

A narrative review of fathers' involvement during labour and birth and their influence on decision making

Abstract

Objective: To identify and critically review the research literature that has examined fathers' involvement during labour and birth and their influence on decision making.

Design: The review follows the approach of a narrative review. Systematic searches of electronic databases Social Services Abstract, Sociological Abstracts, ASSIA, CINAHL Medline, Cochrane library, AMED, BNI, PsycINFO, Embase, Maternity and Infant care, DH-Data and the Kings Fund Database were combined with manual searches of key journals and reference lists. Studies published between 1992 - 2013 examining fathers' involvement during intrapartum care were included in the review.

Findings: The findings of this review suggest that fathers' level of involvement during labour ranges from being a witness or passive observer of labour and birth to having an active supporting and coaching role. The findings also suggest that there are a number of facilitators and barriers to fathers' involvement during labour and birth. There are a limited number of studies that have examined fathers' involvement in decision making and specifically how fathers' influence decision making during labour and birth.

Key conclusions

Future research needs to address the gap in the literature regarding fathers' involvement and influence on decision making to help midwives and obstetricians understand the process in order enhance the transition to parenthood for women and men.

Keywords

Narrative Review; Fathers, Involvement; Decision-making; Women; Labour and Birth

Introduction

The participation of fathers during birth has increased in Western societies since the 1970s (Chandler & Field, 1997). Prior to the 1970s, many maternity hospitals in the United Kingdom (UK) adopted a policy that excluded fathers and other friends and relatives from attending the birth (Chapman 1992, Draper, 1997). By the 1970s, however, medical resistance was overcome by a consumer discourse on pregnancy and childbirth which arose in the United States of America (USA) and the UK. This was influential in undermining some of the medical dogma against fathers (Chapman, 1992) and was associated with the emergence of the natural childbirth movement. Fathers were redefined as a valuable resource for the midwives in the labour room, rather than as an obtrusive sightseer. At the same time consumer discourses included a greater emphasis on the psychological and emotional aspects of birth (Lewis, 1987) and fathers support in labour was seen as being a step towards ensuring these needs were met.

Today labour and birth are a significant event for fathers. Whilst the actual labour and birth can provoke a range of emotions, from fear to euphoria, the birth marks a new phase that brings additional roles and responsibilities (Draper 1997). The transition to fatherhood begins during pregnancy, however, the birth is an important event in the on-going process of adaptation to parenthood (Genesoni & Tallandini 2009). Understanding the process by which fathers are involved or influence decision making during labour and birth may help midwives and obstetricians improve the birth experience and enhance the transition to parenthood for women and men.

Research about father's presence during labour goes back as far as the 1980s when fathers were slowly being admitted to the labour room. In the 1980s the research focused mainly on birth outcomes. The evidence then suggested that a fathers' presence during labour may lead to a shorter labour and birth, better outcomes for the mother, and had a positive effect on parental relationships and attachment between father and child (Bowen and Miller, 1980; Palkovitz 1982; Antle and Perrin 1985). More recent evidence concurred with these findings and suggested that the presence of a father reduces the length of labour, the need for caesarean section and analgesia, increases the number of normal births and decreases the length of labour (Somers-Smith, 1999; Ip, 2000, Chan and Paterson-Brown, 2002; Gungor and Beji, 2007; Hodnett et al., 2011).

Since the 1980s the research evidence has also examined the positive effects on the couple's relationship as well as the father-child relationship (Nichols 1993; Logsdon, 1994; Vehviläinen-Julkunen and Liukkonen, 1998; Greenhalgh, 2000; Grossmann, 2002; Brandao and Figueiredo, 2012). Fathers' involvement during labour has been found to deepen their relationship with their partner and to be an important part of the process of becoming a father (Logsdon et al 1994; Vehviläinen-Julkunen and Liukkonen, 1998). Fathers' involvement at birth has been found to improve the play sensitivity score of babies (Grossmann et al, 2002) and increase the emotional involvement between father and child at one month postpartum (Brandao and Figueiredo, 2012).

Research since the 1990s, when the number of fathers in the labour room was increasing, began to focus on fathers' experiences during labour and birth. The evidence suggests that although fathers have a strong desire to be present they have a mixture of negative as well as positive experiences. Fathers were made to feel comfortable by the nurses and midwives, felt they were helpful to their partner and were happy with the care their partner received. Fathers also reported feelings of joy and happiness when the baby was born (Nichols, 1993; Chalmers & Meyer, 1996; Vehviläinen-Julkunen & Liukkonen, 1998; Chan & Peterson-Brown 2002). However, some fathers felt pressurised into being present, had feelings of discomfort and helplessness and were made to feel like outsiders by healthcare professionals when present. They were also fearful of seeing their partners in pain, reported feelings of fear and anxiety during operative interventions and expressed concerns over the baby's well-being (Chalmers & Meyer, 1996; Chandler & Field, 1997; Vehviläinen-Julkunen and Liukkonen, 1998; Hallgren et al 1999; Chapman, 2000; Johnson, 2002; Eriksson, et al., 2006; Nolan 2011).

Over the last 10 years a number of UK policies have recommended greater involvement of fathers during labour and birth, including the government publication *'Maternity Matters'* (DH 2007) which made recommendations for more active involvement of fathers during childbirth. Guidance from the Department of Health (DH) *'Preparation for birth and beyond resource'* (DH 2011) as well as the Royal College of Midwives' guide *'Reaching out: involving fathers in maternity care'* (2011), and Midwifery 2020 (Midwifery 2020, 2010) all emphasised that health professionals should routinely engage with both parents in maternity care, and ensure that both are well informed. A publication by the former National Health Service Institute for Innovation and Improvement *'Promoting Normal Birth'* (2010)

emphasised the importance of father's involvement in decision-making as part of the process of promoting choice within maternity services. There is also an increased pressure on the midwifery profession to respond in practice to the push to involve fathers during labour and birth from service user groups and through policy directives (Fatherhood Institute, 2008, 2010; Department for Children, Schools and Families, Department of Health 2009; Chief Nursing Officers of England, Northern Ireland, Scotland and Wales, 2011). Several national policies from other countries also support the involvement of fathers during labour and birth (The National Board of Health and Welfare, 1981; Perinatal & Maternal Mortality Review Committee 2009); New South Wales, 2009).

In order to for midwives to respond to this push to involve fathers more during labour and birth, it is important to understand more fully fathers' role in decision making during labour and birth. The aim of this paper therefore is to critically appraise and synthesise the research literature that has examined father's involvement in decision making during labour and birth.

Methods

A comprehensive narrative review of the literature was undertaken with the aim of identifying and critically appraising and synthesising empirical studies that have examined fathers' involvement in decision making during labour and birth. The search strategy was a systematic search of the following electronic databases for empirical studies published between 1992 and 2013: Social Services Abstract, Sociological Abstracts, ASSIA, CINAHL, Medline, Cochrane library, AMED, BNI, PsycINFO, Embase, Maternity and Infant care, DH-Data and the Kings Fund Database. The search terms were developed around three key areas, namely 'fathers', 'decision making', and 'intrapartum care'. Search terms used are presented in Table 1.

Empirical studies and literature reviews were included if they were published in the English language and published between January 1992 and June 2013. The year 1992 was selected in order to identify the most recent studies in the area. Prior to this in 1985, one of the recommendations from the World Health Organisation (WHO) was that women should be supported during labour and birth by a chosen family member. In the UK 1992 was the year that the Winterton Report (House of Commons 1992) and the UK government's response, Changing Childbirth (DH 1993) were published. These reports highlighted the need to

change maternity/midwifery care policy and practice to one based on a 'woman-centred' approach that offered choice in place of birth, birth companion, type of service and 'continuity of care'. As part of this change in philosophy fathers were to be welcomed into the delivery room. (De Vries et al 2005).

Papers were included if they focused on heterosexual fathers' involvement during labour and birth. The aim was to examine the different types and levels of involvement, in order to discover whether involvement in decision making was present. Papers about the following topics were excluded: antenatal care, breastfeeding, infant feeding, postnatal care, preconception care, assisted conception, unwanted pregnancy, surrogacy, same sex parents, stillbirth miscarriage and preterm labour. The second search strategy consisted of both hand searching reference lists of papers identified from the electronic databases for relevant studies and key midwifery journals to find relevant papers meeting the inclusion criteria.

A total of 3144 studies were identified from the searches. Following the removal of duplicates 1189 papers were then screened against the inclusion criteria by the first author. A large number of references were excluded because they were not empirical studies. A total of 27 papers met the inclusion criteria (Table 2). These studies included a mixture of research designs including 17 qualitative studies, 7 quantitative studies, one mixed methods study, one literature review and one metasynthesis. The 27 research studies were conducted in a range of countries including USA (7), Sweden (6), UK (5), Finland (1), Malawi (1), Turkey (1), Netherlands (1), South Africa (1) Taiwan (1), and Germany (1).

Synthesis of themes from the literature

A thematic analysis of the 27 papers was conducted. Two themes emerged and are used to organise and present the synthesis. They consisted of the 'roles adopted during labour and birth' and the 'facilitators and barriers to father's involvement'

Roles adopted during labour and birth

One theme that arose from the literature was the roles that fathers adopted during labour and birth. Many fathers appear to want to be actively involved in labour and birth rather than only be passive supporters for their partners. However, they appear to struggle with the need to balance their own fears and anxieties of labour with their desires to support their partner (Steen et al., 2012). Father's involvement during childbirth has been described in different

ways and frameworks have been developed to describe the different roles fathers adopt during labour and birth (Chapman, 1992, Johnson 2002, Gungor and Beji 2007, Kunjappy-Clifton, 2008). Chapman (1992) identified 3 roles; coach, team-mate and witness. Roles identified in other studies are fathers as providers of physical and emotional support for their partner (Kunjappy-Clifton 2008), and fathers acting as advocate for their partner in interactions with care providers (Bondas-Salonen 1998, Gungor and Beji 2007, Kunjappy-Clifton, 2008, Kainz et al., 2010, Kululanga et al, 2012). The literature suggests that fathers can adopt passive or active roles during labour and birth.

Passive roles

The more passive role of observer or witness was found to be a common role adopted by fathers (Chapman, 1992; Chandler and Field, 1997; Johnson, 2002). Studies suggest that some fathers did not want to adopt an active coaching role and preferred to sit back and watch (Chapman, 1992; Chandler and Field, 1997; Kunjappy-Clifton, 2008; Longworth 2010). In this role fathers viewed themselves principally as companions, providing emotional and moral support. They were in attendance to observe the process and to witness the birth but could at the same time watch TV, read, sleep, or leave the room for long periods of time (Chapman, 2000). In a qualitative study examining the expectations and experiences of Swedish men, Hallgren et al (1999) found that some men preferred the role of a witness and preferred the midwife to support their partners. However, Johnson (2002), in a survey examining the experiences of men post-delivery, found men described their role as being best summarized as passive and that even the role of witness was an exaggerated description for the experiences of some men; indeed active participation appeared to be encouraged only where the birth was anticipated to be normal and not if problems were anticipated. In this study, however, the response rate was low which may have affected the generalizability of the results (Mays and Pope, 1995). In a UK study, Longworth and Kingdon (2010) explored the roles, meanings and expectations that fathers accord to their presence during the birth. They found that men were not merely passively observing but were closely monitoring health professionals and the CTG monitor particularly as they felt they knew their partner's needs and could interpret their partner's wishes at a time when their partner could not. A study in Malawi by Kululanga et al (2012) found that men felt they were unable to offer physical support to their partner during labour as they lacked the knowledge to do so and that even attending antenatal classes did not prepare them for supporting their partner. Men also stated that that neither they nor their partners were involved in decision making during labour and

birth. All decisions were made by the medical practitioners and the couples were just informed of what they were expected to do. However, few participants felt they needed to be consulted about the decisions to be made as they felt that the medical practitioners were the experts. A limitation of this study is that contrary to practices in western societies, there is no cultural expectation that Malawi men should attend the birth of their baby and many do not (Onyango et al., 2010; Kululanga et al., 2012). Also the study recruited men who had been present up to two years after the birth and therefore there may have been recall bias (Mays and Pope, 1995).

Active roles

Several studies found that men adopted a more active role in supporting their partner during labour and birth (Chapman 1992, Nichols 1993, Gungor and Begi, 2007; Lindgren & Erlandsson, 2010; Nolan, 2011; Steen et al, 2012). The active roles adopted were found to be dynamic and varied from practical and psychological support to acting as an advocate for their partner. Chapman (1992) found that two out of the three roles she identified were more active roles. These roles included 'team-mate', where men helped and supported their partner, and 'coach' where men actively assisted their partner during contractions and actively directed women and took control (Chapman, 1992). In an experimental study by Gungor and Begi (2007), one group of men were allowed to participate in the birth, and the other group were not, in order to determine the effects of fathers' attendance on the experience of childbirth. Some men in the experimental group were actively involved with their partner, supporting them in various ways, providing them with physical and psychological support; assisting their partner in mobilising and performing breathing and relaxation exercises. There was no difference between the groups as regards length of labour, use of pain-relieving drugs, or obstetric interventions during labour and birth. However, the study took place in Turkey where, due to cultural and religious reasons, it is only in recent years that hospitals have begun to allow men to attend the birth and this is only in the private hospitals (Gungor and Begi, 2007). Nichols (1993) and Nolan (2011) found that men thought that the most helpful measures for their partners during labour was to provide practical support with aspects such things as physical/comfort measures beyond just their psychological support and their physical presence. In a metasynthesis, Steen et al (2012) also found that fathers offered practical and emotional support during labour and birth. In Sweden, Lindgren & Erlandsson (2010) found that during home delivery fathers active participation also took the form of moving mattresses onto the floor and lighting fires. Other

studies have found that men act as an advocate for their partner in their interactions with health-care care providers and were often the ‘verbal link’ between the woman and the midwife particularly when women were distressed and in pain (Bondas-Salonen 1998, Kainz et al., 2010; Kululanga et al., 2012).

Decision making role

Only a limited number of studies have examined fathers’ involvement in decision making. Three studies have examined fathers’ role in decision making during labour and birth (Martin, 2003; Dejoy, 2011; Hendrix et al., 2010) but only Dejoy (2011) specifically examined men’s experiences of decision making during labour and birth. In a study in the USA, Dejoy (2011) interviewed couples before and after the birth to examine the role of first-time fathers in decision making during childbirth. She found there were a variety of roles that men adopted in relation to decision making. Some fathers in this study felt comfortable providing physical support to their partners during labour, but not participating in decision making. This appeared to be because they did not see decision-making as being part of their role and they were concerned that they might be blamed by their partner for encouraging unwanted interventions. However, some fathers were encouraged to make decisions by their partner. In another study fathers were found to indirectly influence women’s decision to use an epidural for pain relief (Martin, 2003). This US study aimed to explore gender as an internalized technology through examining women’s perspectives of labour and birth. Martin (2003) interviewed 26 women about their labours within three months of delivery. She found that fathers had a powerful influence on the decision about whether and when to have an epidural (Martin 2003). Despite the physical demands of labour and birth, women felt selfish for imposing on their husbands. The decision on whether and when to have an epidural was based on what their husbands thought or how their husbands described them as feeling such as ‘getting tired’ (Martin 2003). Another study examined whether there are differences between the decision-making process of pregnant women and their partners. Hendrix et al. (2010) used a questionnaire, based on the method of discrete-choice experiment, to investigate whether there were differences between the decision-making processes of pregnant women and their partners in relation to aspects of obstetric care in the Netherlands. Sampling was random but reliability and validity of the questionnaire survey was not discussed and therefore it is questionable whether it had been ensured. They found that, for women, it was important that they could influence the decision around place of birth but for

fathers it was the possibility of influencing decision making on pain-relief during childbirth that was most important (Hendrix et al., 2010).

Other studies have examined fathers' influence in deciding when to go to hospital/birth centre when the woman is in labour (Martin, 2003; Nolan et al 2011). In a survey of fathers in the UK, Nolan et al (2011) found that a small percentage of fathers made the decision to go to the hospital or birth centre although for the large majority the decision was made jointly. The study by Martin (2003) also found that almost half the women who were interviewed, decided to go to the hospital based on when their husbands said it was time to go rather than when they thought it was time to leave. The findings from this study were however women's accounts rather than men's accounts of their experiences of their involvement in decision making during labour and birth.

Facilitators and barriers to fathers' involvement during labour and birth

A number of facilitators and barriers to fathers' involvement during labour and birth were identified by studies included in the review.

Facilitators to fathers' involvement during labour and birth

Fathers' attendance at antenatal education classes was identified as a facilitator to fathers' involvement during labour and birth (Kao et al., 2004; Wockel et al., 2007; Nolan, 2011). In Germany, Wockel et al., (2007) conducted a randomized prospective trial with all men who took part in antenatal classes together with their partner. Ten men were selected at random to receive the additional training. The men in the intervention group were given additional training without their partners to prepare them for labour and birth and men in the control group were not. Data was collected using questionnaires. The study found that fathers in the intervention group provided greater support, however it did not state what level of support this was and whether they were involved in decision making. A limitation of this study is that groups were not randomly selected as those men who showed a particular interest in antenatal classes at the midwifery practice were selected for the intervention group. The benefits of randomisation to minimize bias were therefore jeopardised (Mays and Pope, 1995). In a questionnaire survey of 200 expectant couples in Taiwan, Kao et al., (2004) examined parents' expectations of labour and birth. They found that attendance at antenatal education classes was associated with an increased level of support provided by men during labour.

Similarly, this study did not state what level of support was provided by the fathers and whether they were involved in decision making.

Support from midwives and nurses appears to facilitate fathers' involvement during labour (Hildingsson and Haggstrom ,1999; Martin, 2008). In a Swedish study, Hildingsson and Haggstrom (1999) carried out interviews with midwives in relation to their experiences of being supportive to women during pregnancy and found that midwives felt that they advocated for fathers as well as women by empowering them to support women. When fathers were present in the midwives' narratives, it appeared to indicate that they had played an important role in supporting women and were involved in their care. Although the interviews and the transcription of the text were only carried out by the first author, credibility was ensured when the themes and subthemes were discussed with the other author until consensus was reached. However, a limitation of this study was that these were midwives' views and not the views of fathers themselves. Martin (2008) administered a questionnaire survey at two points, prior to and after birth, to examine fathers' attitudes and needs in relation to birth, and found that the majority of fathers perceived that nurses and midwives facilitated their participation during labour and birth. However, while active roles in supporting women were discussed in the study there was no discussion on involvement in decision making.

The use of technology, such as the use of fetal monitoring equipment, has also been found to facilitate fathers' involvement during labour (Williams & Umberson, 1999) although the level of involvement did not include involvement in decision making. Williams and Umberson, (1999) found that fathers in the USA felt involved during labour as the fetal monitor enabled them to detect when their partner was having a contraction before the woman felt it, which increased fathers' feelings of control. However, a literature review by Dellmann (2004) found that fathers had a different level of involvement in a high-technology setting as there was greater potential for conflict between the couple's birth plan and the local hospital policy which meant that fathers could adopt an advocacy role.

Barriers to fathers' involvement during labour and birth

One barrier to fathers' involvement in decision making during labour and birth identified in the literature was poor communication with health care professionals (HPC) (Dellman, 2004; Messner, 2010; Sengane and Nolte, 2012). In a literature review examining fathers' experiences of childbirth, Dellman (2004) found that fathers were angry when healthcare

professionals withheld information. Similarly, a qualitative study conducted in South Africa, found that poor information-giving and lack of encouragement by midwives were barriers to fathers' involvement during labour and birth (Sengane and Nolte, 2012) although it did not specify whether this involvement included decision making.

Similar findings have been reported in a Swedish study by Hallgren et al., (2005). They used observation and interviews, before and after birth, to examine how couples relate to midwives during labour and birth. They found that fathers usually played a minor part in labour and birth and were often neglected by the midwives. Fathers' expectations of being included as part of the team during birth were not met and they felt inadequately informed by the midwives.

In relation to involvement in decision making, Messner (2010) used semi-structured interviews to examine the experiences of first time fathers in the context of caesarean birth in the USA. Messner (2010) discovered that fathers felt excluded from the decision-making process by HPC. Men felt that they had little control over the situation and that the staff actually made the decision to perform the caesarean section. Longworth and Kingdon (2011) found that lack of knowledge prevented fathers from being involved with decision making. They used in-depth interviews to explore fathers' roles and expectations during labour and birth and found that although men did admit they would have liked more control in decision making during labour, they felt that their lack of knowledge may have prevented this.

Another barrier to involvement was the use of medication during labour (Waldenstrom, 1999; Williams and Umberson (1999). Waldenstrom (1999) found that the use of medication, including epidurals, led to lower levels of paternal involvement. Similar findings were found in study in the USA by Williams and Umberson (1999). They compared expectant fathers' and mothers' experiences with medical technology during pregnancy and birth using in-depth interviews prior to and after the birth of their first baby. They found that although some fathers welcomed epidurals others regretted them as it reduced their role in labour support.

In conclusion, the evidence suggests that fathers can adopt passive or active roles during labour and birth. The more passive role of observer or witness fathers viewed themselves principally as companions, providing emotional and moral support. The more active roles included 'team-mate', where men helped and supported their partner, and 'coach' where men actively assisted their partner during contractions and actively directed women and took

control. Only a limited number of studies have examined fathers' involvement in decision making. A number of facilitators and barriers to fathers' involvement during labour and birth were identified in the evidence. The facilitators included fathers' attendance at antenatal education classes, support from midwives and nurses, the use of technology and what men see as being an important aspect of care during labour. The barriers included poor communication with health care professionals and use of medication.

Quality Appraisal

Each paper was critically appraised using the appropriate tool from the Critical Appraisal Skills Programme (CASP). The advantage of CASP in comparison to other appraisal tools is that it provides detailed guidance for each question to be addressed (Solutions for Public Health, 2010).

The studies included in this review were conducted in a number of different countries across continents ranging from Europe, USA and Africa, however, most of the studies were from the USA, Sweden and UK. Most of the studies came from cultures with predominantly western values and beliefs. Only two studies took place in countries which are more underdeveloped and where western values do not predominate. Overall, there was a lack of population and social diversity in the papers in this review such as fathers from ethnic minorities, teenage fathers, men from socially disadvantaged backgrounds, men not living with their partners, and men approaching parenting with surrogate mothers.

There were a range of research methods including 17 studies which used qualitative interviews; one study used qualitative observation; 6 studies collected data via questionnaire surveys; one study was a randomized controlled trial; one paper used a mixed method approach using qualitative interviews and a questionnaire survey. There was one literature review and one metasynthesis. An appraisal of individual studies is included in the literature table, Table 2.

The research design for all the qualitative studies was appropriate as they aimed to explore men's involvement during labour and birth. The sampling method used was mainly purposive and was appropriate for the objectives of the studies. Overall, trustworthiness was demonstrated as it was clearly stated how the data were collected, although not all studies gave detail about the topic guide used (Kainz et al 2010, Longworth and Kingdon 2010) or

whether audio or video recordings were performed (Chapman, 1992, Nichols, 1993). The relationship between researcher and participants was not considered in some studies (Chapman 1992, Hallegran et al 1999 and Kainz et al 2010, Longworth and Kingdon 2010, Messner 2010). In most studies some detail was provided about data analysis. Overall credibility was demonstrated through strategies such as data and method triangulation with use of multiple sources of data and/or methods, repeated contact with participants, peer debriefing, and checking findings with participants to determine if the findings reflect their experiences. Only one study did not discuss credibility of the findings (William and Umberson, 1999)

The quantitative studies were questionnaire survey studies with two randomised control trials. Overall the research question, or aims and objectives were clearly presented with only one study having no clear aims (Wockel et al., 2007). For most studies the sample size calculation was based on statistical power. Two studies used random sampling (Waldenstrom, 1999, Wockel et al., 2007). Most studies used convenience sampling which may have affected generalizability of results (Mays and Pope, 1995). To ensure reliability and validity of the research instruments, some studies piloted their questionnaire or used a standardised instrument, however, many used unpiloted tools. Moreover, some studies (Hendrix et al., 2010; Johnson, 2002; Martin, 2008) did not discuss reliability and validity. Generally the sample size for the majority of studies was appropriate although in two studies (Johnson, 2002; Gungor and Beji, 2007) the sample was small. While most studies assessed the statistical significance, the confidence intervals were not presented with the main results.

The literature reviews and metasynthesis addressed a clearly focussed question or aim. Details were provided about the review process that included the methodology used, the inclusion and exclusion criteria and search strategy. The metasynthesis assessed the quality of the studies however, quality appraisal of the studies in the literature review were not included.

Conclusions

This narrative review has employed a systematic approach to identify and critically review the research literature that has examined fathers' involvement in decision making during labour and birth. Through synthesising 27 studies on fathers' involvement during labour and birth, only two themes were defined; the roles adopted by fathers, and the barriers and

facilitators to their involvement during labour and birth. The review has found that some fathers prefer to take on the role of an observer whereas others are more actively involved, providing practical as well as emotional support as well as acting as an advocate for their partner. Few studies have examined fathers' involvement in decision making during labour and birth. One study by Dejoy (2011) specifically examined men's experiences of decision making during labour and birth but this study took place in the USA (Dejoy, 2011). Another study examined women's experiences which revealed how men influenced their decisions during labour (Martin 2003) and the other examined the differences between the decision-making processes of pregnant women and their partners in relation to aspects of obstetric care (Hendrix et al., 2010). Other studies have examined fathers' involvement in relation to the decisions about timing of admission to hospital/birth centres when the woman is in labour (Martin, 2003; Nolan et al 2011). The review found also that there were a number of facilitators and barriers to fathers' involvement during labour and birth. The facilitators included fathers' attendance at antenatal education classes, support from midwives and nurses, and the use of technology. The barriers included poor communication with health care professionals and use of medication, including epidurals.

A limitation of this review is that although it used a systematic approach, only one author quality appraised the studies (Cipriani & Geddes, 2003). In terms of the included studies, many lack population and social diversity and there is a lack of experimental research. Although some studies have examined first time father's experiences, there are no studies that have examined the experiences of fathers from ethnic minorities, teenage fathers, fathers from deprived backgrounds, fathers not living with their partners and homosexual fathers approaching parenting with surrogate mothers. Although there is a mixture of qualitative and quantitative studies around fathers' involvement, there is a lack of experimental research examining the value of interventions and their effectiveness in pregnancy and during labour and birth in this area.

In order to enhance the experiences of the transition to parenthood for men and women, it is important that researchers' and midwives' have a greater understanding of fathers' experiences when supporting their partner their partner during labour and birth as well as the barriers and facilitators to fathers' involvement in decision making. Future research needs to address the gap in the literature regarding fathers' involvement and influence on decision making during labour and birth.

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