Young parents' perceptions of barriers to antenatal and postnatal care

By Debbie M Smith and Ron Roberts

Abstract

The teenage pregnancy strategy outlines the need for improved support to lower young parents' risk of long-term social exclusion by enabling 60% to return to employment, education or training. While current literature indicates that young parents need support during and after their pregnancy, little UK research has explored the influence of support on young parents' outcomes. This mixed-methods study provides insight into the antenatal and postnatal experiences of young parents in one London primary care trust. Four main barriers to receiving efficient antenatal and postnatal support were highlighted: a lack of male involvement; a poor and uncommunicative relationship between health professionals and young parents; the age restriction of services and a lack of knowledge about support availability. Age, gender and self-esteem were highlighted as influencing the needs and experiences of young parents and thus need to be considered when designing future antenatal and postnatal interventions.

Providing appropriate and accessible information to all women during their pregnancy is a key government priority (Department of Health, 2004; 2007). Accessible and appropriate antenatal care is particularly important for young parents and is seen as crucial in the prevention of adverse outcomes (Department for Children, Schools and Families, 2008). One of the targets of the teenage pregnancy strategy is to lower young parents' risk of long-term social exclusion by enabling 60% to return to employment, education or training (Social Exclusion Unit (SEU), 1999). In pursuit of this strategy, the teenage pregnancy unit claimed it would '…do more to support teenagers if they do have a child' (SEU, 1999: 5). However, little success has been reported in meeting this target, with young parents and their children still at risk for a variety of adverse outcomes (Department for Children, Schools and Families, 2008).

The difficulties faced by young mothers have not improved in recent years despite the availability of increased antenatal and postnatal support (Moffit and E-Risk Study Team, 2002). In addition, young parents face an increased risk of social exclusion and postnatal depression (Berrington et al, 2005). To date, literature on improving the outcomes of young pregnancy in the UK through support is limited (Swann et al, 2003). Exploring young parents' experiences of attending antenatal and postnatal support would be a useful place to begin.

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Influence of antenatal and postnatal support

Young parents tend to have low social support, making support from health professionals essential for them to cope with the transition to parenthood (Dawson et al, 2005). A positive association between healthy pregnancy outcomes and support has been reported in several UK studies (Clemmens, 2001; Goyder et al, 2003; Swann et al, 2003; Furey, 2004). For example, Wiggins et al (2005) found that long-term success for young mothers and their babies can be achieved if support is received during the pregnancy and for a year following the birth. Moreover, satisfaction with social support is positively related with young mothers' attitudes towards their pregnancy and unborn child (Macleod and Weaver, 2003). Similarly, benefits for young mothers and their babies have been reported from programmes promoting access to antenatal care, social support, and educational opportunities (Mead et al, 2005).

Support services and programmes have only recently examined the specific needs of young parents and made the agenda at a local and national level (Goyder et al, 2003). Goyder et al (2003) attributes the low level of support to the unclear national targets for supporting young parents and a lack of long-term funding. Recent government guidance for primary Care Trusts (PCTs) recommended the need for dedicated services for young parents (Department for Children, Schools and Families, 2007). However, this guidance did little to outline how this could be achieved. For this to be realized, the impact of social support on young parents' emotional wellbeing must be much better understood (Harden et al, 2006). Without this greater understanding, support services are unlikely to be improved and the social, health and educational benefits not reaped by young parents.

According to the recent Darzi (2008) report, patient satisfaction and involvement in services is central to the success of the NHS—a view endorsed by the National Institute for Health and Clinical Excellence (NICE, 2008). It is, therefore, desirable that health professionals should support young parents emotionally and educationally in a systematic and targeted manner (Moffit and E-Risk Study Team, 2002).

Young parents' experiences of pregnancy support

Encouraging young parents to attend support services is difficult. Satisfaction and understanding are two components in Ley's (1982) cognitive model of adherence. With young parents reportedly feeling judged, intimidated and dissatisfied with their treatment from health professionals, it is no surprise that they do not feel comfortable attending the support services run by them (Hendessi and Dodwell, 2002; Wiggins et al, 2005). Self-esteem has been reported as influencing young parents' attendance at support services (Speak, 1999). In addition, self-esteem is related to emotional wellbeing in response to society's low acceptance of young parents and their ability to make decisions regarding their future and sexual behaviour (Seal et al, 1997).

Young parents reportedly under-use NHS services as they feel stigmatized, lack confidence and find the content irrelevant, (Hendessi and Rashid, 2002; Allen, 2003). Young parents also tend to be socially isolated, resulting in a lack of understanding about support services (Speak, 1999). Burack (2000) for example, found that 68% of young people (13–15 years old) were unaware of services run by GP surgeries. Wiggins et al (2005) have argued that specialist antenatal clinics and support services that address young parents' individual needs are required in the UK.

Young fathers and support services

In the UK, mens' attendance at antenatal and postnatal support classes is low (Quinton et al, 2002). Interviews with first-time fathers (17–23 years old) concluded that many felt excluded from the pregnancy experience with health professionals failing to consider young fathers' as central to the experience, and lacking the skills to engage them (Quinton et al, 2002). In the USA, the inclusion of men in support classes has been found to impact positively on the health of mother and child (Coles et al, 1999).

The current study investigates young parents' (mothers and fathers) antenatal and postnatal needs at the individual level, and explores the interaction between psychological, social, economic and health factors. This will hopefully result in a clearer understanding of young parents' antenatal and postnatal needs and provide recommendations for ways to improve their uptake of support services.

Method

Design and participants

A mixed-methods study was conducted with young parents who lived in one London PCT. Data collection took two forms: a questionnaire and focus groups.

Young parents are defined in this study in accordance with the PCT's definition, which is young people who conceived (or whose partner conceived) under the age of 22. Young parents were recruited from a previous study (run by the author, DS) and through contacts in the PCT, including health professionals (health visitors and midwives), voluntary and council organizations working with young parents (peer support organizations and charities) and supported housing units. The young parents were given supermarket vouchers for the time they spent participating in the study.

The ethnic profile of the respondents was similar to the PCT's ethnic profile in the UK census (ONS, 2008) and was predominantly White British. The age of the participants at conception ranged from 15–25 years old (mean= 18.0 years). Young fathers were on average slightly older than the young mothers at conception (19.2 years compared to 17.9 years).

Questionnaire

The questionnaire was designed by the researcher (DS) and a youth support worker. To ensure internal validity and suitability, a number of young parents were consulted in the design stage. The questionnaire contained both open and closed questions in five sections: a self-esteem measure; participant characteristics; future plans; antenatal needs and support; and postnatal needs and support. The ten-item Rosenberg Self-Esteem Scale was used to measure participants' self-esteem. It was considered suitable for this sample because of its simple language and short length (Rosenberg, 1989).

Fifty-eight questionnaires were distributed; 87% were returned (n=49) and 81% (n=47) were included after two were eliminated because they were from another PCT. Self-esteem scores were used to divide participants into high (n=22) and low self-esteem groups (n=25) using a medium split (medium= 28). Women were divided evenly in these two groups (21—low self-esteem and 20—high self-esteem) whereas, four men were in the low self-esteem group and two in the high self-esteem group.

Focus groups

The focus group discussions were conducted to add detail and context to the questionnaire findings and were based on the questionnaire themes. Focus groups can stimulate discussion by participants through the sharing of viewpoints and can therefore add depth and context to the data (Morgan, 1998). Two focus groups were conducted; one with young parents-to-be (antenatal group) and one with young parents after childbirth (postnatal group). An accurate response rate is hard to provide as participants were recruited through a snowballing methodology.

Two focus group guides were used to ensure the main topics were addressed—one for the antenatal stage and one for the postnatal stage. Groups were conducted in an informal and semi-structured manner to encourage discussion. Discussion was initially encouraged by splitting the young parents into smaller groups, where they were asked to write down their views on a piece of paper. Subsequently these responses were displayed to the whole group to facilitate group engagement. Three expectant young mothers and two young fathers (aged 16–22) attended the antenatal focus group and five young mothers (aged 18–20) were present at the postnatal focus group.

Ethical approval

Ethical approval was obtained from Kingston University for young parents aged over 16 to be recruited.

Results

Fisher's exact tests were used to test for associations between variables where these were dichotomous (e.g. with self-esteem scores). Thematic analysis was used to analyse the qualitative data. This provides both theoretical freedom and helps to organize interview accounts while maintaining detail (see Braum and Clarke (2006) for a more detailed account of the rationale). To ensure reliability, interview scripts and themes were discussed between the authors.

Questionnaire findings

Three principal sections constituted the questionnaire: society's treatment of young parents; antenatal support; and postnatal support. Associations with age at conception, gender and self-esteem were explored.

Society's treatment of young parents

Eighteen young parents reported negative reactions to the adverse view of young parents held by society. Examples included, feeling constantly judged and less confident:

> *'I feel that society tends to make you feel like everyone is better than me, and that I am a disgrace'*
> *(mother, age 18)*

A significant association was found between self-esteem and young parents' reaction to society's treatment of them. More participants with a lower level of self-esteem reported a negative reaction to society's treatment of them (11 cf. 5) than those with a higher level of self-esteem reporting (7 cf. 13) (p=0.04, Fisher's exact test).

Antenatal support

Thirty-seven participants said they were offered antenatal support; 28 of these attended some classes and 14 attended the whole course. Attendance was associated significantly with self-esteem. More young parents with a higher level of self-esteem (19 cf. 9) attended antenatal support than those with a lower level of self-esteem (p<0.001, Fisher's exact test). Those who did not attend the antenatal support classes (n=19) were asked their reason (some parents stated more than one reason) for not attending (*Table 1*). The main reason given was that they felt they did not have enough confidence and were scared to attend (n=4).

Postnatal support

Fourteen (38.9%) young parents reported being offered postnatal support, of which five young mothers reported attending, and of these three attended less than half the classes. Those who did not attend the postnatal support classes (n=22) were asked their reason (some gave more than one reason) for not attending (*Table 2*). The main reason given was that they had not been told about the classes available (n=11).

Antenatal focus group findings

The discussion was grouped into three main topics: antenatal needs and support, society's view of young parents; and other issues.

Table 2. Reasons for non-attendance at antenatal support classes

Reasons for non-attendance	Frequency
Not enough confidence/scared	4
Were at school/college/work at the time	3
Did not think they needed support	2
Live too far away	2
Not offered any	2
Did not know anyone	2
Not with their partner at the time	2
Did not know of any	1
Everyone was too old	1
Not sure if keeping the baby	1
Baby was 10 weeks early	1
Did not know where it was	1
My girlfriend went	1
Thought they would be judged	1

Antenatal needs and support

Differences in priorities during pregnancy were discussed on the basis of gender. The group felt that issues needed to be addressed differently for men and women, such as the physical aspects of pregnancy (e.g. breastfeeding) which would have different meaning for men and women.

Age and gender were reported as the main barriers to attendance. The age of other people in the support groups was deemed important. Antenatal classes for young parents in this PCT are run for under-22-year-olds but this was

Table 2. Reasons for non-attendance at postnatal support classes

Reasons for non-attendance	Frequency
Not told about support	11
Had no time	5
Had support	4
Did not think they needed support	3
Had to work	1
Low confidence	1
Couldn't be bothered	1
Baby cried a lot	1
Too far away	1
No-one to go with	1
Not with partner	1
Not told about	1
Felt uncomfortable and out of place	1

thought to be unsuitable by the relatively older mother-to-be (21) as she felt that she shouldn't be in a group with 15- and 16-year-olds. In contrast, younger parents in the group reported liking this age-specific group:

'But the group at the surgery was all like grown-up ladies, 25 plus yeah and you completely feel out of place sitting there …they all talk all' (mother-to-be, age 20).

Financial and emotional support received from the 'government' was reported by the two youngest participants as helpful:

'They'll talk to you like you're older and not a kid' (father-to-be, age 16).

However, support from the government was considered to be a negative aspect of antenatal support by older participants:

'… it's helpful information if you are under 19, if you're 19 it's a little bit harder to get help (mother-to-be, age 21).

The exclusion of men from antenatal support was evident from the young mothers' and fathers' accounts. The young mothers remarked that they were not encouraged to bring partners to appointments and felt that the inclusion of men would encourage them to attend. When they did attend fathers-to-be were not included:

'… just sitting there like I'm not there' (father-to-be, age 16).

'…they've never spoken to me, never' (father-to-be, age 22).

The fathers-to-be discussed needing support that focused on their needs instead of the physical aspects of pregnancy. The age of other fathers in the group was not an issue.

Society's view of young parents

All participants thought that society held a negative view of young parents; one that viewed them as poorly educated and lacking prospects. However, none of the young parents reported being influenced by this negative view of them and several explanations as to why were discussed. One mother-to-be reported that the views made her 'angry', while a father-to-be (age 16) commented:

'…makes you realize that you're better than that' (father-to-be, age 16).

Other issues

Two other issues arose: sexual vulnerability and postnatal support. Sex education was discussed in a critical manner. They all felt they had not been educated at school regarding how to avoid pregnancy or about parenthood:

'…we talked about STIs and condoms, but not how to avoid STIs and that' (father-to-be, age 16).

'…you don't get spoken to about what happens afterwards' (mother-to-be, age 21).

The need for more clinics for young people to discuss sexual health issues was raised owing to perceived discomfort with their GP surgery. It was considered preferable for both the young mothers and fathers to discuss sexual and reproductive health issues with a woman. Age was reported again as a barrier to receiving sexual health advice:

'That other place you can phone in, you can't phone in as they aren't interested in you unless you're under 19. And even over-19-year-olds these days don't have a clue about sexual problems they can have' (mother-to-be, age 21).

All the young parents indicated that they would like to attend postnatal classes, but felt they were not given sufficient information about these classes to attend. What happens after the baby is born (for example, how to make a house safe for a baby) was reported as being needed during the antenatal stage in anticipation that they will not attend postnatal support.

'A woman came in and gave us leaflets or something… but you think OK when does it start, does it run every week?' (mother-to-be, age 16).

Postnatal focus group findings

Discussion was grouped under three main topics: postnatal needs and support, society's view of young parents, and future needs.

Postnatal needs and support

Relatives and friends were seen as the most helpful sources of postnatal support. External sources (e.g. doctors and midwives) were considered less helpful. Midwives were reported as being judgmental:

'My midwife was really old, she called me a baby' (mother, age 20).

Doctors were reported as having no time:

'... have a 10-minute slot and they're like "hurry up"' (mother, age 19).

Society's view of young parents

All the young mothers believed society had a negative view of young parents and everyone reported receiving adverse treatment:

'They think you're just a dirty little slag basically' (mother, age 19).

All the young mothers reported not being affected by others' negative views, although a few claimed it had upset them in the past:

'I used to, but now I think you don't know what my life's

like, you don't know me so I don't worry. I don't care really what people think of me, but it annoys me … that people are kinda like stereotypical about us' (mother, age 19).

Future plans

A lack of education and money were reported as barriers to employment. The age limit of 19 for eligibility for the 'care-to-learn' scheme was discussed by several of the young mothers who were contemplating returning to education. They all considered this age limit to be wrong and inflexible, as people mature at different rates.

Discussion

The current study explored the understudied second target of the teenage pregnancy strategy to help young parents and their children avoid a life of social exclusion. Stigmatization and adverse treatment in society were reported by most of the participants, thus, highlighting the need for antenatal and postnatal support. The young parents unanimously displayed their desire to be good parents; support was highlighted as necessary for achieving this. Self-esteem, age and gender were all found to be influential factors on young parents' attendance at support services.

Self-esteem

Self-esteem was associated both with the response to adverse treatment from society and attendance at support services (as found in previous research (Speak, 1999)). However, it is not possible to determine whether high self-esteem encouraged them to attend or if support increased self-esteem (Brage et al, 2000). It is important to understand this association, as attendance at antenatal classes has a positive impact on pregnancy outcomes (Furey, 2004). In addition, low self-esteem in young parents may be acting as a barrier to attendance (Elmer, 2001). The inclusion of self-esteem training should be explored as a component of support offered to young parents.

Age

Age was viewed as a barrier to attendance in three ways: age of others in class; treatment by health professionals; and age-limits on service attendance. Young mothers reported feeling uncomfortable attending classes in which the other parents were older (also found in Speak, 1999). It was felt that the older mothers 'looked down on them'. This perception could arise from the socially constructed negative views of young parents prevalent in society or be a result of the young parents comparing themselves unfavourably to older parents (such as in terms of financial situation) and thus feeling insignificant (Runciman, 1966). Either way it has had an impact on young mothers' inclusion in society and their emotional wellbeing. The age of the other people in the group was not an important factor for the young fathers. Thus, the provision of effective support must take into consideration both age and gender (Wiggins et al, 2005).

Support was not sought from health professionals by young parents because of previous poor experiences. This dissatisfaction may explain their lack of attendance at available support (Ley, 1982). The association between satisfaction with health professionals' treatment and attendance was found by Redshaw et al's (2006) results from a survey of 4800 pregnant women aged over 16. A high level of adherence was found with 86% seeking health support at less than 12-weeks gestation. Of these women 95–98% reported that health professionals at their booking appointment treated them with 'respect and kindness' (Redshaw et al, 2006: 7) and communicated well with them. These findings suggest that specific training is needed with GPs and surgery staff to increase their communication skills with young parents. Doctors, for example, need to be aware of the issues that young parents have, and the organizations and practitioners to which young parents can be referred for specific support. A study conducted in 1999 found that midwives fear they cannot offer the individual care required by young mothers owing to the 'already stretched service' (Shakespeare, 2007: 11).

Finally, the age limit on many support services was highlighted and highly criticized for being too restrictive. The young parents suggested that they would like a break of between one and three years before continuing with employment, education or training, in order to spend time with their child. This break would mean for many

that they would then be too old to receive government support if they wanted to return to education afterwards. These findings concur with Harris et al (2005) who believe the government's teenage pregnancy strategy targets set for young mothers are unfair when compared to older first-time mothers—60% of whom are not in employment when their child is five years old. In addition, Harris et al (2005) argue that many factors influence a young mother's decision to return to education, employment or training, and these need to be addressed if levels of social exclusion are to be lowered (e.g. lack of sexual health knowledge as highlighted in this study). The SEU (2005) acknowledges that the years between the ages of 16 and 25 mark a complex transition to adulthood. Policy and services must account for the different rates at which this transition is achieved and extend the upper age limit past 19 years old. Timely access to antenatal support is vital if the adverse outcomes of a young pregnancy are to be alleviated or avoided (Department for Children, Schools and Families, 2008).

Gender

Different types of antenatal and postnatal support were reported as required by men and women. This could reflect differences in the social representations of parenting roles —parenting roles are imbued with different meanings and thus require different education and support. In addition, the young parents felt that men were excluded from support and saw the responsibility of caring (and thus attendance at support) as being the women's role. This reflects a social norm in which the main responsibility of childbearing is seen to reside with women and men having the duty of providing financial support (Warin, 1999). This needs to be considered in the design of support classes that are accessible to young fathers as recommended by the Department for Children, Schools and Families (2007).

Barriers to support and ways to improve attendance

In addition to a lack of men's involvement, restrictive age limits of support and negative treatment from health professionals, lack of knowledge was also reported as a barrier to attendance. The young parents were found to have poor knowledge regarding the support that is available. Antenatal and postnatal support needs to be more widely advertised although research has suggested that this is difficult because young parents are isolated and hard to reach (Burack, 2000; Speak, 1999). Nevertheless, it would appear that if health-care professionals work together to advertise support then young parents can be reached.

Limitations and future work

Using qualitative research methods such as focus groups concerns the validity of the information given by the participants. Participants may present themselves in a socially acceptable and desirable manner. It is socially acceptable that parents naturally bond with and care for their children. It could be suggested therefore that the young parents have not been totally truthful in their experience of adapting to parenthood and have omitted information about the difficulties and hardship that they have faced in becoming a parent. This may be particularly true for the postnatal focus group. In this group, the young mothers were all unknown to each other. This may have resulted in the young mothers presenting socially desirable images of themselves to the rest of the group.

The young parents in this study were from one area of London, an area that is ranked in the top 100 most affluent areas of the UK (out of 354) according to the index of multiple deprivation (Noble et al, 2004). Results from this study cannot be generalized to areas in London that are classified as more deprived, as research shows that young women from more affluent areas have a higher knowledge of support services than those in more deprived areas (Jewell et al, 2000).

In addition, women from poor and Black and minority ethnic groups (both highly concentrated in more deprived areas) have a low uptake of antenatal care (Rosenblatt, 1998) and support needs to be tailored to their cultural needs, for example, to meet the conflicting values and norms they face from society and their ethnic groups regarding acceptable sexual behaviour (Testa and Coleman, 2006). The findings from this current study suggest that similar research needs to be replicated in other local authorities so that health-care professionals can understand the needs of young parents in their area and design more efficient services to support them and their children. This will aid teenage pregnancy coordinators to reach their local targets for helping young mothers back into work or education.

Questionnaires were eliminated from the analysis because the young mothers did not live in the sampled PCT, although they were attending services in the sampled PCT. A similar phenomenon has been noted in other research. Goyder et al (2003), for example, stated that when areas offer good support for young parents, more young parents move into that area after their conception. More needs to be known about this process, not least because these young people could be at a greater risk for social exclusion. Moving between PCTs may result in young parents being missed by support services.

Difficulties in recruiting young fathers are reflected in the low numbers of young fathers in this sample. This study suggests that the needs of young fathers are not identical to young mothers. Further work is needed to explore their needs so that they can be better supported. This is an issue that needs work at a local and national level.

Conclusion

This study offers insight into the antenatal and postnatal experiences of a selection of young parents in one London PCT. Results support claims that targeted support is needed for young parents by age, gender and at a local level. In addition, findings indicate that young parents are not a homogenous group and support must be tailored to the needs and requirements of specific individuals based on age, gender and self-esteem. Targeted support will require making young parents central to the design and implementation of their care. This, in turn, should increase their satisfaction with the services offered by the NHS and their attendance in antenatal and postnatal care (Darzi, 2008). **BJM**

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Key Points

- **More UK research needs to focus on supporting young parents during and after their pregnancies.**
- **Four main barriers to young parent's attendance were highlighted: lack of men's involvement; poor relationships with health-care professionals; age restrictions on accessing services; and lack of knowledge about availability of services.**
- **The experiences and needs of young parents are influenced by age, gender and self-esteem.**
- **To provide efficient support services local authorities need to understand young parents' barriers to antenatal and postnatal attendance within their area.**
- **Need to involve young fathers in research and not just young mothers.**