Young Black Fathers and Maternity Services

Sue Pollock (University of Bristol), Richmond Trew (St Michael's Fellowship)
Kathy Jones (Fathers Direct)

1 Acknowledgements

This study was funded between 2003 and 2005 by the DH/DfES under a section 64 grant awarded to Fathers Direct. It was conducted as collaboration between Fathers Direct, St Michael's Fellowship (in partnership with Sure Start, Tulse Hill, London) and the University of Bristol. The Field Researcher, Richmond Trew, is a Fathers Worker employed at St Michael's Fellowship and supervised by Kathy Jones, Partnerships Manager at Fathers Direct. The Research Consultant is Sue Pollock, Lecturer in Social Work at the University of Bristol.

2 Summary

A sample of young prospective Black fathers, average age 21 years, was recruited from two antenatal clinics in one major teaching hospital as part of a larger project focused on developing services for young Black Fathers in one London Sure Start area. Information about their current circumstances, their relationships, the conception and their experiences of antenatal care and other support in pregnancy was collected during an interview with a father worker employed by Sure Start. The data suggest that, contrary to popular precepts, these young men were a settled group in generally stable relationships who, despite the fact that the pregnancy was unexpected, were committed to involvement in fatherhood and the future care of their child. However, the men's experiences of antenatal care at the hospital, together with the high degree of involvement of mother's family and friends, tended to reinforce a feeling of being marginal to the pregnancy. The central focus on the young mother by services in the antenatal period did little to reinforce and support men's emerging identity as fathers. There is a need to challenge some of the established ways of thinking and working with this marginalised group in antenatal services in order to promote the development of inclusive services, responsive to the needs of both young men and women at a crucial time in the formation of new families.

3 Introduction and Background

Young fathers are largely absent from public statistics. There are no population- based data on the age at which fatherhood starts, compared with the extensive statistics on motherhood and female fertility. This is, of course, partly because pregnancy and childbirth are observable events with medical and social consequences whereas male responsibility for pregnancy is not always easy to determine. However, the absence of males from the statistics goes deeper than that, to an assumption that pregnancy and childbirth is 'women's business', an assumption that was apparent in service providers' behaviour to the young men in our study.

Research on factors predisposing to young parenthood suggests that young fathers, like young mothers, are likely to come from backgrounds of social disadvantage (e.g. Jaffee et al 2001; Pawlby, Mills & Quinton, 1997; Biehal et al, 1995; Robinson & Frank, 1994; Dearden, et al 1992, 1994, 1995; Hanson et al., 1989; Michael & Tuma, 1985). In addition, young parenthood is popularly linked with increased risks of relationship breakdown (Allen & Bourke Dowling 1998) and social exclusion (Coley and Chase-Lansdale, 1998; Joseph Rowntree Foundation 1995) with the attendant poor outcomes for children (Lamb 2002, Palkovitz 2002, Cummings and O' Reilly 1997). However, other research suggests that stable, intimate partnerships can also effect a transition *out* of social exclusion for young people (Fergusson et al 2002; Pickles & Rutter, 1991; Quinton et al. 1993; Quinton & Rutter, 1988; Sampson & Laub, 1993, Stouthamer-Loeber & Wei, 1998) and the involvement of a committed and well informed father is likely to improve outcomes for children on a variety of measures (Cummings and O' Reilly 1997, Lamb 2002, Palkovitz 2002).

Policy initiatives such as the Teenage Pregnancy Strategy have tended to focus on the role of education, training and employment in promoting economic self-sufficiency and good citizenship for teenage mothers as a way of addressing the perceived risks of social exclusion. Where young fathers are mentioned they are not sufficiently conceptualised as part of the solution.

Consequently the place of the young couple as shared partners in the parenting task is not always acknowledged. Teenage parenthood has tended to be equated with single motherhood, and the effort to support young parents has tended until now to be focused to this end.

The transition to parenthood for both men and women is a *process* rather than an *event*, which begins at the point at which the pregnancy is confirmed and continues after the baby is born. For young people for whom the pregnancy has not been planned or anticipated there are substantial developmental tasks to be accomplished within a relatively brief time frame if they are to have a sense of being ready for the baby when it is born. The process involves the relinquishing of earlier adolescent lifestyles and identities, a re-negotiation of previously dependent relationships with parents in families of origin, a re-assessment of their relationship with each other and a new relationship with each other's parents as prospective grandparents. When these tasks are set against a likely background of earlier family disruption, poverty and poor educational achievement as well as current material disadvantage the need for focused support, based on a 'social model' of parenthood is clear.

Pregnancy is a window of opportunity, a rare time when there is a shared assumption of contact between mainstream professional services in the NHS and young prospective parents. There is also some evidence that pregnancy is a time of optimism when new prospective parents are particularly motivated and able to make use of help (Pollock and Quinton 2005; Cowan, 1996). Services that support young parents in the transition to parenthood are therefore crucial in both recognising and reinforcing the development of a 'parental identity' for young prospective mothers and fathers and in confirming the young man and woman's status as the *parental couple* with a shared responsibility for and investment in their child's future well-being. Antenatal services are critical in facilitating young parent's informed and effective participation in the tasks of parenthood through recognising and addressing anxieties, misperceptions and concerns and offering education specifically targeted at young parent's needs.

However, a range of evidence suggests that men tend not to see themselves as service users even when services are established in community settings specifically to address their needs or concerns (e.g. Lloyd 2000). Evidence from other research suggests that participation in mainstream maternity services is counter–cultural for many men and they are liable to feel awkward, ill at ease or excluded in feminised antenatal clinic settings (Quinton, Pollock and Golding, 2002).

Research on use of mainstream services by black service users suggests that there may be specific issues in the way that services are provided that create barriers to inclusion for non-white groups (Butt, Patel and Stuart 2005). Taken together it would not be unreasonable to assume that there may be specific issues relating to inclusion and equality of access for young Black men and mainstream maternity services.

Very little is known about young Black fathers and the gap tends to be filled with speculation and fantasy often based on unconscious prejudice about whether these young men will 'stay the course' or see themselves as a necessary part of the parenting equation. There is no research which focuses on those young Black men who have chosen to participate in mainstream maternity services and we therefore know very little about their experiences and their views about what they see as helpful and unhelpful. A clearer picture is needed as the basis for developing services for young men during the important transition to fatherhood.

4 Aims of the study

•To make contact with young Black fathers from one London Sure Start in Tulse Hill during the antenatal period
•To ascertain their current needs as a basis for developing services
•To refer fathers to existing services as appropriate
•To develop services for this group of young men (and their partners as appropriate) both inside the health service and in the community

5 Methods

This was a small pilot study in an under-researched area. It included elements of qualitative data collection via semi-structured interview, service delivery and service development.

The target group for inclusion in the study were young (age 17-25 years) prospective Black fathers from one Sure Start area.

I Phase 1

Our original design envisaged that fathers for the study would be recruited from mainstream antenatal ultrasound clinics at Kings College hospital. However after discussion with midwifery staff at the hospital it was decided that an additional recruitment site would be used in order to maximise the potential sample. The additional site was a specialist teenage parents' clinic located at some distance from the hospital. The two recruitment sites were very different from each other (see discussion below, section 13). In addition, a number of young fathers were recruited from other sources.

The researcher was a Black man who was himself an experienced father and a skilled father worker employed at St Michael's Fellowship. His participation was crucial in engaging a population of young men who have been described as 'hard to reach'. The researcher was asked to keep a diary of his experiences as a Black man in the antenatal clinic which provided and additional and illuminating source of data (see below, section 13).

Table 1: Recruitment Site

Mainstream Ultrasound Clinic	**3**
Teenage Parents' clinic	**12**
Other*	**8**
Total	**23**

*Other = Sure Start Referral, ACAPS (Brixton), St Michael's outreach, Players Klub

Recruitment took place over a 6-month period. RT (the research worker) attended the mainstream clinic every Tuesday afternoon and the specialist teenage parents' clinic every Tuesday morning. It had originally been envisaged that potentially suitable recruits would be identified as they arrived from the clinic notes by midwifery/reception staff. As it happened, this system was not workable in the mainstream clinic for a number of reasons, but operated more smoothly in the young parent's clinic with the assistance of the midwives on site.

It was originally planned that the recruiting of young fathers would commence in May 2004. However, this timetable was delayed by the process of ethical approval and fieldwork started in September 2004 and continued to March '05.

It was hoped that a minimum of 40 fathers would be recruited to the study, however the final sample size was smaller than this (23 fathers)

Information about prospective fathers' current circumstances, their needs and their experience of antenatal services was collected during a brief interview (approximately 30 minute) in the antenatal clinic using an interview schedule. Answers were recorded on pre-coded sheets and significant verbatim accounts were noted. At the end of the interview fathers were given a 'Dad bag', specially developed for the study, as a token of thanks for their participation[1]. None of the fathers who were approached refused to be interviewed, an outstanding success rate probably partly attributable to the gender and ethnicity of the researcher. Where an unmet need was identified,

[1] The Dad bag, which had an attractive father and baby logo, contained: a disposable camera (for use in labour); a T shirt with the father and baby logo; a baby shawl plus laminated instructions for swaddling; a disposable nappy also with laminated instructions for use; a disposable razor and shaving cream (in case the labour went on all night). An information booklet for young black fathers.

the young father was referred to existing services where possible and followed up if appropriate via St Michael's fellowship.

This information was collated as the basis for recommendations for development of services (see below, section 14). It is planned that recommendations in relation to service development will be disseminated to key personnel within teenage pregnancy and early years services, direct feedback to maternity staff in the hospital in which the study took place, conference presentations, Fathers Direct magazine and website and academic papers.

6 Description of Sample

Table 2: Age

Age/yrs	Man	Woman
16	0	3
17	1	4
18	2	7
19	8	5
20	4	0
21	1	0
22	0	1
23	0	0
24	2	1
25	2	1
26	0	0
27	2	0
28	1	0
> 28	0	1
Total	23	23

As is clear from the table, the majority of the men (65%) in the sample and their partners (83%) were aged 20 years and below. Three men over the age of 25 were recruited to the study as they had particularly relevant experience of the issues. The average age of the men was 21 years the women 18.5 years

Table 3: Time as couple

Not a couple	**0**
< 1 year	**2**
1-2 years	**6**
2-3 years	**6**
3-4 years	**3**
4-5 years	**2**
5+ years	**4**
Total	**23**

As table 3 suggests, the majority of the men were in stable relationships although were not engaged or married. Two thirds of the men had been in this relationship for more than 2 years. I couple were married and two couples were engaged. A further three couples were thinking of getting married when they were financially able. The majority (65%) were cohabiting either full or part time. Just over a third of the young men lived separately from their girlfriends, a factor that considerably raises the risk for future disengagement from the father role.

The majority of the men (16) were first time fathers. However, seven of the men already had children (3 had one child, two had two and three children respectively). Of these, only two were still living with their children and actively engaged in their lives on a day-to-day basis.

Table 4: Length of time living in the area

< 1 year	**3**

1-2 years	**4**
2-3 years	**3**
3-4 years	**1**
4-5 years	**1**
5+ years	**1**
All life	**10**
Total	**23**

All but one of the young men lived in South London Boroughs, either in or adjoining Lambeth. As table 4 shows, this was a strikingly settled population. Only three of the men had lived in the area for less than a year. The majority of the men were settled in the area and lived near family and friends. Getting on for a half of the sample (44%) had lived in the area all their lives.

Table 5: Ethnic Origin

	Man	**Woman**	**Total**
Black Caribbean	**15**	**8**	**23**
Black African	**3**	**3**	**6**
Black Other (incl. Black British)	**4**	**4**	**8**
Black Asian	**0**	**1**	**1**
Mixed heritage	**1**	**4**	**5**
White	**0**	**1**	**1**
N/K	**0**	**2**	**2**
Total	**23**	**23**	**46**

All the men and all but one of the women in the sample were black or mixed heritage. The majority of both the men and the women identified themselves as Black Caribbean.

Work

The majority of the men (14; 61%) were not currently working and less than a quarter (5 men) were working full time. Most of those that were working were in low paid skilled or unskilled manual jobs such as gardening or driving. Only a small group of the men (4) were in settled jobs where they had been employed for over a year. A small number (3) described themselves as not in the labour force because they were at college. Worries about money and affordable housing were frequently cited although not working meant that them men were more available for involvement in the pregnancy and the care of the baby. This area of London is one of high unemployment. For those in work over half had some flexibility within their working day that could accommodate antenatal appointments or classes. Only three described their working hours as very inflexible.

7 The Pregnancy

Table 6: No. Weeks pregnant at interview

0 – 12	**1**
13 – 20	**9**
21 – 30	**3**
31 – 40+	**7**
Index baby already born	**3**
Total	**23**

The sample was recruited at all stages of the pregnancy. Three of the babies had already been born at the time of the interview and for these men the questions about antenatal care and their feelings about impending fatherhood were asked retrospectively. These men had been recruited to the study from sources other than the antenatal clinics and their babies were less than 6 months old.

Table 7: Expectedness of the conception

Complete surprise	**11**
Half expected	**6**
Timing a surprise	**2**
Planned conception	**3**
N/K	**1**
Total	**23**

Nearly 50% of the conceptions were described by the men as a complete surprise and only 3 of the pregnancies were actually planned. However, none of these pregnancies had been consistently planned *against.* The reality of the pregnancy seemed to have been difficult to envisage in the abstract and the confirmation of the pregnancy was the time when the reality of becoming a father became more concrete for those who had not previously had children, although this was variable (see below, Table 8). While attendance at the antenatal clinic was an acknowledgement of their involvement in the current pregnancy, few of these men had much time to adjust to the *actuality* of parenthood before the baby was born. The antenatal period was therefore a critical time in which the new expectations of fatherhood needed to be articulated and supported by services in contact with the young couple.

Thirty percent (7) of the prospective fathers had had previous children and while most still had some contact with their children only two were still living with their children and their children's mothers and engaged as actively involved fathers. Four of these men had had previous experiences of antenatal care but only one of these had found it to be a helpful experience. Another, a father of three, had been at his children's births and was actively involved with their care, but at previous antenatal appointments had felt uncomfortable being the only man and had stopped attending. For the other five men there was a sense of some distance from their previous fathering

role (see below Table 8). Earlier conceptions had occurred in the context of unsettled partnerships when they were very young. Not attending the antenatal clinic seemed to be an early marker for this disengagement. All spoke of the hope that their current experience would be different.

8 Self image/identity

Table 8: Ability of the men to acknowledge the "reality" of fatherhood during this pregnancy

	Men with no previous children	Men with previous children	Total
Low reality	**3**	**4**	**7**
Medium reality	**8**	**0**	**8**
Very real	**5**	**3**	**8**
Total	**16**	**7**	**23**

The men in the study were evenly split between describing their sense of impending fatherhood as having a low, medium and high reality, a proxy measure for their developing identification with the paternal role. The three men whose babies had already been born were themselves evenly divided between the three categories, suggesting that their recall of the feelings during the pregnancy was likely to be accurate.

Men in the 'low' reality group described a sense that the baby would not seem real until it was born, they could not feel connected to the growing child until they could touch and hold it. Thoughts about the baby were not elaborated in the interview. Men in the 'medium' group described a sense that the baby sometimes seemed real, but at other times they would forget about it. Concrete reminders, like their girlfriend's change in shape or being present at the scan were needed to reinforce the reality:

'*Sometimes it seems real; sometimes I kind of forget it's there. The scan made some difference' (man age 20, girlfriend 38 weeks pregnant)*.

Men in the 'high' reality group described more developed ideas about what was happening and an emotional connection with their unborn child:

'*I didn't tell my grandmother (*about the pregnancy*) for some time. Over Christmas I couldn't hold it in any longer. Before this I just had casual sex. This will mean big changes – it's like a time bomb waiting to go off. Six months ago I wouldn't have taken it on board, but you can't turn your back on it because you're turning your back on another life. It doesn't matter how big or bad you are, just wait until the pregnancy hits you' (man age 20, girlfriend 37 weeks pregnant)*

Unsurprisingly, three of the men who were already fathers felt that the impending birth and the consequent responsibilities was very real for them. What was striking, however, was the fact that four of the men who *already had children* described fatherhood as having an unreal quality. For those men who were struggling with the idea of becoming a father (low/medium reality, 65% of the men interviewed) their attendance at antenatal appointments and reception at the clinic, including the scan clinic, as someone concerned in the pregnancy was likely to be crucial in reinforcing their inclusion and involvement and challenging their sense of disengagement.

Table 9: Anticipated adjustments to lifestyle

None intended	**0**
Few/minor	**5**
Moderate	**10**
Many/big	**8**
Total	**23**

Although many of the men interviewed were finding it hard to connect emotionally with the developing pregnancy, the majority were able to acknowledge that having a baby meant changes in lifestyle. Three quarters were expecting the changes to have a noticeable impact on their way of life and over a third were anticipating having to make major changes in their day to day routines, indicating a serious willingness to adjust to the new demands of fatherhood.

9 Information seeking/Support

Table 10: Motivation to learn about pregnancy

Low	**4**
Moderate	**11**
High	**7**
N/K	**1**
Total	**23**

Table 11: Sources of information

Partner	**6**
Brother/sister/ Other 'peer' relative	**5**
Own/girl friend's parents/aunts/ Grandparents	**11**
Friends	**5**
Magazines/ Leaflets / Books	**8**
TV	**2**

Medical professional	**6**
None	**1**

The majority of the men were motivated to learn more about pregnancy and fatherhood and most felt that they had some sources of information to call upon. Sources of information varied, with partner, family and friends seen as important. Older relatives were particularly valued especially if they were seen as having had relevant previous professional or life experience (e.g. *'my auntie who's a nurse'; 'my mum, she used to be a midwife'*). One man made the point that it was easier to talk to men who were similar to themselves, who would understand things from their point of view: '*I would talk to my mentor – someone I went to school with. He's the only person I can talk to about anything like this' (man age 19)*. This illustrates an important point about the personal nature of asking for information which might expose ignorance or an embarrassing need for reassurance. Very few men were confident enough to ask questions of health professionals in clinics and several used the interview (itself conducted by a man) as an opportunity to ask questions and seek clarification about matters of concern. Written information, in the form of accessible leaflets or articles in accessible magazines were also valued.

Table 12: Sources of support and advice

Source of support	No.
Partner	**5**
Mother	**10**
Father	**1**
Nan	**1**
Sibling	**2**
Man's family	**3**
Girlfriend's mother	**4**
Health professional	**3**

Friend	**2**
Older person with children	**1**

As noted above, the majority of the men interviewed were not employed and many described considerable anxieties about money, housing and work that had become more acute since the confirmation of the pregnancy. Some were also worried about their own or their unborn baby's health (e.g. a worry about the possibility of sickle cell disease or other hereditary problems) or their physical relationship with their partner. As has already been described the majority of the men were settled in the area and many had family living nearby. When asked who they would talk to about these problems it is not surprising that most felt that they would talk to someone in their family, particularly their mother, about what was worrying them, although this choice of confidante could also be a mixed blessing:

'People won't leave you alone…always telling me to do things and trying to force me into it'. (Man age 27)

Girlfriend's mothers were also an important source of support for some and five men mentioned their girlfriends as someone to confide in, although some things could not be broached:

'My child's mum and my dad give me most support. My partner wants to carry on with her career. We had money problems and problems about where we're going to live and jobs…. ……I can't talk to her about her smoking, but I'd like to' (Man age 19)

Only three of the men had thought about medical professionals (doctors or midwives) as a potential source of support or advice and some would have liked to have talked to a health professional but felt uncertain and awkward about it:

I get support from my partner and my mum (about worries about work and money*)…I'd like to talk to a midwife but I don't feel I can…I'd like to talk to her about the pregnancy but I feel uncomfortable because I don't know the technical terms…. (Man age 18)*

What is interesting is that none of the men mentioned other sources of professional help about their employment, financial and housing problems, although there was clearly a pressing need for well-informed advice and support as the birth of the baby became imminent. Several used the contact with the research worker as a chance to seek referral for help. It would appear that attendance at antenatal clinics provides a window of opportunity for contact with father friendly services that could be usefully exploited, either through direct contact with a father worker or through sensitive referral via the midwife. Posters and leaflets made available in the waiting areas of antenatal clinics or other material publicising the existence of father-focussed support endorsed by the clinic could also be valuable in promoting local services for men.

While the men were clearly able to see family and friends as a source of support and advice, the involvement of others in clinic visits and labour, however well meaning was a more contentious issue. Just over a third of the men attended the clinic with only their partner and this was generally held to be the right way to go about things. The other two thirds of the men described the occasional or regular involvement of others in antenatal clinic visits.

Table 13: Others involved in antenatal clinic visits

	His side	**Her side**
Mother/Auntie	**1**	**9**
Sibling	**1**	**4**
Cousin/Friend	**2**	**6**
Total	**4**	**19**

Although others' interest and concern could sometimes be seen as supportive their involvement was more often described as a source of friction, causing the young man to feel marginalised and discounted. This was particularly so when the others were female and closely connected to their partner. Girlfriend's family and friends were almost five times more likely to be involved in clinic visits as the men's family and friends (see table 13). There was a general feeling that women were the source of authority in this department, a feeling reinforced by the feminised clinic environment. Many men felt that the clinic visits should just be about their partners and themselves, a chance to feel that they had a legitimate place and to reinforce their prospective parental relationship:

Interviewer: What do you feel about them coming?

'I feel pissed off that they're involved in clinic visits. It should be the dad alone…It can be good but it sometimes causes conflicts' (Man age 19):

*'I feel worried, I don't like it….it makes me feel pushed out. I don't know what their (*her family's*) reaction would be if I said not to come…' (Man age 20)*

' Her cousin and sister…I feel pissed about it' (Man age 20)

'Her friend and my sister come to the appointments…. it makes me feel pushed out' (Man age 18)

'I don't feel pushed out by her family but I think they should leave it to us' (Man age 24)

As with antenatal clinic visits, the majority of men (78%) were expecting someone else in the family to be there at the birth, only three of the men were certain that it would be just their girlfriend and themselves. Some men saw

this as an expression of support but for many this felt like an intrusion into one of the most important transitional events in their lives.

Table 14: Others expected at the birth

	His family/friends	**Her family/friends**
Mother/father/ Auntie/ Grandmother	**6**	**20**
Sibling	**0**	**4**
Friend	**0**	**1**
Total	**6**	**25**

The same picture of the girlfriend's family being over-represented emerged, as was the case for the antenatal clinic visits with over 80% of those people expected being the woman's family or friends. Some men felt strongly about this, others seemed resigned to the inevitability of the plans, outnumbered and wary of asserting their views:

*'Apparently her mother wants to be there, but it **should** just be mum and dad's time '(Man (age 20)*

'Her mum and dad want to be there. I don't mind but it should just be me and her' (Man age 19)

'Her mum and dad…I'm not comfortable with that – it should just be us' (man age 18)

'Her whole family is going to be there, I wasn't too happy about that' (Man age 19)

It was as if the men did not feel in a strong enough position to negotiate their own space, a position reinforced by the 'mother centred' philosophy of the

midwifery service. There was a danger of the men being relegated to the status of onlooker, reinforcing a feeling of uncertainty about their role in labour described below.

10 Antenatal Classes

The majority of men (two thirds) had not attended antenatal classes. The main reason given for this was that they did not know about them or it was too early in the pregnancy for them to be offered. Others who had heard about them described a feeling of apprehension at the prospect:

'She'd like me to come. I wasn't sure. The thought of all these women with hormones looking at me…'(Man age 20)

Three of the men felt that classes were not necessary because of their previous experience as fathers. Five men had attended at least one class and had mixed feelings about the experience, either because of their age or their gender. For those that could manage their feelings of awkwardness there was a general feeling that this was a useful experience, and gratitude towards staff who had gone out of their way to include them:

'She (his girlfriend) *did say to come but it was boring. The only good thing was the information. It could be better, how they come across and give information'* (Man age 19)

'The health worker came round. She was glad I wanted to be there. It was her that told us about the classes' (Man age 24)

*'I did go, but I felt awkward because I was one of the youngest people there. I saw a video of the birth' (*Man age 18)

'I'll go with her (girlfriend). *She asked me to come. It was different, awkward for me. It was all women and I felt left out, on the side. I am going next week; I'll take in what's showing. You realise how much pain women go through in labour'* (Man age 19)

'It was good to take in what was showing. You realise how much pain a woman goes through in labour. I'm going next week' (Man (age 21)

Clearly attendance at antenatal classes could be experienced as helpful and could assist men's understanding and feelings of inclusion in the birth process. The main difficulty seemed to be firstly in promoting knowledge of the existence of the classes and secondly overcoming men's reluctance to attend. Developing strategies to make it clear that the classes were father and young person friendly as part of a wider strategy for including fathers could be effective. It might also be important to consider the content and delivery of the courses in terms of their relevance to this group of young men by, for example, inviting young men who had already become fathers to participate in the planning and delivery of the classes.

10 Men's Role During Labour

The majority of the men wanted to be present at the labour but very few felt prepared for what to expect, even if they had attended an antenatal class. Many were unsure about their role, other than to hold their girlfriend's hand, comfort her, tell her to stay calm and hope for the best. Several said they would wait to do what they were told. One man, referring to an earlier experience of labour said:

'In that labour I thought I'd be holding her hand or holding up her leg…but the reality was very different' (Man age 18)

Only one man in the sample, an experienced father with three other children, talked in a more pro-active way about his role:

'My role is comforting her anyway I can…taking all the abuse…be her voice, communicate for her. No-one has discussed this with me except my partner. Neither of us want anyone else there – it's mother and father time' (Man age 25)

The majority of the men (14) said that no-one had talked to them about labour or what to expect and another 5 said that they had received rather general information, not specifically relating to their own case. This was as true for those nearing the end of the pregnancy as those for whom their girlfriend's pregnancy was less advanced. The most common source of information was their girlfriend or other fathers. One man mentioned that his main source of information was what he had seen on the TV.

Only two men mentioned receiving specific advice or information from a professional, and one of these sources was an advisor in the hostel in which the man was living rather than hospital staff. Only one man spoke of having received specific advice from a midwife and this was because his girlfriend wanted a water birth. It seemed as if there was a general consensus that you had to learn by experience, rather than feel encouraged to participate in planning and participating in the birth as an actively involved partner. One man talked of being surprised that he had not been given a copy of the birth plan. Others seemed not to know of the existence of such a plan.

11 Feelings of exclusion /inclusion during the ante natal period

Table 15: Exclusion during the antenatal period

Not Thought of	**4**
No Exclusion	**7**
Some Exclusion	**9**
Strong Exclusion	**3**
Total	**23**

Table 16: Sources of Exclusion

Not thought of	**4**
None	**7**
Partner	**0**
Her Family	**2**
Services	**6**
N/K	**4**

When we asked the men whether they had a sense of having been excluded or sidelined at any stage in the pregnancy, four of them had not considered the matter and 7 considered that they had been well enough involved. However, over half of them (12) were clear that this was or had been the case. Despite the strong feelings expressed by the men about their girlfriend's friends and family involvement in antenatal clinic visits and the labour, the main source of feelings of exclusion was the health professionals with whom the men had come into contact in the antenatal period:

'They talk to her because she's the mother. She (girlfriend) tells me everything' (Man age 19)

'The midwife came the other day and spoke with my girlfriend alone. She spoke 98% to her. I had to 'earwig' towards the end' (Man age 20)

'At the scan I wanted to know more but when I was asking the questions the woman didn't really explain. She was talking to T (girlfriend) and giving me one word answers' (Man age 19)

'When they call the mother for the appointment they seem surprised when the man comes as well. When I come into the room I can feel the vibes, the awkwardness' (Man age 25)

'One midwife said 'Is it alright to carry on with him sitting there?'' (Man age 18)

'I do feel excluded. Even that little book about the birth plan…I should have one. I feel excluded, sidelined the majority of the time. No one has tried to include me in the experience…but I will ask questions if I want to know something' (Man age 25, 3 other children)

In the men's descriptions of their contact with staff, it did not take much to reinforce a feeling of either exclusion or inclusion. There was a sense of their being acutely aware of their reception:

'He (boyfriend) had to leave early for an appointment and was saying goodbye, but the woman didn't reply. When the male Dr returned he said 'Where's your boyfriend?'' (Woman age 17)

'I felt excluded, sidelined by the Dr's and nurses before the baby was born. But one Health Visitor after the birth talked to us both and to me 'Do you understand?' on one or two visits which made me feel really included' (Man age 19, baby already born)

Midwives themselves had views of the situation which seemed to contrast with the men's accounts:

'If an expectant young mum is accompanied by the young father he's usually well involved and more often than not seems to be the one answering the questions on behalf of the mother. It's either this or they don't show at all, there seems to be no middle ground' (Hospital midwife)

Table 17: Inclusion during the antenatal period

Not Thought of	**5**
No Inclusion	**5**
Some Inclusion	**3**
Moderate Inclusion	**6**

Strong Inclusion	**3**
N/K	**1**
Total	**23**

Table 18: Sources of Inclusion

Not considered it/ None	**10**
Man's family/ Man himself	**3**
Girlfriend	**7**
Man's friend	**1**
Her Family/Friend	**1**
Services	**2**
N/K	**1**

When we asked the men whether there was anyone who had specifically *included* them or encouraged their involvement in the antenatal process 5 men had not considered the matter and 5 had not felt specifically drawn into things. However over half the men had felt that people had gone out of their way to help them feel a part of things. The most commonly mentioned inclusive person was the man's own girlfriend:

'My girlfriend includes me, tells me what's happening and how she feels' (Man age 18)

'I'm here to help and support and be mindful of how she's feeling. My partner includes me, always tells me what's happening' (Man age 27)

'She likes me there at everything' (Man age 23)

‘My partner and her sister say ‘You have to be involved’’ (Man age 20)

Her friend and my girlfriend. They always talk to me about it (Man age19)

Another man told us of being helped to be pro-active in his participation:

‘I include myself…and my friends…they’d ring me and ask what’s going on and ask questions. If I don’t know they say ‘Go and find out!’’ (Man age 22)

These comments reflect something of the generally positive nature of the relationships of the men with their girlfriends during the pregnancy, the men’s optimism and the couple’s willingness to share the tasks of becoming parents together. Sadly, it seems as if the hospital staff did not generally share this perception of the couple as jointly involved in the process with whom the young men came into contact. Only two men mentioned health professionals as having brought them into the process, although when this did happen it was very powerful:

‘When we were spoken to by the midwife she gave both of us eye contact. It made me feel very included’ (Man age 19)
And see comments about Health Visitor above

It does seem that there is a lost opportunity in the antenatal setting for building on the generally positive and optimistic feelings that these young men were expressing about their impending fatherhood.

12 Men’s views about what would have made their experience at the hospital better

Towards the end of the interview we asked the men to tell us their views about what might have improved their experience of their contact with the hospital in the antenatal period. The men’s answers focused on three themes: Comments about their reception by the staff in the clinics; thoughts about services specifically targeted at fathers; thoughts about the physical setting or routines.

i Reception by staff in the clinics: As has been discussed above, the majority of men felt uneasy in the feminised, medicalised clinic setting and often ended up fearing that they did not belong, particularly if others who accompanied them to the clinic visits were more at ease. The feeling that they were being disapproved of because of their age was common and simple things like more direct acknowledgement of their presence from hospital staff *'staff speaking to you on a level'* or *'little things like a simple hello or a smile'* were very important. Where this had happened, the men would mention it as having been remarkable. While all of the men recognised the importance of the attention given to their girlfriends many spoke of wishing to be included, for their role as the prospective father to be officially sanctioned. As one man put it: '*people telling me what I'm entitled to and what's going on, planning for both of use, not just one'*. Having more time with the staff would help.

ii Services targeted at fathers: Many of the fathers commented on their surprise and appreciation at being approached in the clinic by the researcher, a man like themselves:

'I'd like to talk to someone like yourself to show us what to expect'

'Contact with father worker worked well for me, I could talk to him all day'

' More interviews to understand young people's minds better'

As discussed above, none of the men who were approached by the researcher refused to be interviewed and many took the opportunity to ask questions that they hadn't felt able to broach with the hospital staff. Given the worries about money, housing and work that were uppermost in many young father's minds there would seem to be a clear place in the clinic for specific sources of help and advice from someone who was seen to be approachable and knowledgeable. Other men suggested that antenatal sessions specifically aimed at the father and baby would be welcome alongside the mother and baby sessions. Leaflets about pregnancy and childbirth aimed

specifically at prospective fathers would be well received by many of the men, as would the offer of more accessible information points and contact numbers in the clinic.

iii Physical setting and routines: Rather fewer of the men spoke of the physical setting of the clinics; this seemed to be less important than the way they were received by staff. However the smaller, teen parents clinic was appreciated for being homely and comfortable and less intimidating than had been expected making the setting seem more accessible. One young man would have liked there to be a TV, but others did not share this view. Another young man mentioned that he would value a place to stay with his girlfriend when she was in hospital.

What these suggestions seem to underline is firstly that these young prospective fathers are not asking for there to be big changes in the way antenatal clinics are run. Their suggestions do not carry huge workload implications for busy staff. What seems to underlie their proposals is the wish for a different mind set on the part of those with whom they have contact when they come to the clinic, one that sees the prospective father as an important part of the parenting equation, particularly when fathers are in danger of being marginalised by their girlfriend's family. For these men, attendance at the antenatal clinic was a clear statement of their interest in the pregnancy and their motivation to play an active part in the pregnancy – an important part of the process of developing a new role and identity. Poor experiences in the clinic carried the risk that the window of opportunity for engaging with them was closed. Secondly, there was a clear need for advice and information specifically focussed on the issues of work, housing and money. This is not a midwife's role and needs good liaison with local sources of help specifically focussed on young men's issues.

13 Discussion.

This group of (mainly) young men were on the whole a settled population in stable relationships with their girlfriends and well supported by friends and family in the locality. They were also a group of men who were expressing

their commitment and interest in fatherhood and had gone some way towards taking on the role of father by attending the antenatal clinic. While this was a small sample, and the research cannot tell us how typical these men were of young prospective Black fathers in general, it goes some way towards challenging some of more stereotypical views of teenage prospective fathers and their girlfriends as wanting to avoid commitment and responsibility which have become familiar in the press and in policy statements.

The fact that the majority of these pregnancies were unexpected means that these young people were having to make the developmental, emotional and material transition to parenthood in a very short time period. The data suggest that while the men were beginning to want to engage with the practical issues raised by the transition many were having some difficulty with internalising the new identity of 'father'. They described a general feeling of being poorly informed about the pregnancy and under prepared for the birth.

It was not unusual for men to describe the experience of being marginalised by mother's family and friends at clinic appointments and in labour and the men's reception at the antenatal clinics often did little to reinforce their involvement in the process. The observations made by the researcher (a Black man) throws some light on the men's experience in the different settings. The researcher attended the mainstream antenatal clinic every Tuesday afternoon for 6 months. The clinic was very busy, with a high turnover of patients. There was a feeling of anonymity; it was easy to get lost there. Very few Black men attended the clinic (hence the low number of recruits from this setting); patients were preponderantly white women with their partners. Despite the very positive endorsement of the research by key management, reception staff seemed unaware of the study and this might explain why they did little to welcome the researcher. Some reception staff even appeared suspicious about the researcher's presence in the clinic, despite an official letter confirming his identity and role. There was a high turnover of staff on the desk and it was difficult to make a relationship with any one person over time, contributing to the researcher's feeling of being unimportant and unnoticed. Laminated posters publicising the project and the

presence of the father worker in the clinic were removed from the walls and information leaflets about the project disappeared from the desk. The room allocated for the interviews was withdrawn without notice. The impact on the researcher was to make him feel not wanted or needed and it was hard for him to maintain his commitment to returning on a regular basis to what started to feel like a hostile environment. This raises worrying questions regarding issues of unconscious prejudice in this setting about men in general and Black men in particular, which could undermine genuine attempts at inclusive practice demonstrated by some midwifery staff.

The researcher's reception at the specialist teen parent's clinic was somewhat different. This clinic was based in a community setting and was staffed entirely by midwives who acted as the first contact on the reception desk. This was a stable staff group, committed to working with young people and the researcher found it easy to develop a relationship with individuals over time. The staff went out of their way to help the researcher recruit young men for the study. While the clinic setting was less polished than the main hospital it was considerably smaller and less busy and the atmosphere was personal and welcoming. There was always somewhere private to talk. There were many more Black patients and the researcher began to recognise the same young people over time. There was a sense that this clinic setting would be more receptive to the small changes in practice suggested by the young men in this study, with important potential knock-on effects for both individuals and the community. In a relatively small, settled community, word of mouth recommendations about accessibility (or otherwise) of services can be very influential in encouraging participation in clinic visits by those who would otherwise be wary of such involvement.

While none of the men in this study mentioned their ethnicity as a barrier to services it is important not to assume that being Black, together with being young, male and (on the whole) poor was not important, a quadruple indemnity. There are few places where young, unemployed Black men feel welcomed. As potential fathers they are unlikely to be viewed by many as providers or producers. If, as is highly likely, these young men have met with

racism or other discrimination, at any stage in their lives, feelings of exclusion in any setting are likely to be amplified – the feeling of always being put to the back of the queue. Young people who have already been stigmatised are likely to be very sensitive to subtle slights including such things as negative body language and lack of eye contact. Antenatal clinics are feminised, medicalised, environments and yet it is in this setting that impending parenthood is confirmed and legitimised. It is often the 20-week ultrasound scan that has a powerful impact on making the pregnancy and the impending fatherhood real. It is clear from the interviews with the young men in this study that it does not take much for them to feel that they are not part of the equation. A welcoming reception, and inclusive father-friendly practice in specialist clinics can be very important in establishing inclusion and helping to prepare young men for active and well informed fatherhood as part of the parenting couple.

14 Supporting young fathers: Thinking points for Maternity Services

- It is important to remember that young men who attend antenatal clinics are likely to be making an implicit statement about a desire for inclusion in the pregnancy and a willingness to go down the road of active and involved fatherhood. How they are received in the clinic is likely to have a much bigger impact on their view of themselves as actively involved fathers than may be immediately obvious.
- Young Black men's expectations may be so reduced because of past experiences in the educational and employment systems that they may not expect to be involved or do not know what they need to know.
- It is important for leaders within the NHS to operate systemically to educate their teams about the value of engaged fatherhood. Father friendly (and male sensitive) attitudes must pervade the whole system, from cleaners to consultants.
- Reception staff act as gatekeepers to services and can be influential in supporting or undermining the process of inclusion. Recording the name of the prospective father, acknowledging them by name, making eye contact and addressing both parents can have a big impact. Reception

staff, along with their medical colleagues, may need specific training in raising awareness of how they go about routine contacts.

- Employing a dedicated father worker based on site can help directly, by making regular contact with young Black prospective fathers and working alongside midwives in planning and running antenatal classes, and indirectly, through helping to develop a strategic approach to working with men in the antenatal team. However, father's workers need to be fully authorised and supported to do this work through strong leadership within maternity services so that the responsibility for engaging with fathers is shared.
- The clinic environment can give a powerful message about whether men are expected to be there. What is on display on the walls? What information is easily accessible and with who in mind?
- Services such as antenatal classes for teenage parents with specific sessions for young fathers are likely to be successful if the content and presentation are well thought through and if sessions are timed in response to work and learning commitments and located in accessible settings.
- Special materials for young fathers, such as 'dad bags' full of things for the father and their baby are a very successful way of acknowledging their value as fathers, giving them vital information and establishing on-going links with early years support services.

15 Future research priorities

Key future research priorities include:

- The extension of this work to include representative samples of ethnic minority young parents.
- Further studies on the young fathers who do not appear in this study. That is, those who withdraw from involvement and contact when the pregnancy is discovered (or before).
- Studies of very high-risk samples, especially of looked-after young people, to study the impacts of early parenting in these situations and also to see whether early parenting has the impact on the transition out

of early adversity and social disaffection known to be important for adult intimate relationships.

- Development and testing of young-parent focused and responsive services that link health, housing and social services.
- Incorporation of data on young fathers in new large scale epidemiologically-based and cohort studies.

References

Allen, I., & Bourke Dowling, S., (1998) *Teenage Mothers: Decisions and Outcomes*. Policy Studies Institute, London

Biehal, N., Clayden, J., Stein, M. & Wade, J. (1995*) Moving On: Young People and Leaving Care Schemes*. London: HMSO

Butt, J., Patel, B., and Stuart, O., (2005) Race Equality Discussion Papers. London, Social Care Institute for Excellence

Coley, R.L., and Chase-Lansdale, P., (1998) Adolescent Pregnancy and Parenthood. *American Psychologist,* **53** 152 – 166

Cowan, C.P. (1996) Becoming Parents, What has to Change for Couples? In Clulow, C. (ed) *Partners Becoming Parents. Talks from the Tavistock Marital Studies Institute*, Sheldon Press, London

Cummings E. M. and O' Reilly A.W. (1997) 'Fathers in family context: Effects of marital quality on child adjustment', in Lamb, M.E. (Ed*.) The role of the father in child development,* 3rd ed., New York: Wiley

Dearden, K., Hale, C., Alvarez, J (1992) The educational antecedents of teen fatherhood*. British Journal of Educational Psychology*. 62 pp.139-47

Dearden, K. & Hale, C. (1994) Family structure, function and the early transition to fatherhood in Great Britain. *Journal of Marriage and the Family*, 56, pp. 844-852

Dearden, K., Hale, C., Woolley, T. (1995) The antecedents of teen fatherhood - a retrospective case-control study of Great Britain youth. *American Journal of Public Health,* 85, (4) pp.551-4

Fergusson, David M., Horwood, L John., Woodward, Lianne J. (2002) Deviant partner involvement and offending risk in early adulthood. *Journal of Child Psychology and Psychiatry and Allied Disciplines 43* (2) pp.177-190
Hanson et al., 1989,

Jaffee, S R., Caspi, A., Moffitt, T E., Taylor, A., Dickson, N. (2001) Predicting early fatherhood and whether young fathers live with their children: prospective findings and policy reconsiderations. *Journal of Child Psychology and Psychiatry and Allied Disciplines.* 42 (6) pp.803-15

Joseph Rowntree Foundation (1995) *Social Backgrounds and Post-Birth Experiences of Young Parents.* Social Policy Research 80, Joseph Rowntree Foundation, York

Lamb M. E. (2002) 'Infant–father attachments and their impacts on child development', in Tamis-LeMonda, C.S. & Cabrera, N. (Eds.) *Handbook of father involvement,* (pp. 93–118) Mahwah, NJ: Lawrence Erlbaum Associates.

Lloyd, T., (2000) Don't ignore it and it will go away. *Nursing Times* 96 (13) pp.46-7

Michael, R.T. & Tuma, N.B. (1985) Entry into marriage and parenthood by young men and women: the influence of family background. *Demography*, 22, pp. 315-544
Pawlby, Mills & Quinton, 1997

Palkovitz R. (2002) 'Involved fathering and child development: Advancing our understanding of good fathering', in Tamis-LeMonda, C.S. and Cabrera, N. (Eds.) *Handbook of father involvement,* (pp. 33–64) Mahwah, NJ: Lawrence Erlbaum Associates

Pickles, A. & Rutter, M.(1991) Statistical and conceptual models of 'turning points' in developmental processes. In D. Magnusson, L.R. Bergman, Rudinger, G & Torestadd (eds*.) Problems and Methods in Longitudinal*

Research: Stability and Change. Pp.133-65 Cambridge: Cambridge University Press.

Pollock, S, Quinton, D. (2005) 'Young Men: paths to inclusion in fatherhood', *Sociological Review* (submitted).

Quinton, D., Pickles, A., Maughan, B. & Rutter, M. (1993) Partners, Peers, and Pathways: Assortative pairing and continuities in conduct disorder. *Development & Psychopathology,* 5, pp.763-783

Quinton, D; Pollock, S; Golding, J (2002) The Transition to Fatherhood in Young Men, in Youth Citizenship and Social Change, Research Briefing no.8, Pub. Youth, Citizenship and Social Change Programme, Sheffield (http://www.tsa.uk.com/YSC/RB/TSA_RB_08.pdf)

Quinton, D. & Rutter, M. (1988) *Parenting Breakdown: the making and breaking of intergenerational links.* Aldershot: Avebury Robinson & Frank, 1994,

Sampson, R. & Laub, J. (1993) *Crime in the Making*. Cambridge MA: Harvard University Press.

Social Exclusion Unit (1999) *Teenage Pregnancy.* Social Exclusion Unit, London

Stouthamer-Loeber, M., Wei, E.H. (1998) The precursors of young fatherhood and its effect on delinquency of teenage males. *Journal of Adolescent Health*, 22 (1) pp.56-65

Webster, C., Simpson, D., MacDonald, R., Abbas, A., Cieslik, M., Shildrick, T., and Simpson, S., (2004) *Poor Transitions: Social exclusion and young adults*. Bristol: The Policy Press

Address for queries or correspondence:
Sue Pollock
School for Policy Studies
University of Bristol
Bristol BS8 1TZ
Tel: 0117 954 6733
email: sue.pollock@bristol.ac.uk

Report submitted September 2005