



The expectations of fathers concerning care provided by midwives to the mothers during labour

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Midwives have been criticised for neglecting the expectations and needs of fathers. They either ignore the fathers or pressure them into becoming more involved than they would choose, if allowed to provide support to the mothers during labour. Whilst midwives are providing woman-centred care, it is important that they remember to involve the fathers in decision-making and to acknowledge their role, expectations and needs, because the birth of a child is one of the most important events in a person's lifetime. This study focused on fathers' expectations of the care provided to mothers by the midwives during labour. A qualitative, explorative, descriptive and contextual study design was utilised. In-depth qualitative interviews were conducted with fathers about the care provided to their partners or wives by midwives. Data were then analysed with an open descriptive method of coding that is appropriate for qualitative research. The results of the interviews were subsequently positioned within a holistic health-promotive nursing theory that encompassed body, mind and spirit. The results revealed that fathers saw the provision of comfort and support as the two main aspects for mothers in labour that they expected from midwives. The findings were that midwives should improve their communication skills with the mothers, as well as with the fathers if they are available. Fathers expected midwives to encourage them to accompany the mother during labour and to facilitate bonding between father, mother and baby. The results of this study should assist midwives to provide holistic quality care to mothers and fathers during labour.

Vroedvroue word daarvan beskuldig dat hulle nie voldoen aan die verwagtinge en behoeftes van die vaders nie. Vaders word, óf deur hulle geïgnoreer, óf druk word op hulle uitgeoefen om meer betrokke te raak as waarmee hulle gemaklik is, indien hulle wel toegelaat word om moeders te ondersteun tydens die kraamproses. Vroedvroue verskaf moeder-gesentreerde sorg, maar dit is nogtans belangrik dat hulle onthou om die vaders te betrek in die besluitneming en hulle rol, verwagtinge en behoeftes te erken omdat die geboorte van 'n kind een van die belangrikste gebeurtenisse in hulle lewens is. Die studie het gefokus op vaders se verwagtinge van die sorg wat verskaf word aan moeders tydens kraam. 'n Kwalitatiewe, eksploratiewe, beskrywende en kontekstuele navorsingsontwerp is gebruik. Data is ingesamel deur in-diepte onderhoude met vaders te voer oor die sorg wat aan hul vroue of metgeselle tydens die kraamproses verskaf word deur vroedvroue. Data is daarna geanaliseer deur 'n oop beskrywende metode te gebruik wat toepaslik is vir kwalitatiewe navorsing. Die resultate van die onderhoude is vervolgens geposisioneer binne 'n holistiese, gesondheids-bevorderende teorie wat verwys na liggaam, psige en gees. Die resultate toon dat gemak en ondersteuning die twee hoofkategorieë is wat verskaf moet word deur vroedvroue aan moeders tydens die kraamproses. Die ander kategorieë wat aangedui word in die resultate, is dat vroedvroue hulle onderlinge kommunikasievaardighede moet verbeter, asook hul kommunikasie met die moeders en vaders indien laasgenoemde beskikbaar is. Die vaders het van vroedvroue verwag om hulle aan te moedig om moeders by te staan tydens die kraamproses en om binding tussen vader, moeder en baba aan te moedig.

Introduction

There exist an ever-increasing pressure on fathers to be present during their wives' labour and the birth of their child. Fathers have become more nurturing and consequently want to be actively involved in the pregnancy, labour and delivery and in the subsequent parenting of their children. It has been found also that men who hold more egalitarian views on women's roles expect to be more involved in birth and child care. Professionals need to support the couple, and not only the mother. Little is known about the father's expectations, feelings and needs at this critical time (Littleton & Engebretson 2005:541).

A study conducted by Swiatkowska-Freund, Kawiak and Preis (2007:476) found that one of the most important reasons for a father to be present during labour was his desire to share the experience of the delivery with the mother. The mothers were pleased by their partners' presence



during labour, especially for assisting them to breathe through the pain during labour and delivery. The results indicated that the fathers perceived that they were very helpful to their partners during labour and that experiencing childbirth together created an additional bond between the father and the mother.

Problem statement

Whilst accompanying student midwives in a public hospital labour ward, situated in a semi-rural area of Gauteng Province in South Africa, the researcher observed that fathers were not allowed to support their partners during labour; they were only allowed to accompany them up to the labour ward entrance. Not once did the researcher witness a midwife enquiring about the fathers' expectations of midwives' care during labour. According to Christiaens and Bracke (2007:3), expectations refer to a role system. The role of woman in labour involves a set of expectations that concerns her own behaviour and that of people in other roles, such as the midwife, the partner, or the physician. By achieving the role expected of oneself and each person present, a workable order is created. A violation of expectations disturbs this order and threatens both self-evaluation and relationships with others. In other words, deviation from the normal or the expected creates distress.

Dellmann (2004:20), however, points out that focusing childbirth education and hospital practices more on men's expectations and needs may reduce the distress levels of their partners as well as those of the men, and improve both maternal and paternal satisfaction. Similarly, Sapountzi-Krepia *et al.* (2010:53) conclude that midwives should design childbirth preparation from the man's perspective, discuss expectations with regard to the man's role, and assess his experiences during the birth process. Hildingsson, Cederlöf and Widén (2010:2) add that, in the long term, the father's presence during childbirth and early interaction between fathers and their children have been shown to have a significant impact on children's mental health. It has also been argued that both parents are important for the child's ability to develop healthy psychological, emotional and social behaviour. Today, virtually all fathers in Sweden participate in the birth of their children. It is important, therefore, that midwives understand the expectant father's feelings and plan the care to meet his expectations, as well as the mother's. In their study, Morison *et al.* (1999:37) reported that the final theme elicited was that of 'resolving expectations.' This theme describes how home delivery involves a process where parents formulate their expectations of birth, experience the reality of birth, and then evaluate whether these expectations were achieved. Overall, the parents were pragmatic and realistic about their expectations. Hence the research question: 'What are the expectations of fathers concerning care provided by midwives to mothers during labour?'

Definition of concepts

Expectations: These can be described as the hopeful anticipation of a desired event (Allen 2006:487). In this study

expectations referred to the fathers' anticipation of the care to be provided by the midwives to the mothers during labour.

Father or Partner: A father or partner is the male parent of a child (Allen 2006:504). In this study, the term 'father' is used to refer to the biological father who was taking an interest in the birth.

Midwife: A midwife is a person who has been admitted to a midwifery educational programme, duly recognised in the country in which it is located, who has successfully completed the prescribed course of studies in midwifery, and who has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery (International Confederation of Midwives' Council Meeting 2005:1).

Labour: Labour refers to a series of events by which uterine contractions and abdominal pressure expel the foetus and placenta from the woman's body. Regular contractions cause progressive dilatation of the cervix and sufficient muscular force to allow the baby to be pushed out of the mother's body. It is a time of change, both an ending and a beginning for the woman, the foetus, and the family (Johnson & Boyd-Davis 2003:466). According to Lowdermilk and Perry (2006:328), labour refers to the process of moving the foetus, placenta and membranes out of the uterus and through the birth canal. Various changes take place in the woman's reproductive system in the days and weeks before labour begins.

In this study, labour occurred when the mother had reached term, that is 36–40 weeks of pregnancy, and commenced when the cervix was 3 cm dilated, until complete dilatation that is 10 cm.

Mother: A mother is the female parent of a child or offspring (Allen 2006:903). The mother in this study refers to a pregnant individual who was in labour within the labour ward of a specific hospital in Gauteng Province.

Caring, care: (Note: In this study the terms 'care' and 'caring' are used synonymously.)

Caring is defined as a selected and informed response to the client's needs; it is the act of giving freely and willingly of oneself to another with warmth, compassion, concern and interest. The authors assert that nurses therefore care for others during times of physical discomfort, emotional stress and a need for health maintenance (Arnold & Boggs 2003:145).

In this study, caring refers to:

A reciprocal process between the midwife and mother whereby the midwife accepts the mother unconditionally and continuously utilises her knowledge that enables her to demonstrate feelings accompanying caring in order to assess the needs of the mother, whilst assuring her commitment, support and comfort within a receptive and safe environment that communicates trust and respect, and enhances understanding of the meaning of parenthood. The outcome of this interaction



is promotion of health: for example, satisfaction, potential development and self-fulfilment for both the midwife and the mother (Sengane 2001:211).

Aim of the study

The aim of the study was to explore and describe the expectations of fathers concerning care provided by midwives to mothers during labour.

Research method and design

Design

The study was qualitative, exploratory, descriptive and contextual in nature. Terre Blanche and Durrheim (2004:398) refer to qualitative methodology as suited to 'contextual' research, which is less concerned with discovering universal, law-like patterns of human behaviour, and is more concerned with making sense of human experience from within the context and perspective of human experience. The intention was to reconstruct reality from the fathers' world of expectation, as this would enable midwives to understand the fathers' concept of provision of care by the midwives during labour.

Study population

In this study, population referred to 'all fathers whose wives or partners had delivered in a public hospital labour ward situated in a semi-rural area of the Gauteng Province in South Africa and were cared for by midwives in the postnatal ward.' This is a third-level academic hospital with an overall bed occupancy of 1634. The majority of people served at the hospital are Black people from semi-rural to rural communities. Their economic status ranges from middle to lower class, and most of them, especially those from rural areas, remain poor and unemployed. Most of the people of childbearing age have attended primary school and high school. The people in the area belong to the Tswana ethnic group, and Setswana is the language of communication. Cultural practices of Black South Africans, regardless of geographical distance, tended to be very similar with regard to pregnancy, labour and the puerperium; for example, it used to be taboo for men to be anywhere near the birthing place. The infiltration of modern ideas led to a change in the status quo so that the majority is now interested and willing to be involved during their partners' pregnancy, labour and puerperium.

Sampling method

In this study, a purposive sampling was utilised. No predetermined number of participants was specified. Interviews were conducted until data were saturated and there was no evidence of new information emerging; hence five participants were interviewed. The participants were recruited in the postnatal ward, whilst visiting the mothers after delivery. The fathers were approached in the presence of the mothers. The researcher tried to maintain the integrity of the family as a unity, especially in view of Black South

African culture, which holds it totally unacceptable for a woman to approach another woman's husband without that woman's prior approval. In order to prevent cross-contamination or information sharing, participants were recruited on alternative days, as the hospital stay for mothers after delivery is very short.

The inclusion criteria

Age, marital status and presence during labour were not taken into account. Furthermore, it was not a deciding factor whether the father had previously attended his wife's labour, whether this was a first child or not, and whether the father had attended childbirth classes or not. Participants who met the following criteria were included in the study:

- the father's partner (the mother) must have been observed by midwives for more than 4 hours within the labour ward
- the father's partner (the mother) must have delivered a live baby and her pregnancy must have reached term (36 weeks and above)
- the father must have given informed consent.

Data collection methods

The hospital management allocated the researcher a comfortable room attached to the postnatal ward where interviews were conducted. Firstly, the researcher conducted a pilot study as a trial run (Polit & Beck 2008:213) to determine whether the central question elicited the information sought. In-depth qualitative interviews were conducted with two fathers who were chosen from the population, but were not included in the main study. The question was: 'Please tell me, in detail, what your expectations were concerning care to be provided to mothers by the midwives during labour?'

The results yielded the intended information, that is, the expectations of fathers concerning care provided by midwives to mothers during labour. Hence, the central question was not changed. In-depth interviews were then conducted by the researcher, with the five fathers selected for the main study, following the mother's delivery day. Interviews were conducted in English. A tape recorder was placed strategically to capture dialogue between the moderator (researcher) and the participant. Each interview lasted for about an hour. Data collection occurred simultaneously with data analysis, and saturation was reached after the fifth participant, because there was no more evidence of new information emerging and the identified themes were being repeated constantly.

Follow-up interviews

Follow-up interviews were conducted with two of the participants (fathers) after the data had been analysed. The follow-up interviews were conducted to verify whether the results obtained were indeed reflective of their verbalised expectations. The two participants that were interviewed had made themselves available. The others apologised, providing reasons such as that they were assisting the mother to take



care of the baby, or that they were working overtime on weekends to supplement their income. Both participants interviewed agreed that the stated themes were a true reflection of the initial interviews conducted with them.

Data analysis

Interviews were recorded with a tape recorder, and the recordings were transcribed verbatim. The researcher designed a protocol to enhance the trustworthiness of the data analysis and interpretation, and this protocol was given to an independent coder who had a doctorate and had experience in, and knowledge of, qualitative research methods and midwifery. The protocol comprised Tesch's steps as stated in Creswell (2009:186), which were used because they provide an open descriptive method of coding that is appropriate for qualitative research. The steps involved the reading of all transcripts to gain a sense of the whole. Then one interesting transcribed interview was selected and the researcher made an effort to comprehend what it meant. Thoughts that were derived from the interview were written in the margin. This technique was applied to all the interviews. From the margin information, topics were listed and similar ones were clustered together under, for example, 'major, important and unique.' Topics were assigned a code that was written next to the appropriate section in the transcription. Similar meaningful topics were categorised and named according to the most descriptive word for that category.

These categories were then positioned within the universal categories of Theory for Health Promotion in Nursing (Creswell 2009:184), which was used as a theoretical framework to guide this study (axial coding).

Assumptions that are applicable within this theory are as follows:

- The person is seen as a holistic entity with a body, mind and spirit. The body includes all anatomical structures and physiological (biological) processes pertaining to the individual or family.
- The mind (psyche) includes all the intellectual, emotional and volitional processes of the individual or family. The intellect refers to the capacity and the quality of the psychological processes of thinking, association, analysis, judgement and understanding of which the individual or family is capable. Emotion is a complex state which can be divided into affection, desire and feelings of the individual or family. Volition is a process of decision-making in the execution of choice by the individual or family.
- Spirit refers to that part of the individual or family that reflects his or her or their relationship with God. It also refers to the interaction of the individual or family with their God.

The coder also received the unmarked copies of the transcriptions of the interviews and was requested to analyse the transcribed raw data. Thereafter, the researcher met with the coder to compare and discuss their analysis in order to reach objectivity.

Ethical considerations

Ethical clearance was obtained from the Research and Ethical Committee at the University of Johannesburg (RAU), Faculty of Education and Nursing Science. Permission to conduct this study was sought from the superintendent of the hospital where the study was conducted. Informed consent was obtained from the participants prior to data gathering. A written consent form was handed to the participants (and explained in detail to them) to sign before data gathering commenced. The consent form described the purpose of the study, as well as the rights of the fathers to refuse participation in the research without any fear of victimisation. The participants were informed that they would not be remunerated for participating in the study, but that they would be provided with transportation money on completion of the interview. The participants were provided also with contact details of the researcher should they require more information regarding the research. The researcher assured the participants that they, and the information, would be treated with the utmost respect and confidentiality, and that the tapes that contained the interview information would be erased after transcription of the interviews. The participants were also informed that the results of the study would be published.

Trustworthiness

The model of Lincoln and Guba (De Vos *et al.* 2007:345–347) was utilised to establish and maintain trustworthiness of the study. Credibility was enhanced by implementation of the following strategies:

- member checking, whereby follow-up interviews were conducted with two of the participants for validation of data that had already been gathered
- peer examination, whereby the study was supervised by an expert in research and midwifery. Data were also analysed by an independent coder experienced in qualitative research methods and midwifery.

Transferability was enhanced by giving a thick description with the widest possible range of information, to enable those interested in making a transfer to conclude whether it could be contemplated as a possibility.

Consistency was ensured through peer examination, as discussed under credibility, as well as through stepwise replication, in which the researcher was under the guidance and supervision of the mentor throughout the process of the study.

A dependability audit was ensured by the involvement of an experienced researcher (supervisor) in qualitative methods, who followed through the progression of the events of the study to analyse and evaluate decisions made, and to determine whether comparable conclusions could be reached given the same data and research context.

Establishment of authority of the researcher was ensured by analysing the characteristics of the researcher that enabled



her to conduct the research efficiently. The researcher has obtained a Masters and a Doctoral degree in Midwifery and Neonatal Nursing, which equipped her with knowledge in midwifery and neonatal nursing. She has also developed investigative skills, literature review experience, interviewing skills and experience in qualitative research methods.

Neutrality was maintained by ensuring that the findings were a function solely of the research participants and conditions of the research, with no biases, motivations and researchers' perceptions. The researcher maintained neutrality by utilising reflective thinking, whereby her own speculations, feelings, problems, ideas, prejudices, impressions and hunches were put aside when analysing data.

Literature control

The results of the study were discussed in relation to relevant literature and appropriate research studies for control purposes, and to verify the results of this research and contextualise the data (De Vos *et al.* 2007:84).

Results and discussion

Discussion of the results includes responses from the fathers in the study. Examples of statements cited by fathers are quoted verbatim from the transcribed interviews in order to highlight the quality of their expectations.

Body

With regard to the body aspect, **comfort** was the most important category that was cited by the fathers.

During **admission** the fathers expressed a need for midwives to provide individual, holistic and quality care. They stated that the midwives should welcome the mother warmly with a smile, orientate her and show her on which bed to lie. They expected the midwives to bathe the mothers, collect their history and then monitor their vital signs, specifically mentioning the temperature. They emphasised the need for the midwives to respect the mother:

'A warm welcome with a smile and a brief orientation will make a person calm' (Father or Partner, No. 1).

'The period of labour and childbirth is very important to us as a family and we think ... that eh ... midwives should provide the best quality of care, if there is anything in the health services that we want to see it is quality of care during childbirth' (Father or Partner, No. 3).

'The midwives should provide individualised and holistic care because they are ... dealing with a human being' (Father or Partner, No. 3).

The fathers' expectations in this study are realistic in view of the statement by Longworth and Kingdon (2010:5) that midwives should certainly aim to provide an inclusive and welcoming environment for both the mother and the father. Bothamley (1990:69) similarly observes that some fathers feel inhibited in the hospital environment, even with regard to performing simple tasks such as moving

a chair. She maintains that the fathers and their partners need to be informed and oriented about the hospital setting to enable them to feel welcome and valued. Nicholls and Webb (2006:424) concur with our fathers' expectations by stating that midwives should recognise and treat mothers as individuals; quality care goes beyond professional expertise and is truly caring. Furthermore, Chandler and Field (1997:24) stress that, although husband and wife form a couple and must be treated as such; they are also individuals with unique needs. Morison *et al.* (1999:36) add that the couples in their study identified aspects of midwifery care that they appreciated; these included being seen as both an individual and an equal. It was evident that the midwives provided personalised care appropriate to the individual's needs. Olin and Faxelid (2003: 153) report that it is important for the mother to be seen and respected and to have a trusting relationship with the midwife.

From the above reported perceptions of fathers in this and other studies, it is clear that fathers would like the midwives to make the couple feel accepted in the labour ward and treat them respectfully as unique human beings.

The implications are that midwives should provide a parent-friendly and evidence-based childbirth culture. The 'Batho Pele Principles' (Department of Public Service and Administration 1997:15) should be implemented by the midwives in the labour ward; these principles maintain that citizens should be treated with courtesy and consideration, and that they should be given full and accurate information, amongst other things.

During the **first stage**, the fathers in this study expressed a need for the mother to be provided with pain-relief medication, to be offered a comfortable bed and positioned correctly whilst in bed. They expected the midwives to give the mother food during labour to conserve her energy. They wanted the midwives to provide a clean, well-ventilated environment in which the mother would be nursed, as well as keeping the mother clean by changing her soiled sanitary pads frequently:

'What I expect the nurses to do, is to administer a sedative, that is a pain killer so that she should not be distressed, at least her pains should eh ... be consoled or comforted' (Father or Partner, No. 2).

The expectations of fathers in this study with regard to pain-relieving medication are realistic, but also reveal their lack of knowledge about the non-pharmacological methods that can be used to relieve pain during labour. According to Vehviläinen-Julkunen and Liukkonen (1998:15), fathers in their study felt that more attention should be paid to pain relief during labour. They tended to describe the mother's labour pains as more intense than reported by the mothers themselves. Plantin, Olukoya and Ny (2011:15) argue that the presence of fathers during delivery can reduce pain, anxiety and exhaustion for the mother, shorten the duration of labour, and result in less need for medication. On the other hand, Halldorsdottir and Karlsdottir (1996:49) point out



that reports of dizziness, dysphoria, drowsiness and even hallucinations caused by sedative tranquillisers traditionally given to women, are not uncommon. The medication can also cause confusion and can make the mother feel powerless to cope actively with labour.

Somers-Smith (1999:105), however, states that men's suggestions are often focused on practical, helpful behaviours such as massaging the back, providing 'Entenox,' making the mother comfortable, walking with her, holding her hand and offering her drinks. The fathers' experiences of childbirth in this study are in line with the expectations of the fathers in other studies, such as that reported by Premberg *et al.* (2010:4), who advise that when a mother loses concentration during labour, she should be provided with much patting and massaging on the back, holding of her hand and allowing her to drink sufficient water and juice. Romano and Lothian (2008:99) point out that eating and drinking during labour provides essential nutrition and energy for the labouring mother. Labour is hard, active work that requires calories, not just hydration.

Dellmann (2004:23) found in a study that the father's expectation was for the mother's position to be adjusted regularly by the midwife. According to Adams and Bianchi (2008:108), proper positioning in labour and birth can reduce pain, analgesia use and perineal trauma and enable more effective uterine contractions. The optimal position is determined by assessment of the woman, her phase of labour, foetal position, and the woman's preferences.

Morison *et al.* (1999:35) support the expectations of fathers in this study, regarding the environment, by stating that midwives need to consider how 'place' (home, hospital, clinic, birth centre) influences clients' perceptions of health care and that in any birth setting, midwives can adapt the environment to make it more conducive to birth. On the other hand, Hildingsson *et al.* (2010:5) view the safety of the environment as a priority; hence they stress the importance of the midwife's presence during labour as leading to a safer environment that will also improve interaction between the couple and the midwife.

It is clear from the above findings of both other studies and the current one that most fathers would like the midwives to prioritise pain relief during labour and that the environment should be safe and conducive to childbirth.

The implications are that the couple should be oriented to the labour room, preferably during the antenatal period, to familiarise them with the surroundings of the unit. The couple should be allowed to view a video of the labour ward surroundings and learn about the non-pharmacological methods of pain relief whilst attending the childbirth classes. The pain-relief methods should also be demonstrated to the couple and they should be allowed to repeat the demonstration, with relevant feedback provided. A couple who have not attended the childbirth classes should receive

accurate information and relevant demonstrations in the labour ward when the mother is in labour. The midwife should always find out from the father or partner whether he is coping with the skills. The midwife should ask about the father's or partner's expectations regarding support to be provided to the mother. For some fathers, individual counselling sessions and assertiveness training may increase coping behaviours during labour.

During the **second stage**, the fathers in this study expected the midwives to position the mother correctly and to assist her in controlling her breathing. The need for the midwives to prepare for delivery was also expressed by these fathers:

'...this is the time when the midwife should prepare or even before so that they do not get stuck because of the unpreparedness' (Father or Partner, No. 4).

These fathers' expectations concerning control of the mothers' breathing are supported by Reed (1996:51), who states that fathers are more than observers of childbirth; they have been given active roles in labour and delivery. Physicians interested in natural childbirth, such as Bradley and Lamaze, created roles for men as 'coaches' for their wives during childbirth. Men are now asked to guide and direct birthing women. With charts and manuals in hand, men use stopwatches to time their partners' contractions and help them to breathe through labour and delivery. Lamaze wrote, 'Like so many other men, I took on the role of primary labour coach for my wife. As she laboured I breathed with her and helped maintain the rhythms prescribed in the books.'

According to Premberg and Lundgren (2006:26), the fathers' anticipation for breathing exercises, relaxation techniques and practical training in class was interesting.

From the above expressions of expectations, it is evident that the midwife is expected to guide the couple on what to do when the mother feels the urge to push.

The implications are that the midwife must explain to the couple in simple terms the position that the mother must adopt and how she must push. Couples should be encouraged to attend childbirth classes during pregnancy, whereby the breathing exercises are taught and simulated. The fathers could attend separately from the mothers to enable them to ask questions freely. A male individual should be allowed to facilitate the classes. Fathers could be divided into small groups to enable them to participate effectively. The expectations of fathers concerning the care of the midwife should be clarified in the childbirth classes as well as on admission in the labour ward.

The fathers reinforced the provision of comfort as a priority during the **third and fourth stages**; they expected the midwives to bathe the mother and keep her clean. They wanted the midwives to suture the episiotomy or lacerations, if any, as well as be vigilant for excessive vaginal bleeding. Their wish was that the mother should be given food or hot



tea or coffee, and thereafter allowed some time to rest. Their wishes were expressed in various ways, such as:

'The mother must be cleaned, removing the ...eh... dirty linen. If there is tearing the mother is given stitches' (Father or Partner, No 5).

In a research study conducted by Erlandsson and Lindgren (2009:340), a father relates his experience as follows: 'I saw that the staff was worried when the uterus did not contract properly and the mother lost a lot of blood, but I stayed calm and showed the baby to the mother. At the same time I perceived that they were more worried than they pretended to be in front of us.' One of the fathers, in a study conducted by Olin and Faxelid (2003:155), mentioned that 'pain relief for the mother during suturing was insufficient.'

The implications of the above are that the midwife should continue to reassure the father to give him courage. The couple need to be praised for the job well done. Pain relief during suturing of an episiotomy or laceration should be prioritised and vaginal bleeding should be monitored vigilantly. The mother should receive an injection of local anaesthesia before she can be sutured.

Mind (psyche)

In terms of the mind aspect, another important category that was cited by the fathers was **support**.

The fathers' desire in this study was for the midwives to show love, sensitivity, concern and care. They expressed a need for the midwives to spend quality time with the mother. They also expected the midwives to treat the fathers and mothers with respect, without dehumanising them. One of the fathers stated:

'I know patients are sometimes called by bed numbers or 'the mother of the baby ...who is an albino' or something like that; those little things are dangerous forms of care' (Father or Partner, No. 3).

Rosen (2004:27) supports the expectations of fathers in this study by stating that the hospital's allocation of staff should stay at one-to-one with the mother throughout labour, thus conveying a message of concern for, and valuing of, the mother. Backström and Wahn (2011:71) argue that if the midwife does not listen to the labouring couple, or if she shows a lack of interest or concern during interaction, the father experiences a lack of importance and support.

Halldorsdottir and Karlsdottir (1996:59) also endorse the expectations of fathers in this study by stating that a midwife, who is perceived as caring, is competent and really cares for the mother giving birth. She is involved in the mother's lived experience of giving birth, can help the mother retain or even regain control, and can change even an experience of severe pain to a wave instead of 'being in the middle of a huge surge.' Thus, a caring midwife who works with the mother, encouraging her, empowering her, as well as guiding her, seems to be a key element of a successful birth experience

for a mother. These authors furthermore explain that for professionals, whose role is prescribed as helping another human being in need, it is important to foster a paradigm of caring. Morison *et al.* (1999:36) agree with the expectations of fathers in this study, as they indicate that in their study the parents carefully selected their carer, seeking a sense of rapport and mutual respect in the relationship, which is perceived by parents as love and good care. Halldorsdottir and Karlsdottir (1996:53), however, assert that the need for the mother to take control during labour and delivery may be unfulfilled because of overpowering labour pain, medication or a midwife who is not perceived as caring. Nevertheless, according to Ceronio (1992:62), a woman treated with respect for her strength will believe in herself.

In considering the above, it is clear that the midwife should treat the mother with concern and respect. The implications are that the midwives should personalise the care provided to the mother. They should enquire of the mother how she feels, and also look for non-verbal cues. Midwives should allow the couple to ask questions, and they should encourage the couple to attend debriefing discussion groups.

The fathers in this study expressed a need for the midwives to exchange accurate reports with one another with regard to the mother, as well as to record facts accurately in the mother's file. They also expected the midwives to communicate their actions and findings and to provide guidance on how to perform certain activities such as bearing down. The fathers' wanted the midwives to teach the mother how to breathe during contractions and bearing down. Most of them strongly expressed the wish that the midwives should not shout at the mothers but reassure them throughout labour. Their wish for communication was expressed as follows:

'... spending quality time with the patient and explaining the procedure that they do, whether they are cleaning her up or stitching her up, I think it is important to explain all the time' (Father or Partner, No. 1).

'... like talking to the mother but not talking harshly; I can say like in a soft and polite manner' (Father or Partner, No. 4).

Vehviläinen-Julkunen and Liukkonen (1998:15) agree with these expectations, and point out that some fathers, in their study, said that they would like to see the staff spend more time on encouraging and supporting the mother in labour.

The fathers' expectations in this study also concur with what Hildingsson *et al.* (2010: 8) have alluded to, namely that the fathers expected the midwives to be visible and to inform them and the mothers about the birth process. If the information was insufficient or if the fathers did not receive adequate answers to their questions, they were disappointed and felt excluded from the care. Similarly, Chandler and Field (1997:19) state that fathers expected the midwives to be 'straightforward' and to 'keep them informed of the mother's progress.' They were, however, frequently disappointed with the care rendered, believing that they received inadequate information from the staff. They also alluded to the fact that there were concerns that procedures were not



explained adequately to them (including the mothers) by the physicians or midwives. Similarly, Draper (2002:571) adds that communication is a major contribution that men expect to make during labour and one that is seen by the man to be a key factor to providing physical and emotional support to his partner, and to establishing a positive relationship with the health professionals. Yardley (2009: 360) suggests that fathers require information in order to provide the best support to their partners. Dellman (2004:22) found that the withholding of information by health professionals was the source of immense anger in men. In a study conducted by Bäckström and Wahn (2009:69), fathers wanted the midwife to explain spontaneously what would happen during labour, and why. They also wanted to have the right to ask questions, both important and unimportant ones, and they wanted to receive intelligible and honest answers.

On the evidence of the studies cited above, and the comments of fathers in this study, communication seems to be a priority in providing support to the mother during labour. The mere presence of the midwife is not enough; information and explanations delivered in a kind manner are needed.

The implications of the above are that the midwife should provide accurate and correct information to the couple. She should inform the couple before performing any procedure and provide feedback thereafter.

The fathers in this study also expressed a need for the hospital managers to address staff shortages and to ensure that the midwives are paid a good salary. They expressed as well a need for the midwives' training to be improved by attending in-service training courses or demonstrations regarding the new machines. The quotations below support this:

'I think there are more nurses in the private sector and individual attention is given, but in the public sector they always talk about staff shortages; I think it's about time ...eh ... nurses or midwives are paid a little more and that in the public hospitals where more babies are delivered, have more staff to care for patients, so that the ratio is at one-on-one' (Father or Partner, No. 3).

Halldorsdottir and Karlsdottir (1996:59) concur with the expectations of fathers in this study in that they believe maternity units should be sufficiently staffed to enable midwives to have quality time to communicate efficiently with mothers during labour. Similarly, Rosen (2004:27) states that the hospital's allocation of staff should be at one-to-one with the mother throughout labour.

In support of improving midwives' training, Bäckström and Wahn (2011:71) state that it might be helpful if the midwives in maternity and labour wards undertook special courses about supporting women and their partners during labour. This idea of training is different from that of the participants, because it focuses on supporting women and their partners rather than training on the new machines.

From the above comments it is evident that there is a need for the labour ward to be adequately staffed to ensure that the midwife provides quality care to both the mother and

the foetus, as well as to the father. The implications are that the labour ward should be staffed at a ratio of one-on-one to enable the expectations of fathers to be met within the labour ward. Regular training regarding support to be provided to the fathers, as well as training on new equipment, should be offered to the midwives.

Spirit

In terms of the spirit aspect, the fathers' expectations in this study were for the midwives to enable the mother to identify, touch and hold the baby for a while, and to encourage her to breastfeed the baby. They also expressed a need for themselves to be allowed in the labour ward to provide support to the mother. Their wish was that the midwives make visiting hours flexible, one of them stating that:

'I think they should also show concern to the people who visit the mother; I know the hospital has got rules about visiting hours but they are sometimes applied rigidly even to the next of kin like the fathers, who were supposed to be coming in and the nurses would rigidly say 'NO, the visiting time is three o'clock or four o'clock'' (Father or Partner, No. 1).

In support of these fathers' expectations, Erlandsson and Lindgren (2009:342) noted in their study that at the birth of the child, the father's attention was directed towards his partner. He tried to calm down his partner through body contact and by talking. At the moment of birth he perceived his partner's relief and noticed how tension diminished when she could touch, feel and look at the baby. He experienced calmness after birth when the baby was laying skin-to-skin on the mother's breast. Vehviläinen-Julkunen and Liukkonen (1998:12) suggest that the father should be able to spend time with the new baby from as early as possible after birth. This idea is supported by Erlandsson and Lindgren who report that:

The first sight of the baby was a wonderful experience for the couple; fathers focused on the baby's face, open eyes and facial expressions; something fathers wanted to remember for the rest of their lives. The fathers described the baby as pale, quiet, beautiful, clean, small and sweet with a hint of hair or no hair (Erlandsson & Lindgren 2009:342).

Similarly, Reed reports:

Fortunately, my wife and I were able to cast aside our expectations of a calm, natural delivery and focus our attention on the arrival of our daughter. Our world was transformed by her first shrill cry, and as she nursed at my wife's breast, her pink body filled my consciousness (Reed 1996).

The expectation of the fathers in this study of being allowed in the labour ward is supported by Longworth and Kingdon (2010:5), who noticed that the father's presence at birth enabled him to stake an immediate claim on the infant. Similarly, Blackshaw writes:

Many mothers stated that the presence of their partners could alleviate the loneliness, pain and uncertainty during the delivery and give them strength to endure their suffering as well as share their joy. The presence of the father means communion to the mother, and this communion emanates from the partners caring for each other and their baby (Blackshaw 2003:229).



Hill (1961:430) supports the fathers' expectations by stating that she wishes to make a plea for a more enlightened attitude to normal obstetrics whereby the father is welcomed and encouraged to be present at the delivery. Saptoka, Kobayashi and Takase (2010:4) report that fathers confirmed that their experience had helped them to appreciate how important it was for them to be present at the birth. They each noted that they had helped to boost their wife's confidence and reduce her anxieties about the delivery.

Dellmann (2004:25) suggests that health-care professionals should adopt a *laissez-faire* attitude towards fathers by going along with the father's own expectations pertaining to his role. Flexibility is required to allow for changing needs and situations during labour (Dellmann 2004:24).

Draper (2003:70), however, argues that public reluctance to encourage men to be present during labour is partly rooted in the concern that the presence of the fathers would increase infection rates and might have legal implications, such as an increase in malpractice suits. There was also concern that fathers might panic and faint, thus increasing the workload of the staff. White (2007:43) adds that the presence of fathers might cause psychological, sexual and mental scarring in men, which could ultimately damage the relationship between couples as they make the transition to parenthood. Somers-Smith (1998:105), however, suggests that some men require direction as to the best way that they can help that is more in keeping with their natural helping role, rather than a role they are not accustomed to.

From the above comments in this study and other studies, it is evident that midwives should involve the father by encouraging him to provide comforting and supportive measures to the mother during labour. The mother should be encouraged to initiate breastfeeding.

The implications are that the fathers should be allowed to provide support to their partners during labour. Parents should be encouraged to bond with the baby by spending quality time with the baby.

Limitations of the study

Even though all the participants were able and willing to speak English, they might have expressed themselves better had they used their home language. The participants might have shared more information if a focus group had been conducted and facilitated by a male researcher.

Conclusion and recommendations

The fathers' expectations in this study were based on practical issues that are of major concern in the maternity health-care setting. Some of their expectations also concur with findings from similar studies that were conducted internationally (given the lack of adequate literature sources relevant to this study within the South African context). For example, fathers expected the midwives to: welcome the mother warmly with a smile, spend quality time with the mother, explain the procedures that they perform and respect the mothers, and reassure them throughout labour.

The researcher has also noticed that all the literature sources that were utilised were based on the expectations of the fathers regarding the support that they could provide to their partners, and not on the care that is provided by the midwives during labour. Hence, some of the fathers' expectations in this study were not supported by findings from studies conducted. For example, in this study the fathers expected the midwives to: offer the mother a comfortable bed and monitor her temperature, keep the mother clean by changing her sanitary pads, position the mother properly during delivery, prepare for delivery, keep the mother clean after delivery, perform suturing of the episiotomy or laceration, offer the mother food and allow her to rest after delivery, and not to shout at the mother but to reassure her throughout labour.

The results of this study could add value to midwifery practice by enabling the midwives (independent midwifery practitioners, as well as those in both public and private hospitals, and in clinics) to know what the fathers expect from them with regard to the care that they provide to mothers during labour, and to make an effort to implement these expectations. The results of this study could be included in the Midwifery curriculum to ensure that the students' learning is based on evidence.

Further research studies could be conducted on the experiences of fathers concerning care provided by the midwives to the mothers during labour.

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Competing interests

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Authors' contributions

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