involve multiple cases (Creswell, 2013), the researcher felt that Yin's 'logic of replication' (Yin, 2014, p.56) in multiple case studies, where the researcher looks for similarities in findings across cases to enhance generalisability, would narrow her focus.

3.6 Ethnography

The literature review found little research exploring midwife-father communications and none which employed an ethnographic approach. The researcher approached this under-researched area with a broad lens, open to what she might discover and felt that data collection via direct observation amplified by interview data, had the greatest potential to yield the rich contextual data she sought. Therefore, ethnography was chosen as the preferred option.

3.6.1 The development of ethnography

Ethnography is a field-based approach (Gribch, 1999) to qualitative research. The term describes both the methodological approach and the end-product (Holloway and Todres, 2010) as well as all the stages in the research process, including the methods (O'Reilly, 2017). 'Ethnography' is derived from the Greek, meaning 'writing culture or people'; 'writing the ethnography' involves crafting a story – a narrative account rich in detail. It identifies, and places in context, patterns of social and cultural relationships.

From its early roots in anthropology and sociology (in the late 19th and early 20th century and the 1920s and 1930s respectively), ethnography has been adopted by other disciplines, including health researchers (Dykes and Flacking, 2016). It is an effective approach to use for AHR, because data are collected in 'naturalistic settings' (Francis, 2013, p 67). It can mirror (Schmied et al, 2016) what actually occurs in 'real life' and encourage change in practice via 'improved practical problem-solving' (Brimdyr, 2016, p.31). Current ethnographies, in contrast to the early 20th century studies, include 'macro' studies, focusing on institutions, and 'micro' studies of a single social setting (Holloway and Todres, 2010, p.165).

3.6.2 Ethnography and midwifery research

As the body of midwifery research has grown, so has use of ethnography (Donavan, 2006, p.173; Roberts, 2009). Recent ethnographic studies explore diverse areas: 'creating calm' during labour (Huber and Sandall, 2009); aspects of postnatal care and recovery (Wray, 2011); parents' motivations for using an alongside birth centre (Newburn, 2012); the impact of the built birth environment on behaviours during childbirth (Harte et al, 2016); the meaning of one-to-one midwifery support in labour (Sosa, 2017). Donavan (2006), and other commentators (Hunt and Symonds, 1995; Kirkham, 2016) note that midwifery skills (for example, those of careful observation and listening and the building of trusting relationships) are relevant and valuable in carrying out ethnographic research. They suggest that midwives may have particular aptitude in this approach.

3.6.3 Definition and rationale for employing this approach

Ethnography is concerned with the study of culture, which has as its starting point an interest in human problems (Spradley, 1980). Fieldwork lies at the heart of the approach. Data are collected in their 'natural' setting (Hammersley and Atkinson, 2007, p.6). Through 'immersion' in these settings (Francis, 2013, p.74), the researcher aims to gain a deeper understanding of the social group under investigation, seeking the participants' view of reality - the 'emic perspective' (Creswell, 2013, p.93).

Direct observation, its 'core defining feature' (McNaughton Nicolls et al, 2014) is the primary data collection tool (Hammersley and Atkinson, 2007). Through observation, the researcher witnesses and records peoples' behaviours, going beyond the self-reported data gathered during interviews. It reveals participants' 'tacit knowledge' (Francis, 2013, p.68) – aspects of their culture and behaviours that are so deeply embedded that they are taken for granted by the participants. This was an important element of the rationale for choosing ethnography for this study which involves exploration of the behaviours of midwives.

Ethnography focuses on ordinary activities (Miller and Brewer, 2003) and their social meanings, as they unfold in naturalistic settings (Francis, 2013). Data collection in the real world has great potential to influence practice-change (Brimdyr, 2106, p.49), as the voices and experiences of participants are articulated and expounded. Ethnography's focus on the 'routine activities and customs in the culture' (Holloway and Todres, 2010, p.166) made it a good 'fit' for this study, with its focus on straightforward birth.

3.6.4 The study in relation to different ethnographic 'schools'

'Ethnography', an umbrella term, encompasses a range of sub-divisions, described variously as schools, approaches or sub-types (Creswell, 2013; Gribch, 1999; Francis, 2013). For example, 'classical ethnography', originating with the work of early anthropologists, depicted the researcher as a neutral, reflective documenter who spent

extensive time 'in the field' (Gribch, 1999; Francis, 2013). Now criticised as imperialist and colonial (Gribch, 1999; Okyere, 2016), it is recognised that the researcher's own world view and interpretation of events in the field was far from a 'neutral lens'.

A distinction has been drawn between 'realist' and 'critical' ethnography, the former involving 'pure' observations which are as objective as possible, the latter advocating for the rights of marginalised groups (Creswell, 2013). Other commentators identify similar sub-types; in relation to ethnographic approaches in healthcare, Holloway and Todres (2010) distinguish between 'critical ethnography' which aims for change through focussing on the power dynamics of social interaction, and 'descriptive ethnography', which has implications for practice, but not the specific aim of practice-change. Further sub-types include 'systemic' (Francis, 2013); 'work practice' (Brimdyr, 2016) ethnographies (exploring the structures of organisations and workplaces), and 'interpretive / hermeneutic' approaches (Francis, 2013). This study encompasses elements of critical and interpretive ethnography, as briefly described below.

Critical ethnography

Critical ethnography aims for change (Holloway and Todres, 2010), through focussing on the loci of control and the power-dynamics within interactions. A 'critical lens' is adopted to identify internal and external power relations (Francis, 2013, p.66), seeking to challenge and deconstruct hegemonic practices observed and aiming to empower marginalised individuals and groups (Gribch, 1999). The study therefore has elements of 'critical ethnography', because fathers can be conceptualised as a 'marginalised group' during childbirth due to their ambivalent status (Steen et al, 2013). However, caveats to this statement are made from a feminist perspective and explored in the 'reflexive account' (Appendix D).

Interpretive ethnography

Ethnography used to uncover meaning, described variously as interpretive / hermeneutic (Francis, 2013, p.66) and post-modern / post-structural (Gribch, 1999) places 'a greater emphasis on language and the discourse of power relationships within which both the researcher and the researched have been constructed (Gribch, 1999 p.160). In writing the ethnography the researcher 'displays' the voices of others, so exposing the setting's multiple realities. This study employed an interpretive approach to data analysis, in order to understand the dynamics of the triadic relationships at play.

3.6.5 Framing and developing the research question

In his early writing about ethnography, Malinowski described the starting point as a 'foreshadowed problem' (Malinowski, 1922), from which the study progresses. The 'foreshadowed problem' for this study was the researcher's awareness of the dearth of

evidence on the area of midwife-father communications. This was confirmed as an under-researched area through initial and subsequent searches of the literature.

The original research question (formulated in 2013), was: '*How do communications and relationships between midwives and fathers impact on the birth experiences of mothers, fathers and midwives?*' It was narrowed down through the processes of literature-searching, discussions with the project's ethnographic advisor, undergoing training and beginning fieldwork. In 2016 and 2017, the researcher participated in two courses led by experienced ethnographers. This intensive training came at pivotal points in the research process. Both courses equipped the researcher with helpful perspectives on methodological issues as well as invaluable practical skills in carrying out the study. The first highlighted the research question as being too complex for an ethnographic approach (Okyere, 2016). In its original form it contained two elements: the descriptive, '*What is happening here?*' and the inferential, '*How are these things linked here?*' (Clarke and Reed, 2010, p.240). It was subsequently revised prior to applications for ethical approvals. The second course focussed on all aspects of the skills involved in carrying out fieldwork. Both courses also gave useful opportunities for practising 'techniques' (such as making fieldnotes) and receiving feedback on these, but more importantly, the chance to discuss and reflect with colleagues and experts who were committed to ethnography. This enabled the researcher to test the feasibility of her research proposal.

Ethnographic fieldwork is said to begin as soon as the researcher enters the field (O'Reilly, 2017). In this study, however, the researcher had spent several decades working 'in the field', long before the familiarisation visits to the study site and first 'formal' observation in labour. Every phase of the research process proved to be iterative in nature (Holloway and Todres, 2010). Early stages of data collection and analysis started during meetings with staff, which took place months before 'formal' data collection began.

3.6.6 Research participants

Participants in ethnographic research are often described as 'informants', a term and concept used by Spradley (1979, p.25) at a time when they were more usually referred to as 'subjects'. It was subsequently widely adopted in ethnographic research (Holloway and Todres, 2010). The term 'partner' is also employed (O'Reilly, 2017). These conceptualisations highlight the ethnographer's commitment to learning *from* people, rather than collecting data *about* them (Spradley, 1979, p.4). It encapsulates the potential of the approach to gain insight into the meanings of others' experiences, with the participants and researcher 'co-constructing' (Lincoln et al, 2018, p.114) or 'co-creating' (Russell and Kelly, 2002, p.13) knowledge. The concept of 'learning with' people through collaboration, discovery and understanding are very much in line with

the researcher's core values and beliefs; she embraces the notion of relationality within the research process (Russell and Kelly, 2002, p.4).

Ethnography is a process that 'reflects the training and belief system of the researcher' (Francis, 2013, p. 66). This was a further factor influencing the choice of this approach, since it is congruent with the researcher's view of birth in its social context and her respect for the centrality of parents' experiences. The relationship between researcher and participants is captured by Spradley when he describes the 'essence of ethnography':

Instead of collecting 'data' about people, the ethnographer seeks to learn from people, to be taught by them.

Spradley, 1979, p.4

In this study, the researcher chose to focus on communications between midwives and fathers where the mother is healthy, deemed 'low risk' and suitable for midwife-led care. This group of women makes up approximately 60% of total births in England (NHS Digital, 2018). Caring for these healthy, 'low risk' women is 'core' midwifery work. Because of its every-day nature, there is a risk that midwives may become de-sensitised to the parents' individual experience and so it becomes 'taken for granted'. In focussing on the 'every-day', the researcher helped the 'invisible to become visible' (Brimdyr, 2016, p.31), a clear aim in ethnographic research.

Sampling strategy in relation to the philosophical framework

In accordance with qualitative research principles, 'representation' of the research population was not used as part of the selection criteria, because the epistemological and ontological beliefs underpinning the study 'assume knowledge is dynamic and context dependent' (Taylor, 2013c, p.190). The purposive sampling strategy is also consistent with the study's social constructivist framework: social and cultural context are of central importance.

3.6.7 Data collection and analysis

In ethnographic research, data collection and analysis occur simultaneously, rather than as two separate activities. It is argued that preliminary analysis begins with the framing of the research question (Creswell, 2013; Hammersley and Atkinson, 2006) – Malinowski's 'foreshadowed problem'. Hunt agrees, suggesting that analysis begins in the pre-fieldwork stage, with the identification of generic and topical research questions (Hunt, 1995, p.53); the researcher therefore enters the field 'with some questions in mind' (O'Reilly, 2012, p.180). This iterative 'back and forth' process is congruent with the inductive approach to knowledge acquisition and the social constructivist

framework adopted for the study. Data are summarised as they are collected and interconnections made between early and later summaries (Gribch 1999 p.161).

In considering approaches to data analysis, the researcher reflected on Braun and Clarke's grouping of these into three broad 'forms': 'searching for *patterns*, looking at *interaction* or looking at *stories*' (2013, p.130). Of these, she selected the 'pattern-seeking' approach of thematic analysis (Braun and Clarke, 2013) as most suited to the study's social constructivist approach and emphasis on social and cultural context. This was congruent with the constructionist view that 'meaning is not discovered but constructed' (Crotty, 1998, p.42).

Conceptual contradictions within the 'observer' role

The range of potential researcher roles in observational studies has been described as spanning a continuum:



Figure 2 Participant-observer continuum (adapted from Gold, 1958)

At one end of the continuum, the 'complete participant' is a covert observer, engaging in the same activities as the people she is observing; at the other, the 'complete observer' is situated behind a one-way mirror (Hammersley and Atkinson, 2007). The 'participant as observer' is overt about her role, so for example may work alongside the people she is studying (McNaughton et al, 2014).

The researcher's stance in this study was that of 'observer as participant'. This is an oxymoron: it encompasses a range of contradictory relationships. She positions herself thus in recognition of the fact that you cannot be present in a social situation without being part of it. She aimed to watch, but not to participate (Emerson et al, 2011) and did not attempt to engage with people or to form relationships (McNaughton et al, 2014). However, within the framework of social constructivism, by her presence, the researcher is involved in the 'enactment' of events.

The concept of 'observation' implies 'distance'. This is dialectically opposed to the 'immersion' that ethnographers are urged to seek (Spradley, 1980, p.145). The researcher described her state during observations as 'absorption'; she discovered it was not possible to be a 'detached passive observer'. 'Observer as participant' encompassed the researcher's sense of being involved, through absorption. She was

both 'being with other people' as they experienced the labour and birth and also 'experiencing it for [her]self' (Emerson et al, 2011, p.3).

The dialectics of participant observation encapsulate what give its unique potential to study the 'art' of midwifery (Watson et al, 2010, p. 391) – those aspects involving human relationships, confidence, intuition and the building of trust and reciprocity (MacLellan, 2011). It enables faithfulness to people's complexity (O'Reilly, 2017). In this study, 'complexity' included witnessing how participants coped with the unpredictability which lies at the heart of childbirth.

Interview data

In accordance with ethnographic principles, the interview data include records of brief 'ethnographic conversations' (Spradley, 1979) and 'naturally-occurring talk' (Holloway and Todres 2010 p.171) in the study settings. The 'formal' post-birth interviews were designed in line with the study's social constructivist framework. They encouraged participants to explore the aspects of the experience that were most significant to them (Sherman Heyl, 2001); the interview style was 'collaborative rather than interrogative' (O'Reilly, 2012, p.173).

3.6.8 Challenges and limitations of an ethnographic approach

A number of criticisms of ethnography have been made, many of which are 'of an ontological and epistemological nature' (Cruz and Higginbottom, 2013) and could equally be applied to other qualitative research approaches, in their questioning of what constitutes knowledge and how it can be captured. Some of ethnography's strengths, in particular its flexibility as a methodology, can become weaknesses if steps are not taken to mitigate the particular challenges of adopting this approach (Francis, 2013).

In ethnography in particular, the adoption of participant observation as the key data collection tool means that the researcher is central to the collection and interpretation of these data (Francis, 2013). During observations, the researcher selects what to record (McNaughton Nicholls et al, 2014). Moreover, the fact of the researcher's familiarity with the study's settings as well as the midwifery work undertaken there carried an additional risk that she would be acclimatised to events and so miss the subtleties (Holloway and Todres, 2010) of what was occurring in the field. There is also the risk that the researcher may fail to capture non-verbal interactions (Gribch, 1999). Steps taken to mitigate these pitfalls are described below.

3.7 Quality and rigour in qualitative research

The principle of 'trustworthiness' is employed to evaluate research adopting a constructivist approach (Denzin and Lincoln, 2018, p.20; Taylor and Francis, 2013). Guba and Lincoln (1985) define criteria that contribute to trustworthiness: credibility, transferability, dependability, confirmability and reflexivity; strategies to increase

trustworthiness are suggested, including prolonged engagement in the field, persistent observation and triangulation of sources and methods (Guba and Lincoln, 1985). Other approaches for determining rigour are proposed: a list of 'targeted actions', including assessing the researcher's clarity of purpose, the approaches used to collect and analyse the data and its ability to 'convince' the reader (Morse, 2018, p.814). Bochner argues against the use of criteria to evaluate the 'messy, complicated, uncertain' phenomena studied in qualitative research (2000, p.267), but goes on to specify five characteristics of such research which are persuasive of its quality, for example plentiful concrete detail and 'structurally complex narratives' (Bochner, 2000, p.270). The challenges of developing criteria are acknowledged, due to the 'elusive' and subjective nature of research 'that appears to defy simple categorisation or identification' (Russell and Kelly, 2002, p.2).

A number of criteria-based approaches to establishing quality were considered, including Guba and Lincoln's (1985) principles, Creswell's specific criteria for the evaluation of ethnographic research (2013) and Richardson's four criteria of substantive contribution, aesthetic merit, reflexivity and impact (2018, p.823). However, Tracy's framework, 'Eight 'big-tent' criteria for excellent qualitative research' (2010; listed below), was selected as the most appropriate:

1. Worthy topic
2. Rich rigour
3. Sincerity
4. Credibility
5. Resonance
6. Significant contribution
7. Ethics
8. Meaningful coherence

When embarking on this study, the researcher was a novice. As such, she identified with Tracy's statement that:

...criteria are useful. Rules and guidelines help us learn, practice and perfect...Research on learning demonstrates that novices and advanced beginners in any craft...rely heavily on rule-based structures to learn.

Tracy, 2010, p.838

Although she would classify herself as an 'advanced beginner' (Tracy, 2010, p.838) due to previous study, long career as a midwife and other life experiences, she was still a novice researcher.

Tracy's framework is highly detailed and specific in expanding ways in which each of the eight criteria can be evaluated (Appendix E). Its clear emphasis on the centrality of 'self-reflexivity' in the research process was important due to the nature of this ethnographic study in which the researcher was a midwife investigating a world with which she was very familiar and also felt deep emotional involvement (Cruz and Higginbotham, 2013). A further rationale for choosing this framework was its preference for Richardson's concept of crystallisation (2018), rather than the more commonly employed 'triangulation' of sources, methods and investigations (Guba and Lincoln, 1985) as a route to establishing credibility. This image was powerful in capturing the researcher's experience of coming to see a previously familiar world through different prisms. As Richardson says, a crystal 'combines symmetry and substance with an infinite variety of shapes, substances, transmutations and multi-dimensionality of approach' (2018, p. 822).

In ethnographic research, the highlighting of themes that are unusual and distinguished by their 'difference' is an important test of the study's trustworthiness. Such cases are called variously 'negative' (Guba and Lincoln, 1985); 'deviant' or 'unique' (Small, 2009); 'discrepant' (Dykes and Flacking, 2016), 'outliers' or 'variant' (Morse, 2018). The process of seeking, examining and accounting for this 'contradictory evidence' (Anderson, 2011) serves to demonstrate as that the researcher is actively searching for alternative meanings and explanations. In this study, the term 'variant' case is employed.

3.7.1 Reflexivity

Reflexivity is a vital element in qualitative research in making explicit the role of the researcher in the production of knowledge (Braun and Clarke, 2013). It involves acknowledging 'cultural, social, gender, class and personal politics' (Creswell, 2013, p.215), maintaining awareness of personal prejudices (Taylor, 2013b) and 'honoring [sic] oneself and others in our work through an awareness of the relational and reflective nature of the task' (Russell and Kelly, 2002, p.2). This negotiating of the findings between the researcher and participants has been described as seeking to establish a 'middle way' of 'empathic neutrality' (Ormston et al 2014, p.8). This position acknowledges that research cannot be value-free; rather, it encourages the researcher to be aware of and make transparent her own values, biases and assumptions, aiming for a stance that is neutral and non-judgemental.

Adopting an ethnographic approach means that the researcher is part of the social world under study, however discreetly she conducts herself during observations. Inevitably there is an interactive relationship between the researcher and the participants, since she is a human being present in a social setting and she cannot make herself invisible (Hammersley and Atkinson, 2007; Okyere, 2016). The

researcher is a midwife conducting research in familiar settings; reflexivity was essential to help build her awareness of how these factors could affect her conduct of the research (Symons and Hunt, 1995). Reflexivity is also an important aspect of maintaining 'faithfulness' to the data, aiming 'to describe the phenomena as they are, and not merely how we perceive them or would like them to be' (Hammersley and Atkinson, 2007, p.6). The researcher reflects that her NCT antenatal teacher training (in 1981) made an invaluable contribution to her work as midwife and researcher. A key element of this training included opportunities to 'de-brief' personal experiences of childbirth, to raise awareness of these in order to set them aside whilst teaching and so reduce their potential influence.

A process of continuous reflexivity started in the planning stages of the study and continued through all subsequent stages. These steps were taken to counter the accusation sometimes levelled against qualitative research that the findings are purely subjective and therefore constitute journalism rather than scientific knowledge (Pole and Morrison, 2003, p.5). A full reflexive account is included as Appendix D.

3.8 Summary box

- This study fits within the paradigm of Applied Health Research in its focus on a biopsychosocial approach to childbirth
- The philosophical assumptions underpinning this qualitative study are naturalist, relativist, interpretivist and inductive, within a framework of social constructivism
- Ethnography was chosen as the most appropriate qualitative approach to investigate the research question
- 'Trustworthiness' is used as the fundamental concept against which to assess the quality of the study
- Through a detailed reflexive account (Appendix D), the researcher examines and acknowledges her own experiences, values and beliefs in relation to the research

Chapter 4 Methods

4.1 Introduction

This chapter explains the study's methods: the design, setting, sampling strategy, and ethical issues; processes for publicity, recruitment, data collection and analysis.

4.2 Study design

As conveyed in chapter 3, this is a qualitative study using an ethnographic methodology. Data were collected via:

- Observations during childbirth
- Postnatal interviews with the parents whose labour and birth were observed and the midwives caring for them during childbirth

4.3 Setting

The study setting is an NHS Foundation Trust in the North West of England. It manages and provides a range of health services (hospital and community-based) for the local population.

4.3.1 Demographics

The Trust is in a metropolitan borough with a population of approximately 300,000. Covering a large geographical area of 78 square miles, including densely-populated urban districts and sparsely-populated rural areas, the population is predominately White British (Figure 3):

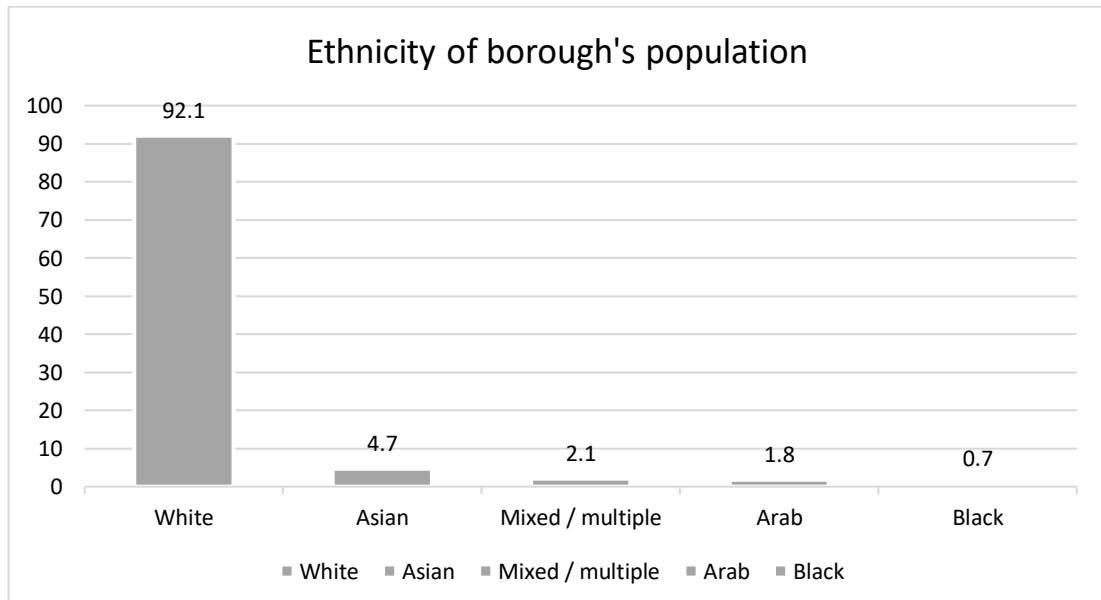


Figure 3 Ethnicity of borough's population (ONS, 2012)

In terms of health and well-being, its population broadly reflects the England average as measured by public health indices: life expectancy, infant mortality and deaths from long term conditions. It includes both affluent and socially deprived areas. Rates of

employment are slightly higher than the national average (Public Health England, 2016). In terms of social-deprivation measures (the number of households living in poverty; rates of violent crime), the borough scores significantly higher than the average. Specifically related to childbearing, the percentage of women smokers at the time of birth and breastfeeding initiation rates reflect the England average.

4.3.2 Maternity services

Maternity services are provided from the Borough's District General Hospital, Gracefields, a pseudonym. Gracefield's website states the service's philosophy of welcoming up to two birth supporters during labour. Furthermore, it makes a commitment to accommodate a woman's partner for overnight stays after the birth. This was not the usual practice in the UK at the time of the study and denoted the site's commitment to inclusion of partners.

There are three 'designated' hospital environments for birth: birth centre, delivery suite and maternity theatre. Approximately 3,500 babies are born annually, the majority (77%) on delivery suite (which includes maternity theatre) and 21% in the birth centre. The homebirth rate is 2% (Euroking, 2015). 'Low risk' women are cared for by midwives during pregnancy, labour and the postnatal period; homebirth is offered to these women, with community-based midwives providing the homebirth service. During the evening and overnight, midwives based on the birth centre are 'on-call' to support the primary midwife at homebirths.

Women who are 'high risk' receive care from midwives plus obstetricians and medical colleagues from other specialities (for example cardiologists, endocrinologists). The on-site neonatal unit has 16 intensive care cots. Women with very complex pregnancies, due to pre-existing or pregnancy-related issues are referred to a nearby 'Level 3' NHS centre, which provides highly-specialised services such as fetal medicine.

4.4 Sampling strategy

There are two groups of participants in this study: parents and midwives. Parents were recruited during pregnancy; the midwives caring for them were recruited during labour.

4.4.1 Parent participants

A recruitment target of 8-10 couples was set. This sample size aimed to enable the thick, rich and dense description that characterises ethnographic research (Holloway and Todres, 2010; Neyland, 2016; Tracy, 2010).

A purposive sampling strategy was employed, based on the following criteria:

- Pregnant woman with a male partner
- Both parents intend that the partner be present during childbirth
- Singleton pregnancy, expecting first or subsequent baby

- Booked for midwife-led care at the time of recruitment (i.e. the pregnancy is free of complications)
- Both parents aged 18 years or over at the time of recruitment
- Sufficiently fluent in English not to need an interpreter

Women whose labours were induced at term for simple 'post-maturity' (pregnancy exceeding 40 weeks) and were still booked for midwife-led care, were included.

Approximately 29% of all labours were induced at the time of recruitment (NHS Digital, 2018); had these women been excluded, the target numbers might not have been achieved.

Rationale for planned 'over-recruitment'

'Over-recruitment' was necessary to ensure that the sample size of 8 – 10 couples was achieved. It was anticipated that not all consented participants would eventually be included, for a range of reasons:

- Labour starts before 37 weeks (approximately 8% of labours; NHS Choices, 2016)
- Complications at the onset of labour: the woman moves to 'consultant-led' care
- The parents decide they no longer wish to take part
- The midwife involved declines to take part
- Researcher unable to be present, for personal reasons (e.g. sickness); labour progressed too rapidly for her to get there
- Researcher not contacted

Recruitment took place from 34 weeks of pregnancy, allowing time for the parents to consider participating, meet the researcher and give written informed consent if they decided to proceed. Couples (n = 2) who gave consent to be involved but who were eventually not included were sent a letter thanking them for their time and willingness to participate.

4.4.2 Midwives

Approximately 115 midwives were potential participants: 70 providing intrapartum care in hospital, 45 in community-based teams, offering homebirths. Midwives caring for recruited parents were invited to participate when labour had started. Midwives' willingness to be involved was essential for the study's success, the researcher therefore aimed for as many as possible to be aware of the study before they were approached to participate.

Student midwives

A total of 42 student midwives from two local universities were undertaking clinical placements. It was likely that students would be involved in care; it was therefore

important for them to have prior awareness of the study, so they were able to make a considered choice about their involvement.

4.5 Ethical issues

The ethnographic study of childbirth involves challenging ethical issues: seeking permission from parents to be present during a significant and personal life event and from midwives to observe them at work. Challenges were 'procedural': securing the necessary ethical and governance approvals, and 'situational' (Tracy, 2010, p.847) – for example, discreetly ensuring on-going verbal consent during labour, an intense time of heightened emotions. Multiple participants were involved: on-going consent was required from each parent and midwife, any of whom could have withdrawn their consent at any stage.

4.5.1 Ethical and governance approvals

This study was conducted in accordance with the Declaration of Helsinki's ethical principles regarding medical research with human participants (WMA, 2013). Favourable IRAS approval was granted by the Bradford Leeds Research Ethics Committee on 20.04.2017 (IRAS reference 17/YH/008; Appendix F).

Governance approvals were sought and granted via the Ethics Committees of:

- The University of Leeds (UoL), Study Sponsor
- Two local universities (students undertake clinical placements at the site)
- Health Regulatory Authority
- Study Site – research and governance department

4.5.2 Service user involvement

The service user (SU) perspective was of central importance to establish that the topic was of relevance, significance and interest (Tracy, 2010) to SUs, ensure that the planned methods were acceptable and the study materials appropriate. A SU involvement strategy (Appendix G) was developed in the early stages and an 'e-group' established, consisting of two fathers and two NCT representatives.

4.5.3 Gaining access

'Gaining access' is recognised as a challenge in ethnography (Hammersley and Atkinson, 2007), in particular to birth environments. Labour and birth unfold behind closed doors; negotiating access to this private environment began with building a relationship with its 'gatekeepers', the most significant of whom are midwives. The researcher acknowledges with gratitude the enthusiasm and encouragement of the Heads of Midwifery (HoMs) and senior team; the interest and support of clinical midwives were equally important.

4.5.4 Informed consent

Key ethical points relating to the written informed consent processes were:

- A 'Plain English' screening tool (Plain English Campaign, 2017) was used to ensure study materials were clear and accessible.
- The Service User 'e-group' commented on study materials and the documents amended in response.
- After parents had received a Participant Information Sheet (Appendix H), a period of time (usually at least 24 hours) elapsed before the researcher contacted them to discuss informed consent.
- The researcher obtained written informed consent (Appendix I) and subsequently sought on-going verbal consent during observation and interview phases.
- The researcher highlighted the voluntary nature of taking part; there would be no repercussions in declining.
- Participants were free to withdraw at any stage, from the point of giving written consent until two weeks after their data had been completed.

4.5.5 Burden on participants and measures taken to minimise

The researcher's presence during labour and birth involved an additional person being present. As an experienced midwife, she was aware of the sensitivities involved in attending a birth. She aimed to ensure she carried out observations unobtrusively, locating herself with regard to the woman's dignity, and moving to a different part of the room where necessary. She maintained awareness of these 'situational' ethical issues, challenging herself over whether the 'means justified the ends' (Tracy, 2010, p.847) during observations and interviews. She was mindful of the potential impact her presence could have for parents or midwife. Whilst observing as unobtrusively as possible, she was also intentionally open about purpose (Dykes and Flacking, 2016) and was in clear sight of all players as she recorded her field notes.

There was no financial burden on participants. Post-birth interviews were conducted at a location and time to suit parent-participants: all chose their homes. Interviews with midwife-participants were conducted within working hours, at their place of work.

Consent of other people present or involved during labour

On occasion there were people present in addition to the study participants: family members to support the parents; the medical team, called to assist in emergency. In line with ethnographic methodology, it was not deemed practical or necessary to seek written informed consent from other individuals (Murphy and Dingwall, 2008), but rather to confirm, discretely, that they were aware of the researcher's role, and in the case of medical personnel, to confirm they agreed for her to be present. It was considered that

any family members present would be there at the invitation of the parents and written informed consent was not needed, as it was the parents' choice to decide who was present, in addition to their clinical caregivers.

4.5.6 Study Distress Policy

It was not anticipated that taking part in the study would cause distress; steps taken to mitigate burden on participants are outlined above. However, childbirth is an unpredictable experience and a time of heightened emotions. Events may have occurred during birth which would give rise to strong emotions when re-visited during post-birth interviews. The researcher was aware of this possibility due to her experience of providing a 'Birth Afterthoughts' service in her previous consultant midwife role. A Study Distress Policy (Appendix J) was developed, outlining on-going available support. The policy was implemented for one couple during their interview, as both father and mother expressed distress when recalling the labour and birth of their child.

Poor outcomes

In the rare event of an unexpected tragedy, for example the birth of a stillborn baby, the study protocol outlined how the researcher would exercise sensitivity and respond appropriately. Parents would have been reminded of their right to withdraw, but also offered the option to continue their involvement, giving them the opportunity to talk, if they wished to do so, with one of the few people who had 'met' the baby.

4.5.7 Researcher's role: emergency / 'poor practice' situations

The 'midwife-researcher' role was clearly explained in the Participant Information Sheets (Appendices H and K), during 'Informed Consent' meetings with parents and briefing meetings with staff. During observations she wore her own clothes (rather than a uniform) and a name badge displaying her 'midwife-researcher' role.

Requirements of the NMC Code

The NMC Code for Nurses and Midwives (2015) outlines the researcher's responsibilities as a practising midwife, including to 'Preserve Safety' (NMC Code, p.13). In rare circumstances she would have moved out of the midwife-researcher role to fulfil this responsibility, for example:

- An emergency at a homebirth, where no other person was present to assist the midwife. In this situation, she would do so, under the direction of the midwife, fulfilling the requirement of the NMC Code: '*always offer help if an emergency arises*' (NMC, 2015, p.14). No data for the study would be collected whilst the emergency was ongoing. Fieldwork would re-commence when the mother and baby were stable and the participants were in agreement. The time of the

emergency would be recorded in the fieldnotes but not its nature, to preserve confidentiality. The Trust arranged an Honorary Contract for the researcher, under the terms of which she was covered by Trust indemnity insurance for any care provided in such a situation.

- Had the researcher observed serious clinical malpractice with the potential to endanger the well-being of a mother or baby, she would have followed her responsibility *'to exercise a professional duty of candour'* (NMC, 2015, p.13), intervening only to safeguard the well-being of mother or baby and reporting this as soon as possible to the senior midwife on duty or on-call Supervisor of Midwives, making contemporaneous midwifery records and informing the midwife of the actions she had taken.

4.5.8 Data management

The anonymity of participants was ensured by the allocation of a numerical indicator; pseudonyms were used in the transcripts. Following the University of Leeds (UoL) guidance on storage of research data (UoL, 2020), the original fieldwork journal will continue to be stored securely at the UoL and the electronic transcripts on the University's secure 'M' drive, to provide an audit trail for the data collection and analysis processes. After five years, these data will be destroyed.

4.5.9 Burden on the researcher and supervisory team

The unpredictable nature of childbirth events gave rise to potential burden on the researcher. She was available and 'on-call' 24-hours a day for several weeks for each couple. There was also the potential for her to be distressed by events she witnessed, despite her experience of working in the childbirth environment. She appreciates that her supervisors made themselves accessible for support and advice during this time, including 'out of hours', thus placing a potential burden on the supervisory team.

In fact, recruitment went smoothly, taking place between October 2017 and January 2018. The periods of 24-hour 'on-call' lasted for two intensive periods, each of two months: November – December 2017 and January – February 2018. During these times the researcher's everyday life was highly unpredictable; however, she quickly adjusted, thanks to her experience of being 'on-call' in her clinical roles.

4.5.10 The 'green light' to proceed

This section, summarising all the ethical issues considered and addressed in laying the foundations for the study, cannot convey the sense of elation felt when REC approval was granted, giving the green light to move into the publicity and recruitment stages:

12/04/17

Well if I could bottle that feeling from the REC meeting yesterday – very affirmed in my project, very excited about the next stage and the future. This is a massive confidence boost, the biggest and best I've had. I have worked very hard and had good advice, and it's all paid off.

Journal extract 12/04/17

4.6 Publicising the study

The publicity strategy began with midwives and the wider maternity team and then moved to parents.

4.6.1 Midwives and the wider maternity team

The foundations for the success of the project rested on gaining midwives' support. The involvement of the heads of midwifery (HoMs) was key in implementing the publicity strategy and subsequent recruitment of participants. Figures 4 and 5 below show the timeline for the development of the study, from conception to completion of data collection.

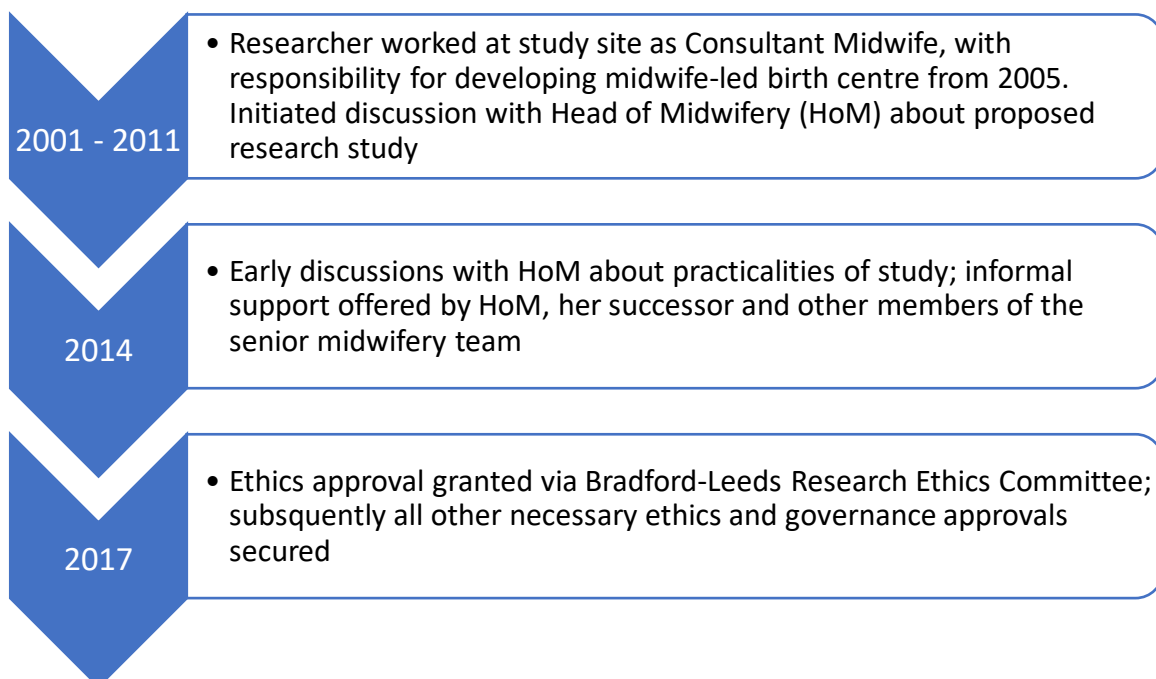


Figure 4 Timeline: engagement with study site to ethics / governance approvals

The researcher then dedicated a 12-week period to publicising the study as widely as possible (Figure 5). She ensured open channels of communication, via personal contact, face-to-face meetings, email, text and telephone, essential in developing rapport, building relationships of trust and establishing her credibility.

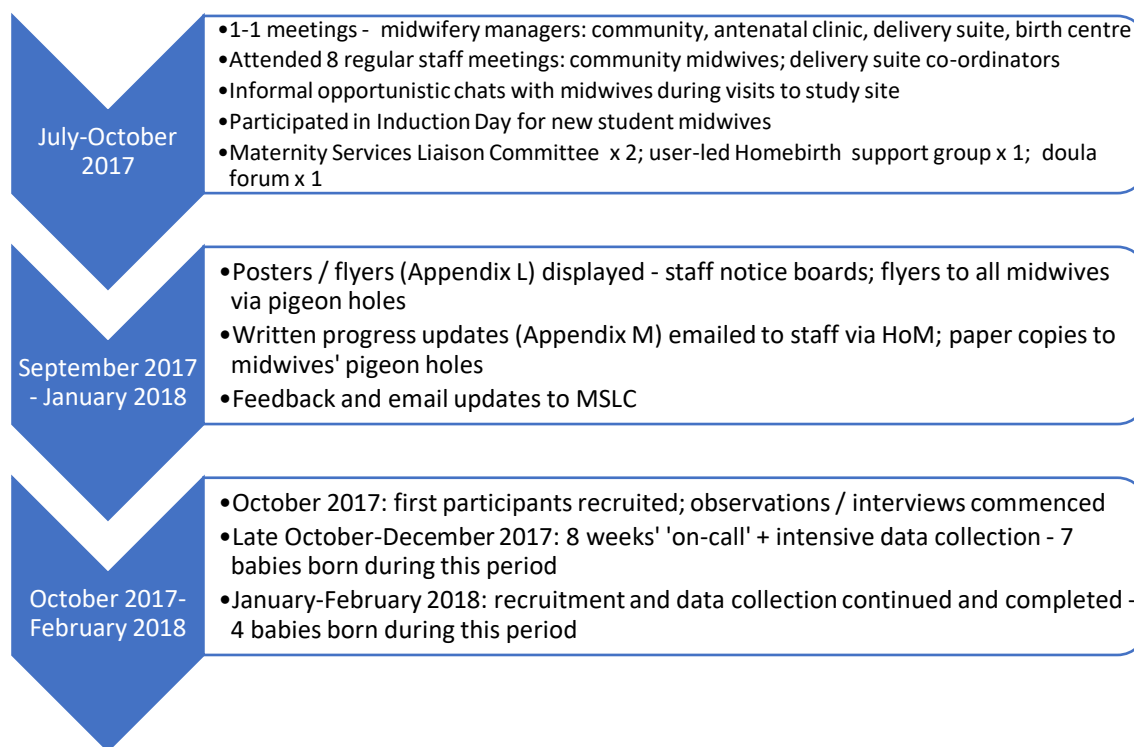


Figure 5 Timeline: publicising study, recruitment and data collection

Each staff meeting involved between eight and 30 midwives. Following a short PowerPoint presentation, lively discussion ensued with helpful suggestions and challenging questions. As time progressed, so did the researcher's feeling of support for the project and her sense that undertaking the research was a venture shared with the midwives she was meeting:

Email from Community MW matron - MWs are excited about the study and want to be involved. Suddenly, the MWs feel like co-researchers...definitely participants and not 'subjects'.

Journal extract 02/09/17

The researcher also engaged with midwives informally, in ones and twos, answered questions and addressed concerns. She explained the rationale for using an ethnographic approach and why real-life observations have the potential to carry more power than data collected via interviews alone. She described in detail the consent processes and midwives' right to decline or withdraw. As a practising midwife, the researcher was aware of potential sensitivities about being observed at work and that some midwives might be reluctant to take part. The time spent in both formal and informal interaction with staff was well-invested: when the data collection phase was reached, only one midwife expressed she no prior knowledge of the study.

The researcher was issued with an ID pass and a security access swipe card, privileges facilitated by the HoM. As she moved around the various maternity care settings in community and hospital, she was aware that this privileged access was enabled by the support she had received from the HoM. Her previous role as an employee may also have been a factor.

The researcher was actively engaged with the site for a seven-month period, during which she provided regular written 'Updates' (Appendix M) for staff, to inform, engage and thank them for their support. During her regular and frequent visits, the researcher continued to talk informally with staff, offering updates on progress and thanks for support received.

Existing communication channels were used to publicise the study, with the same media of flyer and Participant Information Sheet used in all situations for consistency: meetings, newsletters, emails and the Intranet. The same approach was used in meetings with the Education Leads at the two Universities linked to the Trust and in subsequent meetings with the Link Midwifery Tutors and the students themselves.

Publicising the study to the wider maternity team

Members of the wider maternity team (including obstetricians, sonographers and assistant midwifery practitioners) were also made aware of the study. Flyers giving details and the researcher's contact information were widely displayed in all hospital and community staff areas. Every attempt was made to ensure that as many staff as possible were aware of the study.

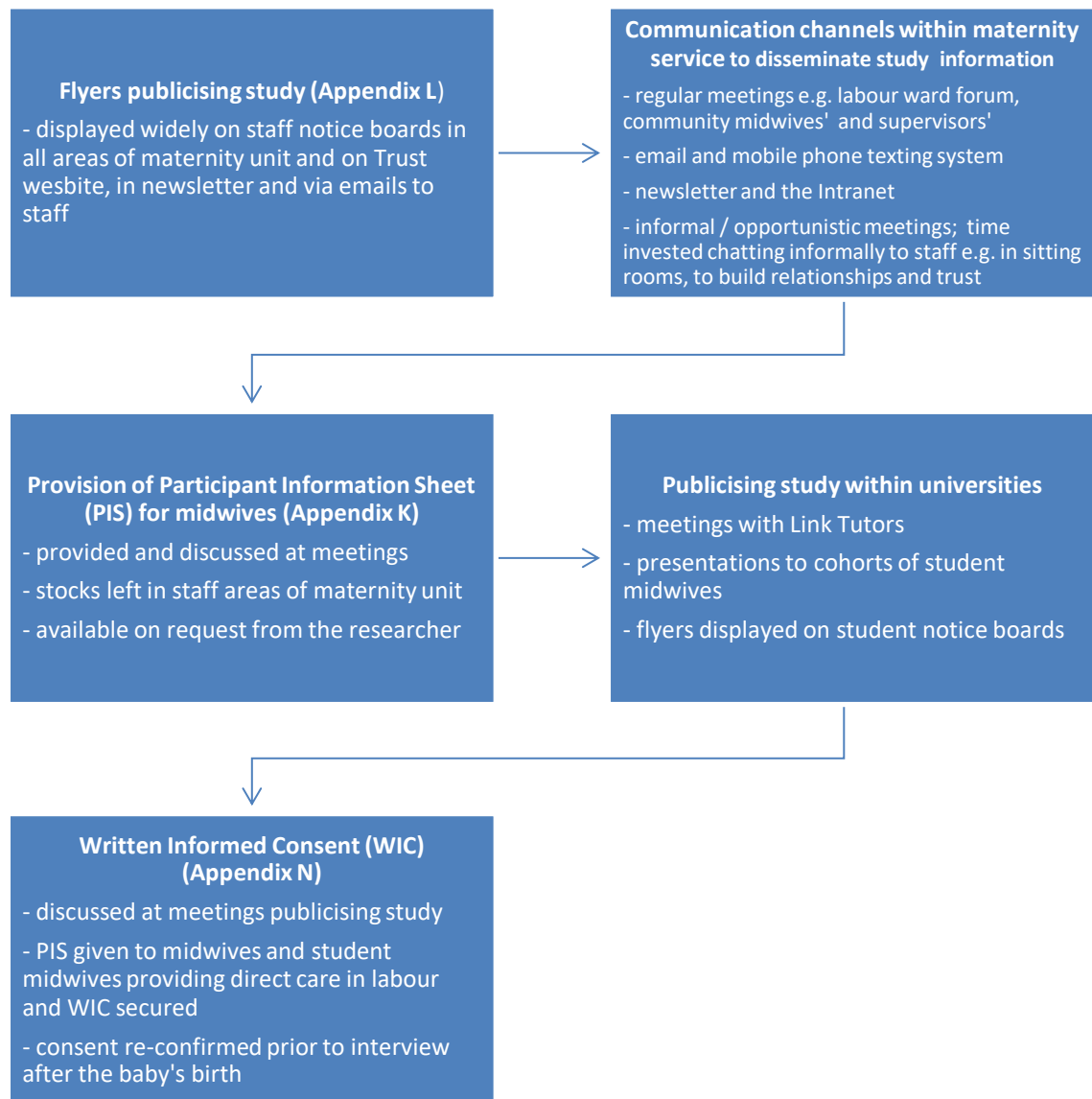


Figure 6 Recruitment and informed consent: midwife participants

4.6.2 Publicising the study to parents

The publicity strategy for parents was planned around flyers (Appendix O), displayed on noticeboards, plus information on the Trust's maternity services website and via the Service Users' Forum Facebook page. Flyers were also distributed via community antenatal clinics, midwives at antenatal appointments from 34 weeks and hospital tours. The researcher attended four meetings with a predominantly service-user membership: two MSLC meetings, one with the Homebirth Support Group and one with local doulas.

Invitation via flyer

One thousand flyers were printed inviting parents to contact the researcher via text or email if they would like more information. Supplies were left in multiple venues and distributed by midwives. This was anticipated to be a fruitful source of recruitment. The

reality proved very different: not one single contact or expression of interest was initiated by a parent through this route.

4.7 Recruitment and informed consent process

Parents were recruited during pregnancy and midwives when labour was underway.

4.7.1 Recruitment: parents

The recruitment and informed consent process for parents is summarised in Figure 7:

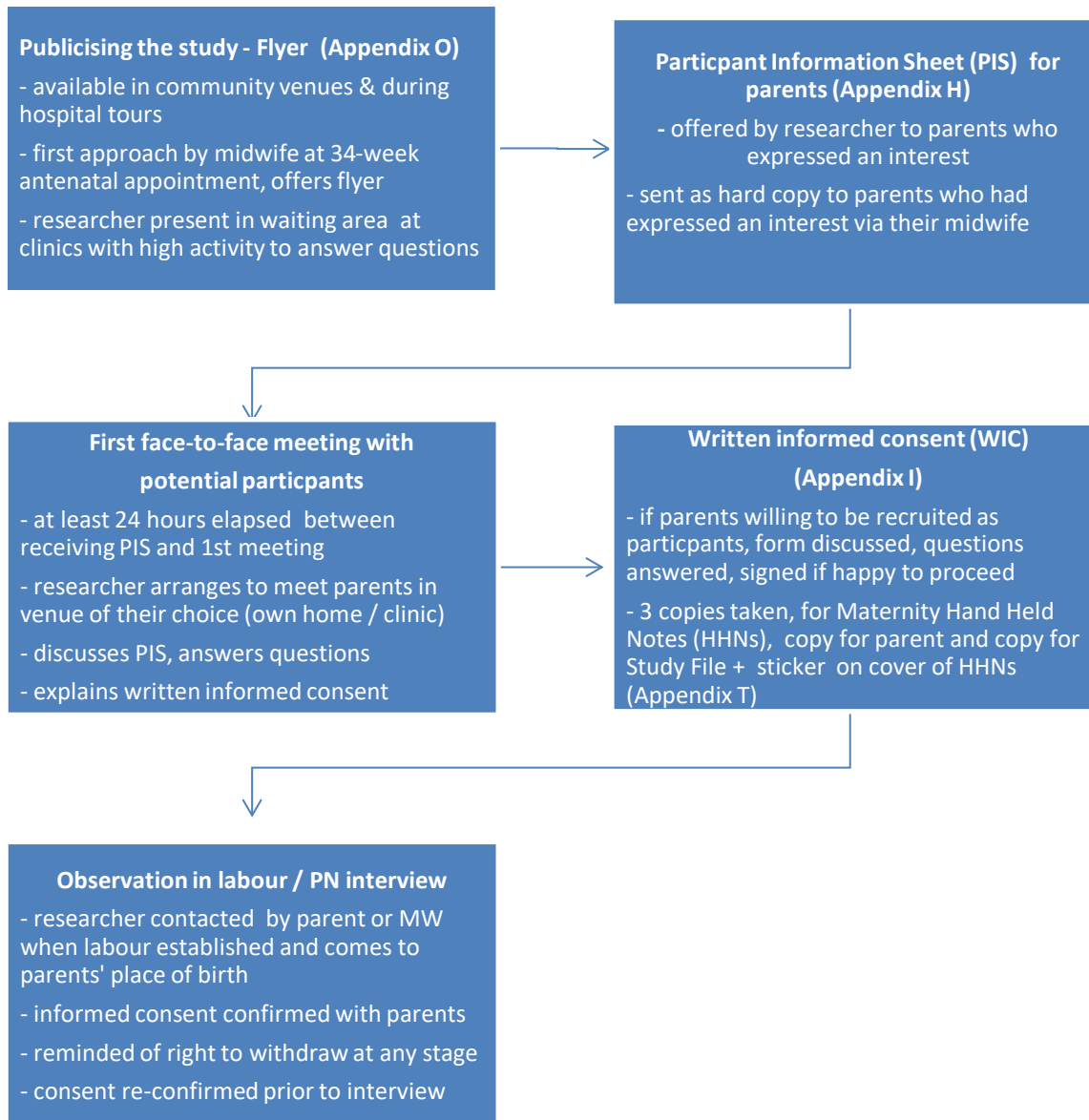


Figure 7 Recruitment and informed consent: parent participants

The most productive approach involved the researcher identifying antenatal clinics with the highest level of activity and being physically present in the waiting area to discuss the study with parents. The initial approach was made by the midwife; she invited the parents to speak to the researcher if they wished to find out more, often making the introductions herself.

Over a period of three months, the researcher made 15 visits to community antenatal clinics and three to the hospital midwife-led clinic. This was a period of discovery and ‘scoping out’ which approaches would work best. She spent many hours driving from clinic to clinic and sitting in waiting rooms, meeting and talking to parents and catching brief conversations with midwives.

Successful recruitment hinged on the support of community and hospital midwives, several of whom engaged enthusiastically with the researcher and the study. They were ‘active collaborators’ in the research, - ‘key informants whose knowledge of the setting is intimate and long-standing’ (Holloway and Todres, 2010, p.170). One community midwife was particularly generous with her time. She texted the researcher on her ‘research phone’ before her clinic’s busiest sessions; the researcher was then able to be present in the waiting room at appropriate times. This midwife spoke to eligible parents about the study, distributed flyers and took the time to introduce the researcher.

Following initial discussion with the researcher, parents were offered a Participation Information Sheet (PIS: Appendix H) and the researcher arranged to contact potential participants approximately 24 hours later. A total of 28 copies of the PIS were given; 13 couples went on to give their written consent.

Eleven of the 13 couple-participants were recruited via personal contact in antenatal clinics. During this first contact, ten of the 11 women were with their partners; one was unaccompanied. The other two couples were approached by the same community midwife; they granted permission for their contact details to be passed on and were subsequently recruited to the study.

How researcher made contact with parents	No. of PIS packs given	No. consented to take part
Community antenatal clinic	19	8
Parents’ details passed by midwife	4	2
Homebirth support group	3	2
Hospital antenatal clinic	2	1
Total	28	13

Table 5 ‘Source’ of 13 recruited couple participants

4.7.2 First face-to-face meeting with potential participants

At the first contact, the researcher agreed to arrange details of the next meeting with the parents by text message (chosen by all parents as their preferred method of contact). This approach put minimum pressure on the parents, who chose whether or

not to respond to her text. If no reply was received, the researcher sent one further text and then made no more contact.

The researcher agreed a suitable time to meet with parents to talk about the study in-depth and to proceed to a discussion of written informed consent, if appropriate. The parents chose the venue - in every case, their own home. The meeting took place within a few days of the initial contact, depending on their availability and was welcomed as an opportunity for discussion:

One father commented that he was 'better listening than reading' and asked me to go through the PIS when we meet.

Journal extract 19/11/17

Recognising the intimate nature of the study, this meeting was seen as an important opportunity for the researcher to explain it, for the parents to ask questions and to understand that their offering of 'informed consent' was an on-going process. The researcher was keen that this was clearly understood.

The meetings lasted between 20 and 80 minutes. There were many and diverse questions about the study; examples are given below:

...he [the father] also said I could 'join in' with caring for Mum – he saw it as a team effort, I'd be welcome to do so. I explained I'd be taking a back seat – he asked, 'Fly on the wall?' and I said 'yes'...

Journal extract 27/10/17

...she [the mother] questioned the 'inclusivity' of the research...initially concerned that certain parents e.g. gay couples were excluded. I gave a full response and she was happy with the rationale of focussing on men...she also questioned how I would seek consent from the MWs involved and the possible implications for them.

Journal extract 19/11/17

All 13 couples with whom the researcher met to discuss written informed consent stated they wished to proceed and be included in the study.

4.7.3 Written informed consent process: parents

The mother and father were invited to sign individual Written Informed Consent Forms (Appendix I). The father signed two copies, one for himself, the other for the Study File. The mother signed three, the additional copy stored in her hand-her records. Green paper was chosen, after consultation with the HoM, to ensure the form was immediately apparent and to avoid confusion with other colour-alert systems (e.g. for safeguarding issues). A sticker denoting the parents' participation (Appendix P) was attached to the front of the woman's hand-held records. The Study File was stored

securely, initially in a locked file in the HoM's office, later moved to the Trust's Department of Research and Innovation and ultimately to The University of Leeds. These storage arrangements were specified in the Ethical Approval application; the researcher lives 50 miles from the University; it ensured that participants' confidential information was kept as secure as possible. Each couple was allocated a Study Number (N18 – N30 inclusive), participants' consent form stored separately from their demographics sheet. The researcher avoided starting at number one when choosing participants' numerical indicators to reduce the likelihood their identification by the chronology of their babies' birth dates.

Contacting the researcher when labour started

After the parents had given their written consent, the researcher requested that when labour established (as confirmed by the midwife), the father should contact her. Each father was offered a card with the researcher's details (Appendix P). The researcher noticed that on almost every occasion, he studied it carefully and stored it away, usually in his wallet. Initially, she had felt that asking the father to contact her during labour could put him under additional pressure at a time when he was already feeling stressed. However, during the ethical approval process, a member of the Bradford-Leeds Research Ethics Committee suggested that the researcher offer the father a card inviting him to contact her when labour had started. This system worked well. The researcher was proved wrong in anticipating that fathers would find this task onerous. In every case apart from one (when the mother texted the researcher), it was the father who made contact when labour had started.

As the meeting drew to a close, the researcher reminded participants that they might not eventually be included in the study for a number of reasons:

- They might change their minds at any point
- Complications could develop that required the woman to move to 'consultant-led care' which would then exclude her from the study
- Written informed consent would be requested from each midwife / providing care. Any of these staff could decline to take part
- The researcher could be unavailable to attend.

Finally, the researcher thanked the parents for their time and willingness to participate, gave copies of the PIS and signed consent forms and wished them well for the rest of their pregnancy.

4.7.4 Parent participant profiles

Brief details of parent participants are given in Table 6; pseudonyms are used and some information changed to protect confidentiality.

NI	Participants' names	
N18	Lou and Donal	Late 20s, co-habiting. Expecting 2 nd baby, planned homebirth, after a straightforward 1 st birth in the birth centre. Work full-time (♂) and part-time (♀), in sales and education
N20	Rosa and Dan	Very early 20s; currently living apart, each with own family. Work in sales and administrative roles 1 st baby; took part in online antenatal classes.
N21	Jill and Mick	Late 30s, co-habiting; 3 rd baby, work full-time (♂) and part-time (♀), in professional roles; graduate and FE qualifications. Two previous births in hospital.
N22	Ayesha and Hamid	Late 30s / early 40s; co-habiting; 3 rd baby; 1 st child born abroad, 2 nd in UK; both hospital births; Hamid excluded from 1 st birth, present for 2 nd . ♀ full-time mother and homemaker; ♂ professional role, education to higher degree level.
N23	Jo and Ricky	Late 20s; co-habiting; graduates; work in charity sector; attended hypnobirthing; planned homebirth.
N25	Hazel and Ben	Early 30s, co-habiting. 1 st baby; graduates, work full-time in professional roles. Attended NCT classes and initially planned to use Birth Centre.
N26	Lorraine and Darren	Late 20s, co-habiting; 2 nd baby, 1 st born early due to pregnancy complications. ♂ works full-time, self-employed: skilled manual role; ♀ combines part-time admin. role with being mother and homemaker.
N26	Maria and Dave	Mid – late 30s, 5 th baby; 1 st 2 born in hospital, 3 rd and 4 th – planned homebirths; planned homebirth for 5 th baby. ♂ skilled manual worker, ♀ graduate: mother, homemaker; couple runs own business from home.
N27	Ashley and Graham	Early 30s, co-habiting; 2 nd baby, 1 st born in hospital, long labour; professional qualifications and work in IT roles.
N29	Dawn and Jack	Early and late 20s; co-habiting; 1 st baby; work full-time ♂ skilled manual labourer; ♀ admin. role.
N30	Rae and Will	Late 20s; co-habiting; 2 nd baby, 1 st born in hospital birth centre; ♂ office-based managerial role; ♀ university student, 1 st degree.

Table 6 Parent participant profiles

4.7.5 The couples who declined to take part

During the recruitment period (October 2017 – January 2018), the researcher met a total of 28 couples who, after initial discussion, agreed to consider taking part and accepted a Participant Information Pack. Of these, 13 decided to participate and gave written informed consent.

The 15 couples who considered participating, but declined, gave a range of reasons. Of these 15, the researcher had only actually met one of the fathers at the antenatal clinic where she met the mothers; she reflects that a face-to-face meeting may be a factor for fathers in deciding whether they wished to proceed. In comparison, for the 13 couples originally recruited to the study, for 10 of these, both parents were present at the first contact with the researcher.

Where a reason was given for declining to take part, this was recorded by the researcher in her fieldnote journal, for example: *'My husband takes a back seat [during labour], he's not one for mauling you and that'*. This couple was having their third by; the woman added, *'I always have my Mum there,'* her tone implying that her mother was her primary support in labour. Another multiparous woman commented, *'My husband's a bit clueless really;* he was not comfortable about taking part in the study. One primiparous woman was keen to take part but explained, via text, that when she discussed it with her husband, *'...he feels a bit uncomfortable and doesn't like the thought of being observed and would like to keep things private'*, adding, *'Sorry to let you down and hope you find others willing to take part'*. A woman having her second baby, her older child having been with a previous partner, said *'he's not keen because it's his first'*. These reasons suggest an element of 'performance anxiety' on the man's part, as though he thought the researcher would have been 'assessing' him.

Other reasons for declining included *'We've had a really stressful year'*; another woman stated, *'We're both really shy people'*. One couple had already disagreed over who would be present: she wanted to have her mother there, and her partner had stipulated that his 'mother-in-law' could only attend if his own mother came as well. The woman declined, saying, *'My partner said it wouldn't be fair because I don't want his Mum there'*. Another couple, expecting their second baby, declined to participate because *'after so many people in the room with the first birth we want it to be just the two of us'*.

The reasons given for declining to take part led the researcher to reflect on the levels of harmony she observed between the couples who did participate. Those whose relationships which were perhaps less than harmonious at that time, or who had other stresses in their lives, were perhaps more likely to decline. The fathers' involvement in all aspects of maternity care may also be relevant: their ease within what is perceived as a 'women's world'.

Of the 13 couples who had consented to participate, 11 went on to do so. A reason for non-participation was offered by one couple (the father had left his mobile phone at home); they expressed disappointment that they had not participated. As per the Study Protocol, a letter (Appendix Q) was sent thanking them for their willingness to be involved. The other couple did not contact the researcher when labour started. Again, following the Study Protocol, a text message was sent when two weeks past the baby's 'due date' had elapsed, enquiring how they were, to which no response was received. The reasons for their non-participation were therefore unknown.

4.7.6 Recruitment and informed consent: midwives

Written informed consent (Appendix N) was sought from each midwife who provided care to parent participants. The researcher was aware that the midwife's priority was the care of the woman in labour and did not wish to distract her by asking for her written consent at an inopportune moment. When the researcher arrived, she requested and received immediate verbal consent to her presence. She then sought the first appropriate opportunity to obtain written informed consent.

4.7.7 Midwife participant profiles

All midwives approached during labour consented to being involved. Fourteen qualified midwives and two students participated in the study. Three of the qualified midwives gave care during two labours. The total number of midwife interviews therefore equals 19. Details about the midwife participants (below) are brief and aggregated, in order to protect their anonymity.

A majority of participating midwives were very experienced; nine had been qualified for over 25 years and three for more than 20 years. One had been qualified for less than five years and one was in her first year of practice. They worked in the community (n=7), birth centre (n= 4) and delivery suite (n=3). One of the student midwives was at the 'observation' stage of training, having started a few weeks previously; the other was in her second year (of a three-year programme) and provided care under supervision.

4.8 Data collection and preliminary analysis

The data were collected over a period of four months, from October 2017 to February 2018. From the early stages of 'formal' data collection, the process of preliminary analysis of these data was on-going, with identification of recurring patterns which informed the collection of the next data set. This process has been described as the 'spiral model for ethnographic analysis' with the researcher moving 'from writing things *down* to writing things *up*' [author's italics] (O'Reilly, 2012, p.179). This captures accurately the experience of the researcher.

Initial descriptive observations 'scanned' the whole setting. As they progressed, they became more selective, focussing on elements most directly relevant to the research

question as the study (Spradley, 2016). This process, termed ‘funneling’ by Spradley (1980), describes how the researcher’s gaze narrows and focusses, becoming more selective (Gribch, 1999). Whilst acknowledging the iterative nature of data collection and analysis in ethnography, for the purposes of clarity, data collection and the various stages of analysis are now addressed in discrete sections.

4.8.1 Data collection Phase 1 - observations

This phase of data collection involved making direct observations of the communications and interactions between midwives and fathers. Additionally, useful observations were made of how the dynamics of the couple-relationship affected communications with the midwife. To ensure anonymity, symbols for man (♂) and woman (♀) and abbreviations for midwives and students were used (‘MW1’ and ‘StMW2’ respectively).

4.8.2 Data collection: birth environments

Data were collected via observations in all three birth environments available at the study site, as well as at home. This fulfilled one of the aims of the study: to compare and contrast midwife-father communications within these different environments; see Table 7, ‘Place of birth’:

Place of birth	No.
Delivery suite	5
Maternity theatre	2
Birth centre	2
Home	2
Total	11

Table 7 Place of birth

All 11 were vaginal births, with two being assisted with forceps and one with a ventouse. Fieldwork was undertaken in all the birth environments used by labouring women, with observations taking place in

- the home (3)
- maternity triage (2)
- the birth centre (5)
- delivery suite (8)
- maternity theatre (2)

Some women laboured in more than one environment during the observation period, therefore the total exceeds the number of parent-participant couples (n = 11). Four couples had all care on delivery suite and one entirely on the birth centre; two laboured and delivered their babies at home. The remaining four laboured in different

environments. For example, one couple transferred from home, to birth centre, to delivery suite, to theatre. One couple had their baby on the birth centre and then transferred to delivery suite for third stage complications; two transferred from birth centre to delivery suite and one of these then to theatre for the birth. Therefore, the data are enriched by these contrasting environments and different philosophies of care, with concomitant implications for midwife-father communications.

Continuous observations commenced at the point where labour was deemed to be 'established' and the midwife became involved in care, although the researcher was also present with two couples (N25, N27) for brief periods in earlier labour.

Recording data during observations

A lined foolscap journal was used for the fieldnotes to record observations. Spradley's (1980) framework for ethnographic observation was deployed (Appendix R), a copy of which was attached to the inside front cover of the fieldwork journal. The researcher made frequent reference to this framework, especially during early observations, as a reminder to keep her focus as broad as possible, including such elements as non-verbal communications, different activities that took place and the physical objects in the room (Spradley, 1980). The ethnographic adviser to the study had cautioned against an over-emphasis on the spoken word, a common pitfall of ethnographic research, in order to maintain 'observational balance' (Nugus, 2017).

Fieldnotes

All fieldnotes were made using pen and paper (Appendix S). No recording devices were used. Ethical approval had been granted for the use of an encrypted iPad to record observations; in practice the researcher felt that using an electronic device would have seemed incongruent. The midwives were using pen and paper for making their records in labour and it felt appropriate for the researcher to do the same. On occasion (for example during observation N29) when there was a larger group of family supporters present, there was general social 'chat' going on. The researcher was included on occasion by family members and stopped making fieldnotes at that point, again because it felt inappropriate to do so. She later reflected that as several family members were texting on their mobile phones while chatting, she could have done the same to record observations, although this may have been perceived by the family as inattention. She recorded these events and reflections as soon as she felt it was appropriate to resume making written observations.

What was recorded in the fieldnotes?

Detailed fieldnotes on actions, interactions, communications (both verbal and non-verbal) were made, with a clear focus on all events and communications which may

have been relevant to the research question. Observations of the 'geography' of the birth space were included, using diagrams where appropriate (Appendix T), as well as artefacts used by participants. Sketches showed furniture, equipment and location of participants at different stages of the labour.

During observations, the researcher made a habit of regularly bringing to mind the research question – the focus of her observations. On occasion, however, she found herself reflecting on the clinical care that was provided. She noted this in her fieldwork journal as 'midwife-head thoughts', abbreviated to 'MWhead'. Having written down her 'MWhead thought' she was then able to return her focus to the research question. She reflects more on this process in the 'Reflexivity' section (Appendix D).

The importance of the sketches

The sketches were initially included as an *aide memoire* for the researcher since 'memory remains a powerful tool' in ethnographic research (O'Reilly, 2012, p.187). However it was apparent from the earliest observations that they also highlighted two important findings which are explored in the Findings chapters: the close physical proximity of the players (midwife and parents) during labour and birth, and the ways in which those present form a 'circle' around the labouring woman. In her ethnographic study on the implementation of UNICEF 'Baby Friendly' practices within a hospital setting, Brimdyr notes:

The environment itself played a powerful role in shaping the actions of midwives and women...both the architectural design and furnishings / equipment influenced how care was provided and how the women experienced care.

(Brimdyr, 2016, p.90)

This also illustrates how preliminary analysis started during the fieldwork phase.

Transcription and storage of fieldnotes

The handwritten fieldnotes were transcribed by the researcher at the earliest opportunity after each observation had been completed, to enable accurate recall (McNaughton Nicholls et al, 2014). This was usually within 24 hours, and in every case, before the interviews with the parents, to avoid the parents' perceptions of events influencing the researcher's. This careful transcription process, which involved considerable reflection on the labour and birth, stimulated the early stages of analysis. The researcher added analytical notes, commenting on possible emerging themes and also made intensive use of her reflective journal during the fieldwork phase. The field notes and personal reflections form part of the audit trail to demonstrate how conclusions have been reached.

Length and timing of observations

As the study progressed, the researcher regularly reviewed the data collected. She was interested in temporal issues - data collection at different times of the day and night, during the week and at weekends. For example, the dim light and quiet atmosphere on the delivery suite at night contrasted with the busy-ness of the day, when 'ward rounds' and visitors increased the general activity. She was also interested to review the different phases of labour she observed during fieldwork as it progressed; communications between midwife and parents during early labour were noted to involve more light-hearted 'social chat' compared to the more intense focus of the later stages. Both were important in ensuring richness and depth of data; the researcher was satisfied to note that the observations covered a wide range in respect of temporal issues and phases of labour.

The length of observations varied between one hour 55 minutes and 13 hours 30 minutes. They took place during the day, at night, on weekdays and at weekends. Approximately 71 hours were spent undertaking direct observations, with the date, time, length of each observation carefully noted (see Table 8 below), along with details of the people who were present and a record of events during the labour as it unfolded.

Participant number	Time observation commenced	Time observation ended	Total number of hours / mins.
N18	10.30	20.00	9 hrs. 30 mins.
N20	16.30	00.35	8 hrs. 5 mins.
N21	07.15	12.05	4 hrs. 50 mins.
N22	08.10	12.10	4 hrs.
N23	06.10	19.40	13 hrs. 30 mins.
N25	12.45	21.00	8 hrs. 15 mins.
N26	22.00	23.55	1 hr. 55 mins.
N27	16.45 21.00 02.00	17.30 21.30 04.00	3 hrs. 15 mins.
N28	18.15	20.10	2 hrs. 55 mins.
N29	06.40	19.30	12 hrs. 50 mins.
N30	14.30	16.30	2 hrs.

Table 8 Length of observations

Timing of observations

Observations and fieldnotes commenced from the point of first contact (usually from the father) to say that labour was established and once informed consent had been granted by the midwife caring for the couple. They continued until the early post-birth period, usually ending when the midwife had made the mother comfortable after the birth, assisted with breastfeeding where appropriate and then left the new family to have some private time together. In designing the study, the researcher recognised that the unpredictability of the length of labour meant she could not state before data collection started, how long each observation would last. She anticipated she would not usually stay longer than approximately 8 hours. The rationale for this time limit was in acknowledgement that her concentration would wane as time went on and to ensure that she was safe to drive home after the observation period had finished. In fact, she learned to take breaks from the study setting, on occasion having a short nap; she was therefore present for the births of all 11 babies born to parents in the study.

4.8.3 Data collection Phase 2 - semi-structured interviews

Semi-structured interviews with each member of the father / mother / midwife triad were undertaken to explore further the participants' experience of labour, bringing clarity, depth and meaning to the data collected during the observations (Francis, 2013). These 'generated data' enriched and amplified the naturally occurring data (McNaughton et al, 2014, p.252) from Phase 1 of data collection.

Interview schedule

The interview 'schedule' was a loose guide, included as Appendix U. After a few minutes of 'social chat', the researcher reminded participants of the focus of the research and asked a single opening question, tailored to the situation (Braun and Clarke, 2013). For parents, this usually consisted of an invitation to '*...talk about your baby's labour and birth, with particular attention to midwife-father communication*'. For midwives, the opening question was linked to the focus of the research, for example: '*...you'll remember that this research is exploring midwife-father communications. Thinking about that question, what are your reflections on what happened during that labour?*' These simple open-ended questions were sufficient prompt for participants to begin talking. The direction of each interview was influenced by the participant's priorities, with the researcher giving discreet guidance and reminders of the focus of the study as necessary. In the parent interviews, balance was sought between meeting the parents' desire to talk freely about the labour and birth of their baby, and the researcher's need to keep focussed on the area under study. Further prompts were offered as needed during the interviews. These were informed and refined based on data collected during the observation phase.

Recording and transcription of interviews

Ethical approval had been granted for all interviews to be audio-recorded. Before each interview took place, on-going informed consent was sought. Participants were reminded that they could opt out of audio-recording (in which case the researcher would take notes), and also of the right to withdraw their data from the study at any stage up to two weeks after the interview had taken place. No participants availed themselves of these rights. The researcher transcribed each interview as soon as practicable after it had taken place, when recall of the interview remained clear (Braun and Clark, 2013).

Timing, location and length of interviews: parents

It was intended that parent-interviews would take place as soon as appropriate and feasible in the first one to two weeks after the birth. In reality:

- Two took place during the first week after birth
- Seven within a fortnight
- Two within three weeks

Timing was a sensitive issue: the need to give clear priority to the parents, their relationship with each other and their baby was balanced with capturing experiences while memories were fresh and before the parents' birth-story had been told repeatedly and 'edited' (Pollock, 1999). Timing was guided by participants' preference, recognising that the early days of parenthood are busy, tiring, demanding and, at times, stressful. The researcher had anticipated needing to re-arrange interviews on occasion, in acknowledgement of these issues; in fact, the only time this arose was for the parents (N27) who had just had their fifth baby and the older children had a series of viral illnesses necessitating cancelling and re-arranging twice.

The parents were invited to choose the location for their interviews, with a room in a community-based children's centre offered as an option. All chose to be interviewed at home. They were also offered the choice of being interviewed together or separately. All opted to be interviewed together, although for one couple (N18), the mother was initially interviewed alone as the father was still out when the researcher arrived at the appointed time and the mother preferred to start the interview immediately.

The parents' interviews lasted for between half an hour and an hour and a half, although one was shorter (16 minutes) and most were between 30 minutes and an hour. The two longest interviews were with parents whose labours had been difficult; the distress they experienced was evident and as with the midwives, talking about the birth during the interview seemed to be a cathartic process (Gamble et al, 2005).

Timing, location and length of interviews: midwives

The intention was to interview midwife-participants as soon as possible after the birth, to respect the midwife's workload and in recognition of the likelihood of best recall taking place before she had cared for other women, also to minimise the burden of arranging a further appointment. As a practising midwife, the researcher was aware of the midwife's priorities when she has finished caring for the mother and baby straight after the birth. These were dependant on the birth environment, with activities following a home birth being different from those in hospital, but may include checking the placenta; completing paper and computer records; assisting the mother to get ready for transfer home or to a postnatal ward; helping to clean and re-stock the room at times of high activity. The midwife may have had other women to care for or be close to the end of her shift.

Of the 19 interviews with midwives (including two with students), five were conducted immediately after the birth, plus four within 12 hours. When it was impractical to conduct the interview in the hours after the baby's birth, the researcher arranged to return at the next convenient opportunity when the midwife was 'on duty'. The remaining interviews were conducted within one week (n=5), two weeks (n=2) and 3 weeks (n=3) respectively. Where it had been impractical to conduct the midwife-interview soon after the birth, arranging it could be a logistical challenge.

Interviews with midwives directly after the birth took the form of a 'contextualised conversation' (Stage and Mattson, 2012) in the sluice, while the midwife was checking the placenta, dealing with the instruments she had used and sorting and disposing of rubbish and dirty linen. The researcher reflects that it is probably her role as a practising midwife that enabled these 'placenta' interviews (as they were nicknamed by one of her supervisors) to take place in this setting, since she was accepted as an 'insider' in this clinical environment. They felt like 'spontaneous, informal conversations' (Hammersley and Atkinson, 2007, p.139). If the interview was delayed to a later date, the researcher met the midwife in a hospital or community venue of her choosing. The time lag and different settings meant these interviews felt more formal to the researcher.

The midwives' interviews varied from very brief indeed (one was under four minutes) to half an hour. Those conducted immediately after birth were without exception the briefest; they were focussed on the birth that had just taken place. The interviews conducted after a period of time had elapsed were longer and somewhat reflective in nature, with the midwife talking more generally about fathers' involvement, as illustrated in this Journal extract about a midwife-interview which took place over three weeks after the baby's birth:

She...was very engaged during the interview, which was long, but sadly more 'theoretical' than the interviews straight after the births...she talked about 'her approach and philosophy' more than what actually happened.

Journal extract, 18/12/17

When labour had been straightforward, the interviews were shorter than when there had been complications. The midwives in these cases seemed to use the interview as an opportunity to 'de-brief' the events of the birth.

4.9 Data analysis

In ethnographic research, data collection and preliminary analysis occur simultaneously, an iterative 'back and forth' process, during which the researcher interacts with the data and interpretation proceeds in parallel with data collection (Holloway and Todres, 2010, p.172). Data are summarised as they are collected and interconnections made between early and later summaries (Gribch, 1999, p.161). The researcher soon recognised the nature of this iterative process unfolding in practice; following her first observation, she identified the importance of the sketches she had made when she was transcribing the fieldnotes the following day.

A 'thematic analysis' approach was employed (Braun and Clarke, 2013), the seven stages of which are summarised as:

1. Transcription
2. Reading and familiarising, taking note of items of potential interest
3. Coding across entire dataset
4. Searching for themes
5. Reviewing themes and producing a thematic map, with themes and sub-themes
6. Defining and naming themes
7. Writing – final analysis

(Braun and Clarke, 2013, p.202)

The listing of these seven steps suggests an orderly, linear progression. In practice, it is a highly recursive, iterative 'messy, creative, complex, interpretative' process (Braun and Clarke, 2018). The researcher engaged with the data not as archaeologist, 'discovering' hidden gems of meaning within the data (Clarke, 2017) but rather as architect, constructing themes through the introspective activities of deep immersion in the data and extensive reflection. Active discussion and debate were of equal importance. These were both 'formal' and recorded - in intensive supervision meetings, during conference presentations and at feedback sessions at the study site, and

informal, with anyone who showed interest in engaging. This latter activity has been described as ‘the babble stage’ of peer review (Morse, 2018, p.813). Such conversations, with a wide range of people - including parents of all ages and different health professionals and academics (the groups not being mutually exclusive) - were significant in helping the researcher develop her analyses. Whilst acknowledging that developing the thematic analysis was not akin to travelling passively on an escalator (Braun and Clarke, 2018) the ‘steps’ are presented below in sequence, to provide an overview. The stages are summarised and illustrated in Appendix V. The researcher aims to demonstrate how rigour and an analytical, sequenced approach (Francis, 2013, p.73) was taken in the interpretation of the mass of ‘messy’ data collected.

4.9.1 Stages 1 and 2: transcription / reading and familiarising, taking note of items of potential interest

Transcription

The two methods of data collection yielded three datasets - transcripts of

- fieldnotes of observations
- interviews with parents
- interviews with midwives

The researcher worked intensively to ensure that, as far as practicable, she transcribed each set of fieldnotes and interviews as soon as possible after collecting these data, usually the following day; the longest time lag was three days. In so doing, she was able to recall details of the events, interactions and feelings during each labour or interview.

Fieldnotes

The researcher read and re-read the fieldnotes whilst transcribing them electronically and also reflected on the sketches she had made. She ascribed names to the different players, whose anonymity had been protected by using symbols and abbreviations in the handwritten fieldnotes. This ‘re-naming’ was important in keeping the participants ‘real’ and alive in her mind. It was so effective that she had to consciously stop herself using them when talking to midwife-participants who later attended feedback sessions at the study site.

As she transcribed her fieldnotes, the researcher was aware that, whilst she had worked to remain focussed on the research question during fieldwork and to keep her ‘gaze’ as wide as possible, her observations were by necessity selective and filtered through her own lens. During transcription, she highlighted issues of potential significance, which could be explored in subsequent interviews. The following fieldnote gives an example:

MW Vicky offers reassuring words, You know everything is going well – said directly to Rae and hands over to MW Melanie that Will wishes to cut the cord. **I notice that MW2 uses mother's name but reflect afterwards I don't think she used father's?**

Fieldnotes Rae and Will, N30

Interviews

The 30 audio-recorded interviews with parents (n =11) and midwives (n =19) were personally transcribed by the researcher. This was a fascinating, painstaking and rewarding experience. The first step was to listen to the entire interview. Then began the process of re-listening via headphones and transcribing the words, phrases and sentences, attributing each utterance to the speaker. Many hours were spent listening and re-listening to short sections of every interview, slowing down the recording where necessary to enable her to hear and transcribe as accurately as possible. This was challenging during many interviews, due to the parents being interviewed together. They frequently spoke at the same time, interrupted each other and finished each other's sentences. Each participant had her / his own individual way of speaking; there was a range of accents and dialects as well as idiosyncratic 'turns of phrase'. The researcher used non-standard spelling (Bucholtz, 2000) to capture these. She listened out for and recorded such speech patterns as pauses, hesitations, emphases, denoting these by using a 'punctuation code' she developed. She was alert for feelings and emotions expressed by participants, commenting on these in the transcripts Thus she employed a systematic notation system (Braun and Clark, 201) for transcription.

The researcher is aware of sensitivities around the choice she made to reflect each participant's individual speech patterns. Transcription is an interpretive, not a technical process (Bailey, 2008) whose goal is responsibility not neutrality (Bucholtz, 2000). These were the principles the researcher espoused in transcribing interview audiotapes. She had a strong sense of responsibility to the participants, aware that 'we are transcribing people when we transcribe talk' (Roberts, 1997, p.170). Her commitment to 'giving voice' to the participants led to the decision to transcribe their individual speech patterns, by using non-standard linguistic forms (Bucholtz, 2000) to reflect their cultural richness and diversity (Bailey, 2008). She is aware that this decision may lead the reader to make assumptions about the speaker (Bailey, 2008). However, she is also aware that to standardise linguistic idiosyncrasies is in itself a value-laden act, with its implication that the original utterance is inadequate (Bucholtz, 2000). She therefore opted for faithfulness to the speaker's voice.

The researcher became very familiar with the data and so deepened her 'immersion' in it (Creswell, 2013, p.66; Holloway and Todres, 2010, p.164; Francis, 2013, p.74). As

she listened to the recordings, she could also recall the display and expression of emotions during the interview itself, thus highlighting the value of transcribing as soon as possible after the interview had taken place. During the transcription process, the researcher regularly found herself so immersed in what she was doing that several hours would pass without her realising it. She experienced powerful feelings of entering the participants' worlds and felt that undertaking this research was a privilege.

Driving home after interviews with Ayesha and Hamid (N22). Hadn't anticipated how emotional this work would be, or how I'd feel such a sense of responsibility to the participants.

Journal extract, 24/1/18

As she completed each interview transcription, the researcher listened again to the recording from start to finish, correcting the transcript as she did so. The 30 interviews were completed within a four-month period (November 2017 – February 2018), by the end of which she was very familiar with the data and as confident as she could be that the transcripts were accurate. After her intense focus on the details within each individual interview and set of fieldnotes, she was ready to broaden her perspective. She assembled all the transcripts, read and re-read each 'set' (parents' and midwives') whilst listening again to all the recordings in the process and again making corrections to the interview transcripts. She therefore undertook this process a total of three times.

Reading and familiarising, taking note of items of potential interest

This 'stage' of analysis occurred simultaneously with the previous 'stage' of transcription, as illustrated above. In later phases of analysis, the researcher also reflected back on previous phases, and recorded these in her Journal.

4.9.2 Stages 3 and 4: coding across entire dataset and searching for themes

The 'formal analysis stage' (O'Reilly, 2012, p.187) then began in earnest. The researcher worked on the systematic coding of each of the three datasets in turn over the next four months (March – June 2018): first the parents' interviews, then the midwives', finally the fieldnotes. She used an inductive approach, undertaking this phase of coding manually (illustrated in Appendix V). She found this approach, which was visually helpful, tactile and visceral, enabled her deep engagement with the data.

The individual items of coded data for each dataset were summarised into preliminary themes (Appendix V). This organic, iterative approach continued throughout the analysis, as the researcher's conceptualisation of the data grew, deepened and evolved (Clarke, 2017). During this process of 'chopping things up and assigning to categories' the researcher found that her deep familiarity with the data enabled her to

‘stay faithful to the social context of speech and action’ (O’Reilly, 2012, p.188), so the themes remained embedded within the data.

4.9.3 Stage 5: reviewing themes and producing a thematic map, with themes and sub-themes

At this stage in the analysis (November / December 2018), the researcher returned to the datasets. During the course of this period of deep re-immersion in the data, she used NVivo to code the transcripts of each set, line-by-line, into 24 themes (Appendix V). The processes used ranged from looking in detail at the NVivo coding, to engaging with the data through mapping and summarising the graphic representations onto a length of lining paper (which eventually extended to ten feet). She identified linkages and areas of repetition. This was an intense phase of reflecting, writing, questioning, and ‘testing’ through formal discussions in supervision and informal with stakeholders (including a member of the Service Users group). By the end of January 2019, the 24 sub-themes were re-worked into seven overarching themes (Appendix V). As the researcher noted the patterns within the data, she also highlighted the ‘variant cases’ (Morse, 2018) – for example the ways in which fathers’ behaviour differed in the home environment compared to the hospital.

4.9.4 Stage 6: defining and naming themes

Further reflection and discussion followed; writing a summary for each theme was a helpful way of ‘testing’ them out (Braun and Clarke, 2018). This resulted in the synthesising of the seven themes (Appendix V) into six (Table 9), with a decision to integrate the ‘research issues’ theme within the reflexive account (Appendix D) and ‘findings’ chapters.

Theme 1	Who’s in the team?
Theme 2	Types of talk (tools of conversation and chat / communication)
Theme 3	Spaces, domains and territories
Theme 4	Circles of intimacy
Theme 5	Fathers’ ways of being and doing (how do fathers learn about birth?)
Theme 6	Midwives’ and fathers’ constructs of birth

Table 9 Integrating preliminary themes from 3 data sets 19.05.22

4.9.5 Stage 7 Writing – final analysis

The final stage in the organisation of the themed data was to perform an overall review of the six themes above, during which the content of themes 5 and 6 was noted to be repetitive. They were therefore amalgamated into a single overarching ‘theme 5’.

These five were then re-ordered and integrated (Table 10) and are presented in the following three ‘findings’ chapters.

Theme no.	Findings chapter no.
1. Spaces, domains and territories 2. Circles of intimacy	1. Spaces
3. Who’s in the team? 4. Types of talk; tools of communication	2. Teams
5. How are fathers socialised into birth? How (far) are midwives socialised into the ‘new’ childbirth, i.e. with fathers present?	3. Navigation and socialisation

Table 10 Five themes re-ordered and integrated into 3 Findings chapters

4.10 Summary box

- The study site was chosen for its strong ethos of midwife-led care and the range of options it offered around place of birth, thus creating opportunities for collection of rich, diverse data
- The support of midwives throughout the service was crucial to successful recruitment of participants and collection of data; time invested in publicising the study and building relationships was invaluable
- All midwives approached consented to take part
- The midwife-interviews which took place soon after the birth were briefer, but richer in detail and spontaneous expression of emotion than the later interviews
- Recruiting parent participants was achieved largely through via face-to-face contact and discussion; collaborative working with midwives, who facilitated the introductions, was a key element
- The commitment to ‘on call’ to enable observations in labour was an intense and rewarding stage of data collection
- Data analysis was an iterative process, which started in the pre-fieldwork phase, continued for an extended period and was on-going during the final write-up. The final themes were developed from all three data sets

Chapter 5 Findings 1: Spaces

5.1 Introduction

The findings of this research are presented in three chapters, the first of which explores two of the five themes:

1. Spaces, domains and territories
2. Circles of intimacy

'Spaces, domains and territories,' (Section 5.2) considers the impact of birth environment on midwife-father communications. The relationships and interactions between the people who inhabit these spaces are considered in Section 5.3.

5.2 Theme 1 Spaces, domains and territories

The concept of 'birth environment' encompasses the different geographical locations through which the parents moved during the course of the labour, as well as the physical space where the baby was born. It also includes the people within the locations. 'Domain' and 'territory' have connotations of 'belonging' and 'control' (Cambridge English Dictionary, 2019). Power relationships between the key players varied according to the 'domain' within which childbirth took place.

The various environments had different physical characteristics and adjunct philosophies of care, whether explicit or implicit. They were staffed by different healthcare professionals, with midwives providing care in all environments. The fathers' varied experiences within these different environments is perhaps linked to the degree of familiarity they had with each, the circumstances of the labour and the issue of how much 'control' they could exercise. All these factors impacted on midwife-father communications. There is a 'familiarity to strangeness' continua for both the father and the midwife (Table 11). The concepts on the left describe the familiarity of the home environment from the father's perspective: he is the 'insider' and 'in the picture'. In the hospital, he was often observed to be 'in the dark'. Within the hospital environment there were gradations of familiarity and 'homeliness,' with the birth centre being the most home-like and maternity theatre the most alien.

Home	Hospital
Private place	Public place
Domestic	Institutional
Social environment	Medical environment
'Home turf'	Unknown territory, has to be navigated
Familiar (safe)	Strange, alien, 'fish out of water'
Insider	Outsider
Freedom to move around	Contained environment

Table 11 Differences between home and hospital for the father

The presentation of findings begins with the home setting. When the father was on 'home turf', he exercised different choices about what he did during labour and the ways he communicated with the midwife. As he moved outside his home, he was stepping into unfamiliar territory; this impacted on these issues.

5.2.1 Homebirth: midwives' and fathers' perspectives

For midwives, labour and birth are - on a pragmatic level - 'all in a day's work'. Caring for women during childbirth is their chosen professional role, for which they have been trained. The landscape of childbirth has become 'taken for granted'; this included birth at home for the community midwives in this study, who were very experienced practitioners, accustomed to going into and out of parents' homes. This was illustrated by their relaxed and confident demeanour as they moved around during the homebirths. They highlighted the benefits of the home environment: its positive impact on relationships with the family:

...you're just *there* with the family - and you're *not* - going *out*, and answering phones, or answering *doors*...and...it's individual care, isn't it? It's really *nice!*

Midwife Yasmin interview, N18

Midwives' ability to offer 'family-focussed' care was recognised by parents; this mother's comment compares previous experience of hospital birth with home:

Lou:...they're *busy*, there's a lot to do, there's a lot of *other people*. I didn't *feel* like that, at all. They were there for *me*, and *us* - and...they were *happy* with that.

Parents' interview, Lou and Donal, N18

The landscape of birth is experienced very differently by the father, as compared with the midwife. Even if he has been present at the births of previous babies, it remains a 'rare' event in his life. The familiarity of the home environment appeared to mitigate the intensity of the experience for the father; this impacted on his behaviours, including his communications with the midwife.

5.2.1.1 Fathers and the choice of homebirth

Three couples opted for homebirth; one was primiparous and two multiparous. The couples who had made this choice considered the needs not only of the mother, but also the father and the wider family in their decision. One couple (Maria and Dave, N28) chose home because it suited their childcare arrangements. Dave was responsible for looking after the four older children during labour:

...so I just said to him, *Don't go in work, jus' so you can go and get the kids from school bas'cally*, so, yeah, it was more - sorting *these* out is more of a priority than anything else.

Parents' interview, Maria and Dave, N28

Home was also perceived as a more appropriate environment for Lou and Donal (N18), due to their previous experience of birth in hospital. Lou explained their rationale:

...just because...*first time*...he was just *sat* there...There was nothing for 'im to do. ...He likes to *do* things, and for him to be *sat down*, doing nothing, for a very long time, he got very bored. And I think *I* was aware of that, even when I was in labour. *I* was asking him if *he* was alright! When really...I shouldn't have been.

Parents' interview Lou and Donal, N18

The fieldnotes record Donal busy and active in the kitchen while Lou was in labour, welcoming the midwives, offering hot drinks, tending to household chores; he paused to tell the researcher that,

...he would always rather be 'up and doing'...[adding] 'we're tidy and organised. If there's a cup to wash, I'll wash it. [He]... tells me about their son Brooklyn and how energetic and lively he is. 'He's got ants in his pants – a bit like me, I s'ppose!'

Fieldnotes Lou and Donal, N18

These activities are conceptualised as 'legitimate tasks'. They were not available to fathers during hospital birth.

5.2.1.2 'Legitimate tasks' for the father at home

The father's familiarity with, and control over the environment at home meant that he and the midwife related to each other in different ways, when compared to hospital. In hospital, the father was in effect 'confined' to the birth space, with entry and egress points locked for security reasons. At home, he is free to move in and out of the birth environment, depending on the stage of labour and wishes and needs of both parents.

At home, fathers occupied themselves with 'legitimate tasks', which contributed to the mother's well-being in labour, creating a wider environment that was well-ordered and providing her with what she needed at different stages. These 'legitimate tasks' included: acting as host to the midwives, doing household chores, caring for other children, assisting the midwife with preparations for the birth and taking ownership of aspects of these preparations. All of these were undertaken in addition to caring for and supporting his partner in labour, in a range of ways.

Acting as host

The father performed the role of host to the midwives. He was the insider, who welcomed them into the home, for example by offering drinks and carefully laid-out refreshments, extending an invitation to midwives (and the researcher) to 'help yourself'. Care and thought were invested in fulfilling this role. Fathers also tended to

their partners' needs for drinks and snacks, and had a wider range of options at their disposal, compared with those available in the hospital environment:

Donal brings glass jar with a lid and integral straw up for Lou, he tells me it's Lucozade, *To keep her strength up*...what a great and practical drinks-container for labour. Donal pays lots of attention to details. He is meticulous in everything he does.

Fieldnotes, Lou and Donal, N18

Later, when the midwife asked Donal for an energy-boosting snack for Lou, he prepared a favourite choice for his partner. This represents a clear reversal of roles: in the hospital environment, the parents were the 'visitors'. A tray of drinks was provided and the parents invited to help themselves, but the elements of choice and control were absent. They were dependent on the midwife to provide and offer this limited range of refreshments.

Doing household jobs

While labour was unfolding, fathers took responsibility for a range of household chores, including tidying and cleaning. This highlights the cultural requirement of men to be 'doers': these activities served several further functions. They were a helpful outlet for the father's anxieties; keeping busy relieved the emotional intensity of the situation and provided valid, useful ways to expend energy rather than 'sitting and waiting'. In hospital, the father did not have these freedoms and may have felt pressure to 'make an excuse' to take a break from the intensity of the situation:

...you've not got your own space...sometimes you sort of see them... almost saying, *'Well I'm just going to go and make a phone call.* 'Cos actually, it prob'ly is really *intense* for dads...a lot of dads feel...a bit *useless, even though they're* not.

Midwife Sue interview, Maria and Dave N28

The father taking responsibility for household tasks relieved the mother of having to concern herself with any aspect of running the home. After the baby was born, the household was restored to its 'new normal' state, with the baby absorbed into it. Donal commented on how easily 'normality' was restored after the birth of their second baby at home:

...within an hour and a half, two *hours*, it was almost...like a normal *night* again...[we] was sat in front of the *telly* - and having something to eat! Pizza and chips!

Parents' interview Lou and Donal, N18

These reflections illustrate the degree to which the father was in control of the environment at a homebirth, with the midwives moving in to, then out of the birth space.

Caring for other children

For both the 'multiparous couples', the father took responsibility for arranging childcare. Maria and Dave (N28), expecting their fifth baby, both saw Dave's role as looking after the other children. Maria's priority was that she could relax and get on with the job she had to do in giving birth, confident that Dave was looking after their four boys:

...I felt better 'cos *he* had *them*. I didn't have to worry about *them*...I felt better then, 'cos I wasn't sort of thinking...with *your* Mum, or *your* sister, or my brother, or my Mum or whatever, it's like, oh, are they being good, or, you're like waitin' for your phone to go off and someone's *done* something...

Parents' interview Maria and Dave, N28

Assisting the midwife

During labour and birth at home, the father played a significant role in assisting the midwife in practical ways. Together, they prepared the home for the baby's arrival, with the midwife giving very specific instructions on the preparations the father should make. This is a complete reversal of the roles and responsibilities in the hospital environment, where all the equipment is ready and waiting when the parents arrive. At home, the midwife had brought the necessary medical equipment for unexpected emergencies. The location of this equipment and its laying-out was discussed and negotiated with the father.

Barbara asks what sort of boiler they have, and checks the arrangements for keeping the water in the pool warm. She ascertains they have a combi boiler – *Good!* She asks him where is a good place for her to create a 'resus' area, reminding him that in hospital there was a resuscitaire in case the baby needed help to breathe after birth, and saying she wants to have everything ready, just in case, adding that the baby is unlikely to need such help. She asks to set this area up on the kitchen table and checks there's a plug nearby and a source of light.

Fieldnotes Lou and Donal, N18

Following Barbara's instructions, Donal assembled all the items requested; together they laid them out on the kitchen table:

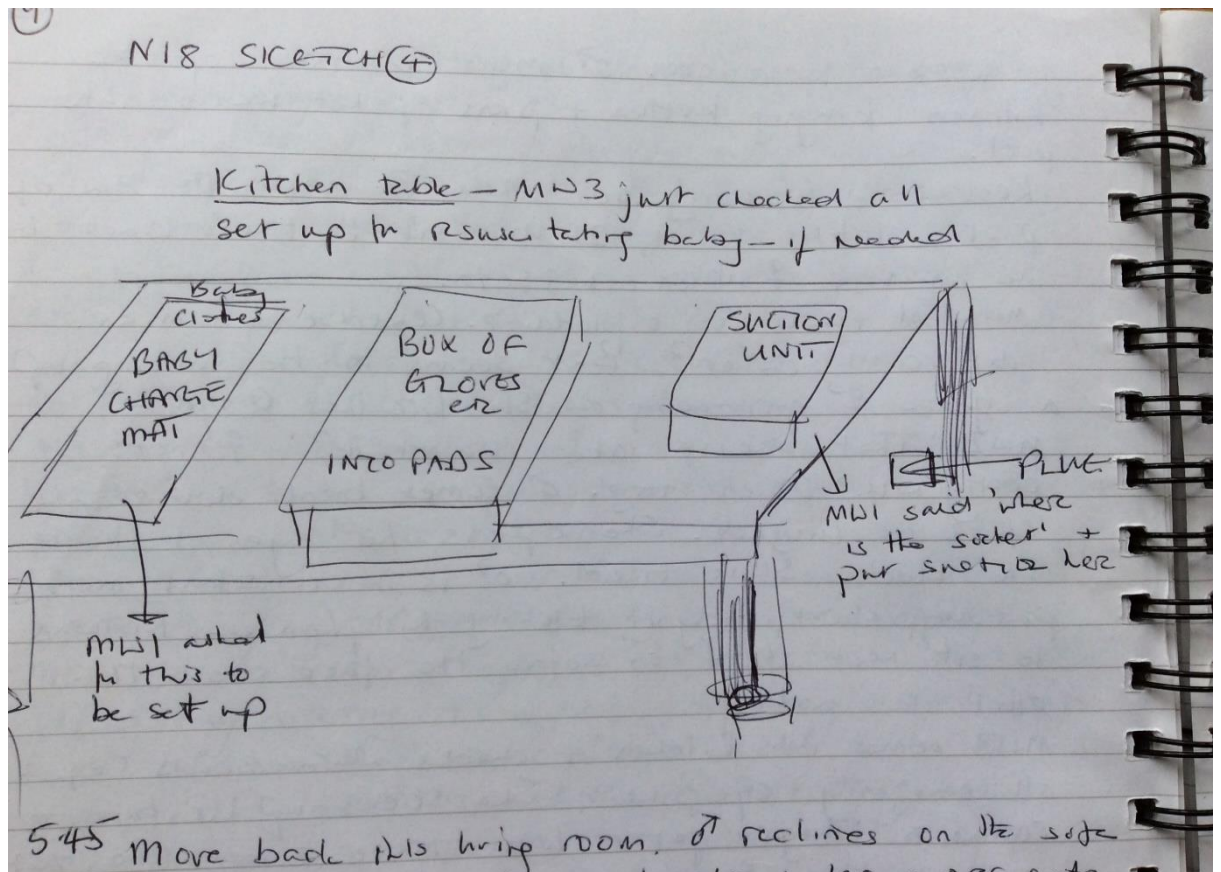


Figure 8 Fieldnotes Lou and Donal N18, sketch 4

The midwife gave a clear, detailed explanation about the resuscitation equipment. This is in contrast to what happened in the hospital where the presence of the resuscitator in the corner of the delivery suite rooms drew anxious curiosity from some fathers, who did not ask questions, but rather glanced around the room at the unfamiliar equipment.

Taking ownership

At home, the father not only assisted the midwife, he also took complete responsibility for aspects of preparing the environment. He could exercise initiative and did not need to seek permission to carry out such tasks as filling the birth pool and maintaining the correct temperature, with frequent checking and re-filling with hot water. This ownership of the birth environment and the significance for the father was recognised by comments made by midwives during interview:

...by *being* at home, he had that opportunity – to...*feel useful*...he *knew* his way around...he *knew* where to put things...he *knew* where things needed to be. Like he'd put the *towel* in the airing cupboard, so...when it got to the delivery – I said to Yasmin [midwife], there's a towel upstairs, and he said, 'Oh yes, it's in the airing cupboard' and he *directed* her to *that*...he said to me [with] his *previous* birth...he didn't know what to *do*, and he felt – *awkward*...he didn't know...how to be involved. Whereas *when* he was at *home*, he was so busy! (Laughs). He *never sat still*!

5.2.1.3 Available but not necessarily present in the room

Homebirth offered fathers the opportunity to support through their physical presence, or to be available elsewhere in the home and to enter the birth space if needed. In hospital, the father was 'confined' within the birth space. The choice to move freely in and out of the birth space involved different levels of midwife-father communication.

At one end of the continuum of 'physical presence' support, during Maria's labour (N28), Dave appeared briefly at the bedroom door on a few occasions, but did not enter the room:

The MW and the woman are laughing quietly together. Maria gives an involuntary push during a contraction and says *I'm sorry*.

Dave puts his head round the door. MW and Maria both say *It's not going to be long*.

Dave stands at the door, which is half propped open, with his work jacket on. His large frame fills the doorway. He is looking round the door and down at Maria's face, she looks up at him. There are sounds from the children downstairs. MW Brenda kneels on the floor and writes in the notes. The parents talk quietly together. I can't hear what they're saying. Dave leaves, shuts the door as he goes.

Fieldnotes Maria and Dave, N28

During the baby's birth, he remained downstairs playing with the older children. During his brief visits, Dave's concern for Maria's well-being was demonstrated through his focus on her face, the love and concern on his own face and his solicitous enquiries about whether she – or the midwives – wanted a cup of tea.

This couple had divided their roles down traditional gendered lines, as observed by the midwife:

I kind of felt he was probably –*happier* at home, because he could carry on being – 'the dad' that he *normally* was – and was sort of almost like...'- Let *Mum* get on with it, on her own. 'Cos that's a *Mum* thing, isn't it and I'll do my *Dad* stuff downstairs'.

Midwife Sue interview, Maria and Dave, N28

Dave, however, clearly felt that his behaviour equated to 'being present'. In subsequent interview he explained: '*I fell asleep with all the others, so I've never really dealt with midwives, y'know what I mean*'. When the researcher innocently questioned whether (given he had been asleep) he had actually therefore been present, he reacted with some indignation:

Hmm. (*speaking clearly and loudly now, this is said in the tone of someone correcting a misapprehension – on my part i.e. that he wasn't there*). I've bin, I've bin there, I've *bin* there at every one.

Parents' interview, Maria and Dave, N28

Dave's interpretation of 'being present' was that he was in the vicinity and he met the baby very soon after birth. The researcher's perception, from observation and interview, was that the labour and birth were a shared experience for these parents, but one within which they played different roles from the other couples in the study.

The researcher situated herself in the kitchen during Lou's labour (N18). Because Donal constantly gravitated there, it was where he had most interaction with midwives. For six to seven hours, Donal was mainly occupied downstairs, while Lou was upstairs with the midwives and her mother. The researcher recorded the scene in the bedroom when she went upstairs to use the bathroom:

Lou is leaning over the birth ball, balanced on the bed – there's lots of chatting in the room, from which I gather her cervix is now 5cm dilated. Progress. The 2 MWs sit on her bed. Chantelle (*Lou's mother*) stands at the door, hands on hips. Chatting going on, at normal voice volume, it's a roomful of women...a very sociable atmosphere. Donal goes up and down, in and out.

Fieldnotes Lou and Donal N18

Ricky and Jo were expecting their first baby and planned a homebirth. In contrast to Donal and Dave, Ricky (N23) rarely left Jo's side, both during early labour at home and then later in the hospital. Jo and Ricky had attended a 'hypnobirthing' course in pregnancy; this advocated the continuous presence of the birth partner, whose main role was to offer a constant stream of verbal encouragement and affirmation:

From his place at the wall, he keeps offering encouraging words; *Keep going*; *you can do this* in a quiet, calm reassuring tone.

Fieldnotes, Ricky and Jo, N23

He also ensured she had all her drinks, snacks and comfort-items close to hand, illustrated in the fieldnote sketch (Figure 9):

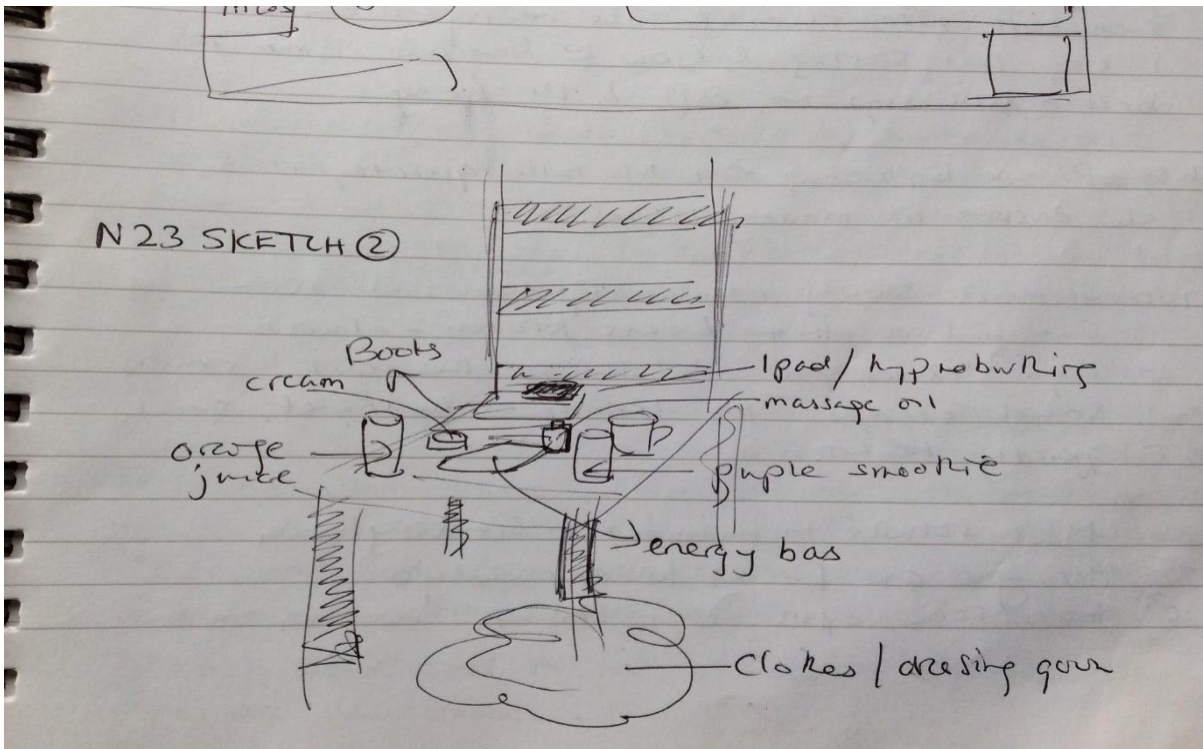


Figure 9 Fieldnotes Jo and Ricky N23, sketch 2

During the labours of both the multiparous women (Lou, N18; Maria, N28), neither Donal nor Dave was continuously physically present during the hours of 1st stage of labour. However, as the birth of Lou and Donal's baby approached, the intensity of the labour increased; Donal was gently guided by the midwife to relinquish his household 'duties' and stay by Lou's side:

Jayne [midwife] says to Lou, *You've got a minute and a half window to eat...* to Donal, *She's cracking on.* Yasmin checks the water temperature and announces *It's 36 degrees.* Jayne asks her to put hot in and Donal gets up to help – but Jayne says to him, *We'll sort it. You've done well. She needs your hands now.*

Fieldnotes Lou and Donal, N18

The midwife's comment to Donal represents a rare verbal acknowledgement and direct affirmation to the father of the valuable roles he was playing, one of the few instances witnessed during observations. From this point on, Donal stayed by Lou's side and concentrated all his energy on supporting her for the final hour of labour:

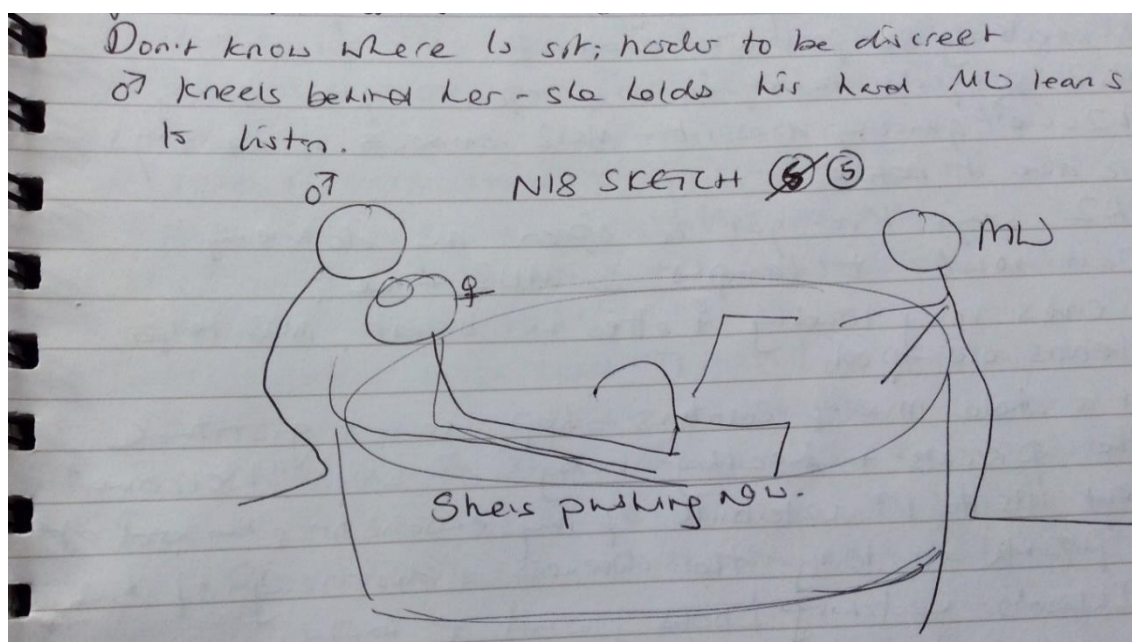


Figure 10 Fieldnotes Lou and Donal N18, sketch 5

5.2.2 Hospital triage: fathers 'handing over' to midwives

Seven of the eight women planning hospital birth started labour at home, in the company of their partners. They continued to labour during the journey there. On arrival, they laboured in various physical spaces within the maternity unit – the car park, reception areas, corridors, stairways, lifts and triage. In most situations, when the couple first met the midwife, she then took the 'history' of the labour from the mother.

The decision about when to go into hospital during labour (for those planning hospital birth) weighed heavily in the minds of fathers. They perceived themselves to be responsible for this journey. Midwives acknowledged this anxiety, on occasion to the father when the couple arrived (an example of direct midwife-father communication) and also to the researcher during interview. They recognised the relief felt by fathers in 'handing over' responsibility:

... [I was] sort of *praising* him a bit for managing to get here in time, encouraging him, and ...saying, 'Oh, you've done your part! Well done! You put your foot down...to get her here in time, for us!'

Midwife Siobhan interview, Jill and Mick N22

This implication (on the part of the midwife) that the father was responsible for the mother's welfare until he 'handed her over' to the midwife's care was witnessed on several occasions. It occurred in both home and hospital settings.

Parents passed through the 'gateway' of triage in order to enter the hospital. There, the decision was made regarding whether the stage of labour was sufficiently 'established' to merit admission. Where the woman's labour was progressing rapidly, the midwife

communicated directly with the father in taking the history of events, illustrated in the following fieldnote where the triage midwife assesses the woman's stage of labour on arrival in hospital:

MW Leila asks Hamid if Ayesha had mentioned about '*feeling damp?*' I think she asks him because Ayesha is having lots of contractions and they're strong so there isn't much gap for chatting. He is messaging his family – locally and 'at home' in Pakistan. He corrects Leila's pronunciation of his wife's name, she confirms the correct pronunciation and apologises.

Fieldnotes N22 Ayesha and Hamid

When labour was moving along at speed, or the mother needed to concentrate on managing her contractions, midwives drew on the father's knowledge of events up until this point. This was a pragmatic decision to gain information the midwife required. Such engagement with the father was not witnessed when the pace was more 'leisurely', despite the fact that every couple had experienced some hours of 'labouring together' before the midwife's involvement.

For some parents, the triage consultation did not result in a clear decision about whether labour was 'established'. They were offered a compromise between being 'admitted' to a birth environment and going home. There was a third option - the 'mobilisation room'. This facility was designed to give parents some undisturbed time in early labour, with the mother encouraged to move around in the hope that contractions would build up. The range of environments within the hospital were familiar to midwives, but not to fathers, for whom the transition from location to location during labour proved a source of stress and uncertainty. One father described his feelings of confusion during the first two 'moves', after their arrival in hospital:

...I found that on the *top floor* [Triage]...when we first came *in*...we were sent to that *room* [mobilisation room], where Hazel was, then ...we were chatting to someone in there, and they [midwives] were like, '*You can go home if you want?*' And then we were like, *Well can we go? Can we not go home? Should we be going home? Should we be here? What should we be doing?* And that sort of reigns *confusion!* And then *that* causes a bit of *anxiousness*, 'cos you think, 'Do we even need to even be *in* here? *Should* we be...? Is this *normal?*'

Parents' interview Hazel and Ben, N25

Ben described the 'mobilisation room' as 'purgatory', because '*...you don't really know where you are*' (Ben, N25, parent interview). Lacking the continuous presence of the midwife, Ben clearly articulated his feelings of confusion and abandonment.

5.2.3 Birth centre

The ethos of the birth centre was to create a home-like setting. A comfortable sitting area in the foyer, with subdued lighting, was furnished with leather sofas arranged opposite each other. A coffee table placed between them created a homely and inviting place to sit. This was used by fathers and other family members during long labours. The birth centre corridor was likewise a quiet, dimly-lit space, with items of household furniture - a hall console table and a 'please help yourself' hot drinks station. Large black and white photographs of parents and babies were hung on the walls; a busy notice board was covered in pictures of babies born in the birth centre. The institutional appearance and 'hospital' atmosphere were mitigated by the use of colour, fabric, pictures, lighting and furnishings. A minimum of 'hospital equipment' was visible.

The impact for the father of the homely environment was that he relaxed and seemed at ease more quickly than in other hospital environments, helped by being surrounded by homely, familiar artefacts. Fathers were noted to move easily in and out of the room where their partner was labouring, probably because the areas outside were welcoming and designed for them to take a break. For example, Jack (N29) spent some time sitting in the foyer with his sister; she was present specifically for his support and to drive him from hospital to home as needed:

Jack has been downstairs for a cig and is now sitting in the BC foyer which has two comfy leather sofas; he is talking to his sister who plans to stay for the duration but isn't coming in.

Fieldnotes Dawn and Jack, N29

The contrast between the birth centre and other hospital areas was noted by Mick (N21), whose partner Jill was having their third baby, the previous two having been born on delivery suite:

It was probably more *relaxed*...the other [delivery suite] room ...you got all the *monitors* and things, beeping away- we didn't have that [in the birth centre]...you don't see...you're not *aware* of the equipment...

Jill and Mick, N21, parent interview

5.2.4 Delivery suite

The delivery suite environment was, for hospital midwives based there, their workspace and their familiar and safe place. Designed for women with obstetric or health problems, or who chose anaesthetist-administered analgesia, there was a considerable volume of equipment on display in birth rooms and visible in storage areas. For fathers, it was an unfamiliar, potentially alien environment.

Entering delivery suite via the foyer waiting area, with its fluorescent lighting, hard chairs and drinks machine, this was unmistakably a hospital environment. The long corridors were brightly lit 24-hours a day. Rae and Will (N30) had previously used the birth centre. Will felt apprehensive on learning that, this time, Rae would be giving birth on delivery suite:

...that was a big part of preparing *mentally*, cos... going into the delivery suite was a lot different to the birthing pool [i.e. birth centre]. The birthing pool was very mellow, very, like, '*oh we're in a big bathroom here*' – (pauses, as if looking around the room) - there's a big pool isn't there, ooh there's a *chair* for me.

Parents' interview Rae and Will, N30

For Will, the birth centre involved '*less of the beepity-boopity machines that yer get wired up to*'. He associated hospitals with injury, illness and death:

...as a child, I was quite clumsy, so growing up I've spent my fair share of time in a hospital bed, sadly and - anything to this day now that resembles surgery, something clinical just – really...flips my stomach. It really just makes me feel sick...obviously no-one likes going to a hospital, but even more so now...I've done what I feel is my fair share of visiting the hospital, I really don't like going there for any reason whether it's for meself, *or* someone else.

Parents' interview Rae and Will, N30

Midwives described adapting the environment to soften its 'clinical' appearance and create a calm atmosphere, for example by adjusting the lighting. This was in recognition of the impact of the environment for fathers as well as mothers:

...in a *high-risk* setting...I think that makes a *big* impact, because you've got to try and make it as *normal* as you *can*, for their well-being and everything...

Midwife Lynn interview, Jo and Ricky N23

Fathers varied in their response to the environment. Some appeared oblivious to their surroundings, possibly due to previous habituation. Efforts were made to soften each room's institutional appearance, by the use of patterned curtains and wallpaper on the wall behind the bed, it was nonetheless a 'hospital room', denoted by the presence of medical equipment – a 'delivery bed', resuscitaire, metal trolleys and a range of artefacts attached to the walls (Figure 11):

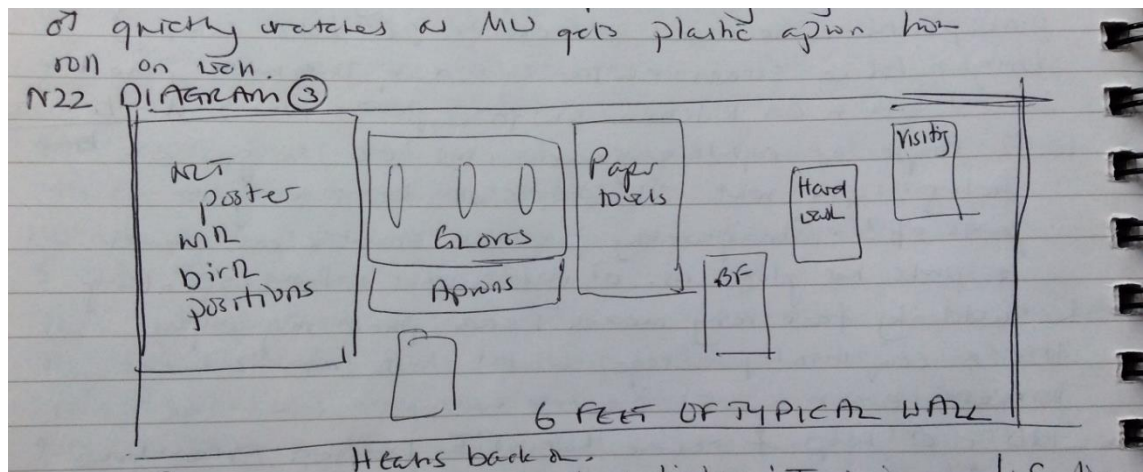


Figure 11 Fieldnotes Ayesha and Hamid, N22 sketch 3

The father's sense of ease and confidence within the delivery suite environment was highly individual, depending on his expectations and previous experience of birth. Ayesha and Hamid (N22) had two older children, the first born in a military hospital in Pakistan. Male family members were not permitted anywhere within the hospital building; they waited in the car park, as explained by Hamid, Ayesha interjecting for emphasis:

Only *ladies* are allowed! [A. Ladies allowed] and everybody else must go away. However her *mother*, my mother, [A. my sister] her *sister* – they *all* came, and...they took care of everything! Literally! (*Laughs*). I have *no idea* what happened!

Ayesha and Hamid, N22, parent interview

The delivery suite birth room was less 'home-like' than the birth centre:

I sit back to take in the surroundings, looking round the room and trying to see it with 'fresh eyes', though Hamid seems oblivious to the surroundings, he is focussed on Ayesha. All the equipment is ranged around the walls. Everything is clinical and functional apart from the NCT 'Positions in labour' posters... [Midwife] Bryony shows Hamid the little kitchen off the delivery room, the tray with everything to make a brew and cartons of orange juice. He offers juice to Ayesha and there's no reply.

Fieldnotes Ayesha and Hamid, N22

The midwife's welcome to Hamid was symbolised by her encouragement to make drinks.

Each room had two large comfortable armchairs available for the parents; however, these were heavy and difficult to move. When the father sat in the armchair, it was positioned in full view of the end of the bed. He therefore had direct sight of all clinic

procedures performed there, including post-birth suturing of the perineum. For example, during the extended delay in third stage after one birth (N21), the father sat in the armchair with a clear view of the vaginal examinations that were being performed in an attempt to deliver the placenta. During Hazel's labour, Ben (N25) chose to sit at some distance from her side, a decision the couple had made together. The only place for him to sit was in the armchair:

MW Sally...asks Ben to go round the other side of the bed as she prepares to examine Hazel. Instead, he goes and sits in the armchair in full view of the examination and catheterisation which is about to happen! Sally has asked StMW Chloe for the bed to be raised. It's now at Ben's eye level. Sally asks Ben to move the central 'operating light' which hangs from the ceiling...He does so and returns to his armchair. Hazel is on her back, legs parted, genitalia exposed to the room. Sally catheterises Hazel, explain what she's doing. She then asks for a fresh pair of gloves. Ben jumps up, saying *I'll get them*. Chloe fetches some from the module.

Fieldnotes Hazel and Ben N25

Ben remained engaged and attentive; he was keen to assist the midwife in practical ways; he did not display distress or concern during this episode, neither did he mention it during interview. However, in neither situation did the father's perspective appear to be noticed by any of the clinical team.

Fathers' past experiences

During observations, the demeanour of some fathers who had prior experience of birth (e.g. Mick N21, Hamid N22) suggested that they were more relaxed within the delivery suite environment than first time fathers (e.g. Ricky N23, Jack N29). These 'experienced' fathers appeared to habituate more readily. However, the father's previous experience of childbirth did not necessarily prepare him for the subsequent birth. In the example above, Will (N30) was disconcerted by being on delivery suite for the second birth, after the informal atmosphere of the birth centre for their first child. Darren (N26) described the converse experience; his partner Lorraine had very serious complications at the end of her previous pregnancy, necessitating a high level of intervention and technological care in labour. He was expecting a similar scenario for the second birth. Darren's expectations were based on his prior experience - the number of people and the medical interventions involved:

...the *doctors* was coming in, they was bringing *teams* of like trainees round...*(he laughs aloud as he is speaking)*...it was like a bit of a circus really, *last time*, the amount of *people* that kept coming in!...I mean, she's *drips*, she's on a *catheter*, she's *monitoring*. You couldn't have a *drink*. There was always at least *two people* in the room! Last time. More than not, three or four...

Parents' interview, Lorraine and Darren, N26

The following fieldnote illustrates the contrast between Lorraine's first labour and this second birth:

The atmosphere is very calm and it feels kind of informal / primal – just a woman labouring away on the floor, her midwife in close physical attendance, her partner quietly supporting her with touch and gesture; the intimacy and ease of this scene is in contrast to the brightly-lit DS environment and the curtain around the door (behind the woman and the MW) is half hanging-off; the simplicity and kind of purity and rawness of the labour in a setting that seems very alien.

Fieldnotes Lorraine and Darren, N26

The midwife experienced this birth as straightforward, 'all in a day's work'. For Darren, the contrast with his first child's birth could not have been greater:

...To just being y'know, Lorraine and the midwife, and meself, and obv'ously *you*, but you – sat back out the way, didn't really *interfere*, just observed. So (*laughs*) that was the main thing, just like the big, *total difference*, from the two.

Parents' interview Lorraine and Darren, N26

Birth is a rare event for the father: he formed expectations based on previous experience; however, this experience was not discussed with the midwife. He was therefore required to make rapid re-calibrations to these if the subsequent birth was very different.

5.2.5 'Transfer' in labour and midwife-father communications

Changes of location impacted on midwife-father communications. All the couples, apart from the two whose babies were born at home, experienced labour in a range of hospital environments. All the women were admitted via triage; four of the five women who used the birth centre transferred to delivery suite for clinical reasons; two had a further move to maternity theatre. From the father's perspective, each move required him to re-habituate to a different, unfamiliar environment and changing personnel.

Seven of the eleven babies were born on delivery suite. These parents journeyed through several environments during the course of the labour. Jo and Ricky (N23) had planned a homebirth for their first baby. Delay during the first stage of labour necessitated transfer to hospital; the rehydration fluids Jo received on the birth centre were ineffective in increasing her contractions. She transferred to delivery suite for a hormone 'drip' and eventually had her baby, assisted by forceps, in maternity theatre. Ricky reflected on the move from birth centre to delivery suite, describing the changed power dynamics and philosophy of care he experienced within the new environment:

...it became *less of...a birthing process...more of a medical...there was a problem to be solved...It felt more like we were...the objects, rather than...we*

were all...a *team*, delivering a *baby*. We were...a *problem*, to be *solved*...in the delivery suite. More clinical...less *personal*...It definitely felt like there was a mood change...It was definitely 'They [doctors and midwives] were the experts and we were the...'patients, clients', that sort of thing'.

Parents' interview Ricky and Jo, N23

Midwives involved in care, aware the couple had planned a homebirth, collaborated to keep staff changes to a minimum. However, the need for medical intervention drew other midwives plus doctors into the space. Ricky, who had been awake for over 36 hours, described his feelings of disorientation by the time their baby was born:

...it's difficult...it was such a *long*...and sort of *varied*...*experience*...I guess the constant changing of personnel ... got a little bit overwhelming...it was hard to keep track of...who's in charge and who you were talking to, and what was going on. That was a little bit...disorient' [Jo interjects 'ating'] –yes...

Parents' interview Ricky and Jo, N23

The feelings of disorientation, of finding it hard to '*keep track of who's in charge*', were highlighted by Ben (N25), in his description of moving from triage, to the 'mobilisation' room. The arrival of the midwife, after about an hour, assuaged these feelings. Her presence conferred feelings of safety and security; Ben valued the sense of her 'taking charge'. Both parents liked Sally's approach, which made them feel very confident. When they transferred from birth centre to delivery suite (Sally's usual place of work), the parents commented on her changed demeanour following the transfer. They felt her approach to care fitted well with the delivery suite environment, demonstrating awareness of the different philosophies of care associated with different environments. Ben's perception of the birth centre philosophy was that it would suit couples and midwives with particular expectations:

...you're expecting your *candles*. And you're expecting the...*mood music* and all this jazz!

Parents' interview, Hazel and Ben, N25

5.2.6 Maternity theatre

Fathers faced particular challenges when birth occurred in maternity theatre (described henceforth as 'theatre'). It is an operating theatre and equipped as such; priority is given to the needs of medical personnel, clinical tasks that must be performed and the maintenance of high standards of infection prevention and control. There was a strict limit of one birth companion for the woman. For both couples whose babies were born in theatre, this companion was the father.

The father's journey to theatre

The father made the short journey from the delivery suite room to theatre via a small anteroom, where he and other family members (if present) were escorted by the midwife, while the mother was taken to the anaesthetic room in preparation for theatre:

The anteroom where the family wait is bare, with no windows; a small table has a couple of disposable theatre gowns on it and two boxes of disposable theatre hats. It is where dads get changed into theatre garb and wait until called. There are no distractions in there...

Fieldnotes Dawn and Jack, N29

For both couples, the mother's transfer to theatre occurred during 2nd stage of labour, following many hours of 1st stage, slowing of progress, a number of interventions to try and stimulate labour, transfer from birth centre, to delivery suite, then to theatre. The fathers were both physically and emotionally exhausted. For Jack, this final transfer felt almost too much to bear, as acknowledged by midwife Becky, who reflected during her interview:

...when we talked about who was going to go into *theatre* with her, he said, *No I don't want to go*. He said, *it'd be different if it was me or my pain, but I can't bear to see her like this, in so much pain*, that he didn't want to go to theatre with her, and the *sister* was gonna go in...on one hand I thought, oh what a shame you're not going to be there for the birth of your baby, but if you don't want to be there, maybe that's the right thing to do?

Midwife Becky interview, N29, Dawn and Jack

The process of transfer to theatre increased the fathers' visible levels of anxiety and their sense of disorientation was palpable, illustrated in this fieldnote extract:

Jack is crying and says he will be no use to Dawn 'Like this'. He can't bear to see her in so much pain. He says *I'm scared* and looks around at each of us, his eyes are darting about.

Fieldnotes Dawn and Jack, N29

In the event, Jack did go into theatre, despite the feelings of fear and trepidation, encouraged by delivery suite midwife co-ordinator:

...Jackie, the co-ordinator (C-O) comes in and talks to Jack and explains that once the spinal anaesthetic 'is in', Dawn will be pain-free. She encourages Jack to go into theatre, saying it would be a shame to miss the birth after being there all day. Looking around, he starts to put on the gown and I do the same. The tapes are confusing but DS C-O helps. She is warm, kind and matter-of-fact. She kind of sweeps Jack along and together we go into theatre. He walks in a sort of daze, looking straight ahead.

Fieldnotes Dawn and Jack, N29

For both Jack (N29) and Ricky (N23), the delivery suite midwife co-ordinator became involved when the decision to transfer the mother to theatre was made. In each situation, she escorted him to the anteroom, where she gave instructions on donning the 'scrubs', which he must wear to enter theatre. She offered support to the father as he walked the few yards from the anteroom to theatre. As Ricky was making this short journey, the co-ordinator addressed him directly, with a question about whether he had any 'issues' around going into theatre. She made clear eye contact, smiling calmly and reassuringly.

The period when the father was separated from both his partner and the midwife who he had come to know, was of indeterminate length. Usually lasting for 20 – 30 minutes, it was a time of intense anxiety, loneliness and fear for the father, recognised by midwife Sue:

It's always hard when...dad goes in to that sort of little *room* and the mum has to come and have the *spinal*...that...must be quite *scary* and also theatre...it's just *bright* and...sort of *impersonal*...and it's quite *frightening* really...and you're introducing *lots of new faces* and lots of *people* and it becomes a lot more painful.

Midwife Sue interview, Jo and Ricky N23

The researcher stayed with each father in the anteroom, in order to learn about his interactions with midwifery staff. Jack (N29) had family members with him; Ricky's situation, as Jo's sole birth supporter, was different. If the researcher had not been there, he would have been alone. During interview, he recalled this period; addressing the researcher, he said:

I always remember...when I was getting changed into like the theatre gear? Like you – you came in. And you – you asked me how *I* was. And that was when (*laughs*) ...me bottom *lip* started going...I was like, 'A little bit shaky!' And then...you gave me just the *niciest hug*. (*Laughs again*) ...I remember thinking, I'm gonna have to get it together, 'cos Jo is going to be...looking at me for reassurance (*laughing ?nervously as he speaks*) ...I was glad you were there. 'Cos I can't imagine having to do that it on my *own*. Just being – in that *room*...not *really sure* what's going *on*...

Parents' interview Ricky and Jo, N23

This was one of two significant occasions when the researcher's interactions with fathers went beyond social pleasantries or brief non-verbal exchanges. Both of these were in the theatre setting and involved the researcher offering some words of comfort and a hug. She stepped outside the non-participant observer role and acted instinctively in response to a human being in distress. Had she not been present, it is likely that no-one would have been there to support the father. She reflected on the appropriateness of her actions and concluded that it would have been callous not to

have offered this support, whilst recognising that her change in role was likely to impact on the father's experience.

The father arriving in theatre

Maternity theatre, as with other hospital environments, is one to which health professionals are well habituated. For the father, this was the most alien environment:

I try to see the theatre as if for the first time, through Jack's eyes. The theatre is very brightly lit and quite cold. The operating table is in the centre and there is equipment arrayed around. I count 9 people in the room: Dawn is on the table in the middle and she looks very small and pale, her eyes are open wide. Her legs are in stirrups and there are two doctors washing her genital area and putting sterile wraps over her legs. I stand at the side, some feet from her head. Jack has gone straight to her side and is holding her hand. MW3 is moving around and makes a couple of phone calls. The anaesthetist is at Dawn's head, there are a couple of men...operating theatre personnel. They are moving around slowly and confidently. Every now and then they glance towards the bed – I am guessing, this is to see how close the baby is to being delivered and to anticipate what equipment may be needed. There are two staff members near the resuscitaire – I guess a paediatrician and an advanced neonatal practitioner. The DS co-ordinator comes in so there are now 10 people in the room. I can't see Jack's face.

Fieldnotes Dawn and Jack, N29

In terms of familiarity, a theatre is far removed from home. The sights, sounds, smells and personnel are all usually completely outside the every-day experiences of non-health professionals. As many procedures are now performed under local anaesthetic, the situation of the theatre-patient being awake is not uncommon. However, it is very unusual indeed for the patient to have a lay companion in theatre. The presence of a 'layman' in the theatre environment is therefore also outside the norm for many theatre staff.

The shock of the transfer to theatre and of the theatre environment itself, was clearly evident for both fathers. Although neither situation was an acute clinical emergency, the fathers perceived it as such. There was some urgency in safely delivering the baby; this involved a change in pace. The connotations of an operating theatre, with its associations of surgery and illness, increased the fathers' anxiety.

When summoned into theatre, the father was directed to a specific physical location: a metal stool to the right of his partner's head. This was the only environment where such precise instructions were given, denoting the regimented organisation of the operating theatre. Once seated, each father appeared isolated from the busy-ness around him. The fathers' shock and sense of disorientation were palpable, in contrast to the measured, orderly purposeful working of the theatre team, as each moved calmly around the room, sure of her or his responsibilities. During the birth of Jo and Ricky's

baby (N23), co-ordinator Jackie was opposite Ricky and comforting Jo, who lay in silence on the operating table, staring straight up at the ceiling as the doctor worked to deliver the baby. Jackie glanced and smiled at Ricky from time to time, who was watching the doctor's actions intently. Ricky described sensing Jackie's concern when the baby was taking longer to arrive than she was anticipating. During interview, Ricky said:

I could see the...*actions* of all the *doctors* and the *medical* staff as well. And *that* was quite traumatising, that was a little bit horrible. 'Cos they obviously have to...pull quite *hard*. And you could see like the *whole* of...Jo's body just *shifting*...down the bed, like quite *violently*...it was *really shifting*. And...when the MW...*had* that change of demeanour, I remember thinking 'Things...are going *wrong*. Something's going to be wrong with the *baby*'.

Parents' interview, Jo and Ricky, N23

Throughout this narrative, during which Jo was weeping quietly, Ricky understated the terror he felt as he witnessed the doctor working to deliver the baby, and went on to explain that his priority was to continue to support Jo:

... [I was] just trying to encourage you, 'You're doing really well', but at the same time, thinking, like the baby's going to be *dead*...I was thinking, it's not going to *survive*. And then, when they finally *got* the baby out, then lifted it¹ ...I remember...he was a lot more *purple* than I thought he was going to be, but I mean, y'know it wasn't *crying*. So I remember thinking, 'If it's not *crying*', it's not really *doing anything*.... see I thought he was *dead!* (*J is heard laughing – disbelief was on her face*) when he first came out.

Parents' interview Jo and Ricky, N23

In theatre, there was even less direct verbal communication with the father than in other scenarios, while the team focussed on expediting the baby's birth. Theatre was quiet, with an absence of general social chatting to lighten the atmosphere. The fathers in each situation were silent, anxiously scanning the room, the people in it, their gaze returning repeatedly to the woman on the theatre trolley. As in other situations, they scanned the midwife's face for clues as to how the birth was going.

The peak of anxiety for both fathers came after the baby's birth. Dawn and Jack's baby needed assistance to establish regular breathing:

After he is born, the cord is clamped and cut and he is taken to the resuscitaire. After maybe 30 seconds he starts to cry, it sounds as though he has mucous in his throat. Jack leans over Dawn and embraces her. His shoulders are shaking. MW comes over after a few minutes and invites him to go to see the baby. I follow behind him. He looks at the baby, whose face is very bruised. Jack is trembling, shaking, crying and he is very pale. He looks at the baby and seems stunned.

Fieldnotes Dawn and Jack, N29

¹ The parents did not know the baby's gender until birth

As Jack was at the resuscitaire, the researcher observed from a distance of several yards. She noticed that Jack had become pale and sweaty, his legs buckling under him, so he was swaying from side to side. The staff were busy resuscitating the baby; the researcher assessed that Jack was about to faint, so stepped briefly out of her 'non-participant observer' role and moved to support him. As with Ricky's acknowledgement of the researcher's brief support for him (before he went into theatre), Jack later mentioned that he had valued the researcher's presence and comfort. The staff correctly prioritised caring for the baby; in these extreme circumstances, the father's needs for support and information could not be addressed. These needs should not be underestimated. The impact of each father's continuing distress was clearly evident during subsequent interviews.

5.3 Theme 2 Circles of intimacy: people create the birth space

This section begins by focussing on the couple dyad and moves on to the triadic relationship that developed when the midwife became involved. Within this triad, a number of dyads operated. The father and midwife formed a 'circle of intimacy' around the labouring woman. For some, the involvement of other family members and friends widened the circle. This is conceptualised as a Greek chorus, whose function in classical Greek drama was to describe and commentate upon the action of the play.

5.3.1 The couple

The original focus of this research was the midwife-father relationship. However, as recruitment and data collection commenced, it became apparent that the centrality of the parents' couple-relationship was relevant to the study's analysis and findings. It was the dynamic that was present before they met the midwife.

5.3.1.1 The couple connection

During her pre-birth meetings with the parents, the researcher had noted that the couple-connection appeared to be powerful for the participants. Couples' spontaneous reflections on their attunement are illustrative. One father commented: '*we spend years trusting each other and that trust has been built up*'. (Parents' interview Ashley and Graham, N27). A mother (Rae, N30) described the ways they had worked together during her first labour as a reflection of their relationship:

...that's jus' the way we *are* with each other, I mean we do fight like cat and dog (*laughs*) but – when we *need* to pull together, that's how we are we. We are very much a team...it's what you *need* on the day...

Parents' interview, Rae and Will, N30

5.3.1.2 How the couples prepared for childbirth

All the couples had prepared together for birth. This shared planning was an element of their attunement. The preparations varied according to parity, previous experience of childbirth, expectations about the father's roles, and place of birth. The pre-birth discussions described by one woman were typical:

...he asked me, *What would you want from me?*...it is helpful to have that conversation beforehand so - you've got *some* kind of plan, even though you don't have a clue what's going to happen...you've got *some* idea of how you're going to *behave* with each other on the day - I just remember saying to you, it's just *support*, someone to hold me hand, you know just *reassurance*, and you really took that on board didn't you?

Parents' interview, Rae and Will, N30

The four couples expecting their first babies had made more detailed preparations. For some, these also involved joint investment of time in antenatal classes. One attended NCT; one did a hypnobirthing course; one participated in an online antenatal session. All these classes were designed for couples. They helped to reinforce the couple-connection as the primary dynamic and gave the couple an action plan, with shared purpose and goals. Other parents, at the woman's instigation, watched *One Born Every Minute* together by way of preparation.

All the couples planned to experience labour and birth together; some also invited others to be present. These plans formed part of their preparation. One 'multiparous' couple invited the woman's best friend to be with them; during their first baby's birth, she had played an important role in supporting Will as he in turn supported Rae:

Will: Well, the first time round that burden, if you will, was - *halved* in a sense.

Rae: Yes, she was as much support for you as she was for me actually.

Parents' interview Rae and Will, N30

Two of the 'first time' couples had invited other family members to be present, each choosing a specific support-person for the father. One had invited the father's sister:

An obv'ously me an' Dawn were there – together – but it *really* 'elped 'avin' Laura (*Dawn's sister*) there, an' like it 'elped me 'avin' me sister jus' outside. 'Cos like *how* Dawn is with Laura, I'm the same with *my* sister. So the support them two give us, it's like...you can't *ask* for that

Parents' interview, Dawn and Jack, N29

Rosa and Dan (N20) each had their own mother with them, Dan's specifically to support him.

5.3.1.3 Couple communication in labour

Communications between the couple ebbed and flowed during labour, although the couple-connection remained the bedrock:

Will hands a tissue to Rae as she is a little tearful, comments *you've done this before*; Rae replies *Yes I have*; Will *Keep going, keep breathing, well done, that's it'* feeling in room is very close (between parents, very connected; Rae speaking very little, just in response) very concentrated atmosphere, calm.

Fieldnotes Rae and Will N30

Will's comment during interview, affirmed the couple's attunement during labour:

...me 'n' you have an emotional connection, if you panic, I'm gonna panic...vice versa if I'm calm – you are gonna be more calm...

Parents' interview Rae and Will N30

During labour, a strong flow of support from the father towards the mother was observed. There was also evidence of mutual concern, which the labouring woman was unable to express at the time. Ashley (N27), for example, worried that Graham had not eaten a 'proper meal' for several hours and that there were no facilities for him to purchase one. She was also concerned for his emotional wellbeing:

...there was no consideration for the *stress* on the partner. The fact that there's the *stress* of *'Is their baby gonna be OK?'* And there's also the stress of watching their partner go through something...

Parents' interview Ashley and Graham, N27

Other mothers would have liked reassurance that their partner was 'safe'. Some were concerned that he had driven home after their babies' births, having been awake for longer than 24 hours.

5.3.1.4 Couples' individual ways of working together in labour

Couples' knowledge of each other informed their plans for coping with labour, together. Sometimes the midwife viewed their agreed strategies as unconventional or hard to comprehend. For example, Ben (N25) had brought a book to read during labour, on the advice of a friend who had suggested Hazel would find this reassuring. Midwives perceived this as withdrawing and being detached. During labour, they repeatedly encouraged him to be at Hazel's side, by inviting him to move closer. On occasion, he complied, but then moved back to his place several feet away at the first opportunity:

Sally needs to get to the monitor which is bleeping so Ben moves away and to the armchair; Sally invites him to come back when she's finished but he declines, saying he doesn't want to be in the way of the machines.

Fieldnotes, Hazel and Ben, N25

The couple had planned this strategy based on their knowledge of themselves and of each other:

I'm the same as Hazel - you want sort of to curse under your breath and to be left alone. You don't need someone saying, '*Are you alright?*' 'Cos it takes energy to say '*Yes that's fine! Oh thanks very much for rubbing my back!*'

Parents' interview, Hazel and Ben, N25

During the birth of their fifth child at home, Dave (N28) remained downstairs looking after the children and did not attend the birth. The midwives viewed the decision as unusual, but added the caveat that Dave was being supportive in his own way. Being at home enabled the midwives to broaden their interpretation of 'support' beyond physical presence.

5.3.1.5 The couple-connection in labour

Midwives acknowledged the unique nature of the couple connection. They were aware of participating in an intimate shared experience and expressed pleasure in this:

I just felt he was very loving and encouraging. You know, they were a very tactile couple...he was very close to her.... because he was close to her, he could have that tactile time with her, and it was just lovely. They loved that baby out, didn't they, really? It was just really nice.

Midwife Bryony interview, Ayesha and Hamid, N22

The researcher was repeatedly struck by the intensity of the father's focus on his partner during labour. On many occasions, she was deeply moved by the intimacy of the exchanges she witnessed:

Jo breathes quietly but audibly as the contraction comes. Ricky sits at the head of the bed, curled round on a pillow, cradling Jo, speaking very quietly to her. I feel so moved by the tenderness of this moment. Tears prick my eyes.

Fieldnotes Jo and Ricky, N23

Being in the role of non-participant observer enabled the researcher to make observations of the many small acts of thoughtfulness a father demonstrated towards his partner, which arose from his intense and undivided focus on her:

Dawn is kneeling in the pool, breathes quietly, looking down. Jack is at her side, flannel full of ice cubes, he presses it slowly and carefully onto her back and forehead. He is concentrating 100% on her...he is squatting by the pool – gazing intently at Dawn's face. She sniffs and Jack asks her if she wants to blow her nose. I think how attentive and aware he is; he goes to re-fill the washcloth with ice and continues to press it on different areas of her face; speaking very quietly, he says *Breathe, big breaths.*

Fieldnotes Dawn and Jack, N29

The respect and appreciation of how hard the woman is 'labouring' to birth the baby was expressed through these many small gestures of loving care and attention. On occasion it was also verbalised, by Will, for example, as the birth of their second child rapidly approached:

Will is very calm and focussed on Rae. He is watching Rae's face intently and says:
It's what you women do for us men.

Fieldnotes Rae and Will, N30

The sense of the couple travelling as companions on this journey, was articulated by Ayesha: 'I wanted him by my side. Nobody else! ...you can like –*share* the pain with your husband like that...he was there supporting me...' (Parents' interview, Ayesha and Hamid N22). Midwives' recognition of a couple's closeness led to the expectation that the father was best-placed to support his partner. However, labour is an unfamiliar situation for fathers; some struggled to translate this closeness and knowledge of their partners into practical ways of offering support.

5.3.2 Triadic mother-father-midwife relationship

From the point where the midwife became involved, a fresh set of dynamics developed. The father, literally and symbolically, 'handed over' some responsibility for the woman's safety and wellbeing to the midwife. Initially, the mother-midwife dyad took centre stage, with the father tending to take a step back. After the initial admission procedures, a core 'triangular' relationship of mother / father / midwife developed. This triad contained a range of 'pair dynamics' in addition to the couple's.

The father's personality and the couple's plans and preferences for labour impacted on the triadic relationship. There were also 'midwife factors' at play: different communication styles and ways of involving fathers. In each case, the midwife was meeting the couple for the first time. In the absence of a systematic approach to discussing the couple's expectations of the fathers' involvement, she was working out, mainly through reading cues from the couple, how they wished to 'play it'. One question was asked of all the first-time parents, regarding antenatal class attendance or the preparation of a birth plan. This was the most overt attempt to establish expectations.

5.3.2.1 Observation reveals the triadic relationship

The intimacy of the social situation of labour and birth was a powerfully-enduring finding revealed through observation. The researcher's 'outsider' perspective enabled her to observe the very close physical proximity that occurred when the midwife was caring for the woman, and which often included the father. A fieldnote sketch (Figure

12) shows the couple, midwifery assistant and midwife gathered into a space of a few feet, within half an hour of first meeting:

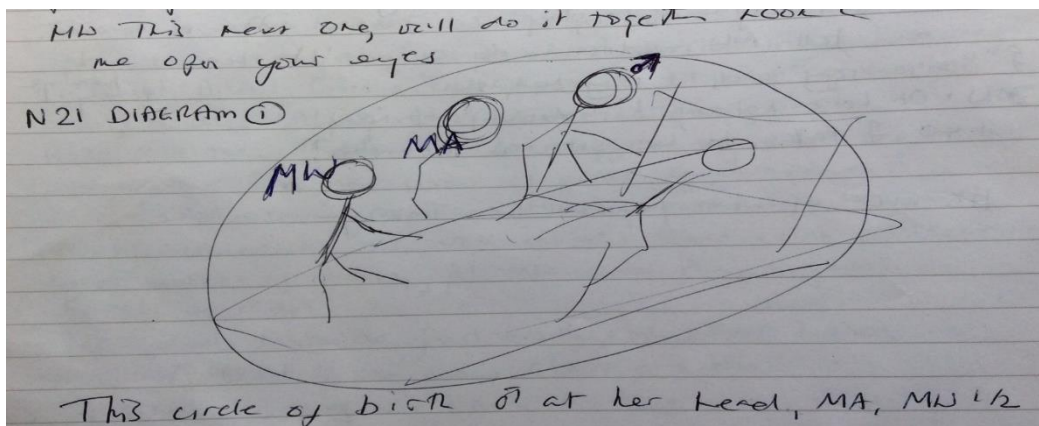


Figure 12 Fieldnotes Jill and Mick N21, sketch 1

The fieldwork sketches also identified an intense ‘triangle of communication’ between the couple and the midwife, often characterised by physical proximity. This is illustrated in Figure 13: the woman kneels on the bed encircled by her partner on her right and midwife to her left:

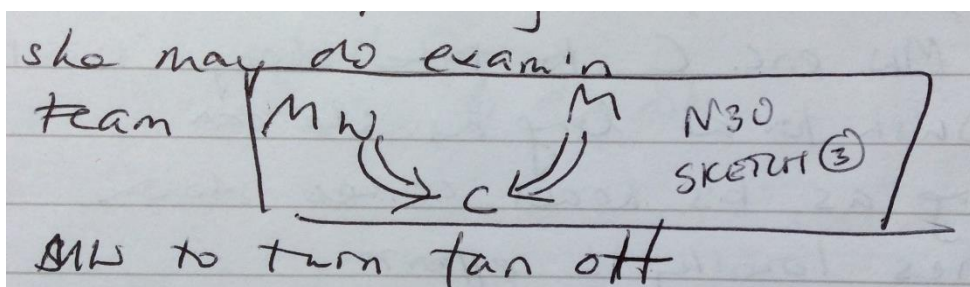


Figure 13 Fieldnotes Rae and Will, sketch 3

Although physical proximity between the key players was noted in most observations, there was one exception, as previously discussed and highlighted as a ‘variant case’. Hazel and Ben (N25) had decided before labour that both partners preferred Ben to remain at a distance (Figure 14). The midwife was keen for him to conform with her own expectations that he should be at Hazel’s side; she repeatedly encouraged him to move closer and when he maintained his distance, she perceived his behaviour as ‘very stand-offish’ (Midwife Sally interview, N25). When Hazel was in second stage, Ben periodically positioned himself nearer to her. The midwife’s comments in interview illustrated that she saw this as denoting his increased involvement.

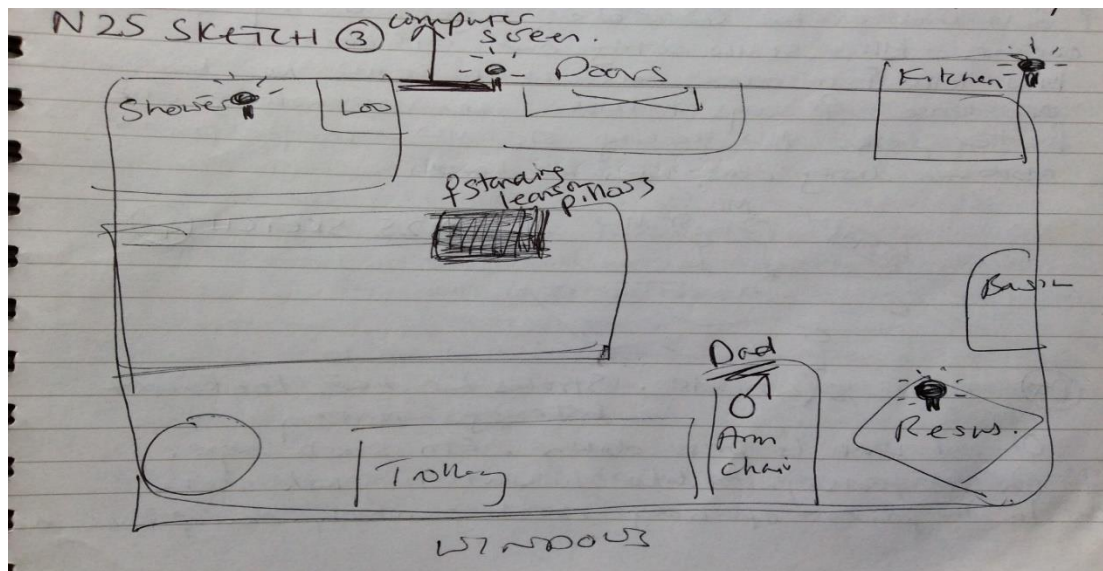


Figure 14 Fieldnotes Hazel and Ben N25, sketch 3

5.3.2.2 The midwife-mother dyad

Physical closeness and emotional intensity are ‘all in a day’s work’ for the midwife and taken for granted. The midwife’s concentration and powerful focus on the mother were observed to be qualitatively different in nature to everyday interactions. The midwife-mother dyad represented the primary relationship in some labours; for example Maria (N28) and Lou (N18) – both labouring at home - had the midwife as their primary physical presence for all or part of their labour, while the fathers were busy elsewhere in the house.

Where a multiparous woman’s labour was progressing rapidly, the midwife’s priority, verbal communications and clear focused attention was on the mother:

The atmosphere is very quiet and concentrated. The MW speaks *Everything’s alright, Jill. Have a bit of gas. Jill whimpers. The MW says, This next one, we’ll do it together. Look at me, open your eyes.*

Fieldnotes Jill and Mick, N21

In these scenarios, the father was also focussing intently, his attention divided between mother and midwife; he appeared to absorb everything the midwife was saying and doing. Later, during interviews, the fathers expressed that they had wanted the midwife to concentrate solely on their partner, as they knew the baby’s birth was imminent.

5.3.2.3 Recognition-seeking within the triad

Where there was less urgency for the midwife to prepare for an imminent birth, some fathers expressed a need for acknowledgement by the midwife. They wanted her to recognise

their couple-relationship, affirm their roles in supporting the woman (one father said he would have liked 'a pat on the back' from the midwife) and recognise that the birth marked a transition to becoming parent, for the father as well as the mother:

...maybe that could be something that a midwife would take on board, that - it's an experience of *two* parents, not one...

Parents' interview, Rae and Will, N30

Mothers looked for recognition of her partner's involvement and also evidence that he and the midwife were forming a rapport. It was important to women that they could relax and not feel worried about their partner's relationship with the midwife.

Some fathers cited the longevity of their couple relationship as evidence of how well the couple knew each other. They would have liked the midwife to draw on this knowledge. One father expressed this frustration:

We work together in all things, don't we? In *our* relationship – I mean – I'm 32 years *old* and we've been together over *half* of our lives...we were together when we were 15 years old, *nobody* knows Ashley better than *me*, you can guarantee...y'know, *nobody*. 'Cos I've known you for so *long*. And our relationship *works* that way.

Parents' interview Ashley and Graham, N27

He was disappointed that the midwife did not draw on his knowledge, both of his partner and how the previous labour had gone. Other fathers shared the frustration that Graham expressed:

'...for me, it was just an *under-utilisation* of a resource that was there in *front* of them, y'know, it was *in their face* – 'I am here! I am ready to help!

Parents' interview Ashley and Graham, N27

There were, however, marked variations in fathers' expectations. Some, like Will and Graham, sought high levels of involvement. Others were content to remain on the side-lines. (Ben, N25) described himself as being of 'the old school'; he did not want to impede the midwife by behaving '*...like an eager little pup*':

I think there's a place for – *dads* – and I don't think it's getting' in the way, and holding hands, and all of this. You let people do their *jobs*! '

Parents' interview Hazel and Ben, N25

Graham and Ben had very different approaches and expectations. However, the depiction of an 'under-utilised resource' could equally be applied in both cases. Midwives were not observed to explore fathers' expectations about their roles. A brief discussion between the midwives and fathers would have yielded useful insights such as those highlighted by the fathers above.

5.3.2.4 Three-way communications

During some labours, a triadic flow of communication was observed, illustrated in the fieldnote below, where father and midwives join in a chorus of encouragement:

MW Hayley: *I know it's really hard, you are doing so brilliantly*; Will comments *Even a professional says you're doing well*; MW2 encourages Rae not to resist the desire to push *Just go with it, let it happen*; quietly efficient, re-adjusts clip on baby's head unobtrusively, notes CTG, gives encouraging words with every contraction.

More 'duet encouragement' from Will and MW2:

Hayley: *OK go with it*

Will: *Go with it, focus on the breathing*

Hayley: *Do what you need to do. You can use the gas if you want to. Your body's just doing it. It's normal*

Will: *It's natural*

Fieldnotes N30 Rae and Will

These triadic dynamics conjured up an image of a 'circle of intimacy' created around the mother as she laboured. This circle worked to maintain the couple-connection within the public domain of hospital.

5.3.2.5 The circle fractures

If the woman needed to transfer to theatre for birth, this circle was fractured. The parents were separated, the midwife accompanying the mother to the anaesthetic room where she was prepared for the procedure. In theatre, a more formal circle was waiting, comprising the clinical players: the team of obstetricians, anaesthetist, theatre technicians and midwife co-ordinator.

The group of HCPs [health care professionals] once assembled in theatre, awaited the arrival of the mother, who was joined soon afterwards by the father. Each member of the team stood in a space that seemed to be pre-ordained, lending a more formal atmosphere, compared with the other birth environments. The focus was on the task in hand – the delivery of the baby.

Fieldnotes Dawn and Jack, N29

Between eight and ten HCPs were involved, causing the researcher to question the strict rules (which operate within most UK maternity services) regarding the number of people who can be present during a 'normal' labour and birth. Within the institution of the hospital, the presence of a large group of HCPs was sanctioned because each had

a clearly delineated role, the decision defined by clinical need. There was no discussion with, or explanation to, the parents.

The parents entered theatre from their separate rooms. The mother, transported on a theatre table, preceded the father, who was summoned when she was on the operating table. Following the fracturing of their close couple bond, when they were eventually 'reunited' in theatre, the mother was lying 'centre stage' on the operating table. The father was by her side, physically close, but at the periphery; in both situations, his partner stared upwards or ahead. He appeared to be an isolated observer.

There was no discussion of the father's role during the two assisted births in theatre. The fieldnotes record him as a helpless bystander, despite the occasional word or signal of reassurance offered by a midwife. There were clear implications for father-midwife communications, because her full attention was now on the procedure being employed to assist the woman to give birth, with minimal direct communication with the father. Following birth in theatre, the woman was taken to a 'recovery room' for a period of observation by the midwife. Both fathers reported in later interviews that this space also enabled them to 'recover' from the theatre experience. However, the trauma felt during the birth persisted and was expressed in later interviews.

5.3.3 A Greek chorus

For the three couples who had members of their social network present, the 'circle of intimacy' of mother / father / midwife expanded to include these people. The 'additional' birth companions formed an extension of the couple unit, moving in and out at different points, widening the circle around the labouring woman (Figure 15), and also offering support to the father. These couples had introduced social elements of their home environment into the hospital.

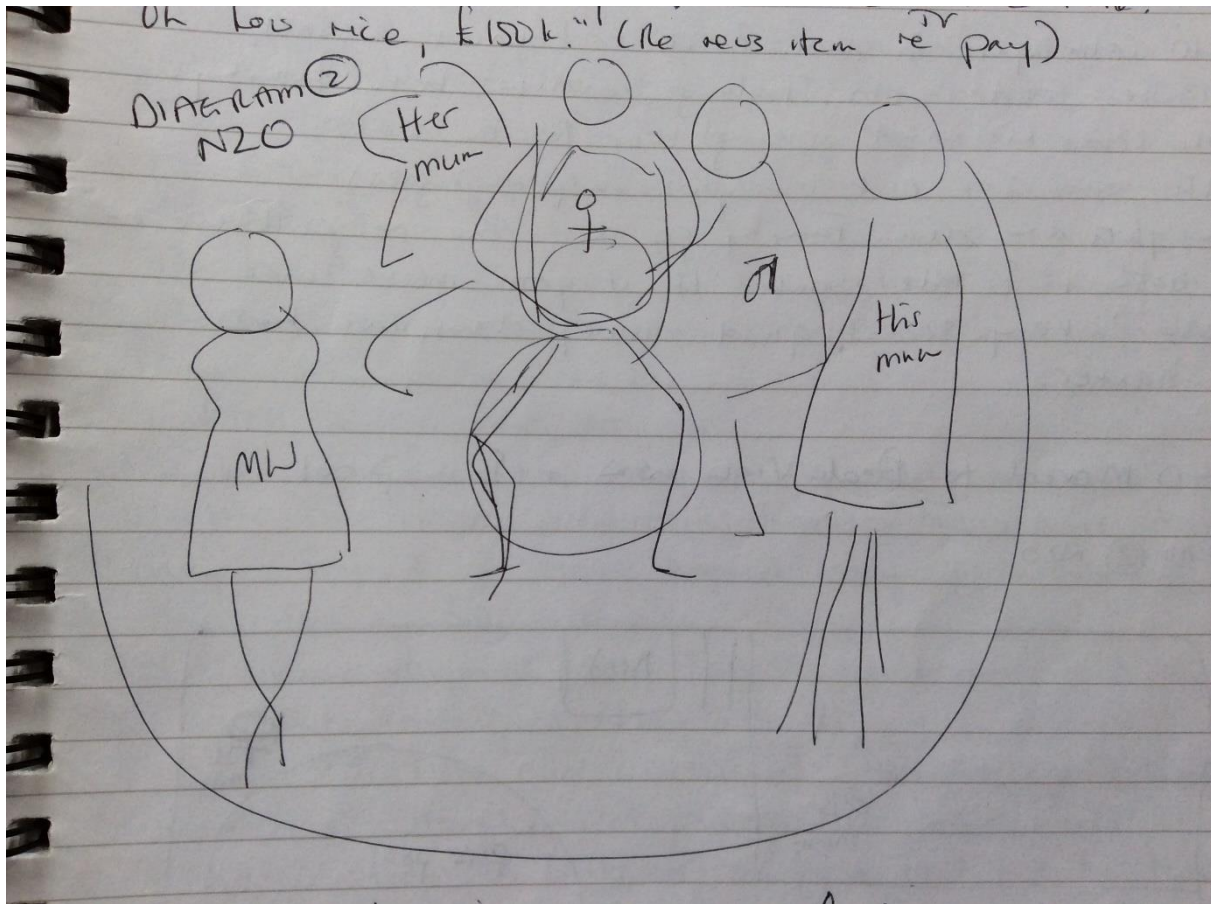


Figure 15 Fieldnotes Rosa and Dan N20, sketch 2

The fieldnote-descriptions and sketches called to mind an image of a Greek chorus. At the centre of the 'action' is the labouring woman, with the other 'actors' commenting on and describing the main action of the play.

She is encircled by people around the birth ball where she is sitting, feels sociable, but respectful of her and her labour, no general chat which excludes Dawn, it's all about labour, birth, her labour and small tips and comments, encouraging her to drink etc.

Fieldnotes Dawn and Jack, N29

The conversations in the birth space were muted and respectful of what the labouring woman needed. The atmosphere grew quieter as labour became more intense. The midwives caring for these couples commented on the excellent support provided by these extended family groups, and how well they worked as a team. The midwife was often at the periphery of this circle, and was aware of this, welcoming the support that the wider family group offered:

...you think of midwives jus' sitting on their hands and staying in the background, it was very much *their* experience and they were in charge of their own experience, I wasn't in the room dictating what went on, so I did *want* to be

in the background and let them get on with it, because they seemed to be doing such a good *job*...

Midwife Becky interview, Dawn and Jack, N29

The female circle of support of mothers, sisters, friends, midwives, plus the presence of the female researcher (all women who had themselves given birth) meant that in each situation the father was in a male minority. This seemed to cause him no discomfort; his focus was on his partner. The company of a group of women with experience of birth appeared to have a reassuring effect. The labouring women seemed to be relaxed and comforted by the 'normality' of the social support around them. Thus the 'home team' couple-partnership was strengthened by the presence of other supporters:

...when we was in the *big* room it felt better 'cos ev'ryone was there an' I think it's better with more people in, 'cos you've got support off say, Stacey, Laura and then me...I preferred it up in the bigger room...

Dawn and Jack, N29, parent interview

Comments and suggestions by the female birth supporters drew on their own experiences and demonstrated their shared female knowledge of birth:

MW Bryony and her Mum are one at each leg. Rosa says *I can't do it* and [Mum] Karen responds *We've all heard it, we've all said it. Once you've got the head out, the rest just comes.*

Fieldnotes Rosa and Dan, N20

Such comments were offered in an empathetic tone. Where this wider social support was absent and it was 'just' the couple and the midwife, the man was not able to fulfil this 'chorus' function. This was particularly the case during a first labour, if he was not getting from the midwife a sense of the progress and development of the labour course. He was then left searching for cues and clues. During two labours of second-time mothers (N27, N30) each father offered a constant flow of verbal encouragement to the mother, but this was focussed on reassuring her rather than commenting on events and progress. This verbal support was the father's chosen strategy, clearly not arising from the female experience of labour and birth. Rather, it was based on what had worked in the first labour, watching *One Born Every Minute* and the couples' wider relationships which involved high levels of verbal discourse.

Pre-birth discussions between the couple and their additional companions had included sharing expectations of the roles they would play. It was evident that these companions respected the centrality of the father's role in supporting the woman and welcoming their baby. One father felt that the unobtrusive support from both mothers had assisted him to step up and into his new role as a father:

I liked it! 'Cos then it *made* me – it *forced* me into – being a parent, whereas...I could've just let them – go ahead with it. I wouldn't know what to do now - with her [the baby]. So... It did help! They said that from the start. They wanted me to be next to her. 'Cos Rosa kept calling me when I went out the room!

Parents' interview Rosa and Dan N20

5.3.3.1 Midwives attitudes to 'additional' companions

Additional birth companions were present during three labours, two in hospital and one at home. All the midwives involved in care recognised that couples having the freedom to choose their birth companions was important in creating the optimum environment for the woman in labour. The woman was the midwife's priority and she viewed the father as the 'prime supporter'. Recognising the potential for the presence of other people to inhibit and displace the father, midwives needed assurance that this was not occurring. They were watchful that the father was not pushed to the periphery:

And then her Mum only stepped in...when she actually started to *cry* a bit, and...he wasn't quite sure what to *do* with her! Maybe he would've figured it out, but Mum came over didn't she, and kind of took over, and *hugged* her...

Midwife Tina interview, N18 Rosa and Dan

The midwife was satisfied that Dan was Rosa's primary support, with 'the mothers' standing quietly and attentively on the side-lines, only stepping in when he hesitated. Midwives valued these chosen companions for their social support, especially for the continuity they provided when transfer from one birth environment to another was necessary. Although the hospital's written policy was to limit the number of birth companions to two, midwives played an advocacy role in enabling this wider social support.

Once satisfied that the wider circle of support was working well for the woman and her partner, midwives welcomed the additional companions; they commented positively during interviews on the family support and highlighted the particular benefits of the presence of women who had themselves given birth. When midwives handed over care at the end of their shift, or if transfer to a different birth environment was required, they negotiated with colleagues for these additional companions to remain with the couple. Midwives therefore maintained 'territorial influence' over the birth space, working with the couple to create the optimal environment for these parents. The following chapter moves from a focus on birth spaces to how people, conceptualised as 'teams', function within them.

5.4 Summary box

- Birth is 'all in a day's work' for the midwife: for the father it is a rare and extraordinary experience.
- Different birth environments are on a continuum of familiarity for the father. Being on 'home turf' helps to mitigate the unfamiliarity of the world of birth. He has legitimate tasks with which to occupy himself. He is available, but not necessarily present in the room.
- Changes in location during labour are very stressful for the father as he has to orientate to the new environment.
- The depths of the father's stress and distress in theatre may go unnoticed.
- Couples are individual in their approach to birth; midwives may make assumptions about the couple's past experience and expectations regarding the roles of father.
- There is scope for midwives to make use of the father as a resource, especially in his knowledge of the woman.
- Where a couple has female birth supporters, their presence affords designated support to the father, and benefits both parents.

Chapter 6 Findings 2: Teams

6.1 Introduction

This, the second of three 'Findings' chapters, explores the following themes:

- Who's in the team? (Section 6.2)
- Types of talk and tools of communication (Section 6.3)

Section 6.2 explores in more detail the relationships at play within the birth space, and how they operate in terms of who is 'leading the team'. Section 6.3 analyses the tools of conversation and communication employed by the different players within the team.

6.2 Theme 3 Who's in the team?

In the preceding chapter, the couple was conceptualised as the 'home team'. The midwife's arrival and joining the team was welcomed; it appeared to ease the anxiety felt when the 'home team' was unaccompanied:

Hazel: I found that bit at the start, getting to four centimetres...that was horrendous, and actually I wonder if that was because there was *no support* – there was just us two, just in a room? If *she'd* been there, and talking you [Ben] through, and giving you that reassurance...

Parents' interview, Hazel and Ben N25

The midwife's presence and familiarity with the landscape of birth instilled confidence.

This appeared to confer a sense of security:

The family seems relaxed and maybe relieved that someone's kind of in charge now, as this midwife has a quietly confident and assertive manner.

Fieldnotes Dawn and Jack, N29

When she became involved, the midwife assumed the role of 'team leader', with leadership style influenced by:

- The midwife's approach.
- The midwife's assessment of the couple and family.
- The father's and the couple's expectations of his involvement.

These factors are explored below.

6.2.1 The midwife's approach

Conveying a sense of calm and 'normality' was a priority for midwives. From this shared starting point, a range of styles was identified.

6.2.1.1 The midwife leading 'from the front'

'Leading from the front' was adopted by some midwives as their signature approach.

This played out in the giving of clear instructions and information to the father. In

situations where this dynamic was observed, during later interviews the fathers expressed appreciation of this assured approach and gently assertive 'leadership style'. In observations, they also appeared visibly relaxed in response to the 'leading from the front' approach.

The circumstances of the labour impacted on the ways the midwife 'led the team'. At certain transition points in labour, a midwife was more likely to 'lead from the front', so she was clearly 'in charge'. This was most evident when a clinical situation required transfer from one birth environment to another. Midwives were observed to adapt their approach and adopt deliberate communication strategies to ease these transitions. Often occurring at a time when both parents were anxious and exhausted, the midwife leading from the front served to reassure them:

Jackie, the DS co-ordinator introduces herself to each parent and says, *I'm the midwife in charge*. She is smiley, calm, professional and imparts a reassuring air of being in charge.

Fieldnotes Jo and Ricky, N23

6.2.1.2 Facilitating, steering and working as a team member

Some midwives consciously adopted a facilitative approach to leading the team. This created an image of the midwife with a gentle yet firm hand on the tiller, steering and guiding the boat when necessary; based on the belief that

...part of your role as a midwife, is actually to know when to take a step back - when...a couple are working very well together...It's a bit like...the less interruptions you can give, if ev'rything's going to plan, the better. And leave the couple to do what they need to do, what... they do, the best.

Midwife Sue interview, Jo and Ricky N23

This 'steering' approach to leading the team was particularly evident where additional birth companions were present. Midwives expressed appreciation of the support these companions gave to both parents and valued the specific support afforded to the fathers. They also saw the benefit to themselves:

MW Tina comments to me after the family has left the room, *These are very good with her. It makes my job ten times easier.*

Fieldnotes Dawn and Jack N29

In these circumstances, midwives perceived themselves working as equal team-members with the father and other companions, taking pleasure in enabling and witnessing the family's involvement, and recognising the different types of support each person offered.

6.2.1.3 Midwives' strategies to engage father as a team member

Midwives enabled fathers' involvement in a range of ways. They expressed during interviews that providing clear, honest explanations and information was important in winning the father's trust. Open discussion with both parents was viewed as helpful, conferring a sense of involvement which respected the couple-relationship. For example, midwives used a discursive approach with the couple when there were decisions to be made about choice of analgesia. After giving information, the midwife encouraged conversation between the parents.

There was a specific type of communication which some fathers felt was lacking: they would have liked the midwife to 'think out loud' and describe the events of labour as they unfolded. The researcher noticed that during observations, she would find herself semi-consciously 'assessing' how the labour was going. As she observed the midwives at work, she assumed that they were doing the same: she noted that they watched and listened to the labouring woman, then – without speaking - made notes in the woman's records. This internal monologue comes from familiarity with the landscape of birth. Fathers desired information both about what was happening 'in the moment' and what the likely sequelae were:

I was *pretty sure* Shona [midwife] had already made her *mind* up a couple of minutes advance as to what was prob'bly gonna occur *next*...

Parents' interview Ashley and Graham N27

Fathers looked for explanations of the midwife's 'taken for granted' perspective.

In interviews, midwives highlighted how they engaged the father through suggesting practical tasks they could perform to support the mother; for example, by offering drinks and snacks, 'mopping her brow' and reminding her to pass water. Midwives were observed on occasion to teach measures such as back massage. The father responded eagerly if the midwife suggested specific tasks. Some midwives went further and helped fathers to read the woman's cues and to respond to these. This included support of a personal nature, such as a hug. Fathers in the hospital environment needed more encouragement to engage in these simple measures, compared with those at home. However, although midwives stated that they regularly involved and included fathers by giving them tasks to perform, observations revealed that this was not the routine occurrence that their reported accounts would suggest.

Midwives and fathers both highlighted that at homebirths, fathers had jobs of a practical nature. Midwives directed and instructed the father and gave specific tasks, for example assembling and warming clothes and blankets in anticipation of the baby's arrival, or fetching equipment from the midwife's car. In fulfilling these roles, the father was acting as a co-worker and team-mate for the midwife; each provided support for

the other. At home, the father was also observed to be taking the initiative and making suggestions. In hospital, where all the necessary artefacts for childbirth were in place, midwives were aware that they had to look actively for ways to involve fathers.

There was one singular task that every midwife in the study sought to 'delegate' to the father: the cutting of the umbilical cord. The symbolic importance of this significant act is discussed in the final 'Findings' chapter.

6.2.2 The midwife's assessment of the couple

On first meeting the couple during labour, the midwife reviewed the woman's handheld maternity record. This contained details of her medical history, pregnancy, an outline of her social situation and risk assessments of any safeguarding or domestic abuse concerns. She then sought to establish their preparedness for and expectations of labour.

6.2.2.1 Working out couple dynamics and wishes for father's involvement

In assessing how the father might wish to be involved, in addition to the one routinely-posed direct question regarding antenatal class attendance, midwives made a range of assumptions regarding the father's 'preparedness' for childbirth and the couple's wishes for his involvement. They relied on 'picking up cues' and noting the father's demeanour:

...he had obviously been through it, it was his third baby, so he knew some of what was –*occurring*, unlike some of the dads that come in...

Midwife Siobhan interview, Jill and Mick N21

Midwives were aware of this process of 'picking up' and 'sensing' couple's expectations regarding father involvement, describing how, 'you sort of piece everything tog' – I mean, not *consciously* piece everything together...' (Midwife Jayne interview, Lou and Donal N18). The subtle process of picking up cues continued throughout labour. It was one of the elements of midwife-father communications that was identified as nebulous and difficult to define. Post-birth interviews revealed that in some instances, the midwife had interpreted the father's cues accurately. The interviews also demonstrated fathers' awareness that, for the midwife, it was potentially challenging to undertake this rapid assessment of the couple:

Ben: ...*is* it the midwife's role to say, well, does dad want to sit and join us as well? And, does *dad* know what's going on? But I don't know if that *is* the midwife's role, because that might be part of the *relationship*-dynamic of the *couple*?

Parents' interview Hazel and Ben N25

Sensitive direct questioning to explore expectations would be helpful in revealing, clarifying and exploring the potential for father-involvement.

6.2.2.2 Midwives' views on fathers' involvement

Midwives expressed that they did perceive facilitating fathers' involvement as part of their role, although they may not have engaged the father in direct discussion of his expectations. However, the mother's needs were foregrounded by midwives, who viewed the primary reason for the father's presence as being to support his partner. Midwives assumed that as the person who knew her best, he would be the best support to her. Many added a caveat that the father's contribution should not compromise the mother's wellbeing, for example by offering over-enthusiastic support in the second stage of labour. When this occurred, the midwife felt she was in the difficult position of needing to intervene, which was done with sensitivity.

Midwives affirmed the supportive benefits, to the woman, of the father's physical presence, especially when he was actively participating (by helping the mother to move around, for example) and offering verbal encouragement. They also valued the father's emotional involvement and sensitivity to what his partner needed in terms of moral and practical support:

...and Jack...was just really focussed on her, he used a *lot* of positive language – with her...*'you can do this'*... he kept on putting the icy flannels on her head, he was very attentive to her...

Midwife Becky interview Dawn and Jack N29

Midwives recognised that as the father supported his partner, the couple was working together as a team. This sense of camaraderie between the couple as they experienced labour together was seen as evidence of shared endeavour and achievement, perceived to strengthen their bond. Midwives also highlighted that participating in this shared experience enhanced their job satisfaction.

The presence and positive input of the father was also framed in terms of his value to the midwife. Several described the father as 'a useful resource', of practical help in keeping the woman company and contributing to a positive birth experience for all members of the birth triad. However, midwives' priority was that the father had a role in supporting the mother. They perceived this as his primary reason for his presence.

6.2.3 Fathers as team members

Each father had different perceptions of his role and expectations about his involvement. These influenced how he related to the midwife and how the roles of the various team members played out. Each contributed in his own way to the work – both the physical tasks and the emotional support - of caring for the woman in labour. A father's previous experience, his preparation for labour, his personality, confidence in communicating with health professionals, the nature of the couple relationship and the presence of other family members were all factors that impacted on his

communications with the midwife. There were also individual life experiences that shaped fathers' expectations: one had grown up on a farm, for example, which shaped his perception – offered in a pragmatic tone - that childbirth 'isn't pretty'.

6.2.3.1 Fathers' expectations of involvement

Fathers who had been present at the birth of one or more previous babies, had retained detailed memories of previous births. Couples had discussed what had worked well; past experience influenced their expectations, including about how they would work with the midwife.

During observations, three of the fathers demonstrated a very clear, active involvement in supporting their partner during labour, displayed by a continuous flow of verbal encouragement. The midwives at these births focussed most intently on the mother, possibly judging that the father was confident in his role. All three fathers mentioned during interview that they saw this active involvement as central part to their role, illustrated by Will's comment: 'I was jus' purely trying to be the *positive* gang...'
(Parents' interview Rae and Will N30).

Observations also revealed an equally intense but quiet, unspoken, 'solidarity' support, particularly during the labours of the couples having third and fifth babies and also for two of the four couples having first babies (Rosa and Dan N20; Hazel and Ben N25). For Mick (N21) and Hamid (N25), their intense and mainly silent focus on their partner seemed to emanate confidence:

Ayesha half-sits, half-lies on her right side, propped up on the bed. Hamid sits next to her and watches intently as she rocks to and fro and breathes the gas and air. She reaches for his hand. His eyes never leave her face.

Fieldnotes Ayesha and Hamid N22

This was tinged at certain points with anxiety, contained and not expressed:

The heat's back on, the MW left the room to adjust it, I think, in anticipation of the baby. She puts her apron on, and pumps the bed higher, *Just in case!* She is smiling. Ayesha and Hamid are more or less at a level with her now. The MW notices Hamid listening to the baby's heartrate on the monitor and she explains that because the baby's head is 'coming down', the heartrate drops. Hamid looks reassured.

Fieldnotes Ayesha and Hamid N22

There was a continuum illustrating two contrasting approaches to support in labour, which had implications for communications with the midwife. At one end sat the reserved, observant, watchful individual; at the other stood a more extrovert, actively-

involved father, who offered a flow of verbal encouragement as an integral part of his support. In interviews, midwives recognised the benefits of both approaches and all the gradations in between. However, they reserved the highest praise for those fathers who remained physically close; this proximity was especially valued and seen as denoting ideal support.

Some fathers chose to take their place on the side-lines. Ben, for example, perceived the midwife as very experienced: 'I picked that up off her straight away. I thought, you can leave this lady to do her job!' (Parents' interview, Hazel and Ben N25). For Maria and Dave (N28) their 'work' during labour split very clearly down gender lines. In explaining their rationale for choosing homebirth (their fifth child and third homebirth), Dave commented, '...it's easier. [Coughs] We're only giving birth, everybody else does it...' In response to Dave's apparently casual attitude to childbirth, Maria retorted:

... (*Laughing*) There's no 'we' in it mate! (*Laughs again!*) That's a *man* point of view that, i'n't it? Ey! (*Said to researcher in a bit of a conspiratorial tone*)

Parents' interview Maria and Dave N28

Dave's interactions with the midwife were confined to carrying her equipment upstairs and offering her cups of tea. He demonstrated confidence in the midwives' care for Maria and was happy to 'leave them to it'.

6.2.3.2 Working in tandem with the midwife

During fieldwork, there were many instances where midwife and father were seen to be caring together for the mother. They worked in harmony and responded to what the woman needed on a moment-by-moment basis. With father and midwife equally focussed on the woman, there was a wordless communication occurring; they worked together quietly and seamlessly, as a team:

Jo is violently sick into a plastic mixing-shaped bowl held by Ricky. Lynn sits on the bed, clean bowl at the ready, which she exchanges when Ricky passes her the full bowl. Lynn goes out to empty it.

Fieldnotes Jo and Ricky N23

This midwife-father teamwork also involved verbal support for the mother; midwife and father alternated in their words of encouragement, in a chorus endorsing her efforts:

MW Melanie: *OK go with it*

Will: *Go with it, focus on the breathing*

MW Melanie: *Do what you need to do. You can use the gas if you want to. Your body's just doing it. It's normal*

Will: *It's natural*

Rae: *When can I start pushing?* MW2 explains she may do an exam (*i.e. a vaginal examination*)

I note it feels like a team and draw a diagram with Melanie and Will circling Rae

MW Melanie to Rae *If the urge is really strong, give me a push into your bottom*

Will *If you need to push, then push*

Sounds in room – pulsing of baby’s heart on monitor, Melanie and Will’s voices at same tone and level, quiet, reassuring, duet-patter

Duet of quiet encouragement for Rae continues from Will and Melanie

Fieldnotes Rae and Will N30

This partnership of support was noted by women in labour, illustrated by Rae’s comments below. She distinguished between the role of ‘the professional’ and that of her partner and valued both. Each conferred a sense of security, the midwife from her clinical role and experience and Will from his familiarity and their closeness:

Will was *next* to me, holding me hand...having the midwife on the other side, is also quite important...that professional support...when you’re in a situation like that, when you’re in so much *pain*, you can only really pick out certain voices, and I’m obviously searching for *Will’s* voice...if the midwife said something and [I] didn’t necessarily *hear* it, having Will repeat it or say it as well...it *definitely* did help, yeah.

Parents’ interview Rae and Will N30

Midwives also acknowledged this ‘partnership of support’ and commented positively on occasions when a woman responded to her partner’s voice in preference to their own. This affirmation demonstrated that midwife and father had a shared focus on the woman in labour and also the midwife’s recognition of the couple-relationship.

6.2.3.3 Father takes his lead from midwife

During fieldwork, fathers were seen watching the midwife intently, and listening carefully to what she was saying. It was unusual for a father to ask the midwife a direct question. Instead, he was picking up cues and clues as to how the labour was going. He was also seen and heard to be mimicking the midwife, as illustrated in the fieldnotes above (Rae and Will N30). Will hoped to be ‘*a good co-pilot*’ (his phrase) with the midwife. He emulated not only her words, but her actions. When he noticed she had put an apron on, remembering from the first labour that the midwife donned an apron when birth was imminent, he asked the midwife if he too should have an apron to wear. There was surprise in the midwife’s voice and expression as she replied to this request. When she responded positively, passing Will an apron, he saw this as affirmation of his role. The midwife commented during interview that ‘...*the apron would*

have shown he had a useful part in the proceedings', demonstrating her awareness of the symbolic value Will attached to the wearing of an apron.

6.2.3.4 Father seeks inclusion and affirmation by the midwife

Affirmation of his role by the midwife was important to some fathers. Midwives' comments during interviews demonstrated they recognised and valued the father's emotional and practical support for the mother, using phrases such as, *'he was doing a brilliant job with her'*. In labour, they made similar affirming comments to the woman, praising their partner's support. However, such comments were very rarely directed to the father. Those who sought endorsement of their role, would have appreciated this affirmation during labour itself. For every father, the woman was his priority, but for some there was also an unmet need for encouragement addressed to him personally:

I could really have done with some of that reassurance as well ... *'You're doing the right thing. Keep her calm. Keep going. You're OK.'* Just that *calm*, kind word towards you to say, *'You're doing the right thing. She's doing well'*.

Parents' interview Ashley and Graham N27

These fathers sought what one described as 'a bit more man-management' and 'coaching' from the midwife, to supplant the 'guesswork' he was engaged in. The tangible elements of father-support (for example, offering comfort measures) were more easily 'measurable' than the less tangible, unique emotional support the father's presence brought. Fathers looked for reassurance and affirmation of this type of support. Individual encouragement symbolised recognition by the midwife of his own experience of the birth and transition to fatherhood.

6.3 Theme 4 Types of talk and tools of communication

This theme explores the 'types of talk' employed by midwives and fathers (for example, social 'chatting', banter, information sharing) and the tools of non-verbal communication observed. It encompasses how midwives communicated and engaged with fathers - how the relationship was initiated and how it changed and developed over time. The relationship between mother and midwife is clear and defined. A student midwife participant commented in a wry tone, '...at University it's drilled into you, it's 'woman-centred, woman-centred, woman-centred'. She went on to express that as a first-year student, she felt she could have been better prepared for relating to the father (Student midwife Kirsty interview, Jill and Mick N21).

6.3.1 Factors influencing communications

The midwife's primary focus for communication was the mother. The extent to which the father was included depended on several factors (Figure 16). Each of these is explored in more detail below.

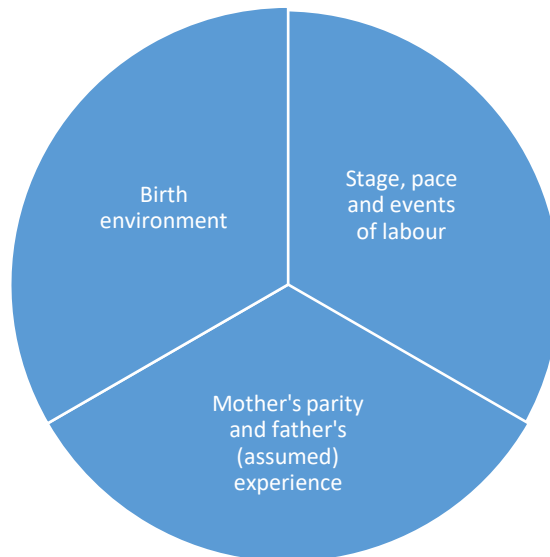


Figure 16 Factors influencing midwife-father communications

6.3.1.1 The stage, pace and events of labour

The pace of the early stages of a first labour afforded the opportunity for the social chatting, birth-planning and rapport-building described in the following section. In the rapidly-progressing labour of a woman who has given birth before, however, the midwife could often do no more than glance at the father and offer the occasional word of reassurance, as she focussed on the mother and the imminent arrival of the baby. During the rapid, intense birth of Jill and Mick's third baby (N21), the midwife, student and Mick formed a close circle of concentrated support around Jill, with few words being exchanged. Then followed several hours' delay before the placenta was eventually delivered, during which the midwife deliberately engaged in 'social chatting' which included Mick. This was designed to distract both parents and to relieve anxiety, and illustrates how the unpredictability of events during labour require flexibility and adaptability in the midwife's approach to communications:

...Jill was talking to Mick, and we were chatting about – lots of different things. About *teaching* and...similar age gaps between children and stuff like that...the fact that he looked like his Dad, and that he looked like he might 'ave a bit of red 'air...

Midwife Nancy interview Jill and Mick N21

Midwives were aware of deliberately adopting a different communication style in response to events during labour, particularly when there were warning signs of problems or in emergency situations. In these cases, they needed the parents to understand and follow the instructions they were given.

6.3.1.2 Mother's parity and father's (assumed) experience

The mother's parity and father's (assumed) related birth experience impacted on midwife-father communications. Four couples were having first babies; during these labours, midwives engaged in more detailed explanations and a higher level of information-giving than for those having subsequent babies. The assumption was that all the 'experienced' fathers had been present at the births of their previous children; in fact, this was not the case. Therefore, the mother's parity was not an appropriate measure of the father's experience of birth. The father's experience and expectations can only be accurately gauged through dialogue, which was not observed as a usual part of birth-planning, either during pregnancy or in labour itself.

Two of the fathers present at the birth of their second baby were surprised at the rapid progress of the second labour. Both expressed what a difference this faster and more intense experience made for them. One described finding it hard to 'keep up' with what was happening and so feeling '*...behind the ball on it*'. Both fathers engaged in an almost constant flow of verbal encouragement for their partners. The midwives perceived each as very supportive and expressed this during interview. Yet these fathers' outward appearance of confidence belied their underlying need for reassurance and affirmation. Midwives noted the apparent self-assurance and calm demeanour of the two third-time fathers; it may be that previous exposure to the sights and sounds of labour habituated these fathers, so they were able to control transmission of their own anxiety.

6.3.1.3 The birth environment

When labour took place in hospital, the midwife was in familiar territory, whereas the father was in entirely or relatively unknown territory. The dynamics within the different birth environments and the father's concomitant degree of control and involvement have been discussed previously; they are illustrated below by findings comparing home and hospital.

The impact of being at home and in the role of 'host' rather than visitor, generated more personal types of 'social chat' between fathers and midwives. These chats were often triggered by the couple's home environment, which prompted the midwife to engage in different topics of conversation with the father:

Lou asks Jayne (MW): *Do you prefer homebirths?...in response, Jayne says, Yes! How much fun is this?* Am struck again at the party-atmosphere. The two MWs and the parents are chatting about food and cooking – Lou's a vegetarian; Donal hates Quorn...One of the MWs comments on the many photos of their wedding, that are displayed on the walls and asks where they got married? *Sienna! It was lovely! 40 people went for a week and they had a few days longer. Lou and Donal talk happily about their time in Sienna and their marriage We partied for a week. It was fabulous.*
Fieldnotes Lou and Donal N18

The father contrasted this 'personal' chatting with his previous experience in hospital. He described his relationship with the midwife during the first birth:

...in hospital...I don't remember...apart from making a bit of 'chit-chat' (at which Lou intersperses: I don't remember any chat!) – I think we had a bit of chit-chat in hospital. But they came in, did blood pressure, and then they disappeared for a bit. Sort of floated in and out.

Parents' interview Lou and Donal, N18

In hospital birth environments, the range of topics covered whilst 'chatting' during labour was less wide ranging and tended to be limited to brief conversations about the forthcoming baby and any older children. Various extrinsic factors therefore impacted on midwife-father communication. Within these variations, the starting point for all midwives was the building of rapport with the parents.

6.3.2 Building rapport

When midwife and couple met for the first time, the foundation stones were laid for building the rapport that developed in labour. The researcher soon identified how very different the parents were from each other; midwives' styles and approaches were equally varied. They displayed skills and versatility in responding and building rapport quickly, with all these different people.

6.3.2.1 Initial assessment in labour

At the first contact, the midwife's priority was to perform a 'labour assessment', through a combination of observing the mother's behaviour, carrying out physical checks and asking questions. This process of assessment was much more complex than it first appeared. Different 'types of talk' and non-verbal communications occurred simultaneously, with the father involved and engaged to varying degrees, both through occasional direct comments from the midwife and non-verbal acknowledgment of his presence. To explore the complexity of these interactions, the three 'types of talk' depicted below (Figure 17) are explored in more depth. The three were interwoven,

therefore some overlap and cross-referencing occurs.

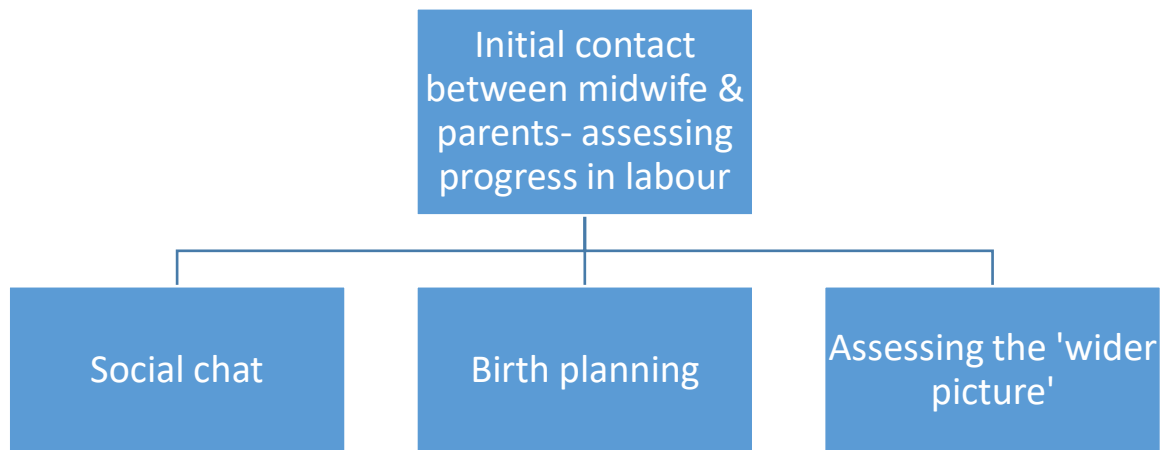


Figure 17 Types of talk during initial assessment in labour

6.3.2.2 Social chat

Informal 'chatting' was the predominant 'type of talk' adopted by the midwife. This was especially apparent in the early stages of labour and when first forming relationships with the parents and other people present. Midwives highlighted that building rapport with parents was a priority. They saw it as an integral part of their role, rather than an 'optional extra' task. They recognised the importance of 'first impressions' and the tenor of these initial conversations. The following extended fieldnote extract illustrates the midwife engaging in 'social chatting' as she carries out her labour assessment. She included the father, gaining a sense of the 'wider picture' through noting his involvement and awareness of events:

Arrived at Triage, where the parents are in a very small side room, the door shielded by disposable pleated curtains. In the room are a Student MW Chloe and MW Leila...

Hamid sits at the left side of the head of the bed, on a hard plastic chair. He stands and indicates to me to sit down when I arrive; I decline and after the 'hellos' check if it's OK for me to stay in the room during the admission procedures, which include a vaginal examination. Ayesha is fine with this so I go and stand behind the blue pleated curtain, between the large bin and the basin. The room is very cramped and it's hard to know where to put myself.

There's a little conversation going on between [midwife] Leila and Hamid about the implications in an Asian family of being the 'middle child' and only daughter, with a brother on each side. This is Leila's position and she identifies that when this baby is born, (expected to be a son), the couple's daughter who's just 6, will also be 'Daddy's princess'.

After the Student MW has examined Ayesha, the MW repeats the examination *to confirm findings*. I have moved to stand next to Hamid. The MW sits on the bed to do the examination and she has completely covered Ayesha's abdomen and legs with a draw sheet, so no part of her body is exposed. I wonder if this is Leila's usual practice? I must ask her.

Hamid sits holding Ayesha's hand as Leila does the examination. He looks calm. Ayesha is very relaxed and there's a conversation about whether the membranes have ruptured?
MW says: *You're sitting in a puddle* and Ayesha replies, *As long as it's a good puddle.*
The MW asks what time Hamid was woken up and he replies, *About 6-ish.*
Ayesha turns onto all-4s for a contraction.
The MW's asking lots of questions, trying to establish when the waters have gone...
Fieldnotes Ayesha and Hamid N22

During fieldwork, fathers' attentive watchfulness was frequently witnessed: listening closely as the midwife carried out her initial assessment of the mother and gave explanations to the mother or the student midwife.

Midwives described the qualities they engaged in building rapport, seeking to be courteous, helpful and understanding whilst maintaining a balance between professionalism and friendliness. They sought to be approachable and available to both parents, achieved in part through striving '...to address everything to both of them...as much as you can' (Midwife Sue interview, Jo and Ricky N23). Honesty and openness were cited as necessary in building trust.

Social chat was usually initiated by the midwife. In hospital, 'social chatting' with 'multiparous' fathers centred on the other children; for first-time fathers it involved questions about preferred names for the baby, and whether the parents knew the gender from the scans. Instances of the father initiating social chat or reciprocating by asking the midwife questions about her own life were rare and limited to homebirth.

Banter and humour were used by some midwives in an attempt to lighten the atmosphere. One described how she liked to,

...make a *joke* of things... *'Don't think you're gonna be sittin' there with yer feet up all night while I'm doing all the running around, y'know...This is your baby... I always try and get the Dads to do it and I always say that's either job share or 'For God's sake, I've got me hands full here, don't you think I've done enough...you do that'.*

Midwife Shona interview, Ashley and Graham N27

The 'social chat' and banter used to build rapport with the father often had this light-hearted and sometimes jocular tone. Midwives appeared to use 'standard scripts' that were noted in different observations and adapted to suit the circumstances. As labour progressed and became more intense, the social chat usually subsided, replaced by communications focussed on the mother.

Fathers varied in their responses to this 'social chatting' type of talk; most welcomed it and responded in kind. However, on occasion (Ayesha and Hamid, N22), the father's reaction was discomfort. Ethnography revealed the complex reactions of the three

members of this birth triad to 'social chatting'. This father viewed 'chatting' as a distraction from the main focus of the midwife's attention, which he felt should be on his wife:

There were *considerable* interaction... when they were actually engaging with me, I did not know how to engage back! There were certain communications, which I thought were essential...which I could really appreciate – to tell me, what is going to *happen*. But where they were trying to just *chat* to me in terms of *other things*...those things were –at *that point* – foreign to me. My concern was her!

Parents' interview Ayesha and Hamid N22

The midwife's aim was clear: 'I think I probably made him feel a bit more at ease because I was talking to him about other things' (Midwife Bryony interview). Ayesha very much appreciated the chatting that went on between Hamid and Bryony; before they started 'chatting', she described feeling 'pressured' to engage in social interaction:

I was *trying* – to calm the mood in between...throwing in *jokes*, though I'm not in the position to throw in any jokes, but still I'm trying to. Because she [midwife] *sitting there*...looking at the charts and stuff. I just felt that...she was *waiting for me*. So I was like in kind of a *pressure*, because she was not talking...when she started talking to *him*, I was more relaxed... because at least they are *talking*. And the limelight would've been away from me, that *I have to do something!* When she was talking with *him*, [I] was more relaxed. *OK they're conversing, and they're OK. They're fine!*

Parents' interview Ayesha and Hamid N22

This vignette illustrates the fine balance between the midwife focussing on the clinical care of the mother, which is what Hamid wanted, and creating a relaxed atmosphere through social interaction, which is what Ayesha valued. It also illustrates the importance to the mother that her partner and the midwife have a harmonious relationship.

Social chatting and building rapport with parents are elements of the 'taken for granted' work of the midwife. Rather than being taught as part of the formal curriculum, the skills are 'picked up', as students watch experienced practitioners engage with parents. Observing a new student midwife who appeared awkward when left alone in the room with the parents after the baby's birth, the researcher reflected:

When and how do we learn as MWs to relate to parents through chatting? About how to create and build rapport? And become habituated to the very close physical proximity that our job involves?

Fieldnotes Jill and Mick N21

6.3.2.3 Birth planning

The midwife's direct question about antenatal class attendance formed the basis on which she engaged in 'birth planning' during the initial assessment. Classes were viewed as 'officially sanctioned' preparation for birth, as denoted by the response being

recorded in the maternity records. Fathers were not asked if they had other children, or about attendance at previous births. If the woman was primiparous, it was assumed this was also the father's first baby. First-time fathers were perceived as needing some guidance; in comparison, female birth companions who had given birth themselves were assumed to be equipped to support a woman in labour.

The question about antenatal class attendance was reserved for first-time parents. It differed from other direct verbal interactions, because it often involved communicating with the parents, as a couple. Surprise was expressed if a couple expecting their first baby had not accessed classes. An affirmative response to the question shaped the midwife's assumptions about the couple's expectations for labour and how the father might wish to be involved. This was particularly the case with hypnobirthing, which prepares the father to be the channel of communication between the midwife and the mother, based on the principle that this 'protects' the mother from interruptions that may intrude on her state of hypnosis. For 'multiparous' parents, the midwife assumed that the father had been present at a previous birth and that this sufficed as preparation.

It was assumed that a father who had attended classes would be confident about supporting his partner. One midwife explained: 'a *lot* of men that've been to NCT, or Active Birth Workshops, they will just *do it!*' (Midwife Sally interview, Hazel and Ben N25). When Ben (who had participated in classes) did not meet this expectation, the midwife was surprised:

...I felt as though, when I first *met* him, his eyes were...sort of *glaring* at me, as if to say, 'Help me!'...his eyes were very *intense*, and I'm thinking, *Oh my goodness, what's happened here?*

Midwife Sally interview, Hazel and Ben N25

Some midwives also asked about other types of 'informal' preparation, such as watching *One Born Every Minute*, reading books and accessing websites. Parents' responses were not noted.

6.3.2.4 Mutual assessment: receiving and transmitting impressions

On first meeting the couple, each midwife assessed the 'wider context'. They referred to 'picking up' how the father wanted to be involved:

...you go in and introduce yourself and kind of get a bit of a *feel* for the family environment that you're coming across, and then, just tentatively...I don't know – try and *guess* what they want from you, and...build a relationship that way...

Midwife Lynn Interview, Jo and Ricky N23

While the midwife was 'trying to guess' what the parents expected from her, she was aiming to create a calm and reassuring environment, and thus to make 'safe' this

labour-situation, through her interactions. Midwives recognised that the unfamiliarity of the situation was a potential source of anxiety for the parents. While the mother was busy focussing on the labour and birth, the father was in a state of hyper-vigilance, on 'high alert' and trying to make sense of an unfamiliar experience, which he may see as potentially fraught with danger. One father recalled, '...I was sort of constantly worried' (Ricky, N23). The midwife recognised that her own confidence in the birthing process, as well as her skills in creating a calm atmosphere and adapting the birth environment helped the parents to relax.

As the midwife cared for the mother and picked up cues about how the mother and father 'presented', at the same time, the father was assessing the midwife and her ways of being and doing. The process of mutual assessment, as midwife and father 'weighed each other up', usually took place in the background as the mother focussed on her labour, although this was not always the case; some women remained sociable and chatty in demeanour throughout labour.

Whether or not the mother was ostensibly involved in interactions that were going on, she nevertheless had a clear investment in the midwife-father relationship. She recognised that a harmonious working relationship between father and midwife was of benefit to her and the progress of her labour. It was also an expression of women's concern for their partners' wellbeing; even when they were going through labour and birth, they were reassured by this harmonious relationship. One mother commented to her partner during post interview, 'I needed you to get on with them' (Rosa and Dan, N20). At times when a mother was unable to engage with the midwife, the father fulfilled this role. The woman was aware of them communicating and noticed their relationship.

There was a wide variation in fathers' hopes and expectations around communications with the midwife. These ranged from an attitude of 'ignorance is bliss' and deliberately leaving the midwife to get on with her job, to actively seeking information and collaboration. During interviews, fathers repeatedly expressed faith, trust and confidence in the midwives. When fathers summed up their impressions of communications, they were likely to express that the midwife was 'very good' overall, and that he 'couldn't fault her'. There seemed to be a low expectation of direct communication because the father prioritised the care of his partner over everything else.

6.3.3 Dyadic communications

In planning the study, the midwife / mother / father relationship was envisaged as a triad; this was reflected in the ethics application and protocol. In fact, during

observations and interviews, a pattern of a series of dyadic communications became apparent, including the couple relationship, midwife-mother, midwife-father, father-researcher. This section focusses on the father-midwife dyad, with a brief reflection on father-researcher communications.

Every father had differently nuanced expectations about his role and how he would interact with the midwife. This highlights the importance of the midwife facilitating an open conversation with the couple. All shared a desire for the midwife's main focus to be on the woman, but varied in their needs for information, 'updates' and support.

Some fathers felt they were undeserving of the midwife's attention:

...my main part was...that they was looking after *Lorraine* properly! You know... (*laughs and sounds a bit embarrassed / unsure*) – I'd rather they focus all their attention on *Lorraine*, and make sure her *and* the baby's...doing well. Rather than – 'ave to worry about, 'Oh, well, actually, how are *you* doing Dad?'

Parents' interview *Lorraine* and *Darren* N26

6.3.3.1 Direct father-midwife communications

In the early stages of labour, there were direct verbal communications between the father and a midwife, via the first telephone contact with maternity triage. This was the first step in the symbolic 'handover' of the mother's care from father to midwife:

...I rang *Triage*, and I let them know that you were in *labour*. And they took some details from me, for example the amount of *time* between *contractions*, and they wanted to talk to *Jo*, but she was throwing *up* at the time...and then she spoke to *Jo*, and took similar sorts of information...

Parents' interview *Jo* and *Ricky* N23

Fathers were perplexed that, having relayed information to the triage midwife on the phone, their partner was then asked to repeat it.

During labour, there were rare instances of the father addressing the midwife directly. These usually involved questions about timescales. When a father did communicate directly with the midwife, she responded to him:

...if I had a question, it was answered, in the same was as if *Rae* had a question it was answered. The midwife didn't treat me any differently than she treated *Rae*.

Parents' interview *Rae* and *Will* N30

As previously noted, birth environment was significant. When in his own home, there were more examples of the father initiating conversation.

There were also occasional instances of the father advocating for the woman (e.g. over choice of analgesia), but these were unusual: an interesting finding in light of the 'advocacy' role which is strongly promoted in antenatal classes and on birth websites.

Fathers who had anticipated being an advocate, but in reality found the intensity, uniqueness and unfamiliarity of the birth experience rendered this role impossible, were left with feelings of failure and inadequacy.

6.3.3.2 Fathers listening and learning to navigate unfamiliar terrain

A key communication strategy used by fathers was listening. This was an important approach in building up a picture of what was happening. It was one of the actions taken to learn about childbirth, make sense of events and increase skills in supporting the mother. This included listening to what the midwife was saying, even when her remarks were addressed to the mother, rather than to him. Fathers valued being included in such conversations.

Fathers also practised 'listening in' when a midwife was talking to a colleague and the conversation did not ostensibly include the parents. Examples included during 'handover of care' from one midwife to the next at a shift change and when a midwife provided detailed teaching to her student. Midwives were aware that fathers 'listened in' and identified this as a strategy they could use at critical moments to communicate key points indirectly. The following example (a telephone call between the midwife at a homebirth and the delivery suite co-ordinator) demonstrates the father's awareness that he was 'allowed' to overhear the conversation, which took place on the landing outside the bedroom. He wondered whether this was a deliberate strategy on the midwife's part:

...strangely, the most information you get is where she had to call in!...because though she'd just go outside the *room*, I could...*hear* that she was saying, 'Oh, she's *struggling a bit* ...'low ketones'. I remember thinking I didn't want Jo to hear this, so I'd try and just *talk*. I was *pretty tired*, so I didn't really know what to say, I'd just try and talk *loudly* at Jo, so she couldn't hear...I don't know like the reasons *why*, but it just felt...she communicated a lot more *to* them...

Parents' interview Jo and Ricky N23

Fathers also listened to the woman, to what she said and the sounds she was making, noting how the midwife responded to her and picking up clues as to how to support her. This was a very effective strategy through which the father learned about labour as it unfolded, even when the parents had done a minimum of pre-birth preparation.

As fathers listened to the midwife and their partner, they would mimic or echo what the midwife was saying, for example in encouraging the mother during second stage, resulting in a sort of 'ping-pong' of communication directed at the mother. The interactions between father and midwife were often non-verbal:

Graham is leaning over and speaking quietly, very close to Ashley's face. He looks / glances at midwife Shona from time to time.

Shona hums. She is very focussed indeed on Ashley's perineum. Ashley pushes and groans.

The midwife leans forward and says *let's work together* and glances at Graham, who says *Use it, use it*.

Fieldnotes Ashley and Graham N27

Fathers used this as a strategy to reinforce what the midwife was saying. There were also examples of the father acting as a deliberate 'go-between', listening to and absorbing information from the midwife and then relaying it to the mother. This process drew on discussions the parents had engaged in when planning for labour and so enabled decision-making. On occasion, the father was then able to articulate the woman's wishes.

6.3.3.3 The father as 'go-between'

For women, the overwhelming intensity of being in labour often rendered usual 'social communication' impossible:

But I couldn't *verbalise* anything. I felt like I was...*locked* in almost, like – just *couldn't* summon the energy to...*communicate* at all.

Parents' interview Jo and Ricky N23

In such situations, the father was able to act as a 'go-between' and communicate with the midwife. Where parents had not engaged in detailed pre-birth discussions about preferences, he then used the closeness of their relationship to interpret what the woman wanted.

Women articulated during post-birth interviews that, at times, they had been unable to listen or to hear what was being said by the midwife, or to process information. They were, however, aware of their partner's presence and able to focus on his voice, which took precedence over anyone else's. They were also aware of the midwife 'using' their partner to communicate, and valued this:

...initially they tried to speak to me, to kind of *gauge* – where I was at, and how intense the *pain* was. But I think because I was...almost to the point of not being *really* able to speak, they then spoke to you, didn't they? So it was really *both* of us that were involved in that conversation.

Parents' interview Jill and Mick N21

Midwives therefore used fathers in their 'go-between role', both to gain information and to transmit it.

6.3.3.4 Fathers picking up midwives' non-verbal cues

A further strategy used by fathers in their communications with midwives was the detecting and interpreting of non-verbal cues. This could be in relation to the midwife's air of being competent and confident: 'You just felt she *knew* what needed to be done with that baby. No big *fuss!*' (Parents' interview, Hazel and Ben N25). The feeling of being 'in safe hands' increased the father's own confidence. Although midwives may not feel flattered to be described in the terms used below, this father's comment was intended as a compliment:

This sense I s'ppose their *demeanour* was quite calming as well...the way they communicated with each other was quite reassuring...they were like *experienced old pros*...you could tell they'd been round the block, and they'd probably been there at *hundreds* of births!

Parents' interview Lou and Donal N18

Most of the midwives (12 of the 14) had more than 20 years' experience; the two who had qualified more recently were in their late 30s. It is therefore not possible to draw comparisons with how fathers perceived younger or newly qualified midwives in terms of conveying confidence.

When there were potential or actual complications, fathers interpreted cues as to what might be evolving, without any information being conveyed verbally:

...it felt like *they* were concerned that it was going on too long? And there might be a problem? They didn't communicate that to me, that's just what I picked up from sort of...*body language*...

Parents' interview Jo and Ricky N23

On several occasions, the researcher witnessed minute changes in midwives' demeanour, but was unsure if the fathers had sensed them too, since they were so subtle. Post-birth interviews confirmed that fathers' state of 'high alert' during labour made them acutely sensitive to the midwife's transmission of feelings.

6.3.3.5 Father- researcher communications

During observations, the researcher adopted a low a profile in the birth environment. She very rarely initiated communication and only joined in conversations if addressed directly. Occasionally she exchanged a non-verbal signal with a father who caught her eye and looked particularly anxious, recorded, for example in the fieldnotes of a long labour:

09.55 I catch Jacks' eye, he's sitting in the recliner armchair at the other end of the room, and I mouth *You OK?* And he mouths back *I'm shattered*. He and Dawn have now been awake and up since yesterday morning - > 24 hours as it's about 10am. He is pale and looks a bit anxious.

18.30 Jack looks at me imploringly as I am opposite him, at the side of the room, sitting on my hard stool. He is glancing around and looks frightened. I feel helpless but smile back and remember that if I am looking calm, this may make a difference.

Fieldnotes, Dawn and Jack, N29

Even when the researcher was trying to be as unobtrusive as possible, she was included by some fathers in their 'scanning' of the birth space for cues that all was well. There were comments that revealed they felt the researcher was present for them:

It's jus' like the way yer *face* looked, 'cos obv'ously I'm aware that you're a bit of a veteran in this field, so when *you're* calm, an' well, '*If Debbie's alright, then we mus' be fine...if Debbie panic then I panic...*' 'Cos I was grateful that you were there, you were a *calm* face for me, which I felt was reassuring, cos when evr'yone else is like – (*stops and gestures with hand held up*), you were jus' like (*in a high voice*) '*It's ok, it's perfectly normal*' An' I was jus', 'Thank you, at least one person thinks it is!'

Parents' interview Rae and Will N30

As the researcher did not actually speak during this observation; the father's description of her saying '*It's ok, it's perfectly normal*' was a projection of the reassurance he was feeling from her presence. Will articulated his perception that, just as the midwife created a safe space for the birth, the researcher created a safe space for him:

The midwife in the room, obv'ously...she is to the room what you did for me, in the sense of, it's the *professional* in the room, someone who does this all day long, someone who...sets the *vibe* for the room...if you're calm, we should be calm. If *you're* panicking, what we gonna do? We're not going to be laughing are we? We're gonna...really have a bad time...

Parents' interview Rae and Will N30

The researcher gave brief emotional support via a hug to the two fathers whose babies were born in theatre:

When we arrive in the [theatre changing] room, Ricky crumbles. He cries briefly, and I give him a hug. He says *I must be strong for Jo*. Loneliness and fear are in his eyes.

Fieldnotes Jo and Ricky N23

These interactions were acknowledged by the two fathers during interviews:

Ricky: I was glad you were there. 'Cos I can't imagine having to do that it on my *own*. Just being – in that *room*...yeah...not *really sure* what's going *on*...

Parents' interview Jo and Ricky N23

Both their partners also commented in interview that they had viewed the researcher's presence as supportive to the father. This highlights the anxiety that the woman may carry when such perceived support is not available for him.

6.3.4 Types of talk and communication between midwives and fathers

Midwives viewed that involving fathers was an important part of their role:

...I think it *is* really important to involve dads...We've *got* to support them, haven't we? 'Cos for them to bond with the *baby* and to be a supportive father and *husband*, afterwards, it's really important for them to be involved from the word go...

Midwife Lynn interview, Jo and Ricky N23

There was a range of ways in which midwives communicated directly with fathers.

They expressed in post-birth interviews that childbirth was often an emotionally taxing experience for the father: frightening in its unfamiliarity and distressing due to witnessing his partner's pain, while being impotent to stop it. However, as midwives' focus during labour was on the woman, they did not have the capacity at the time to address fathers' distress, which they acknowledged later. They also underestimated the stress that a father may experience during a 'normal' labour and birth.

6.3.4.1 Midwives' awareness of fathers' needs

Midwives recognised the potential toll on fathers of being present throughout labour, which may have lasted 24 hours or more. They acknowledged both the physical and emotional aspects of the experience. The impact of this exhaustion was not expressed by fathers during labour; they did, however, talk about it in post birth interviews. During observations, fathers' strain and weariness was evident, especially when labour was prolonged. Due to their shift patterns, each midwife was involved for a portion of these long labours, whereas the researcher's experience matched more closely that of the father's, in being continuously present. This gave her a keen sense of the toll on these fathers. Some had been awake for over 24 hours (including the latent stage of labour before the researcher arrived) and then drove home after the baby's birth.

Midwives acknowledged during interview that fathers benefitted from breaks and rest. Those who smoked were observed to make this an excuse to leave the birth environment, 'to get some fresh air', when they went for a cigarette. Non-smokers did not have a 'valid' reason to leave. The hospital lacked designated places for the father to take a break (although the birth centre's comfortable foyer served this purpose). This may be one explanation for the fact that midwives very rarely suggested this to the father. This was less relevant for the couples who had additional companions present; these fathers moved easily in and out of the room and took short breaks, confident that their other family members would provide support in their absence.

Midwives expressed a particular recognition for fathers' need for break from the intensity of the birth environment when there were complications in labour. This, however, was the time when the father felt most anxious and the mother most in need

of his support. He was therefore even less likely to absent himself. In these circumstances, the midwife was least able to offer support to the father, as she focussed on supporting medical colleagues in the safe birth of the baby.

The hospital birth environment did not cater specifically for the father. The armchairs on delivery suite were large and bulky and could not be moved close to the bed if the woman was labouring there. On the birth centre, where women were more likely to be moving around within the room, there was a range of more comfortable options (small armchairs, birth balls, low foam seats) which were used by both parents. In theatre, the father was directed to a metal stool, where he sat for a relatively short period of up to an hour. The same type of metal stool was sometimes used in delivery suite.

Offering the father somewhere to sit was prioritised by some midwives, who saw it as a symbolic gesture of inclusion. Offering a comfortable place to sit signalled to the father that he was welcome. When the midwife did direct a father as to where he could sit, this nurtured a sense of confidence in him:

...she told me where to [sit] and everything like that. There wasn't really any time where I was unsure of what I should – be doing, at all...

Parents' interview Rosa and Dan N20

Fathers' basic needs in terms of drinking and eating were, to some extent, catered for by midwives. The drinks station on the birth centre corridor enabled fathers to take a short break; delivery suite rooms included kitchenettes equipped with a tray to make drinks. Food, however, (apart from slices of toast, which midwives sometimes offered to make for the father) was not available.

6.3.4.2 Midwives' aspirations in communicating with the couple

Midwives articulated an ideal of communicating with both parents. The fieldnotes record an example of such clear and direct communication:

After the examination, she explains clearly to Ashley and Graham what she has found, that the plan is [to] re-examine her in 4 hours and break the waters if it's possible to do so. She says to each of them in turn, '*You alright with that?*' and receives a nod of assent from each. The couple exchange glances...both seem relaxed.

Fieldnotes Ashley and Graham N27

This 'checking out' with the father validated his presence and role and helped him to feel at ease with what was happening. When this 'couple communication' was achieved, it was acknowledged and valued and seen as 'inclusive care' by the father. Conversely, the father noted when the midwife's body language excluded him, by (for example) conducting a conversation with the woman while her back was turned to him.

Working collaboratively with the couple was another ideal that midwives aspired to. This was played out in involving him in decision-making, and allowing time for consideration of options, where possible. When there was detailed information to absorb, for example regarding side effects of pharmacological pain relief, there were many instances of the midwife involving the father and seeking his opinion.

Fathers, especially first-time fathers, were on a steep learning curve about labour and birth. They valued information-giving and explanations by the midwife which helped them to learn. For the fathers having their second babies, there was a similar need for information to help them navigate, since the second labour tended to be very different from the first. Therefore they could not necessarily, as the midwife might assume, transfer prior learning to this new situation:

...and even though it's your *second* – you *still* haven't got a clue, because it's a completely different *experience*...because - of the fact that – it was *so different*...

Parents' interview Lorraine and Darren N26

Managing uncertainty is an integral part of the midwife's role, and one that it is challenging to convey to the father whilst maintaining his trust. The 'types of talk' and communications between fathers and midwives are central to the final 'findings' chapter: the ways in which fathers are socialised into the world of birth, as they and midwives navigate the terrain.

6.4 Summary box

- The midwife-father relationship is founded on communications characterised by assumptions and guesswork.
- The midwife employs a range of approaches to 'leading the team;' her presence confers a sense of security for the father.
- The midwife performs her clinical role while managing a complex social situation by engaging in different 'types of talk'.
- The midwife is the chief initiator of communication with the father; his role as the woman's advocate may be unrealistic, leading to unmet expectations.
- Antenatal class attendance is the 'officially sanctioned' approach to preparing for childbirth.
- Fathers have varied expectations of their and the midwife's roles. Direct, verbal exploration of these would remove elements of the assumption and guesswork currently employed.
- Mothers are aware of midwife-father communications and also of the impact for their partner of being present.

Chapter 7 Findings 3: Navigation and socialisation

7.1 Introduction

Midwives and fathers have different perspectives on the world of childbirth. For the midwife, this is a familiar world, in which her role in relation to the mother is well understood. However, this research reveals that midwives' socialisation into the realities of having the father present is less well developed. For the father, the childbirth environment is very different from his everyday life and experiences. Through a process of familiarisation and socialisation, he has to learn how to navigate it.

7.1.1 Theme 5: navigation and socialisation

This third 'Findings' chapter explores the fifth and final theme: midwives' and fathers' socialisation into the world of childbirth. Section 7.2 considers the midwife's perspective and Section 7.3 the father's.

7.2 Midwives and childbirth: on familiar terrain

The role of the midwife is clearly defined, her professional responsibilities ordained in NMC statute, and guided by the policies of her employing NHS Trust. It is shaped by societal expectations and developed through education and experience. During the process of midwifery training, the midwife is socialised into her role and becomes habituated to the landscape of childbirth. Within it, she is on familiar terrain; furthermore, her involvement there is 'all in a day's work,' in a literal sense. This is the job that she is employed to do. The mother and her baby are the focus of her care. Although she is also encouraged to include the father, her roles and responsibilities towards him are undefined.

The mother's fundamental role in childbirth is to deliver her baby. For the father's role, however, there is less clarity. It is within this grey area of uncertainties – about the midwife's and father's roles in relation to each other – that this research is situated. The midwife and the father are inhabiting the same world during labour and birth, but their experiences of it are significantly different.

7.2.1 Midwives' socialisation into childbirth

Each midwife held her own schema and framework for childbirth, which arose from her experience and philosophy of birth. Whatever her personal approach, every midwife had followed a standardised programme of education, during which she became habituated to the world of birth - its sights, sounds, smells and the feelings that are a normal part of this world. She learned to manage her responses to these sensory stimuli, as part of her role in conveying a sense of calm. This habituation is illustrated

in the following fieldnote, in which the midwife appeared not to register the sounds emanating from a nearby room:

A loud, high-pitched scream is heard from a nearby room. The pulsing sounds of the monitor fill the air in our room. The contrast is stark.

Hamid now stands by the bed, still on Ayesha's right side, so he's facing her back. More loud shouts and cries are heard from a neighbouring room. I feel anxious, poor woman, what's going on?

Shrill screams are heard. Is it an assisted delivery? Hope it's over soon.

Another buzzer is going. More screams are heard. The MW sits quietly, writing. She offers Ayesha some water.

Fieldnotes Ayesha and Hamid N22

The researcher became aware of the degree to which such phenomena are 'taken for granted' by midwives. The father's perspective is very different, illustrated by the following fieldnote made in theatre as the team of health professionals worked to deliver the baby using forceps:

Ricky perches on his hard little metal stool near to her. He leans forwards towards her. I wonder at how exhausted he must be, how it's normal for MWs to see and hear these sights and sounds – but very much not so, for him. The intensity and intimacy we kind of take for granted.

Fieldnotes Jo and Ricky N23

Midwives become habituated to witnessing intense emotions, physical exertions, pain and the expression of this pain and the changes in 'norms' and definitions of privacy and dignity which accompany birth. Midwifery involves monitoring and assessing what is happening in the present moment whilst simultaneously reading the landscape ahead to anticipate and address problems that may arise. Managing uncertainty is a key part of the role. Midwives have learned that labour and birth are unpredictable, an important aspect of the experience for which they are prepared during training. The uncertainties of labour are integral to the 'taken for granted' work of the midwife, but for fathers who are in unfamiliar territory, these were recognised as a source of anxiety:

I think...men *like things set* in – 'This is gonna happen, *and then that's* gonna happen, and then that – and 'You do this, and you – 'But childbirth's not like that! Is it?

Midwife Jayne interview, Lou and Donal N18

Another midwife, qualified for over 20 years, reflected that only recently had she developed an awareness of the father's perspective:

I've become more aware recently of dad's role – over the past two years really. It's a female-dominated environment. We focus on Mum.

Midwife Melanie interview, Rae and Will N30

This suggests that the father's presence has become accepted as part of a midwife's 'taken for granted' work; unless she is particularly alert to his roles and needs, he may be, 'just an ornament in the room' (Will; Parents' interview, Rae and Will N30).

7.2.1.1 Midwives' emotions during childbirth

Midwives' socialisation into childbirth involves learning how to control the transmission of personal emotions. This enables the maintenance of a calm appearance even when labour becomes complicated. During interviews, midwives frequently demonstrated awareness that their own calm persona helped the father to remain calm; these comments were made with a sense of quiet pride. Although at times midwives did feel worried (as revealed later during interview) they did not display this emotion at the time. They were able to continue to do their job in stressful situations. This was noted to be another aspect of the 'taken for granted' work of the midwife.

'More than a job' - midwives' sense of wonder

Midwives regularly made a statement of quietly positive affirmation following a birth, a summing-up of what had just occurred. These declarations referred to the birth itself and to the couple and family. Apart from these positive affirmation-statements, midwives gave only very occasional glimpses into the emotion work involved in their role, although several mentioned that their own emotions were particularly triggered by the sight of a father's outward display of emotion.

The midwives in this study moved comfortably within the landscape of childbirth; it was clearly their 'familiar place'. However, although in one sense, birth was 'all in a day's work', they regularly expressed wonder at being present at a birth, exemplified by this midwife's spontaneous reflection - addressed to the room rather than to any individual - on the birth she had just witnessed:

Bryony says, *I tell you, nature's an amazing thing...*

Fieldnotes Rosa and Dan, N20

Midwives derived enjoyment, delight and a sense of wonder from childbirth. Through socialisation they had become accustomed to the experience of birth, but they did not take it for granted.

Reciprocal gratitude between midwife and mother was regularly expressed in an easy flow of shared emotion at the birth of the baby, often with the father included:

...But they were so grateful and thankful! And / was! / had tears in me eyes, because I thought, 'What an experience!'

Midwife Siobhan interview, Jill and Mick N21

Midwives clearly shared the emotions surrounding the birth of the baby; their comments demonstrated awareness of the significance of the experience for the father and the couple-relationship.

7.2.1.2 Midwives normalise birth & help the father to navigate

Midwives identified that their confidence and demeanour were important factors in helping the father to feel more comfortable in the unfamiliar environment of childbirth, especially when labour was progressing rapidly and the midwife's attention was by necessity on the mother. They regularly used the word 'normal' to convey that although the situation is far outside the father's experience, to a midwife, such situations were an every-day occurrence:

...she was actually like transitional* when she was saying to him, 'Get out of my space!' (*midwife laughs*) ...I just sort of said to him... 'That's normal'...

[* approaching the end of 1st stage]

Midwife Nancy interview, Lorraine and Darren N26

When birth is complicated: midwives' awareness of fathers' perspectives

No serious or life-threatening emergencies occurred during any of the births, but there were complications in four of the eleven. When midwives talked in interview about these labours, they spoke of the stress and anxiety for the fathers in such situations. Arguably, this was predictable; they were aware that the research focused on fathers' experiences and this may have increased their own sensitivity towards the father's perspective. They highlighted the father's anxiety, rather than their own, a further illustration of how the process of socialisation encourages midwives to set aside their own emotional responses, sometimes at the expense of their emotional wellbeing. This subjugation of their feelings is reflected by the fathers' control of the emotions they were feeling, in order to protect their partner from their own distress. This issue is explored in section 7.3.4 below.

When there were complications requiring medical assistance, midwives recognised the emotional trauma that fathers can experience: 'The dads are *absolutely*, completely *petrified*. And you can see it, they're just like *so scared*' (Midwife Lynn interview, Jo and Ricky N23). Such situations triggered recognition that the father's experience was very different from their own:

...and it *is* frightening, y'know it's an every-day thing for *us*...but when you've never *seen* anything like that happen before...it *must* be scary...

Midwife Becky interview, Dawn and Jack N29

Therefore, when there were complications and medical intervention, midwives expressed their awareness of how alien the landscape of birth was for fathers. However, when labour and birth were 'uncomplicated' there were swathes of this childbirth landscape that midwives took for granted, but which fathers found alien:

...The other thing that I *vividly remember* is...*almost all* the way through, Jo's... *breathing*...was...y'know, exhaling in *pain*. And when she had the gas and air – it just made it *sound so horrible*. So like, sort of like...(demonstrates – a *high, long exclamation of pain as breathes out*) You know, but *through* a tube, so it sounded more like *metallic* and...I just remember *thinking*, you'd been in pain for *so so long*...and you were just *shattered*.

Parents' interview Jo and Ricky N23

This vignette illustrates how midwives' habituation to the sights and sounds of childbirth inure them to their significance for the father. Their perception of what is 'normal' during childbirth therefore raised the threshold of what they would consider traumatic for the father; they were 'immune' to these 'normal' sights and sounds. Instead, they focussed on the potential trauma for the father when there were complications.

7.2.2 Midwife's expectations of the father

In the absence of a standardised approach for midwives to explore fathers' expectations of their roles in childbirth, midwives used different tools to work this out and also had unspoken expectations about what constituted an 'ideal supporter'. There was one expectation, however, which was articulated and shared by all the midwives, which was that the father should cut the umbilical cord. This is explored in Section 7.2.6 below.

Explicit conversations between the midwife and father (or couple) about the roles he might play were rare. Instead, midwives relied on intuition and sensing the degree and type of involvement they felt the father wanted, describing a process of working out '*...the bits they're comfortable with, and the bits they're not...*' (Midwife Brenda interview, Maria and Dave N28). This was a matter of trial and error; midwives regularly used phrases such as being able to 'pick up' on what fathers wanted. Midwives expressed the primary purpose of his presence was to support the mother; his active engagement was signalled by, for example, physical proximity to her.

7.2.2.1 Midwives reflect on fathers' presence

Midwives' assumptions about fathers' reasons for being present during childbirth were linked to their own expectations of him and also to the fact that this has become a

powerful norm. They recognised he may feel pressure to attend from his partner, or due to societal expectation. Some midwives suggested that there should be discussion and negotiation around this issue during pregnancy.

There were situations when the pressure to be present came from midwives. For example, one father was initially reluctant to accompany his partner into theatre; he felt so frightened that he thought his distress would be transmitted to the woman. After discussion with the midwife co-ordinator, he changed his mind.

Reflecting on this father's decision to go into theatre, midwife Becky (involved during the preceding hours of labour) wondered if he had felt coerced. She also identified her personal belief that the absent father is 'missing out,' based on the preferences she and her own partner had shared. This father's perspective, after a few days had passed, showed that despite the fear and anxiety felt at the time, he was glad he had been present: 'I'd go through it all again tomorrow. A hundred per cent.' (Parents' interview Dawn and Jack N29).

For some parents, it was not the norm for the father to be present during childbirth. One couple was motivated to participate in the study specifically in order to encourage other parents from their Asian ethnic background to consider having the father present. The midwife involved in care commented that - in her experience - women from this heritage often chose to have a female companion. The midwives at the homebirth of the baby whose father chose not to be present, were left speculating as to why he had made this decision. Although he was occupied with childcare, the parents had other family members who could have fulfilled this responsibility, enabling him to be present. These 'variant cases' demonstrate that the father's presence is now taken for granted, but uncertainties persist around his roles, reasons for being present and the midwife's expectations of these. Until such a 'variant case' presented, these were rarely discussed, further evidence that his presence is 'taken for granted' by the midwife.

7.2.2.2 Midwives helping to shape fathers' role

When discussing fathers' presence, midwives emphasised the importance of having a defined role and specific jobs, to counteract the helplessness that is often reported. They gave examples of 'tasks' that they would devolve to partners, perhaps to demonstrate to themselves, as well as the parents, that the father had a valuable role. During labour, these tasks were focussed on the mother. They also had specific expectations of tasks which delineated a role for the father in relation to the baby, demonstrating endorsement of him as father, rather than the woman's partner. For example, facilitating skin-to-skin cuddles between father and baby was seen as

important, perhaps symbolising the start of the post-birth fathering relationship, with the inclusion of the baby as well as the mother in the father's supportive role.

This section has explored midwives' expectations of the father's presence. Part of their rationale was to mark his transition to fatherhood, but midwives placed clearer emphasis on his active and practical involvement, signified by his 'busy-ness' and closeness to the mother. These are explored in the following two sections.

7.2.3 Fathers being busy and involved

Midwives helped the father to 'ground' himself in the unfamiliar landscape of childbirth by orientating him to the physical environment. This was a routine procedure for some midwives, but for the father it formed an important aspect of teaching them about the childbirth landscape:

... [she told me] what everything was in the room, so I knew what to do in case something happened, and the midwives were out as well... like – if she needed to go to the toilet or...if she was sick, if she needed gas and air, or she if needed *immediate* help with the emergency button. Just *basic* things like that...which I need to know, but...nothing more complicated which I wouldn't need to know and get you confused with everything else then. So – it's just what I needed, really.

Parents' interview Rosa and Dan N20

Enabling the father to understand the physical environment and have some control over it helped him to habituate. Simple, everyday actions like offering refreshments and teaching the father how to use the bed controls, 'normalised' the environment and were symbolic of his involvement.

Midwives placed high value on fathers appearing to be busy and involved. 'Busy-ness' signified involvement and also demonstrated that the father had an important role to play. The father's active participation symbolised his involvement with and commitment to the mother and the baby; it was seen as giving him 'ownership'. Midwives at homebirths, however, recognised that during hospital birth, ways in which the father could be occupied were very limited compared to home. In the hospital setting, where the birth environment was equipped with everything required, none of the father's 'fetching and carrying' jobs were required; also, having fathers wandering around the public areas such as corridors was seen as a potential security risk. One midwife's reflection on '...what it must be like, to *sit* for *twelve hours* in a room, actually without very much to do' (Midwife Brenda interview Lou and Donal, N18) resonated strongly with the researcher's perception of the father as 'confined' during hospital birth.

7.2.4 Fathers being close and involved

Midwives reserved special approval for father's support of the mother which involved physical closeness. The father's physical proximity and the close attention he paid to the mother represented his tangible support and were affirmed by the midwife as representing the intimacy of the couple connection. Such behaviours also seemed to signify that the father was working on the same team as the midwife, acting as a resource and mirroring her own role at the birth. Witnessing such communications added to the midwife's sense of job satisfaction.

A father who 'just sat there, very quietly' (Midwife Jayne interview, Lou and Donal N18), or kept his distance, was seen as a detached observer and was the subject of midwives' disapprobation. Such fathers were perceived as being immobilised observers; some midwives suggested that this was due to feeling the situation was out of his control or that he was unable to help. When a father appeared to be disengaged, this behaviour was challenging to midwives. Repeated attempts would be made to draw him into the circle of intimacy, by suggesting comfort measures he could adopt to help the mother.

At the homebirths where the father had a range of other tasks and activities to undertake, midwives were accepting of the fact that he was not physically present at all times. These fathers were perceived and described as 'supporting' the mother, even though they were not necessarily physically present.

7.2.5 Midwives assess the father's performance

Midwives measured fathers' 'performance' against their expectations of what fathers would do during labour and the different roles they could play. The notion of an 'ideal' birth partner was based on the father being actively involved, physically close, verbally communicative and able to take the initiative. Indicators of what constituted a good supporter were highlighted by the midwife's use of positive language to describe what he was doing when he was coming up to her mark, and meeting her ideal:

...he was very involved, he was wanting to take quite an active role and be very supportive. And he was very supportive of her. He was really good with her.

Midwife Lynn interview, Jo and Ricky N23

The phrase '*he was really good with her*' affirmed Ricky's closeness with Jo and hence his ability to support her in sensitive and appropriate ways. It also suggested that he was 'managing' his partner's behaviour in ways that were helpful for the midwife. This was an important aspect of midwives' notion of an 'ideal' supporter. Such comments were repeated frequently by midwives during interviews.

The process of 'assessing' the father started in the early stages of the midwife / mother / father relationship, usually via the question about antenatal class attendance, as discussed in the preceding chapter. The midwife sought to establish the father's level of knowledge as signifying his 'preparedness' for labour. Antenatal classes were the midwife's 'officially sanctioned' mode of preparation; she then judged how effectively this translated into support for his partner:

I was *aware* that he had the *knowledge*, but he didn't know how to *put* that knowledge into action...

Midwife Sally interview, Hazel and Ben N25

Such comments suggested that midwives' familiarity with the landscape of birth, combined with their primary focus on the woman, blunted their awareness of how alien and unfamiliar it was for fathers. The usual response was to suggest practical jobs; encouraging such involvement was seen as a positive way of affirming his presence. Midwives helped fathers to learn about the potential of the role. One father acknowledged, '*I learnt a bit about birth and the whole process on the day*' (Parents' interviews Rae and Will N30). He was learning both from the midwife and his partner.

Midwives noted what fathers actually did and during interviews endorsed signs of active involvement. Particular approval was expressed for the times when a father was supporting the woman spontaneously and 'intuitively', without being told what to do, especially if he had no previous experience of birth. This sensitivity and level of confidence were valued highly, perhaps as denoting that the couple was well-attuned. It also signified that the father was not a cause for concern for the midwife: he was an extra resource, rather than an extra job for her.

Midwives were measuring fathers' performance against their expectations of a 'good supporter' and how they contributed to the whole experience. They did not explicitly list the qualities they looked for in a 'good supporter'. Their comments, however, indicated they were making assumptions about the father's role:

...he was obviously *supportive* and – at her *side* and everything, and doing what he was meant to be doing [researcher's emphasis], from a *supportive* role...

Midwife Siobhan interview, Jill and Mick N21

These assumptions could be deduced by their comments on the activities and behaviours of the fathers who earned their approbation.

'Staying calm' was a behaviour that was repeatedly praised by midwives, especially when the father was tired or experiencing intense emotion. His calm demeanour was perceived as supportive to the mother. It reflected the midwife's personal aspiration to

transmit a sense of calm and enabled her to fulfil her clinical role. Midwives also identified when their job was made easier because the father offered excellent support.

On occasion, particularly during long first labours, midwives noted and responded to the father's own practical needs, by offering drinks, food, or somewhere comfortable to sit. During midwives' post-birth interviews, there was clear recognition of the father's emotional needs, feelings, anxieties and his thirst for reassurance, combined with acknowledgment of the support he had given to the mother at a cost to himself. Those occasions when the father had sacrificed himself and his own needs to do so were noted; these behaviours brought strong approval from the midwife:

I could see that he was really tired in the night, as the hours went by, I could see he was exhausted, but he was still *really* good with her. He didn't lose patience with her, and some men *would* do. But he was very supportive right through and – was lovely with her, which was nice to see...he was *lovely*. ...he never *snapped* or - lost patience with her a' all, or anything...

Midwife Lynn interview, Jo and Ricky N23

During interviews, midwives spontaneously reflected on the labour from the father's perspective, expressing empathy for him and recognising that he had felt – or had actually been – helpless. This empathy was reserved in the main for fathers where there had been problems in labour. Midwives' main focus was on the mother; they also identified that the father's priority was that she cared for the woman in labour, a view that was expressed repeatedly by fathers during post-birth interviews. However, midwives' comments demonstrate that they were also noticing fathers' needs and picking up on their distress, even if they did not acknowledge it at the time.

7.2.6 Cutting the cord

Fathers' involvement in 'cutting the cord' is addressed as a discreet issue because it is the only aspect of care in which every midwife in the study invited the father to be involved. 'Cutting the cord' involves the severing of the umbilical cord connecting the baby with the placenta *in utero*, after the baby has been born. It is an element of the midwife's care for mother and baby during the 3rd stage of labour and is part of her 'taken for granted' work. The father's perspective, however, is completely different (even when he has 'cut the cord' during a previous birth), as demonstrated by this father's response:

Because when the midwife *asked* me to cut the cord...I don't know *why* – but, for reasons I can't explain, I thought there was some electrical cord that needed fixing (*the parents are laughing loudly together*). And I was thinking, 'Well, why would I want to fix an *electrical system* right now!' But...once she *showed* me, and gave me the *scissors*, it became apparent, 'no', that it was *this* cord that I was supposed to cut!

Parents' interview Ayesha and Hamid N22

This father's initial response to the midwife's invitation to 'cut the cord' drew on his memories and associations of other types of 'cord', a vivid illustration of midwives' and fathers' very different constructs of birth.

Discussion about 'cutting the cord' was initiated by midwives. It was typically framed as a straightforward question directed to the father, usually posed shortly before the baby's birth: 'Midwife Siobhan says, *'Mick, are you going to want to cut this cord in a few minutes?'*' (Fieldnotes Jill and Mick N21). In some cases, the question as to whether the father wished to cut the cord was rhetorical, with an unspoken assumption that the father would choose to do this task. One midwife abbreviated the question to 'Are you cutting?' (N27), assuming that the father would know what she was talking about.

7.2.6.1 Midwives' conceptualisation of 'cutting the cord'

For midwives, enabling the father to cut the cord was seen as important, demonstrated by fact that during handover of care from one midwife to the next, if the father had expressed a wish to do so, this was deemed worthy of mention. The father's cutting of the cord was imbued with greater significance (by midwives) than a simple 'task' that had to be performed. Whether this significance was as a token gesture of his involvement or as a symbolic act, part of his 'rite of passage', seemed to vary from midwife to midwife. However, in either instance, involving the father was viewed as a priority. One father recalled that following the birth of their first baby, during which his partner was extremely unwell and required 'high dependency' care, he had nevertheless been invited to cut the cord:

...even with *Curtis*, and with all the complications, and what 'ave you, they still...even *she* said, 'D'you want to cut the cord?' So I mean, I s'ppose it's the standard thing, what they say...

Parents' interview Lorraine and Darren N26

The importance invested in cutting the cord was highlighted by a midwife who expressed disappointment that the father had been unable to do so; the baby had needed urgent resuscitation, so the doctor had cut the cord straight after birth (Dawn and Jack, N29). Once the baby's breathing had established, the midwife invited Jack to trim the cord. She viewed this as an important token gesture, which she judged worthy of mention:

...I'm glad I got him to trim the *cord*, because I think people like to say, *'Oh I cut the cord'*

Midwife Becky interview, Dawn and Jack N29

Midwives' comments during interview suggested that the father cutting the cord was an important symbolic act, marking his transition to fatherhood and embarking on parenthood as a shared venture. Their comments revealed their own values and beliefs:

I think it's nice for them (*said in a higher tone*) because it's that *final ...baby* doesn't *just* belong to *Mum* any more, once he's cut that cord it belongs to *both* of them...up until that *point*...*Mum has been 'is sole carer... that - cuttin' that cord, it's 'im saying, 'Right, now it's my turn - to take care of the both of yer'...*

Midwife Shona interview, Ashley and Graham N27

Cutting the cord carried the status of a role ritual, perhaps signifying to the midwife that the father was fully involved in the birth process. It required close supervision by the midwife:

Graham watches intently as midwife Shona clamps the cord and shows him where to cut it. The baby is lying on the bed.
Ashley kneels on the bed. She cuddles the baby.
Graham stands at the side of the bed, looks calm and he's smiling.
Shona to baby: *can we just pop you in a dry towel and you can go to Graham to hold*
Graham receives the baby from the midwife and says *There you are. There's my boy.*

Fieldnotes Ashley and Graham N27

This fieldnote extract shows the midwife handing the baby from the mother to the father. This can be interpreted as a ritualistic act of separating the baby from the mother and passing over care to the father, or a symbol of the three-way family connection, or simply as a practical step in the midwife's conduct of the 3rd stage of labour.

Midwives regularly offered praise to the father for his expertise in carrying out this act:

Mick gives Jill a drink. Siobhan passes him the scissors – she clamps the cord with two cord clamps and shows Mick exactly where to cut: *It is going to squirt between the two – oh well done! An expert!*

Fieldnotes Jill and Mick N21

During the second stage of labour and the baby's birth, the midwife's focus was very intently on the mother, the wellbeing of the baby *in utero* and the progress of the labour. Once the safe passage of the baby had been ensured, the midwife was able to widen her attention and include the father; in effect, she 'handed over' care of the mother and baby for these moments. There are no commonly-used measures of fathers' involvement in childbirth: the act of cutting the cord, and the attention afforded to it by midwives, distinguishes it from other types of involvement. Some midwives commented during interview that not all fathers want to cut the cord; they expressed

respect for their choice. However, evidence from observations suggested that midwives preferred fathers to perform this task.

7.2.6.2 Fathers' conceptualisation of cutting the cord

Midwives' perception of 'cutting the cord' as a significant ritual act did not necessarily accord with the parents' perspectives. Fathers varied greatly in their responses to the midwife's suggestion. Some fathers shared the view that cutting the cord was a symbolic act, denoting their role and involvement during the birth and marking the start of independent life for their baby:

I wouldn't go back on the experience, very glad that I was there, I was involved, it's something that I can be proud of for ever now...I cut the cords for both my Sophie and Meg - I broke - disconnected them from their first home - you know - 'You're on stand-alone now, you know, you are your own person'...very intense though...

Parents' interview, Rae and Will N30

Some fathers expressed enthusiasm; others showed reluctance, illustrated in the exchange noted below, after which the father proceeded to cut the cord:

MW Shona to Graham:	Are you cutting? (She means cutting the cord)
Graham	No I'm not...I will if you want me to...
MW	Job share! (In a jokey tone)
	Fieldnotes Ashley and Graham N27

Graham's response suggests he complied under pressure. The midwife commented during interview that she adopted this jokey, bantering tone to encourage the father to agree to cutting the cord, because she felt it was an important ritual for him to undertake,

I always try and get the Dads to do it and I always say that's either job share or 'For God's sake, I've got me *hands* full here, don't you think I've done enough - ...*you* do that'.

Midwife Shona interview, Ashley and Graham N27

The act of cutting the cord had a significant emotional impact for some fathers:

Midwife Melanie says to Will <i>Now it's your job</i> and hands the sterile scissors to Will to cut cord; this is? first comment she has made directly to him. 15.45 Will cuts cord, comments to Melanie before he does so, along the lines of <i>it's a bit tough isn't it, I remember from last time</i> . Will walks around the room, seems to be recovering? Comments <i>I don't know what to do with myself</i> ...Will is slightly flushed, eyes widened, pacing, looking round; Will goes into the ante kitchen (through an archway, just off the room) for water while MW checks perineum for stitches; Will asks what clothes baby needs, he is looking in suitcase which is in kitchen on the surface.
Fieldnotes Rae and Will N30

During interview, Will expressed pride and satisfaction that he had cut the cord but also described the ways in which this had impacted on him. He recognised he was 'squeamish' and had needed to recover his composure afterwards.

Other fathers expressed ambivalence about cutting the cord. For example, Darren (N26), who cut the cord following the births of both his sons, had felt unprepared each time that he would be invited to do so. He did not see it as a significant act; his comments suggest he felt under pressure from the midwives to agree:

...I don't think it really *entered my mind* as to have any like *symbolic* type thing...it was just...*I don't know!* Really. I mean, it's not the *niciest* thing to do (*laughing*) you're scared of...y'know...I'd *rather* someone who has been trained *professionally* do this!

Parents' interview Lorraine and Darren N26

This father expressed embarrassment at his ambivalence about the cutting the cord, suggesting he saw it as a 'test' of his stamina. His tone when he talked more about it suggested he had 'resigned' himself to doing it, because it was expected of him; he would have preferred a 'professional' to do it.

As illustrated, some fathers felt reluctant or ambivalent about cutting the cord and perceived they were under pressure to do so. However, at the homebirth (N28) where the father had opted not to be present in the room during the baby's birth, he actually felt able to decline. Perhaps he was confident to do so because he was in his own home; also, this was his fifth baby and he had considerable experience of childbirth:

Midwife Brenda says to Dave, *Daddy, do you want to cut the cord?* And he replies, *Oh no, I can't watch Casualty* and Maria says, *Oh, no, no, no, no, NO!* Brenda responds with, *It's your last chance*
Dave stays in the room, leaning against the wall, watching, smiling. His head is bowed, a gentle giant of a man. He opens the door as sounds of children are heard. He leaves the room as sounds from downstairs escalate.

Fieldnotes Maria and Dave N28

The fact that this one specific aspect of care was singled out in every situation as one in which the father could be actively involved, raises interesting questions, including those concerned with norms of masculine behaviour. These are considered in the 'Discussion' chapter.

7.3 Fathers and childbirth: learning to navigate unfamiliar terrain

This section explores how fathers were socialised into the previously unfamiliar world of childbirth and how they learned to navigate as labour unfolded. This involved preparation and anticipatory activities plus learning 'on the job' when labour began. It considers how fathers prepared themselves; used their past experience of birth; drew

on their wider life experience to make sense of what was happening; subjugated their own feelings and needs in order to support their partner; developed their roles and ways of being and doing and perceived the midwife in helping them to navigate.

7.3.1 How fathers prepared themselves

All couples had done some pre-birth planning which related to their commitment to the father's attendance. Fathers used a range of approaches to anticipate what labour might be like, working to build up a picture of this landscape they would need to navigate. The depth of this planning varied widely and was linked to a range of factors including the parents' personalities and relationship, past experience of birth and their expectations of the father's involvement.

7.3.1.1 'Going with the flow' versus seeking control

In describing the preparations they had made for birth, fathers showed awareness that their own disposition as well as the dynamics of the couple relationship impacted on their particular approach. A continuum was identified, from 'going with the flow' to 'seeking control'. These parents, for example, expressed a relaxed attitude and an openness to whatever occurred:

And she didn't know what she wanted to do! And...I just knew one thing. Whatever she want, [Ayesha: yeah – go with the flow] – go, go with the flow...It was *not* something...I would say she *has* to do this way! Or she *has* to do *this* way! I just wanted...everyone to be *fine*. Them being fine. That was to me – whichever method they take – doesn't matter. The answer was to be fine – at the end of the day!

Parents' interview Ayesha and Hamid N22

This couple's approach was at the other end of the continuum:

...we'd gone over it a *million* times, we'd thought about the eventualities as well, 'cos we're *terrible* for having to plan everything! And we *hate* it when it doesn't go to plan. But that's why we plan *everything* – 'cos then it means, 'If *this* happens, we do that. If *that* happens then we do *this*'. So I knew the *principles* of...what did the outcome *have* to be of this, for Ashley to be happy the day after? 'Cos that's what's key to me! ...but as long as you're happy the day after, and things are coming *back*, I think that's what was always key.

Parents' interview Ashley and Graham N27

The priority for both couples was that mother and baby should be well, and the mother as happy as possible, following the birth. They had shared hopes for the same outcome; each couple's approach for reaching this goal was congruent with their outlook on other aspects of their lives. These preparatory discussions formed part of the father's navigation through childbirth.

7.3.1.2 Activities during pregnancy

Fathers who were unable to attend antenatal appointments felt they were disadvantaged. They perceived this regular contact with the midwife as preparation for, and orientation into, childbirth and felt they were missing out. Some couples who attended appointments together used the contacts in later pregnancy for birth-preparation discussions with the midwife. Those who planned to have additional birth companions, for example, sought reassurance and permission that this would be acceptable.

Some couples drew on external resources to help them prepare: antenatal classes, television, books, contact with other people. None attended midwife-run NHS antenatal classes. Some books and private antenatal classes prepared fathers to adopt specific roles in labour, for example as advocate for the woman in challenging midwives' actions (which was rejected by one as potentially too adversarial) or as 'labour coach'. One couple had written a birth plan (N23); each midwife who was involved in care discussed and affirmed this.

Other couples drew on 'lay knowledge' from family and friends to help the father prepare. This included inviting family members who were equipped by their own experiences of childbirth to be present. This was perceived as a valuable source of knowledge:

And with Laura [Dawn's sister], she's 'ad kids. My Mandy [Jack's sister], she's 'ad kids, and Stacey's 'ad quite a lotta kids [Stacey has had seven and is step-mum to five] so - there isn't nuffin really that they don't know...

Parents' interview Dawn and Jack N29

Another father had gone out for a drink with a friend, specifically to ask his advice on how best to stay calm during labour. Tips he received included taking a book to read, to instil and convey a sense of calm and normality, with the caveat, 'you get some *funny looks*, when you're sitting reading a book' (Parents' interview Hazel and Ben N25). Acknowledged as an unconventional tool for coping with the labour-situation, it was adopted by this father.

In preparing for the birth of their babies at home, two couples attended a homebirth support group meeting at Gracefields. Facilitated by a parent member of the service user forum, it was attended by parents – fathers as well as mothers – whose babies had been born at home. Hearing the experiences of other parents reassured the fathers and increased their confidence.

Other 'lay' sources of knowledge, information and support accessed to help fathers prepare for birth included *One Born Every Minute* and YouTube clips. Watching other fathers' responses in labour enabled these fathers to formulate ideas about how they

might navigate their own way through childbirth. The opportunity for lay people to witness childbirth via old and new media is a recent phenomenon. This helped to habituate the father to the world of childbirth; through observing others, he was able to start shaping and planning his own role during labour. However, those who had already been present during birth articulated that the reality of childbirth was different from the edited, sanitised version of *One Born Every Minute*.

Couples made practical preparations for labour by assembling snacks and drinks for the hours ahead. Where there were additional family members present, these fathers were well catered for by these supporters, compared with the couples who were by themselves. Two fathers whose partners laboured through the night found the snacks they had brought were inadequate and they suffered as a result. This practical planning was easier for couples at home:

...we *had* all the boxes ticked in terms of – the *sweets* you wanted, the *Lucozade*...obviously we always had *bread* in, and, and *jam*...‘cos we *knew* that the energy levels needed to be at a good place...So yeah – we had all the boxes ticked. Everything was *prepared*.

I felt like I had – all the *tools* at hand, to do *my job* – to do my job as best as I could do...

Parents’ interview Lou and Donal N18

7.3.2 How fathers used their past experience of birth

Four of the couples were having first babies; the remaining seven their second ($n = 4$), third ($n = 2$) and fifth ($n = 1$) respectively. The seven fathers who had older children made reference to these babies’ births; they highlighted in particular the impact of their first experience of childbirth and their sense of stepping into the unknown:

...the first time round...it’s a new environment, you don’t know what to *expect*, you don’t know – *how* these things...you don’t know what’s *normal* and what isn’t normal. ...you just don’t know! What to expect at all. You...just have to get through it.

Parents’ interview Jill and Mick N21

Themes recurred throughout fathers’ accounts of the first birth: of being disorientated, confused and stoically enduring the labour, combined with helplessness at witnessing the person you love ‘*in an extreme amount of pain...and there is nothing you can do about it! All you can do is sit and watch*’ (Parents’ interview Ashley and Graham N27). This father also highlighted an important point about fathers’ memories of childbirth: whilst, for women, the effect of labour-hormones is often to blur these memories, the father does not have the same hormones at work.

7.3.2.1 Fathers approaching a second birth

Fathers drew on their clear, vivid memories as they anticipated the second birth; they felt more prepared than before the first birth. However, for each of the four couples having their second baby, there were marked differences in the course of the second labour, compared to the first, leading one father to comment, '*...I didn't know what would happen, it was completely diff'rnt, so I didn't know...*' (Parents' interview Rae and Will N30). Fathers were once again surprised, and in some instances shocked, by events during labour. This is important to highlight, as the midwives involved in caring for these multiparous women tended to assume that the fathers had gathered experience during the first labour which would enable them to navigate the second. Three of the women had second labours which were much quicker than the first, resulting in less time for the father to orientate himself to what was happening. This experience was described as being - at the time - more intense and 'scarier'. After the birth, these feelings were supplanted by relief at the benefits of a shorter labour.

Fathers' expectations of this second birth were, understandably, based on experiences of the first, because their exposure to this landscape is so limited. Where there were differences, this was a source of stress. A woman whose first labour had necessitated high levels of intervention due to pre-eclampsia, went onto have a very rapid second labour that started spontaneously at home. This proved very stressful for her partner; he described his acute anxiety that she might deliver their baby at home, saying, as he waited for Triage to answer his call, '*...Lorraine's in a lot of pain, and God forbid anything did happen, what am I gonna do?*' (Parents' interview, Lorraine and Darren N26). He felt an overwhelming sense of responsibility which was eased somewhat by the presence of the midwife on arrival at hospital. However, he was still unprepared for this second labour, which was so different from the first, in terms of speed, intensity and health-professional involvement.

When fathers were able to use elements of their first experience to comprehend and interpret events during the second labour, a sense of relief followed. Their desire for midwives to do more 'thinking out loud' was based on their need to orientate to a landscape which was once again unfamiliar.

7.3.2.2 Building experience: third births and beyond

Fathers present for the births of their third child had accumulated valuable experience from the two earlier labours and also an increased awareness of the unpredictability of childbirth, summed up by Ayesha (N22) - '*...all three [labours] had different experiences. All kids have brought their own set- things we don't, didn't know about*' (Parents' interview Ayesha and Hamid N22). Witnessing the pattern of a first and then

a second labour had habituated the father to both the sights and sounds of childbirth and the sequence of events plus the fact that there may be variations:

...now it's third time round...*because*- we'd been through it...I was more relaxed, I wasn't as *on edge*, I don't think, as I was with the other two. Even though it's happening *quick*. 'Cos you've kinda *been there...and done it*, for me...I think I was *calm* – again, because it was the third time round.

Parents' interview Jill and Mick N21

As fathers' experience of childbirth grew, they came to understand that each labour is likely to include the unexpected. One noted that he had anticipated a quicker labour for this third child, '*...because that's what the trend was*' (Parents' interview Ayesha and Hamid N22); he was therefore initially concerned that the labour went on longer than the second, but adjusted to this after the midwife had offered explanations.

Both fathers, present for the births of their third babies, had some experience of previous labours to help them make sense of what was happening. They used knowledge gained during these two earlier labours to help the couple decide when it was time to go to hospital. The fathers reported very accurate recall of the pattern of contractions with the previous labours; this increased habituation enabled them to observe calmly what was happening and also to fulfil their assumed role of transporting their partner to the hospital.

7.3.3 Fathers drawing on wider life experience to navigate

Until the popularity of television programmes about birth, the world of childbirth was hidden from public gaze. Before the birth of their first child, most fathers have had no or very minimal direct experience of this world. There are exceptions, as illustrated within this study sample. Maria (N28) gave birth at home, with the four older children in the house. The oldest had experienced the birth of his three youngest siblings at home. Although not present in the room, he was wandering around the family's small home while his mother was in labour. Even as a 15-year old, he had accumulated more experience of birth than is currently the norm. Midwife Brenda, who attended Maria, commented:

...to 'im, that was just a day in the normal life of his *family*, 'cos he'd seen it before. Whereas if it was – the lady's [his mother's] *first* childbirth, it might've been a bit different for him.

Midwife Brenda interview Maria and Dave N28

One first-time father drew on his experience of growing up on a farm to help him prepare for their baby's birth:

...to me it's the most natural thing in the world! 'Cos like with *lambing season*...and you've cows, and...you've all sorts of *pets*. And you have them

having, you know like lamb and sheep whenever I was a young child. You can very much realise what it is. It's a *natural process*.

Parents' interview Hazel and Ben N25

This father maintained an outwardly calm appearance during labour and birth, perhaps drawing on his childhood experiences as preparation for the realities of childbirth.

7.3.3.1 Habituating to the hospital setting

The fathers whose babies were born in hospital (nine of the 11) needed to habituate relatively quickly to a setting which was largely unfamiliar to them. Although some had been present during a previous labour, for most, this birth was taking place in either a different hospital, or different setting within the same unit. In terms of familiarity, one father was an exception; his IT job involved working within maternity hospitals, he was confident in that environment and felt able to communicate easily with staff.

Fathers who did not have the benefit of ease within the hospital setting, were entering an unfamiliar environment where they would then be encountering an unfamiliar set of experiences, all of which they needed to navigate:

I didn't really know *what* to expect...I've never had any *involvement* with babies or 'ospitals, or midwives, or anything like that...I was just going *blind* really...

Parents' interview Rosa and Dan N20

Fathers rarely expressed positive associations with hospitals. Dislike and anxiety were feelings they worked to set aside, in order to fulfil their role. Memories of being a patient, especially as a child, triggered some difficult emotions. Will (N30) for example, recalled, '*...as a child I was quite clumsy, so growing up, I've spent my fair share of time in a hospital bed sadly*.' Fathers also recalled memories of visiting sick and dying relatives in hospital, describing feelings of anxiety that were linked to unfamiliarity with, and dislike of hospitals.

Ambivalence about hospital gave rise to fathers' need for midwives to be dependable and confer a sense of stability and security. When they left the room for any reason, fathers often felt more anxious if they did not return within the timeframe given. In his work role, one father provided services to people in their homes, which involved keeping to agreed appointment times. He made this analogy when talking about his expectation that midwives would be reliable, relating how irate his customers would be if he was late for an appointment.

Other fathers also drew on their work experience and skills to develop their own constructs around what was happening during labour and to navigate what was happening in this unfamiliar environment. For one, his legal background was evident in the way he framed his role, which was to observe, but to 'stay out of the midwife's way'

unless something was going 'horribly wrong'. Another used his 'management perspective' to assess what was happening in the birth environment, taking in both what was occurring moment-by-moment and the 'bigger picture'. Thus he employed work-acquired skills (in dealing with complexity and uncertainty) to interpret what was happening in labour:

...I think it's my job as well – I'm *used* to keeping half an ear on ev'rything that's going on *around* me, while I'm dealing with whatever's in *front* of me...you're trained to know *ev'rything* that's going on, as *much* as possible...

Parents' interview Ashley and Graham N27

7.3.3.2 Fathers draw analogies from other areas of their lives

Fathers created analogies from other areas of their lives as they worked to interpret what was happening, what their role should be and how to manage their own emotions. Sporting analogies were frequently used, for example one father described feeling '*... behind the ball on it...I was picking up what midwife Shona said and then starting to deal with it with Ashley...*' (Parents' interview Ashley and Graham N27). During this rapidly-progressing second labour, he described 'running to catch up'. Another drew on the experience of jogging to frame what was happening during labour, using the analogy of needing to move through pain to reach the goal.

Fathers used further sporting analogies to frame their support roles, recognising that physical touch,

...can be reassuring and you see sportsmen do that, you know a bit of physical contact it's just good for the positive mentality thing...

Parents' interviews Rae and Will N30

This father likened the verbal encouragement he was giving as '*...chanting her on, 'Go on Rae!*'. As he said this, it sounded like a football chant. He described his role as '*...more like a cheer-leader, I was trying to be peppy and positive and just reassuring basically... you know, stand there with me pom-poms*'. He also compared the scale of the emotions he felt, with the experience of being at a live football game:

...if you go to a game, you get the atmosphere you get...70,000 people around you who are also experiencing with you... And that's how it felt in the room, as if there could have been that many people there, like you know, chanting her on – but...at the same there was just two people in the room there was just me and her in the room, me and Rae in the room...

Parents' interview Rae and Will N30

Physiological labour, especially the early stages with a first baby, can unfold very slowly. To the father, watching his partner in pain, with little idea about what lay ahead, this slowed-down pace and apparent lack of progress could give rise to anxiety and an

expressed desire for timescales and predictability. In adjusting to this environment, one father used a comparison with his experience of decorating his home:

...well that *first* bit - 'cos you couldn't see the results...it's like prepping a room to paint it. But you can't see the results. But when you get to the labour ward, it's still hard, it's the hard bit, you're putting on your final coat...but you can see the results, so it drives you on. So the *baby's* there, the *doctor's* sort of saying, 'And I can see the *head...*' - but that stage *before* it, you can't see any of the results...

Parents' interview Hazel and Ben N25

7.3.4 Fathers subjugate their feelings

During fieldwork, as she observed midwife-father communications, the researcher was able to record fathers' emotional responses which the midwife either had not noticed, or had been unable to respond to at the time. During interviews, many fathers spoke at length about their feelings during childbirth. As previously conveyed, midwives did make comments demonstrating awareness of the difficult emotions that fathers may have experienced. However, during labour, when the midwife's focus was on the woman, she did not address these with the father.

While the midwife focussed on the mother, the researcher repeatedly recorded fathers' quiet, watchful waiting and their intent focus on their partner:

Ayesha half-sits, half-lies on her right side, propped up on the bed. Hamid sits next to her and watches intently as she rocks to and fro and breathes the gas and air. She reaches for his hand. His eyes never leave her face.

Fieldnotes Ayesha and Hamid N22

As fathers kept their vigil, they betrayed signs of the emotions they were experiencing only by small non-verbal cues. Verbal articulation of their feelings was very rare, usually confined to snatched conversations with other family members, out of the hearing of the woman in labour. Their joy and relief after the baby's birth were more openly expressed.

7.3.4.1 Fathers' feelings of anxiety during labour

With one exception, every father described feeling a degree of anxiety during labour. For some, the undercurrent of anxiety was ever-present: '*...I mean I was sort of constantly worried...at each stage, I was just waiting for - bad news...*' (Parents' interview Jo and Ricky N23). Others appeared more relaxed overall but shared the view that '*...it does very much so toy with your emotions, birth...*' (Parents' interview Rae and Will, N30).

There were repeated examples of fathers working to suppress their feelings, which were betrayed by signs of underlying emotion: '*...Jack leans over Dawn and embraces*

her. *His shoulders are shaking...*' (Fieldnotes Dawn and Jack N29). There were also overt indicators of depth of emotion; again, attempts were made to disguise these:

Jack is sitting on the armchair. He leans forward (maybe to hide his face) and wipes away tears with his hand. He looks distressed and lonely.

Fieldnotes Dawn and Jack N29

There were many such examples, drawn from labours which were proceeding 'normally' from the midwife's point of view. There were no problems with mother or baby, yet the intensity of the fathers' emotions was clearly visible. When problems did occur, requiring the mother to move into a different birth environment for medical intervention, the father's anxiety levels escalated. For example, when Jo (N23) who had planned a homebirth, needed to transfer into hospital, the researcher witnessed Ricky saying goodbye to Jo:

Jo and MW Lynn are going in the ambulance, Ricky's following by car. He says to Jo as she climbs into the ambulance, *Goodbye. You're doing great. I love you.* He kisses her.

Fieldnotes Jo and Ricky N23

This father was clearly working hard to control his emotions; during interview later, he explained why:

...you're *in* a medical situation...there *is* always the chance that...well, it might be the end! You're like – something could've happened in the ambulance, or, in *theatre* or something – and you *could've* died. So I just wanted to say goodbye, 'cos – I love you, and stuff like that...

Parents' interview Jo and Ricky N23

For the fathers whose babies were born in theatre, the anxiety they had felt during labour increased to levels that would best be described as 'terror'. The following extended extract from a parents' interview is illustrative:

Ricky: And then...when they said the head had come out, I remember just before *that*, all the *blood*, like the *blood* just...like - *dripping*...like, almost like a *river* off the bed [*Jo is half-laughing in disbelief; I'm so sorry!*] I remember thinking, 'I don't know if that's *normal* - or not'. I was like...are you sure, *surely* if it was going to – if people are going to bleed *that much*, they'd have something to *catch* it? Rather than just...*dripping* all over the floor! Yeah! I remember thinking... '*Shit*, that looks *bad!*' Sorry, pardon my language. 'That looks *bad*. But I can't let...Jo...I can't let Jo know that I'm – slightly *freaking out!*' [*R is laughing? nervously as he talks and J joins in with her own nervous laugh*] So...

Jo: You did a *very good* job of covering that up!

Ricky: I didn't really know - like - just trying to encourage you, 'You're doing really well', but at the same time, thinking, like the baby's going to be *dead*...So I remember thinking, 'If it's not *crying*', it's not really *doing anything*...'

Jo: See I thought that was a *good* thing!

Ricky: See I thought he was *dead!* [*J is heard laughing – disbelief was on her face*] When he first came out. [*J Oh God*] ...

Jo: They wouldn't show you a *dead baby* would they?

Ricky: I don't know!

Parents' interview Jo and Ricky N23

This father's visual perspective had enabled him to witness the actions of the medical team working to deliver the baby. He was shocked at the degree of effort involved, which caused his partner's body to shift down the table. During this interview, two weeks after their baby's birth, the parents discussed the entire experience for the first time; the father repeatedly used language which minimised his own suffering. In this way he continued to subjugate his own feelings and to protect his partner from them.

7.3.4.2 Strategies fathers employed to deal with emotions

Every father worked hard to keep difficult emotions under control and to conceal them, explaining that this was necessary to protect his partner. Hearing the women's expressions of pain, to which midwives are habituated, was a searing experience for fathers. Described by one as 'shrieks of pain', many fathers described vividly the impact upon them of the woman's cries during labour. Witnessing this pain caused feelings 'uselessness', which fathers attributed to their inability to remove it.

The father feeling disorientated, unsure of his role and input, risked rendering him a helpless bystander as the woman laboured to deliver their baby. One father, who identified such feelings, corrected his partner when she mis-interpreted them:

Hamid: I just wanted to know *what* to do! But I did *not* know what to do! It was the - feeling of *helplessness* –

Ayesha: I know – the fear of the unknown.

Hamid: It's not the fear of the *unknown* – it's being *helpless!*

Parents' interview Ayesha and Hamid N22

Midwives are accustomed to the attentive watching and waiting that lie at the heart of care during a straightforward labour. For some fathers, this enforced inactivity at a time when they felt anxious and stressed, was almost intolerable. Fathers used strategies such as 'keeping busy' as an antidote to these feelings. In hospital, there were few activities to provide such distraction; the offering of a constant stream of verbal reassurance was employed as an alternative which helped fathers to feel as though they were 'doing something' and being 'useful'.

Fathers' exhaustion also played into their anxiety and their general ability to function. Some snatched short breaks, while staying in the room, having snacks in an attempt to keep energy levels up. These fathers made no mention of their hunger and exhaustion; they remained close to their partners because there were no other family members present to take their place. Where the father was supported by others, he was able to leave the room and take a break, using this 'time out' to compose himself, again protecting his partner from how he was feeling. In the absence of wider family support, fathers appeared more reluctant to go out for a break.

When fathers were unable to take a break by leaving the room, some described creating some psychological distance, by imagining this was a story that was happening to someone else, or focussing on the 'everyday' world outside the room. Other fathers identified that during labour, they had been in a different and altered state of heightened awareness. This was observed frequently during observations, as fathers 'scanned' the environment, apparently seeking clues as to how to interpret events. Will (N30) noted, '*...shortly after the baby was out, I think I snapped out of my zone that I was in*' and elaborated:

I had no idea what to *do*...it was like I'd taken a step *out* of myself and I was looking down at myself for a moment and I just ended up laughing just like, wow, what am I doing, what, what *can* I do, this is *crazy*...for a moment I kind of *lost* a sense of reality...

Parents' interview Rae and Will N30

In such situations, the attention of midwives and other health professionals were focussed on the safe delivery of the baby while the father dealt with his strong emotional responses to what was happening.

7.3.4.3 Relief and joy at the baby's birth

Following the hours of labour, during which fathers experienced a rollercoaster of emotions as they worked to subjugate their own needs and feelings, the joy at the baby's birth was overwhelming and often openly expressed. Midwives were observed to include the fathers in their gaze at this stage; as previously conveyed, they shared in this flood of positive emotion experienced at the baby's birth. Although the experience of supporting his partner in labour had been a taxing ordeal for some fathers, none expressed regret at having chosen to be there. The joy more than compensated for the anxiety, fear and helplessness that had gone before; it was coupled with relief that their partner had come through the labour he had witnessed.

7.3.5 Fathers working out how to 'be' during childbirth

Fathers expressed they received little guidance during pregnancy or labour on what their roles could be. As previously conveyed (Section 7.2.2), midwives saw the father

as a resource and yet this perception did not accord with fathers' experience; several felt that the midwife did not tap into their potential contribution:

...and what *really* puzzled me...Why not *utilise a resource*? The *husband* is a *resource*! ...For me, it was just an *under-utilisation* of a resource that was there in *front* of them, y'know, it was *in their face* – 'I am here! I am ready to help!'

Parents' interview Ashley and Graham N27

A further challenge for the father was having to adapt to waiting patiently for labour to unfold. Providing verbal encouragement was perceived by some fathers as an 'activity' and a way of passing the time. It also fitted well with midwives' ideal of a good supporter. Where the woman valued verbal support or comfort measures, these also fulfilled the father's need to divert his attention from his own anxiety. However, whilst 'being busy' might fulfil a need in the father, it was not necessarily helpful for the woman. Some women preferred to focus on their labour with a minimum of partner-input, which they found distracting. For those couples, the father had to navigate different ways of dealing with enforced inactivity.

A major challenge for fathers, as they navigated the world of childbirth, was the unpredictability of the journey that labour would take. The intensity of the unfamiliar situation for the father, especially in unfamiliar hospital settings, was exacerbated by the many 'unknowns' of the course of the labour. Being in a confined space and close proximity to other people reminded the researcher, from the first observation, of being on an aeroplane flight. The biggest 'unknown' was how long the flight would last. With this insight, the researcher acknowledged the challenges the father faced in navigating his roles.

7.3.5.1 How long is the flight, where are we going and what is my role?

The researcher's analogy between childbirth and being on an aeroplane flight grew more significant and multi-dimensional as data collection and analysis progressed. It was particularly relevant to labour in hospital, where the players are within a confined space. The proxemics of the situation brought the father into close physical contact with strangers. He had limited recourse to activities, outside distraction and the ability to meet his own practical needs.

The mother and midwife have clearly defined roles; in contrast, as previously highlighted, the father's role is ambivalent. His expectations of his role, including in relation to the midwife, are also contained within the flight analogy. He was unsure whether he was expected to be passenger, steward, or 'co-pilot' as conceptualised by Will (N30). Some fathers were prepared to 'sit back' and leave the midwife to get on

with her job. In contrast, one expected to be 'in the lead' in supporting the woman, prepared for this role by attending hypnobirthing classes (Jo and Ricky, N23). In effect, he was looking to 'fly the plane' in close communication with the midwife. This was in contrast to the father who viewed himself as passenger alongside his partner, or as co-pilot with the midwife. At homebirths, the father acted as steward who offered the care, refreshment and distraction to help the journey pass more quickly and comfortably.

There were also parallels between the role of the midwife and that of the cabin crew in conveying a sense of calm and 'normality', which may help passengers to contain their anxiety. Expanding the analogy further, on a flight, the provision of information may serve to reassure an anxious passenger, for example when turbulence causes a period of 'bumpiness'. When the midwife volunteered information about what was occurring, this was valued by the father in terms of helping him to interpret events; it 'anchored' him into what was happening. Midwives know that the course of labour is unpredictable. This may lead reluctance to do the 'thinking out loud' that was valued by fathers, recognising that this may result in disappointed expectations.

The unpredictability of childbirth is a familiar feature of the childbirth landscape for the midwife. She is used to managing the 'unknowns' about the course and length of labour. This highlights an interesting difference between childbirth and an aeroplane flight. On an uneventful flight, the length and destination are predictable. With birth, there are fewer certainties, particularly concerning length of labour.

These uncertainties combined to compound the father's feelings of anxiety. In addition, he has a close and personal relationship with the mother and is committed to staying for the entire flight. The midwife, in her professional role, is working a shift. Midwives were observed to 'pace' their input and energy as they cared for the woman in labour, with their involvement becoming more intense as labour progressed. The midwife also knows when the stopover for re-fuelling is scheduled and that she will be leaving at that point. Managing these uncertainties within an unfamiliar environment is inevitably very challenging for fathers, especially those present during labour for the first time.

This highlights one of the most challenging roles for many fathers: to 'simply' be present, without apparently 'doing' anything, conceptualised as 'silent solidarity support'. More tangible aspects (comfort measures and verbal support) were visible; they were both easier for the midwife to teach and for all involved to identify. They also received strong approbation from the midwife. Quiet presence and emotional support were the states that appeared to be most alien and unlike everyday life for most fathers. This finding highlights the potential for the midwife to help the father to discover and develop his role during childbirth.

7.4 Summary box

- The midwife's socialisation into the world of childbirth means she 'takes for granted' many aspects of this world. This may include the father's presence.
- The father is in an unfamiliar world which he must learn how to navigate.
- There is no standard approach taken by the midwife to exploring couple's expectations of father's role. Both midwives and fathers make recourse to assumptions and guesswork.
- Midwives recognise the potential for complicated birth to be distressing for fathers, but do not register that a 'normal' labour can cause acute anxiety.
- Midwives place high value on fathers who are busy, actively involved and physically close to the mother; they focus on giving 'tasks' to the father.
- The enforced inactivity in hospital may increase the father's distress, because 'busy-ness' is a distraction from his own anxiety.
- 'Watching and waiting' are key elements of the midwife's role in straightforward labour. This may cause feelings of intense helplessness for the father.
- The father's silent solidarity support may be most helpful for the woman.
- There is untapped potential for the midwife to help the father discover and develop his role within the birth space.

Chapter 8 Synthesis of findings

8.1 Introduction

This chapter provides a 'bridge' between the 'Findings' and the 'Discussion' chapters.

The findings from the three preceding chapters are synthesised as follows:

1. Key findings about the midwife-father relationship
2. Midwives' and fathers' experiences of the childbirth landscape
3. The midwife-father relationship in different birth environments
4. Midwives' and fathers' expectations
5. The birth triad: its potential for knowledge-sharing

8.2 Key findings about the midwife-father relationship

The use of direct observation as the central data collection tool enabled insights which would not have been revealed by interviews alone.

8.2.1 Midwives and fathers: the nature of their communications

The midwife-father relationship is founded solely on communication which is characterised by guesswork and assumption. Communication is a fundamental element of the midwife's relationship with the mother, but in addition, she has a defined role to fulfil: to provide midwifery care and assist her to birth her baby. The midwife does not provide any clinical care to the father, therefore their relationship is entirely communication-based.

8.2.2 Non-verbal communications are central to the relationship

Communications between the midwife and father are largely non-verbal. There are verbal elements, for example 'chat' and social banter, designed to build rapport; midwives also offer information and explanation. These verbal elements are almost always initiated by the midwife. It was rare to witness the father asking a question, or initiating a conversation. The father watches the midwife intently, seeking cues and clues as to what is happening. Through her non-verbal and verbal communications, the midwife often includes the father as she interacts with the mother, but rarely has separate dialogue with him.

8.2.3 A relationship based on guesswork

This study found that the midwife-father relationship is based on largely on guesswork, combined with elements of assumption. The father and the midwife have a shared priority: the woman's care and well-being. The midwife recognises that the father also has needs, but because these were not explicitly explored, at times they were not met. The midwife tries to 'pick up' how the father envisaged his role during the labour; she

also assumes that if he was 'multiparous', his past experience would equip him for this birth. The father, in turn, tries to work out what the midwife expects of him.

8.3 The childbirth landscape: midwives' and fathers' experiences

Midwives and fathers perceive and experience the landscape of childbirth very differently. These critical differences underpin many of this study's key findings. Midwives are habituated to the world of childbirth. Being present during birth is part of the 'taken for granted' work of their role. The father's presence in the birth space has become accepted and is also 'taken for granted' by the midwife. For the father, birth is a momentous, extra-ordinary experience. In post-birth interviews, midwives acknowledge this. However, most did not appreciate that even when labour is straightforward, it is nonetheless a deeply intense experience for the father, often underpinned by worry and anxiety.

8.3.1 Birth as a 'social event'

The presence of other lay companions during labour has a significant and beneficial impact for the three key players. For the father, their presence mitigates the unfamiliarity of the childbirth landscape; for the mother, it provides reassurance that her partner has his own 'designated supporter' and so relieves her of this responsibility. The midwife plays a role in facilitating the involvement of other birth companions; they in turn support her as she provides care.

This is a clear and unexpected finding from this study, whose primary focus was on midwife-father communications within the triadic relationship of the three central players. In the social situation of childbirth, however, it is important and relevant to see these communications in the context of other players who were present. The parents who invited other family members to be involved, did so in the expressed hope that their presence would offer support for the father as well as to the mother. These expectations were fulfilled in each case.

8.3.2 How midwives can help fathers to navigate

Fathers recognise midwives' skills in both assessing what is happening in the 'here and now' and using their experience to scan the road ahead and anticipate likely events and timescales. They would like midwives to do more 'thinking out loud' about what is happening, to help them to navigate this unfamiliar landscape.

8.4 The midwife-father relationship in different birth environments

The differences between midwife-father communications at home, compared with hospital environments, demonstrate the choice, autonomy and flexibility the father can exercise when in his own environment. At home, the father has the freedom to move in and out of the birth environment; he is available to the woman if and when needed, but not necessarily present with her at all times. At home, fathers were more likely to ask questions and initiate social chat with the midwife. In hospital, communications were generally initiated by the midwife, with notable exceptions. This finding, along with others (for example around sharing of tasks and responsibilities at home) demonstrates that the midwife-father relationship at homebirth is that of co-workers.

8.4.1 Fathers confined

In hospital birth environments, the father is in effect 'confined', as if on an aeroplane flight. The researcher made this comparison during early observations in hospital. In her clinical midwifery role, she had the freedom to move in and out of the birth environment. In her researcher role, she aligned herself with the father, so in this respect her experience reflected his. 'Being confined' represents a key difference between hospital and home birth.

8.4.2 Freedom and autonomy

A planned homebirth affords the father a higher degree of control over the environment and the freedom to do as he wants – to move around from room to room; enter and leave the birth environment; create his own domain; occupy himself with 'legitimate tasks'. Fathers at home were observed moving around freely and initiating interactions with midwives. At home, the father also plays a significant role in assisting the midwife in practical ways. Together, they prepare the home for the baby's arrival. The father has responsibilities which give purpose and clarity to his presence and role.

8.4.3 Fathers and maternity theatre

Maternity theatre is the birth environment that is most unfamiliar for the father. It arouses feelings of intense anxiety and fear. Midwives are aware of this, but in this environment they are least available to offer direct support to the father.

8.5 Midwives' and fathers' expectations

Every father's priority is the midwife's care of his partner. The father and midwife share this priority. Midwives express recognition that every couple is different and that each dyad has different expectations of the father's role. However, their behaviours and

comments during interview suggest that there is a conceptualisation amongst midwives of an 'ideal' birth supporter.

8.5.1 Midwives and the 'ideal' birth partner

For midwives, an 'ideal' birth partner is one who is physically close to the woman, offering practical comfort measures and verbal encouragement. This signals that he is positively engaged. The findings suggest that midwives are most comfortable with this 'ideal'. Midwives express awareness that some fathers wish to be more actively 'involved' than others, but their ideal does not acknowledge the 'silent solidarity support' and intense focus on the woman which is a powerful element of father-support witnessed in all this study's observations.

8.5.2 Fathers' expectations

Fathers do not expect their needs to be prioritised in any way. However, they do have varying expectations of their possible roles and look for different types of involvement. There is very little discussion about these issues. The father values information and guidance from the midwife. Some would have appreciated affirmation of their role, looking in vain for this approval; these fathers felt that their input during labour was 'taken for granted' by the midwife as they were lower down on her list of priorities.

8.6 The birth triad: its potential for knowledge-sharing

The three key players are conceptualised as the birth triad. Between them, they hold a wealth of complementary knowledge. This study finds that there is great potential for this knowledge to be shared. More effective communication between the midwife and the father could enable this to happen. There is untapped potential for the midwife to learn about the woman from the father, and for the father to learn about childbirth from both the woman and the midwife. Currently, the midwife's expectation is that the father should prepare for and learn about childbirth during pregnancy, via antenatal classes. To unlock the potential for the father to learn during childbirth, the midwife's expectations would need to change, so that she sees labour as an ideal opportunity for the father to gain knowledge and understanding. The father's presence during childbirth is a very recent phenomenon; this study demonstrates that all members of the birth triad are in the process of negotiating his place and roles.

8.7 Summary box

Synthesis of findings

- Key findings about the midwife-father relationship
- Midwives' and fathers' experiences of the childbirth landscape
- The midwife-father relationship in different birth environments
- Midwives' and fathers' expectations
- The birth triad: its potential for knowledge-sharing

Chapter 9 Discussion and conclusions

9.1 Introduction

This is the first study to focus on midwife-father communications during childbirth.

These are the key findings:

1. The midwife-father relationship is founded on communications which are characterised by non-verbal elements, assumption and guesswork.
2. Midwives and fathers experience the childbirth landscape in fundamentally different ways. There is scope for midwives to help fathers to navigate this unfamiliar landscape.
3. Birth environment, in terms of places and people, impacts significantly on midwife-father communications. The presence of additional birth companions affords particular support to the father.
4. There is considerable variation in fathers' expectations of their roles during childbirth. These are rarely discussed with midwives. Midwives have a concept of an 'ideal' birth partner which may not accord with parents' preferences.
5. There is untapped potential for the members of the birth triad to engage in knowledge-sharing to the benefit of all.

There has to date, been scant focus on midwife-father communications. These findings contribute new knowledge about this specific area and add to existing literature about fathers' experiences. The methods adopted are important. Most studies about fathers' experiences have collected data via interviews or questionnaires, as established in the Scoping Review (Chapter 2); to date, few (Chapman, 1991; Jepsen et al, 2017) have employed direct observation. This is the first study in which *all* parent-participants were involved in data collection via both observations and interviews. The use of ethnography was key to the study's central findings, for example about the largely non-verbal nature of midwife-father communications. Such discoveries would not have been possible using interviews alone. In addition, the use of multiple birth environments enabled a novel contribution with the comparison of differences in midwife-father communications within each.

In ethnographic research, the highlighting of themes that are unexpected or unusual contributes to demonstrating the study's trustworthiness, as previously conveyed in the Methodology chapter. The researcher chooses to frame unusual cases as 'unique' (Small, 2009) and 'variant' (Morse, 2018). These positive terms reflect the fact that such cases shed fresh light on the study's findings. They are highlighted as 'variant cases' throughout the discussion.

This chapter has four sections:

- Statement about the study's original contribution to knowledge
- Situation of key findings in relation to the wider literature and Vygotsky's sociocultural theory of human development (Hopwood, 2013; McLeod, 2018).
- Strengths and limitations
- Recommendations for practice, research, and policy

9.2 The study's original contribution to knowledge

This study is the first to focus specifically on midwife-father communication during childbirth. Communication forms the entirety of the relationship, since no clinical care is involved. This study finds that non-verbal communications form a key element of the interactions between midwife and father. Previous studies have found that the father often feels side-lined during labour (Backstrom and Herlfet Wahn, 2011; Lindberg and Engstrom, 2013; Thies-Lagegren and Johansson, 2019) and suggest that the midwife is well-placed to involve him (Longworth and Kingdon, 2011). This study found that comments addressed to the father by the midwife increased his sense of involvement; there were many instances where this occurred, but missed opportunities were also observed and reported. Fathers were most likely to feel side-lined during births in maternity theatre.

This study identifies the dyadic midwife-father relationship as a discrete element within the birth triad. This finding indicates the importance of developing a framework for discussion between the midwife and father in order to meet his individual and independent needs. This is envisaged as part of a three-way discussion which involves mother, father and midwife.

Birth environments

Data were collected for this study in a range of birth environments. Included within the concept of 'environment' are the people who inhabit the birth space. Previous studies have tended to focus on hospital (see Table of ScR studies, Appendix B) or home (Jouhki et al, 2015; Lindgren and Erlandsson, 2011) or on fathers' experiences of transferring from one birth environment to another (Kuliukas et al, 2017). This study's inclusion of four different birth environments enabled rich comparisons to be made between home and hospital and how the different settings impacted on midwife-father communications.

This study reveals that the involvement of additional birth companions impacts on midwife-father communications, as well as on all other dynamics within the birth-space. Their presence can be of great benefit to each of the three central players. These

findings have clear implications for midwifery practice within the institutional environment, for the organisation of the environment itself and for hospital policies regarding the inclusion of additional birth companions.

Midwives' conceptualisation of an 'ideal' birth supporter

The midwife-participants in this study stated they welcomed and valued the father during labour. They perceived him as the person who was best-placed to support his partner, due to his knowledge of and relationship with her. However, even though each father knew his partner well, this intimacy did not necessarily prepare him for how her behaviours may change during labour. This was especially true for the 'primiparous' father and was exacerbated by his need to adapt to the unfamiliar landscape of birth. The midwife therefore had expectations about his ability to offer appropriate support which the father may be unable to fulfil.

Midwives placed clear emphasis on the father's active engagement and 'busyness', as denoting his involvement. By implication, the absence of such behaviours was perceived as 'passivity' or lack of involvement. This study found that some fathers offered 'tangible' support (including, for example, staying physically close to the mother, embracing her and giving high levels of verbal encouragement). However, observation revealed that every father focussed intently on his partner and offered what this study identifies as 'silent solidarity support'. Such support was witnessed, whether or not the father was continuously (physically) present in the room. This finding runs counter to midwives' ideal of 'busyness' denoting a 'good' birth partner.

9.2.1 What was revealed through the lens of ethnography?

Ethnographic studies of labour and childbirth are unusual, as previously established, due to the ethical and practical issues involved. The choice of ethnography for this study enabled discoveries that would not have been possible using, for example, interviews alone. Observation revealed that midwives' reported accounts of how they engaged fathers did not necessarily accord with what happened in the real world. Also, fathers' needs were at times greater than midwives may have realised, especially when birth was straightforward from the midwife's perspective.

Midwives' and fathers' perceptions of the birth environment

The potential of ethnographic investigation to reveal midwives' 'tacit knowledge' (Francis, 2013, p.68) was realised in relation to their confidence and ease within this landscape. In contrast, fathers were disorientated by their exposure to this world and needed support to acclimatise. Employing an ethnographic approach also revealed differences between the physical and emotional intimacy of childbirth, as compared

with many other social situations. The midwife is habituated to this, the father is not. This discovery would not have been made without the use of direct observations.

Observations in different birth environments revealed many differences between the father's experience of birth at home and in hospital. These included important differences in midwife-father communications. Ethnographic observations showed that 'environment' for birth is far more complex than the built environment. It includes all the people within it. Ethnography highlighted issues about the proxemics involved in childbirth and the 'containment' of the father within the hospital environment. Ethnography also enabled interesting and unexpected findings about the presence of additional birth companions and their impact on all the relationships within the birth-space relationships.

Complexity of the midwife's role

Direct observations revealed the complexity of the midwife's role as she provides clinical care, establishes rapport and learns about the couple. In the course of her everyday work, the midwife fulfilled her primary professional duty of caring for the mother and baby, whilst managing a complex range of responsibilities and relationships with skill and ease that were revealed by direct observation, but which she took for granted. The father's presence is now accepted within the birth environment. This study finds that this presence has become taken for granted by the midwife. This acceptance confers benefits for the parents but also potential disadvantages in terms of identifying and responding to the father's unmet needs.

9.3 Key findings situated in relation to existent literature

The key findings will next be situated in relation to existing literature, before offering a way of considering these findings in relation to Vygotsky's (Hopwood, 2013; McLeod, 2018) sociocultural theory of learning.

9.3.1 The midwife-father relationship: characterised by non-verbal communication

The definition of 'communication' adopted for this research, as previously outlined, is:

...shar[ing] information with others by speaking, writing, moving your body, or using other signals...talk[ing] about your thoughts and feelings... help[ing] other people to understand them...

(Cambridge English Dictionary, CED, 2020).

The root of 'communication' lies in the Latin verb *communicare* meaning 'to share'. Involving sender, message and recipient, effective communication implies a connection between people 'that allows for the exchange of thoughts, feelings and ideas and leads to mutual understanding' (Mager, 2017). Mager highlights that the 'message' is

composed both of word-based content and also feeling and emotion, conveyed through such non-verbal cues as pitch and tone of voice, body language, facial expression and gesture. This study's finding that midwife-father communication is based primarily on non-verbal components results in both individuals engaging in guesswork. The midwife and father seek to establish mutual expectations through a combination of interactions, with direct verbal communication performing a minor role in most instances.

Direct observation revealed that the use of non-verbal communication – the '*other signals*' of the definition above (CED, 2020) – played a more significant role in midwife-father communications than conversation. It also revealed that in most cases, verbal communication was initiated by the midwife. It was rare for the father to address a comment or question directly to the midwife; he waited to be spoken to and engaged.

An extensive body of knowledge has developed around midwife-mother communication since Kirkham undertook her seminal ethnographic research in 1987. The area has been further studied by the original author and others (Hunter 2006; Hunter et al, 2008; Kirkham, 2000, 2010; Lewis et al, 2017). In comparison, midwife-father communications have to date received scant attention, although there is some research that considers aspects of midwife-father communication in the context of the midwife / mother / father triad (Hallgren et al, 2005; Jepsen et al, 2017; Kuliukas et al, 2017). One study was identified whose focus was healthcare professionals' interactions with fathers (Dallas, 2009). This covered the entire childbirth continuum up to 24 months after the birth and recruited adolescent black fathers. Some of its findings have implications for other groups of fathers; others are of specific relevance for this particular sub-group.

Research on fathers' experiences of childbirth consistently highlights that the midwife is ideally placed to offer information to the father, so reducing his anxieties, and to involve him in practical ways (Backstrom and Herflet Wahn, 2011, Backstrom et al, 2017; Hildingsson et al, 2017; Longworth and Kingdon, 2011; Porrett et al, 2012). The importance of inclusive communication, through relating to the parents as a couple, has been clearly identified (Backstrom and Herflet Wahn, 2011, Backstrom et al, 2017; Chandler and Field, 1997; Ledenfors and Bertero, 2016). Existing research also recognises that the father has specific needs which are independent from the woman's: for information, support and reassurance (Deave and Johnson, 2008; Eggermont et al, 2017; Eriksson et al, 2006; Rominov et al, 2017; Symon et al, 2011). However, there is a dearth of research whose specific focus is on practical ways of meeting those of the father's needs which are independent of the woman's (Hollins Martin, 2009). This current study's findings highlight a practical way to do so: through open dialogue between father and midwife. The current study's findings also suggest that the father's

needs may, at times, run counter to the woman's. For example, as the intensity of labour grows, the woman may become verbally non-communicative. Her overriding need may be for a peaceful atmosphere and feeling of security (Odent, 2008); she may not appreciate or benefit from the verbal explanations which are particularly valuable for the father.

This study found that as labour progressed, the father's levels of anxiety, displayed through non-verbal cues and reported in interviews, tended to increase. At this time, the woman's attention was focussed on dealing with the accompanying powerful sensations. Existing research, spanning a period of 30 years (Bertsch et al, 1990; Chandler and Field, 1997; Chapman, 2000; Ledenfors and Bertero, 2016; Roberts and Spiby, 2019) illustrates how the father's feelings of helplessness and anxiety increase as labour progresses. Such feelings are most likely to arise when the comfort measures he offered in early labour are no longer welcomed by the woman (Ledenfors and Bertero, 2016). The current study's findings are consistent with the findings of these previous studies, but extend them by highlighting that this is the time when words of explanation and reassurance from the midwife to the father would be of great value. It should also be acknowledged that this is the time when the midwife's attention is most clearly on the woman. This was particularly the case in maternity theatre, where the focus was on assisting the safe birth of the baby; there were very few verbal communications between any of the players. The presence of a large group of health professionals and the atmosphere of watchful expectancy induced levels of anxiety in the father. These were later described (by fathers) as 'terror', associated with thoughts that the mother or baby might die.

Fathers expressed a desire for the midwife to 'think out loud' to enable him to interpret and understand the woman's behaviours. Early studies of father-involvement in childbirth identified that he looks to the woman as his guide to what is happening and what he needs to do to help her (Chapman, 1991; Somers-Smith, 1999). This expectation may be unrealistic; even if he knows his partner well, her behaviours in labour may be unexpected and alien to him. The midwife is well placed to help him understand what is happening for his partner and suggest useful ways to respond. Such father-specific communication could also help to reduce the father's feelings of being 'side-lined' when the woman does not acknowledge his presence. These feelings have been highlighted in previous research (Roberts and Spiby, 2019). The current study found that when the midwife adopted an educative role, sometimes because she had a student working with her, this equated to the 'thinking out loud' that the father sought. This underlines the importance of the current study's finding that fathers benefit from midwives 'thinking out loud' even when, from the midwifery perspective, all is

going well. When the midwife offers information and explanation via explicit verbal communication, this is very valuable to the father in addressing his unspoken concerns. It also opens the possibility of dialogue.

This study found that the powerful, focused attention of the father on the mother during labour (conceptualised as 'silent solidarity support') does not equate with passivity or lack of interest and engagement. However, without the feedback and reassurance from others in the triad, he may not recognise the value of this type of support. Furthermore, it may run counter to the midwife's 'ideal' of a busy, active birth partner. It reiterates this study's finding that it is vital - for the father - that the midwife articulates clearly that his 'presence' is of great importance to the woman.

Existing research demonstrates that the father underestimates the value to the mother of his 'presence' and simply 'being there' (Kainz et al 2010; Thies-Lagegren and Johansson, 2019). Roberts and Spiby's (2019) study suggests that for many men, 'doing nothing' – in any environment - runs counter to their conceptualisation of appropriate masculine behaviour. In identifying the role of 'silent solidarity support', this study highlights the benefits for both the midwife and the father of re-framing the gendered expectation that the father's presence is of most benefit when he is 'busy'. Chapman's early research identified three roles played by the father during labour: that of coach, team-mate and witness (Chapman, 1991); however, this framework has not yet been applied and evaluated in practice. The valuing of 'silent solidarity support' accords with the role of being a 'witness' to events but extends Chapman's finding; it foregrounds the importance and value of this type of support. In this study, solidarity support was observed to lie at the heart of all the fathers' presence.

There were two exceptions to the tendency towards non-verbal communication: the midwife's question about 'cutting the cord' (discussed in Section 9.3.4 below) and the direct and closed query about attendance at antenatal classes - the 'officially sanctioned' preparation for childbirth. Accurate data on fathers' attendance at antenatal classes are not available. The collation of national statistics regarding women's attendance started as recently as 2019, when the Care Quality Commission's Maternity Survey (CQC, 2020) included a question about women's attendance at NHS classes. 30% of women responded in the affirmative and partners' involvement was not recorded. A minority of fathers in this study had been to antenatal classes, which is probably a reflection of the national pattern. However, all this study's fathers had made a range of different preparations for birth which were not elicited in response to this closed question about class attendance. Research indicates that even when fathers have accessed antenatal classes, they may not feel prepared for childbirth (Smyth et

al, 2015; Tarlazzi et al, 2015). Therefore, midwives' expectations that classes afford adequate preparation for the realities of labour may be misplaced.

9.3.2 Experiences of the childbirth landscape

Midwives and fathers perceive and experience the landscape of childbirth very differently. These critical differences underpin many of this study's key findings. The midwife is familiar with the world of birth, is confident within it and takes for granted many of its features. This study found that the father's presence has become one of these 'taken for granted' features: midwives accepted and welcomed fathers; there was no question of their 'right' to be present. There were frequent examples of midwives including the father in their interactions with the mother and gestures towards meeting his needs for comfort and refreshment. This is relevant to the study's focus, because through these words and actions, midwives demonstrated their acceptance of the father's presence. These findings about midwives' acceptance of fathers' presence reflect those of the midwives in Rominov et al's (2017) study on the subject of fathers' involvement. All 106 participants completed an online survey; semi-structured interviews were conducted with 13 midwives. There was unanimous agreement that engaging fathers was part of the midwife's role. However, 83% had received no formal training in ways to work with fathers (Rominov et al, 2017). None of the midwives in the current study had participated in such training.

This current study's findings about the marked differences between midwives' and fathers' perceptions of the childbirth landscape contribute further to the findings of prior studies about midwives' attitudes to fathers (Rominov et al, 2017) and fathers' experiences of inclusion in the birth environment (Longworth and Kingdon, 2011; Premberg et al, 2012), by highlighting practical ways in which midwives can engage with fathers. This study pinpoints specific training for midwives which may be of benefit, for example, engaging in verbal dialogue with the father about his expectations, 'thinking out loud' and offering explanations of those elements of the childbirth landscape which midwives take for granted. A few words may help the father to orientate. These are considered further in the 'Recommendations' section (9.5).

For the father, many of features of the childbirth landscape which are 'taken for granted' by the midwife are deeply unfamiliar and may be a cause of stress and distress for him. For him, these features are novel, alien and often unexpected. This finding reflects evidence from Tarlazzi et al's (2015) phenomenological study. In-depth, semi-structured interviews were conducted with six Italian fathers within the first ten days after birth. The study explored the meaning of the father's experiences of his partner's labour pain; it found that for the father, the sights, sounds and odours of

labour as well as the woman's expressions of pain are a source of distress for him, which must be endured.

9.3.2.1 Proxemics and the extra-ordinariness of birth for the father

A key difference between midwives' and fathers' experiences of the childbirth landscape lies in the proxemics of birth. These involve physical and emotional intimacy which is unusual when compared with many other social situations. Proxemics theory, developed by anthropologist Hall in 1966, defines four zones of distance observed in human interaction and behaviour. 'Intimate distance' involves extreme closeness, from actual physical contact to one foot away; 'personal distance' describes situations where people are one to four feet apart; 'social distance' involves four to 12 feet of separation; large social spaces are designed to enable people to maintain 'public distance' of 12 to 25 feet, with no physical contact and little eye contact (Hall, 1966).

In childbirth, within a few minutes of meeting for the first time, the midwife, mother and father are often gathered close together, occupying the 'personal space' of two to four feet which is usually reserved for people who are known and trusted. As labour progresses, the birth triad moves closer together to share the zone of 'intimate' personal space, that is, they are in direct contact or within a foot of each other. For some couples (those where the labour is progressing rapidly and birth is imminent) this level of intimacy occurs very quickly – within a few minutes of meeting for the first time.

Such sets of interactions within intimate and personal space are, for the father, likely to be very different from his everyday life. They are usually reserved for times shared with his partner, child or another individual with whom he has a close and trusting relationship; they also occur during contact sports. In other situations where people are physically close, for example during a journey on public transport or a visit to the cinema, they sit side by side; communication with strangers, including eye contact, tends to be minimal and functional. Childbirth, by contrast, involves not only physical proximity but also the players facing towards each other, symbolising emotional intimacy. Within this intimate personal space, the father was observed to focus intently on his partner and the midwife, his mien characterised by intense watchfulness.

This finding is important. Childbirth is acknowledged to be an experience of deep emotional significance for fathers (Dallas, 2009; Ledenfors and Bertero, 2016; White, 2007). It has also been demonstrated to give rise to feelings of helplessness (Backstrom and Herflet-Wahn, 2011; Chandler and Field, 1997; Chapman, 2000; Tarlazzi et al, 2015). This study identifies that, for fathers, the physical proximity and emotional intensity of birth, to which midwives are habituated, is usually outside their experience. This points to the potential role of the midwife in easing this intensity.

9.3.2.2 How midwives orientate fathers to their world

This study found that the midwife's familiarity with the landscape of birth, her calm manner and confidence as she fulfils her role, combined with explanations and information when offered, helped – in part - to orientate the father. By these means she taught the father about birth in practical ways that are very different from the theoretical preparation offered at antenatal classes.

This important aspect of the midwife's role in relation to the father was rarely recognised or acknowledged by midwives during interview. It was another aspect of the 'taken for granted' nature of her work. Fathers paid close attention to the midwife at work, picking up clues about how the labour was going, through 'checking out' her expressions and actions. The non-verbal aspects of the midwife's communications were - in part - effective in orientating the father to the world of birth. In most instances, they received reassurance from these signals. However, his reliance on picking up clues from the midwife also meant that he had some unmet needs.

There is a downside to the midwife's familiarity with the landscape: it blunts her sensitivity to how strange, extra-ordinary and - at times - frightening it is for fathers. Due to their habituation to the world of birth, most midwives did not appreciate that even when labour is straightforward, it is nonetheless a deeply intense experience for the father, underpinned by worry and anxiety. This study found that fathers suppressed their emotions in order to protect their partner, a finding which reflects the work of Eggermont et al (2017), Ledenfors and Bertero (2016), Lindberg and Engstrom (2013) and White (2007). It highlights the importance of the midwife working with the father to identify and meet his individual emotional needs. The current study found that the father was reluctant to express his own needs, feeling he was undeserving of such attention from the midwife. This is understandable in the context of the findings of this and other studies (Eriksson et al, 2006; Premberg et al, 2011) that the father prioritises the needs of the mother over his own.

9.3.2.3 Birth as a social event

This study's focus is midwife-father communications. However, its social constructivist framework involves viewing these interactions in their social context. This led to unexpected findings about the involvement of additional birth companions, considered here as 'variant cases'.

The additional companions shared a range of characteristics. They were all women who had given birth themselves, bringing a wealth of childbirth knowledge and experience into the room. Most were related to one or other parent and were older, although the friends and sibling-companions were contemporaries of the parents. They offered 'designated' support to the father, identified by these couples as the main

reason for inviting additional companions. They provided a sense of normality for the father, knew him well as an individual and were able to offer support tailored to his needs. No other research has been identified which focuses on this issue of additional 'family and friends' birth supporters. However, the findings of Jepsen et al's (2017) study (of birthing women's partners' experiences of caseload midwifery) are relevant. When the father had met the midwife in pregnancy, his sense of being 'known' increased his feelings of inclusion during labour and confidence in the midwife and provided a valuable 'link' to the world outside the birth environment, which served to 'normalise' what was occurring within it. The presence of these lay supporters fulfilled similar functions for the parents in this study.

Each midwife involved expressed initial caution about whether the presence of additional supporters would marginalise the father, demonstrating her perception that the couple-relationship was central and primary. She was protective of this relationship and needed reassurance that the couple remained at the centre. Once received, from the respectful behaviour of the other birth supporters towards the couple, she welcomed their involvement. This finding illustrates that the midwife perceives the father as central, even though she may not articulate or demonstrate this.

Midwife-father communications were different in these situations: once the midwife was satisfied that all companions were playing a supportive role, she took a step back. Her own role became more 'observational' or 'monitoring', as she moved in and out of the circle to provide clinical care. The father drew on the support of the additional companions to help meet his own needs.

9.3.3 Midwife-father relationship: different birth environments

The inclusion of different birth environments revealed their impact on midwife-father communications, with important differences noted between home and hospital. The birth centre environment also made a difference for fathers; they commented on feeling at ease in the relaxed and 'homely' atmosphere, as compared to delivery suite. This atmosphere did not, however, encourage fathers to initiate interactions with the midwife. As in other hospital environments, they waited attentively to be addressed.

At home, the father initiated conversations with the midwife and was more likely to ask spontaneous questions. This was the most marked difference when compared with hospital. Previous research about the impact of birth environment on communications has focussed on midwife-mother interactions (Dahlen et al, 2008; Hammond et al, 2013); where midwife-father communications are mentioned, the father is treated as an adjunct to the central midwife-mother relationship (Clancy and Gurgens Gjaerum, 2019).

Three couples in the current study had chosen homebirth, a decision informed by previous experiences, combined with discussion and information-gathering during pregnancy. Fathers' role in decision-making about place of birth has been identified as an important factor in making this choice (Bedwell et al, 2011); however, Bedwell's study also highlights that fathers hold strong assumptions about hospital as being the 'normal' and safest option. The relaxed demeanour of the fathers in this study, whose partners were labouring at home, should therefore be viewed in the context that the decision to have a homebirth was made jointly by the couple and supported by the father.

9.3.3.1 Freedom versus containment

At home, the father has the freedom to move in and out of the birth environment; he was available to the woman if needed, but not necessarily present with her at all times. This freedom meant the woman also had the choice as to whether he stayed by her side or moved in and out of the room, thus removing concerns about his welfare. A range of 'legitimate tasks' required his attention and energy. This demonstrates to all the players, including himself, that he is fulfilling valuable roles. There has to date been a dearth of research into what fathers actually 'do' during labour and birth at home. However, a recent Norwegian study exploring midwives' and mothers' experiences of homebirth (Clancy and Gurgens Gjaerum, 2019) mentions the father's 'caring, housekeeping role' (p.127) during labour at home and highlights that his activities did not conform to gender stereotypes which would preclude him from, for example, doing housework. These findings resonate with the current study's. Clancy and Gurgens Gjaerum's hermeneutic phenomenological study involved seven homebirth mothers and five midwives. It gathered data about the lived experience of homebirth for mothers and midwives via focus groups, with the alternative of a written narrative account for those unable to participate. The authors stated their intention to report on interactions between mother, midwife and partner. However, although these triadic interactions are mentioned as a 'theme', the emphasis was in fact on mother's perceptions of her partner's role, for example in acting as 'host' in the home environment. Therefore the focus in the study appeared to be on the midwife-mother dyad, evidenced by the recruitment of these players, to the exclusion of fathers.

This current study found that when at home, the father is able to take breaks and look after his own needs for refreshment and recuperation. Fathers valued the autonomy afforded by the ability to look after their own needs, as well as their partner's. Previous research has identified that fathers have practical needs during childbirth that are separate from the mother's. Hospital security systems involve fathers relying on staff members to allow re-entry to the birth environment, once they have left it (Symon et al,

2011). Consistent with previous literature, the current study found that fathers felt anxious that if they left for a break, they might not be able to gain re-admittance. This was cited as a reason for one couple to opt for homebirth; it highlights the extent to which the father can feel not only marginalised, but literally excluded.

9.3.3.2 The functions of 'busy-ness'

These findings about fathers' use of activity as a strategy for enhancing their sense of autonomy and coping with anxiety are interesting when considered in the context of midwives' expressed desire to find jobs for the father to do. For midwives, the father being 'busy' and occupied is seen as a useful distraction and also evidence to all the players of his active involvement. It conforms with stereotypical norms of masculine behaviour (Driesslein, 2016) and as established, is very challenging in the hospital environment where the father's chief – and possibly only - 'legitimate task' is to support his partner by being physically present. Feelings of helplessness were clearly articulated, exacerbated in hospital by enforced inactivity and being confined in a small physical space. This was different at home, where other activities provided distraction.

This current study found that when couples did not have additional supporters present, the father was reluctant to leave the room. It revealed fathers' use of psychological distancing techniques, on occasion, to cope with their intense emotions. Previous research has also demonstrated that fathers may need the midwife's permission to leave the room and take a break. An interview study which explored the meaning of labour pain for fathers, highlighted that the midwife may need to 'instruct' the father to take a break. He was reluctant to do so without the midwife giving 'permission' (Tarlazzi et al, 2017).

9.3.3.3 The impact on fathers of birth in maternity theatre

This study found that for the fathers of the babies born in maternity theatre (n = 2), the experience was extremely stressful. They are considered here as 'variant' cases. In theatre, there was even less direct verbal communication with the father than in other scenarios. Theatre was quiet, with an absence of general social chatting which could have lightened the atmosphere. The stress and trauma experienced by fathers following complicated birth has been well documented (Daniels et al, 2020; Lindberg and Engstrom, 2013; White, 2007), although the impact (both short- and long-term) of witnessing such events has received less attention (Daniels et al, 2020).

The three studies cited above differed in their approach to recruitment and data collection which will affect their findings. However, there were recurring themes across all three. Eight fathers whose partner had required intensive care after childbirth; participated in Lindberg and Engstrom's (2013) research; the definition of 'complicated

childbirth' was therefore decided by the researchers. Data were collected via semi-structured interviews within three months of birth and analysed via content analysis. Daniels et al (2020) employed mainstream social media platforms (e.g. Twitter) to invite fathers, who self-identified as having experienced trauma during childbirth within the preceding ten years, to complete an online qualitative questionnaire describing their birth experience. Thematic analysis was used to analyse the data obtained from responses of the 61 fathers who participated. White's (2007) research involved 21 fathers, all members of an online birth trauma support group. The fathers' involvement with this group, as well as the difference in the time elapsed since their experience of trauma (within the past year and as long ago as 27 years previously), are likely to have impacted the findings.

The results of these studies are viewed in the context of the different methods employed. However, all found that fathers felt excluded, helpless and frightened during complicated births; they lacked the information they needed to understand what was happening and also did not have follow-up support to help them process the trauma experienced. The use of direct observations in this current study enabled the findings from these prior studies to be amplified. The father's loneliness, fear and lack of support witnessed during observations cannot be over-stated, yet it was suppressed at the time and minimised in later interviews. To date, insufficient consideration has been given to ways of addressing his perspective and experience when a baby is born in theatre.

9.3.4 Midwives' and fathers' expectations

The father's ambivalent status in relation to maternity care has been established in previous research (Steen et al, 2012), highlighted by the title of the authors' metasynthesis, 'Not-patient and not-visitor'. Early (2008) proposes that the father's participation in childbirth confers the status of 'consumer' of maternity services, but that his rights and responsibilities as a consumer are undefined. The current study found that some fathers sought affirmation from the midwife that their presence and roles were important. They expressed during interview that feedback from the midwife would have offered reassurance that they were fulfilling a helpful role in supporting the woman. They viewed such appreciation as recognition of their role. Importantly, it also symbolises validation of the father's emotions during childbirth and their inclusion in the experience. Studies spanning over 20 years have found that fathers have an unmet need for recognition of acknowledgement of these emotions (Chandler and Field, 1997; Chapman, 2000; Eggermont et al, 2017; Longworth and Kingdon, 2011; Thies-Lagegren and Johansson, 2019). This unmet need is combined with the studies' findings about fathers' desire to protect the woman from their own feelings and to

appear calm and steadfast by controlling transmission of these emotions. This current study highlights that fathers are managing a range of conflicting emotions whilst navigating an unfamiliar landscape. It serves to underline previous research (Inglis et al, 2016; Ledenfors and Bertero, 2016) which provides evidence regarding the ongoing post-birth distress experienced by some fathers.

9.3.4.1 Midwives' expectations of fathers: the 'ideal' birth supporter

This study found that while not asking directly about the role/s the couple wished the father to play, midwives' prototype of an 'ideal' birth supporter was physically close, verbally encouraging and spontaneous in providing comfort measures for the mother. This conceptualisation placed clear emphasis on 'busyness' and active engagement and can be traced back to the development of 'husband coached childbirth' (Bradley, 1962). The notion of the father as 'coach', with its sporting associations, has been described as conforming to gendered definitions of masculinity (Driesslein, 2016); this approach has influenced models of childbirth preparation espoused by a wide range of antenatal education providers from the 1960s to the present day, including the NHS and NCT. Two of the three roles adopted by fathers in Chapman's (1991) study – as coach and team-mate – are consistent with midwives' affirmation of 'busyness'. Encouraging the father to be actively involved suits some women and couples, but it is not a good fit for all. It further illustrates reliance on guesswork rather than direct verbal communication within the midwife-father relationship.

This study's finding that midwives perceive the father as 'the best' birth partner and uniquely qualified to support the woman in labour, is based on their stated assumption that as he knew her so well, he was best placed to fulfil this role. However, the findings also highlight that in the unfamiliar situation of childbirth, the father – however well he knows the woman – may struggle to meet her needs. To date, no studies have been identified which address this issue of mismatched expectations.

9.3.4.2 'Cutting the cord'

Midwives' invitation to the father to cut the umbilical cord after the baby's birth represented the (physically) closest and most tangible task in which he was invited to participate. It is a practice that appears to have evolved over the past 20 – 30 years, although its history is undocumented. To date, there has been little research on this issue, despite one identified study (conducted in Portugal) which describes the midwife's invitation to cut the cord as routine practice (Brandao and Figueirido, 2012). In the context of 'busyness', this act symbolised to all involved that he was actively engaged. It also conforms to performative stereotypes of masculine behaviour (Driesslein, 2016) which require men to be active and 'doing'. This current study found

that there was, on occasion, spoken or perceived pressure on the father to perform this task and that he usually conformed.

9.3.4.3 What constitutes 'being present' during birth?

Two of this study's 'variant cases' highlight the issue of what constitutes 'being present' during childbirth: the couple who preferred that the father remain physically distant from his partner during labour and the homebirth where the father was physically absent during the baby's birth. The former caused consternation on the part of the midwife; the latter raises interesting questions about the meaning of 'presence' during birth. Also relevant to 'presence' is the finding that when a woman labours at home, the father is available to her if needed, but may be absent from the birth environment for long periods of time. This finding is in contrast to the conceptualisation of the father 'confined on an aeroplane flight' analogy in hospital birth environments, where he does not have the choice to move in and out of the birth environment.

9.3.5 The birth triad: its potential for knowledge-sharing

This study identified a range of dyadic relationships playing out during childbirth. Its findings envision a re-conceptualisation of these dyadic relationships into a more fluid triadic relationship which draws the father in, to the extent that is appropriate for the couple and the situation. These findings resonate with previous research (Kainz et al, 2010) which demonstrate that when interactions flow between mother, father and midwife, the sense of the triad working as a team enhances the woman's experience. The current study extends Kainz et al's (2010) study by identifying practical ways in which such a triadic flow of communication may be developed, to the benefit of all three central players. These include such strategies as the midwife 'thinking out loud' and offering verbal explanations about what is happening. These would supplement some of the interactions that currently occur non-verbally.

9.3.5.1 How the father learns about birth

This study found that midwives perceive antenatal classes as the 'officially sanctioned' route for fathers to learn about childbirth. Little literature was found which focussed on the broad issue of how men learn about birth. Existent research (Dellman, 2004; May and Fletcher; 2013; Shirani et al 2009) reflected the perception of this study's midwives; it focused on the content of antenatal classes and the extent to which fathers' needs were addressed and met. A minority of fathers attend antenatal classes; those who do vary in their assessment of the classes' value in preparing them for labour (Smyth et al, 2015). Faced with the realities of labour, the father may find himself unable to apply what he has learned in classes (Roberts and Spiby, 2019). This

lack of empirical evidence on how men learn about birth is relevant because it highlights the importance of the midwife's educative role during labour itself.

The father learning about birth from the woman

This study found that 'multiparous' fathers had learnt about birth from their partners' previous labours. They used their experience of how their partner had behaved in past labours, to provide indicators of how this labour was going and help anticipate what might happen next. They had built up their knowledge about childbirth from being with the woman. This strategy was of limited value when the woman's subsequent labour was very different from the previous experience.

Midwives also – on occasion – helped the father to learn by interpreting what the woman's behaviours mean about progress in labour. Previous literature has suggested that fathers looked to the woman to be his 'guide' during labour (Chapman, 1991; Somers-Smith, 1999), but that in reality, she was unable to fulfil this expectation when she was focussing on dealing with it. This highlights the scope for midwives to be proactive in offering interpretations of the woman's behaviours, particularly for first-time fathers and those whose partners were having a labour that was very different from their previous experience. This study found that midwives tend to assume that 'multiparous' fathers need less interpretation. Fathers' comments do not support this assumption.

The father learning about birth from the midwife

Fathers saw the midwife as a source of knowledge, experience and information. There is great potential, which is currently largely un-tapped, for the midwife to share this knowledge. This would complement the other strategies identified in this study, for example fathers working out what was happening through cues and clues. Fathers recognised the midwife's experience enabled her to 'read the road ahead' and would have liked her to share her thoughts. However, they were very unlikely to ask her direct questions, apart from during labour at home.

Recent research has suggested the development of clinical guidelines for midwives on ways to support the father (Inglis et al, 2016) and the introduction of training for midwives in this area (Rominov et al, 2017). Inglis et al (2016) call for such clinical guidelines to 'require' the midwife to support the father. A recent NMC definition of the midwife's role (NMC, 2019) states that this includes involving the woman's partner. However, following this declaration, the clear emphasis throughout is on her responsibilities for the mother and baby, reflecting the international definition of her role (World Health Organisation, 2020). The RCM's advice on involving fathers in maternity

care (RCM, 2011) was later incorporated into an online learning resource, estimated to take 20-30 minutes to complete (RCM, 2016). This is a step in the right direction, but the importance accorded to the father is indicated by the module's length.

This current study's findings advocate for specific guidance to midwives to enhance their role as educators for the father during labour. These findings highlight the need to shift away from emphasising antenatal classes as the 'officially sanctioned' approach to childbirth preparation; they point to an expansion of the midwife's expectations to include the other ways in which parents prepare. They can be used to translate current guidance on involving and engaging with partners during childbirth (e.g. RCM, 2018) into practical training materials.

The findings around fathers' reluctance to initiate conversation or ask questions of the midwife in hospital environments calls into question some of the content of antenatal classes offered by NHS and independent providers. There is a clear emphasis in classes on the father being a busy and active supporter, carrying out tasks and offering comfort measures to the mother. His role as 'advocate' for the woman, ensuring that her wishes are conveyed to the midwife, is also emphasised (NCT, 2021). He is encouraged to negotiate over decisions and choices regarding care. This study found that the realities of the hospital childbirth environment tend to render him speechless and therefore unable to fulfil these roles. This finding may go some way to explain why many fathers are left feeling helpless and distressed after childbirth.

9.3.5.2 The midwife learning about the woman from the father

This study found that midwives have well-developed skills in picking up cues about couples and in developing rapport. A further finding is that midwives rely on 'working out' what couples expect, need and want using these skills. Sensitive, appropriate but direct verbal engagement between the midwife and the father could unlock the potential for the father to 'teach' the midwife about his partner, representing a reciprocal exchange where the midwife teaches the father about birth – her field of expert knowledge - and the father shares the hopes and expectations of his partner and helps the midwife to interpret her wishes and behaviours. This engagement implies a greater depth of emotional exchange than the sharing of a 'shopping list' birth plan. This study found that 'multiparous' fathers in particular could have shared helpful information about the course of previous labours; they expressed frustration that the midwife did not draw on their knowledge. Previous studies recognise that the father has 'insider knowledge' of the woman (Kuliukas et al, 2017, p.e28), calling for this knowledge to be honoured (White, 2007). This study supports these findings and extends them by highlighting the potential for the midwife to learn about the woman from the father, and the father to learn about birth from the midwife and the woman.

9.3.6 Synthesis of findings in relation to social constructivism

This study's findings align well with Vygotsky's sociocultural theory of human development (Salkind, 2004). Developed in the early 1930s in relation to human learning and education, this theory of social constructivism stresses 'the fundamental role of social interaction' (McCleod, 2018, p.e128) and is based on three key principles:

- Social interaction is fundamental to the development of cognition and in making sense and meaning of what is happening in any situation
- The concept of the 'more knowledgeable other': within any social situation, individuals have varying degrees of understanding
- The 'zone of proximal development': the notion that there are areas of skill that an individual can achieve independently, and other areas that s/he can learn, with help from the 'more knowledgeable other'

The study's key findings about the nature of midwife-father communication can be interpreted through Vygotsky's principles. The finding that midwife-father communication is characterised by guesswork and assumption and is thus dominated by important non-verbal aspects, highlight the potential for expansion and development of this relationship. This could include more verbal elements. In this way the midwife, who is the 'more knowledgeable other' in her experience of childbirth, can assist the father to make sense and meaning about what is happening. This will help him to orientate himself with the unfamiliar landscape of childbirth, addressing the study's second key finding. It has the potential to open up the kind of spontaneous dialogue which is more likely to occur in the home environment and encourage exploration of the wide range of roles and contributions possible for fathers. Importantly, this should include the midwife highlighting that 'being present' is not a passive role, even when the father feels his inactivity equates to passivity.

The father is the 'more knowledgeable other' in relation to his partner. Through sensitive dialogue, he may provide be able to provide valuable insights for the midwife. There are areas of skill and knowledge that he can draw upon as he supports the woman. There are, however, further areas that he can learn from the midwife. The woman is the 'more knowledgeable other' about what is happening for her, physically, emotionally and psychologically during labour. The midwife can help the father to learn about birth from the woman, through explaining and so enabling him to interpret what is happening. This study found that the close attentive watching and listening undertaken by fathers during labour helped them to build up their own knowledge. This process could be supported by the midwife's contributions.

9.4 Strengths and limitations

The rationale for choosing ethnography as the methodological approach was validated by the study's findings. These demonstrate originality in their contribution to this field of knowledge and that a deeper understanding of fathers' perspectives on childbirth and their lived reality of the experience (Creswell, 2013) have been gained. Direct observations during labour revealed insights which became apparent through recording the minutiae of interactions and dynamics in the 'real world' of birth. This fulfilled the ethnographic aim of 'offer[ing] insight that goes beyond verbal accounts' (McNaughton et al, 2014, p.245). However, limitations have also been identified linked to the use of direct observation as the key data collection approach and the sole researcher's involvement as the main 'data collection tool'. Her active engagement with the reflexive process (Appendix D) underpinned the steps she took to remain aware of her own potential biases and possible effects her presence may have had. However, these 'researcher effects' are acknowledged as a limitation.

This was a small, qualitative study, conducted on a single UK study site. Transferability of the study's findings to other maternity settings should be approached with caution. The context of maternity care within this site was of a service with a well-established history of midwife-led care, dating back to the provision of a 'GP (general practitioner) Unit' in the early 1980s, where midwives were the main care providers and GPs provided medical back-up if needed. This culture formed a strong foundation for the development of midwife-led care in the 1990s. The service offered considerable flexibility to families, for example in its inclusion of 'additional' birth partners. It has a history of healthy multi-disciplinary working, therefore boundaries between consultant-obstetric and midwife-led care may be more flexible than in other services.

The study's parent participants

This study involved a range of parent participants, of varying occupations and educational and socio-economic backgrounds and a degree of ethnic diversity. A limitation regarding parent-participant profile involves ethnic diversity. With one exception, the couples were white and British born. The couple who originated from the Asian sub-continent expressed that father's involvement in childbirth was not the norm within their community and gave this as part of their motivation to participate. They felt they were 'atypical' and wanted to encourage others from their own community to consider father-involvement.

The parents' parity varied, as did the environments they had chosen for birth. These factors are identified as strengths. Although the sampling strategy was purposive and did not seek this demographic variation, it was achieved by the study's recruitment

strategy. This relied largely on the researcher meeting potential participants face-to-face and she visited antenatal clinics in diverse areas of the borough to do this. The range of participants is therefore wider than previous studies which have recruited fathers who are attending antenatal classes or appointments, which, as acknowledged by Chapman (1991), may bias the sample towards 'middle class' participants.

A potential limitation concerns the study's the nature of the parent-participants' couple relationship. Without exception, they appeared to be well-attuned. From the point of recruitment onwards, powerful 'couple-connections' were noted. These became more evident during initial meetings, labour and birth and post-birth interviews. A couple whose relationship was not harmonious and mutually supportive at that time, might choose not to take part. This was borne out by the reasons given for declining to participate ('Methods' chapter, section 4.7.5). Also, for a majority of the parents recruited to the study, the fathers had already shown a level of engagement with maternity services as demonstrated by their attendance at clinic. It is relevant to add a caveat that not all partners accompany a woman to antenatal clinic with her best interests in mind – for some, it may be for reasons of coercive control.

Recommendations about implementing the study's findings are made bearing these factors in mind.

The midwife participants

The researcher was known to almost all the midwife participants. This was unavoidable and may have been a factor in enabling her to gain access. She was aware that the converse was possibly true: some midwives may have felt under pressure to participate. She minimised this possibility by emphasising (at times, over-zealously, as some midwife-participants reflected to her) that taking part was completely voluntary and that the midwives were free to withdraw consent at any time. None did so. Whilst she has outlined the measures employed to balance the pitfalls of observational research, the researcher recognises that as with any ethnographic study, she remained part of the social setting under study. This limitation is therefore acknowledged.

Heteronormative family focus

This study has explored midwife-father communications. The researcher has been aware throughout that in choosing this focus, she risks further marginalising families who do not conform to this heteronormative stereotype, including women who do not have a male partner who is the baby's father: lesbian couples, single mothers and others with different family make-ups. This is acknowledged as a limitation. However, it is intended to ensure that in disseminating the findings, most of which are relevant for

the relationships between midwives and all birth companions, active steps are taken to be inclusive of these diverse family make-ups.

9.5 Recommendations: education, practice, research, policy

These recommendations are made to enable the study's findings to be translated into practice in order to maximise support offered to the parents as they start life as a newly-formed family. Where the term 'father' is employed, it is used for brevity and consistency within the thesis; all recommendations are made acknowledging the diverse nature of family composition and that a birthing woman may be supported by a partner and a range of companions.

The impact of the Covid-19 pandemic on many aspects of maternity care is acknowledged, in particular the exclusion of the pregnant woman's partner or 'significant other' at all stages of the childbearing continuum. These restrictions have been very distressing for women, their partners and families. Many of the changes in practice that were introduced at the beginning of the pandemic (March 2020) remain in place at the time of writing present, 12 months later. This presents an opportunity for investigation of the impact of these enforced changes and a re-evaluation of the involvement of the woman's chosen supporters during childbirth. The following recommendations are made in the context of this research having been conducted pre-pandemic, but in recognition that its effects on health and healthcare will be felt for many years to come. They are organised in three sections: education and practice; maternity services' policy; future research. Plans for dissemination are outlined in Appendix W.

9.5.1 Education and practice

The following recommendations are aligned with the five key findings explored in this Discussion chapter. These are a summary; further details are in Appendix X. The plan is to disseminate the findings during midwifery education and on-going training, through the medium of interactive workshops. In this way, the learning from this research will continue to evolve. Publication and online media will also be employed.

9.5.1.1 Key findings about the midwife-father relationship

Future workshops will highlight three elements of the midwife-father relationship that were identified through this research: the current reliance on non-verbal elements, assumption and guesswork; that the father may be reluctant to ask questions or initiate conversation; that the midwife has an important educative role during labour. With increased awareness of these issues, midwives can explore approaches to facilitating direct verbal communication between father and midwife and to employing sensitive 'thinking out loud', even when labour is progressing 'normally' from her perspective.

9.5.1.2 Midwives' and fathers' experiences of the childbirth landscape

This study's findings will be employed to deepen midwives' understanding of the father's perspective of the childbirth landscape and to develop approaches which help him to habituate to a landscape which is unfamiliar to him. This could include offering opportunities for orientation, asking questions and taking restorative breaks.

9.5.1.3 The midwife-father relationship in different birth environments

There is rich scope for learning from midwife-father interaction in the home setting, which can be applied to hospital environments, in particular the finding about the father at home being available to the mother, but not always present in the room with her. Two other areas of importance are highlighted: to review the support offered to fathers in maternity theatre and to encourage dialogue between parents and midwives (during pregnancy) about who the mother plans to accompany her during labour and the roles they may fulfil. This discussion can explore whether it is the preference of both parents that the father is present, moving away from the assumption that he will be there.

9.5.1.4 Midwives' and fathers' expectations

This study highlights the scope for debate about the conceptualisation of the ideal birth partner as busy and actively involved. This 're-framing' of roles needs to include and affirm the fundamental importance of 'presence' and exploration of what this means to midwives and both parents.

9.5.1.5 The birth triad: its potential for knowledge-sharing

This study proposes that there is potential for each member of the birth triad to be conceptualised as the 'More Knowledgeable Other' and to draw on each other's expertise. Training opportunities will be developed for midwives to explore this potential and to reflect on the consequences of the current focus on the midwife-mother dyad.

9.5.2 Policy

Maternity services policy consistently states that the father should be included and involved at all stages in the childbearing continuum. The findings of this study lead to the following recommendations to operationalise this aspiration. All are made in the knowledge that, in some situations, there will be safeguarding concerns that render them inappropriate; individual assessment should be made in each case. They are also made with the caveat that the mother's wishes are the midwife's priority: it is not intended that the father's needs should take precedence, but rather that the inclusive, triadic conversations envisaged in recommendations for practice are actualised.

1. All maternity case-notes to include a proforma for recording details about the father / co-parent / partner, including status as parent for the first / subsequent time and past experience of childbirth. Completing this to be viewed as equally important as completion of details about the mother and audited in the same ways, whilst not marginalising lone parents.
2. Re-structure the provision of all elements of antenatal care (appointments and classes) to suit the practical needs of both parents, so fathers are able to participate.
3. In the antenatal schedule, introduce an opportunity for discussion with both parents, about labour; this to include who the woman plans to have with her and the roles this person or people may play. Raise the possibility with parents of having other birth companions present, for part or all of the labour.
4. Review the arbitrary limit on two birth supporters which is current in most UK maternity hospitals, with a view to relaxing the restriction. This is not an evidence-based regulation.
5. Provide appropriate facilities in hospital that enable the father to have breaks and take care of his own needs for rest and recuperation. These should include showers, toilets and refreshment facilities and be situated close to the environment where the woman is labouring.
6. Provide appropriate seating for fathers within all birth environments, with awareness of his positioning in relation to his view of clinical procedures e.g. catheterisation, suturing.

9.5.3 Research

The rationale for this study's focus on midwife-father communications was made at the outset – that fathers' involvement during childbirth is a relatively recent phenomenon and that there is a dearth of evidence about midwife-father communications. Many of the study's findings are transferable to other situations and are relevant to, for example lesbian couples and women who have a family member or friend as their primary supporter. However, there is scope for future research with a specific to focus on childbearing within diverse family forms. The first two recommendations are therefore made to address some of this study's limitations:

1. Further research to explore midwife communications with co-parents for same-sex couples. The ethnographic approach employed for the current study yielded such rich data, that it is envisaged that a similar methodology be adopted. The number of potential parent-participants is smaller; it would probably be necessary to seek ethical approval from a range of study sites. It is hoped that

the granting of ethical approval for this study has laid the foundations for future applications.

2. Ethnographic research on midwife-father / birth supporter communications with parent-participants from a range of ethnic backgrounds and where an interpreter is involved. Valuable insights would be gained by extending the reach of the study to include parents for whom it is not the cultural norm for fathers to be present.

The following suggestions for future research are also made, arising from the study's findings and suggestions made by its participants:

3. Exploration of the impact for all members of the birth triad of having additional lay-supporters present. This is an under-researched area and one which merits further study of childbirth as a social phenomenon.
4. An area highlighted by several parents in the study, was that of fathers' involvement in postnatal discharge. This is a field ripe for future study, particularly in the context of short postnatal stays and reduction in community midwife visits; both factors mean that the father is a key player in the early postnatal days and weeks. The researcher is keen to design an ethnographic study of the processes involved in postnatal discharge from hospital, to learn about partner's involvement in this.
5. A key area for future study concerns exploration of partners' motivations to be present during childbirth and the roles they anticipate they will play, alongside exploration of mothers' and midwives' perspectives. As demonstrated in this study's ScR, there has been a move in recent years towards maternity-care research which seeks to understand the differing perspectives of the three central players on the same issue. A longitudinal study which explored pre-birth expectations compared with post-birth reflections would be one approach.
6. Midwives' emphasis on the importance of the father cutting the cord merits further investigation. It raises questions round other tasks and activities in which he could be involved, if both parents desired this 'hands on' participation. The researcher is keen to pursue a qualitative research project on this issue.

9.6 Final summary

This study set out to explore communications between midwives and fathers during childbirth, within the context of the triadic mother / father / midwife relationship. It found that even though the father is a relative newcomer to the world of childbirth, he has already become part of the 'taken for granted' features of the landscape. This is one of the key messages from this thesis. It underpins the central findings about the nature of

the midwife-father relationship, its current dependence on non-verbal elements and guesswork. It can result in the father feeling 'in the dark' as he works to find his way.

Ethnography enabled fresh discoveries about the father's perspective of the childbirth landscape, by highlighting the unfamiliarity of a world that, for the midwife, represents the 'every day'. Insights about the impact of different birth environments point to ways in which this learning may be applied to enhance parents' experiences in hospital. The study's scope expanded beyond the original triadic focus, to include relationships with other lay supporters within the birthspace. Discoveries about the benefits of additional supporters during labour and birth challenge the status quo of limiting parents' options about this choice.

This study's findings offer signposts to assist parents and midwives, as all players continue to navigate the father's place within the landscape of birth. The importance of the father's 'presence', his silent solidarity support, points to a re-conceptualisation of the 'busy, active' birth partner. It also highlights the potential of all three central players to learn from each other during labour, visualising a triadic flow of verbal and non-verbal communication. It advocates for discussion and debate at every level: between policymakers and commissioners, within research communities and those developing midwifery curricula, amongst charities concerned with childbirth and parenting and between midwives and parents, without whom this research would not have been possible.

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Appendices

Appendix A: Key concepts and variants employed in literature searching

Concept	Synonyms and variants
Father	Father* Patern* M?n Partner* Dad* Husband*
Midwives	Midwi* Nurs* Nurs*-midwi* Obstetri*-nurs* Doula*
Labour and birth	Pregnan* Pregnant wom#n Lab?r Antenatal Intrapartum Deliver* Birth*
Communications	Communicat* Relation* Interaction* Role* Support*

Appendix B: Key studies for Scoping Review

5 themes in final column: 1. Fathers' needs 2. Fathers' roles 3. Fathers' feelings 4. Father's behaviours 5. Midwives' attitudes towards fathers

Qualitative studies

Study (First author, year, country, title)	Study type	Participants	Data collection	Data analysis	Findings / Comments	Thematic synthesis (Section 2.4.3)
1. Backstrom, C. & Herflet Wahn, E. 2011; Sweden. Support during labour: first-time fathers' descriptions of requested and received support during the birth of their first child.	Qualitative	10 1 st -time fathers; recruited on ward within 24 hours of birth	Semi-structured interviews with fathers in 1 st postpartum week	Qualitative content analysis	Main theme 'Being involved or being left out'. 'Good support' = able to: ask questions; interact with partner and MW; choose when to step back. Important to be seen as part of the 'labouring couple' and as an individual. Fathers want to feel involved; if they feel left out, their feelings of helplessness increase. MWs should develop their support for the 'labouring couple' and work to increase paternal involvement, remembering that every father has individual experiences and expectations	1, 2, 5
2. Backstrom, C. et al 2017; Sweden. 'To be able to support her, I must feel calm and safe': pregnant women's partners perceptions of professional support during pregnancy.	Phenomenography	14 fathers and co-mothers whose partner was pregnant for 1 st time: strategic sampling strategy seeking demographic variation	Semi-structured telephone interviews with fathers at 36-38 weeks of pregnancy	7-stage process of phenomenographic analysis	MW offering support to mother and partner together, as a couple, strengthened the couple-relationship. MW should also confirm partner's importance and recognise partner as an individual with own preferences and expectations and needs, giving practical information and concrete advice on how to support. Information-giving is important but is best absorbed in ways that engage partners emotionally. When excluded, fear increases.	1, 5
3. Brown, J. et al 2009; Canada	Qualitative	10 couples who had experience of 23 births between	Semi-structured interviews; mothers and fathers interviewed	Thematic analysis approach, manual coding then NVivo	4 key aspects to nurse role: supporter / educator / patient advocate / provider of continuity.	1

Womens and their partners' perceptions of the key roles of the labor and delivery nurse.		them, range 1 – 5 children: purposive sampling strategy	separately; timing of interview ranged from immediately after birth – to 10 years later.	7; techniques of immersion and crystallisation employed.	Parents' should be involved in a continuous process of evaluating own needs NB timing of PN interviews varied greatly i.e. from straight after baby's birth to 10 years later; (range not stated); this variation inevitably has impact on parents' recall of birth; no distinctions drawn between data collected from 1 st / subsequent births, so different perspectives of experienced parents not considered.	
4. Chandler, S. and Field, P.A. 1997; Canada. Becoming a father: first-time fathers' experience of labor and delivery.	Descriptive exploratory design	14 1 st time fathers: 8 primary informants who were interviewed pre and post birth and 6 secondary informants, interviewed post-birth only	Semi-structured Interviews with fathers; primary informants (8) interviewed twice - at 37 weeks of pregnancy and 4 weeks post-birth; secondary informants (6): interviewed once, 4 weeks post-birth	'Line by line analysis' and subsequent coding into themes; member-checked	Reality of labour differed from expectations. Fathers saw themselves as 'co-labouring' i.e. part of a labouring couple; staff perception differed – they saw a woman who is accompanied by her partner; father finds it more challenging as it progresses and less able to comfort his partner; fathers' fear stress and helplessness increase as labour progresses; fathers' physical /emotional needs not addressed Pre and post birth interviews, span 2 –month period; enables comparison of expectations and experiences; interviews took place at home, partners not present	1, 3, 4, 5
5. Chapman, L. 1991; USA. Searching: fathers' experiences during labor and birth.	Grounded theory	20 couples, 10 x 1 st time 10 x subsequent Sample biased towards 'white, middle class' had attended AN Classes'	Observations and semi-structured dyadic interviews; 4-6 weeks post-birth. 14 couples interviewed; 6 observed and interviewed 3 observed, but not interviewed	Grounded theory	Conceptualisation of triple helix with spirals composed of 3 interwoven, interdependent paths: the labour path, the woman's and the father's. Three roles identified for fathers: 1) coach, 2) team-mate, 3) witness, based on varying degrees of fathers' physical and mental engagement; described as 'co-labouring' Labouring woman was the father's 'primary guide' giving directions or clues to help him meet her needs, with HCPs as secondary guides. The woman influenced the degree of his involvement and directed /led him, but information was provided by HCP. Fathers are 'searching for place' (p.27) – trying to define their role/s; when cannot do so, sense of alienation results. 4 stages: identify role / engage in / testing / evaluate it.	1, 2

					NB 13 of 20 fathers had attended previous labour. One of few studies to include data collection through observation.	
6. Chapman, L. 2000; USA. Expectant fathers and labor epidurals.	Grounded theory	17 couples; 16 attended antenatal classes during this / previous pregnancy; 12 1 st -time fathers, 5 2 nd -time	Semi-structured interviews with couple, approximately one-month post-birth	Grounded theory	6 labour 'phases' identified (holding out / surrendering/ waiting/ getting/cruising/ pushing) impact of epidural for father was to reduce the woman's inward focus and enhance the couple's ability to relate to each other; described as 'losing her' and 'getting her back' (p. 132) Exploration of impact of woman having epidural on father's physical and emotional involvement; study's finding that epidural increased ability of couple to 'labour together' because it reduces woman's inward focus casts light on other studies' findings that fathers can feel 'helpless' when woman's focus becomes internal. Fathers were not prepared for the changes they would witness in the woman's behaviour during labour; advocates that being prepared for these and understanding them would reduce men's feelings of anxiety, frustration and helplessness	1, 3, 4
7. Dallas, C.M. 2009; USA. Interactions between adolescent fathers and health care professionals during pregnancy, labor and early postpartum.	Qualitative case study design	25 unmarried adolescent fathers, age range at recruitment 14 – 19 years; 75% were 17 – 19 years	6 x semi-structured interviews; mothers and fathers interviewed separately at 28 weeks of pregnancy and 1 / 6 / 12 /18 / 24 months post birth	Content analysis methods	Interactions between HCPs and fathers divided into 3 categories: supportive (giving information, emotional / material support), distancing (actively negating / denigrating father's role) and neutralising (failing to affirm father's support role / his own transition to fatherhood) Data relating to childbirth is important for this current study: highlights importance of HCP recognising birth as a social process, affirming role transition to fatherhood and offering him support. This benefit both parents, their relationship and his relationship with baby	2, 5
8. Deave, T. and Johnson, D. 2008; UK. The transition to parenthood: what	Qualitative	Purposive sampling strategy: 20 1 st -time fathers	2 interviews with fathers, 1 in last trimester of pregnancy and 2 at 3 - 4 months post birth	Content analysis	Findings relating to childbirth were heightened anxiety at this time, challenges of a long labour and feelings of exclusion (other findings related to AN and PN periods). Improved information giving plus role models could help address	1, 2

does it mean for fathers?					Longitudinal study, focussed on fathers' information and care needs using prospective AN and retrospective PN interviews; clear finding that fathers perceive themselves as 'bystanders.'	
9. Inglis, C. et al 2016; Australia. Paternal mental health following perceived traumatic childbirth.	Qualitative	69 fathers with self-reported traumatic childbirth experience, recruited from social media platforms; mode of birth – 26% vaginal; 14% assisted; 60% CS of which 45% emergency 30 x 1 st time 39 x subsequent	69 completed online survey 7 – semi-structured interviews, 5 face-to-face, 2 via Skype Data collected between 2 and 6 months post-birth	Thematic analysis (Braun and Clarke)	Global theme = 'standing on the side-line' Witnessing trauma; in unknown territory; being unprepared, out of control; dealing with the aftermath – some experienced post-traumatic growth. Lack of communication exacerbated distress; MWs were gatekeepers of information; fathers marginalised by caregivers – assigned a spectator role. Recommends that clinical guidelines require MW to support partner	1,2,5
10. Jepsen, I. et al 2017; Denmark. A qualitative study of how caseload midwifery is experienced by couples in Denmark.	Ethnography	Convenience sample of 10 co-habiting couples 5 x 1 st babies; 5 x subsequent	Field observations during labour; 6 observed in entirety; 2 for part of labour; 2: no observations. Semi-structured dyadic interviews, 1-4 days after birth	Hermeneutic phenomenological approach	Where father had met MW during pregnancy, feeling of being 'known' was significant for the father – enhanced sense of inclusion and his trust / confidence in the MW. Eased the transition to hospital because met by a 'professional friend' on arrival. MW and parents worked as a team – a 'trinity' (p.e66) during intense later stages of labour. MW represented security and preserved link to the world outside the birth environment → calming, reassuring, and normative. 1 st study to explore the effects of continuity of carer for the father	3, 4, 5
11. Kainz, G. et al 2010; Sweden. The child's father, an important person for the	Qualitative, hermeneutic	67 1 st time mothers recruited from 3 different maternity units within a month of birth	Face-to-face, semi-structured interviews with mothers	Hermeneutic text analysis	Main finding: father's presence in childbirth is of great importance to mothers (but this research also illustrates that fathers underestimate what a difference their presence made). Interactions between the mother, father and MW gave a feeling of working as a team and this added to women's positive views of the experience.	2

<p>mother's well-being during childbirth: a hermeneutic study.</p>					<p>5 subthemes:</p> <p>Woman's confidence increased by father's familiarity and 'unwavering presence'</p> <p>Father acted as communication channel from woman to MW, when his partner was unable to speak for herself</p> <p>Father gave the woman strength, courage to carry on and faith in her own abilities</p> <p>There was a sense of 'shared endeavour' achieved through working together; this aroused feeling of pride</p> <p>The shared moment of becoming parents was the culmination of their joint endeavour</p>	
<p>12. Kuliukas, L. et al 2017; Australia.</p> <p>The woman, partner and midwife: an integration of three perspectives of labour when intrapartum transfer from a birth centre to a tertiary obstetric unit occurs.</p>	<p>Qualitative</p>	<p>15 triads of woman, partner and MW</p> <p>11 x 1st babies</p> <p>4 x subsequent babies</p>	<p>45 semi-structured interviews based on 'story telling' approach; mothers, fathers and midwives interviewed separately; 43 face-to-face, 2 telephone</p>	<p>Descriptive phenomenological analysis</p>	<p>Each member of triad shares some aspects of experience but viewed through different lens and with own priorities, feelings and perceptions.</p> <p>Themes of each member of triad being 'in my own world', E.g. woman in labour zone / man filled with anxiety and stress / MW aware of clinical responsibility. Father's protectiveness for woman heightened as result of transfer to obstetric unit. There was also some overlap and sharing of experiences within the triad e.g. both father and MW felt less involved and in control in obstetric unit – his and the MW's 'insider knowledge' of the woman ignored. Each of the 3 is immersed in own experience → limited insight into other's.</p> <p>Findings suggest how MW can 'customise' her care to meet the different needs of woman and partner and advocate respect for the father's role in the 'birth journey'</p> <p>1st published paper to compare the experiences of 3 members of 'birth triad'</p>	<p>1, 3, 5</p>

13.. Ledenfors, A. and Berterö, C. 2016; Sweden. First-time fathers' experiences of normal childbirth.	Qualitative	Purposeful sampling strategy; 8 1 st time fathers whose partners had spontaneous vaginal birth; 6/8 attended ANC	Semi-structured interviews with fathers; 2-6 months post birth	Thematic analysis	Overarching theme; childbirth is a transformative experience for the father. Fathers need information prior to and during labour; they feel vulnerable in this new situation; they feel need to control their inner stress and emotions; as birth approaches, their fear increases, more unsure how to support partner. Affirmation of their presence as part of the 'couple unit' + information and support from MW can reduce this fear and vulnerability and the experience can be joyful.	1, 2, 3
14. Lindberg, I. and Engström, A. 2013; Sweden. A qualitative study of new fathers' experiences of care in relation to complicated childbirth.	Qualitative	Purposive sampling strategy: 4 x 1 st time fathers, 3 x 2 nd , 1 x 3 rd	Semi-structured interviews with fathers interviewed; 6-12 weeks post birth; 'story-telling' opening question plus prompts focussing on their needs.	Thematic content analysis	When complications occur, fathers struggle to be recognised by HCPs as father and an active partner in the process who values the opportunity to be involved; feel side-lined at a time when he wants to guard and protect, leads to inner conflict; needs on-going care and opportunity to de-brief; would like to discuss birth with partner but fears burdening her. Sharing difficult experience strengthened the couple relationship for some. Father's physical presence may be welcomed but his emotional participation is not.	1
15. Longworth, H. and Kingdon, C. 2011; UK. Fathers in the birth room: what are they expecting and experiencing? A phenomenological study.	Phenomenology	11 1 st -time fathers attending hospital AN classes	Semi-structured interviews x 2 with fathers: 1 st in 3 rd trimester, 2 nd between 1 st and 8 th day post birth	Interpretive summaries written by the 2 researchers independently following familiarisation with transcriptions	4 main themes: fathers' disconnection from partner at end of pregnancy and in labour; fathers on the periphery of events during labour and reluctant to seek further inclusion; feeling lack of control over decision-making; birth seen as marking the beginning of fatherhood. MWs well-placed to enable the involvement of father – help him to support his partner and to recognise the significance of the birth in his transition to fatherhood. Recruitment bias acknowledged: those not attending AN classes were excluded	2
16. Premberg, A. et al 2011; Sweden. First-time fathers' experiences of	Phenomenology	10 x 1 st -time fathers	Re-enactment interviews with fathers, 4-6 weeks post birth	Phenomenological lifeworld approach	Childbirth is a mutually shared process for the couple; for fathers it is a pendulum swinging between euphoria and agony; his experience of her pain and his fear of the unknown are difficult to bear; how the mother copes with labour influences the father's experience; active engagement of the father is fulfilling for both parents	1, 3

childbirth – a phenomenological study.					<p>Gendered pre-conceptions of 'manly' behaviour' considered in context of female arena of childbirth where traditional gender order is reversed.</p> <p>Scope identified for MW to recognise father as parent-to-be and offer individualised support that acknowledges his conflicting emotions, also to draw on his exclusive knowledge of his partner and her needs.</p>	
<p>17. Roberts, J. and Spiby, H.</p> <p>2019; UK.</p> <p>'The calm before the storm': a qualitative study of fathers' experiences of early labour.</p>	Qualitative interpretivist	<p>Opportunistic sampling strategy; 12 fathers who had been present in partner's spontaneous labour; 10 x 1st time; 2 x subsequent.</p> <p>11/12 had attended AN classes, 9 for this baby and both 2nd time fathers for previous baby</p>	Semi-structured interviews: face-to-face x 10, telephone x 2; fathers interviewed (mothers present in room for 2 interviews); within 12 months of birth;	Thematic analysis	<p>Fathers felt little involvement in decision-making about when to go into hospital; took role of spokesperson in ringing hospital but MW always asked to speak to the woman; fathers found it hard to apply knowledge from AN classes when faced with reality of labour e.g. when to go into hospital.</p> <p>As labour intensified, father felt more side-lined because the woman wasn't acknowledging him; 'doing nothing' (p.5) sat uneasily with the male role.</p> <p>MWs could suggest practical ways the father can support woman at home in early labour; also by endorsing the value of presence as support – does not = 'doing nothing'.</p> <p>1st qualitative study to explore fathers' perspectives on early labour, despite assumptions by MWs that they play a role in 'keeping' the mother at home.</p> <p>Research question / aim not clearly stated</p>	1, 2, 4
<p>18. Somers-Smith, M. J.</p> <p>1999; UK.</p> <p>A place for the partner? Expectations and experiences of support during childbirth.</p>	Ethnographic*	8 couples	2 x semi structured interviews; mothers and fathers interviewed separately ('sometimes' mother was present in room during father's interview); 1 st interview at 34 weeks of pregnancy, 2 nd interview at 10-16 weeks post birth	Familiarisation with transcripts; manual coding; themes developed from codes	<p>Fathers' support evoked overall +ve responses from women – valued emotional and psychological support from his presence; fathers felt they were helpful in practical ways but women hadn't always wanted these comfort measures; fathers looked to woman to direct him; experienced stress and uncertainty; fathers' needs and roles should be regularly assessed by HCPs.</p> <p>Advocates for a 'psychological framework' for father's support for mother</p>	1

					<p>Potential for selection bias in this study, because in recruitment, men from 'lowest socio-economic groups' were excluded by AN clinic 'vetting procedures' which are not explained; does not state if fathers are 1st time / subsequent</p> <p>* Study's methodology does not accord with accepted definition of ethnography as involving observation; questionable rigour in analysis process</p>	
<p>19. Tarlazzi, E. et al 2015; Italy. Italian fathers' experiences of labour pain.</p>	Phenomenology	<p>Purposive sampling strategy; 6 1st time fathers > 25years old, present during vaginal birth without use of pharmacological analgesia</p>	<p>Semi-structured interviews with fathers, within 10 days of birth</p>	<p>Colaizzi's 1978 framework for descriptive phenomenology</p>	<p>5 core themes within context of internal conflict – father's desire to be present vs worry about how he will cope:</p> <p>Inevitability of labour pain; 2nd stage perceived as more painful, but father could be more actively engaged</p> <p>Feelings of helplessness - unable to take pain away; aware his presence gave woman courage, but he struggled with his own fear</p> <p>Remaining present was seen as test of own courage as he endured sights and odours of labour</p> <p>Felt unprepared for degree of pain and changes in woman's behaviours; anxiety increased when MW was absent</p> <p>Father had his own needs; would have liked MW to give him permission to leave the room to meet these for himself.</p>	1, 2, 3, 4
<p>20. White, G. 2007; New Zealand. 'You cope by breaking down in private': fathers and PTSD following childbirth.</p>	Phenomenological	<p>Purposive sampling strategy; 21 fathers recruited via Trauma and Birth support website</p>	<p>Father's birth story submitted on tape / as written account / told directly to researcher plus a 'small number' of interviews (not stated how many); interval from birth < 1 – 27 years</p>	<p>Colaizzi's qualitative content analysis</p>	<p>4 key themes</p> <p>Father seen as spectator / supporter / fetcher-carrier = witness rather than participant; could → feelings of alienation</p> <p>Father's integrity not acknowledged → felt excluded as individual and within his couple-relationship</p> <p>Negative impact on sexual activity post-birth as triggered memories</p>	1, 2

					<p>Suppressing emotional distress → feelings of humiliation, shame, helplessness</p> <p>Plus: aspects of social, emotional, spiritual aspects of the birth for the father not considered; fathers should choose whether or not to be present and their knowledge of their partner should be honoured</p> <p>No reflections on study's limitations</p>	
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Quantitative studies

<p>1. Bertsch, T.B. et al 1990; USA</p> <p>Labor support by first-time fathers: direct observations with a comparison to experienced doulas.</p>	<p>Quantitative To compare fathers' presence, activities and behaviours during labour with doulas'</p>	<p>14 primiparous women and their male partners; 3 doulas; recruited in labour.</p>	<p>14 x 1 hour observations, recording every 30 seconds woman's state and categories of 5 supportive behaviours</p> <p>30-item Likert-scale questionnaire administered separately to mothers and fathers postnatally prior to discharge from hospital</p>	<p>No specifics given; states analysis of observational data was performed only for periods when mother was uncomfortable due to contractions, clinical procedures, position changes 'Supportive behaviours' tabulated e.g. talking / touching / proximity</p>	<p>Fathers' and doulas' behaviours very different in all categories; doulas more verbally interactive and closer physically; fathers behaviour in early labour was different to late labour when they moved further away and there was less physical contact Doulas, unlike fathers, have a 'secure role' in the hospital hierarchy. Clarifying and affirming fathers' roles may enhance their effective support for mothers and their own experience</p>	<p>2, 4</p>
<p>2. Eggermont, K. et al 2017; Belgium.</p> <p>Needs of fathers during labour and birth: a cross-sectional study.</p>	<p>Quantitative</p>	<p>Consecutive sampling of 72 fathers present during 'natural childbirth' 33 x 1st time 37 x subsequent</p>	<p>Questionnaire with 4 and 2 point Likert scales</p> <p>Completed by fathers on hospital postnatal ward, 1-5 days after birth</p>	<p>Multivariate analysis</p>	<p>Hypothesis: fathers play an important role during childbirth, but are sometimes side-lined by midwives. Studies about fathers' needs are scarce. Needs identified: for information is the priority – about procedures, process, equipment, how to be involved by offering ♀ emotional support; supersedes needs for e.g. interaction Fathers suppress their emotions, do not disclose to woman or midwife. Should be offered opportunity to express their needs to MW. More inclusive approach to couple advocated,</p>	<p>1, 2, 5</p>

					tailored to individual needs e.g. multiparous fathers and those with higher ed. expressed less need for information.	
3.Eriksson, C. et al 2006; Sweden. Content of childbirth-related fear in Swedish women and men- analysis of an open-ended question	Quantitative	308 women and 194 men, couples whose baby had been born in a 12 month period 1 st time and subsequent as denoted by ♀'s parity	Postal questionnaire sent post-birth – timing was from between 2 to 12 months after birth; series of statements and questions, self-rated on 6-point scale	Content analysis	6 main categories of fear: labour and delivery / health and life of baby / own capabilities and reactions (women) / own capabilities and reactions (men) / own or woman's health and life / professionals' competence and behaviour. Ranked differently for women and men. Men more concerned for health of woman than she was for herself. Part of the problem of childbirth-related fear is located within the health system itself – not being treated with respect / receiving adequate care; HCPs should have more awareness of women's and men's individual needs.	5
4.Gungor I. and Beji N. 2004; Turkey. Effects of fathers' attendance to labor and delivery on the experience of childbirth in Turkey.	RCT.	50 low-risk primigravidae women recruited; in experimental group, 1 st 25 women were allowed to have partners present; in control group, partners not allowed to participate.	Separate questionnaires to mothers and fathers in immediate post-birth period: Perception of Birth Scale: women self-reported their views on specific aspects of the father's presence and involvement Fathers self-reported via questionnaire on their involvement Researcher observed fathers' behaviours and support during labour and ranked their participation style	Statistics programmes	Fathers' support helped mothers to have more positive experience in all measured aspects of childbirth. With support from HCP, father can play active roles. Fathers should no longer be excluded; their support for the mother is enhanced by HCP supporting the couple; importance of individual discussion and care planning with each couple. Data collection and analysis – inadequate detail given to enable rigorous quality analysis	1, 5
5.Hildingsson I. et al 2011; Sweden. Fathers' birth experience in relation to midwifery care.	Quantitative	595 new fathers, recruited at mid-trimester scan 258 x first time 337 x subsequent	Questionnaire with 4-point Likert scale and 5-point scale re positive / negative birth experience; completed 2 months post-birth	Odds ration with 95% confidence interval and logistic regression analysis	82% of fathers reported positive birth experience; 3 most significant factors were midwife's presence, her support and information-giving→ midwifery actions are important in enabling fathers to have positive experience	1
6.Hollins Martin, C.J. 2009; UK.		Stratified sample 78 fathers 42 x 1 st time 36 x 2 nd -time	Quantitative survey: the Birth Participation Scale (BPS) administered pre and post birth (exact timings not stated); participation and		Post birth scores found small shift in attitude in a positive direction – only 4% found birth partnering more difficult than anticipated. Midwives are facilitating the majority of fathers towards a positive birth experience. BPS may be useful to ascertain if fathers wish to be present and to assess their concerns and needs.	1, 2

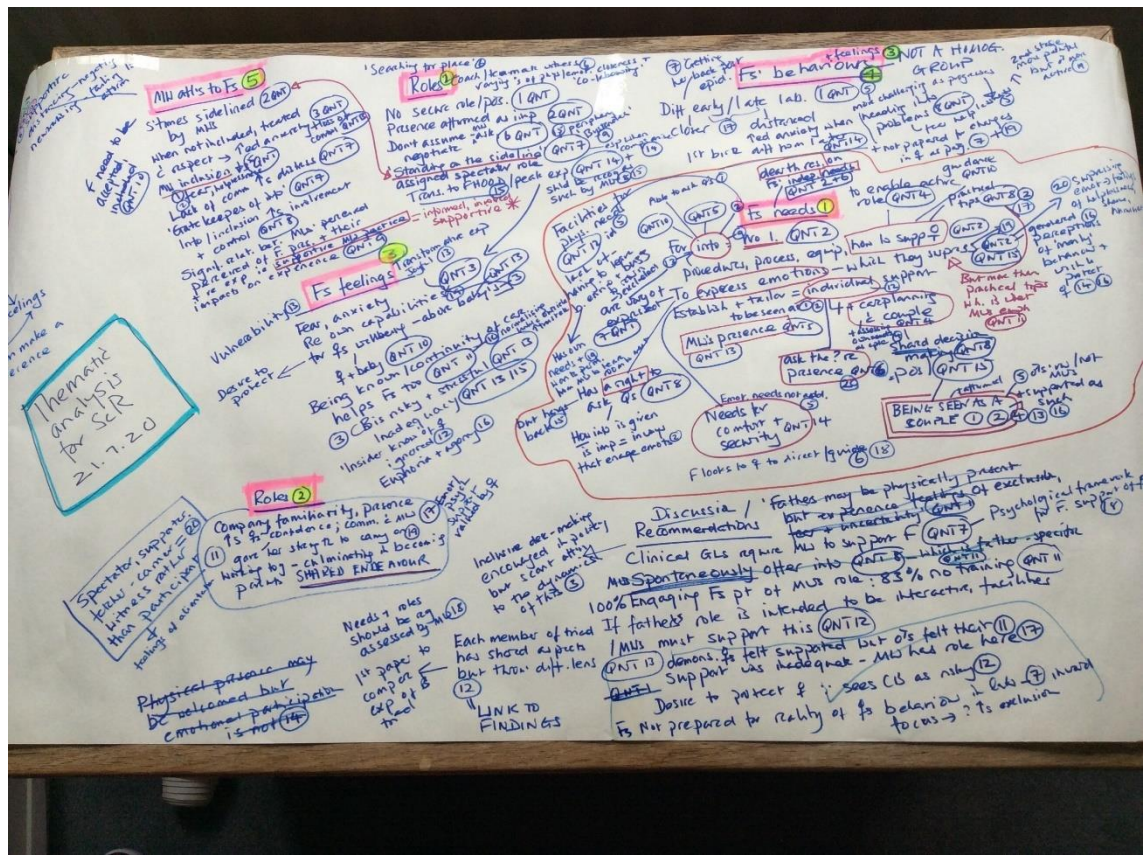
A tool to measure fathers' attitudes and needs in relation to birth.			difference in scores assessed		NB highlights dearth of research re father's needs, 'independent' of the woman's	
7. Johansson, M., and Hildingsson, I. 2013; Sweden. Intrapartum care could be improved according to Swedish fathers: mode of birth matters for satisfaction.	Quantitative; cross sectional design; part of prospective longitudinal study	827 fathers recruited at 20 weeks of pregnancy 47% 1 st time 53% subsequent	Quality of care index, 9 questions, at 2 weeks post-birth	Descriptive statistics and logistic regression analysis	Dissatisfaction with care from: Deficiencies in medical care Lack of involvement in decision-making; this may not be possible in emergency but fathers were wary of expressing own anxiety. HCPs' communication improves fathers' sense of control, involvement and security, involves him in birth experience in ways that feel supported and safe; need to highlight he has a right to ask questions; also improved by MW's presence in room, MW spontaneously offering information and giving practical tips on how to support; encouraging shared decision-making. Fathers' loss of control and increased anxiety about the woman's wellbeing associated with assisted birth and CS.	1, 5
8. Porrett, L. et al 2012; Australia. An exploration of the perceptions of male partners involved in the birthing experience at a regional Australian hospital.	Quantitative	163 x 1 st time fathers; consecutive invitations given post hospital birth to 200 fathers	14-item postal questionnaire with 10-point Likert rating scale; Post-birth, timing not stated	Predictive analysis software	Significant relationship demonstrated between perceived benefit of partner presence and positive perception of birth involvement. Supportive midwifery practice impacts on fathers' experiences: positive feelings are enhanced when they feel well-informed, involved and well-supported during birth.	5
9. Symon, A.G. et al 2011; UK. Care and environment in midwife-led and obstetric-led units: a comparison of mothers' and birth partners' perceptions.	Quantitative.	Parents recruited 1 week post birth from x 3 obstetric-led (OL) and x 6 MW-led (MWL) units 559 birthing ♀ 551 partners (gender not stated but masculine pronoun used throughout) Parity of ♀ stated but parenting status of ♂ not identified	Postal survey sent a week after birth	Wilcoxon signed rank test (<i>paired difference test</i>) Loglinear analysis (<i>2 or more variables</i>)	Lack of facilities for partners noted – toilets, drinks, food, comfortable seating; environment was very warm. Partners in OL units more likely to report less space for them, even though the MWL units had smaller, more cluttered rooms. Power / control issues as partner had to leave birth environment to meet his basic needs and was then in effect 'locked out' so had to buzz for readmission. Partner's role is intended to be interactive and to support the mother so facilities should be provided that enable this NB highlights that each member of the birth triad has different needs and views of the birth environment. This study promotes understanding of partner's. Research aim not clearly stated. Funded by NHS Estates	1, 3

<p>10. Thies-Lagegren, L. and Johansson, M.</p> <p>2019; Sweden.</p> <p>Intrapartum midwifery care impact[s] Swedish couples' birth experiences – a cross sectional study.</p>	<p>Quantitative, comparative cross-sectional study, within an RCT of use of birth stool vs any other birthing position</p>	<p>209 heterosexual couples ♀ - primiparous ♂ - parenting status not identified</p>	<p>Online questionnaire based on tested quality of care instrument; administered separately to mothers and fathers 1-4 years post birth</p>	<p>Statistical Package for Social Sciences V.23 Birth experience dichotomised: very positive / positive vs. negative / very negative</p>	<p>High level of uniformity between couples: 79% ♂ / 73% ♀ = positive or very positive Less positive experience involved not feeling in control; not receiving adequate information; MW absence from room. Highlights: importance of MW support that fathers felt unable to fulfil ♀'s support needs <u>but</u> ♀ felt support by ♂ → message is not effectively conveyed to fathers that it is their <u>presence</u> that's supportive; MW has role in educating ♂ about this and supporting him to support ♀. Father most concerned about mother's health / mother about baby's; father's view of childbirth as risky and stressful can be counterbalanced by information from MW + confirmation re what is normal + increasing father's sense of control and involvement through 'authentic and holistic approach'. NB high proportion of couples in Sweden attend AN classes together</p>	<p>1, 2, 3, 5</p>
<p>11. Waldenstrom, U.</p> <p>1999; Sweden.</p> <p>Effects of birth centre care on fathers' satisfaction with care, experience of the birth and adaptation to fatherhood.</p>	<p>RCT – comparing 'standard' maternity care (SC) with 'birth centre care' (BC) To investigate the hypothesis that BC care would have positive effect on outcomes.</p>	<p>Expectant <u>fathers</u> randomly allocated to birth centre (576) and standard maternity care (567); response rates 99% and 94% respectively. Parenting status not identified.</p>	<p>Questionnaire administered 2 months after birth</p>	<p>Null hypothesis – of no difference between the BC group and the SC group – 2-sided student's <i>t</i>-test with un-pooled standard deviation</p>	<p>BC fathers made more positive assessment of their care, felt were treated with greater respect by staff, MW in labour more supportive of their needs as partners and they were more involved in decision making. BUT BC care did not have similar positive effect on father's experience of labour and birth – e.g. levels of anxiety, freedom to express personal feelings, value of their support to partner. Longer term benefits (e.g. in terms of fathers' well-being, involvement with baby) did not differ in 2 groups. Ethical issues noted: place of birth allocated by father's randomisation process → lack of choice and loss of control for woman.</p>	<p>1, 2</p>

Mixed-methods studies

<p>1. Premberg A. et al 2012; Sweden.</p> <p>Father for the first time – development and validation of a questionnaire to assess first-time fathers' experiences of childbirth.</p>	<p>Mixed methods*: *quantitative, with domains and items for questionnaire developed from qualitative interviews with 1st-time fathers, literature search and focus group with midwives.</p>	<p>200 x 1st time fathers completed postal questionnaire (response rate = 81%)</p> <p>NB highlights that as no 'paternity registry' exists, access to fathers' address was via mothers' address and this may -> sample bias</p>	<p>Postal questionnaire, 2-3 months post-birth</p>	<p>Exploratory factor and multi-trait scaling analysis plus external validity testing.</p>	<p>4 principle components: worry + anxiety about mother and baby / information – guidance and comfort / emotional support , how to support the woman (linked to 'information')/ acceptance = degree to which father felt accepted NB Swedish context: fathers have been present for decades, but still some were not well received</p>	<p>1, 3, 5</p>
<p>2. Rominov, H. et al 2017; Australia.</p> <p>Midwives' perceptions and experiences of engaging fathers in perinatal services.</p>		<p>106 MWs recruited via webpage and Australian College of Midwives advert</p>	<p>Online survey completed by 106 MWs – rated a series of exploratory questions 13 also participated in semi-structured interviews</p>	<p>Statistical package for Social Sciences V22- frequency % distribution; descriptive analyses summarised results. Interviews coded using semantic thematic analysis.</p>	<p>Unanimous agreement - engaging fathers = part of MW's role; 83% had no formal training on working with fathers. MWs emphasise role = teaching practical parenting skills over attending to father's emotional wellbeing / the couple relationship. Gave jobs to do during labour and tips e.g. on helping with breathing skills. Highlights need to provide 'father-specific' information and to do so in ways that are congruent with fathers' learning styles. Continuity of care models enabled MWs to develop rapport and engage with fathers.</p>	<p>1, 2, 3</p>
<p>3. Vehrolainen-Julk, K. and Luikkonen, L. 1998; Finland.</p> <p>Fathers' experiences of childbirth.</p>	<p>Mixed methods – survey</p>	<p>Non random sample of 107 fathers; 81% response rate; fathers aged 17 – 51 years, mean age 32. 47 x 1st time 60 x subsequent</p>	<p>Survey using postal questionnaire with combination of Likert scale & open-ended questions; piloted with 10 fathers. Completed by fathers prior to mother's discharge from hospital, usually within 3 days of birth. NB Specific question re improving midwifery care.</p>	<p>Quantitative analysis using SPSS/PC software and presented as frequencies, percentages and factor analysis. Qualitative content analysis used for open-ended questions.</p>	<p>Feelings and experiences grouped into 4 factors: discomfort / pleasure and pride / related to staff members* / related to nursing environment. Young fathers and those present at a 1st birth reported feeling more uncomfortable than others. Being present marked transition to fatherhood. Best experience = moment of birth *Midwives should provide more support and guidance to fathers to help them support the woman as well as paying attention to their needs for comfort and security in the birth environment</p>	<p>1, 2, 4</p>

Appendix C: ScR key studies: development of Thematic Analysis



The 34 studies in the ScR were read and re-read. Notes were made of concepts and phrases relevant to the review. The Table of Studies (Appendix B) was populated with the studies' details. The map above shows the development of the TA's five themes, with linkages and differences between studies highlighted. This was used as the basis for the thematic synthesis.

Appendix D: Reflexive account

The first-person voice employed acknowledges the relationship between the researcher and the research process, including its participants (Tracy, 2010).

My experiences, values and beliefs

I view childbirth as primarily a biopsychosocial experience, rather than a medical event, a philosophical stance informed by my personal experience of childbirth as a daughter, mother and grandmother, and by 40 years' work as a lay childbirth educator for the National Childbirth Trust (NCT). I trained as a midwife after the birth of my fourth child and have worked in midwifery for 30 years. Throughout my midwifery career I have continued with NCT teaching. I maintain both professional and lay perspectives on birth and identify strongly with Mavis Kirkham's statement that she 'has retained the outsider view at the back of her mind throughout her career as a midwife' (Kirkham, 2016, p.xi).

I am in the unusual and privileged position of having attended births as a lay supporter (in my NCT role) before training as a midwife. I have also been with my daughters when they gave birth, in my role as their mother. Over the past 40 years, I have listened to hundreds - probably thousands - of birth stories and personally attended several hundred births as a midwife. All these experiences inform my approach to midwifery; I see birth in the context of the mother's close relationships and her family and social circumstances. They give me a range of perspectives which are different from those gained as a professional midwife and are relevant to the methodological approach I chose for my study.

One personal experience of childbirth is relevant to my choice of research focus. Arriving at the midwife-led unit shortly before my third baby's birth (1984), I clearly remember the midwife-manager (who I knew through NCT) greeting me at the door, smiling, saying quietly, 'Welcome, Debbie. Thank you for coming'. I mention this because it had a huge impact on me and my practice as a midwife. Those simple words expressed so powerfully the power of human communication and contact which lie at the heart of midwifery.

Reflections from a feminist perspective

The evidence from existing literature identifies that fathers, as a group, may be described as 'marginalised' during labour and birth (Harvey, 2010; Steen et al, 2012; Walton, 2001). However, as a feminist, I am struck by the irony of advocating for men's rights within a patriarchal society and in one of the very few contexts that has been an almost entirely female domain, occupied and owned predominantly by women.

However, within this domain, power relations exist: midwives exercising power over

labouring women, doctors exercising power over midwives in the medical hierarchy (Henley-Einion, 2003). The father – or whoever is supporting the woman in labour, including same-sex partners and female family members or friends, is often at the bottom of the hierarchy in terms of the care-givers' priorities and the identification and meeting of needs. One father in this study expressed with a strong sense of pain and loss, how he was treated following his partner's miscarriage:

'It's like – 'Your job's done, you're of no interest to us now. You're in the room, but not there' [speaker's emphasis].

Journal extract, 13/11/17

My study's focus on midwives and fathers is undertaken with the aim of improving birth experiences for all the players; it is therefore consistent with my feminist beliefs.

Reflections on the study design

Throughout my work with parents I have been influenced by the writings of anthropologists and sociologists, including Mead (1973), Kitzinger (1994) and Oakley (1980). Their work encourages me to see childbirth in the broadest of social contexts. This wide-lens perspective was a significant factor in choosing ethnography, rooted in anthropology and sociology.

Ethnographic midwifery research has had a profound influence on my practice - a further reason for choosing this approach. Kirkham's seminal study on midwives and information-giving during labour (1987), with its focus on midwives' use of language, links to my undergraduate study of English Language and Literature. My enjoyment of stories, story-telling and of writing further motivated me towards ethnography. Hunt's work on the social culture of the 'delivery suite' (Hunt and Symons, 1995) also had a strong impact on my practice. Her stance accorded with my own worldview, particularly regarding feminism and social justice. I had experienced 'first-hand' the potential for ethnographic research to have a direct impact on practice. During my own ethnographic work, the experience of 're-viewing' the familiar as unfamiliar, deepened my understanding and awareness of situations that I had previously taken for granted. This led to changes in my own clinical practice, before completion of the research.

The 'insider / outsider' debate

A 'insider' researcher who 'belongs' to the group she is researching, shares some aspects of identity with research participants' (Braun and Clarke, 2013). I shared 'parent' and 'midwife' identities with both groups of participants. However, there are differences too. I am a woman and a mother, focussing on men who are fathers.

Braun and Clarke highlight that 'for any research, we are likely to have multiple insider and outsider positions' (2013, p.10): this has been my experience. These insider /

outsider positions encompass layers of complexity. My role as a midwife confers 'insider' status; as such I was aware of the risk that I would be 'immune' to events and occurrences within the birth environment. I took measures to stay alert to the newness of the situation for fathers by adopting an approach of naïve curiosity, imagining I was 'observing the behaviour and beliefs of an unknown tribe' (Silverman, 2013, p.1).

Although an experienced midwife, I was a novice researcher. It was salutary to discover that I felt an 'outsider' in this new world of research. I lacked confidence about my abilities and knowledge and experienced strong feelings of inadequacy. However, achieving all the necessary ethical approvals and moving towards recruitment boosted my confidence. I noticed my 'role allegiance' shifted from midwife to researcher:

Feel I'm moving towards my research as my main professional focus – 2 days a week clinical, but find myself starting to 'think more ethnographically' at work.
Journal extract 26/08/17

Advantages of being an 'insider'

Being an 'insider' carried many advantages. I had trained and worked at the study site in the early 1990s; I returned in 2001 and worked as consultant midwife for over 10 years until leaving to resume a clinical role and start doctoral studies. Five years elapsed between returning to the study site as a researcher; nevertheless, I was very familiar with the service and knew many of the staff. Initially apprehensive that because I had been in a senior management role, some midwives might be reluctant to participate or feel pressurised, I emphasised repeatedly the voluntary nature of their participation, highlighting my new role as 'midwife-researcher', denoted on my badge.

Gaining access to birth environments is challenging. Birth in the UK takes place in an environment which is largely unobserved; midwives, once qualified, are practising in a 'protected space' when looking after women in labour. All UK birth environments aspire to providing privacy for labouring women and to shield them from un-necessary intrusion and interruption. My previous history of working at the study site definitely 'opened doors' and afforded me privileged access. The HoM and senior colleagues placed a high level of trust in me; I recognise I was in a privileged position.

Appearance management and acceptability

I was aware that how I presented myself was important: I had to consider how I would be perceived by both parents and midwives. I eventually decided on a 'research uniform' – a neutral coloured, 'smart-casual' outfit with layers, so I could adapt to the extreme cold of the winter months and the warmth of the birth environment. It was also

comfortable, easy to wash and quick-drying. Putting these clothes on helped me make the mental adjustments I needed to move into my 'researcher' role.

There were similarities between my midwife and researcher roles. Both were community-based but also involved time in hospital. My car was my 'base' as I drove to parents' homes and shared their excitement with their new baby. Other similarities: on-call commitments, getting up during the night and the 'emotion work' of the research:

Driving home after interviews with N22. Hadn't anticipated how emotional this work would be, or how I'd feel such a sense of responsibility to the participants.

Journal extract 24/1/18

Parents' comments during recruitment suggested they felt that my status as a midwife would make my presence acceptable during labour. Equally important was my acceptance by clinical midwives in my new 'researcher role'. Many staff had known me as a midwife; some had 'mentored' me as a student in the early 1990s, others had known me as consultant midwife, a leadership role. I needed to convey that as a midwife-researcher I would be present in a different capacity. In pre-recruitment meetings, I explained I was combining a part-time community-midwife role with doctoral studies, leading one midwife to observe: '*You're back on the shop floor now*' (Journal, 15/08/17). During fieldwork, more births happened at night and at the weekend than at other times. Seeing me appear at Gracefields on several consecutive weekend evenings drew favourable comments from midwives, seeming to confer kudos.

Reflective journal

I maintained a reflective journal throughout, discussing extracts with my supervisors. It helped to shape the development of the research. During data collection, it was at times a 'repository' for de-briefing difficult experiences. I explored the feelings and emotions triggered during observations. I noted 'MWhead ('midwife-head') thoughts' during data collection - occasions when I noticed I was making 'internal comments' on the care the midwife was providing, semi-consciously drawing on my midwifery experience. Identifying these 'MWhead thoughts' enabled me to move on from them as the focus of my observations was not the midwife's clinical care. I also noted the times when, working as a midwife or NCT teacher, I was reflecting my research findings back into my own practice. Although I had been involved in the world of childbirth for 40 years, I was repeatedly surprised during fieldwork observations, by the fresh insights gained through seeking a different perspective: that of the father. I reflected frequently on the quote taken from the email sign-off of my study's ethnographic advisor:

... the task is not so much to see what no one yet has seen, but to think what no one yet has thought, about that which everybody sees.

Arthur Schopenhauer, 1851

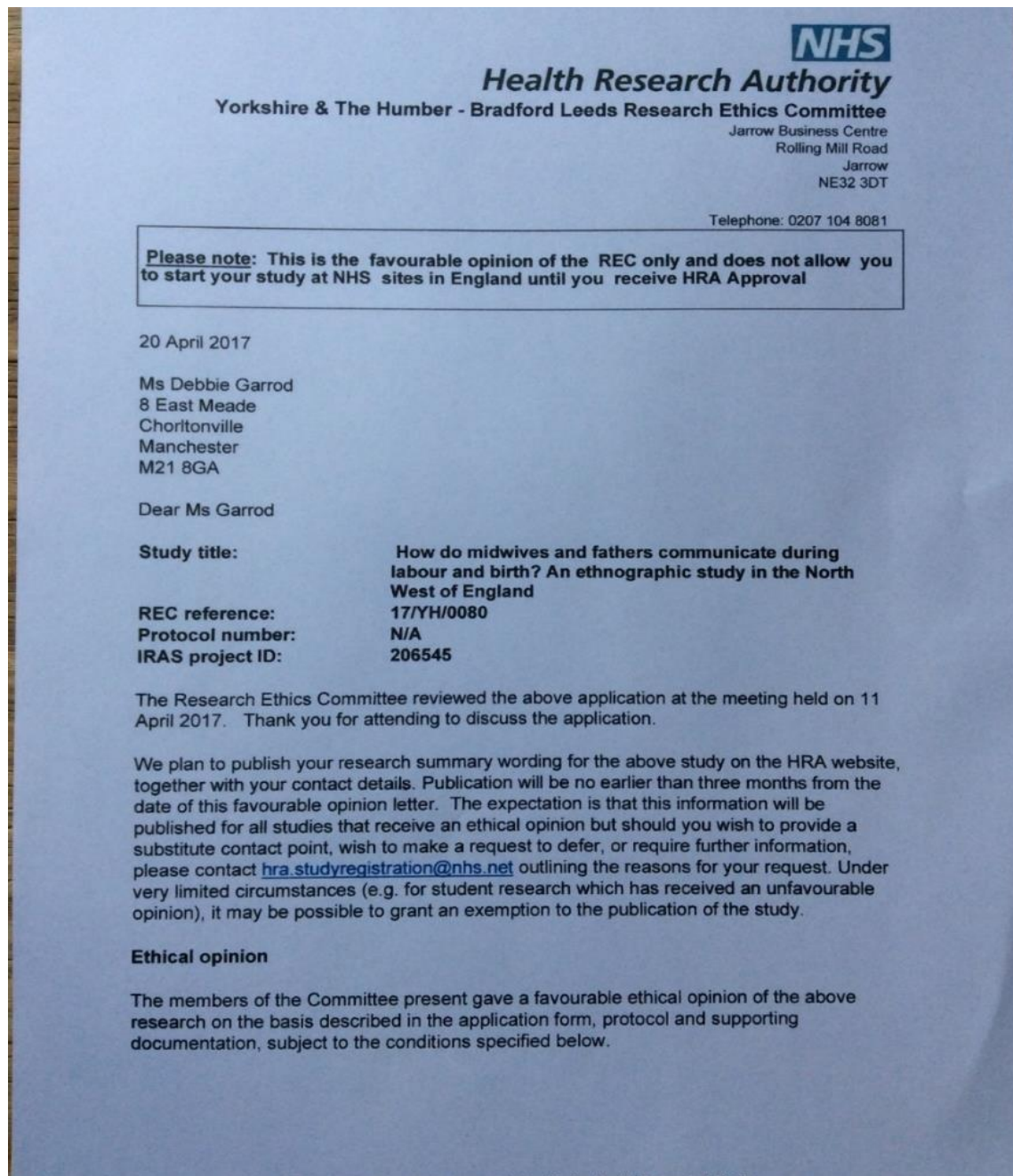
Appendix E: Tracy's 8 'big-tent' criteria for excellent qualitative research

Criterion	Approaches, practices and methods used to demonstrate
1. Worthy topic	<p>Relevant, timely, significant, interesting</p> <p>Timely societal or personal events; questions taken for granted assumptions; points out surprises</p>
2. Rich rigour	<p>Uses sufficient, appropriate theoretical constructs, data / time in field, contexts, data collection and analysis processes</p> <p>Richness rather than precision, generated through 'requisite variety' (Weick, 2007, p.16) = 'tool or instrument needs to be at least as complex as phenomena under study'; abundant data, nuanced and complex.</p> <p>Evidence of 'due diligence': time, effort, care, thoroughness – beyond convenience and opportunism.</p> <p>Data are sufficient to support meaningful and substantial claims.</p> <p>Care and practice in data collection and analysis; clear audit trail demonstrating how the raw data are organised and transformed</p>
3. Sincerity	<p>Characterised by self-reflexivity about researcher's values, biases and inclinations; transparency about the methods and challenges</p> <p>Authenticity, genuineness – demonstrated through reflexivity, vulnerability, honesty, transparency; thorough audit processes.</p> <p>Self-reflexivity woven throughout report</p>
4. Credibility	<p>Marked by thick description, concrete detail, explication of tacit knowledge, 'showing rather than telling'</p> <p>Trustworthiness, verisimilitude, plausibility; persuasiveness of findings.</p> <p>In-depth description, abundant concrete detail → show not tell; author provides enough detail to enable reader to make up own mind</p> <p>Crystallisation – multiple types of data, range of methods, numerous theoretical frameworks → more complex, in-depth understanding of issue</p> <p>Multivocality from analysing social action from participant's point of view; provides empathetic understanding. <u>Divergent</u> cases are significant.</p> <p>Member reflections – taking findings back to the field and 'sense-checking'</p>

Criterion	Approaches, practices and methods used to demonstrate
5. Resonance	<p>Influences, affects or moves readers and audiences by aesthetic evocative representation; naturalistic generalisations; transferable findings</p> <p>Practices that promote empathy, reverberation, identification – provides reader with vicarious experience which enables naturalistic generalisations</p> <p>Aesthetic merit – report affects the heart as well as the head; includes skills from other disciplines</p> <p>Findings reverberate and are transferable to other setting</p>
6. Significant contribution	<p>Conceptually/ theoretically; practically; morally; methodologically; heuristically</p> <p>Study extends knowledge, improves practice, generates ongoing research, empowers</p> <p>Conceptualisations that help explain social life in unique ways and are transferable</p> <p>Heuristically – linked to ‘show not tell’ - moves people to explore further</p>
7. Ethics	<p>Procedural, situational / culturally specific, relational and ‘exiting’ ethical issues all considered</p> <p>Procedural – ethics and governance procedures dictated by national and local institutions / governing bodies</p> <p>Situational – ethical decisions based on the particularities of the scene; constant, ongoing</p> <p>Relational – researcher mindful of actions and their consequences on others</p> <p>Exiting – how researcher leaves the scene and shares results</p>
8. Meaningful coherence	<p>Achieves what it purports to be about; uses methods that fit its stated goals; meaningfully interconnects literature, research question, findings, interpretations</p> <p>Eloquent connecting of research design, data collection and analysis with theoretical framework and research goals</p>

Appendix F: Ethics and HRA approvals

Ethical approval was granted on 20.04.17, following a meeting of Bradford Leeds Research Ethics Committee (REC) meeting on 11.04.17. REC reference: 17/YH/0080. IRAS project ID: 206545 (see below); favourable ethical opinion of Substantial Amendment 1 was granted on 07.05.17, inviting fathers to contact researcher when labour established. Health Research Authority approval was granted on 16.08.17.



Ms Debbie Garrod
8 East Meade
Chortonville
Manchester
M21 8GA

Email: hra.approval@nhs.net

16 August 2018

Dear Ms Garrod,

Letter of HRA Approval

Study title:	How do midwives and fathers communicate during labour and birth? An ethnographic study in the North West of England
IRAS project ID:	206545
Protocol number:	N/A
REC reference:	17/YH/0080
Sponsor	University of Leeds

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

Appendix G: Terms of Reference (ToR) for Services Users' (SUs') Reference Group

These ToR were developed in line with guidance from INVOLVE 'Ways that people can be involved in the different stages of the research cycle' (INVOLVE 2012 p.25).

SU involvement was significant in shaping the research, the proposal discussed informally with fathers, mothers, midwives and service user organisations over a period of several years preceding commencement of the project. This confirmed the topic as relevant and of interest to a range of key stakeholders. When doctoral studies commenced, the approach to SU involvement was formalised through establishment of a small 'reference group'.

The Reference Group was established in 2014 and gave feedback and advice at various stages, including

- reviewing the main research proposal
- involvement in applications for ethics approvals
- 'sense-checking' all written materials for research participants
- giving advice regarding dissemination of project findings

Membership

- Two fathers with recent experience of maternity services
- Two representatives from the NCT (the Head of Research and Information and an antenatal tutor), to access a wider range of voices and views through their networks and on-going work with fathers

The Group was most involved during year 4 of the study (October 2016 – September 2017) when the proposal and data collection tools were developed and ethical approvals sought. The time commitment amounted to approximately 6 hours over this 12-month period. There were no resources to fund SU involvement; the input of the Group is therefore acknowledged here and in all outputs (e.g. conference presentations; papers) that ensue.

Reference

INVOLVE (2012) Briefing notes for researchers: involving the public in NHS, public health and social care research; Eastleigh, INVOLVE

Appendix H: Participant Information Sheet – Parents



UNIVERSITY OF LEEDS

IRAS Project ID 206545

How do midwives and fathers communicate during labour and birth?

Participant Information Sheet for parents (Version 1.3 27/06/17)

We are inviting you to take part in a research project. This leaflet explains more about the research -

- why it is being done
- who is doing it
- why you have been invited to take part
- what it involves

It also answers some questions you may have. Please read it carefully as it will help you decide whether you would like to take part. You will then be able to ask the researcher any questions you have about the project.

Why is this research being done?

Childbirth is a very important event in a couple's life. Many mothers and fathers want to share it together. This research wants to find out how midwives can best help and support fathers during labour and birth. When fathers feel supported, they are better able to support their partner and their own experience can be more positive as well.

'Labour and birth' are called 'childbirth' during the rest of this leaflet.

Who is doing this study?

This research project is being carried out by a Midwife, Debbie Garrod. She is a part-time student at The University of Leeds, working towards a doctorate in midwifery and works part-time as a midwife in South Manchester. The names of her Supervisors at the University of Leeds are given at the end of this leaflet. Debbie is also an antenatal teacher for the National Childbirth Trust (NCT). The NCT is the UK's largest childbirth and parenting charity.

Who can take part in the study?

This study involves parents who

- have booked to have their baby with [Trust] Maternity Services
- plan to have the baby's father present during labour and birth
- are having 'midwife-led care'
- start labour after 37 weeks of pregnancy

'Midwife led care' is for women who are healthy and well during pregnancy and at the start of labour. A majority of women have 'midwife-led care'.

We are telling as many parents as possible about the study. We are hoping to gain written consent from about thirty couples to take part in the study.

What does the study involve?

1. A meeting in late pregnancy with both parents when Debbie will discuss the study and ask for written consent for you to be involved
2. Observation during labour and birth, focussing on how midwives and fathers communicate
3. Interviews with both parents, together or separately, about two weeks after the baby's birth

First meeting in pregnancy, to find out more about the study

If you are interested and would like to find out more, Debbie will arrange to meet you over the next week or so. She will explain what would be involved if you decide to take part and answer any questions you have. This meeting will last from 30 – 60 minutes. You will choose where we meet - your home, at the clinic or centre where you have your antenatal appointments, or at the hospital.

If you decide to take part, each of you will be invited to fill out and sign a consent form.

- This will include your personal details (for example, name, address, age, contact details via mobile, land line and email, date the baby is due and planned place of birth)
- This information will be stored securely at The University of Leeds and will not be shared with anyone else

What to expect during the consent process

The consent form will give Debbie permission to:

- be present during labour and the birth of your baby in order to observe and make notes on how the midwife and parents communicate
- meet with you after your baby's birth for an interview to talk about how the labour and birth went for you

Observation during labour

- When labour starts you will go, as planned, to the hospital (if you are having your baby on the birth centre or delivery suite) or call the midwife to come to your home, if you are planning a homebirth.
- When the midwife caring for the mother tells you that labour is well under way (known as 'established labour'), Debbie who will come as soon as she can and usually stay until the baby is born. Either the midwife or the father-to-be will contact Debbie to let her know.
- The research involves Debbie observing how the midwife communicates with the father and making some notes about this. She will not be making audio or visual recordings. She will not be involved in caring for you.
- The observation phase will last roughly 8 hours, depending on the time of day / night and the progress of labour; Debbie may need to leave before the baby has been born to ensure she is safe to drive home
- After your baby has been born, Debbie will leave the room when the midwife leaves, to give you privacy and time alone with your baby

Post-birth interviews

- After your baby has been born, Debbie will arrange to come and meet you to ask you about your experience of labour and birth. She will interview both the mother

and the father either separately or together. It will be up to you – you can decide what feels most comfortable and is most practical.

- These interviews will help her to understand more about how things went for you during labour and what the midwives said and did that was helpful.
- The interviews will take roughly one hour. You can choose where to meet. Your own home is likely to be the most convenient place, because the interviews will be timed for about two weeks after your baby's birth.
- The discussion will be audio-recorded. This means that no visual images will be recorded, just what you have said. The recordings will then be typed up so the data can be analysed.

What are the possible benefits of taking part?

Some people get involved in research projects because they feel it may be of benefit to other people in the future. For example, this research may help midwives to understand how they can involve fathers in positive ways during childbirth. In this way, other parents may benefit in the future. Some parents find it helpful to talk about the labour after the baby has been born.

What are the possible risks and disadvantages of taking part?

- Childbirth is a very personal experience. You may feel uncomfortable about having someone else present during labour and birth.

Please be aware that the researcher is an experienced midwife, who has attended many births over the past 25 years. However, if after labour has started, you change your mind about her being present and want her to leave at any point, she will do so.

- When you meet the researcher after the birth, and she asks questions about the labour, it is possible you may feel distressed by discussing it.

The researcher has experience of talking to parents about their birth experiences and would not carry on asking questions if you were upset and wanted her to stop. If you wanted to arrange to discuss your birth experiences further after the interview, this would be arranged with via the Head of Midwifery, whose contact details are at the end of this leaflet.

If I sign a consent form, will I definitely be included in the study?

If you decide you would like to take part in the study, and complete the 'Informed Consent' process, there is a chance that you may not eventually be included in the study. We hope that 8 – 10 couples will eventually take part in the observation and interview stages of the study. In order to increase the chances of reaching these numbers, we hope to recruit about 30 couples to the study. This is to make sure that the minimum numbers for the study are achieved. This will probably be between 8 and 10 couples. This means that some parents who consent will not be included in the study. There are other reasons why you might not be included. For example:

- Labour may start before 37 weeks of pregnancy
- Labour may progress quickly before the researcher is able to be there
- There may be complications during pregnancy (for example high blood pressure) which mean that labour may need to be 'induced' (started off) for medical reasons
- You may change your minds about being involved and decide to withdraw from the study
- The midwife caring for you may not want to be take part in the study and in this case you would not be included

What happens if I lose the capacity to give informed consent to take part?

It is very unlikely that you would be in the position of 'losing the capacity to take part' in the study. This would be if, for example, one of the parents became too unwell to give informed consent to continue to take part. If this did happen, your participation in the study would stop. Any data which have already been collected will be used during the analysis stage, but no further data will be collected.

What will happen if I decide I no longer wish to be involved in the study?

If at any time you change your mind, you are free to withdraw. This includes

- before your baby is born
- during labour
- before or during the interview after your baby's birth
- up to two weeks after the interview has taken place

It is also possible that one parent could decide to withdraw from the study. In this situation, you (as a couple) would both be withdrawn from the study. The data already collected (for example, from the observations made during labour) would be included, provided you both gave consent for this.

If you decide to withdraw, this decision will not affect your care in any way. If you decide not to carry on with the study, you also have the option to withdraw any data that has been collected, up to two weeks after the interview has taken place. It will not then be used in the research.

How will my information be kept confidential?

Your personal details will be stored securely at [Trust] until they can be transported to The University of Leeds. They will be destroyed securely after 5 years.

All the observations Debbie makes and everything you say during the interviews will be kept confidential. There are a few exceptions to this that you need to be aware of. These include, if:

- there is a risk of harm to yourself or someone else
- a law may have been broken
- there has been possible bad practice by a member of NHS staff

In any of these situations, Debbie has a duty to report concerns to the Head of Midwifery.

Do I have to take part?

No you don't have to take part in the research; it is entirely up to you. Your care will not be affected in any way whether you take part or not.

Will anyone reading the final report be able to identify me?

No names or other identifying features will be used in the research. Everyone who takes part will be given a number to identify them. Names will be changed and 'pseudonyms' (another name, not your own) may be used when writing about the research. You may be able to identify yourself if you decide to ask for a summary of the research to be sent to you after it has been completed (see below).

What will happen to the results of this study?

At the end of the study, when all the information has been analysed, the research will be published as a 'Doctoral Thesis' by The University of Leeds. The findings will be presented at conferences, in journal articles and on websites accessed by health professionals and parents, for example the National Childbirth Trust website. Pseudonyms or number codes will be used to make sure that you cannot be identified in any of these publications or presentations.

A short summary of the research findings will be made and offered to all parents and midwives who have taken part. If you would like to receive a summary of the findings, Debbie will make a note of this and send you a copy of the report.

Financial issues

There are no financial benefits to taking part. We cannot offer any payment, although we can cover car park and public transport costs (receipts needed) for the meeting in pregnancy and the interviews after your baby's birth, if these take place away from your home.

Who is funding this study?

Debbie receives some financial support for the research from the NCT. The NCT pays Debbie's tuition fees at The University of Leeds.

Who has reviewed the study?

All University and NHS research projects involving NHS patients are reviewed by an independent group of specialists and experts. This is an NHS Research Ethics Committee (REC). This project has been reviewed and approved by (details of Ethics Committee and date).

There is a small group of fathers and experienced NCT antenatal teachers who give advice on different aspects of the study. They have read and made comments on this leaflet.

Who will know I have taken part in the research?

If you decide to take part in the study, a sticker will be fixed to the front of your notes. This will give the name of the study and the researcher's contact details. The midwives caring for you in labour will also be taking part and they will know you are involved.

What if there is a problem?

If you have any concerns about anything to do with the study, you can contact one of Debbie's Supervisors at The University of Leeds. If you would prefer to talk to someone who is independent of the research project, you can contact [name] Head of Midwifery or the Trust Patient and Customer Liaison Service. All contact details are at the end of the leaflet.

What should I do now if I am interested in taking part in the study?

Please contact Debbie Garrod, Midwife Researcher. She will arrange to come and meet you to discuss the study in more detail, answer any questions you have and sign the Consent Form. You can contact Debbie by

- Texting or calling her mobile 07503 517436. If there is no reply, please leave a message and she will phone you back
- email at hss7dmq@leeds.ac.uk
- completing the slip below and returning it in the stamped addressed envelope provided

Thank you for reading this leaflet and for considering taking part in the study.

Wishing you well for the rest of the pregnancy and for the birth of your baby.

Debbie Garrod, Midwife Researcher

Supervisors at The University of Leeds

Professor Linda McGowan l.mcgowan@leeds.ac.uk 0113 34 31339

Dr Zoe Darwin z.j.darwin@leeds.ac.uk 0113 34 30549

Head of Midwifery [Name and contact details]

Patient and Customer Liaison Service [Contact details]

Research study - How do midwives and fathers communicate during labour and birth?

REPLY SLIP - if you would like more information, please return in the attached SAE

Name:

Mobile phone number:

Landline number:

Is it OK to leave a text message YES / NO

Voicemail message YES / NO

OR you can text Debbie on 07503 517436 email at hss7dmq@leeds.ac.uk if you would like to arrange a meeting to find out more about the study

Appendix I: Written Informed Consent Process – Parents



IRAS Project ID 206545

Research study - How do midwives and fathers communicate during labour and birth?

Background information – MOTHER (Version1.0 05/02/17)

Participant Identification Number for this study:

Please fill out the following background details to help us describe whose views we are representing in the research. We will not use any identifying details when reporting the research.

Name:

Address:

Age (in years)

Email address

Mobile phone number:

Landline number:

Is it OK to leave a text message YES / NO

Voicemail message YES / NO

How many times have you been pregnant?

Do you already have any children? YES / NO

How many children do you have? Please include their ages.

Are any of your children from a previous relationship? YES / NO

If 'YES', please give the age/s of the children who are from a previous relationship:

Date your baby is due:

Some background information about yourself

How would you describe your ethnic group?

Education: please circle the highest degree or level of education you have completed

- No schooling completed
- Secondary school, left at 16 years
- Further education, to 18 years old
- Higher education, beyond 18 years
- Trade/technical/vocational training/ apprenticeship
- Bachelor's degree
- Master's degree or higher

Employment: are you currently:

in paid employment	YES / NO
working FULL-TIME or PART-TIME occupation	(please circle the one that applies to you) or PREFER NOT TO SAY
receiving state benefits	YES / NO
a full-time student	YES / NO
full-time carer	YES / NO
on sick leave	YES / NO

Written Informed Consent Form – mother (Version1.0 05/02/17)

Front sheet to be stored separately will have demographics: name, address, age, parity, contact phone no's, email address, date baby due, planned place of birth, education and employment status + Study number for cross referencing

Participant Identification Number for this study:

Title of Project: How do midwives and fathers communicate during labour and birth?

Name of Researcher: Debbie Garrod

		Initials
1.	I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to think about the information, ask questions and have had these answered satisfactorily.	
2.	I understand that taking part is voluntary. I am free to withdraw at any time without giving any reason. If I withdraw, my medical care or legal rights will not be affected. I understand that if I withdraw from the study, there is a two-week period during which I can also choose to withdraw my data from the study. After this time period, the data may be used in the study.	
3.	I understand that if I give my written informed consent to take part in the study, and subsequently lose the capacity to give on-going consent, my participation in the study will cease. Any data which have already been collected will be used during the analysis stage, but no further data will be collected.	
4.	I understand that data collected during the study will be anonymous and confidential. The only exceptions are if any information disclosed suggests that myself or another person may be at risk of harm, if there is a possible breach of the law, or in the event of malpractice by NHS staff.	
5.	I understand data will be collected during labour and birth in the form of handwritten notes and on an i-Pad which will be used to make sketches of the layout of the birth room. I give permission for this. I understand that no audio or visual recordings will be made during labour and birth.	
6.	I understand that the interviews after our baby's birth will be audio-recorded and I give permission for this. I understand that the audio-recordings will be transcribed into electronic form and that following transcription, the recordings will be deleted.	
7.	I understand that I will not be individually identified during the research and that any information I give and direct quotes that are used will be anonymised.	
8.	I understand that data collected during the study may be looked at by the Researcher's Supervisors at The University of Leeds, other University personnel or staff at [Trust] and NHS regulatory authorities who are authorised to do so. The reason for this is to make sure that the research has been properly carried out.	
9.	I understand that the research data will be stored securely for five years, may be used to support other research in the future, and may be shared anonymously with other researchers. After five years, the data will be destroyed.	
10.	I agree to take part in the study.	

Name of Participant

Date

Signature

Name of Person taking consent

Date

Signature

Research study - How do midwives and fathers communicate during labour and birth?

Background information – FATHER (Version 1.0 05/02/17)

Participant Identification Number for this study:

Please fill out the following background details to help us describe whose views we are representing in the research. We will not use any identifying details when reporting the research.

Name:

Address:

Age:

Email address

Mobile phone number:

Landline number:

Is it OK to leave a text message YES / NO

Voicemail message YES / NO

Do you already have any children?

YES / NO

If yes, how many children do you have? Please include their ages.

Are any of your children from a previous relationship? YES / NO

If 'YES', please give the age/s of the children who are from a previous relationship:

Date baby is due:

Some background information about yourself

How would you describe your ethnic group?

Education: please circle the highest degree or level of education you have completed

- No schooling completed
- Secondary school, left at 16 years
- Further education, to 18 years old
- Higher education, beyond 18 years
- Trade/technical/vocational training/ apprenticeship
- Bachelor's degree
- Master's degree or higher

Employment: are you currently:

in paid employment

YES / NO

working **FULL-TIME** or **PART-TIME**

(please circle the one that applies to you)

occupation

or PREFER NOT TO SAY

receiving state benefits

YES / NO

a full-time student

YES / NO

full-time carer

YES / NO

on sick leave

YES / NO

Written Informed Consent Form – father (Version1.0 05/02/17)

Front sheet to be stored separately will have demographics: name, address, age , contact phone no's, email address, date baby due, no of children, planned place of birth, education and employment status + Study number for cross referencing

Participant Identification Number for this study:

Title of Project: How do midwives and fathers communicate during labour and birth?

Name of Researcher: Debbie Garrod

		Initials
1.	I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to think about the information, ask questions and have had these answered satisfactorily.	
2.	I understand that taking part is voluntary. I am free to withdraw at any time without giving any reason. I understand that if I withdraw from the study, there is a two-week period during which I can also choose to withdraw my data from the study. After this time period, the data may be used in the study.	
3.	I understand that if I give my written informed consent to take part in the study, and subsequently lose the capacity to give on-going consent, my participation in the study will cease. Any data which have already been collected will be used during the analysis stage, but no further data will be collected.	
4..	I understand that data collected during the study will be anonymous and confidential. The only exceptions are if any information disclosed suggests that myself or another person may be at risk of harm, if there is a possible breach of the law, or in the event of malpractice by NHS staff.	
5.	I understand data will be collected during labour and birth in the form of handwritten notes and on an i-Pad which will be used to make sketches of the layout of the birth room. I give permission for this. I understand that no audio or visual recordings will be made during labour and birth.	
6.	I understand that the interviews after our baby's birth will be audio-recorded and I give permission for this. I understand that the audio-recordings will be transcribed into electronic form and that following transcription, the recordings will be deleted.	
7.	I understand that I will not be individually identified during the research and that any information I give and direct quotes that are used will be anonymised.	
8.	I understand that data collected during the study may be looked at by the Researcher's Supervisors at The University of Leeds, other University personnel or staff at [Trust] and NHS regulatory authorities who are authorised to do so. The reason for this is to make sure that the research has been properly carried out.	
9.	I understand that the research data will be stored securely for five years, may be used to support other research in the future, and may be shared anonymously with other researchers. After five years, the data will be destroyed.	
10.	I agree to take part in the study.	

Name of Participant

Date

Signature

Name of Person taking consent

Date

Signature

Appendix J: Study distress policy

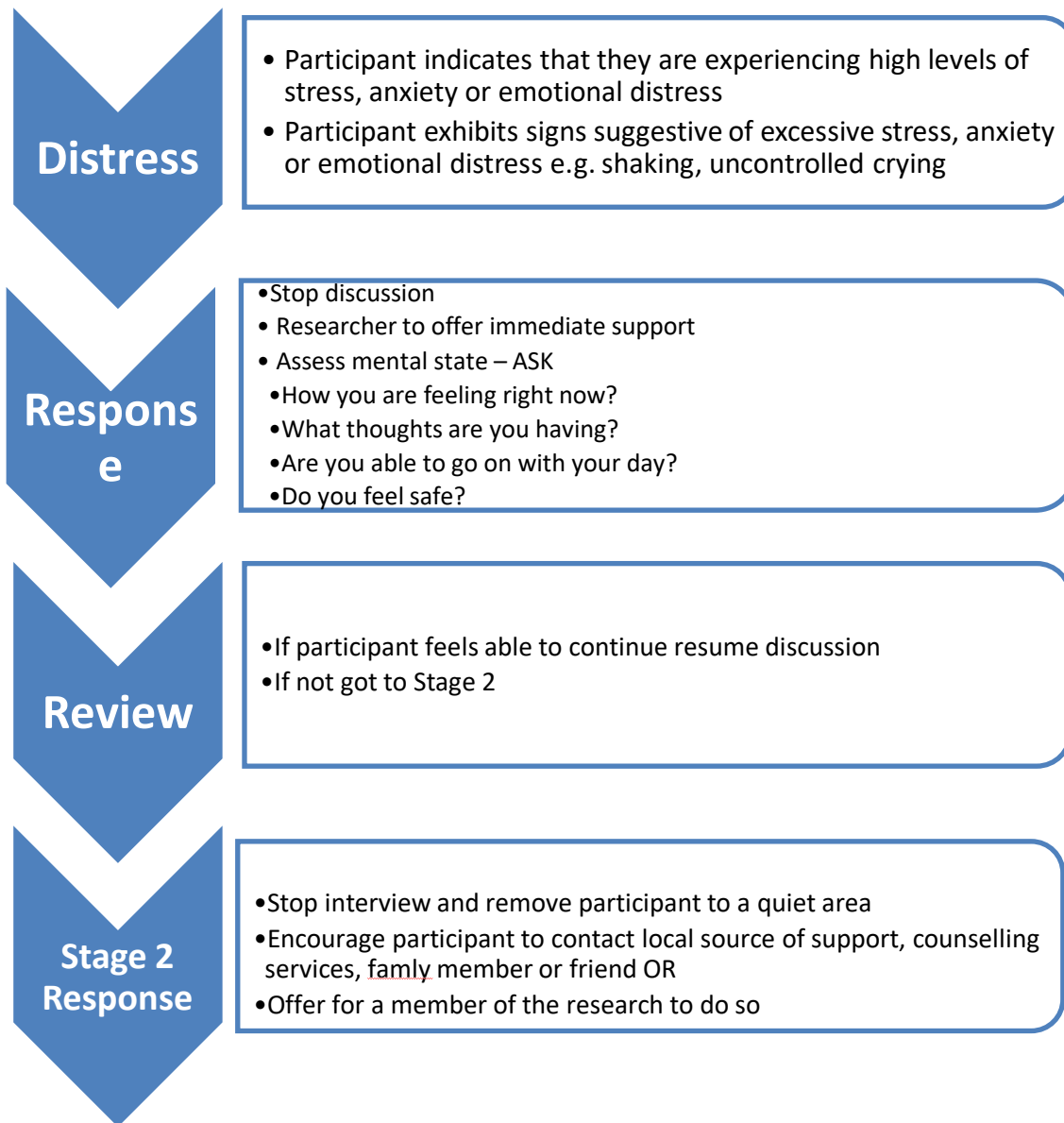
How do midwives and fathers communicate during labour and birth?

The second phase of data collection for this study involves interviews with participants following the baby's birth. These will take place as soon as possible after the birth for midwives and within approximately two weeks for parents. Parents will choose whether to be interviewed together or separately.

It is not anticipated that these interviews will cause distress for most participants, but as childbirth is a highly emotional event, it is possible that talking about it may give rise to strong emotions, including distress. This is more likely if the birth has been difficult or experienced as traumatic, or if loss of any kind has occurred. It is also recognised that couple dynamics may give rise to distress during interviews, particularly if domestic abuse is an issue for a couple.

At the start of the interview, participants will be reminded of their right to withdraw from the study at any time and that they can decline to respond to any question. They will also be reminded that they have the right to withdraw their data up to two weeks after the interview has taken place. All these rights are included in the written informed consent that participants will have signed prior to labour observations.

DG has received training in conducting interviews and in caring for women with mental health issues. She also has experience in caring for families where fathers have mental health problems. She is supported through regular contact with her academic supervisors, both of whom are experienced in the fields of maternal and family health research and have extensive experience in research into sensitive topic areas that are potentially distressing. DG also has over 25 years' experience working as a clinical midwife and is therefore well used to exploring sensitive issues with parents. For four years ran a clinic providing a 'de-briefing' service for parents whose birth experience had been traumatic. She has also been a Supervisor of Midwives for 20 years and has considerable experience of working with midwives through challenging events, such as the loss of a baby. She will be alert to visual, auditory and other cues indicating distress and will discontinue the interview if necessary. If the participant becomes distressed during the interview, DG will follow the distress protocol (outlined below).



The above Distress Policy is taken from the Epoch Study (Engaging Partners in Childbirth for the Prevention Of Mother-to-Child Transmission Study) and is used with the permission of Professor Linda McGowan

Protocol for managing distress in the context of research focus group or interview
(Adapted from Haigh and Witham, 2010)

Leaflet for parents - how to access support, if needed, after interviews
Research study: How do midwives and fathers communicate during labour and birth?

On-going support for parents following the birth of your baby

Having a baby is a very important event in your life as parents. Even when all goes well during labour and birth, there may be questions about what happened, that you would like to discuss. Sometimes birth does not go as planned and parents can feel distressed afterwards. Talking about labour and your baby's birth with the midwife-researcher as part of this research study may bring up questions or issues for you.

There is on-going support available for you from experienced senior midwives at [Trust]. For some parents, this may be months or even years later. You can contact the Head of Midwifery and arrange a meeting if you feel you need this support:

[Name], Head of Midwifery at [Trust] [Contact details]

You can also contact your GP or Health Visitor for support if you feel that your health and mood are being affected by your baby's birth.

Thank you for taking part in this study.

If there are any issues you would like to raise which relate directly to how the study has been conducted, you can contact one of Debbie Garrod's academic supervisors at The University of Leeds:

Supervisors at The University of Leeds

Professor Linda McGowan 31339	l.mcgowan@leeds.ac.uk	0113 34
Dr Zoe Darwin	z.j.darwin@leeds.ac.uk	0113 34

Appendix K: Participant Information Sheet - Midwives



IRAS Project ID 206545

How do midwives and fathers communicate during labour and birth?

Participant Information Sheet for midwives (Version 1.4 21/07/17)

This leaflet explains more about the research -

- why it is being done
- who is doing it
- how you may be invited to take part
- what it involves

It also answers some questions you may have. Please read it carefully as it will help you decide whether you would like to take part. You will also be able to discuss it with Debbie Garrod (DG), who is conducting the research. .

Why is this research being done?

Over the past 50 years, fathers' presence during labour and birth has increasingly become the norm. Existing evidence tells us that fathers can play a number of roles during childbirth, for example offering practical support and verbal encouragement to their partner and witnessing the birth of their baby. It also describes the wide range of experiences and emotions that fathers may have. Current research identifies that midwives are very well placed to involve fathers in positive and appropriate ways during labour and birth, but that there is a lack of evidence which describes exactly how they can do this.

Aim of the study

This research aims to find out how midwives can best help and support fathers during labour and birth. When fathers feel supported, they are better able to support their partner and their own experience can be more positive as well. By involving the father in positive ways, it may also mean that midwives' job satisfaction may be enhanced.

The study will focus on communications between fathers and midwives during childbirth (i.e. labour and birth) in different birth environments: delivery suite, birth centre and home. The purpose of the study is to enable the development of a model for communication and support during childbirth.

How is the study being carried out?

This study has two phases:

1. Direct observations of approximately 8 – 10 labours, across different birth environments (birth centre, delivery suite and home), to find out more about exactly how midwives and fathers communicate during childbirth
2. Individual interviews with midwives and parents after the birth, to understand in more depth the experiences of all the participants.

Who is doing this study?

This is a PhD study conducted by a Midwife Researcher, Debbie Garrod. She is a part-time student at The University of Leeds and works part-time as a midwife in Manchester. The names of her Supervisors at the University of Leeds are given at the end of this leaflet.

DG is also an antenatal teacher for the National Childbirth Trust (NCT).

Who is invited to take part in the study?

[Trust] Maternity Service has been chosen as the site for the study because it offers a full range of choices for place of birth. It is hoped to recruit parents who are having their babies in the birth centre, delivery suite and at home, to enable comparisons to be made.

Midwives

You will be invited to take part in the study if you are providing care in labour to one of couples who has given their written informed consent to take part in the study. If you are caring for one of these couples, you will be asked for your written informed consent to take part in the study. Details of this process are given below.

Parents

Approximately 30 couples who are receiving care from [Trust] Maternity Services, will be recruited based on the following inclusion criteria:

- Pregnant woman with a male partner
- Both parents intend that the expectant father will be present during childbirth
- Both parents aged 16 years or over at the time of recruitment
- Booked for midwife-led care at the time of recruitment
- Sufficiently fluent in English not to need an interpreter
- Labour starts after 37 weeks and is complication-free at onset

The observation / interview phase of the study will involve approximately 8- 10 couples. To achieve these numbers, it is necessary to 'over-recruit' because consented participants may not eventually become part of the study for a number of reasons, including

- Labour starts before 37 weeks
- Labour progresses too rapidly for the researcher to be present There may be
- Complications during pregnancy which mean that labour needs to be induced for medical reasons
- The researcher is unable, for personal reasons (e.g. sickness) to be present
- The parents change their minds
- The midwife involved in care does not contact the researcher or does not wish to participate

The target number of couples to be recruited is 30, to ensure the minimum numbers for the study are achieved. Inevitably, therefore, some parents who consent will not be included in the study. This will be made clear to parents during the 'informed consent' process.

Participants will be recruited from 34 weeks of pregnancy, when all women attend for an antenatal appointment. This will allow sufficient time for parents to think about if they wish to be involved in the study, to discuss the implications with the researcher and to give written informed consent. It is intended that observations of 8-10 labours will be

undertaken, but over-recruitment is necessary to ensure these final numbers are achieved.

Parents who agree to take part in the study will sign a consent form. A sticker will be attached to the front of their notes.

What to expect during the consent process

When one of the couples who has consented to take part in the study goes into labour, DG will be contacted, either by the couple or the midwife carrying out the initial assessment in labour. When DG arrives and before she begins observations, you will be asked to read and sign a consent form, stating you are willing to take part in the study. If you are a midwife taking over care of the couple at the start of a new shift, you will be asked for your informed written consent for DG to continue observations.

The consent form will give DG permission to:

- be present during the labour and the birth of the parents you are caring for, in order to observe and make notes on how the midwife and father-to-be communicate
- meet with you after the baby's birth for an interview to talk about your experience of these communications

The observation phase

The observation phase of the research involves DG observing how the midwife communicates with the father and making notes about this. She may also use an iPad to make sketches of where you and the parents are located in the birth environment at different stages during labour, but she will not be making audio or video recording and will not be involved in caring for the parents. She will remain as unobtrusive as possible and will be located wherever in the room that you and the parents feel is appropriate.

Observations will begin when labour is established (i.e. when the cervix is approximately 3-4 cm dilated in the presence of contractions that are getting progressively longer, stronger and closer together) and continue for approximately 8 hours, or until the baby is born. DG will need to make a decision about whether to stay until the baby arrives, depending on the time of the day / night and her own safety in driving home.

After the baby's birth, DG will leave the room when the midwife leaves, to give the parents privacy and time alone with their baby.

DG is present as a midwife researcher and not as a clinical midwife. The only exception to this would be in the event of an emergency at home, where no other person was present who could assist the midwife. In this situation, DG would undertake clinical duties if required to do so, under the direction of the midwife responsible for providing care.

Post-birth interviews

After the baby has been born, DG would like to talk to you about your experience of the labour and birth. This will be a brief, semi-structured interview, with open-ended questions to help her to understand more about how things went during labour and how you felt about the father's presence and involvement. This is expected to take roughly half an hour. The discussion may be audio-recorded for later transcription and analysis, or may be recorded via handwritten notes.. It is hoped that the interview can take place soon after the baby's birth, although DG is very mindful of the midwife's workload, priorities and paperwork. She may arrange to come and meet with you for the interview

the next time you are on shift, if it is not possible to conduct the interview soon after the birth.

The parents will also be interviewed about their experience of labour and birth. These interviews are planned to take place within two weeks of the birth.

What happens if I lose the capacity to give informed consent to take part?

If you give your written informed consent to take part in the study, and subsequently lose the capacity to give on-going consent, your participation in the study will cease. Any data which have already been collected will be used during the analysis stage, but no further data will be collected.

What are the possible benefits of taking part?

Taking part in the study may be counted towards the NMC requirement that midwives undertake a minimum of 35 hours' continuing professional development (CPD) over a 3-year period in order to remain on the NMC Register (Guidance and Information for Revalidation, NMC 2016). Using the template on the NMC website (NMC 2016 p 46), you can describe and reflect on your experiences of participating in the research, on your own practice in relation to the topic of the research and the implications for this practice of taking part in the study.

Some midwives get involved in research projects because they are interested in helping to build the body of knowledge and evidence about midwifery practice. They feel their contribution may be of benefit to midwives and parents in the future. For example, this research may help midwives to understand how they can involve fathers in positive ways during childbirth.

Research with fathers tends to recruit participants from antenatal class attendees, which means that some groups of fathers (i.e. those who do not attend) may be under-represented. Additionally, much research with fathers collects data via reported accounts and retrospective questionnaires. There is currently very little evidence which looks 'first hand' at what happens during labour. No research has been found to date which focuses specifically on the father's point of view. You would therefore be contributing to a new and potentially interesting and valuable piece of work.

What are the possible risks and disadvantages of taking part?

You may feel uncomfortable about having someone present and observing your interactions with parents during labour. Please remember that the researcher's aim in being present is specifically to find out more about how midwives and fathers communicate. She is not there to observe clinical care. If, however, you change your mind about her being present and want her to leave at any point, she will do so. This decision will not be discussed with any member of the maternity services' staff. DG would however need to explain to the parents the reason for her leaving and would do so in a sensitive manner, aiming to minimise any potential effect on the on-going relationship between midwife and parents.

Financial issues

There are no financial benefits to taking part. We cannot offer any payment.

What will happen if I decide I no longer wish to be involved in the study?

If at any time you change your mind, you are free to withdraw. This includes during labour, before or during the interview after the baby's birth, or up to two weeks after the interview has taken place. If you decide to withdraw after the observation phase of the study, but

before the interview, DG will ask for your permission to use the data she has collected during the observations. However, If you do decide to withdraw at any stage, you also have the option to withdraw any data that has been collected. It will not then be used in the research.

How will my information be kept confidential?

Your personal details will be stored securely in a locked filing cabinet at the hospital, designated solely for this use, and subsequently at The University of Leeds and destroyed securely after five years. All the observations DG makes and everything you say during the interviews will be kept confidential. There are a few exceptions to this that you need to be aware of. These include, if:

- there is a risk of harm to yourself or someone else
- a law may have been broken
- there has been possible bad practice by a member of NHS staff

In any of these situations, DG has a duty to report concerns to the Head of Midwifery.

Do I have to take part?

No you do not have to take part in the research; it is entirely up to you.

Will anyone reading the final report be able to identify me?

No names or other identifying features will be used in the research. Everyone who takes part will be given a number to identify them. Names will be changed and 'pseudonyms' (another name, not your own) may be used when writing about the research.

What will happen to the results of this study?

At the end of the study, when all the information has been analysed, the research will be published as a 'Doctoral Thesis' by The University of Leeds. The findings will be presented at [name of Trust] and at external conferences, in journal articles and on websites. Pseudonyms or number codes will be used to make sure that you are not identifiable in any of these publications or presentations.

A short summary of the research findings will be made and offered to all parents and midwives who have taken part. If you would like to receive a summary of the findings, DG will make a note of this and send you a copy of the report.

Who is funding this study?

DG receives some financial support for the research from the NCT. The NCT pays DG's tuition fees at The University of Leeds. DG also received some financial support during the second year of her studies from her employing Trust (University Hospital of South Manchester) and from The Iolanthe Midwifery Trust.

Who has reviewed the study?

All University and NHS research projects involving NHS patients are reviewed by an independent group of specialists and experts, the Research Ethics Committee of the Health Research Authority. This project has been reviewed and approved by the Bradford-Leeds NRES Ethics Committee on 25th May 2017.

There is a small group of fathers and experienced NCT antenatal teachers who give advice on different aspects of the study. They have read and made comments on this leaflet.

What should I do if I have any concerns about the study or my involvement?

If you have any concerns about anything to do with the study, you can contact one of DG's Supervisors at The University of Leeds. Their names are at the end of the leaflet. If you would prefer to talk to someone who is independent of the research project, you can contact the Head of Midwifery, your Professional Midwifery Advocate or your Trust Research and Development Lead.

What should I do now if I am interested in taking part in the study?

If you have any questions at this stage, please contact Debbie Garrod, Midwife Researcher. She will arrange to come and meet you to discuss the study in more detail.. You can contact Debbie by

- Texting or calling her mobile 07503 517436. If there is no reply, please leave a message and she will phone you back
- email at hss7dmg@leeds.ac.uk
- completing the slip below and returning it in the stamped addressed envelope provided

Thank you for reading this leaflet and for considering taking part in the study.

Thanks too, to [Trust] for its support for the study.

Debbie Garrod, Midwife Researcher

Supervisors at The University of Leeds

Professor Linda McGowan	l.mcgowan@leeds.ac.uk	0113 34 31339
Dr Zoe Darwin	z.j.darwin@leeds.ac.uk	0113 34 30549
Head of Midwifery	[Name and contact details]	

Appendix L: Flyer - study summary information and publicity for staff

(Version1.0 05/02/17)

(Produced in A3 and A4; the sole document used to publicise the study to staff.)

How do midwives and fathers communicate during labour and birth?



We are planning a research study to look at how midwives and fathers communicate during childbirth. We want to find out how midwives can help fathers to be involved in ways that are right for each couple.

A series of meetings will give more details about the study, which parents will be eligible to take part, how they will be recruited, what will happen during the study and how you can be involved.

The study is being carried out by Debbie Garrod, a midwife and part-time PhD student at the University of Leeds.

If you would like more information, please contact Debbie Garrod, email hss7dmq@leeds.ac.uk

Mobile number 1234 56789



Appendix M: Written update for staff



IRAS Project ID 206545

How do midwives and fathers communicate during labour and birth?

PhD study conducted by Debbie Garrod, Midwife-Researcher

Update 4 January 2018

A very happy New Year to you and your families and loved ones. I hope you had a good Christmas and New Year.

Thank you!

First of all, I want to say a really big 'thank you' to all midwives and other colleagues for your support with my study. At every stage, from publicity and recruitment, to my data collection, being present during labours and births and your time for interviews afterwards, I have been helped and supported so much. My study would not be possible without this help and I really do appreciate it.

Update on progress

My 'target number' of participants for the study was 8 to 10 couples and the midwives caring for them in labour. Since I began recruiting to the study in late October 2017, a total of 8 couples have given their consent to take part. I attended 7 labours and births in November and December, and have interviewed all the parents and the midwives who looked after them. This achievement is due to the support you have given me, so thank you again.

A request for help

I am now keen to recruit the final few parents I need to complete my data collection. I would like to do this in the first two weeks of January if possible. I have discovered that recruitment works best when I come to antenatal clinics and meet women who are as close as possible to their 'due date' at the time of our first meeting.

Please can you check your clinic lists for January and contact me if you have two or three women booked in who are 36 – 38 + weeks? I can recruit at any stage of late pregnancy. I am including women who are having labour induced for post-dates, so am happy to meet parents whose baby is 'overdue'.

A reminder of the main 'eligibility criteria':

- Women who are 'low risk' and receiving midwife-led care at the time of recruitment
- Expecting their **first or subsequent** baby
- Booked to give birth at [hospital] or at home in [Trust]
- Have a male partner who plans to be present during labour and birth
- 18 years or older
- Sufficient command of the English language not to need an interpreter

Please text me with details of your clinic dates and times, or with any other questions, and thank you again for your help. **Debbie Garrod 07507 390006**

Appendix N: Written Informed Consent Process - midwives



IRAS Project ID 206545

Research study - How do midwives and fathers communicate during labour and birth?

Background information – midwives and student midwives (Version 1.0 05/02/17)

Participant Identification Number for this study:

Please fill out the following background details to help us describe whose views we are representing in the research. We will not use any identifying details when reporting the research.

Name

Email address

Mobile phone number:

Landline number:

Is it OK to leave a text message YES / NO

Voicemail message YES / NO

Are you a qualified midwife **Please complete Section A.**

Section A: qualified midwives

Main place of work:

Years qualified as a midwife (please tick) < than 2 years []

2 – 5 years [] 6 – 10 years [] 11 – 15 years []

16 - 20 years [] 21 – 25 years [] > 25 years []

Have you undertaken any specialist training you feel may be relevant to the study?

Please indicate YES / NO

If 'YES' please give brief details of this training:

Are you a student midwife **Please complete Section B.**

Section B: student midwives

Pre-reg student midwife **Year of study** 1 2 3

Post-reg student midwife **Year of study** 1 2

Written Informed Consent Forms – midwives and student midwives (Version1.0 05/02/17)

Front sheet to be stored separately records demographics: name, address, age (in bands e.g. 21 – 30 years etc) contact phone no's, email address, year qualified as midwife, years of experience, midwifery role / area of expertise, year of study if student + Study number for cross referencing

Participant Identification Number for this study:

Title of Project: How do midwives and fathers communicate during labour and birth?

Name of Researcher: Debbie Garrod

		Initials
1.	I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to think about the information, ask questions and have had these answered satisfactorily.	
2.	I understand that taking part is voluntary. I am free to withdraw at any time without giving any reason. If I withdraw, my legal rights will not be affected. I understand that if I withdraw from the study, there is a two-week period during which I can also choose to withdraw my data from the study. After this time period, the data may be used in the study.	
3.	I understand that data collected during the study will be anonymous and confidential. The only exceptions are if any information disclosed suggests that myself or another person may be at risk of harm, if there is a possible breach of the law, or in the event of serious clinical malpractice.	
4.	I understand data will be collected during labour and birth in the form of handwritten notes and on an i-Pad which will be used to make sketches of the layout of the birth room. I give permission for this. I understand that no audio or visual recordings will be made during labour and birth.	
5.	I understand that the interview after the baby's birth will be audio-recorded and I give permission for this. I understand that the audio-recordings will be transcribed into electronic form and that following transcription, the recordings will be deleted.	
6.	I understand that I will not be individually identified during the research and that any information I give and direct quotes that are used will be anonymised.	
7.	I understand that if I give my written informed consent to take part in the study, and subsequently lose the capacity to give on-going consent, my participation in the study will cease. Any data which have already been collected will be used during the analysis stage, but no further data will be collected.	
8.	I understand that data collected during the study may be looked at by the Researcher's Supervisors at The University of Leeds, other University personnel or staff at [Trust] and NHS regulatory authorities who are authorised to do so. The reason for this is to make sure that the research has been properly carried out.	
9.	I understand that the research data will be stored securely for 5 years, may be used to support other research in the future, and may be shared anonymously with other researchers. After 5 years, the data will be destroyed.	
10.	I agree to take part in the study.	

Name of Participant

Date

Signature

Name of Person taking consent

Date

Signature

Appendix O: Flyer for parents – publicity for the study

(Version 1.0 05/02/17)

(Produced in A3 and A4; sole document used to publicise the study to parents).

How do midwives and fathers communicate during labour and birth?



Are you a couple expecting a baby?

Planning for the baby's father to be there during labour?

We are planning a research study to look at how midwives and fathers communicate during childbirth. We want to find out how midwives can help fathers to be involved in ways that are right for each couple.

Interested in taking part in the study? Your midwife will offer you more information at your 34 week antenatal appointment.

The study is being carried out by Debbie Garrod, a midwife and part-time PhD student at the University of Leeds.

If you would like more information at this stage, please contact Debbie Garrod, email hss7dmq@leeds.ac.uk

Mobile number 1234 56789



Appendix P: Contacting the researcher when labour is established

(Version 1.0 30/04/2017)

Sticker for handheld notes

**‘How do midwives and fathers communicate
during labour and birth?’**

A PhD study at The University of Leeds.

This woman has given written consent for you to contact Debbie Garrod RM, Chief Investigator, when labour is established. Please call or text. Thank you.

Mobile no 1234 5678

Card to remind father to contact researcher

**‘How do midwives and fathers communicate
during labour and birth?’**

A PhD research study at the University of Leeds

When your partner is in labour and the midwife has told you that labour is ‘established’, please contact Debbie Garrod Midwife-Researcher. You can call or text

Mobile no 1234 5678

Appendix Q: 'Thank you letter' to parents not included in the study

(Version 1.0 30/04/17)

This 'Thank you letter' will be sent to potential parent-participants who were recruited to the study but not subsequently included.



UNIVERSITY OF LEEDS

IRAS Project ID 206545

Dear

How do midwives and fathers communicate during labour and birth?

I would like to thank you for your being willing to take part in this PhD study and for your time spent in discussing the study and giving your informed consent to take part. As I explained when we met, I had to recruit more parents to the study than would eventually be needed to take part. This means that some parents who kindly agreed to be involved, would not in fact need to be and this may have been the case for you. I will therefore shred all the information you gave in preparation for taking part in the study, including your personal details and your informed consent sheets.

If you are interested in receiving a copy of the 'summary report' when the study is completed, please contact me via the email address or mobile number given below.

Once again, thank you very much for your interest and for being willing to take part.

With best wishes for the future

Debbie Garrod, Midwife Researcher

Hss7dmg@leeds.ac.uk

Mobile no: 07503 517436

Supervisors at The University of Leeds

Professor Linda McGowan l.mcgowan@leeds.ac.uk 0113 34 31339

Dr Zoe Darwin z.j.darwin@leeds.ac.uk 0113 34 30549

Appendix R: Observation guide, informed by Spradley's 9-dimension framework for ethnographic observation

	Dimensions of the social setting	Examples for this study
1.	Space	Layout of the physical setting; movement within and between spaces; where participants choose or are directed to stand / sit.
2.	Actors	Names and relevant details of study participants – parents, midwife, student midwife; other people within setting.
3.	Activity	The various activities of the actors.
4.	Objects	Physical elements – e.g. furniture, equipment, possessions.
5.	Acts	Specific individual actions.
6.	Events	Particular occasions e.g. meetings.
7.	Time	The sequence of events.
8.	Goals	What actors are attempting to accomplish.
9.	Feelings	Emotions in context, as expressed by participants verbally / denoted via facial expressions and other non-verbal cues

(Spradley, 1980)

Appendix S: Example of fieldnotes

shattered. I wish I could say to him, just curl ⁽⁶⁾
up in bed for 1/2 hour + I'll talk ♀ through these
ctns. He keeps offering encouraging words 'keep
going' 'you can do this' in quiet, calm
reassuring tone. I think less on up for 24 hours
now,
♀ It hurts all the time. It hurts so bad
MSI Where are you feeling it ♀?
♀ In the lower part of my tummy
MSI We need these strong ones to get baby out
♀ my exclamation - 'Something is leaking out'
♂ is there 100% for ♀. Who is there for him??
♂ 'You're doing so well, ♀, so well'
I think, so are you, but no-one's telling you!!!

MSI asks ♂ how much water she's had, he shows
the pint glass - white disc. & MSI re quantity
♂ feeds her a bit of banana 'That's amazing,
that's great' MSI 'Well done'

♂ to ♀
I'm just having a snack but ♀. Would you like
one? No reply

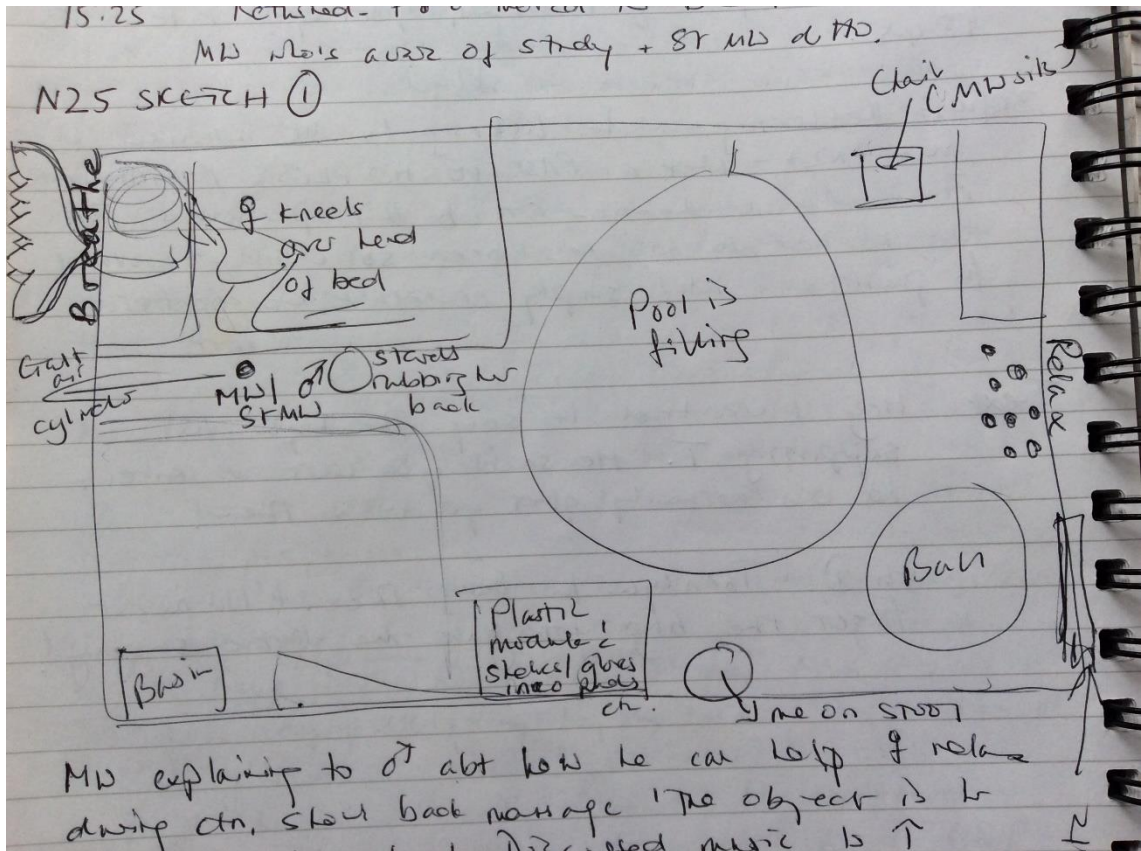
08.05 I can hear MSI giving up due on progress
to DS with. ♂ continues his words of assured
encouragement during ctns.

MSI ^{to ♂}
You OK? Long job isn't it? Nothing can prep you
^{to ♀} you alright in the position?

MSI relays suggestion from obs. of breaking uterus
to speed things up as only concern = the ketones

Extract from fieldnotes N23

Appendix T: example of fieldnote sketch



Fieldnotes N25 sketch 1

Appendix U: Semi-structured interview guide

Interviews aim to enhance the observational data by learning more about the participants' individual experiences, with a focus on how the midwife communicated with the father and how the mother experienced these communications. Questions are open-ended and adapted as necessary.

Midwives

Interviews with midwives are planned to take place as soon as possible after the birth, and it is anticipated that these will be brief reflections on events during labour and birth, focussing on midwife-father communications, the ways in which the midwife felt she involved the father and how she felt about the experience overall, in terms of these communications.

Parents

Parents are given the option of being interviewed together or separately, in a time and place of their choice

Introduction

- An introductory question, designed to put the participant at ease, e.g. a brief opening question (for parents) about how life has been since coming home with the baby
- A reminder of the focus of this research, to help guide the interviewee to stay on topic

'In this research, I'm interested in finding out more about how midwives and fathers communicate during childbirth. The questions I ask will be focussed on this topic.'

Main body of interview

- The main interview questions will be broad, following the reminder of the focus of the research, for example, for parents:

Thinking about your relationship / communications with your midwife when (baby's name) was on his / her way, can you tell me how this went for you?'

For midwives:

Thinking about how things went just now during labour, focussing on your relationship/ communications with the baby's Dad, what thoughts do you have about this....

Following the responses, asking *'What went well / what could maybe have been different?'*

- The sequence of events in labour will be used as a time-line to bring logical order to responses, where appropriate, although DG recognises that when telling their birth story, participants will naturally focus on the parts that were most significant for them
- In order to help the participant stay on topic, prompts and probe questions will be used as needed, or to pick up on interesting phrases, words or gestures e.g. *'You just said...please can you say a bit more about that?'*
- The researcher is particularly interested in finding out more about participants' feelings and will encourage reflection on internal states as well as on events *'I noticed when you said....you looked happy / excited / worried / a bit sad. I wonder how that felt for you?'*

Drawing to a close

- A general question towards the end of the interview, e.g. *'Is there anything else you'd like to tell me?'*
- Thank participants for their time and involvement in the study; give leaflet with sources of further support if needed (Appendix J) and check if they wish to receive a summary of the study on completion

Appendix V: Summary and illustration of Thematic Analysis

The following Journal extract and images outline the steps employed. It is a retrospective summary of a process that was complex, challenging and ultimately rewarding.

This is the process I've used to reach this stage:

- 1. I read and re-read all 11 parents interviews, and made notes of ideas and themes as I identified them. I've done 5 of these with LMcG and ZD and discussed as we've gone along.*
- 2. I started by listing points from each interview and colour-coding. It soon became evident that this is far too complicated. I moved to a form of spider-diagram which is easier to take in (Image 1).*
- 3. As I read each successive interview, I noted the themes which I'd identified in previous interviews, and highlighted those which were new to the interview under review.*
- 4. I looked at all the ideas and thoughts when I'd finished, and wrote each individual one on a coloured post-it, and had a go at grouping these into broad themes (Image 2)*
- 5. Then I transferred these onto large sheets of paper (Image 3), moving some of them around where I thought they fitted better into a different theme, though some cross over themes in any case*

Journal extract 23/05/18

Image 1: 'Spider diagram' - manual coding of transcript of parents' interview (Gemma and Craig N27). Highlighter pen makes links with 'mini themes' in other transcripts

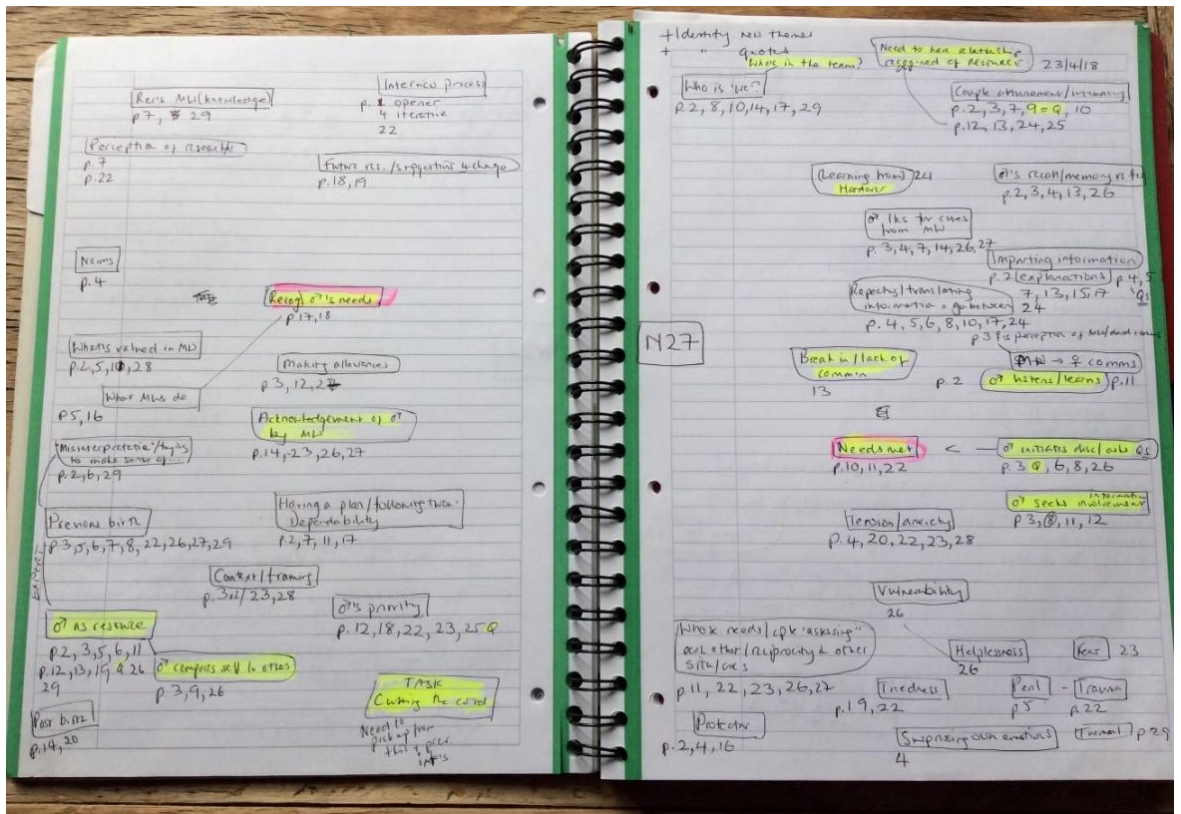


Image 2: Coded data 'colour coded' into broad themes

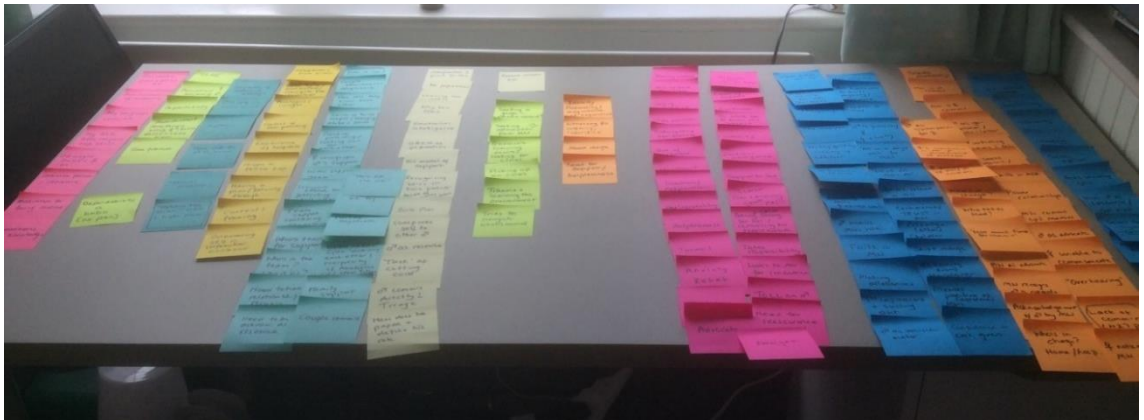
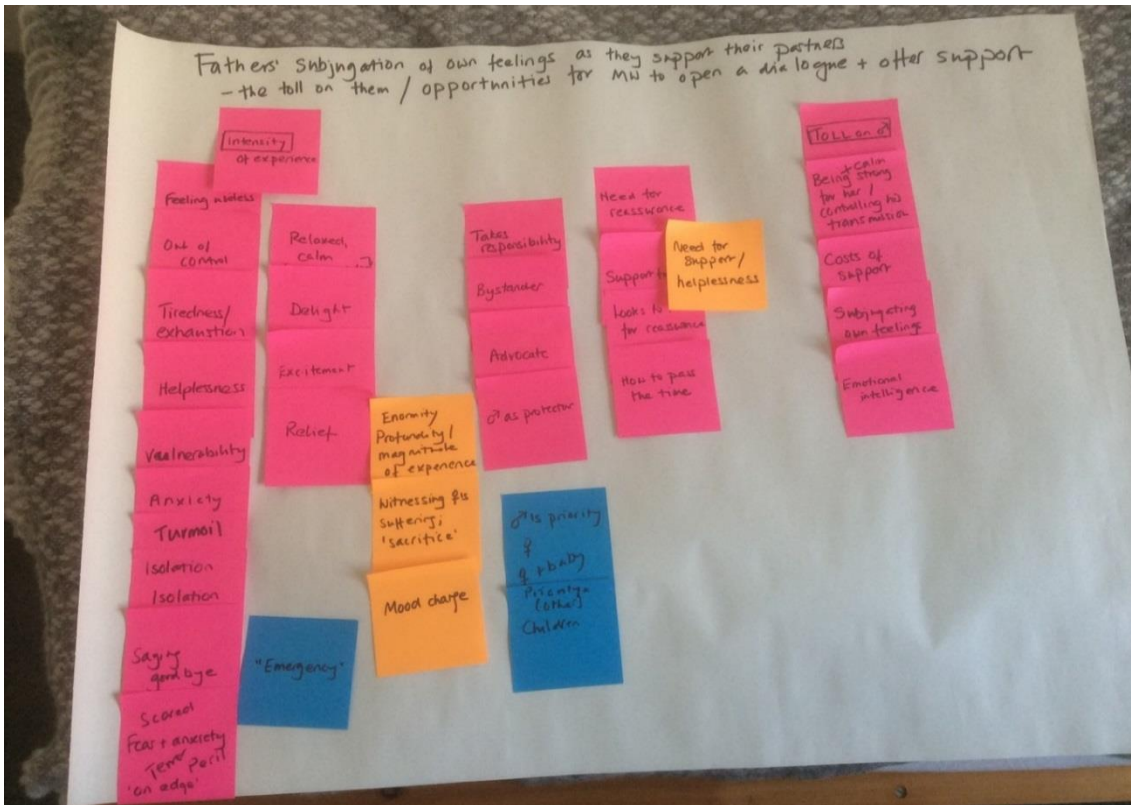


Image 3: The development of an emergent theme



Parents' interviews	Midwives' interviews	Fieldnotes
1. Father's subjugation of his own feelings and needs	1. Ways of being and doing	1. Who's in the team /in charge / who takes the lead
2. Fathers develop their own framework / constructs	2. Communication and engagement – map journey	2. Circles of intimacy
3. Building partnerships for communication	3. Who's in the team? Dyads, triads and wider team	3. The couple connection
4. The ways that midwives communicate	4. Roles and behaviours – witness, bystander etc	4. Types of talk
5. Midwife stuff: father's perception / assessment of midwife; midwife's constructs 'all in a day's work'	5. Who leads and who's in charge?	5. Seeking the father's / emic perspective
6. Who's in the team/ who is 'we'?	6. Midwives' constructs	6. Impact of environment
7. How father prepares himself / sees his role	7. Birth environment	7. Research issues
8. Setting / players/ norms in different birth environments	8. Research issues	
9. Research / reflexivity		

Table 12 Summary of preliminary themes from the three data sets; V1.1, 2018.11.28

Data source: **Fieldnotes** **MW interviews** **Parent interviews** **New theme via integration**

1	2	3	4	5	6	7
Who's in the team / in charge / who is 'we'?	Types of talk Tools of conversation and chat	Impact of environment	Circles of intimacy / couple connection / Greek chorus	Focus on fathers / 'emic' perspective	Research issues	Constructs: midwives' and fathers'
Who's in the team? Dyads, triads, wider team	MWs engage and communicate with fathers / assess their 'performance'	Birth environment	The couple connection	Roles and behaviours: witness / bystander etc.	Research issues	MW constructs – 'all in a day's work' (NB but does this include the father?)
Who leads and who's in charge?	Building partnerships for communication	Settings, players and norms in different birth environments	Couple connection	Fathers' ways of being and doing	Research / reflexivity	Fathers develop their own frameworks / constructs
Who's in the team? Who is 'we'?	The ways that MWs communicate			Fathers' subjugation of own feelings and needs		'MW stuff': fathers' perception / assessment of MW (MW constructs / 'all in a day's work')
				How father prepares himself / see his role		

Integrating Preliminary Themes from 3 data sets V1. 2019.01.31; then see Tables 9 and 10 in thesis.

Appendix W: Dissemination plan

The aim is to share the findings as soon as practicable with stakeholders. The researcher is energised by possibilities; her enthusiasm for this area has increased over the course of the past seven years. She has shared the findings as they developed; the discussions she has had (formal and informal) confirm that this is an area of great interest to parents, clinicians, academics and policy-makers.

The researcher is yet to 'test' her findings with maternity services commissioners, relevant because her 'recommendations' include the provision of appropriate spaces for partners within built birth environments. A consequence of the global pandemic has been to focus attention on who is present to support the woman during childbirth; the restrictions have received much media attention. This is an ideal time to promote debate amongst stakeholders; the researcher is keen to be involved in such debate and at all levels of policy-making.

Two potential barriers counter the researcher's high levels of motivation to disseminate the findings. She will address her 'novice status' in using social media by accessing a training to gain these skills. The second is funding. She will use her experience of successful funding applications, combined with extensive networks to identify opportunities to share her findings.

The aims in dissemination are four-fold: to raise awareness, promote discussion, increase understanding and change practice (NIHR, 2019). Each involves different audiences and media and the use of both tailored and targeted messaging. The first task is to complete a summary to share with the research participants and at the study site. Some groups of wider stakeholders are already engaged (the NCT, Fatherhood Institute, midwives and academics within the researcher's networks). An early task is to extend the 'reach' of these established contacts to reach the widest possible group of 'end users' (Elsberry and Mirambeau, 2021).

The researcher plans to produce a 'press release' aimed at popular media. She is committed to publicising her findings widely and will seek opportunities to do so via radio and television media. An item on BBC Radio 4's 'Woman's Hour' in 2014 helped shape her research question; her ambition is to 'complete the circle' by securing an invitation to take part in a discussion on this programme. She plans to write a book for parents based on her PhD research, as well as looking for opportunities to contribute chapters in edited books for midwives.

The researcher looks forward to ongoing work with her supervisors, to seeking publication opportunities and to undertaking further research in areas identified by this study; also to exciting collaborations with colleagues outside the field of health and midwifery (for example, architects), as well as within. Many possibilities lie ahead.

Appendix X: Recommendations for education and practice

Key finding	Recommendations
<p>No. 1 Key findings about the midwife-father relationship</p>	<p>Develop approaches to facilitate direct verbal communications with fathers, during pregnancy and labour. Introduce structured discussion about the father's involvement and roles. Recognise the father's possible reluctance to ask questions or initiate conversation; develop ways to establish independent lines of communication with him, which encourage him to do so. Balance the father's needs for direct verbal communications with the mother's needs for a quiet environment. Highlight the importance of the midwife's educative role in labour itself, moving away from a reliance on antenatal classes; sensitive and appropriate 'thinking out loud' about the progress of the labour has potential benefits for all present.</p>
<p>No. 2 Midwives' and fathers' experiences of the childbirth landscape</p>	<p>Deepen midwives' understanding of the father's perspective; raise awareness of the marked differences between midwives' / fathers' experience of the childbirth landscape, particularly in clinical hospital environments. Increase awareness that childbirth may be intensely stressful for the father, even when labour is progressing 'normally'. Develop approaches which help the father to habituate to the alien setting, which is 'taken for granted' by midwives; aim to alleviate the intensity of the environment e.g. encourage the father to explore the environment and ask questions; suggest breaks / time for rejuvenation. Seek opportunities to provide appropriate spaces and facilities in hospital.</p>
<p>No. 3 The midwife-father relationship in different birth environments</p>	<p>Utilise findings about midwife-father communications at home, compared to hospital, to enhance experiences of the father in hospital e.g. at home, the father is available, not necessarily present. Explore the possible involvement of additional birth companions, recognising their potential to offer support to both parents in labour. Develop ways to support the father when birth takes place in maternity theatre</p>
<p>No. 4 Midwives' and fathers' expectations</p>	<p>Promote debate around 're-framing' of fathers' roles; raise awareness of the importance of 'presence', help re-shape the perception that 'doing nothing' is a passive role; acknowledge his presence as part of his emotional experience of childbirth. Challenge the conceptualisation of the 'ideal' birth partner as physically close and 'busy'. Recognise that there are many ways to give support in childbirth. Explore these with parents in antenatal contacts as well as during labour. Acknowledge that the father has needs which are independent of the mother's for affirmation of his presence and role and for information; develop ways to meet these needs.</p>
<p>No. 5 The birth triad: its potential for knowledge-sharing</p>	<p>Acknowledge the 'More Knowledgeable Other' status of each member of the birth triad. Highlight the untapped potential for all members of the birth triad to learn from each other. Recognise that while the father's presence is welcomed, he may have become 'taken for granted' by the midwife; maximise opportunities to engage actively with him during labour and birth.</p>

