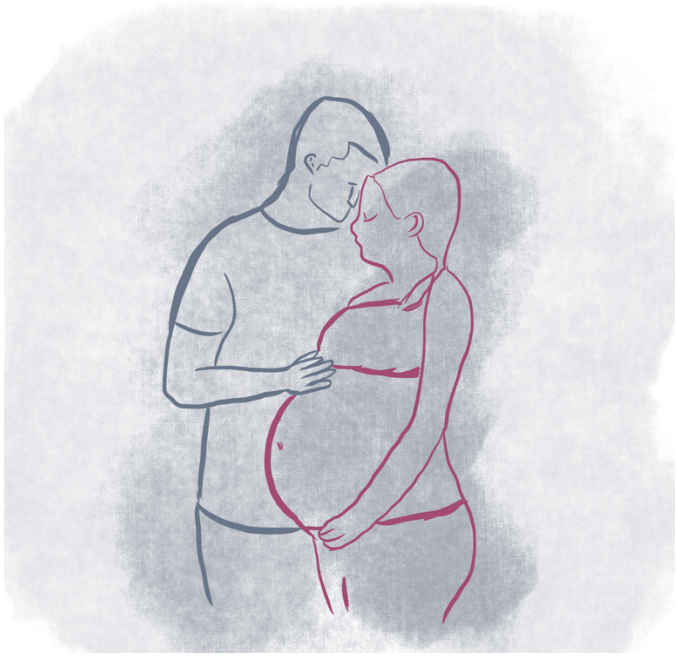
Master's Thesis

Master's Programme in Midwifery – Department of Nursing and Health promotion- Faculty of Health Sciences - Oslo Metropolitan University



Birth partners experiences on midwifery care during childbirth

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Abstract

Title: Birth Partners' Experiences on Midwifery Care During Childbirth

Aim: This study aims to explore birth partners' experiences of being cared for by midwives during childbirth, specifically examining partner involvement, information and guidance provided by midwives, and factors contributing to a sense of security and recognition as parents/couples.

Research question: *"How do birth partners experience care from the midwife during childbirth?"*

Method: A qualitative study with eight (8) semi-structured life-world interviews of partners who were present at the birth of their first child in the year 2022. Graneheim & Lundman's content analysis used.

Results: The analysis revealed three main themes; *A compassionate midwife ensures a safe birth experience, The importance of understanding my role & The care during childbirth is subjected to the quality of the information, continuity, and professionalism*

Discussion: This study reveals the need for improvement in aspects such as information relay, involvement, and a sense of empathy towards partners in order for them to feel valued. Overall, this study highlights the importance of midwives optimizing care for birth partners to enhance their experience and sense of security during childbirth.

Keywords: birth partners, midwifery care, qualitative study, childbirth, labor, delivery, fathers, co-mother

Sammendrag

Tittel: Ivaretakelse av partnere under fødsel

Hensikt: Studien tar sikte på å utforske fødselspartneres opplevelser av å bli tatt vare på av jordmødre under fødsel og spesielt undersøke partnerinvolvering, informasjon og veiledning gitt av jordmødre, og faktorer som bidrar til en følelse av trygghet og anerkjennelse som foreldre/par.

Forskningsspørsmål: *"Hvordan opplever fødselspartnere å bli ivaretatt av jordmor under fødsel?"*

Metode: En kvalitativ studie med åtte (8) semistrukturerte dybde intervjuer av partnere som var til stede ved fødselen av sitt første barn i år 2022. Graneheim & Lundmans innholdsanalyse ble benyttet.

Resultater: Analysen avdekket tre hovedtemaer; En medfølende jordmor sikrer en trygg fødselsopplevelse, Viktigheten av å forstå min rolle som partner & Omsorgen under fødsel er underlagt kvaliteten på informasjonen, kontinuitet og profesjonalisme

Diskusjon: Denne studien avdekker behovet for forbedringer i aspekter som informasjonsformidling, involvering og at empati overfor partnere for at de skal føle seg verdsatt. Denne studien belyser viktigheten av at jordmødre optimaliserer omsorgen for fødselspartnere for å forbedre deres opplevelse og følelse av trygghet under fødsel.

Nøkkelord: fødselspartnere, jordmor omsorg, ivaretagelse, kvalitativ studie, fødsel, fedre, med-mødre

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1 Introduction

The woman's birth partner has not always been perceived as an integral part of labor and childbirth. Indeed, they were considered a source of infection, and due to strict health regulations, partners were not encouraged or allowed to attend the maternal ward or delivery room (Draper, 1997). Labor and birth were viewed as "a woman's business" (Schmitt et al., 2022), and this was the norm until scientists in the 1970s started exploring how birth partners could affect the mother and the child (Palkovitz, 1985; Schmitt et al., 2022).

There is an increased interest in gaining knowledge about the relations between birthing partners and their families, which resulted in changed practices in the hospitals. From there on, partners were gradually included in more parts of the labor process and are now considered an essential part of modern maternity care. Plantin et al. (2011) estimated that around 95% of the women's partners participated in labor in the 1990s, which still aligns with today's cultural norms (Johansson et al., 2015; WHO, 2020). This study will now adhere itself to the knowledge development of birth partners regarding intrapartum care in the hopes of advancing it by contributing insight.

1.1 Background

The partner's presence has been shown to lead to an increased likelihood of spontaneous onset of labor and a shorter labor (Bohren et al., 2017). As for the child, several health benefits for their development were also shown (Sarkadi et al., 2008). In the 70s, David Lynn concluded that the father had a more participatory role in the care of the newborn the earlier he was exposed to the child (Palkovitz, 1985). The first meeting with the child also contributed to increased oxytocin levels and thus stronger attachment to their child, which in return had a good effect on the family as a whole (Gettler et al., 2021).

Birth partners' experiences in the labor and delivery rooms two-sided (Steen et al., 2012). Studies of partners' birth experiences reveal a great interest in participating in the birth process (Bohren et al., 2019; Johansson et al., 2015; Schmitt et al., 2022), but the organization of birth care does not facilitate this. Rather, the meeting with the health services generated fear, uncertainty, and a feeling of exclusion. Partners described that they felt involved in the birth process when healthcare professionals provided high-quality

communication and sufficient information and guidance (Johansson et al., 2015; McNab et al., 2022; van Vulpen et al., 2021). This contributed to a safe and positive birth experience (McNab et al., 2022). In addition to a positive impact on the individual level (Bohren et al., 2019), partners reported that they felt a responsibility to empower the birth woman and establish a connection with their child (Johansson et al., 2015). However, there are reports of partners who felt helpless and unprepared during the birth (Bohren et al., 2019; Johansson et al., 2015; van Vulpen et al., 2021). The encounter with the unknown presupposed more preparation for the birth, and thus, the need for guidance was even greater. This is particularly evident in first-time fathers (van Vulpen et al., 2021). Keywords such as vulnerability, confusion, frustration, and worry are recurring words that are used to describe their experiences (Bohren et al., 2019; Johansson et al., 2015; Schmitt et al., 2022). The partners were given a passive role during the birth if there was a lack of guidance and information, which is associated with less positive birth experience (Schmitt et al., 2022). Intense emotions, such as fear for the woman and the child's health, were reinforced by the woman's labor pains.

Studies show that partners do not always have equally positive experiences around births and say that they are often neglected (Etheridge & Slade, 2017; Vallin et al., 2019). A systematic review emphasized that support persons felt excluded, small, and undervalued in the delivery room (Venning et al., 2021). During the COVID-19 pandemic, negative experiences came to light, particularly when hospitals introduced companion restrictions. They reported psychological stress and worry by having a longer time apart from the child even after birth (Vasilevski et al., 2022), as well as feeling like secondary parents in relation to the mothers. This affected them and the family as a unit (Wells et al., 2022). The essential meaning of partners' birth experience includes "an interwoven process that pendulating between euphoria and suffering" (Premberg et al., 2011) and by examining it with a qualitative approach, we can use the findings to optimize the partners' birth experiences, improve well-being and promote an active and satisfying role.

In relation to health personnel, partners felt that their role was not recognized and that their care was de-prioritized due to the lack of clear benefits for women in the labor (Bohren et al., 2019). The lack of recognition of the birthing woman's partner indicates that midwives do not have sufficient knowledge of the partners' needs and how their presence benefits the mother and child.

1.2 Aim of the study

Several studies have investigated the needs, experiences, and expectations of care for birth partners during childbirth. These studies showcase that caring for birth partners can be nuanced (Bohren et al., 2019; Johansson et al., 2015; Schmitt et al., 2022; Vallin et al., 2019). As birth partners experience the life-changing event of childbirth, they also issue some key elements that need improvement regarding their supportive roles (Poh et al., 2014; Premberg et al., 2011). In terms of intrapartum care, general themes that recur seem to be about acknowledgement for their role as birth partners including needs and expectations during childbirth, feelings of involvement and lack thereof in the birth process and factors that influence their birth experiences. However, detailed research on these themes can be somewhat scarce. Further investigating these aspects aims to uncover potential gaps in their care and provide deeper insight, as to exactly what influences their birth experiences. This current study will focus on optimizing partner care during birth with three main objectives. Firstly, to identify factors that make them feel recognized as birth partners in the delivery room. Secondly, to understand how birth partners experience guidance and involvement by midwives in the labor and delivery process. Lastly, if the provided information and guidance by the midwife contribute to a sense of security. The overarching goal of this study is to delve into partners' experiences of being cared for in the unknown and unpredictable aspects of birth.

1.2.1 Research question

The research question: "How do birth partners experience care from the midwife during childbirth?"

1.3 Definitions of key terms

1.3.1 Birth partner

The term "birth partner" refers to when the birthing woman chooses their partner to accompany them through labor and childbirth. The present term is sourced from the term "labor companionship" which The World Health Organization describes as the support a partner, family member, friend, doula or healthcare professional provides to a woman in labor and childbirth (WHO, 2019). Women normally choose a trusted person, usually their partner or husband as a companion during labor and delivery (WHO, 2020). Likewise, most partners

desire to be present and support women during labor and delivery (Green et al., 2007). Especially in Western countries, there has been a significant rise in the attendance of partners during childbirth and it is highly encouraged (Hildingsson et al., 2014; Plantin et al., 2011).

In a modern and inclusive society, such as Norway, where same-sex couples and families are steadily increasing (Dahl, 2015), it is important to adopt gender-neutral language. Consequently, using the term "birth partner" will refer to both fathers and co-mothers in this study.

1.3.2 Childbirth

"Childbirth" encompasses a complex physiological and dynamic process that cannot be defined by one specific event (Blix & Bernitz, 2020, p. 442). In a physical sense, the meaning of childbirth can be described as a process in which the fetus, placenta, and membranes are expelled through the birth canal (Jackson et al., 2020, p. 448).

In the field of midwifery, it is common to divide normal birth into four distinct phases. Firstly, the "dilation phase" also known as the first stage of labor involves the recognition of the onset of labor and all of the processes that result in a fully effaced and dilated cervix (10 cm dilated). The phase can be further categorized by a latent phase and an active phase which is typically characterized when the cervix is 3-4 cm dilated, to name one example. The second stage of labor, also called "the expulsion phase" is when the cervix is fully dilated and effaced until the baby is born. Similar to the first stage of labor, this phase can also be sorted into a latent phase and an active phase. The latent phase of the second stage of labor is from a fully dilated cervix is identified until the presenting fetal part has fully rotated and has descended further on the pelvic outlet and until the woman feels a strong urge to bear down or push. The active phase of the second stage is when the woman experiences a compulsive urge to push until the baby is born. The third stage of labor marks the period from when the baby is born and ends when the placenta is expelled and the hemorrhaging is under control. Lastly, the fourth stage of labor can be translated as the "bonding phase" and usually lasts for approximately two hours, a critical time when the family gets to bond (Blix & Bernitz, 2020, p. 442).

The research question does not explicitly define which phases of labor it is limited to. However, the scope of the study is restricted to the period from when the couple is admitted to the hospital until the end of the fourth stage of labor. Admission to the hospital is regulated by their own routines and when the couple decides to contact the ward.

1.3.3 Midwifery care

The scope of this study is to care for the women's birth partners throughout the birth of their child using midwifery practice as a foundation and guide. In The Lancet Series, midwifery is defined as *"skilled, knowledgeable, and compassionate care for childbearing women, newborn infants, and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum, and the early weeks of life…"* (Renfrew & et al., 2014). Midwifery care is further anchored by the International Code of Ethics for Midwives by the International Confederation of Midwives (hereby ICM). The four mandates to promote health and well-being comprise how midwives should relate to others, how to practice midwifery, how to uphold professional responsibilities and duties, and how to ensure the integrity of the midwifery profession. (DNJ, 2016; International Confederation of Midwives, 2014). This is further elaborated in the second chapter where I lay the framework for midwifery care for partners.

1.4 Structural outline

A short description will be provided to achieve a reader-friendly overview of the present chapter and the following chapters. The main structural outline of my study consists of seven chapters. The first chapter is an introduction including a presentation of the theme and outlining the background, aim of the study and research question, definitions of key terms, and scope of the study. Chapter 2 "Theoretical Framework" provides a comprehensive overview of significant and relevant literature according to my theme. "Methods" is the third chapter and involves intricate descriptions of how I have conducted my research study explaining the study design, sample, and analysis. The following chapter "Results" is where I present the results of my analysis. The fifth chapter is called "Discussion" and focuses on a final interpretation of the results, ultimately increasing my understanding of the theme and research question. Here I will also discuss the strengths and limitations of my method. In the following chapter, I conclude this research paper's main body with a short conclusion (Bui, 2009). Finally, the last chapter presents a list of my references.

2 Theoretical framework

This chapter sets the stage for my research by establishing its conceptual foundation and connecting it with prior knowledge. The theoretical framework serves as the backbone of what maternity care is for birth partners while outlining key aspects that will guide my exploration of the research question. Firstly, I will delve into factors contributing to birth partners feeling recognized as parents in the delivery room. Secondly, I will review studies that shed light on how providing information and guidance enhances the sense of security. Finally, I will elaborate on the significance of guiding and involving birth partners during labor and birth, seeking a comprehensive understanding of their role in the childbirth experience.

2.1 To recognize the birth partner as part of a unit

ICM's International Code of Ethics for Midwives does not explicitly include how to care for the woman's birth partner and acts as a general guide on how to care for the woman's reproductive life cycle. Nevertheless, parts of the four mandates involve the word "families" which can apply to their partner. The first code *Midwifery Relationships* states how a midwife should relate to others. In relation to the women and their families, midwives should support their right to be involved in decisions regarding their care and also empower them to advocate for themselves on matters that impact their health. In the second code *Practice of Midwifery,* states that midwives should provide care with respect for cultural diversity while simultaneously actively eliminating harmful practices within the same cultures. This code further elaborates on utilizing current evidence-based knowledge to ensure their proficiency in safe midwifery practices and to respond to the different needs of women whether it is psychological, physical, emotional, or spiritual well-being.

Recognizing the birth partner as a part of a family unit corresponds with the needs of Norwegian women in labor. It is reported that continuous support during childbirth is an important aspect of maternity care as well as being considered as one entity. Furthermore, it was expressed that it was of great importance that the partners were looked after both physically and emotionally by the midwife (Vedeler et al., 2022).

2.2 The importance of guiding and involving the birth partner

Despite a body of evidence proving the worth of birth partners, some still express that they feel excluded from the life-changing event of childbirth and need support from professionals in order to cope with the challenges associated with birth (Bohren et al., 2019; Fenwick et al., 2012; Venning et al., 2021). A meta-synthesis by Steen et al. (2012) reveals that if a partner does not feel supported or included in the birth process, they may struggle to provide effective support to the woman in labor. Furthermore, the World Health Organization (hereby WHO) underscores the importance of involving the birth partner as numerous profound health benefits exist for the parents, their relationship, and their child. This is underlined as integral support for advancing maternal care (WHO, 2019). When birth partners are accommodated, they serve as vital intermediaries between healthcare providers and women during childbirth. For instance, they contribute by supplementing information about the birthing process, facilitating communication, and arranging non-pharmacological pain relief for women in labor. More importantly, they act as spokespersons for women in labor, providing practical and emotional support, including motivation (Bohren et al., 2019). This notion is deeply embedded in the guidelines and recommendations for maternal care (WHO, 2020).

2.3 Enhancing birth partners' sense of security

According to (2011) and Premberg et al. (2011), the behavior and communication of medical staff greatly impact the support partners receive during childbirth. For first-time parents experiencing birth, information emerges as a crucial (Eggermont et al., 2017). Eggermont et al.'s study prioritized formal information needs over involvement in the birthing process, yet midwives sometimes overlooked this or provided unwarranted information. Furthermore, Premberg et al. (2012) discovered that fathers whose children were delivered via cesarean section also highly valued information provision. Furthermore, the information fathers seek pertains to understanding the events and how they can contribute (Schmitt et al., 2022). They desire assistance in supporting the woman, with the midwives demonstrating supportive techniques they can imitate (Bäckström & Hertfelt Wahn, 2011; Howarth et al., 2019). Clear, appropriate information boosts their confidence (Schmitt et al., 2022)

Positive birth experiences are linked to involvement in care, trustworthy and supportive staff, satisfaction with the midwife's presence, and effective information provision (Hildingsson et

al., 2011). Conversely, negative birth experiences are associated with limited involvement in decision-making, insufficient staff support, and a lack of information (Johansson et al., 2012). The more informed fathers are, the more likely they are to perceive the birth as they expected. However, fathers often feel receive insufficient professional support during the birth process. They wish that the midwife could be present more frequently and provide them with more information about the birth process. There is a noticeable difference between what they feel they receive in terms of information and the level of importance they place on that information (Schmitt et al., 2022)

3 Method

This project's methodological approach is the main focus of this chapter and will include in-depth descriptions of the strategy for collecting empirical data. The thesis question requires a qualitative approach, whereas individual semi-structured life-world interviews are most suitable. The birth partner's experiences of midwifery care during labor will be the foundation for data. Their experiences will come through using an interview guide as a tool. Furthermore, this chapter will include the author's prior understanding and knowledge of the present subject as it affects the research. It is imperative in the qualitative paradigm to showcase transparency within the process and strategy (Kvale & Brinkmann, 2015).

3.1 Qualitative Study Design

The investigating nature of a qualitative method suits well when exploring dynamic processes such as human interactions. While this method purposefully investigates a phenomenon's deeper meaning rather than an explanation, Malterud (2017) further explains that this method go hand in hand with concepts that are less defined or where there is a certain knowledge gap, after all studies regarding women's birth partners experiences that are held in Norway are limited. A qualitative method contributes to diversity, nuances, and subjective experiences. Through this strategy, we can increase our understanding of a certain concept or subject. In this study, I want to discover the experiences of women's birth partners during childbirth. Anchored by an interpretive paradigm, qualitative methods represent an umbrella term for common strategies that involve scientific approaches that recognize active processes such as thoughts, attitudes, motivations, and expectations within an individual. Furthermore, this term is characterized by the systematic interpretation of empirical data combined with theoretical perspectives encompassing a wide range of structured collection, interpretation, and analysis of data material. The material is usually from conversations, observations, and written sources (Malterud, 2017, p. 30-32 & 35-36).

3.1.1 Qualitative Research Interviews

A qualitative research interview attempts to understand the world from the informants' point of view and unfold the meaning of their experiences. It is when knowledge is developed through normal conversations of daily life which are also professional. Interviewing is an active process where the interviewer and the interviewee, through their relationship, produce knowledge. This concept of knowledge development is not rule-governed, on the contrary, it

relies more on the practical skills and personal judgments of the interviewer. This method of inquiring insight is characterized by being professional but organic and requires a specific approach and technique of questioning in order to truly bring a subject's own personal perspectives forward. Brinkmann and Kvale (2015) describe this interview as a semi-structured life world interview. This method is best suited when one attempts to answer questions that require one to gather information about what may be a personal and vulnerable experience. A benefit to interviewing rather than answering questionnaires is that the researcher can get unexpected answers, as opposed to being limited by yes/no questions, which only confirm or deny a statement. It also allows for a deeper understanding of the themes within the research question when they are asked open-mindedly.

3.2 Sample and recruitment

3.2.1 Convenience Sample And Inclusion Criteria

A convenience sample is about including participants that are available and accessible at the time of the project. To successfully finalize this thesis within the given timeframe, I included the first eight birth partners present at the birth of their first child in 2022. The inclusion criteria for this study are that they have never been in a birth setting and worked with midwives in a hospital. Undoubtedly, parents consider the birth of their child a moment to remember; nevertheless, concerning recall bias, I restricted the study to include births from the year 2022. After seeing through that the candidates were appropriate subjects for the study, they got the option to choose the time and location of the interview.

3.2.2 Sample

Some mothers who contacted me wanted their birth partners to participate due to self-interest in the study. However, their birth partners were hesitant to be a part of the study due to language barriers or difficulties in finding time to do the interview. A few others who took interest in the study were not first-time fathers or co-mothers and did not pass the criteria to join. See the sample presentation below.

Participant 1	Father	Birth of first child in June 2022
Participant 2	Father	Birth of first child in August 2022
Participant 3	Father	Birth of first child in February 2022
Participant 4	Co-mother	Birth of first child in October 2022

Participant 5	Father	Birth of first child in 2022
Participant 6	Father	Birth of first child in July 2022
Participant 7	Father	Birth of first child in 2022
Participant 8	Father	Birth of first child in December 2022

3.2.3 Recruitment

Recruitment happened through the social media platforms Facebook and Instagram, in which I presented my master thesis and research question in an open post. My friends were able to share this post to their friends allowing the persons who are interested in being a subject to contact me. The first eight persons that passed the inclusion criteria were included and it took less than a week to gather the sample. In order to find candidates I also posted to private Facebook groups like “Pappaklubben” including around 9,5 thousand members and groups where expectant mothers shared due dates according to months. However, I only successfully managed to share this on one group that shared due dates in the month of November in 2022. I did not have a personal acquaintance to any of the participants.

3.3 Collecting The Material

3.3.1 Interview Guide As A Tool

In formulating questions for the interview guide I used the research question as an anchor and drew insights from prior studies. Qualitative research often benefits from a broad research question, as the method warrants a more dynamic and flexible answer. This approach encouraged me to reflect upon what midwifery care for partners truly entails. There was a need to break down a broad concept, in which I turned to existing studies. From there I identified four key themes that intrigued me: information from the midwife, physical guidance to support the laboring woman, being involved in the birth process and acknowledgement, and lastly their role in child birth.

Given that I have no prior experience in conducting interviews I revised suggested questions to use, essentially forming a script, which ensured that each theme was thoroughly explored during the conversation. However I did not follow the sequence of the themes that is listed, and went back and forth between the themes as they naturally came up. I also added follow-up questions in the interview guide to further help me in the process. To kick off the conversation in a manner that would be perceived as if we were just acquaintances talking

(Kvale & Brinkmann, 2015) , I always asked about “how it all started” and “what their thoughts or impressions about the midwife that met them”. The overall goal is to craft an interview guide that would enhance the richness of insights gathered during interviews while aligning it with the academic standards that is expected.

Using an interview guide/script ensures more or less a structure (Kvale & Brinkmann, 2015, p. 162). This is an outline with topics to be covered whilst being conscience about being flexible for other directions that might open up. Throughout the data collection process, the interview script/guide must be revised if needed, requiring me to continuously evaluate if the interview questions needs to be formulated in way that is better understood by the informants or grasps an idea in another way (See attachment 1).

The interview guide initially had a few suggestions on how to ask each topic and when one of them was understood easily by an informant I saved them for the next. This made me revise the interview guide almost every after interview. During the interviews I consistently went back to topics that were not mentioned by the informants by themselves and the guide was a perfect check list that ensured I had the material needed regarding my research question. After the pilot interview and the first interview, I also added the question about how they felt being asked these questions regarding their own experience. This opened up a few directions that I initially did not intend to include, though resulted to a more rich conversation and strengthen the material.

3.3.2 Pilot Interview

In this study, one pilot interview was conducted to optimize the interview questions in the interview script/guide. The pilot interview was conducted by me and the informant was a previous colleague. The informant’s first baby was born in August of 2022 and had never been in a birth setting, which made him an equal to other informants that passed the inclusion criteria. The adjustments in the interview guide are therefore considered valid as the informant was also a valid candidate.

Personally, I don’t have much experience on conducting semi-formal interviews. Therefore, this opportunity was also utilized to practice and to optimize the use of my tools and skills. This also included trying which method was simpler being that I am the sole maker of this

project. I tried having physical handouts and used my computer devices to take notes or to checked off some topics, in order to see which method optimized the situation best. I also tested audio recordings and made sure along the way that I was on time according to how I had planned. I adjusted many things after this pilot interview and made the first interview easier to manage.

The informant of this interview stated that the order of the questions felt natural and somewhat easier to remember details of the events. However, it was also expressed that though the birth was not too long ago, a few details were harder to reimagine as a birth partner or companion does not really expect to be asked questions like this.

3.3.3 The Interviews

To collect rich and relevant empirical data, the location should strive to be characterized by familiarity and calmness. Choosing the location for the interview allows for vulnerable stories and interactions to be told in a place where they feel safe as well as an even better likelihood that the stories will be told precisely. When the stories are accurate the material is deemed more robust (Malterud, 2017, p. 69.70).

I accommodated the participants' preferred interview times, especially considering some were on paternal leave, making it challenging to leave their baby. To enhance their comfort and security, I offered to conduct interviews at their homes. This environment fosters openness and reflection, particularly when discussing potentially vulnerable moments. Two interviews were held via Zoom, four at a private meeting room in their workplace, and two at their homes.

The only condition was ensuring a quiet area for good audio recording and privacy. I expressed a preference for in-person meetings to interpret body language better and maintain a casual conversation atmosphere. When a digital meeting was suggested, I respected their choice, understanding the potential adjustments to their personal and work schedules. All interviews, except two involving their homes and baby, took place in quiet and private settings.

There was casual small talk about how their day was, and here, I took the opportunity to show appreciation to them for taking the time to explain the study. Before I proceeded into explaining the technicalities around the interview, I reminded them not to name specific places, their name, or their partners' names and dates and that they avoided talking about the partner's experience and rather to talk about their own personal experience. I explained that an application called "Diktafon-app" on my mobile device would record the conversation and assured them that this was a secure method developed by Nettskjema.no. I also had my laptop on hand, as I was the only one interviewing. This was a practical tool if I had to jot down a few things that they mentioned whenever the conversation naturally developed away from this. However, I did not use this as I wanted to prioritize being present and showcase that I was a person that was willing to listen to their stories.

I also went through the information and consenting form/agreement (see attachment no.), which they signed during the first minutes of the meeting. This included repeating the main purpose of the study. The time limit for every interview was an hour. However, the interviews were around 40-50 minutes, excluding one that lasted for an hour and fifteen minutes.

It was integral that the interview felt like a normal conversation and facilitating an environment where the informants can open up about a potentially vulnerable moment was vital. However, a dilemma occurred as it was a hard balance where I also had a project in which I needed stories of events as material. I often felt that the interview was an outlet for their own agenda or thoughts that were unrelated to the research question. I let them speak about it as I deemed it to be a step into opening up. Whenever non-related statements were further explained I relied on my own ability to ask follow-up questions and used the interview guide as a checklist. I quickly learned to remind them to talk about their own personal experience and to not reflect as much about why. Some informants hesitated and justified why things happened the way they did, especially if what they described could be deemed negative. Reassuring that their experiences or what they did were valid and that there were no wrong or correct answers to the questions was important to maintain the relationship where one is unfolding personal matters.

I did not ask the questions in direct order as they are stated in the guide. Informants spoke about events that organically brought follow-up questions. The only thing that did not change was the start and ending of the conversation, where I asked about how the birth process

started and ending notes. A few informants would show an emotional response in remembering back to their experiences, which made it hard for me to decide on the spot if I should move on to another topic or to further investigate on what affected them. I used follow-up questions religiously and would often go back to topics that was not explained thoroughly. A few questions may have seemed repetitive as it was also a process where I tried to navigate on how questions should be asked.

When the interview was about to end, I asked them if they had any thoughts or questions regarding the study and that they were free to reflect around the interview as a whole. This is where I also summed up the conversation allowing them to confirm if I understood the content that they shared. A few times, the conversation would naturally bring up new themes during the last few minutes before ending entirely, and this prevented the informants from unfolding something after the recording had ended.

3.4 Preparing for the analysis

3.4.1 Transcription

To transcribe means to transform or to change from one form to another. In this case transcriptions are translations from an oral discourse to a written discourse going from one narrative mode to another. Transcribing is also one of the first steps to abstraction which means that the live physical presence is decontextualized and loses the nuances and tones of a voice, as well as body language like gestures (Brinkmann & Kvale, 2015; Kvale & Brinkmann, 2015).

MS Word's transcription setting through MS365 was a solution that I used that ensured ethical considerations. Although it had an automatic function which made the process simpler, I still had to go through the transcription and manually transcribe parts of it to confirm that the transcription was thoroughly correct as there were some mistakes due to inaudible quality from the interviewee. The audio recordings were then transcribed into text as a whole, however frequent repetitions along with verbal expressions such as "mm" and "ah" were deleted. A few pauses by the interviewee where they had to take time to reconstruct their statements or to reimagine the events were excluded from the transcription. On the other hand, emotional expressions that gave further context to a thought or a statement

were included if it was integral in understanding the text. Examples of this could be laughter or if the interviewee teared up.

The text was transcribed in Norwegian as this was the language that was spoken in all of the conversations/interviews.

3.4.2 Translation

The main thesis paper will be in the American English language, however, only citations that will be actively used in the results will be translated by the author. This will ensure anonymity. I have used my own ability to translate the material that is presented from Norwegian to English, as I conducted the interviews.

3.5 The Process Of Data Analysis

Qualitative content analysis is a systematic method to analyze qualitative material like transcribed interviews, which is the strategy that I have chosen. Graneheim & Lundman's content analysis offers a method where one analyzes with various levels of abstraction and interpretation. They present a six-step process where I have focused on inductive analysis with a manifest approach. I have chosen this method because I was familiar with the method and my mentors knew this method as well.

When the material has been read through several times and its content is adequately known, the second step is to identify a meaning unit. A meaning unit can be sentences, word constellations or statements that has direct relation with the research question. After this, it is optional to condense or to shorten if the meaning unit is too extensive. As this part was not necessary, I progressed onto the next step which is labeling the meaning units, also referred to as "coding". I chose to have a manifest approach where I coded with similar words to the meaning unit without being too abstracted. After all of the meaning units have been coded, codes with a similarities are then gathered into subcategories and categories. The last step is to search for the underlying meaning within the categories and describe a recurring theme (Graneheim & Lundman, 2004; B.-M. Lindgren et al., 2020; Lundman & Graneheim, 2017, p. 10). The steps were done independently in the order that is presented. See example from table 1 below.

Table 1: Process of analyzing	
Meaning unit	*"It was always like that with the midwife - she had the time to stay for as long as we needed her, and she even stayed when her shift ended. She stayed until the spinal or epidural anesthesia was administered, making sure it was done before she left for home. She wanted to make sure it was done, so we had a midwife who went the extra mile and did the extra things."*
Code	The midwife was there as long as we needed her
Sub-category	The midwife had ample time for us
Category	The midwife going the extra mile was reassuring
Theme	A compassionate midwife ensured a safe birth experience

3.5.1 From A Meaning Unit To A Sub-Category – De-Contextualizing

The accumulated material was vast, and combing through the transcribed texts to identify meaningful units was lengthy. Finding meaningful units was systematically done by starting with the first transcribed interview and subsequently working my way through the last. The goal was to decontextualize the content into smaller pieces to obtain a better overview of the comprehensive material. I uncovered several identified meaning units that were not relevant and therefore excluded, ultimately making the material more manageable to code. Labeling the units into codes required creating a word or a sentence that symbolizes the meaning unit without losing its main essence. In the process of sorting the coded content into sub-categories, several codes were either too abstract or too similar in length to the meaning units. This required further alterations by giving more accurate labels that adequately represented the unit as a whole. The next step was to gather the codes into subcategories where identifying codes that shared similarities, differences, or corresponding notes within the content created a sub-category. Table 1 shows the process of coding meaningful units and gathering them into a sub-category.

TABLE 1: Example of a the analytic process – from meaning unit to sub-category

Meaningful unit	Code	Sub-category
I think maybe we were lucky to have a labor that started maybe when she had just come on duty because that's what it seems like she has, if we have labor in the afternoon and she was still at work late at night, so what then I don't think she was on morning duty, then she might have just arrived at work, and then we were very lucky to have her one who was rested and ready for work then. (P6)	Lucky to have a well-rested midwife	The appointed midwife is coincidental
So I was very aware that I don't know what kind of midwife we are getting, I don't know what kind of day the midwife has, does she have a good day, or a bad day? is it really busy at work or not? right? It is not necessarily her fault if she had been very, very busy and had no time for us. So I was kind of prepared for something like that Ok, it could be anything here (INF 2)	The midwife could be anyone	
It is clear that it is very stupid that it feels a bit like whether you get a good experience or not, is a bit like bingo, and the midwife has a very big role in that (INF 7)	A good experience depends on which midwife you have	
So there is quite a big difference between midwives and what people are like, everyone can have a good day everyone can have a bad day, so I just don't hold a grudge against any of those people, but it's a bit of a bingo whether you get a good one or a bad one or less good then, and it has nothing to do with the professional knowledge, it's about that, it's on the interpersonal emotional level, where some are better than others in my opinion (INF 7)	It is random which midwife you get	

3.5.2 From Subcategories To Themes – Re-Contextualizing

The core of formulating categories and themes is to rebuild what was taken apart and apply a level of abstraction and interpretation. To go beyond what is evident and avoiding summarizing the content into just “experiences” was a challenge that proved qualitative content analysis to be a complex and time-consuming process. Here I relied on my ability to take a step back and connect the de-contextualized pieces. To obtain a level of abstraction I drew in personal creativity and explored nuances of word meaning to formulate categories and themes. In this process, I managed to identify x categories and three themes.

Table 2: Example of sorting sub-categories into categories and the corresponding theme

Sub-categories	Category	Theme
Limited trust to unknown people	Distrust towards the unknown	The midwife had inadequate care for my role and needs as a partner
The appointed midwife is coincidental		
Fear of being in a medicalized process		
I was not acknowledged	Lack of recognition for the partner's role	
Knowing what's best for the woman in birth		
My needs were not recognized		

3.6 Prior understanding

Studies with a qualitative approach is distinguished by how the author balances proximity and distance in regards to their own research. The author becomes a co-creator as a result of this alternating act (Lundman & Graneheim, 2017, p. 10) and this particular thesis project is no exception. Whenever a researcher is within proximity of a certain concept, their personal prior understanding will inevitably influence and color the project as a whole. Gadamer argues that one's personal experiences forms a base for their interpretation of any given subject (Malterud, 2017, p. 44). Accordingly, I can never stay objective due to the colors of my own experiences, interests and acquired knowledge and this comes through when being in new situations as it never happens with completely blank canvases. Malterud further describes that this prior understanding influences the method of collecting data along with how one reads and interprets data. Thus, it is important to be aware of this throughout the whole research process as a preconceptions can contribute to advantages and disadvantages (Malterud, 2017, p. 44). In regard to this project, it acted as a foundation for momentum and sparked an assortment of issues and ideas within this concept. It made it possible to ask the research question. A common mistake is that the preconceptions overshadow empirical material causing a marginal difference between the project plan and the actual project itself (Malterud, 2017, p. 44). Ultimately requiring a conscious relationship to my own preconception, the informants and the material in order to avoid this downfall (Malterud, 2017, p. 45 ; Ruyter, 2014, p. 238). In favor of this and to actively use my own preconceptions as a "contrast" to the subject I need to document this beforehand (Fangen, 2010, p. 47).

3.6.1 My painted canvas

The idea of birth partners' involvement was introduced to me during my time shadowing a midwife as a nursing student. Back then, I was doing clinical studies in public health, and the midwife I observed was based in antenatal services covering a sizable municipality. Despite the routine nature of check-ups guided by protocols, the midwife infused a humane touch into her interactions with expectant women. She showed genuine concern for their expectations and the support systems surrounding them. This piqued my interest in the role of birth partners. Even though none were present during my visit, the midwife routinely inquired about them.

I asked whether it was the norm for partners to be absent or if they weren't welcome. The midwife clarified that partners were indeed welcome, but due to time constraints during appointments, most women preferred to attend check-ups solo to ensure time for their own questions. This revelation sparked my curiosity about how birth partners prepare for the significant life change of becoming parents without tapping into valuable resources like these check-ups.

As a midwife student involved in clinical studies, I gained more experience and insights into this process by being present at multiple childbirths—one of life's most monumental events. Some partners appeared to feel out of place, both physically and mentally, in the delivery room. They had numerous questions but often viewed themselves as less critical participants of the event. However, when given specific instructions on how to ease labor pain, they eagerly stepped up to fulfill their role. It struck me that many partners may not have been part of the preparation during pregnancy, which contributed to their awkwardness in their role. Recognizing them as integral parts of the evolving family, I contemplated how, as a midwife student, I could facilitate a smoother transition during this brief yet crucial moment in their lives.

3.7 Ethical considerations

In adhering to ethical considerations within the framework of a master's degree research project, measures have been implemented to ensure transparency, informed consent, and the protection of participants' rights. Applications were formally submitted to the Norwegian Centre for Research Data (NSD), accompanied information sheets, consent forms, and

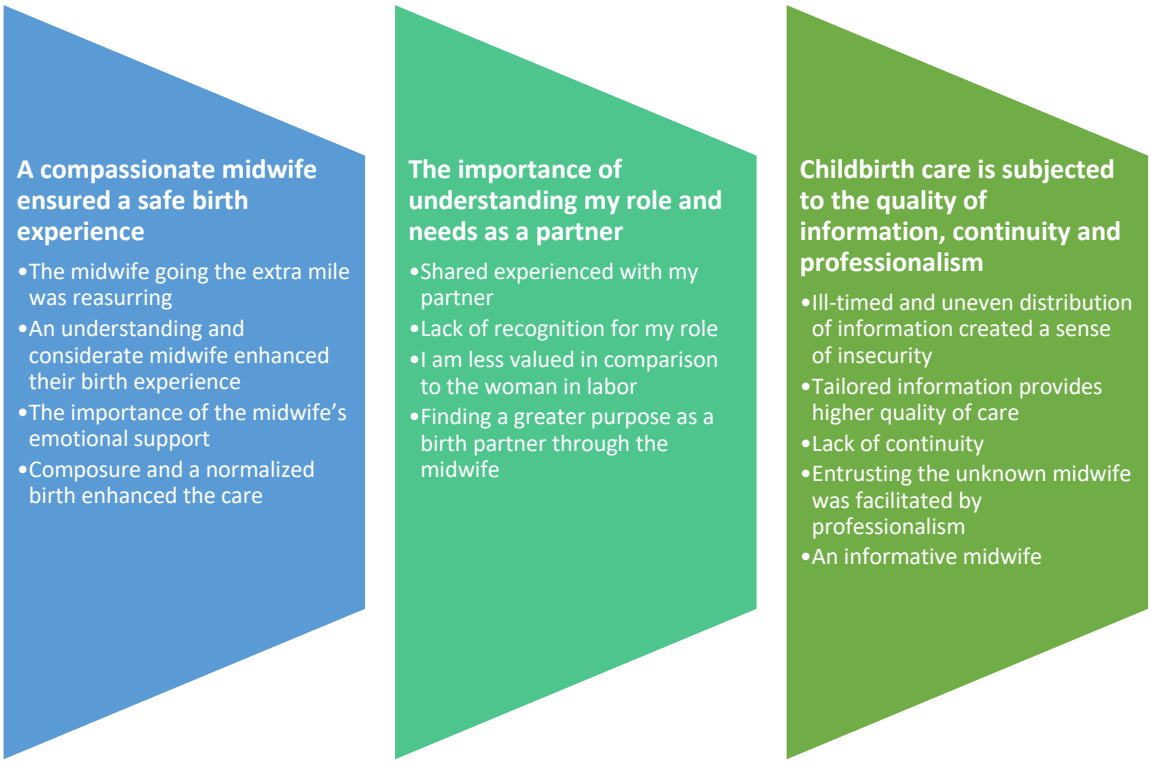
interview guides, along with the project description. Each prospective participant received the interview guides, consent forms and information sheets, either in electronic or hard-copy format, well in advance. This made sure that they had ample time to review and comprehend the study's purpose and procedures.

Furthermore, the data collection process adhered to established ethical standards. Due to the nature of the research question it was necessary to have a direct interpersonal exchange between the informant and the researcher. The interviews were recorded with "Nettskjema-dictaphone," a tool that encrypts the recordings for enhanced security. Informants were further explicitly explained of the storage protocols for their information and that within the text their identities would remain anonymous, further ensuring the preservation of confidentiality. Participants were also informed that they can withdraw from the study at any time without no apparent reason.

Taking these ethical considerations and securing approval from the NSD ensures the principles of integrity, respect, and responsibility in its interactions with participants (Malterud, 2021).

4 Results

This chapter will unveil the participants' stories, bringing their experiences to the forefront. Their narratives are empirical findings derived from the semi-structured interviews, which will answer the main research question about birth partners' experiences in perinatal midwifery care. Three themes emerged from the content analysis; *A compassionate midwife ensured a safe birth experience, The midwife had inadequate care for my role and needs as a partner,* and *The care during childbirth is subjected to the quality of information.* These three themes cover fifteen individual categories, which include three to seven sub-categories each. See the diagram below for an overview of the assorted categories and themes. Upon reading this chapter the reader is first presented with a general description of each theme. This is followed by the elaborations of the content in each category. Each category is further accompanied by one statement from the participants to fully grasp the essence of the category.



4.1 A compassionate midwife ensured a safe birth experience

The first theme embodies the birth partners' experiences of how a midwife ensured a safe space by being compassionate. Some participants described the midwife's commitment and

reassuring presence, whilst others described the midwife's ability to emotionally support related to the birth of their child. Being understood by the midwife in their role as a birth partner and creating a safe space for them allows fathers and co-mothers to do their part in supporting the woman at birth.

4.1.1 The midwife going the extra mile was reassuring

The participants described that a compassionate midwife was reflected in their actions, having ample time for the couple and being completely present throughout the whole birth. One partner was reassured by the midwife's presence as they would have someone to ask due to the unknown situation that they were in. The partners further described in various ways how the midwives exceeded their expectations by giving information about different pain-relieving methods and how to be a supportive partner. A partner explained how he got instructions on how to massage his wife to help out with the contractions and information about cutting the umbilical cord while specifying that the midwife had a plethora of information throughout the different phases of labor and birth. Another expressed the extraordinary dedication of a midwife, which made him feel reassured, highly valued, and prioritized, especially when she put her own personal needs aside. One partner described;

"It was always like that with the midwife - she had the time to stay for as long as we needed her, and she even stayed when her shift ended. She stayed until the spinal or epidural anesthesia was administered, making sure it was done before she left for home. She wanted to make sure it was done, so we had a midwife who went the extra mile and did the extra things." – Participant 2

4.1.2 An understanding and considerate midwife enhanced their experience

The expectant fathers and co-mother elaborated on several elements to being understood by the midwives in labor and birth. The main elements mentioned were the midwife's ability to read the room and being perceived as an important role by being looked after and being assisted throughout the process. The midwives' ability to read a room was described by the partners in that they knew when to offer guidance or saw if they were in discomfort or were tensed up. It helped them realize that they needed to relax and that they were seen as a person and not only a bystander. One co-mother explained how being acknowledged and praised by the midwife was vital for the birth experience and resulted in a sense of achievement in her

role. One expectant father explained how the midwife understood and supported his role as a birth partner;

"*The midwife told me that it's important for me to also motivate her while she was there in front of her, and she said that it's important for me to also help a bit in that regard, I believe she told me to speak to her, while speaking to me as well ... I felt very well placed because I had been instructed on how I should stand, how I should provide support. I think that was the most important instruction to receive, really, not just sitting and waiting in the chair; that would have been a disaster. One would want to help in any way possible, and I think they also felt reassured that I was very present there.* – Participant 6

4.1.3 The importance of the midwife's emotional support

The birth partners explained how imperative emotional support from the midwife can foster a nurturing and emphatic atmosphere throughout the birth. Key elements such as the midwife being on the same emotional page as the couple resulted in a positive experience. The midwives mirrored their emotions, like being excited as they progressed further in the birth or how they reacted regarding the woman's labor pain. This facilitated the feeling that the midwives were emotionally involved in their birth and acknowledged them as two individuals in the process of being parents. The partners also reflected on the midwives who shared their personal characters, and sharing jokes made the partners feel more at ease. On the other hand, the midwife's lack of emotional care can emphasize the need for empathy. One of the fathers longed for comfort and human touch as he became exhausted after several hours without sleep, wearing out his patience. This left him feeling that his vulnerability went unnoticed. Several of the birth partners remarked on how the midwives' workload affected their birth experiences, as they seemed stressed and distracted. A father experienced the midwife being physically present, though distracted as if her head was in another place. Moreover, other partners underlined this statement by encountering that the midwives were stressed due to multiple tasks or other couples that needed to be tended to. Another father described that his birth experience was characterized like a business, as they were so focused on their job that they said nothing else other than what was important, referring to the midwife as if she was on autopilot. A birth partner reflected on this matter and stated,

“It felt more like we were just another couple giving birth in a way. I perceived her as quite tired and exhausted in a sense. It was a bit sad because we didn't quite establish the same chemistry or connection with her as we did with the two previous midwives. It's not that you necessarily have to engage in small talk, but it's just, I don't know, something about feeling that the person is present and takes you seriously” – Participant 4

4.1.4 Composure and a normalized birth enhanced the care

The co-parents also found the midwives’ calmness reassuring despite the multiple tasks on hand. Their calmness was viewed as if they knew what they were doing, adding an element of safety into labor and delivery. Being able to lower the pulse and be present was calming as the co-parents noted positively their ability not to bring the stress and transfer it to them. Co-parents experienced other elements as reassuring, such as the midwife doing small talk and normalizing the space. One of them described that the physical birth room was normalized through dimmed lights and less noise, which made the birthing suite less medical, as if you were hospitalized. Small talk was deemed positive and made talking to the midwife easier. One father said;

"It was sort of like human conversation, talking about nice things, talking about other stuff, like what we do for work, and that made it feel more normal. I think it's important, not everyone likes small talk, but in those situations it can be good, and it was good, so it was nice, and it helped us get to know each other a bit better. And it also made me feel more reassured with the midwife." - Participant 1

4.2 The importance of understanding my role and needs as a birth partner

The fathers and co-mothers opened up on how they experienced midwives in relation to their own role through the birthing process. They shared how there was a lack of recognition for being in a vulnerable state, also in the process of becoming a parent. They elaborated on being a birth partner for the first time; feeling somewhat useful yet helpless at the same time. Moreover, participants embarked on feeling less valued or secondary, as it is natural for childbirth to focus on the mother and the child, rather than the partner. Being acknowledged as a couple and having joint experiences with the birthing woman is also an important factor they have shared with a potential to be optimized.

4.2.1 Shared experiences with my partner

The birth partners shared their experiences on being acknowledged as one entity. It was especially positive when the midwife communicated directly towards the couple, recognizing more than just the woman in birth. Nevertheless, they were going through birth together, as one father stated. Furthermore, several partners expressed the significance of caring for the woman in birth, as this was a joint experience. In regards to birth pains, the partners could feel a kind of discomfort themselves, when the birthing woman was not adequately relieved of her pain. Similarly, father expressed that he was reassured as soon as his wife got the epidural for pain relief, while confessing that it was just as intense for him as it was for her, when he observed her having painful contractions. The birth partners exclaimed that it was tough not being able to alleviate the birthing woman's pain. In order to tend to the birthing woman, the partners made it a goal to cooperate with the midwife in various ways. From doing maneuvers in order to turn the baby's presentation to ensuring that information was understood when instructions were exchanged by the midwife, their common goal was to care for the woman. Ultimately, caring for the woman in birth was caring for the partner too. One partner shared;

"It does, after all, greatly affect my experience how well she was taken care of... I'm primarily there just to sit beside, but there's something about my role as a kind of supporting person that works much better if I also feel safe and see her being taken care of. You can do a better job that way" – Participant 4

4.2.2 Lack of recognition for my role

The participants conveyed a sense of being overlooked and unacknowledged as partners during labor and delivery. They revealed that they felt unnoticed and unseen, stating that some midwives did not extend a simple greeting upon arriving at the delivery ward, which left some feeling like they were an inconvenience. Some birth partners felt that their own needs went unnoticed. For instance, one father expressed his longing for a simple inquiry about his well-being, or if he needed some rest further expressing that he wished for someone to take the initiative in providing assistance in his role. As midwives attempted to understand their roles as birth partners, they emphasized the significance of being recognized as the primary advocates for laboring women. The participants stressed that they possessed personal

knowledge of their partners and were entrusted with the responsibility of advocating for them. Nevertheless, they clarified that this was not the reality they encountered. One partner stated;

"If I saw something that worried me, and I tried to let them know about it, it was sort of brushed off. They would say, "Oh, it's fine, don't worry about it." It was very dismissive. Both that and the fact that I expressed that, you know, she doesn't usually behave like this, something must be done. And they just brushed it off… I know her. I know who she is, and she wasn't herself. She was very sick". – Participant 4

4.2.3 I am less valued in comparison to the woman in labor

The fathers recounted their experiences in compact birthing rooms with no designated space for them, except for an uncomfortable chair tucked away in a corner. In one case, a father was asked to leave the room during a birth complication as the medical staff required extra space to carry out their work. A different father was informed of the possibility of leaving the hospital in the middle of the night due to capacity issues regarding the induction room that his wife was using. Another father, however, expressed gratitude for being provided a yoga mat to sleep on the floor, stating that it was quite uncomfortable and barely got any sleep, though emphasizing that it was better than going home. The birth partners also conveyed a sense of being less valued in their birth experience, such as lack of information directed to them in comparison to their wives and being physically acknowledged yet not quite on the same level as the laboring women. One father encapsulated these feelings and concluded with a statement;

"It's quite obvious that the overall feeling throughout the entire process is that the mother and child is sitting at the summit of the ladder… and then you have fathers, we are, well, at the bottom or somewhere else, just in the way. No, I felt like I was going along for the ride as a father and an observer; the midwife was doing her job for the mother and the baby, and I was just there." – Participant 7

4.2.4 Finding a greater purpose as a birth partner through the midwife

Navigating through birth for the first time with no expectations and no prior experience in cooperating with midwives, the feeling of helplessness was inevitable, according to the birth

partners. They quickly recognized that maternity care required more than their role as birth partners and often necessitated professional assistance. Moreover, in their efforts to improve the pressures associated with the role of a birth partner, they discovered that taking on tasks, and actively participating in the birthing process created a greater sense of purpose. For instance, grabbing a wet cloth or supporting in and out of bed. Several of them expressed relief in learning how to support the woman and even instruct in breathing through contractions. Being involved in the birth was significant to the partners. One describes having high regard for the involvement due to a fast-paced and intense birth. Another viewed cooperating with the midwife and receiving small acts of participation added a sense of usefulness, which in turn alleviated the anxiety, fear, and stress that is accompanied with birth. The simple tasks they received from the midwife played a pivotal role and significantly influenced their capacity to provide care for the woman. This shaped their overall birthing experience positively. One partner said,

"It's very nice when you feel a bit hopeless and helpless, and there's someone in the room who is like the adult in the situation, telling you that even though you feel hopeless, there are things you can do to help. And then you might feel a bit more useful because I know that even though she's here and going through the most significant part, there's something I can contribute along the way. It was a relief because I've never felt so useless in my entire life. But it was very, very good, and it was needed, absolutely." – Participant 4

4.3 Childbirth care is subjected to the quality of the information, continuity and professionalism

The fathers and co-mother experienced that the quality of care during childbirth is shaped by and heavily linked to the information that is provided to them. Low quality of information refers to when the information is unclear, inconsistent or lacking, which in turn resulted to a feelings of uncertainty. The importance of these elements in regards to information were apparent and influenced the sense of safety and confidence during their hospital stay. On the other hand, receiving tailored information by midwives was well-regarded by the birth partners.

4.3.1 Ill-timed and uneven distribution of information created a sense of insecurity

The fathers went into further detail about how the information was often ill-timed and lacking. One father stated, that it would be more reassuring and clearer if the midwife explained the process of labor and birth from the start. Instead, a midwife explained this after being admitted after several hours into labor. He clarified that although his wife was in severe pain and received epidural to ease it, it was not in his understanding that they would be admitted for the birth due to this. It was further explained that couple were sent home several times prior, which made him unsure if this would be the final admission due to the lack of information. The father also reported that he was unaware that the amniotic sac would be manually ruptured about four hours after the epidural was administered if there were no significant progress in birth. On another note, another father shared having an overwhelming response to the information by the midwives as it was too overbearing, hard to process, and unfortunate in the timing. This father reported a feeling that the birth as a whole was quite extreme due to the feeling of unpreparedness, wishing that if he had more information about the birth, it would have been a better experience. He stated;

"When we were nearing the moment of "ok, now the baby is actually coming out", a lot of information came very suddenly. Like, now the baby is coming out, and this and this and this will happen, and you have to do this and this and this. When we had as much time as we did, most of the information could have been given earlier. And maybe a reminder on what was going to happen of course, right before as well. Because if I had heard it again, say right at the beginning, or when I arrived, if I had received the information about what happens when active labor started it would have not been as stressful in the end. Because I felt that we or I was really overwhelmed of everything that was going to happen and how things were going to happen." – Participant 1

4.3.2 Tailored information provides higher quality of care

The birth partners emphasized that when the information was given in a comprehensible manner combined with understanding the reasoning behind necessary procedures, it enabled them to make a decision about matters regarding the birth. One father explained in detail the knowledge and information he acquired about the baby's back-to-back position, which made it not in the best of interest for the baby to be born vaginally. He also added how it was described and shown through ultrasound, that the baby presented high in the pelvis which

was why vaginal delivery by vacuum was not conceivable. This father experienced that he had ample time to the major adjustment and was well-informed when a cesarean delivery was their only remaining alternative. It became apparent that they were notified and explained of the procedure hours beforehand, mitigating the sense of loss of control. This is further anchored by similar statements from other partners, that they felt more equipped to handle unanticipated circumstances especially when complications were developing as they received information, prior to when it happened. This was highly well-regarded. Another element that was significant to all of the partners was that the more information they received, the more it warranted predictability and a sense of control over the situation. Being constantly updated on the situation and having a verbal note on the happenings was highly important. When the information corresponded with the happenings it avoided confusion and insecurities regarding the birth. One of the fathers mentioned that it was invaluable and reassuring to gain that security although it was a lot of information at once. As first-time birth parents they considered every bit of information valuable and regarded them as knowledge, helping them cope with the struggles that are associated with birth. One birth partner stated;
"This was my first birth, and it's helpful to get updates on what's going to happen next and what's required. You gain some experience being there, but I knew nothing about dilations and what had to be done, and how dilated she had to be and how long it takes. That was important information, I feel like it was a step closer to the goal" – Participant 5

4.3.3 Lack of continuity

The birth partners referred to a lack of continuity in different areas throughout the birth process. One of them included that navigating and interacting with more than one midwife was overwhelming. This father experienced that his wife had a complicated vaginal birth, which required several midwives and other health personnel throughout the entire birth process. This left him with a sense that the birth process was critical and serious. The idea of only having one midwife to engage with was further anchored by another birth partner, who stated that engaging with several midwives can lead to more confusion. Secondly, birth partners stated that being left alone left them vulnerable. Regarding the woman and the child are the most important people in their lives, it was deemed negative whenever they were not followed up, or the midwife was hard to find. One explained that the midwife did not meet them until later in the process due to another birth on the ward. Some of the birth partners mentioned taking the initiative to involve themselves, that their inquiries were not met, or that

the information given was conflicting between the midwives, which left them feeling that the care for the whole family was severely lacking, along with a sense of insecurities towards the midwives. One father said,

"We experienced various issues, in two instances, I took the midwife out into the hallway and provided feedback that they needed to improve. My wife was supposed to receive medication or pills at specific intervals, including pain relief at certain intervals. However, I had to keep following up on it since it wasn't happening on its own, and it was quite exhausting." – Participant 7

4.3.4 Entrusting the unknown midwife was facilitated by professionalism

Encountering midwives in the hospital were also portrayed with doubt and uncertainty. One of the fathers stated that they were lucky to encounter an experienced midwife, whilst another expressed gratitude in having a new and well-rested midwife for the critical part of the birth. In light of their doubts, some birth partners found it hard to entrust midwives with the most important happening in their life, due to the fact that this is their job. One father reflected on why midwives would take particular interest in them, investing time and energy, as many came in every day, and they were totally unknown to the midwives. On the other hand, they praised the midwives for having experience and speaking in a way that did not illuminate any insecurities in their field. The fathers recalled that the midwives were educative, confident, determined, credible and trustworthy in the way that they acted and spoke. However, the dominant feeling was that they were filled with anticipation and felt as if their birth experience heavily relied on the midwives they had through labor and delivery, which was perceived mostly as coincidental. One of the birth partners stated;

"So there is quite a big difference among midwives in how people are, everyone can have a good day, everyone can have a bad day, so I don't hold it against any of those people. But it's a bit like playing bingo if you get a good or bad, or less competent one. And it has nothing to do with the professional skills, it's more on the human and emotional level where some are better than others in my opinion." – Participant 7

4.3.5 An informative midwife

An informative midwife was one of the main highlights in experiencing birth as a safe space as information brought more understanding and knowledge into an unknown situation such as birth. One co-parent further described that the more information, the better, making the birthing process less harmless. It was through being educated by the midwife on the characteristics of contractions in the latent or the active phase, and especially when complications arose that the co-parents found it comforting and reassuring to understand and be informed by the midwife on what exactly was happening. One co-mother explained that they were reassured by knowing that there was an end to the birth process, and that the midwife talking the pair through the potential of a caesarean section and practical information within it was helpful. Having knowledge prepared her on what to expect, such as where to be and where their child would be while the surgical procedure happened. One of the birth partners said;

"She just told me a bit about what's on the fetal heart monitor, what's normal, so that I could kind of understand. She mentioned that typically, you might start with a certain number of contractions per ten minutes, and so on. 'You're already here,' she said to my wife, and then I thought, 'Okay, now I understand, and this is in full swing.' I remember sitting there, thinking that I kinda grasped what was happening, but you're just on the sidelines and can't do much. That's just how it is, but just understanding and being explained what's going on was very helpful." – Participant 2

5 Discussion

The presence of a compassionate midwife played a crucial role in ensuring a secure and comforting birth experience for birth partners. However, there was a notable deficiency in understanding their role and addressing their needs. This was shown through a lack of acknowledgment and experiences of being less valued. The quality of care during childbirth is intricately tied to several factors, including providing accurate information, the continuity of individualized care, and the level of professionalism exhibited by the midwives.

5.1 A compassionate midwife ensures recognition of the birth partner

The birth partners experienced the dedicated commitment of their midwife, who went above and beyond to ensure a comfortable and safe first-time birth experience. An exemplary instance of this commitment was observed when one of the midwives extended her presence beyond the designated shift hours to oversee the procedure of the epidural anesthesia that the laboring woman received. This demonstrated a level of care and dedication to the well-being of the expectant mother, which made a notable and reassuring experience for the expectant father. This finding is further anchored in a systematic qualitative review from 2018, highlighting the elements that matter most to women during childbirth. What held the utmost importance for the majority of women was a positive birthing experience that aligned with or exceeded their individual and sociocultural beliefs and anticipations (Downe et al., 2018). Although this review focuses on women's needs and expectations regarding intrapartum care, the results can be applicable to expecting partners as well. The reasoning behind this is also showcased in the current study, where elements of birth are a joint experience for the couple. A randomized controlled trial in Sweden (Thies-Lagergren & Johansson, 2019) further supports this notion as eight out of ten couples consistently rated their shared childbirth experiences of midwifery care, either positive or negative, affirming their mutual and common expectations of the birthing process. For many birth partners, intrapartum midwifery care is understood by the midwife's actions, influencing their experiences for better or worse. Aligning with several prior studies, the importance of presence is the epitome of support from the midwife; without it, the less positive their birth experience will be. It is evident that without a present midwife facilitating the emotional and physical work that accompanies birth, there is a higher likelihood that the birth is perceived as a negative experience. When the midwife goes to greater lengths to ensure a sense of security during birth, the birth

partners notice the midwife's determination and the small sacrifices they make that are unnecessary, resulting in a greater sense where they feel more valuable and prioritized.

The expectant birth partners remarked on the comforting impact of the midwife's ability to establish a normalized birthing environment physically and through verbal engagements. For instance, they valued that the midwife engaged in “small talk” and efforts in creating a physically non-medicalized birth setting. Dimmed lights, along with casual, everyday conversations, were particularly appreciated by the birth partners, emphasizing the positive influence it has on intrapartum care. Drawing parallels to fathers’ experiences in home births, in-depth interviews of eight Swedish fathers were conducted (H. Lindgren & Erlandsson, 2011). The birth partners in this qualitative study highlighted the secure atmosphere of a home environment related to the familiar situation of being in their own home and the absence of unknown health personnel. It was also easier to find a supportive role for the laboring woman at home as they can relax more than in a hospital setting where they feel more of a guest. The idea of normal birth, which is more facilitated through home births, can be understood as a similar approach to the efforts of achieving a non-medicalized setting within a hospital context. Another study examining fathers’ experiences with planned home births (Sweeney & O’Connell, 2015) also underlines the difficulties for birth partners to engage in a hospital-based birth process. This is because they can feel side-lined or overlooked by the medical staff. As a birth partner, obtaining a human connection through everyday conversations with the midwife can be seen as familiarizing with health personnel, whilst dimmed lights can take the focus away from visual medical clutter in the environment, such as cables, buttons, and computers. Birth partners highly appreciate midwives’ efforts in normalizing the birth process by engaging in small talk and ensuring a less hospitalized and medical experience. This is remarked by birth partners as pivotal in achieving a reassuring birth experience, as it seems less critical.

5.2 Being involved and understood in childbirth signifies the birth partners’ importance

All of the partners conveyed in some capacity a sense of less significance to the birth process due to the limited birthing environment One of the participants articulated that being a father in the birthing suite felt physically hindering for the medical staff and shared feelings that

reduced him to a mere spectator of the birthing process. Others felt adrift without a designated place for them to be. These findings resonate with the outcomes of a comprehensive systematic review conducted by Bohren et al. (2019), which describes the perceptions and experiences surrounding labor companionship. The review incorporates numerous studies where male and female partners emphasized challenges regarding the physical environment of labor and delivery wards. They highlighted the physical space was perceived as a barrier, as maintaining privacy was difficult due to open floor plans with only curtains separating the beds. Furthermore, another systematic review (Venning et al., 2021) focusing on the experiences and needs of new fathers revealed a prevailing sense of being insignificant to the birth process. One general theme that surfaced was that fathers felt marginalized and excluded by the healthcare system, including midwives. One of the studies in the review referred that although the hospital's name encompassed "women" and "children," there was a clear absence of "men" in this setting. This further supports that statement regarding no designated place for partners. These findings can be understood as symbolic and point to a broader systematic issue, suggesting a lack of understanding regarding the role of birth partners. It can be understood that the physical aspect of this challenge, involving confined spaces and regards surrounding healthcare systems' lack of inclusivity, implies that maternity services are perceived exclusively for women and their children. This also suggests a lack of family-friendliness as they fail to accommodate expectant birth partners. More importantly, these issues are not unique to Norwegian birth partners but extend globally (Steen et al., 2012). As midwives, we must recognize the vital role of birth partners in providing support during labor and take immediate steps to improve their involvement in the process.

In recognizing the birth partners for their role, the expectant partners found a greater purpose as supportive characters by cooperating with the midwife and actively participating in the birth process. Taking on simple tasks assigned by the midwife was found to be a valuable aid to the common feelings of helplessness that all of the birth partners remarked in this study. They combatted the pressures regarding their role by receiving clear instructions from the midwife and contributing throughout the birth, which made them feel useful rather than hopeless. Instructing and supporting the laboring woman how to breathe through contractions or helping them to get in and out of bed were all regarded as small, yet significant acts that positively shaped their birth experience. The findings are supported by a meta-synthesis of fathers' experiences in labor and birth (Johansson et al., 2015). The synthesis elaborates on

the pivotal role played by the midwives in enabling fathers to participate and offer assistance, which was imperative for ensuring a positive childbirth experience for first-time fathers. The midwives provided valuable guidance on what the partners can do to support women in the birth process, which is consistent with the present study. These findings can be understood in relation to the lack of recognition of the partners that were mentioned prior. Evidently, there is a need for a change in accommodating birth partners intrapartum. However, these findings suggest it does not necessarily require a significant systematic change. Instead, the small act of delegating tasks increases their sense of involvement and control. Furthermore, the current findings can be viewed as a pathway to enhancing the understanding of birth partners. As they venture into unfamiliar territory with the underlying intention of being present and supportive, there is no guarantee that they possess a clear roadmap for offering effective support or coping with the challenges of being present during childbirth. This sentiment aligns with a qualitative study conducted in Sweden that delves into fathers' experiences of childbirth (Premberg et al., 2011). The study underscores the notion that childbirth is an uncharted territory that often induces anxiety. There is a clear benefit when birth partners are actively involved and engaged in the birth process through midwives. It alleviates the pressures associated with them and consequently increases their sense of purposefulness at birth. Ultimately, small acts are big efforts in recognizing and understanding the birth partners' role.

5.3 The quality of intrapartum care is enhanced by the quality of information and upholding continuity

Birth partners experienced that the provision of information was two-sided. On the one hand, it was ill-timed and deficient, which made the birth experience generally overwhelming, especially when unwanted situations arose. Furthermore, the expectant partners voiced that less information resulted in insecurities and underpinned their vulnerability. On the other hand, receiving tailored information characterized as clear and easily comprehensible information enabled and achieved a sense of control among the partners, underscoring the importance of extensive information throughout every stage of the birth process. A cross-sectional study by (Eggermont et al., 2017) underscores a pronounced demand for formal and sufficient information regarding the birth process, deeming it a high priority in comparison to

other aspects such as feeling involved. Numerous studies corroborate this perspective indicating that extensive information is vital for partners to feel secure, involved and engaged during childbirth (Hildingsson et al., 2011; Poh et al., 2014; Schmitt et al., 2022). Conversely, a lack of information is reported to contribute to feelings of confusion, helplessness, and the feeling of being overlooked (Vallin et al., 2019). Moreover, research also show that midwives had shortcomings in providing timely information, particularly during critical moments. This underscores the significance of continuous information for first-time parents facing challenging events (Johansson et al., 2015). Tailored information is also reported to have positive notes, helping partners better manage birth complications and cope with events. However, critical events could be exacerbated when medical professionals lack sensitivity and use medical jargon. This can have a detrimental effect on fathers feeling marginalized during traumatic deliveries (Vallin et al., 2019). These findings prove that the information provided might be insufficient in relation to specific events within the birth process. Events characterized as critical, such as emergency cesareans, might warrant more information than normal births. Partners' perception of deficient information may, therefore, be influenced by the critical nature of these events and that these complex events require more time than what is typically available. In the present study, partners received information about possible critical events beforehand, which mitigated the stress around the birth process and left the partners more mentally prepared for the unexpected. This indicates that the timing of information delivery is more important than the content itself. Timely information provision can be regarded as a form of tailoring information to the partners. This emphasizes the lack of strategic communication in supporting partners through birthing experiences and ultimately voicing the need for midwives to reflect upon when information provision provides the most reassurance.

The birth partners experienced a lack of continuity during labor and birth in various aspects. For instance, the midwife juggled multiple tasks in the ward, which instilled a sense of vulnerability and insecurity in the birth partner as the midwife was absent and preoccupied. One of the birth partners felt the need to seek out information at his own initiative due to inadequate follow-up regarding medical inquiries. While the absence of a midwife was an issue for some birth partners, others experienced that interacting with several midwives and medical staff was overwhelming and manifested confusion. The lack of continuity was even more apparent when the birth needed more attention or was increasingly critical. To illustrate similar situations, a qualitative study investigating partners’ expectations and experiences of

implementing a continuity model (Larsson & Thies-Lagergren, 2021) revealed that establishing a connection with a midwife generated a sense of security for the birth partner. It is a comparable narrative where partners highlight the importance of having a midwife who is both known and accessible. This facilitated a sense of security, especially for first-time parents. To further support this finding, a study on parents' experiences of student midwives providing continuity of care was explored in Norway (Aune et al., 2012), who found comfort in having a midwifery student present in the delivery room. They valued the proactive support that was provided as they did not require explicit requests for assistance, while reassurance derived from the familiar face of the student midwife who was present during critical moments involving multiple health professionals was particularly noteworthy. The participants stressed the significance of avoiding the need to interact with several midwives and the importance of maintaining a sense of continuity, even as midwives changed during shifts (Aune et al., 2012). The study conducted by Larsson & Thies-Lagergren (2021) had a broader scope encompassing aspects of pregnancy, childbirth, and postpartum aspects, and also considered the geographical distance to medical assistance to their home, where they might be situated. This contrasts with the setting of the present study, which exclusively examines the experiences within a hospital setting. Moreover, student midwives can be regarded as having a similar role to midwives, with the distinction lying in their academic qualifications. In Norway, to be an authorized midwife, one must obtain a degree in nursing and practice nursing before attending a master's degree in midwifery school. Consequently, all midwifery students are formally recognized as authorized nurses (Norsk Sykepleierforbund, n.d.). Overall, continuity in midwifery care and lack thereof is a crucial element that influences birth partners' birth experiences and their feelings of security.

6 Strengths and limitations

Firstly the strengths of this study will be elaborated. The research question “How do birth partners experience care from the midwife during childbirth?” addresses a theme that has not been extensively explored in a Norwegian context, thus making it an intriguing and relevant area of investigation. The aim and the objectives of the study are well-defined and seek to understand and illuminate the experiences of birth partners. It is addressed by an appropriate method and study design. Furthermore, the chosen sampling strategy is robust as it justifies the selection by aligning with the outlined inclusion criteria. There has been deliberation on whether to include experienced birth partners who have participated in several births, considering the potential insights that they have gained from multiple births. The inclusion of inexperienced partners is valuable in providing a fresh perspective that is untainted by previous experiences. Still, acknowledging that including experienced birth partners could offer enriching comparative insights also underscores the need for a more extended timeframe and more sophisticated sampling strategy, which is beyond the time frame of what this dissertation has. The rationale for the chosen participants is clear and relevant characteristics have been described. In terms of data collection for this study, efforts have been undertaken to ensure both comprehensiveness and depth, facilitating robust support for generating and interpreting findings. This is also thoroughly described in the study. The choice of the data collection set is thoroughly justified, with a clear articulation of the method selected—individual semi-structured life-world interviews. The data collection process is meticulously described, encompassing details about the interview guide and a pilot interview conducted to validate its efficacy. The form of data, audio recordings, was transcribed with a dedicated program and is clearly stated, and the need for translation is acknowledged and discussed. Moreover, utilizing digital interviews can be regarded as a benefit in this study as it enhanced accessibility for the participants who were unable to attend in-person meetings. Digital interviews are a strength as they allowed me to be more accessible to participants who could not meet up in person.

In constructing my analytical framework, I engaged in a comprehensive process, evaluating factors that might influence data interpretations. Ethical considerations are addressed, with measures taken to ensure consent, confidentiality, and ethical clearance from an ethics committee. The analysis process is transparently explained, complemented by tables illustrating the steps taken. The connection between collected data, quotes, and identified

categories is thoughtfully demonstrated, contributing to the overall clarity and reasonableness of the data interpretation. Strengths of this approach include a well-crafted research question, clear objectives, and meticulous attention to detail in data collection, all of which enhance the trustworthiness of the study's results.

However, limitations exist. There is a notable absence of discussion on data saturation and a self-assessment regarding the potential influence of my role on data collection, sample strategy, and analysis, and the presented findings are lacking. Addressing these limitations would contribute to more comprehensively evaluating the study's robustness. In addition to the identified limitations, it is crucial to acknowledge the potential drawbacks associated with digital interviews. While these interviews offer convenience, they may restrict the recognition of non-verbal cues that individuals often respond to instinctively. Particularly when delving into potentially vulnerable situations, such as those encountered by the informants in this study, the absence of certain non-verbal cues may impact the depth of understanding. Non-verbal communication, including body language and facial expressions, is nuanced and can be more effectively gauged in face-to-face interactions than online settings (Brinkmann & Kvale, 2015). Furthermore, the study's scope is confined by the involvement of a single researcher. Collaborative efforts with a potential research partner could have enriched the discussions and provided a more nuanced exploration of various perspectives. This limitation underscores the importance of recognizing the inherent subjectivity and potential biases associated with a solitary researcher's lens. While every effort has been made to uphold ethical standards in this study, this area is limited and is a notable constraint.

7 Conclusion

In exploring birth partners' experiences of midwifery care during childbirth. The findings underscore the importance of compassionate midwifery, acknowledging partners' roles, and providing tailored information for a positive birthing experience. The study highlights the significance of factors such as a normalized birthing environment, recognition of partners, and timely, sufficient information in mitigating feelings of vulnerability and insecurity. The results emphasize the need for family-friendly, inclusive birthing environments and the impact of continuity in care. The clinical implications suggest that enhancing midwifery practices, recognizing partners' roles, and prioritizing communication can contribute to a more supportive and empowering childbirth experience for birth partners.

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Attachment 1: Intervjuguide

Før intervjuets oppstart informeres deltakeren/informanten om viktigheten av taushetsplikten:

- *Begge parter har ansvar for å opprettholde taushetsplikten*
- *Informanten skal ikke gi opplysninger som kan identifisere dem selv, kvinnen eller barnet, både direkte eller indirekte, som for eksempel navn, stedsnavn og dato.*

Sist oppdatert: 3/2-23

Intervjuguide

Kort om masterprosjektet:

Masterprosjektet sikter på å få innsikt og øke kunnskap om erfaringene til fødekvinnens partner om å bli ivaretatt under fødselen av deres første barn. Forskningsspørsmålet: «Hvordan opplever fødekvinnens partner å bli ivaretatt av jordmor under fødsel?»

Temaer	Spørsmål	Oppfølgende, inngående og spesifikke spørsmål
«Starten» Å komme inn til sykehuset og bli innlagt for å føde	**-Kan dere fortelle meg om hvordan hele fødselsprosessen startet? For eksempel fra dere ble «innlagt» for å føde? Hva skjedde da?**	Kan du forklare mer rundt ... ? Når du sier ... mener du at? Hva slags tanker har du rundt det? Hva skjedde da? Kan du gi noen eksempler på det? Hvordan følte du deg da? Hva gjorde/tenkte du da? Hva tenker du var viktig da? Hva synes du om det? Når jordmor sa/gjorde det, hva tenkte/gjorde/følte du da? Hvordan fikk du vite det? Følte du at du forsto hva som ble sagt? Hvordan opplevde du denne informasjonen? Bra/dårlig? Når jordmor informerte deg om de tingene, hva følte/tenkte/gjorde du da?
Det første møtet med jordmoren	**-Var det jordmor som tok dere imot?** **-Hva kan du si om jordmoren/jordmødrene som hadde dere?**	
Informasjon fra jordmoren	**-Hva fikk du informasjon om?** - Praktisk informasjon? Omvisning? - Forklaring på prosedyrer/hendelser? **-Opplevde du at du manglet informasjon om noe fra innleggelse til fødsel, isåfall om hva?** **- Kan du fortelle om du fikk noe informasjon rundt det som skjedde?** **-Hvordan var det å få denne informasjonen?**	
Fysisk veiledning fra jordmoren i å støtte fødekvinnen	**-Hva slags innspill/veiledning fikk du i hvordan du kunne tilrettelegge for den fødende?** **-Hvordan ble det formidlet til deg/Hvordan kommuniserte jordmoren dette?** **-Var det noe du ettersøkte selv? Eller kom de med veiledning spontant?**	Kan du gi noen eksempler? Når jordmoren sa/gjorde det, hva tenkte/gjorde/følte du da? Gjorde det deg trygg? Hva satt du igjen med av følelser når du fikk veiledning?
Involvert i fødselsprosessen Anerkjennelse	**Hva skjedde som gjorde at du ble involvert/fikk deg til å føle at du var involvert i fødselsprosessen?** **Hadde du en opplevelse av at du var en del av et team?** **Var det noe spesielt jordmoren gjorde for at du følte at du var en del av fødselsprosessen fra innleggelsen?** **Følte du deg anerkjent/sett av jordmoren?**	Hva syntes du om det? Bra/dårlig? Kan du utdype? Kan du gi eksempel på ting jordmoren gjorde/sa? Hvis ivaretakelse blir nevnt → Når følte du det? Hva skjedde da? Var det noe jordmoren sa/gjorde? Hva tenker du om det selv? Hva sitter du igjen med?

Før intervjuets oppstart informeres deltakeren/informanten om viktigheten av taushetsplikten:

- *Begge parter har ansvar for å opprettholde taushetsplikten*
- *Informanten skal ikke gi opplysninger som kan identifisere dem selv, kvinnen eller barnet, både direkte eller indirekte, som for eksempel navn, stedsnavn og dato.*

Sist oppdatert: 3/2-23

		Hvis anerkjennelse/ordet sett blir nevnt → Kan du utdype det? Kan du snakke litt mer om det? Hva mener du da?
Fødekvinnens partners rolle	**-Hva slags rolle du gikk inn for? Følte du at det ble oppnådd?** **-Var det noe jordmoren gjorde som resulterte til at du oppnådde den rollen? Eller den rollen du forventet ble bedre?**	Hvordan? Hvorfor/hvorfor ikke? Kan du forklare ... litt mer? Hva føler/synes/tenker du om det? Kan du gi noen eksempler på det som var bra/ikke bra av det du nevner?
Refleksjoner	**Har du noen generelle/oppsummerende tanker og refleksjoner om ...** - **fødselserfaringen din?** - **jordmoren/jordmødrene?** - **informasjonen, veiledningen?** - **egen rolle/innsats?** **Hva tenker du om å bli spurt om dette?**	

Attachment 2: Informasjonsskriv og samtykkeskjema

Vil du delta i forskningsprosjektet
"Ivaretakelse av fødekvinnens partner under fødsel"

Dette er informasjon til deg som ønsker å delta i forskningsprosjektet. Prosjektet skal ta for seg hvordan fødekvinnens partners opplever jordmors ivaretakelse under fødsel. Med dette skrivet gis du informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

Formål
Dette er et masterprosjekt av jordmorstudent [redacted] via OsloMet – storbyuniversitet. Det sikter på å få økt kunnskap om erfaringene til fødekvinnens partner rundt det å bli ivaretatt av jordmor under fødselen. Formålet med oppgaven er dermed å undersøke temaer relatert til følgende;

- hvordan fødekvinnens partner opplevde å bli veiledet og involvert i fødselsprosessen?
- hvorvidt informasjonen og veiledningen som er gitt av jordmor bidro til trygghet og følelse av ivaretakelse under fødselsforløpet?
- hvordan jordmoren bidro til at de muliggjorde rollen som en støttespiller?
- hvilke faktorer som gjorde at du følte anerkjennelse fra jordmødre?

Forskningsspørsmålet lyder slik: *«Hvordan opplever fødekvinnens partner å bli ivaretatt av jordmor under fødsel?»*

Hvem er ansvarlig for forskningsprosjektet?
OsloMet – storbyuniversitet er ansvarlig for prosjektet.

Hvorfor får du spørsmål om å delta?
Rekrutteringen har foregått gjennom å presentere masterprosjektet ved ulike digitale plattformer. Her har du tatt kontakt og meldt ønske om å delta i prosjektet. Du var tilstede og var fødekvinnens partner ved fødselen av deres første barn. Du var ivaretatt av en eller flere jordmødre under fødselsprosessen på et sykehus.

Hva innebærer det for deg å delta?
Å delta vil innebære at du deltar på et intervju. Tidspunkt for intervjuet vil avtales etter at interessen er meldt og nødvendige etiske godkjennelser er på plass. Det vil bli satt av inntil 60 minutter til intervjuet hvor selve intervjuet tas opp via lydopptak. Jeg vil også notere underveis og det vil bli stilt åpne spørsmål i form av en samtale for å kunne svare på problemstillingen.

Det er frivillig å delta
Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykket tilbake uten å oppgi noen grunn. Alle dine innsamlede anonyme opplysninger vil da bli slettet. Dette med mindre opplysningene allerede er inngått fullført transkribering, analyser eller brukt i

vitenskapelige publikasjoner. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger
Opplysningene du oppgir vil kun bli brukt til de formålene som er beskrevet i dette skrivet. Dine opplysninger behandles konfidensielt og i samsvar med personregelverket. Det er kun de ansvarlige personene i relasjon til prosjektet ved OsloMet som vil ha tilgang til datamaterialet. Disse er:

- Personen som står for prosjektet: [redacted]

Prosjektet vil følge OsloMet sine retningslinjer for datahåndtering og personsikkerhet. Lydopptak vil skje gjennom Nettskjema.no sin Diktafon-app. Nettskjema.no vil også kryptere og lagre disse lydfilene i 90 dager eller til jeg sletter dem.

Navn og personopplysninger vil bli anonymisert, kodet og adskilt fra øvrige data. Dataen og alle personopplysninger vil bli forsvarlig lagret underveis. Under intervjuet er det ønskelig at du unngår å oppgi opplysninger som kan identifisere deg slik som navn, stedsnavn og sykehus. Utvalgte sitater vil også brukes i teksten, men ikke slik at de som er intervjuet gjenkjennes personlig. Det vil ikke være mulig for andre å identifisere hva som blir sagt under intervjuet i det endelige produktet.

Hva skjer med personopplysningene dine når forskningsprosjektet avsluttes?
Prosjektet vil etter planen avsluttes den 18.06.2023. Opplysningene anonymiseres når prosjektet avsluttes/oppgaven er godkjent og sensuren er lagt.

Hva gir oss rett til å behandle personopplysninger om deg?
Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra OsloMet – storbyuniversitet har Personverntjenester vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Dine rettigheter
Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke opplysninger vi behandler om deg, og å få utlevert en kopi av opplysningene
- å få rettet opplysninger om deg som er feil eller misvisende
- å få slettet personopplysninger om deg
- å sende klage til Datatilsynet om behandlingen av dine personopplysninger

Hvis du har spørsmål til studien, eller ønsker å vite mer om eller benytte deg av dine rettigheter, ta kontakt med:

- OsloMet – storbyuniversitet ved [redacted]
- Vårt personvernombud: Ingrid S. Jacobsen, epost: personvernombud@oslomet.no

Hvis du har spørsmål knyttet til Personverntjenester sin vurdering av prosjektet, kan du ta kontakt med:

- Personverntjenester på epost (personverntjenester@sikt.no) eller på telefon: 53 21 15 00.

Med vennlig hilsen

[redacted] (Forsker/veileder)

[redacted] (jordmorstudent)

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet *«Ivaretakelse av fødekvinnens partner under fødsel»* og har fått anledning til å stille spørsmål. Jeg samtykker til:

☐ å delta i intervju

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet

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(Signert av prosjektdeltaker, dato)

Attachment 3: NSD-vurdering

Vurdering av behandling av personopplysninger

Referansenummer
670138

Vurderingstype
Standard

Dato
03.01.2023

Prosjekttittel
Ivaretakelse av fødekvinnens partner under fødsel

Behandlingsansvarlig institusjon
OsloMet – storbyuniversitetet / Fakultet for helsevitenskap / Institutt for sykepleie og helsefremmende arbeid

Prosjektansvarlig
[redacted]

Student
[redacted]

Prosjektperiode
14.11.2022 - 18.06.2023

Kategorier personopplysninger
Alminnelige
Særlige

Lovlig grunnlag
Samtykke (Personvernforordningen art. 6 nr. 1 bokstav a)
Uttrykkelig samtykke (Personvernforordningen art. 9 nr. 2 bokstav a)

Behandlingen av personopplysningene er lovlig så fremt den gjennomføres som oppgitt i meldeskjemaet. Det lovlige grunnlaget gjelder til 18.06.2023.

Meldeskjema

Kommentar
OM VURDERINGEN
Sikt har en avtale med institusjonen du forsker eller studerer ved. Denne avtalen innebærer at vi skal gi deg råd slik at behandlingen av personopplysninger i prosjektet ditt er lovlig etter personvernregelverket.

TYPE OPPLYSNINGER
Prosjektet vil behandle alminnelige kategorier av personopplysninger og særlige kategorier av personopplysninger om helse.

DATABEHANDLER
Ved bruk av databehandler (spørreskjemaleverandør, skylagring, videosamtale o.l.) må behandlingen oppfylle kravene til bruk av databehandler, jf. art 28 og 29. Bruk leverandører som din institusjon har avtale med.

FØLG DIN INSTITUSJONS RETNINGSLINJER
Vi har vurdert at du har lovlig grunnlag til å behandle personopplysningene, men husk at det er institusjonen du er ansatt/student ved som avgjør hvilke databehandlere du kan bruke og hvordan du må lagre og sikre data i ditt prosjekt. Husk å bruke leverandører som din institusjon har avtale med (f.eks. ved skylagring, nettspørreskjema, videosamtale el.)

Personverntjenester legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

MELD VESENTLIGE ENDRINGER
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til oss ved å oppdatere meldeskjemaet. Se våre nettsider om hvilke endringer du må melde: https://sikt.no/melde-endringar-i-meldeskjema

OPPFØLGING AV PROSJEKTET

Vi vil følge opp ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet.

Lykke til med prosjektet!