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Review Article

Parental confidence in newborn care: a scoping review

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Abstract

Introduction
When a child is born, parents must provide care essential to the newborn's development. This responsibility is integral to the transition to parenthood, which begins during pregnancy and becomes tangible with the newborn's arrival. Identifying barriers to and facilitators of parental confidence in newborn care may help assess couples' needs and plan interventions centered on the mother–father–newborn triad, thereby supporting a healthy transition and a positive experience of parenthood. We therefore conducted a scoping review to identify the available evidence and related knowledge gaps.

Objective
To map the evidence on barriers to and facilitators of parental confidence in newborn care.

Methods
The review followed the Joanna Briggs Institute (JBI) methodology for scoping reviews. We searched MEDLINE Ultimate, CINAHL Ultimate, MedicLatina, the Cochrane Database of Systematic Reviews, Web of Science, and PubMed. Eligible studies addressed barriers to and facilitators of parental confidence in newborn care among parents of healthy newborns in any care setting. We considered studies published in Spanish, French, English, or Portuguese from January 2018 through September 2025. Two reviewers assessed the studies for eligibility.

Results
Sixteen studies were included. The findings were organized into five categories: technological facilitators; social, physiological, and educational barriers and facilitators; and professional and gender-related barriers and facilitators. Key facilitators included online programs, in-person and online support groups, continuity of care from the prenatal to the postnatal period, skin-to-skin contact, and rooming-in. Major barriers included limited attention to the postnatal period, insufficient postnatal support and education, conflicting advice from family members, primiparity, and limited parental leave.

Conclusion
The findings highlight the importance of strengthening postnatal care, fostering reliable, informed support networks, and including fathers in newborn care.

Keywords
Father; Mother; Parental Confidence; Parenthood; Newborn Care.

Introduction

Parenthood is considered a period of change and instability for couples and involves assuming and transitioning into new roles. The International Council of Nurses (ICN)[1] defines parenthood as fulfilling the responsibility of being a mother or father. During the first months of life, newborns are entirely dependent on their parents. Maintaining and promoting newborn health requires the informed and motivated involvement of both mothers and fathers.[2] During the postnatal period, mothers and fathers undergo major changes as they transition to parenthood and adapt to a new way of life.[3] This transition encompasses attitudes that influence adaptation to pregnancy and preparation for the role of mother or father.[1]

Changes in life circumstances and behavior give rise to transitions and require adaptation to new routines and circumstances associated with these events.[4] The transition to parenthood begins during pregnancy and continues until both parents have developed confidence in performing their new role.[5] The ICN[1] defines confidence as a sense of security and a belief that others are reliable and well-intentioned. The aim is therefore to foster parental confidence, a dynamic, subjective, and individualized attribute[6] that enables individuals to cope with challenges.[7] In turn, parental confidence supports a safe and positive postnatal transition.

The transition to parenthood is framed within Meleis' Transition Theory; this middle-range theory describes transition as a passage from one stable state to another equally stable state through a dynamic process of change, adaptation, and acquisition of new knowledge and skills.[8] According to this theory, transition begins when change is anticipated and continues until the individual achieves stability and mastery of the new role.[8,9] This process may involve a variety of events that influence how individuals experience the transition and adapt to the new parenting role[8]; these events are often described in the literature as barriers and facilitators. The development of confidence is a key indicator of both the process and the outcome of a healthy transition.[10] Parental confidence is therefore an important indicator of the quality of the transition to parenthood, reflecting the degree of adaptation and mastery parents have achieved in newborn care.[10] Strategies that help couples manage their interactions more effectively can increase their confidence.[10] Confidence develops progressively, enabling parents to master the new skills required to navigate a healthy transition.

Developing parenting skills is essential for providing safe newborn care and is a priority during the transition to parenthood.[11] Parenting competence encompasses the knowledge, skills, and attitudes that enable mastery of the parenting role and support the child's full potential for growth and development.[12] Building parents' capacity is fundamental to this process, which requires effective health promotion strategies and an appropriate, individualized education plan.[13]

Historically, childcare and household responsibilities were largely assigned to women, whereas men were expected to be the economic providers.[14] This pattern has been changing, with fathers increasingly participating in health services, particularly during childbirth.[15] Fathers have also assumed a more prominent role in newborn care[12], a shift reflected in men's uptake of shared parental leave. The percentage of men taking shared parental leave rose from 27.5% in 2015 to 45.7% in 2021.[16] Today, women also invest in their careers and incorporate their professional aspirations into their plans for parenthood rather than devoting themselves exclusively to this transition.[12] Some couples live independently rather than with extended family, often away from their social support networks, a living arrangement that affects family reorganization.[12]

Mothers receive greater attention in this process. However, both parents experience the transition to parenthood. Coparenting describes the relationship between parents and occurs when mothers and fathers share responsibility for raising their children through mutual support and coordination.[17] The concept does not, in itself, imply that the parenting role is shared equally.[17] However, the collaborative involvement of both parents, increasingly common today, can support effective coparenting. Effective coparenting requires mutual coordination and teamwork, whereas competitive and conflictual coparenting can adversely affect the transition to the parenting role and, subsequently, newborn behavior.[18]

It is important to understand the contribution of the nurse specialist in maternal and obstetric health (EEESMO) to the care of the mother–father–newborn triad. This perspective is supported by the Quality Standards for Specialized Nursing Care in Maternal and Obstetric Health issued by the Portuguese Order of Nurses[19], which recognize the newborn and the father as care recipients during the postnatal period. Fathers should be recognized as individuals with their own values, beliefs, and wishes from pregnancy through the postnatal period. Therefore, mothers and fathers should be recognized as individuals with their own needs and as partners who complement one another through inclusive, supportive coparenting in newborn care.[18,19]

In Portugal, the scope of EEESMO practice encompasses the entire transition to parenthood, including pregnancy, childbirth, and the postnatal period. During the days and weeks after birth, postnatal care addresses the needs of the mother–father–newborn triad by supporting the early detection of complications and fostering parents' confidence in adjusting to their new circumstances and in caring for their newborn.[3]

We therefore conducted a scoping review to examine the barriers to and facilitators of parental confidence in newborn care. This approach enables a broad examination of a topic[20] and can generate evidence to inform EEESMO decision-making and couples' needs assessment. Few studies have focused on the continuity of interventions designed to build parental confidence and to support newborn care during the postnatal period.[21] Assessing couples' needs is a prerequisite for planning individualized interventions that strengthen parental confidence and parenting skills and promote a positive experience of parenthood. "Providing care for women within their families and communities during the postnatal period"[22] is one of the specific competencies of EEESMOs. These professionals should design, plan, implement, and evaluate interventions that promote and support adaptation during the postnatal period; identify and monitor changes in transition processes; and foster responsible parenthood. Expanding their professional knowledge is also essential for EEESMOs to optimize care and contribute to improved health outcomes.

A preliminary search of the Cochrane Database of Systematic Reviews and JBI Evidence Synthesis identified no systematic reviews or scoping review protocols on this topic published during the 5-year period examined. Accordingly, this scoping review aimed to map the evidence on barriers to and facilitators of parental confidence in newborn care.

Methods

We conducted a scoping review in accordance with the Joanna Briggs Institute (JBI) methodology for scoping reviews[20] and reported it using the PRISMA Extension for Scoping Reviews (PRISMA-ScR) checklist.[23] We developed a scoping review protocol that specified the objectives, methods, and planned data management procedures[24] and registered it on the Open Science Framework (https://osf.io/9nr8d/overview). The review question was: "What are the barriers to and facilitators of parental confidence in newborn care?"

Eligibility criteria were defined using the Population, Concept, and Context (PCC) framework.[24] The population comprised mothers, fathers, and couples; the concept encompassed barriers to and facilitators of parental confidence in newborn care; and the context included any setting in which care was provided to healthy newborns. We excluded studies of parents whose newborns required specialized care or follow-up, including admission to a neonatal unit, or had congenital or genetic malformations or respiratory, neurological, metabolic, or gastrointestinal diseases. We also excluded study protocols and studies involving maternal conditions that precluded rooming-in, including illnesses or complications requiring care in other units, severe psychiatric disorders, or drug abuse.

We used a three-step search strategy.[20] In April 2024, we conducted an initial search of MEDLINE Ultimate and CINAHL Ultimate via EBSCOhost using topic-related terms. We examined the text words in the titles and abstracts of the retrieved records, as well as the index terms used to describe them, to inform the full search strategy. In the second step, also conducted in April 2024, we developed a full search strategy and adapted it for each information source: MEDLINE Ultimate, CINAHL Ultimate, MedicLatina, and the Cochrane Database of Systematic Reviews via EBSCOhost, as well as Web of Science and PubMed. The search strategies are presented in Box 1.

In the third step, we screened the reference lists of the included reports to identify additional relevant sources of evidence. We also searched organizational websites for gray literature. We updated the search in September 2025 to identify newly published sources relevant to the review.

We included all types of published and unpublished sources of evidence, including experimental and quasi-experimental studies; descriptive and correlational studies; qualitative and quantitative studies; systematic reviews; case studies; opinion articles; and conference abstracts. We considered sources published in Spanish, French, English, or Portuguese from January 2018 through September 2025.

Box 1. Search strategies by database

Database	Search strategy
MEDLINE Ultimate	(Father* OR Mother* OR Parents* OR MH Fathers OR MH Mothers OR MH Parents) AND ("Self-confidence" OR confidence OR MH Trust OR MH "Self-Assessment") AND (Barrier* OR Obstacle* OR Difficult* OR Facilitator* OR Enabl*) AND ((MH "Infant, newborn" OR Newborn) AND (Care))
CINAHL Ultimate	(Father* OR Mother* OR Parents* OR MH Fathers OR MH Mothers OR MH Parents) AND ("Self-confidence" OR confidence OR MH Trust OR MH "Self-Assessment") AND (Barrier* OR Obstacle* OR Difficult* OR Facilitator* OR Enabl*) AND ((MH "Infant, newborn" OR Newborn") AND (Care))
Mediclatina	(Father* OR Mother* OR Parents*) AND ("Self-confidence" OR confidence OR Trust OR "Self-Assessment") AND (Barrier* OR Obstacle* OR Difficult* OR Facilitator* OR Enabl*) AND (Newborn AND Care)

Cochrane of Systematic Reviews	(Father* OR Mother* OR Parents*) AND ("Self-confidence" OR confidence OR Trust OR "Self-Assessment") AND (Barrier* OR Obstacle* OR Difficult* OR Facilitator* OR Enabl*) AND (Newborn AND Care)
Web of science	(Father* OR Mother* OR Parents*) AND ("Self-confidence" OR confidence OR Trust OR "Self-Assessment") AND (Barrier* OR Obstacle* OR Difficult* OR Facilitator* OR Enabl*) AND (Newborn AND Care)
PubMed	(Father* OR Mother* OR Parents*) AND ("Self-confidence" OR confidence OR Trust OR "Self-Assessment") AND (Barrier* OR Obstacle* OR Difficult* OR Facilitator* OR Enabl*) AND (Newborn AND Care)

The search results were imported into Covidence[25], which automatically removed duplicate records. Two reviewers independently screened the remaining records by title and abstract against the eligibility criteria. They subsequently assessed the full-text reports and excluded those that did not meet the eligibility criteria. A third reviewer resolved disagreements.

Two reviewers independently charted data from the studies included in the scoping review using a form developed for this purpose. The form included the title, authors, year, country, study design, sample size, objectives, methods, findings, reported barriers and/or facilitators, and secondary conclusions.

We summarized the relevant charted data in a table containing the following information: authors, year, country, methods, objectives, sample, and findings, including barriers and facilitators. Analysis of the included studies identified barriers to and facilitators of parental confidence in newborn care.

Results

The updated search identified 1,099 records: 205 from MEDLINE Ultimate, 124 from CINAHL Ultimate, 0 from MedicLatina, 3 from the Cochrane Database of Systematic Reviews, 446 from PubMed, and 321 from Web of Science. After the records were imported into Covidence[25], the software automatically removed 391 duplicate records. Two reviewers excluded 668 records during title and abstract screening. In the next stage, 40 full-text reports were assessed for eligibility. Of these, 25 were excluded because they involved parents of newborns admitted to a neonatal intensive care unit; were study protocols or abstract-only publications; described interventions or outcomes unrelated to parental confidence; or included mothers with complications or drug abuse.

The database searches identified 15 eligible studies. Reference list screening, the third step in the search strategy, identified one additional study. The review therefore included 16 studies. The search results and study selection process are presented in the PRISMA 2020 flow diagram[26] (Figure 1).

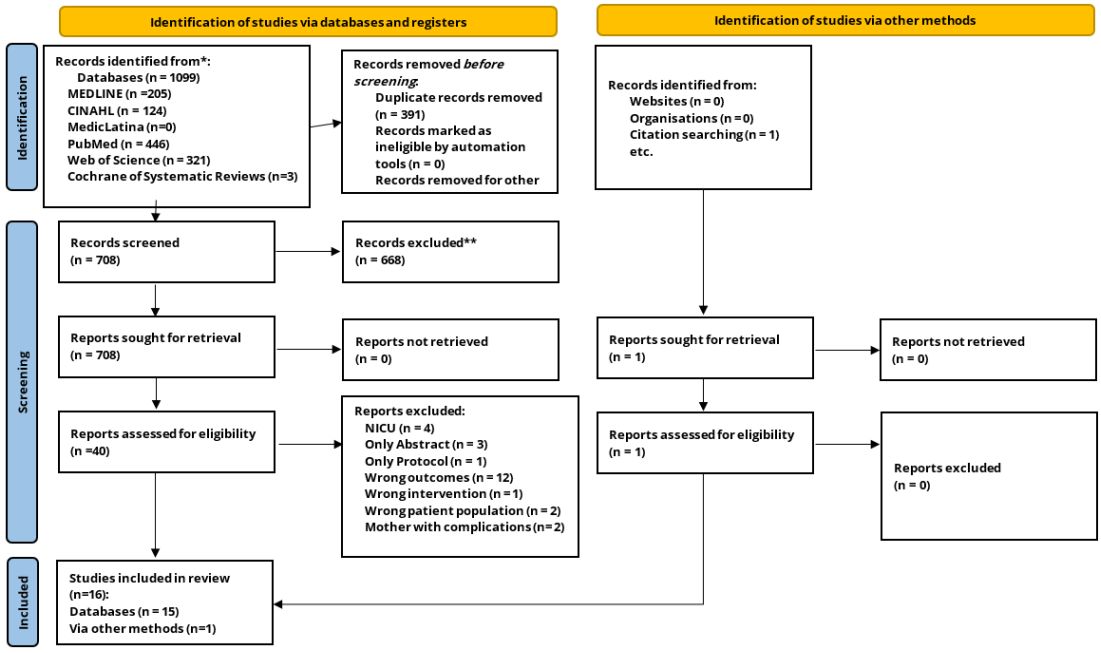

Figure 1. PRISMA 2020 flow diagram.

The 16 included studies were published between 2018 and September 2025. Study designs included 5 descriptive qualitative studies, 2 longitudinal qualitative studies, 2 cross-sectional qualitative studies, 1 hermeneutic phenomenological study, 1 qualitative evidence synthesis, 1 prospective cohort study, 1 randomized controlled trial, 1 qualitative study, 1 cross-sectional mixed-methods study, and 1 exploratory mixed-methods study. The studies were conducted in the United Kingdom (n = 3), the United States (n = 3), Canada (n = 2), Singapore (n = 2), India (n = 1), Australia (n = 1), Italy (n = 1), South Korea (n = 1), the Netherlands (n = 1), and Tanzania (n = 1). Study populations included couples, mothers, and health professionals. Data collection and analysis methods included semistructured and structured interviews, focus groups, and statistical analyses.

Table 1 summarizes the relevant data charted from the included studies: authors, publication year, country, study design and methods, study population and sample, objectives, and findings, including barriers and facilitators. Analysis of the included studies identified barriers to and facilitators of parental confidence in newborn care.

Table 1. Findings from the included studies.

A1.		
Authors, year, and country		Machold, C., Rinn, S., Mckellin, W., Ballabtyne, G. & Barrett, J. (2021) Canada
Study design and methods		Hermeneutic phenomenologic study; semistructured telephone interviews conducted 1–19 months after delivery
Population/sample		10 women who had previously undergone a planned or unplanned cesarean delivery and were scheduled for a repeat cesarean delivery
Objective		To describe women's experiences of cesarean birth with and without skin-to-skin contact
Findings	Barriers	Participants reported feelings of shame or guilt about having had a cesarean birth.
	Facilitators	Skin-to-skin contact Participants reported that breastfeeding after a skin-to-skin cesarean birth differed substantially from their previous experiences, with greater breastfeeding confidence and a longer duration of breastfeeding. Skin-to-skin contact also helped alleviate feelings of guilt and shame and strengthened their confidence during the transition to parenthood.
A2.		
Authors, year, and country		Finlayson, K., Sacks, E., Brizuela, V., Crossland, N., Cordey, S. Ziegler, D., Langlois, E., Javadi, D., Thomson, L., Downe, S. & Bonet, M. (2023) United Kingdom
Study design and methods		Qualitative evidence synthesis
Population/sample		800 family members, including fathers, partners, coparents, grandparents, parents' siblings, and aunts and uncles of the parents
Objective		To explore factors influencing women's and families' uptake of postnatal care
Findings	Barriers	Limited paternity leave Many fathers felt anxious and insecure in their parenting role because concern for their partner's health took priority. Health professionals provided conflicting advice.
	Facilitators	More home visits; flexible opportunities for contact during the postnatal period; 24-hour access to a professional when needed; and dedicated father-only support groups, particularly for fathers experiencing difficulties during the postnatal period.
A3.		
Authors, year, and country		Shorey, S., Ang, L. & Goh, E. (2018) Singapore
Study design and methods		Descriptive qualitative study; interviews
Population/sample		50 fathers
Objective		To understand new fathers' lived experiences
Findings	Barriers	Limited paternity leave Fathers' fear of bathing their newborns because they lacked the necessary skills and confidence, which hindered their involvement; lack of information and guidance from health professionals after hospital discharge; and conflicting advice.
	Facilitators	Measures to promote father involvement, including longer paternity leave and requiring fathers to take parental leave; enhanced prenatal classes that more actively involve fathers; social support from grandparents; and previous experience caring for older children.
A4.		
Authors, year, and country		Athavale,P., Hoeft, K., Dalal, R., Bondre, A., Mukherjee, P. & Gutierrez, K. (2020) India
Study design and methods		Cross-sectional qualitative study; semistructured interviews
Population/sample		33 mothers and paternal grandmothers caring for children aged 0–2 years
Objective		To assess barriers to and facilitators of caregivers' implementation of recommended infant and toddler feeding practices in two urban communities
Findings	Barriers	Family members' work commitments, which limited the support available to mothers; communication gaps; conflicting recommendations from health professionals and family members; family power imbalances that limited mothers' decision-making authority; and limited social support.
	Facilitators	Extending professional nutrition guidance to households and communities; family support, including time spent in the maternal home or a positive relationship with the mother-in-law.
A5.		
Authors, year, and country		Shorey, S., Yang, Y. & Dennis, C. (2018) Singapore

Study design and methods		Descriptive qualitative study; face-to-face semistructured interviews
Population/sample		17 participants (5 couples, 4 fathers, and 3 mothers)
Objective		To explore the views of parents of newborns regarding the content and delivery of an mHealth app–based postnatal educational program
Findings	Barriers	
	Facilitators	Use of technology Parents viewed the mHealth app as an accessible source of information tailored to their individual needs; it also allowed them to revisit content. They used it to confirm routine newborn care procedures and manage difficulties during the first week. Through the discussion forum, parents could receive clear, individualized responses from a midwife that they considered more reliable than generic information found online. Participants reported that the app supported continuity of care and connected them with a virtual community of parents undergoing the same transition. These features increased their confidence and satisfaction in caring for their newborns.
A6.		
Authors, year, and country		Cummins, A., Griew, K., Devonport, C., Ebbett, W., Catling, C. & Braird, K. (2022) Australia
Study design and methods		Qualitative descriptive study; focus groups and one-to-one interviews with service users and maternity care providers
Population/sample		7 pregnant women, 2 partners, 9 midwives, and 1 obstetrician
Objective		To explore the value and acceptability of an antenatal and postnatal midwifery continuity of care model among women, midwives, and obstetricians before implementation
Findings	Barriers	
	Facilitators	Participants valued the model for promoting a sense of safety and connection, allowing more quality time and greater confidence, fostering a sense of community, and respecting cultural diversity. Women reported that receiving care from the same midwife throughout pregnancy and the early postnatal period made them feel safe and connected. Continuity enabled midwives to know women better and reduced the time spent on initial assessments and documentation. Women and providers considered implementing a model similar to those used in the United Kingdom valuable and consistent with high-quality maternity care. The absence of intrapartum care by the same midwife was considered acceptable. Midwives believed that providing care in women's homes would help them anticipate and better understand women's needs and reinforce women's capabilities during the transition to parenthood.
A7.		
Authors, year, and country		Levi, D., Ibrahim, R., Malcolm, R., MacBeth, A. (2019) United Kingdom
Study design and methods		Uncontrolled prospective cohort study; Mellow Babies or Mellow Toddlers group-based program delivered 1 day per week for 14 weeks
Population/sample		183 mother–child dyads
Objective		To investigate the association between participation in Mellow Parenting and improvements in maternal and child outcomes
Findings	Barriers	
	Facilitators	Participation in the parenting program was associated with significant improvements in maternal mental health and parental confidence. Mothers with partners attended more sessions and showed greater improvements in mental health and confidence than single mothers.
A8.		
Authors, year, and country		Perez, A. et al. (2021) United Kingdom
Study design and methods		Cross-sectional mixed-methods study; online survey with forced-choice and open-ended questions
Population/sample		590 expectant parents and parents of infants, including 564 women
Objective		To investigate how COVID-19 and associated restrictions influenced mood and parenting confidence among expectant parents and those in early parenthood and to identify barriers and facilitators
Findings	Barriers	Reduced physical contact; unreliable health information; reduced support; and loss of childcare.
	Facilitators	Technology Social isolation may become a facilitator, particularly for first-time parents. Fathers had more time with their families and cared for their children independently, which made them more attentive. For mothers, having to rely on their instincts in the absence of additional support also made them more confident and resilient.
A9.		
Authors, year, and country		Consales, A. et al. (2020) Italia
Study design and methods		Descriptive study; structured interviews
Population/sample		328 mothers and 333 newborns
Objective		To investigate maternal knowledge of rooming-in and barriers to and facilitators of adherence
Findings	Barriers	Fatigue and cesarean delivery were indirect barriers because mothers reported them as the main obstacles to rooming-in.
	Facilitators	Rooming-in
A10.		
Authors, year, and country		Demirci, J. et al. (2019) United States
Study design and methods		Randomized controlled trial; semistructured telephone interviews conducted 4–6 weeks postpartum
Population/sample		17 mothers
Objective		To assess the feasibility, acceptability, strengths, and limitations of telelactation services for rural mothers
Findings	Barriers	
	Facilitators	Telelactation via a mobile app

		The "hands-off" nature of video support, which required mothers to "do the work," was viewed as potentially increasing maternal confidence. Reported benefits included greater breastfeeding confidence; resolution of breastfeeding problems; prevention of worsening problems; and more efficient use of time during newborn visits. The findings indicate that telelactation offers convenient access to breastfeeding support and triage for breastfeeding-related concerns. It may also increase breastfeeding confidence when transportation is difficult or access to lactation support is inadequate.
A11.		
Authors, year, and country		Lee, I. (2023) South Korea
Study design and methods		Descriptive qualitative study; interviews
Population/sample		165 refugee women
Objective		To generate data to inform the development of a newborn care education program
Findings	Barriers	Lack of knowledge and younger age
	Facilitators	Greater knowledge and older age
A12.		
Authors, year, and country		Biringer, A. et al. (2024) Canada
Study design and methods		Qualitative study; semistructured telephone interviews
Population/sample		18 service users
Objective		To explore the impact of a hybrid perinatal care model during pregnancy and the early postnatal period
Findings	Barriers	
	Facilitators	Perinatal social support Participants described the postpartum period as challenging and reported feeling vulnerable as new mothers. They reflected that the relationships developed through the Group Perinatal Care model provided support in multiple ways and increased their confidence and competence. Their partners' involvement in the process and the entire group's support helped them feel less alone during challenging times. The model was designed to support families through the transition from prenatal care to the intrapartum and immediate postpartum periods.
A13.		
Authors, year, and country		Veltkamp, G. et al. (2020) Netherlands
Study design and methods		Longitudinal qualitative study; two interviews conducted 6 months apart
Population/sample		12 first-time couples
Objective		To describe how social contexts relate to the competencies parents develop
Findings	Barriers	
	Facilitators	Experiential knowledge from other family members
A14.		
Authors, year, and country		Robinson, A. et al. (2019) United States
Study design and methods		Prospective cross-sectional qualitative study; online focus group interviews
Population/sample		22 participants
Objective		To identify African American mothers' experiences with Facebook breastfeeding support groups and their breastfeeding beliefs, decisions, and outcomes
Findings	Barriers	
	Facilitators	Online support groups Participants reported that these groups made them feel more confident and empowered in their breastfeeding decisions.
A15.		
Authors, year, and country		Dol, J. et al. (2019) Tanzania
Study design and methods		Descriptive qualitative study; demographic survey followed by semistructured interviews
Population/sample		8 mothers and 8 midwives
Objective		To explore mothers' and midwives' experiences with postnatal discharge
Findings	Barriers	
	Facilitators	Sufficient knowledge and higher educational attainment Mothers felt that any information they received and any opportunity to provide care while in the hospital increased their ability to care for their newborns, helped them build their knowledge and experience, and helped them gain confidence in newborn care.
A16.		
Authors, year, and country		Fisher, E. et al. (2025) United States
Study design and methods		Exploratory mixed-methods study; interviews and questionnaire
Population/sample		16 participants in the qualitative phase and 62 in the quantitative phase
Objective		To examine clients' perspectives on how the Healthy Start program supports parent and child well-being during and after pregnancy
Findings	Barriers	
	Facilitators	Community health worker programs The program empowered participants and strengthened their confidence in advocating for appropriate care. Interviewees reported greater confidence and lower stress levels, which they associated with better overall health, mental health, and child health.

The findings are presented in Table 2 and accompanied by a narrative synthesis. Data charted from the studies were organized into five categories: technological facilitators; social barriers and facilitators; physiological barriers and facilitators; educational barriers and facilitators; and professional and gender-related barriers and facilitators.

Table 2. Synthesis of findings.

Social barriers	A8, A4
Physiological barriers	A1, A8, A9, A11
Educational barriers	A11
Professional and gender-related barriers	A2, A3
Technological facilitators	A5, A8, A10, A14
Social facilitators	A2, A3, A4, A5, A6, A7, A8, A10, A12, A13, A14, A16
Physiological facilitators	A1, A3, A8, A9, A11
Educational facilitators	A7, A11, A15
Professional and gender-related facilitators	A2, A3

Technological facilitators. Several studies identified technology as a facilitator.[27,28,29,30] One study[28] addressed the period of COVID-19 restrictions. The authors examined barriers to and facilitators of confidence in early parenthood and reported that, although participants preferred face-to-face contact, online resources and interactions were useful during lockdown.[28] Technology provided practical health care resources, social interaction, and psychological support when in-person contact was not possible.[28]

Another study[30] examined a 4-week educational program delivered after postnatal hospital discharge. The program enabled couples and midwives to exchange photographs and messages and allowed parents to submit questions that were answered within 24 hours.[30] It also provided parental education through videos on newborn care procedures.[30] Participants reported satisfactory continuity of care and indicated that interacting with a community undergoing the same transition increased their confidence and satisfaction in caring for their newborns.[29,30] This interaction facilitated a smooth transition from hospital to home and contributed to satisfaction with the parenting role and a positive experience of parenthood.[30]

Finally, telelactation—a mobile app through which mothers could access unlimited free video calls with an International Board Certified Lactation Consultant—expanded access to breastfeeding support for mothers with limited access to professional lactation support.[27] The app was reported to strengthen maternal confidence, allow more isolated mothers to have their questions answered, help prevent complications, and make more efficient use of home visits for newborn care.[27]

Social barriers and facilitators. Social support may act as either a facilitator or a barrier, depending on parents' attitudes and the type of support they receive. Several studies examined support provided through online groups.[27,29,30] These groups formed online communities that included licensed professionals who provided breastfeeding support and enabled new mothers to interact with one another, become empowered, and make informed breastfeeding decisions.[29] In one focus group, all participants reported feeling more confident and empowered to breastfeed.[29] Perceiving an online group as large was positively associated with breastfeeding confidence and duration.[29]

The presence of trusted, knowledgeable people who can provide advice in these groups is therefore important.[29]

In another study, mothers—particularly first-time mothers—reported feeling unsupported during the postpartum period and while breastfeeding.[31] Mothers also reported needing access to a 24-hour service where they could have their questions answered.[32] Health professionals' heavy workloads prevented them from answering mothers' questions, leaving mothers without the guidance needed to feed their newborns appropriately.[31]

These difficulties prompted mothers to seek information from family and friends. When this information conflicted with guidance from health professionals[31,33], mothers felt confused, and most followed their relatives' advice.[31] Mothers reported stress and insecurity, which reduced their sense of control while caring for their newborns and made them more likely to defer to a family member's authority.[31] Fear of making the wrong decisions, together with guilt about not following guidance from community leaders and family members, undermined their confidence in newborn care.[31] Counseling sessions involving families and communities may help reduce this barrier and strengthen maternal confidence by providing reliable information.[31]

Mothers who had reliable information about their children's health were more confident in providing care and better able to resist social pressure from family members, friends, neighbors, and advertising, even when these sources appeared credible.[31] However, the same study found that support from the maternal grandmother or a positive relationship with the mother-in-law may promote more positive maternal attitudes, greater confidence, a greater ability to care for the child, and adherence to recommendations from a trusted professional.[31] In this context, social support acted as a facilitator. The experiential knowledge of family members may also instill confidence in new parents by encouraging them to trust their own intuition, thereby strengthening their confidence in caring for their children.[34] During the COVID-19 pandemic, the loss of social support was

sometimes experienced as beneficial to parental confidence: managing childcare without outside help gave parents more direct caregiving experience and encouraged them to trust their instincts and judgment.[28]
A continuity-of-care model spanning the prenatal and postnatal periods was positively evaluated and was associated with feelings of safety and confidence during the postnatal period.[35] Perinatal support groups that extended support into the community were also reported to have positive effects.[36] Mothers who felt unsupported during the postpartum period received several forms of support from these groups, which strengthened their parental confidence and competence.[36] The groups brought together mothers with similar expected delivery dates and included a midwife and two family physicians.[36]
Parenting programs for parents and children provided follow-up beyond prenatal and postpartum care[37,38], sometimes until the children reached 5 years of age.[38] These programs consisted of workshops and home visits tailored to the children's ages. Although parental confidence was not the primary focus of some programs, it emerged as a secondary outcome[38]: most respondents reported greater confidence in providing care and lower stress levels.[38] Some parenting programs also highlighted the importance of having someone consistently available to listen to and validate concerns and to address problems during the early stages of parenthood.[37]

Physiological barriers and facilitators. Skin-to-skin contact after cesarean delivery was described as shifting control from health professionals to the mother.[39] Participants reported that this contact helped alleviate feelings of guilt about having undergone a cesarean delivery and strengthened their confidence during the transition to parenthood. They also reported a different breastfeeding experience, including a longer duration of breastfeeding and, consequently, greater confidence.[39] Another study highlighted rooming-in[40], which was associated with greater maternal confidence in newborn care and improved breastfeeding.[40] Similar findings were reported in a study conducted during COVID-19-related isolation, in which reduced physical contact was associated with lower confidence.[28]
Maternal characteristics such as age, family structure, and obstetric history may influence confidence in newborn care.[41] Younger age—under 30 years—and primiparity were associated with lower confidence in newborn care.[41] Conversely, having more children, greater experience[33,41], and older age were associated with higher confidence.[41]

Educational barriers and facilitators. Education may influence parental confidence. Women with an elementary school education or less had lower parental confidence.[41] Limited knowledge of newborn care was associated with lower confidence in providing care and inadequate parenting behaviors.[41] Mothers reported that receiving sufficient education was important for developing confidence and that such confidence was essential for caring for their newborns.[42] This education focuses largely on the prenatal and intrapartum periods, whereas the postnatal period receives less attention in both clinical care and education.[42] Although this period is critical to the development of confidence, providing postnatal education in the hospital is difficult because of limited technical and human resources and a lack of guidelines for postnatal care.[42]
Models providing continuity from prenatal to postnatal care support the need for education throughout this period.[38] One model identified in the included studies emphasized the importance of continuity during the postnatal period. Parents reported that this continuity made them feel safer and strengthened their confidence.[38]

Professional and gender-related barriers and facilitators. Fathers' work commitments and limited paternity leave were identified as barriers that restricted father involvement and contributed to insecurity and fear about providing newborn care.[33] Fathers prioritized maternal well-being over their own needs and felt insecure and anxious in their new role.[32] They suggested longer parental leave, father-only support groups for those experiencing the transition to parenthood, and parenting preparation programs with a stronger focus on father involvement.[32,33]

Discussion

This scoping review identified 16 studies published between 2018 and September 2025 that examined factors influencing parental confidence and addressed the review question: What are the barriers to and facilitators of parental confidence in newborn care?
The barriers identified were social[28,31,32]; physiological[28,39,40,41]; educational[41]; and professional and gender-related.[32,33] The facilitators were technological[27,28,29,30]; social[28,29,31,32,33,34,35,36,37,38]; physiological[28,33,39,40,41]; educational[38,41,42]; and professional and gender-related.[32,33]
Digital technologies can help maintain communication and access to specialized support when in-person contact is not possible, as observed during COVID-19-related isolation[27,28] and when families live in areas with

limited access to services.[27] Digital applications that provide easily accessible information tailored to individual needs can help answer routine questions not addressed by standardized information freely available online.[30] Programs that included support from health professionals with specialized expertise reassured parents as they cared for their newborns after hospital discharge and increased their satisfaction with the parenting role.[30] The videos and documents provided during the program offered guidance and strengthened parents' confidence in their parenting role.[30] Other findings indicated that support groups on digital platforms provided continuously available spaces for obtaining information, sharing experiences, and seeking support from specialized health professionals and peers.[29] Users valued the platforms' ease of access and their ability to go beyond simply conveying information by enabling the development of broader support networks.[29] These resources enabled users to acquire new knowledge and develop greater confidence.[29]

Despite the benefits of technological advances in contemporary society, technology should not be used as the sole source of support. Many participants still preferred in-person contact[28]; therefore, digital communication should be used to provide targeted support and address minor difficulties.[29] This approach may facilitate the assessment of potential problems and allow in-person visits to be used more effectively.[27]

Across the included studies, social support was the factor most frequently identified as either a barrier or a facilitator. It is particularly important during the transition to parenthood and may benefit mothers, newborns, and couples.[43] Support may take several forms, primarily family and professional support; its availability may positively influence the transition to parenthood.[43] Partners can support one another, and a partner's absence from appointments, labor, and postnatal programs may affect mothers' participation in these programs and the development of their confidence.[28,38] Mothers can also provide support to fathers.[33] Groups formed through perinatal support programs and social networks enable participants to build relationships, thereby increasing parental confidence and competence.[28,29,36] These groups provide reassurance by connecting people undergoing the same transition[36] and are often created through technology, demonstrating that social support can extend beyond in-person contact when it is accessible and timely.[27,30]

Family support can act as either a facilitator or a barrier to couples' confidence when conflicting opinions and disagreements arise between family members and health professionals[31,37], potentially creating additional stress for parents.[33] This barrier was examined during COVID-19 restrictions.[28] Although family support may protect parents' emotional well-being and thereby enhance parental confidence, losing this support and having to rely on their own instincts when caring for their newborns were also reported to foster confidence.[28] At the same time, family members' experiential knowledge may strengthen new parents' confidence.[34]

Families can be empowered to support a positive transition, thereby strengthening parental confidence.[31] The EEESMO therefore plays an important role at this stage by serving as a mediator within the social support network and providing health education not only to couples but also to their extended families.[31] Early identification of people who are significant to the couple and their inclusion in the transition to parenthood may promote consistent messaging and support evidence-based decision-making. The possibility that couples may turn to less reliable sources, such as social media, advertising, and conflicting information, should be addressed. Beginning in the prenatal period, couples should be provided with reliable sources of information and dependable social support to foster parental confidence.[37] This intervention may help reduce conflicts arising from traditional beliefs and promote a more consistent and reliable support network.

A trusting relationship with the EEESMO and continuity of care provided by this professional are therefore important. The EEESMO supports couples during the prenatal period and continues to provide care during the postnatal period. This continuity is expected to improve the quality of care.[30,32,35,36] Often provided through perinatal programs, continuity of care also reassures couples during a period of major change[35,37] through home visits, regular contact[37], and greater access to psychosocial support. Parents reported needing feedback on the care they provide.[33] These programs may strengthen parental confidence, reduce stress, and connect families with other community resources, including specialized support related to feeding, mental health, and other aspects of physical, psychological, and emotional recovery.[37] Establishing a communication network between couples and the EEESMO may facilitate follow-up and help answer questions.

These interventions align with the Quality Standards for Specialized Nursing Care in Maternal and Obstetric Health[19] because they support adaptation to parenthood, empower families during the transition to the parenting role, and optimize health–illness processes among women living in the community.[19]

Physical contact may influence parental confidence.[28,39] Given that barriers to skin-to-skin contact persist during the postpartum period, understanding them is essential to overcoming them. In one included study[39], participants reported that skin-to-skin contact after cesarean delivery strengthened their confidence during the early stages of parenthood and helped alleviate feelings of shame and guilt associated with having undergone a cesarean delivery.[39] These feelings may hinder the development of confidence.[39] Skin-to-skin contact requires changes to routine procedures because it can disrupt the sterile field. Implementing this practice requires

logistical changes within an already overburdened system, sufficient nursing resources, and a willingness to improve or revise procedures and protocols.[39]

Nevertheless, the literature indicates that these changes are feasible.[39] Care teams should be made more aware of the importance of this practice, and appropriate nurse staffing ratios should be ensured to support best practices that foster parental confidence. Rooming-in facilitates skin-to-skin contact and may strengthen parental confidence by helping parents recognize their newborn's needs.[40] Fatigue may hinder rooming-in, highlighting the central role of the EEESMO in supporting these mothers.[40]

Each couple's individual characteristics may influence the development of confidence.[41] An individualized assessment is therefore needed to tailor parenting preparation programs.[41] Some studies identified greater vulnerability among women younger than 30 years, primiparas, and women with an elementary school education. In contrast, others found that experienced parents were more confident, competent, and motivated in newborn care.[37] The EEESMO should pay particular attention to this more vulnerable population by developing and implementing effective programs that prepare them for the postpartum period and support a positive transition to parenthood. The organization of health services should also be reconsidered to improve continuity from prenatal to postnatal care, which has been studied as a factor that may support a successful transition.[35] Services should be organized so that the EEESMO can support couples throughout the continuum from prenatal to postnatal care.

Effective programs must also address educational barriers and facilitators. Studies indicate that greater knowledge and opportunities for hands-on practice are associated with higher levels of parental confidence.[38,41,32] Conversely, limited knowledge is associated with lower confidence[41], while the absence of standardized educational guidance, gaps in the content provided, and limited time may affect the quality of learning.[42] Mothers value the education they receive and recognize its importance in enabling them to care for their newborns.[42] Opportunities to provide newborn care under the supervision of an EEESMO help consolidate parental confidence.[42] These findings underscore the importance of structured parenting programs that integrate emotional support and learning while strengthening the mother–father–newborn triad; such programs have been associated with higher confidence levels.[38]

Care should include fathers rather than focus solely on mothers. Fathers play an important role in this process and increasingly wish to participate actively rather than remain passive participants.[32,33] One study suggested extending parental leave and noted that shared parental leave may not be ideal because it may require mothers to relinquish part of their leave and may affect newborn care.[33] Another study described maternal behavior that excluded fathers from childcare based on the belief that they lacked competence; this behavior limited father involvement and affected paternal confidence.[33] Social beliefs about masculinity may also discourage fathers from participating in postnatal activities.[32] Thus, traditional gender norms act as barriers to paternal confidence, whereas contexts that include fathers in care may support the development of such confidence.[32,33] Parenting preparation focuses more heavily on the maternal role.[33] Fathers' participation in these programs is also constrained by their availability and limited ability to take time off work to accompany their pregnant partners.[44] Therefore, EEESMO-led courses specifically for fathers, in which they could share common difficulties with other fathers, may help foster a sense of security and parental confidence.[32]

Conclusion

This scoping review identified barriers and facilitators that may influence the development of parental confidence in newborn care. Identifying, analyzing, and discussing these factors is important because the World Health Organization includes parents' confidence in caring for their newborn among the criteria used to assess readiness for discharge.[45] The findings indicate that parental confidence may be influenced by technological, social, physiological, educational, and professional and gender-related factors, underscoring the multidimensional nature of the transition to parenthood. Most of the barriers identified in the included studies concerned mothers, and only two studies examined fathers as distinct participants in this transition. This finding points to a gap in the scientific evidence on fathers' involvement in the transition to parenthood. Further research should examine paternal confidence and the interventions best suited to fostering it.

The findings may help the EEESMO develop and implement interventions to eliminate or minimize some barriers and build on facilitators. Interventions designed to foster parental confidence should not be limited to a single stage of the transition to parenthood; they should begin during the prenatal period and continue after birth into the postnatal period. This continuity is needed because parents perceive the postnatal period as receiving less attention and report feeling insufficiently supported during it. Continuity of care with the same EEESMO during the prenatal and postnatal periods may offer a useful model. Health services should assess the feasibility of this model, given constraints on the availability of health personnel.

In clinical practice, postnatal consultations should include ongoing monitoring of parental confidence and continuous support, with an emphasis on assessing parents' educational and emotional needs and providing opportunities for supervised hands-on practice. Complementary digital support programs should also be developed. However, technology should not be the sole source of support; rather, it should complement care by facilitating communication and thereby contributing to the success of EEESMO interventions during this period of major change for couples. Parenting preparation programs should be restructured to promote greater inclusion of fathers and accommodate work-related constraints by offering father-only sessions throughout the transition to parenthood.

Finally, continuing education for EEESMOs is important because the findings point to the need to develop educational strategies, strengthen content designed to promote parental confidence, establish standardized protocols, and build professional capacity in these areas. These measures are intended to support individualized, family-centered interventions grounded in the best available scientific evidence.

Study limitations

Restricting the publication period was a limitation of this scoping review because relevant studies may have been excluded.

Author contributions

RM: Study conception and design; Data collection, analysis, and interpretation; Drafting the manuscript; Approval of the final version of the manuscript and taking responsibility for it.

SR: Study conception and design; Data analysis and interpretation; Critical review of the manuscript; Approval of the final version of the manuscript and assumption of responsibility for it.

MHP: Study conception and design; Data analysis and interpretation; Critical review of the manuscript; Approval of the final version of the manuscript and assumption of responsibility for it.

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