A literature review on childbirth education

Jordaan C, BCur, Professional Nurse and Advanced Midwife
Labour Ward, Steve Biko Academic Hospital

Correspondence to: Ms C Jordaan, e-mail: stellax01@gmail.com

ABSTRACT
Childbirth education falls under the concept of health literacy. It is also referred to as prenatal, antenatal or perinatal education and aims at preparing women and their partners for childbearing and childrearing. Before westernisation and industrialisation women acquired knowledge on these issues by means of informal information sharing between female community members, but due to the breakdown of the “women’s network”, more formal methods of information sharing developed. This article will focus on the history of and the current trends in antenatal education and will attempt to find evidence to illustrate the aims and importance as well as the limitations of this subject. Childbirth education in the South African context will also be discussed.

Introduction
When “childbirth education” is mentioned, a picture of middle or upper class women attending formal antenatal classes comes to mind. Gagnon confirms this when saying that the vast majority of literature on antenatal education describes the courses offered to typical attendees, i.e. well-educated women in the middle to upper socioeconomic strata.1

There is much more to childbirth education, however, and the importance rather than the luxury thereof is often forgotten. This article will focus on the history and the current trends in antenatal education and will find evidence of its positive aspects and limitations. Attention will also be given to the status of childbirth education in South Africa.

The development of childbirth education
Before the existence of formal antenatal education, the only information women received to prepare them for childbearing and child rearing came from family members such as grandmothers and aunts. This is referred to as “the women’s network”. Traditional birth attendants, who gained experience by giving birth themselves, attended to childbirths. Knowledge about pregnancy and childbirth was for women’s ears only and as births and childrearing took place at home, younger women were often exposed to it.2

Westernisation can be blamed for the breach in the women’s network. The following situation in England, as described by Nolan, is a good example. In the nineteenth century, rapid urbanisation caused inadequate sanitation and overcrowding of living areas. Parturient women had to move into the public hospitals to escape unhygienic environments and lack of privacy. Young women were no longer witnessing births and they were desperate for knowledge of themselves as women.3

Nolan states the following: “Since Victorian times, the non-availability of the women’s network to middle class women has forced them to seek knowledge of their own bodies, confidence in their childbearing capacities and the support of other women through formal educational opportunities.”4

In the seventeenth century, physicians first portrayed birth as a pathologic condition which required medical intervention.5 The Chamberlain dynasty of doctors’ creation of the obstetric forceps marks the involvement of “medical men” in childbirth.6 From there onwards, obstetrics developed as a specialty and women no longer had the same confidence in their innate ability to give birth.

Midwives’ influence declined along with women’s control over childbirth.7 Between 1900 and 1930, midwifery almost ceased to exist, because it was not seen as practising medicine. The midwife was part of the women’s community and spoke their language. It was only in the 1970’s that midwifery had a revival.7

Early childbirth education programmes
Whilst traditional methods of information sharing were declining, structured education in preparation for childbirth and parenthood came into existence.1 In 1908, in New York, classes in maternal hygiene, nutrition and baby care began in reply to the demand for childbirth education as a universal preventative health concept.1

Initially antenatal education programmes mostly included information based on the beliefs of childbirth educators. In the 1950’s and 1960’s there was a realisation in Europe and North America that obstetrics had become over-medicalised with the use of drugs and operative delivery. There was an emphasis on complications of childbirth, rather than talking about healthy pregnancy. This gave way to the development of the approaches of “natural childbirth” by Dick-Read and Lamaze’s “psycho-prophylaxis”, which became popular and are still used in childbirth education today.6

Current childbirth education programmes
Modern antenatal education programmes make use of Lamaze’s and Dick-Read’s emphasis on a healthy pregnancy, physical fitness, education on the physiology of normal birth, elimination of fear during labour, use of relaxation and breathing techniques and continuous support by a familiar person. They also have the
additional goals of good health habits, stress management, anxiety reduction, enhancement of family relationships, feelings of empowerment, enhanced self-esteem and satisfaction, successful infant feeding, smooth postpartum adjustment and advice on family planning.1,5

In the late 20th century the western world began to realise that antenatal education should not be regarded as a luxury, but as a vitally important aspect of healthcare.2 This was in response to a need to improve antenatal care and maternal-infant outcomes. In 1989, a report of the United States Public Health Service Expert Panel on the Content of Prenatal Care stated that health education should become a more integral part of prenatal care.6 The Swedish government introduced childbirth and parenthood education classes as an integrated part of antenatal care in 1980.7

Throughout the western world antenatal education classes, also known as “childbirth education programmes” and “prenatal classes” are attended by a large percentage of pregnant women. Obstetrical agencies such as public health departments, hospitals, private agencies, and some obstetricians’ and midwives’ practices have been reported to provide childbirth education. In developing parts of the world, however, pregnant women still rely on traditional, less formal information sharing where childbearing and childrearing are concerned. Information is passed on to them by their mothers and traditional birth attendants.1

The aims and importance of childbirth education

Maternal health literacy can be defined as the acquisition of cognitive and social skills which determine women’s ability to obtain, understand and use information in ways that will promote and maintain their health.8 It involves preparation for labour and birth, as well as for parenting.10

A pregnant woman, just like any other human being, has the innate need to be in control of her own body and of the environmental factors which have an influence on her. A report by the Expert Maternity Group in London condones the importance of this premise:

“The woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved.”

Childbirth education aims to ensure a healthy baby and a healthy, empowered mother, family and community.10 Women need to leave antenatal education classes with the skills and confidence to take a range of actions that contribute to successful pregnancy, childbirth and early parenting.9

Lack of support, lack of control, anxiety and depression are given as reasons by women describing their negative labour experiences.11 In a study in Montreal, women reported that their main reason for attending childbirth classes was to reduce their anxiety about labour and birth. The men stated that their main reasons for attending antenatal classes were to satisfy the wishes of their partners and to learn about caring for the infant.4 Adequate birth preparation by both the pregnant woman and her partner is also advantageous for the midwife. When a couple is well-prepared, they cope better with the childbirth and the stress of the process.9

Attaining antenatal education through group antenatal classes has been found beneficial due to the socialisation with other expectant parents.4 Couples participating in childbirth education often develop relationships with other couples in the group and meet with them long after the births of their babies. This suggests that antenatal education has a positive impact on new parents’ social network. In their study, Fabian et al reports that 58% of women in their study sample had met with other couples within one year after birth.7

Cochrane reviews have been done on childbirth education. The facts that antenatal education aims to prepare expectant parents for childbirth and parenthood and that women and their partners look for important information such as pain relief, decision making during labour, infant and postnatal care and breastfeeding are mentioned. Fewer unnecessary hospital consultations for false labour are also hypothesised.12 Unfortunately, high-quality evidence on the effects of antenatal education is not available.1,12

The limitations and negative aspects of childbirth education

From the history we can deduce that antenatal education is seen as an artificial construct. It attempts to replace the facts and emotional insights traditionally transmitted by the women’s network, but according to Nolan, it has not been very successful yet.5

Hospital-based education programmes have a tendency to be for the purpose of orientating women to the specific facility or to familiarise them with their appropriate ways of giving birth. Giving education on a variety of issues like pain relief techniques and the pros and cons thereof does not seem to be a priority.11 Antenatal classes equip women to manage decisions during pregnancy and childbirth, but give little attention to preparing women and their partners for the actual event of labour.8

The effects of antenatal classes depend on the characteristics of those who attend the classes, the skills of the teacher, and the objectives of the programme.7 The practitioner or educator may be from a different cultural background. A particularly important aspect of communication is sensitivity to the diverse cultural needs of the population being served.7

Gagnon criticises modern antenatal education programmes by saying that they are usually not based on the expressed needs of the participants, but on the information educators believe they should impart.1 The fact that midwives and voluntary educators often do not pay due attention to the principles of adult education, worsens the problem.3

Antenatal education in South Africa

The Department of Health has set certain standards for educating women in South Africa. The aim is to educate them on important topics such as booking for delivery, child preventative care, child feeding, care of breasts, vaginal bleeding, signs of hypertension and diabetes, anaemia, labour rights and family planning. Evidence suggests that it is crucial to meet these standards, but that several barriers are causing difficulty.13
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In the 2002-2004 confidential enquiry into maternal deaths in South Africa it was reported that non-attendance of antenatal care carried a four times increased risk of maternal death. One can only assume that the correct antenatal education could have played a part in preventing many of these deaths.

Women in South Africa have a wide variety of sources of antenatal education. Those who can afford it attend formal childbirth education programmes at hospitals or private practices and buy books, magazines or search the internet. Those living in urban areas and who do not have the financial resources for antenatal classes rely on the health workers at their local municipal clinics for information.

South Africa's unique situation, with a significant chasm between the practices of the affluent and the poor, presents the health care system with major challenges. There are reduced numbers of health care personnel and services, and services have been found to be inaccessible, unavailable and/or unaffordable.

Some women in rural areas still rely on family members to prepare them for childbirth. There could be a large percentage of women not receiving any kind of education prior to the delivery of their babies and who are totally unprepared for this life-altering event.

Conclusion

Childbirth education is not a new concept, but it has changed significantly over the last few centuries. In earlier times, it came to pass in a mostly informal way, through family and friends. Nowadays there are various types of formal antenatal education programmes.

The most important aims of antenatal education as suggested in available literature are that it empowers the woman and her partner and equips her with the knowledge to be able to make informed decisions during labour and childbirth. Specific programmes based on the methods of Dick-Read and Lamaze train the woman and her partner to apply certain techniques during labour in an attempt to relieve pain by shifting the focus.

There are negative aspects to childbirth education. The manner in which it is conveyed relies on personal characteristics of the educator – and problems such as cultural differences can have a negative impact. Birth plans can make the woman feel in control, but it can also give her the unrealistic idea that a very unpredictable life event is controllable.

The status of antenatal education in South Africa is not formally stated in any of the available literature, but it is known that variables such as socioeconomic status influence women's attainment of childbirth education. It is clear that education – especially on risk factors and behaviour during pregnancy and childbirth – is a necessity and can improve maternal and fetal outcomes.

References:


