International Journal of Sustainability and Advanced Integrated Research
Volume 2, Issue 1 (January-March 2026) | ISSN: 3107-7854
DOI: https://doi.org/10.65339/ijsair.V2.I1.83

Challenges of Fathers Encountered During Pregnancy and Childbirth

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Publication history: Received: December 27, 2025; Revised: January 19, 2026; Accepted: February 25, 2026
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Abstract

This descriptive quantitative study investigated the challenges encountered by fathers during pregnancy and childbirth at Dr. Lorenzo P. Ziga Memorial District Hospital (DLPZMDH) in Tabaco City, Albay from July-September 2025. Using quota sampling, 100 biological fathers completed Likert-scale questionnaires assessing their roles, involvement levels, and barriers, analyzed through weighted means. Results showed high paternal role fulfillment (WM=3.41), involvement (WM=3.33), and challenges (WM=3.36), primarily financial struggles (3.77) and work conflicts (3.71). Anchored on Social Role Theory and Attachment Theory, findings reveal systemic gaps in father-inclusive maternal care. Recommendations target hospital protocols, policy reforms, and community interventions. This study examines the challenges faced by fathers during pregnancy and childbirth at Dr. Lorenzo P. Ziga Memorial District Hospital (DLPZMDH), Tabaco City, Albay, through a descriptive quantitative approach that identifies paternal roles, measures involvement levels, and proposes targeted support measures to bridge gaps in Philippine maternal healthcare systems where traditional gender norms, economic constraints, work-family conflicts, and mother-centric institutional practices limit fathers' active participation despite substantial evidence demonstrating benefits for maternal well-being, family cohesion, early infant bonding, and long-term child development outcomes.

Keywords: *Drug-Resistant Tuberculosis, Treatment Compliance, Socioeconomic Factors, Physiological Effects, Philippines*

1. Introduction

The family constitutes society's fundamental unit, with fathers serving as indispensable pillars in maternal and newborn health through emotional support, antenatal accompaniment, financial provision, and active presence during childbirth—processes increasingly recognized as vital for optimizing maternal outcomes, enhancing paternal bonding, and fostering early child development amid evolving gender paradigms. Yet in the Philippines, where 86% of pregnant women access skilled antenatal care (Philippine Statistics Authority, 2022) but paternal involvement remains ancillary, fathers confront multifaceted Absent Father Syndrome variants: physical exclusion from mother-centric delivery rooms and prenatal consultations, emotional disengagement via work-maternity conflicts, and structural marginalization through inadequate paternity leave implementation under RA 8187 (7 days) despite Expanded Maternity Leave provisions (RA 11210), compounding COVID-19-induced disruptions that severed hospital visitations and intensified economic precarity for Tabaco City's 4th-class municipality families (Asis, 2022; DOH, 2023).

Internationally, the World Health Organization (2024) positions perinatal fatherhood as a pivotal developmental juncture where involvement buffers paternal perinatal depression (affecting 10% globally), strengthens partner attachment, and mitigates newborn health risks, yet systematic barriers—cultural norms framing pregnancy as "women's domain," institutional policies restricting labor room access, and economic pressures prioritizing remittances over relational presence—precipitate paternal anxiety, role confusion, and diminished self-efficacy (McNab et al., 2022; Werner-Bierwisch et al., 2025; Smith et al., 2024). Empirical evidence confirms: low prenatal participation correlates with postnatal distress and suboptimal breastfeeding initiation (Jeong, 2023); perceived exclusion erodes life satisfaction absent institutional mediation (Copland et al., 2025); prolonged work-family separations foster developmental disconnects in Southeast Asian contexts (Ageng et al., 2024; Kurtulu et al., 2025). Domestically, Filipino fathers manifest heightened emotional turmoil, logistical upheavals, and coping divergences during perinatal transitions (Biscocho et al., 2024); OFW/migrant households reveal financial support surpluses yet physical/emotional engagement deficits impacting maternal recovery and infant bonding (Lantiere et al., 2022); work absenteeism ties directly to diminished hospital accompaniment (Garcia-Macatugob, 2023), well-being fluctuates with church/community buffers (Sablaon & Madrigal, 2021), and paternal voids exacerbate partner relational strain (Yap et al., 2022). Rural-urban disparities in Bicol Region's OFW-heavy locales like Tabaco City (Albay 1st District) underscore barangay networks' partial mitigation (Villanueva & Mercado, 2022), yet DLPZMDH's maternity wards serving 150-200 monthly deliveries across Sto. Cristo (947

households), Tayhi (604), Pawa (508), and Divino Rostro (102) adolescents/youths per 2020 census remain empirically uncharted—no localized quantification exists for physical (e.g., fatigue from overnight vigils), psychological (e.g., anxiety over complications, diminished provider self-worth), or social sequelae (e.g., peer/stigma substitutions) among its recent fathers, necessitating this study's descriptive quantification of roles, involvement, and barriers to inform inclusive perinatal protocols.

2. Material and Methods

2.1 Research Design

This study employed a descriptive quantitative research design to identify the roles of fathers during pregnancy and childbirth, determine the level of fathers' involvement, and assess the challenges encountered by fathers at Dr. Lorenzo P. Ziga Memorial District Hospital (DLPZMDH) in Tabaco City, Albay, Philippines. The design was appropriate because the study aimed to describe existing conditions, characteristics, and experiences of the respondents without manipulating any variables, focusing instead on capturing authentic paternal realities during perinatal transitions. The descriptive quantitative approach allowed systematic collection of numerical data on socio-demographic profiles, fathers' roles (financial, emotional, practical), involvement facilitators (confidence, encouragement, policies), and multidimensional challenges (economic, institutional, psychological) via structured 4-point Likert scales. Patterns were analyzed using weighted means, frequencies, and percentages to reveal prevalence and intensity trends. This design provided an objective snapshot of experiences during July-September 2025, with standardized instruments ensuring quantifiable, comparable responses for evidence-based insights and hospital policy recommendations.

2.2 Research Setting

The study was conducted at Dr. Lorenzo P. Ziga Memorial District Hospital (DLPZMDH) in Tabaco City, Albay, Philippines, which serves as a primary government district hospital providing comprehensive pregnancy, childbirth, and postpartum services under the Department of Health's maternal and child health programs. The hospital comprises maternity wards, prenatal outpatient clinics, labor and delivery rooms, and postpartum recovery areas, catering to both urban residents of Tabaco City and rural communities from surrounding barangays in Albay's First District. These health facilities are responsible for routine antenatal monitoring, normal spontaneous deliveries, cesarean sections for complicated cases, newborn care, and family health counseling, including basic orientation for accompanying fathers during their partners' hospital stays. DLPZMDH was specifically chosen as the research setting due to its high volume of documented childbirth cases (averaging 150-200 deliveries monthly), the consistent presence of biological fathers during labor and delivery, and the logistical accessibility of respondents during the July-September 2025 data collection period when postnatal wards were active. The setting provided an appropriate, real-world environment for assessing paternal roles, involvement levels, and challenges, as it authentically reflects the conditions of provincial Philippine public hospital maternity care, including resource limitations, staff workloads, and cultural dynamics that influence fathers' participation in perinatal processes.

2.3 Respondents

The respondents of the study were biological fathers whose partners had given birth at DLPZMDH from July to September 2025, who were physically present at the hospital during their partners' childbirth, and who voluntarily agreed to participate; a total of one hundred (100) respondents were included via quota sampling due to the non-predetermined exact number of eligible fathers. The respondents were selected based on the following inclusion criteria: (1) confirmed biological father of the newborn delivered at DLPZMDH, (2) present in the hospital premises during the labor, delivery, or immediate postpartum period, and (3) able to provide informed consent and complete the questionnaire independently or with minimal assistance. Fathers who were absent during delivery, not biologically related, or who declined participation were excluded from the study. The selection of these recent fathers as respondents was particularly appropriate, as they directly experienced the immediate challenges associated with pregnancy monitoring, labor support, delivery witnessing, and early postpartum adjustment. Their participation provided rich, firsthand quantitative data regarding roles performed, barriers to involvement, and specific needs, offering authentic insights essential for improving hospital protocols and support systems for paternal engagement.

2.4 Research Instruments

The first instrument was a demographic questionnaire designed to obtain comprehensive information on the respondents' socio-demographic and contextual characteristics, including age, civil status, educational attainment, employment status, monthly family income, number of children, and duration of accompaniment during the hospital stay. These data were used to describe the profile of the respondents, identify vulnerable subgroups, and contextualize their reported roles, involvement, and challenges. The second instrument was a researcher-developed Likert-scale survey questionnaire to quantitatively assess three key areas: (1) roles of fathers (e.g., providing financial support, offering emotional reassurance, attending prenatal check-ups, preparing baby essentials), (2) level of involvement (e.g., personal confidence, partner's encouragement, knowledge of pregnancy processes, access to paternity leave), and (3) challenges encountered (e.g.,

financial difficulties, work schedule conflicts, hospital restrictions, emotional strain, lack of family support). Responses were rated on a 4-point Likert scale (1=Strongly Disagree to 4=Strongly Agree), with verbal interpretations: 3.26-4.00 (Very High), 2.51-3.25 (High), 1.76-2.50 (Moderate), 1.00-1.75 (Low). The use of these validated, structured instruments allowed for systematic, quantifiable data collection and robust statistical analysis of fathers' perinatal experiences.

2.5 Data Collection

Prior to data collection, formal permission to conduct the study was obtained from the DLPZMDH hospital administration, medical director, and ethics review committee. Ethical considerations were strictly observed, with informed consent forms presented in the local language (Tagalog/Bikol) and secured from all respondents before participation. The researcher personally administered the survey questionnaires to eligible fathers in the postpartum wards, labor waiting areas, and family visitation rooms during scheduled non-urgent periods (e.g., after delivery stabilization), coordinating with nursing staff to avoid disrupting clinical care. The purpose, procedures, voluntary nature, and confidentiality of the study were clearly explained verbally and in writing, with respondents assured anonymity and the right to skip items or withdraw without affecting their partners' hospital services; assistance with reading or clarification was provided as needed to ensure comprehension. Data collection spanned the approved timeframe of July-September 2025, with completed questionnaires retrieved immediately after 15-20 minute administration to prevent loss and verify completeness. All raw data were stored in password-protected digital files and locked cabinets, used exclusively for academic research purposes in compliance with the Data Privacy Act of 2012.

2.6 Data Analysis

The collected data were meticulously organized, coded (e.g., SD=1, D=2, A=3, SA=4), and entered into SPSS or Excel spreadsheets for statistical analysis. Descriptive statistical tools were primarily employed, including frequency counts and percentages for socio-demographic profiles, and weighted means for interpreting levels of roles, involvement, and challenges. Frequency counts and percentages summarized categorical respondent characteristics (e.g., age groups, income brackets), while weighted means calculated the central tendency of Likert responses, paired with adjectival descriptions to denote intensity (Very High to Low). Results were presented in clear tabular formats with rankings of highest/lowest indicators, facilitating pattern recognition and trend analysis aligned with study objectives. These statistical outputs served as the foundation for interpreting key findings, linking them to theoretical frameworks (Social Role Theory, Attachment Theory), comparing with existing literature, and formulating targeted conclusions and actionable recommendations for hospital policy improvements.

2.7 Ethical Considerations

Ethical standards were strictly observed throughout the research process, in full compliance with the Declaration of Helsinki and the Philippine National Ethical Guidelines for Health Research. Prior written approval was secured from the DLPZMDH Institutional Review Board (IRB)/ethics committee and the hospital administration. All respondents received comprehensive information about the study's purpose, duration, procedures, potential benefits (improved services), minimal risks (emotional distress from recalling experiences), and their rights, including voluntary participation and the right to withdraw at any time without prejudice. Signed informed consent was obtained from each father, with assent for illiterate respondents documented via thumb mark and a witness signature. Confidentiality and anonymity were rigorously maintained—no names or identifiers appeared on questionnaires (codes were used instead), data access was limited to the researchers, and digital files were encrypted. No physical, psychological, or financial harm was inflicted; procedures posed only minimal discomfort related to recalling experiences, which was mitigated by allowing participants to skip questions and providing debriefing as needed. The principles of respect for persons, beneficence, and justice guided participant selection, data handling, and dissemination of results, with findings shared with the hospital to support service enhancement. All data will remain securely stored for five (5) years after the study, after which they will be destroyed.

3. Results and Discussion

3. 2.1. Demographic Profile of Respondents

Table 1 shows the majority of respondents were aged 26-35 years (48.0%), male (100%), married (72.0%), high school graduates (45.0%), employed (62.0%), with monthly household income below ₱20,000 (55.0%). These characteristics reveal a profile of working-age, predominantly married fathers from low-to-middle income brackets in a provincial setting, where economic productivity coincides with perinatal responsibilities, amplifying financial and time-related challenges to involvement.

Table 1. Demographic Profile of the Respondents (N=100)

Demographic Profile	Frequency	Percentage
Age: 26-35 years	48	48.00
Sex: Male	100	100.00
Civil Status: Married	72	72.00
Educational Attainment: High School Graduate	45	45.00

Employment Status: Employed	62	62.00
Monthly Family Income: Below ₱20,000	55	55.00
TOTAL	**100**	**100.00**

4. 2.2 Roles of Fathers During Pregnancy and Childbirth

Table 2 indicates fathers demonstrated high role fulfillment (weighted mean = 3.41, "High"), with financial support (3.82, "Very High") and emotional support (3.75, "Very High") as top performers, while attendance at prenatal check-ups (lower means) suggests logistical barriers. This aligns with Social Role Theory, where Filipino men prioritize provider roles amid cultural expectations.

Table 2. Roles of Fathers During Pregnancy and Childbirth (N=100)

Indicator	Weighted Mean	Adjectival Description
1. Providing financial support	3.82	Very High
2. Offering emotional support	3.75	Very High
3. Awareness of maternal/pregnancy risks	3.43	High
4. Preparing baby essentials	3.41	High
Average	**3.41**	**High**

5. 2.3 Level of Fathers' Involvement During Pregnancy and Childbirth

Table 3 shows high overall involvement (weighted mean = 3.33, "High"), led by partner's encouragement (3.79, "Very High") and personal confidence (3.72, "Very High"), but moderate workplace support (e.g., paternity leave). Per Attachment Theory, relational factors enhance bonding despite institutional gaps.

Table 3. Level of Fathers' Involvement (N=100)

Indicator	Weighted Mean	Adjectival Description
1. Partner's encouragement	3.79	Very High
2. Personal confidence in role	3.72	Very High
3. Financial capacity to support	3.61	High
4. Knowledge of processes	3.34	High
Average	**3.33**	**High**

6. 2.4 Challenges Encountered by Fathers

Table 4 reveals high challenges (weighted mean = 3.36, "High"), dominated by financial struggles (3.77, "Very High") and work conflicts (3.71, "Very High"), with family support relatively lower. These confirm literature on structural barriers in low-resource Philippine contexts, hindering full paternal participation**.**

Table 4. Challenges Encountered by Fathers (N=100)

Indicator	Weighted Mean	Adjectival Description
1. Financial struggles	3.77	Very High
2. Work schedule conflicts	3.71	Very High
3. Hospital restrictions/policies	3.48	High
4. Emotional/psychological strain	3.29	High
Average	**3.36**	**High**

7. Conclusion & Recommendations

This study concludes that fathers at DLPZMDH exhibited high role performance (weighted mean 3.41, "High") and involvement levels (3.33, "High") during pregnancy and childbirth, particularly in financial and emotional support domains, yet encountered significant high-level challenges (3.36, "High") dominated by financial difficulties (3.77) and work schedule conflicts (3.71), validating Social Role Theory's emphasis on provider expectations and Attachment Theory's insights on relational bonding amid barriers; these patterns reflect broader Philippine provincial realities where economic vulnerability and mother-centric services limit paternal inclusion, despite demonstrated benefits for family health outcomes. The findings underscore the need for systemic interventions to mitigate these obstacles, as enhanced father support correlates with improved maternal satisfaction, paternal mental health, and early child development. Based on the results, the Department of Health and DLPZMDH administration should implement father-inclusive protocols such as dedicated prenatal classes for couples, on-site emotional counseling corners during labor waits, policy revisions allowing unrestricted father access to delivery rooms (within infection control), and partnerships with local government for transport/financial subsidies targeting low-income fathers. Healthcare providers must receive training on paternal engagement, integrating father education modules into every antenatal visit and offering post-delivery bonding sessions with skin-to-skin facilitation. Policymakers should advocate expanding RA 8187 paternity leave to 10-14 days with stricter employer compliance monitoring, while LGUs launch barangay-level campaigns using social media and church networks to normalize father involvement and combat stigma. Community-based TB navigators or "Father Support Coordinators"

could be piloted to assist with work-hospital coordination and family mediation. Regular audits of these measures should track compliance improvements longitudinally. This study acknowledges limitations including its cross-sectional design and single-hospital focus in Albay, potentially limiting generalizability to urban or other regional contexts; self-reported data via researcher-made tools may involve social desirability or recall bias, and the quota sample of 100 constrains detection of subgroup variations. Future research should employ mixed-methods or longitudinal approaches across multiple provinces, validate instruments psychometrically, explore mediators like mental health or digital tools, and evaluate intervention efficacy through randomized trials to refine father-support frameworks nationally.

Compliance with ethical standards

The authors declare no conflict of interest. This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors; the study was self-funded by the researcher. Ethical standards were followed to protect participant dignity and rights. Approval was obtained from the DLPZMDH Institutional Review Board and hospital administration. Permissions were secured from maternity and postpartum units prior to data gathering. Respondents were fully informed of the study's purpose, procedures, risks/benefits, and rights; informed consent was obtained individually, with voluntary participation assured and withdrawal permitted without consequences. No harm resulted, and confidentiality was maintained—no identifiers used, data secured, used solely for academic purposes. Principles of respect, beneficence, and justice were upheld throughout

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