

THE CHILDBIRTH AND BREASTFEEDING EXPERIENCES OF PRIMIGRAVIDAS WHO ATTENDED CHILDBIRTH EDUCATION CLASSES

Ms Irmin B Segeel

M Cur (Midwifery and Neonatology)

Registered nurse, midwife, community health nurse, psychiatric nurse

Dr Diana du Plessis

D Cur (Midwifery and Neonatology)

Senior Lecturer, Faculty of Health Sciences, School of Nursing, University of Johannesburg

Corresponding author: dwdp@edcur.rau.ac.za

Keywords: childbirth; childbirth education; childbirth educator; primigravidas; birthing experience

ABSTRACT

Knowledge brings with it power, confidence and courage. It is important to prepare for childbirth not only physically, but also emotionally and psychologically. This research tells the story of the childbirth and breastfeeding experiences of the primigravidas who attended childbirth education classes. The objectives of the research were to explore and describe how childbirth education contributed to the birthing and breastfeeding experiences of the primigravidas, and to write guidelines for the childbirth educators to aid them in improving the childbirth education contents. Semi-structured, phenomenological interviews took place with women who met the selection criteria. Permission was obtained from the University of Johannesburg as well as a private hospital in Gauteng and informed consent was obtained from the women volunteering to participate in the research. Recorded interviews were transcribed and analysed using the technique by Tesch (in Creswell, 1994:155-156). The results showed that childbirth education and support reduces fear and helps women to cope better with labour. Lack of all the information leads to unrealistic expectations and may result in negative birthing experiences. Emotional support from the midwife in the hospital is important to the labouring women; therefore, it is important for the childbirth educator to work together with the midwives in the hospital in order to avoid disappointment and unmet expectations. Guidelines were written for childbirth educators, labour ward and maternity staff and midwifery practice.

OPSOMMING

Kennis gaan gepaard met mag, selfvertroue en dapperheid. Dit is dus belangrik om nie net fisiek nie, maar ook emosioneel en sielkundig op die bevalling voor te berei. Hierdie navorsing vertel die verhaal van die bevallings- en borsvoedingservarings van primigravidae wat geboorte-opvoedingsklasse bygewoon het. Die doel van die navorsing was om te verken en te verduidelik hoe geboorte-opvoedingsklasse tot die bevalling- en borsvoedingservarings van die primigravidae bygedra het, en om sodoende riglyne vir geboorte-opvoeders daar te stel om hulle te help om die inhoud van geboorte-opvoedingsklasse te verbeter. Semi-gestruktureerde, fenomenologiese onderhoude het plaasgevind met vroue wat aan die steekproefkriteria voldoen het. Toestemming is van die Universiteit van Johannesburg en 'n privaathospitaal in Gauteng verkry en ingeligte toestemming is verkry van al die vroue wat ingestem het om aan die navorsing deel te neem. Onderhoude wat op oudioband opgeneem is, is getranskribeer en geanaliseer deur van Tesch (in Creswell, 1994:155-156) se tegniek gebruik te maak. Die resultate het getoon dat geboorte-opvoeding en -ondersteuning vrees verminder en vroue help om die bevalling beter te hanteer. Gebrek aan inligting lei tot onrealistiese verwagtinge en dit kan tot negatiewe bevallingservaringe lei. Emosionele ondersteuning van die vroedvrou in die hospitaal is vir vroue in kraam belangrik, en daarom is dit vir die geboorte-opvoeder belangrik om saam met die vroedvrou in die hospitaal te werk ten einde teleurstelling en onvervulde verwagtinge te voorkom. Die navorser het gevolgtrekkings geformuleer en aanbevelings gemaak ten opsigte van die praktyk van verpleegkunde, verpleegonderwys en verpleegnavorsing. Riglyne is daargestel vir geboorte-opvoeders om hulle te

INTRODUCTION

For thousands of years it was the women's network, which, in all parts of the world, kept women informed about labour and birth. Acquiring this knowledge was part of the socialisation of young girls (Nolan, 1998:1-2; England & Horowitz, 1998:4). Childbirth was seen as a normal event and babies were born at home, under the care of women, such as the local midwife, neighbours or family members (Greene, 2000:1). In the 1950's and 1960's in Europe and North America, natural childbirth and psycho-prophylaxis began as alternatives to what was perceived as over-medicalised obstetrics.

Many different programmes appeared at around the same time, all with a single common aim: The use of psychological or physical non-pharmaceutical modalities for the prevention of pain in childbirth (Enkin, Keirse, Neilson, Crowther, Dudley, Hodnett & Hofmeyr, 2000:24). When Lamaze classes were first offered in the early 1960's, pregnant women were given basic information about the physiology of pregnancy and birth and they were taught coping skills that enabled them to avoid medication. These basic skills included breathing and relaxation techniques. The husbands were included in the classes and were trained to coach and provide emotional support to the women during the labour process (Lothian & De Vries, 2005:91).

In the 1970s, Greek midwives became champions for the rights of women to be informed about pregnancy and birth and their right to shape their own childbirth experience (Taousani-Ziogas, 2000:15). Changes in the family structure, as well as the technology that has since been introduced in the United States of America (USA) and the Republic of South Africa (RSA) to improve prenatal care and maternal-infant-outcome has made it progressively harder to give birth naturally and many women currently continue to hand over their births to obstetricians and hospitals. In an ideal world, women do not need to take formal classes to give birth with confidence, however in a culture that relies heavily on technology the need for childbirth education was created (Taousani-Ziogas, 2000:15).

Pregnant families in South Africa, who currently wish for a natural childbirth, have little choice over the birth setting and attendants. A few private midwives in South Africa offer an integrated service of prenatal, intra-natal and postnatal care (Nolte, 2000:9; Expectant Mothers' Guide, 2000:47) but the current South African Health Care System seems to be dominated by a curative approach with relatively low priority being given to health education in general and to childbirth education classes in particular (Nolte, 2000:115). Most women who contribute to medical aids, go to private medical practitioners/obstetricians during the antenatal period, and the views of the practitioners on childbirth education classes determines whether they will attend childbirth education classes at all (Du Plessis, 2005). Few medical aid schemes recognise childbirth education classes as essential or important, and therefore do not contribute towards the costs (Anon, 2005)

What is childbirth education?

Sellers (1993:166) defines childbirth education as the process to prepare the pregnant woman and her family for pregnancy, for labour, *the puerperium*, including breastfeeding and the subsequent care of the newborn child. Lothian and De Vries (2005:92) argue that childbirth education classes must provide knowledge and skills as well as an understanding of the possible negative influences of technology on women's ability to give birth and to equip them with strategies to minimise unnecessary interventions.

The advantages of childbirth education

According to Nolte (2000:115), England and Horowitz (1998: xii) and Lothian and De Vries (2005:93) the advantages of childbirth education include the following:

Childbirth is a right of passage, not a medical event (even when medical care is part of the birth) and childbirth education promotes childbearing as a normal, healthy and natural process.

Childbirth education helps the members of the family to solve their problems more easily. It helps them to participate in their own healthcare and improves their

self-image and self-confidence, thus preparing for birth-in-awareness.

Childbirth education classes support the mother's right to choose a birth option, which is right for her and individual needs and differences are taken into account.

Parents are motivated to take responsibility for their own health as active participants.

Childbirth education also enriches the marriage and enhances psychological maturation.

Childbirth education provides parents with information of the physical and psychological needs of their child to establish a sound relationship. This relationship results in optimal growth and development of the child.

PROBLEM STATEMENT

From unstructured observation of labouring women in a private clinic in Gauteng, the researcher observed that expectant parents, who did not attend childbirth education classes, tend to need more reassurance and on-the-spot teaching during labour. Fathers appear to be unaware of what is expected from them and how and where they can participate or assist the mothers. Even though fathers have re-entered the birth room, they verbalise that they feel "invisible" during labour and appear to be emotionally absent. Mothers on the other hand, seem unable to empty their minds of expectations and judgments that narrow the possibilities for coping with pain.

The researcher has observed that women who attended childbirth education classes seemed to have a clearer idea of what to expect: they are more relaxed during the first stage of labour and are more accepting if labour does not go as expected. They appear to cope better with labour and breastfeeding.

Due to a lack of qualitative studies on women's views on the contribution of childbirth education classes to their birthing experiences, the researcher formulated the following question: How did childbirth education classes contribute to the birthing and breastfeeding experiences of the primigravida?

PURPOSE OF THE STUDY

The purpose of the study was:

- To explore and describe how childbirth education classes contributed to the birthing and breastfeeding experiences of the primigravidas.
- To write guidelines that will assist childbirth educators in the improvement of the childbirth education contents.

DEFINITIONS

A **primigravida** refers to a woman who is in or who has experienced her first pregnancy (Sellers, 1993:73; Beckman, Ling, Laube, Smith, Barzansky & Herbert, 2002:11). In this study, a primigravida refers to a woman who has attended childbirth education classes with her first pregnancy, regardless of marital status.

Birthing experiences refer to all the sensations, feelings and behavioural responses, and physical perceptions experienced by the primigravida during the birth of her baby (Nolte, 2000:75).

Childbirth education is the process designed to assist the couple in making the transition from the role of expectant parents to the role and responsibilities of parents of a new baby, which includes the period from the time of conception to approximately three months after the birth (Nolte, 2000:114).

In this study, the **childbirth educator** refers to a registered nurse who practices under R2598/387/2488 and has a special interest in childbirth education. She acts as a teacher, facilitator, communicator and an advocate for pregnant women, their partners, infants and new families (Sellers, 1993:137).

RESEARCH DESIGN

A qualitative, exploratory, descriptive and contextual design was used to gain insight and understanding of how childbirth education classes contributed to the birthing and breastfeeding experiences of the primigravidas in a private hospital in Gauteng. An explorative and descriptive approach was used in an attempt to describe the meaning women ascribed to their birthing and breastfeeding experiences in relation to childbirth education classes they attended (Mouton, 2002:80), in order to formulate guidelines for the childbirth educators in private practice. Finally, a contextual approach

was used, as the setting for this research study was a maternity ward in a private hospital in Gauteng (Creswell, 1994:62).

POPULATION

The population was identified as women in Gauteng, married or single, who experienced labour, birth and breastfeeding for the first time, regardless of birthing outcome (vaginal delivery, assisted vaginal delivery or caesarean section).

SAMPLING

A purposive convenient sampling strategy was used to ensure that the sampled population is composed of elements, with specific attributes, necessary for this study (De Vos, 1998:198). Purposive sampling yielded diverse information because each individual shared her experiences that would contribute to answering how childbirth education classes contributed to her birthing and breastfeeding experiences. The sample was first-time mothers who had attended childbirth education classes, and who have delivered in a particular private hospital in Gauteng. The participants who were included in this study had all attended different childbirth education classes, met the selection criteria and were willing to participate in the study.

SELECTION CRITERIA

Sampling criteria can be defined as the characteristics essential for membership in the target population (Burns & Grove, 1997:236). The characteristics essential for inclusion in this study were:

Only primigravidas were selected for the study, so that previous birthing and breastfeeding experiences could not influence the findings of this study. Subjects had to have attended a full cycle of the childbirth education classes, so that they had received all the information given by the childbirth educator. The spouse/partner had to have attended the childbirth education classes because the lack of a support person might affect her experiences negatively. They had to have had a term pregnancy. Subjects had to be willing to provide detailed information of their birthing and breastfeeding experiences, and had to agree to the interviews being recorded to be transcribed. They had to have a good

understanding and ability to express themselves in either English or Afrikaans as the interviewer and co-coder speak and understand English and Afrikaans. This was to avoid misunderstandings and misinterpretation. Subjects had to be at least twelve hours post-delivery so that they would have recovered from the stress of labour and delivery, and would be in a position to engage in a discussion about their experiences. Subjects had to be prepared to give written informed consent.

METHODS OF DATA COLLECTION

Data were collected by means of phenomenological interviews where the researcher tried to gain knowledge of and insights into the interviewee's world (Rubin & Rubin, 1995:1-5). Eight phenomenological interviews were conducted until saturation of data were achieved and repetitive themes emerged. The phenomenological interview of this study's central question was as follows: *"How did childbirth education classes contribute to your birthing and breastfeeding experiences?"* The researcher tested this question with two women who met the sampling criteria to identify any problems that may be encountered in the actual study. The two participants placed emphasis on their emotional and physical reactions during the birth. These initial interviews gave the researcher the opportunity to formulate the opening statement with vocal emphasis on the words "childbirth education".

The researcher conducted tape-recorded interviews until saturation of data, as demonstrated by repeating themes, occurred. Rapport was established with the women through an attitude of unconditional acceptance, respect, empathy, honesty, openness and modesty (Poggenpoel, in Rossouw, 2000:154). In order to validate the uniqueness of each woman's experience, the researcher accepted a not-knowing stance; thereby communicating a genuine curiosity, being open for and taking seriously anything the women may say (Rober, 1999:212). The researcher used communication skills that included the following: responsive listening, minimal verbal response, probing, reflecting, clarifying, summarising and silence. Field notes were written as soon as possible after the interviews as a system for remembering the observations that were made, and most importantly for retrieving and analysing them (Schurink, 1998:285). These included: observational notes, theo-

retical notes to derive meaning from observational notes, methodological notes and personal notes that contained the researcher's reactions, reflections and experiences.

TRUSTWORTHINESS

Lincoln and Guba's measures to ensure trustworthiness were applied (Lincoln & Guba, 1985:290-327). The strategies used included the following:

Credibility: by extended exposure in this field, keeping field notes, triangulation of the data and by means of a literature control. The researcher conducted all the interviews herself. The participants determined the content as well as the direction of the interviews.

Transferability: by means of a literature control, the use of purposive sampling and dense description of the methodology used to conduct this study.

Dependability: by means of a dense description of the data and the use of an independent coder.

Confirmability: was achieved by ensuring an audit of the entire research process.

METHODS OF DATA ANALYSIS

Recorded interviews were transcribed and analysed using the descriptive analysis technique by Tesch (*in* Poggenpoel, 1998:343). All transcriptions were read through carefully and the information was then analysed to identify meanings and themes. Similar topics were clustered together and then arranged into major, unique and leftover topics and themes. The list was taken back to the data and topics were coded.

A set of clean data was provided to an independent coder who has experience in qualitative data analysis. After this separate interview analyses, both met for a consensus discussion to ensure that the data reflected were accurate. Central themes were identified and discussed. A thorough literature study was performed according to Morse and Field (1996:106). Books, relevant research material and scientific articles were utilised. Guidelines were discussed and formulated. Telephonic interviews were conducted with all the participants to validate the findings. No significant changes were needed to the original transcripts and the participants

expressed their surprise and satisfaction with this telephonic conversation.

ETHICAL CONSIDERATIONS

The permission to conduct this research was obtained from the ethics committee of the Faculty of Education and Nursing, University of Johannesburg and the hospital manager. Additional permission was obtained from the participants in the form of written consent for the interviews. The researcher ensured that the participants had assimilated essential points regarding the purpose, content and process of the study before consenting to participate in the study (Burns & Grove, 1997:209). Consent contained all the rights, to which subjects were entitled, which included the following: anonymity and confidentiality, the right to privacy and the right to protection from any discomfort or harm (Burns & Grove, 1997:197-206; DENOSA, 1998:1-8).

DESCRIPTION OF THE RESULTS

Table 1 presents a brief summary of the themes and sub-themes identified during the study of women's experiences of the contribution of childbirth education classes to labour and breastfeeding:

Theme 1: Physical discomfort experienced during childbirth

Sub-theme 1.1: Experience of pain

It is evident from the study that all the participants were surprised by the extent of the physical discomfort due to the contractions or other physical causes they experienced during the birth. Some coped very well by making use of relaxation skills and breathing techniques learned in childbirth education classes: "*I was breathing through the pain, played games ...*". Breathing techniques and labour positions cannot eliminate the pain, but are coping mechanisms that can assist in reducing fear (Yerby & Page, 2000:53). Some stayed at home longer: "*there are more things you can keep yourself busy with to distract you from the pain, and I must say it is true*". "*Our (childbirth educator) drilled it into us ... we played games, my husband brushed my hair he normally did ... and because of continuing as if nothing is happening, I could manage longer with the pain at home ...*". In this study, the participants found that by actively engaging in normal activities, they could

Table 1: Women's experiences of the contribution of childbirth education classes to labour and breastfeeding

MAJOR THEMES	SUB-THEMES
Theme 1 Physical discomfort experienced during childbirth	The experience of pain Information received on pain relief options
Theme 2 Expectations of the labour ward personnel	- Labour ward personnel as support persons - Labour ward personnel as breastfeeding experts
Theme 3 Application of information received at childbirth education classes during labour, birth and breastfeeding	- Information given during childbirth education classes prepared them for labour and help them to stay in control - Information received in the hospital - Educating the support person

cope better physically and emotionally to avoid or reduce the stimuli that cause pain and physical discomfort. The participants made use of breathing exercises and water as a method of pain relief: *"We were breathing throughout the contractions and he (partner) used to count for me that helped me to concentrate on the breathing. Thinking back I'd say I coped very well The water does have a calming effect because when I went into the water it was still very painful but much better"*. Many participants were walking which made a difference in their birthing experience: *"I spent most of my time walking ... to try and keep my mind off the pain and it really helped"*. Freedman (1999:41) agrees that a healthy woman should remain at home during early labour for as long as possible and continue with normal activities such as eating, drinking fluids, walking and resting. Enkin *et al.* 2000:315 states the mother would be able to manage the painful stimuli by actively engaging in normal activities.

Some mothers could not cope with the pain despite the methods they were taught in their childbirth education classes. The idea of what pain should feel like, or how she is supposed to respond, can overwhelm the mother: *"If that (the pain) happens, you will begin looking for a way out, thinking you cannot handle it or fearing it will never end"*. Another participant stated: *"I believed that I will cope with the pain"*. One mother felt

childbirth education classes did not prepare her for the reality and intensity of the contractions. *"Our childbirth educator was pro-natural and her classes convinced me that I can do this naturally..... all I could think of was that I wasted money at the classes ..."*. This is indicative of the Psycho-prophylaxis movement which implied that the woman, who was in control, will not hurt as *"she will not weakly give way to pain"* (Velvoski, Platonov, Ploticher & Shugom, 1960:225). Crowe and Von Baeyer (*in* Clement & Page, 1998:132) argue that women's expectations of pain are frequently neither accurate nor realistic and unrealistic expectations in turn lead to surprise or shock during childbirth. This is supported by the following quotation: *"... the pain took me by surprise, I did not think that it would be that bad"*.

Sub-theme 1.2: Information received on pain relief options

All the women in the study expressed strong emotion when discussing pain and pain relief. Some women felt in control of their labour and managed the pain of labour well. Others could not manage the pain of labour at all. The women who felt in control felt well informed by the childbirth educator about the methods of managing pain during the labour process: *"I knew exactly how to cope with the pain ..."*. *"Because my husband knew how strongly I felt over not having an epidural, he encour-*

aged me and gave me the strength to carry on". The childbirth education classes helped them to establish their own attitudes and beliefs regarding pain, helped to mobilise emotional support and helped them to practice pain-coping techniques. As evidenced by the following statements, they managed the breathing well: *"We were breathing throughout the contractions ... (it) helped me to concentrate on the breathing. Thinking back, I'd say I coped very well"*. Some mothers could not cope with the pain despite the methods they were taught in their childbirth education classes and opted then for pharmacological choices. They felt well-informed of their choices, and although they felt guilty for not coping, they were knowledgeable about the other methods of pain relief. Some women tried water for pain relief and stated that they would not have known about the benefits of water if they did not attend the childbirth education classes: *"The water does have a calming effect because when I went into the water it was still very painful but much better ... to try and keep my mind off the pain and it really helped"*.

The mother who attended the pro-natural childbirth education classes felt she did not receive enough information with regard to pain relief. This influenced her experience very negatively and she regretted not being open-minded and realistic: *"I should have stayed open-minded and just maybe it would not have been so bad"* and *"my husband and I agree that the classes were a waste of time and money ..."*.

Mander (1998:144) and Moore (1997:64) feel that it is important for women to have the ability to make an informed choice regarding the analgesia or anaesthetic methods to use during labour. Yerby and Page (2000:56-57) agree that a lack of information may lead to increased fear about the process of labour, resulting in an enhanced perception of pain. Without adequate information and understanding, decision-making is impaired. Enkin, Keirse, Neilson, Crowther, Dudley, Hodnett and Hofmeyr (2000:25-26) argue that the objective of the classes must be made clear and that unrealistic expectations must be avoided. The quality, content and nature of childbirth education contributed to a good or bad experience.

The women who received epidurals felt that they had the knowledge to make the decision to have the epidural, but what stood out was the shock they experienced

when the epidural was not working as promised in the childbirth education classes. None of them was adequately prepared for the possibility of an epidural not working as echoed by the following: *"I felt miserable because the epidural was not working ..."* and *"I actually regretted why I took the epidural"*. Nolte (2000:174) and Mander (1998:156) argue that it is important that the women be prepared for the possibility of an epidural not working effectively. Besides this, the women who received the epidurals perceived the information given in the childbirth education classes as up-to-date as either the hospital midwife or the anesthetist gave similar information.

Theme 2: Expectations of the labour ward personnel

Sub-theme 2.1: Labour ward personnel as support persons

In spite of the realisation of the importance of continuity of care of pregnant women, most women giving birth have fragmented care. In this study the women delivered in a private hospital while under the care of a medical practitioner who visited them briefly during the labour process and was only seen when the actual delivery occurred. The labour ward nurse/midwife had ongoing contact with the mother – observing the labour progress, monitoring the fetal heart rate and informing the doctor. Kitzinger (2005:63) reports on an observational study in a large hospital, where it was found that midwives regularly changed shifts and sat and talked to mothers for only 15% of the time. No doctor, during 20 minute videotapes, ever sat down or had a conversation with the mother. "This not only means that they are unable to form relationships with the professionals they encounter, but it is emotionally unsatisfying for the midwives and doctors caring for them, too".

The overall experience of the hospital labour ward staff was negative and the participants felt blame towards their childbirth educator. This is illustrated by the following statements: *"... (childbirth educator's name) spoke so highly of the staff of (hospital's name)"* and *"... (childbirth educator's name) told us that the nurses in (hospital's name) are wonderful and that they are very helpful"*. They felt the childbirth educator put them under a false perception of what to expect from the hospital labour ward staff. A nice picture was drawn for them and they were not fully equipped on how to handle

negative staff. This had a detrimental effect on their ability to cope with the pain. *"Well, at first when we just arrived and I sensed the coldness, I immediately started to feel panicky ... anxious and worried ... and I could feel I was not coping with the pain"*. The birth plan that was carefully compiled due to the encouragement of the childbirth educator was totally ignored in some of the cases and the staff was very negative towards it: *".... She was telling me that birth plans never works ... it turned out not to be a good idea (to compile one)"*. Many health professionals see a birth plan as a sign that the woman is going to be "difficult". Yet birth plans have become part of the birth scene, even if accepted grudgingly and readily dismissed in practice (Kitzinger, 2005:89). One woman found the staff to be unfriendly and unsupportive, and this had a negative effect on her labour experience: *"... We were taught the importance of staying relaxed ... I was getting more anxious. Relaxing neither did nor exists in the hospital"*. England and Horowitz (1998:205) emphasise that the personality and attitude of the nurse attending the birth can be a surprising critical factor in the birth outcome. In this research they expected the staff to be more supportive. For them it felt as if the childbirth educators did not know what was happening in the hospital labour wards. Simpson and Creehan (2001:613) say that disappointments and unmet expectations for the labour, birth and postpartum experience can be avoided if childbirth educators are fully familiar with the policies and practices of the hospital labour wards.

In this study, some women chose the epidural for pain relief because of the lack of support as well as the perceived condescending attitude by the midwife caring for her: *"I felt more anxious because I was not comfortable with the sister ... and I had to take the epidural"*. Support during labour requires giving explanations, encouragement and progress reports, listening to women, giving undivided attention and consulting women about their wishes. Emotional support and physical comfort measures enable women to cope better with labour pain by reducing fear and anxiety (Nolte, 1998:114). In this study, the women who had a good relationship with the staff were able to use a greater number of coping strategies: *"... and because the sister who looked after me was so supportive, together with my husband, I managed to have my natural labour without any pain relief, and I felt so proud ..."*.

Emotional support from the midwife in the hospital labour ward can contribute immensely to the birthing and breastfeeding experiences of the women. She needs to give information and straightforward explanations in response to the woman's queries about obstetric events, and she must provide emotional reassurance and encouragement. Midwives have a very responsible role to play in the eventual overall psychological, emotional and physical experience and well-being of the woman in labour (Yerby & Page, 2000:54). It is therefore essential that the childbirth educator work together with the hospital labour ward midwife.

Sub-theme 2.2: Labour ward personnel as breastfeeding experts

Some participants felt misled by the childbirth educator's advice on how to establish breastfeeding in the postnatal period. They were led to believe that the baby could latch itself if given sufficient time and that the personnel were well trained to assist them. The majority of the women experienced disappointment, resentment and anger towards the personnel, including the childbirth educator. *"... the class on breastfeeding was excellent. Again, it is just that they practice something different in the hospital"* and *"it is very disappointing ... in a matter of seconds somebody comes and takes it away from you and its something you can't reverse..."*. The participants furthermore felt that the staff was unsupportive and uncaring in their efforts and that the midwives were unable to spend enough time on counseling. They felt that they were not given enough time on their own and were not encouraged to ask questions. This is illustrated by the following statements: *"The sister just grabbed my breast and latched the baby"* and *"I suppose they are too busy to spend too much time on teaching us how to breastfeed"*. In this research, it was found that the discrepancy between what was taught in the childbirth education classes and the lack of support during the postnatal period had a major influence on the women's successful attempts. *"I think they neglect this part and just assume that things are done in the manner they teach and expect it to be done"*. The post-natal midwives followed a hard-handed approach resulting in anger and resentment in the participants. *"The fact that they just take the breast and put it in your baby's mouth really makes you feel as if you don't have a say ... I disliked it and felt anger more towards my childbirth educator for not preparing me for this"*. The women did

not experience the midwives as competent practitioners and blamed the childbirth educator who painted a more positive picture. "... And I feel that our childbirth educator misled us into thinking that the staff is so great, and therefore we were not prepared for something totally different ...".

Theme 3: Application of information received at childbirth education classes during labour, birth and breastfeeding

Sub-theme 3.1: Information given during childbirth education classes prepared them for labour and helped them to stay in control

The content of childbirth education classes depends to a large extent on the childbirth educator's philosophy of childbearing. Some classes focus on teaching routine hospital procedures and others place priority on empowering women to make informed decisions. Their focus may also be on teaching coping mechanisms for labour and decreasing unnecessary medical intervention. Various psychological factors influence a woman's perception of pain and her ability to cope. Positive or negative feelings about the labour experience relate to whether the woman feels in control of events. For some, control is related to the duration of labour, for others it is part of decision-making (Niven & Gijsbers, 1996:117).

In this study, the women who delivered vaginally felt that they had received adequate knowledge to empower them during labour and birth. This helped them to stay calm and they felt in control of their labour process: "*I felt so calm and relaxed because I had the knowledge of what is and what's going to happen*". "*I had the knowledge to make the right decision ... And I stayed calm and in control*". These experiences were confirmed by Freedman (1999:40) and Spinelli, Baglio, Donati, Grandolfo and Osborn (2003:94-101). Simkin (1991 in Clement & Page, 1998:88) reported that women who had a sense of control over what happened to themselves and over decisions about their care during labour were more likely to express long-term satisfaction over the whole experience twenty years later. The participants in this study expressed similar feelings: "*The classes helped me to make the right decisions ... I could feel safe in making the decision to take the injection, I had peace of mind*". In contrast to this finding, Kitzinger (1992 in Clement & Page, 1998:88) de-

scribes women who, years after the event, were still trying to deal with memories of horrific childbirth experiences over which they had little or no control. To deprive a woman of control during childbirth is therefore no small matter. Kitzinger (2005:54) argues that control is a vital element in empowering the woman to obtain the information needed to make her own decisions, control the birth environment, and everything that is done to her and her baby.

Writing birth plans has become a ritual of modern pregnancy, intended to encourage parents to be more involved and active in the decisions taken during childbirth. It furthermore serves as a tool to open dialogue with hospital personnel. Garford and Garcia (1987 in Clement and Page, 1998:89) argue that birth plans are of no use if they are simply ignored when a woman is admitted. The participants in this research felt angry, disappointed, frustrated and rejected when their birth plans were not implemented as they felt their thoughts and desires were ignored. The disregard for her wishes and expectations affected her negatively and took away her sense of control and autonomy.

One woman felt that it was a waste of money to attend the childbirth education classes because the labour ward staff repeated everything she was taught in the childbirth education classes. It is thus evident that childbirth education classes need to be more than just receiving information about labour. Parents today expect more than just a safe delivery of their infant; they want to be treated as responsible, capable of making decisions, participating actively and receiving emotional support from their childbirth caregivers (Nolte, 2000:114).

The women who underwent caesarean sections also felt inadequately equipped with information for the procedure. They felt that too little time is spent during the childbirth education classes on this topic. This gave them a false perception that labour always ends up in a vaginal delivery. "*I ended up with a Caesar and we spent so little time on Caesars ... I don't feel good about it*". "*Our childbirth educator was pro-natural and her classes convinced me that I can do this naturally*". Yerby and Page (2000:56-57) argue that a lack of information may lead to increased fear about the labour process which in turn makes it impossible to make decisions.

Sub-theme 3.2: Information received in the hospital

One woman in particular felt that the childbirth education classes were unnecessary because the labour ward staff told her everything she needed to know. The other participants in this study appreciated the information that was repeated by the midwives in the hospital because it reassured them and refreshed forgotten information: "... *You cannot remember everything that you were told at the antenatal classes so you need someone to tell you about everything again and that's what the sisters did*". Lavender, Walkinshaw and Walton (1999:43) conveyed that those who received adequate and accurate information throughout labour are less likely to view their labour negatively. Consistent advice can relieve some of the anxieties and fears women experience during childbirth and therefore decreases the pain.

Sub-theme 3.3: Educating the support person

A repetitive theme in this research was the significance of support by the partner: "... *with him there it felt much better, you feel so lost when you (are) in pain and alone*". The participants in this research appreciated their support person's effort and support and felt he could adapt to being a birthing partner because of the childbirth education classes: "*My husband was a very good support of which I think would not have been the case if he did not attend the classes with me*". They felt their partners understood them better and knew how to help them to cope during the labour process. Freedman (1999:54) observed that couples who prepared for labour and birth together generally enjoy the sessions as a special time in their relationship. Kitzinger (2005:169) agrees with this and argue that a couple can become closer by sharing the birth experiences as the man gains a deeper appreciation of his partner's need. During childbirth education classes, the spouse is taught how to motivate her during labour and how to provide an emotional connection, and to serve if necessary, as interpreter or mediator between her and her professional attendants. One woman indicated that her husband took the classes more seriously than what she did. Enkin *et al.* (2000:256) reported that only a few women prefer not to have anyone with them during labour, and that most women express pleasure and relief when their partners could stay and disappointment when they were unable to do so.

The father mostly gives support during birth and for this reason, it is important for him to accompany the mother to childbirth education classes. Nolte (2000:115) argues that there is evidence that husbands who are actively involved in childbirth education classes and labour are more concerned with the newborn. This further serves to improve the parent-child-relationship.

SUMMARY

Most of the participants felt that childbirth education prepared them adequately for the birthing experiences. It helped to reduce their fear of 'the unknown' through education and support; it helped the women to work through and cope with the pain in labour; it was enriching for their marriages and it enhanced their psychological maturation. The content and nature of childbirth education classes furthermore contributed to a good or bad experience. Childbirth education classes needs to be more than just conveying information about labour and parents expect to be treated as responsible, informed, capable of making decisions while actively participating in the labour process.

The overall experience of the hospital labour ward staff was negative and the participants felt blame towards their childbirth educator for painting a positive picture.

GUIDELINES

From the themes and sub-themes identified in the study, the researcher formulated the following guidelines to enhance the birthing experience. The researcher described guidelines for childbirth educators, the clinical practice and midwifery education.

Childbirth educators

Childbirth educators should foster a relationship and not merely convey information.

Childbirth educators can design a comprehensive educational curriculum by using a team approach to provide the families with important information about pregnancy, childbirth, infant care, and the transition to parenthood. Including parents and peers as part of the childbirth education team enhances the likelihood that topics offered would be what parents want and need to know. A written curriculum, in a more condensed form, can be sent to various role players for evaluation and

recommendations. The curriculum should include basic knowledge of pregnancy and birth, birthing options, caesarean sections, medicated and non-medicated forms, pharmacological and non-pharmacological forms of pain relief, early parenting issues, breastfeeding and bottle-feeding. Unbiased information based on the best available scientific evidence should be conveyed to enable women to make an informed decision. Childbirth educators must place more emphasis on unexpected outcomes in labour such as prolonged labour, emergency caesarean sections or even the death of a baby.

Childbirth educators should be involved in the clinical practice

Ongoing communication between childbirth educators and the labour ward staff is important. The childbirth educator can attend staff meetings and can spend time in the unit with a labour ward midwife to maintain an awareness of the daily realities of the childbirth experiences and unit routines. Disappointments and unmet expectations for the labour, birth and postpartum experience can be avoided if childbirth educators are fully familiar with the policies of the maternity unit. Childbirth educators should discuss the importance of the birth plan with the maternity staff as the creation of a birth plan has the potential to be an educational process for all concerned.

Childbirth educators should provide or facilitate continuous support for the fathers in the preparation for birth

Every effort should be made to ensure that all labouring women receive support, not only from those close to them but also from the experienced caregivers. The support that should be routinely offered to the labouring women should include continuous presence (when wished by the mother), the provision of hands-on comfort, and verbal encouragement. The father seems to be the most important support person; he should be prepared adequately so that he can support his partner. All labouring women must be allowed to choose their own support persons and the support offered to labouring women must be extended to their support persons.

Childbirth educators and labour ward staff should participate in continuous education

They should attend the midwifery symposiums and

continuation education programmes and keep up to date with available research, especially with regard to breastfeeding, so that they can offer better health care. In-service training programmes should focus on dealing with emerging issues, which could affect the childbirth experience. Hospital staff must be knowledgeable about support systems after discharge and should refer couples to breastfeeding consultants if needed. The image of the hospital nurse and midwife should receive attention – in-service training should include professional conduct. The use of an image consultant could be of value.

Clinical practice

Labour ward and maternity staff must be knowledgeable about the need for decision-making

Simkin and O'Hara (2002:131) identified information and communication between women and their caregivers as important in labour support. The women should be empowered to be involved in their labour by involving them in decision-making. A birth plan should be implemented if presented. Making it easier for her to achieve her wishes is an important factor in helping the mother to feel good about her childbirth experience (Enkin *et al.* 2000:314). Caregivers should welcome and support mothers and their companions from the moment of arrival. They should introduce themselves and give information about others whom the mother might see during labour (Enkin *et al.* 2000:256). All midwives should strive to support women both physically and emotionally. This implies attending to pain, hunger and thirst, to advise, explain, praise and encourage. All these actions will help to alleviate anxiety and fear. Labour admission should include questions related to the type and extent of childbirth education as nurses have a responsibility, whenever possible to facilitate an experience for each couple that matches their expectations. Knowledge and skills learned in the childbirth education classes are enhanced when the nurse present during labour and birth believes in and supports the couple. Allow women to be in control of their labour by involving them in decision-making such as birth plans, interventions done, their needs and wants. Gibbins and Thomas (2001:302) found that a sense of being in control is important in helping women feel positive about their labour experience. Women need to feel in control of their bodies and the options concerning pain relief.

No labouring woman must feel forced or coerced into having, or not having pain relief; it must be a conscious decision from her. Simpson and Creehan (2001: 424) feel that women choose pain relief strategies based on what they learned in the childbirth education classes. Caregivers should ask each woman, preferably before labour begins or at least before it is well advanced, what she hopes for and expects in terms of pharmacologic pain relief. Given the previous comment, women should be allowed the freedom to exercise a choice regardless of the staff's preferences.

Midwifery education should address childbirth education

Student midwives should be made aware that every woman has her own needs, values and desires, which should be respected. During the training of midwives, more emphasis could be placed on the importance of childbirth education classes.

LIMITATIONS OF THE STUDY

The data collected were based on the women's ability to recall what they experienced and the information received before and during labour. They may not have remembered all the information given to them. The primigravida might be disposed to evaluate what has been experienced as positive, presumably because they have no knowledge of alternatives (Walsh, 1999: 66), and therefore have a tendency to express satisfaction with their childbirth experiences because of the emotional intensity of labour (Green, Renfrew & Curtis, 2000:187; Walsh, 1999:166). The researcher is a midwife who worked in the labour ward during the period of conducting the interviews, and was wearing a uniform that could have affected the responses because of concern that their responses could influence their care as clients.

RECOMMENDATIONS FOR RESEARCH

Further research on the contributions of childbirth education classes towards birthing and breastfeeding experiences of the primigravida is recommended using a larger population, to enable universal generalisation of the findings. The study took place in Johannesburg, Gauteng. This research can be extended to other cities and areas for validation of these findings. Auditing of the childbirth education curriculum, as well as criti-

cal evaluation of the childbirth education classes is recommended.

CONCLUSION

From this study, the researcher has realised that it is important to prepare for childbirth not only physically but also emotionally and psychologically. Knowledge brings with it power, confidence and courage. The researcher hopes that by promoting awareness on the topic, childbirth educators and practitioners will be more sensitive to the needs of the expecting couple and better equip their childbirth education content.

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