North Western Health Board
Bórd Sláinte an Iar-Thuaiscirt

Review of Antenatal Education in Sligo / Leitrim

SUMMARY

oreword

Health Promotion and Antenatal Education: The Links

Pregnancy is a time of enormous change in the life of a family and the antenatal period is unique in terms of the contact a family has with the health services.

Pregnancy is not an illness and in general, parents-to-be want the very best outcomes for themselves and their baby. Therefore, the role of health services in this period must be to maintain and promote the health of the mother, to ensure so far as it is possible the safe delivery of a healthy baby and to impact positively on the future health of mother, father and child.

Antenatal education was understood here to include all opportunities for education about pregnancy, childbirth and parenting during the antenatal period and all preconceptual education and information that prepares for the antenatal period.

Traditionally, antenatal education has been primarily concerned with preparing mothers-to-be for labour and delivery through the provision of a number of formal antenatal classes. In some instances fathers or other support persons have been included in this preparation to varying degrees. Normally some information on infant feeding and care of the new-born baby is also included.

However, there are many other sources of information about pregnancy and childbirth including people's general education; "lifeskills" education (e.g. NWHB Lifeskills Programme); media sources (e.g. magazines, TV, Radio); Health Promotion campaigns (e.g. Folic Acid) and informal social networks of family and friends. The reality is that antenatal education begins in childhood when attitudes that may influence later behaviours and lifestyle decisions are formed as a child grows up in his or her family of origin.

A mother and father confirming a pregnancy embark on the journey to parenthood with their own individual sets of experiences and feelings. A mother-to-be may have a lot of information or very little, may want to know everything or be in denial about aspects of pregnancy, may embrace her condition with joy or be repelled or fearful about the experience. She may be in a loving relationship with a supportive partner, be embedded in a strong social network and have financial security or may be feeling lonely and isolated without a partner or with a partner who is unable to provide the support she needs. A man may be feeling out of his depth, trapped, uncertain of his role or afraid of what will be expected of him or sharing the joy and excitement at his imminent fatherhood.

Whatever the circumstances, these are the people who 'get' antenatal education. This education may encourage and empower them to make healthy choices or may urge them into compliance with a system that lacks the flexibility to accommodate their particular needs.

The antenatal period provides many opportunities to have a long term impact on a family if all healthcare service providers work together to provide appropriate information to parents-to-be at each stage along the way, taking each parent-to-be 'where they are at'. That is, if a health promoting approach is adopted, promoting the health of families means allowing time and opportunities for people to discuss their concerns and enabling them to have control over the decisions they make for their own health and that of their baby

A health promoting approach presupposes a high degree of co-operation between various professional groups and a common understanding of the health issues involved. It also requires confidence in parents' abilities to make good decisions when they have the information they need and are given the power to do so. A further requirement is a holistic view of each person as an individual that takes into consideration the parents' physical, mental, social, psychological and spiritual health and recognises all the factors that impact on their health.

April 2000

This is a report of the work of the Antenatal Education Project Team which came together in 1998 to review antenatal education in the Sligo/Leitrim area.

Introduction

The need for this project was identified in the Report of the Advisory Group on Women's Health and Welfare Services (1995) and by a number of service providers in their Service Plans. The review was mentioned in the action plan in the North Western Health Board (NWHB) Service Plan (1998). This review was submitted by the NWHB to the Office for Health Gain as the Board's demonstration Health Promotion Action Project.

The project team included a number of parent representatives and a broad range of service providers who currently or potentially have a stake in antenatal education. Every effort was made during the course of the review to ensure equality and inclusion for all members of the group.

Overview of Issues in Antenatal Education

In recent times more is expected from antenatal education than before. In the past the goal was that mothers would learn about adequate nutrition, healthcare during pregnancy, pain relief. Safe delivery of a healthy baby was the desired outcome. Parents' expectations now extend to feeling healthy and well in pregnancy, having positive experiences during labour and delivery and having high levels of confidence and satisfaction postnatally to care for themselves and their baby and antenatal education is looked to as a means of achieving these.

Evidence for the effectiveness of traditional forms of antenatal education is limited and often conflicting. Antenatal classes are often provided on the basis that they are "a good thing" rather than because attendance at classes clearly shows more positive outcomes than non-attendance.

There is evidence that targeted antenatal education programmes (e.g. programmes targeted at minority populations) and those that include a strong focus on parenting and social support can result in higher levels of confidence, a greater sense of control and satisfaction and in some cases can mediate against the development of post natal depression. When innovative consumer driven programmes are implemented attenders at these programmes are shown to benefit.

Health promotion is defined by the Ottawa Charter (1987) as:

"the process of enabling people to increase control over, and to improve their health".

The US Expert Panel on the content of Antenatal Care suggests that the goals of antenatal education are essentially the goals of health promotion. The panel describes antenatal health promotion as follows:

"Health promotion consists of education and counselling activities to maintain and enhance health, support healthful behaviours, increase knowledge about pregnancy and parenting and encourage the woman and her family to participate in the decisions needed during prenatal care."

The goals for antenatal education providers are outlined by this Expert Panel as follows:

- **To prepare and support parents-to-be in pregnancy and childbirth**
- **To help the growing family to promote its own health and well being**
- **To review periodically their philosophy of childbirth education including needs of families and awareness of group dynamics.**

Evaluation of programmes to assess their effectiveness is essential. The literature highlights the reality that antenatal education is an *educational* not an *obstetric* intervention and evaluation criteria need to reflect this.

Methods

Both qualitative and quantitative research methods were used and the project team was actively involved throughout the whole process. Research took place in the following four stages:

» **Research on models of good practice nationally and internationally**

» **Postal questionnaire to 184 service-users on sources of information and satisfaction with information received; uptake and feedback on antenatal education services; lifestyle and experiences in labour and delivery. Response rate was 58.2%.**

» **Focus Groups with service users and service providers around perceptions and experiences of antenatal education, pregnancy and childbirth. Members of project team were trained in qualitative research methods and undertook facilitation of these groups. A visioning process undertaken by the team following prese**

Results

Overall, the findings indicate that information is most often acquired from sources other than health professionals. In general, results show moderately high levels of satisfaction with the information people received during pregnancy and from antenatal education classes which were attended by just under half of respondents to the questionnaire.

However, the results also highlight the fact that both service users and service providers feel that parents' education and information needs are not being adequately met. This is evidenced by the sense of not being able to influence how things happen during labour and by the feeling of inadequacy expressed by many parents in the post natal period particularly in relation to infant feeding.

- **Less than half the women who responded to the questionnaire had attended antenatal education classes which are the NWHB's main vehicle for providing antenatal education. Most of those who did attend were having their first baby.**

- **Reasons given for non attendance included:**
  - Childcare difficulties
  - Timing of classes not suitable
  - Feeling they knew enough already **(see Figure 1)**

- The main reasons why men did not attend along with their partners were:
  - Work commitments
  - They did not know they were welcome
  - Only 2% of women *did not* want their partners present **as shown in Figure 2.**

Figure 1

Main Reasons for not Attending Classes

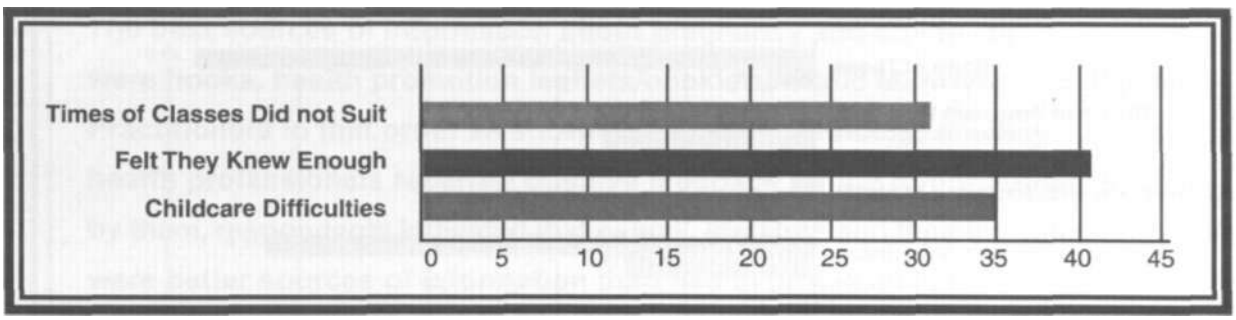


Figure 2

Feelings About Partners Attending Classes

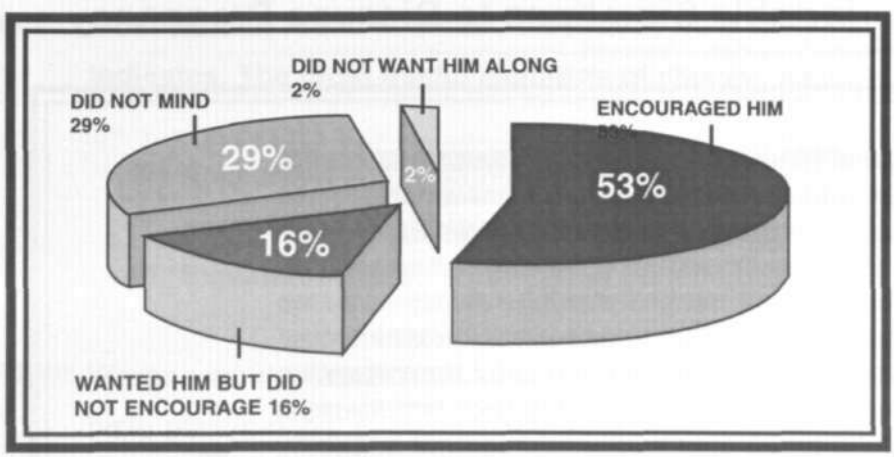


Figure 3

Most and Least Comfortable Situations to Discuss Pregnancy

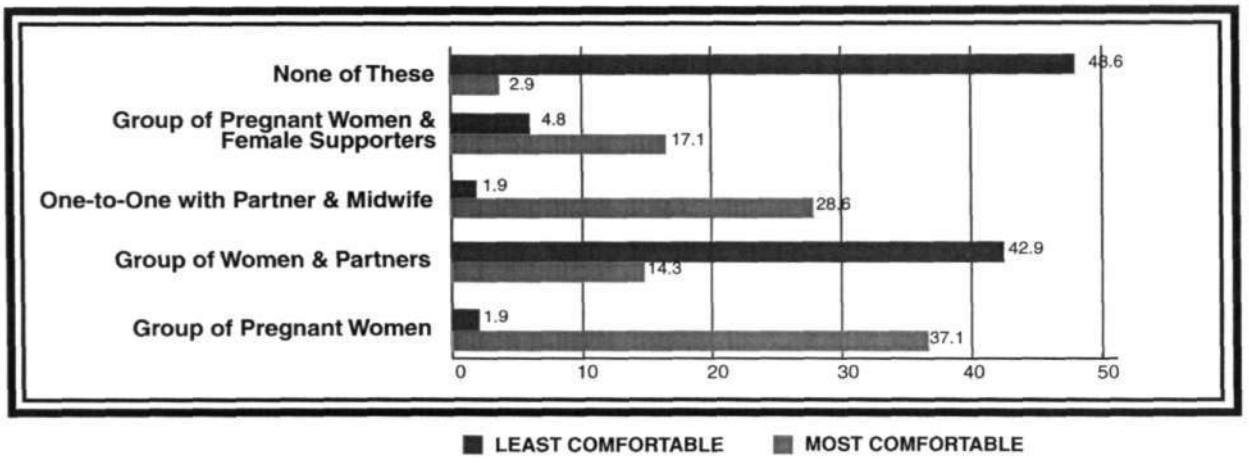
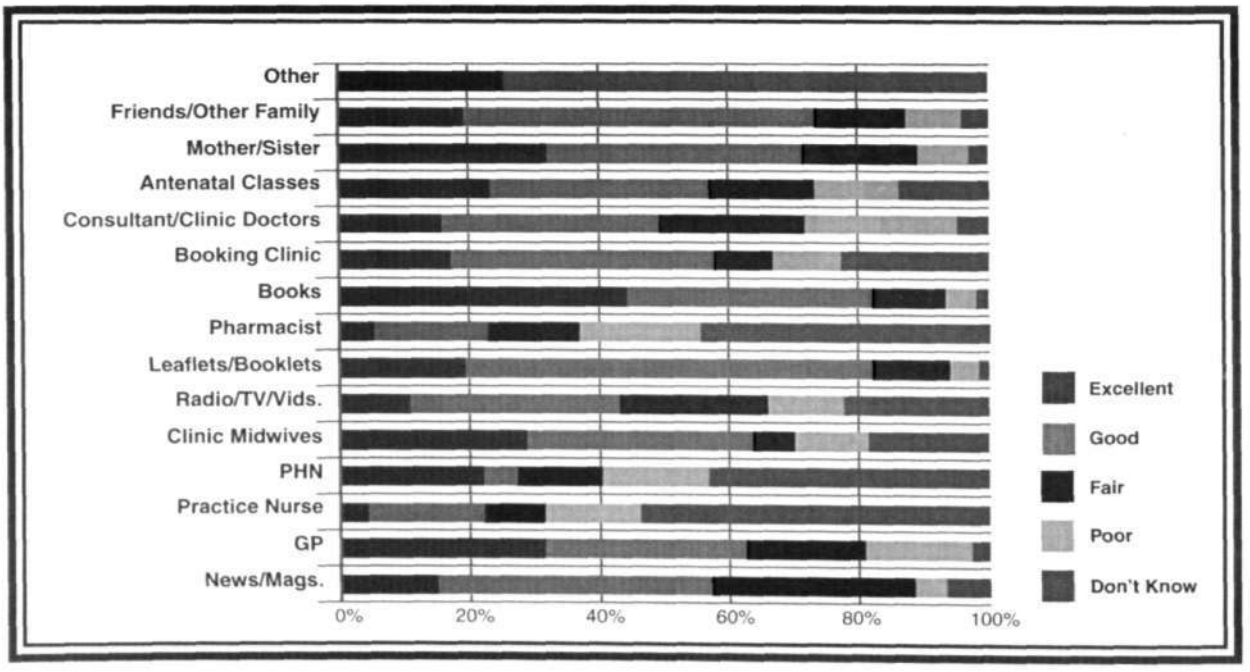


Figure 4

Most and Least Comfortable Situations to Discuss Pregnancy



37% of women said that a group of pregnant women only was the most comfortable situation for them to discuss pregnancy issues (see Figure 3).

The best sources of information about pregnancy and childbirth were books, health promotion leaflets/booklets, Clinic Midwives and General Practitioners in that order as shown in Figure 4. Although some groups of health professionals received positive feed back for the information provided by them, respondents indicated that overall, literature and their informal networks were better sources of information than health professionals.

While there were few clear indications as to what influenced health decisions, General Practitioners appear to have a key role in influencing smoking behaviour, taking folic acid and a number of other lifestyle behaviours.

Most women found antenatal classes at least fairly helpful as Figure 5 indicates. The most useful elements of classes were:

- **Relaxation and breathing exercises.**
- **Information about labour**
- **Explanations about pain relief (see Figure 6)**

Women would like more information on exercises, assistance with a birth plan, caring for babies and infant feeding (see Figure 7).

Only a minority of mothers had discussed or completed a birth plan and fewer still understood the options involved.

Only one quarter of the sample was breastfeeding at the time of responding (3-6 weeks postnatally) and half of the sample had bottle fed exclusively from the outset (see Figure 8). Women who breastfed were more likely to have higher levels of education. Women aged 25-29 had the highest levels of breastfeeding.

The majority of women decided how they would feed their baby before becoming pregnant or in early pregnancy. This was particularly true for those who bottle-fed exclusively and for those who were breastfeeding at the time of the survey (see Figure 9).

Mothers reported being inadequately prepared for the difficulties associated with breastfeeding. They felt unprepared in the postnatal period and spoke of inadequate support in the postnatal ward and at home.

Service users and service providers both recognised that understaffing limits educational opportunities on the ward as women are reluctant to 'bother' busy Midwives for information. It was identified that parents do not have access to the information and support they need postnatally at home. This often causes feelings of isolation, anxiety and helplessness at this stage.

Women spoke of not being prepared for the enormity of the experience of giving birth, even if they have adequate information. Many women described their experience during labour and delivery as "traumatic" even when they did not experience a medical emergency. Some of this trauma resulted from not having clear information about what was happening and feeling that they were not being listened to. The point was made that women are often not given adequate information to make informed choices in relation to labour and delivery.

Some health professionals suggested that to some degree pregnancy is over-medicalised. They proposed that some routine physical checks might be unnecessary in a healthy low-risk pregnancy and time might be better spent providing information and support for expectant families.

Men's need are not being met in relation to antenatal education. The role of fathers as supporting persons to their partners during pregnancy, labour and delivery has not been given adequate attention and classes are not designed to include fathers or adequately meet their needs.

Traveller women were positive about the services they received. They tend to receive individualised antenatal education and they saw pregnancy and childbirth as the domain of women, so they were not anxious for partners to be involved.

Figure 5

How Helpful Attenders Found Classes

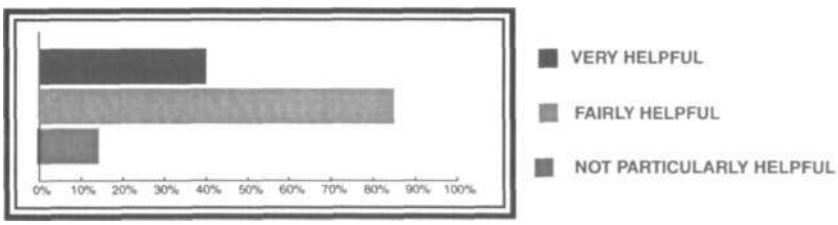


Figure 6

Most Helpful Aspects of Classes

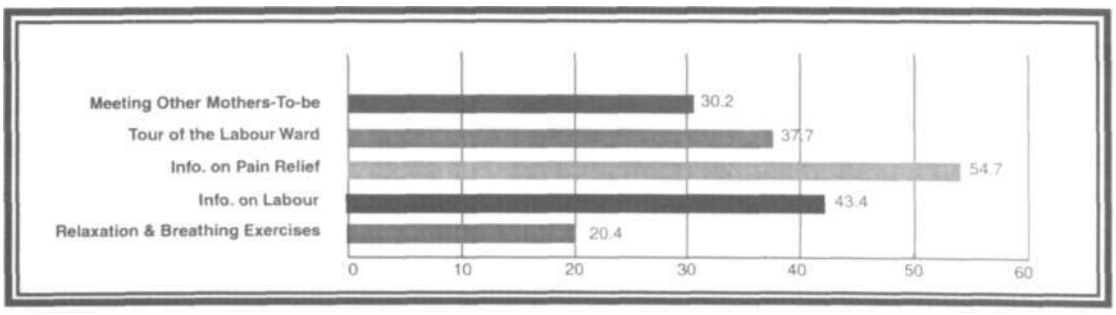


Figure 7
What Respondents Would Like to Have More of in Classes

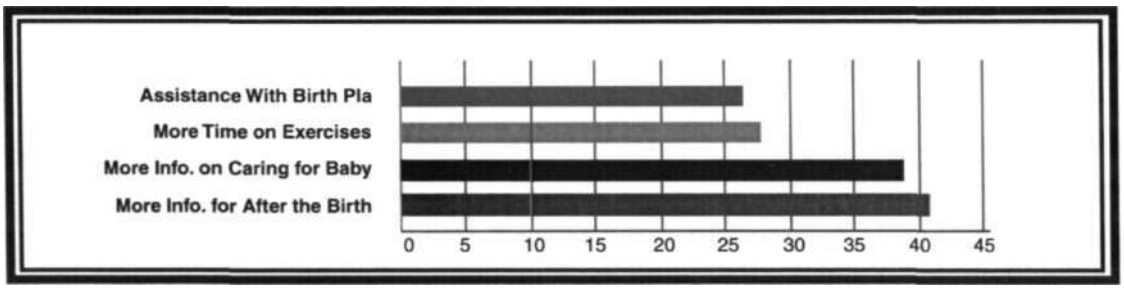


Figure 8
Method Of Feeding

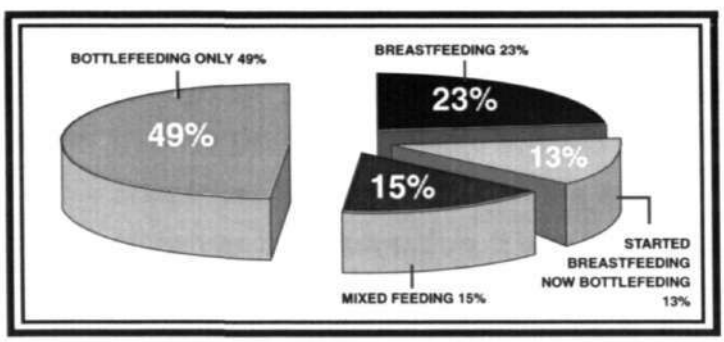
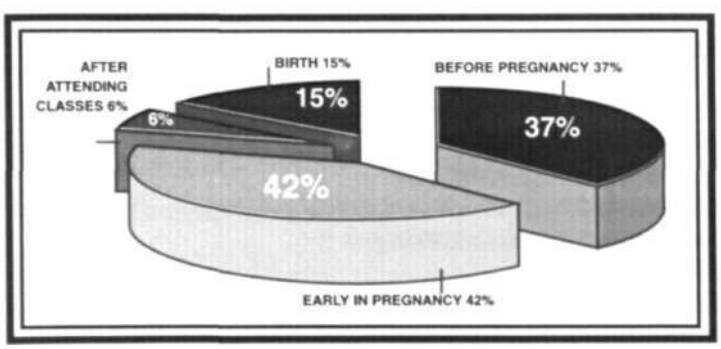


Figure 9
When Method of Feeding was Decided



Vision of Antenatal Education

The Project was underpinned by a central belief that 'if we always do what we've always done, we will always get what we've always got'.

Elements of a 'Whole Systems Approach' were used in the process. The theory underpinning this approach is essentially that in planning change, all elements of a system, the stakeholders, must be involved in the change process for it to happen successfully with outcomes that benefit all concerned.

From the start of the project, antenatal education was considered as part of a continuum of development that starts in early childhood and includes attitudes, knowledge and behaviour.

The short time span when "antenatal education", (i.e.short educational programmes) is provided has limited potential to change attitudes, knowledge and behaviour. From this perspective, the importance of looking at the "whole system" becomes clearer. We begin to realise that to have healthy pregnancies, healthy babies and healthy families - antenatal education needs to start long before a baby is conceived. Young boys and girls need to learn early about how to be assertive in relationships, how to prepare themselves physically and psychologically for pregnancy, childbirth and parenting.

Following presentation of the results of the research process, the project team engaged in a visioning exercise. Based on the findings and the research into models of good practice, the following were the features of the ideal situation in the North West in 2005 across various stages in the life span.

- **0-12 year Olds** are introduced to the facts of life at a basic level, have information on birth, breastfeeding etc. included in their school readers, and have parents who listen to them.

- **12-15 year olds** have a good understanding of the facts of life, are involved in group discussions on sexuality, are assertive and confident, feel they have choices and are well informed about social, emotional and financial matters.

15-18 year olds have pre-conceptual education, are in a position to make informed choices around sexual behaviour, know about contraception and use it and can be comfortable communicating with parents and other adults about their fears, concerns, needs etc.

Young people 18+ feel confident enough;

- not to need drugs/alcohol or unhealthy relationships,
- have supportive networks in their lives,
- only have planned pregnancies,
- have a greater understanding of the importance and responsibility of the parenting role.

Young people considering pregnancy

- are in stable relationships,
- are healthy,
- do not smoke,
- take Folic Acid,
- are treated with respect,
- know that babies are not toy dolls,
- and understand that babies have rights too.

In the first trimester

- women know they are pregnant,
- know they are supported,
- are given information on and clearly understand what to expect,
- are given and understood information on the services available to them in the area,
- are clear about the care they need and receive adequate information to make informed choices on their care,
- get (non-directive) information on all the options,
- have a positive experience at the hospital where they feel listened to, understood and helped,
- are treated in a sensitive manner if they experience a miscarriage,
- meet their midwife and start to build a relationship early on.

In the second trimester

- they can talk about their fears,
- are aware of their social welfare entitlements,
- can enjoy the pregnancy,
- are assured that this is a normal life event,
- feel healthy.

in the third trimester

- have access to women who have recently become mothers,
- can talk about their fears,
- have time off work to attend classes,
- can job-share,
- have a home visit from a Midwife,
- can unwind and try to enjoy this special time.

During labour

- people understand everything that is happening and the reasoning for actions,
- women are supported by informed, confident partners,
- there is a relaxed atmosphere with children present when appropriate,
- they have space and are allowed to walk about.

Immediately after the birth of the baby

- mother, father and baby have some time alone,
- women are helped to understand that this might not, for everybody, be the most wonderful
- moment of their life and that they might not feel instant attachment to the baby,
- people have ways of contacting peer support.

during the time in the post-natal ward

- women can rest,
- more Midwives are available,

- a Counsellor is on hand to talk over the experience,
- mothers feel confident about breastfeeding,
- father's visiting time is just that - for fathers,
- they are asked 'how do *you feel?'.*

In the six weeks after the birth

- there are community midwives,
- mothers have partner, family and community support,
- and fathers know how to help/what to do.

The vision of the future has implications for the education and for other organisations.
It also suggests a future in which all health professionals will work together and will use every available opportunity to provide people with information to enable them to make healthy choices.

Within the ideal scenario, it becomes possible to visualise a "childbirth preparation" system which:

- Is flexible, accessible, run in satellite clinics
- Is based on needs, wants of participants
- Includes partners
- Is founded on good models of adult education
- Is evidence - based
- Includes quality standards
- Ideally has 10-12 members in groups
- Is made available and easily accessible to special needs groups e.g. "have to know" material might
- be included in a special session for young mothers at morning clinics.

In order that these programmes be developed and be supported by the whole system, there is a need for the provision of training for a range of service-providers and facilitators would have a wide rang of skills. Training would be provided for the following:

- For those who provide/facilitate "childbirth education"

- For staff in labour wards as what is said in groups needs to reflect on what happens in hospital.
- For G.P.s, PHNs, Radiography staff, Physiotherapists and other health professionals to ensure consistency of health messages.

* For clinic staff and G.P. administration staff to ensure that needs of parents are understood and given consideration.

- For parents, who with their experience of pregnancy, childbirth and parenting, could provide valuable information and support through education programmes

Discussion and Synthesis of Findings

The potential exists for influencing health and social gain for mothers and families if educational opportunities are developed to respond to consumer needs. In light of the poor uptake of classes as they are currently offered, the development of an approach to antenatal education which is consumer led and needs driven is proposed.

In particular there is a need to enhance the health promoting role of a number of health professionals especially GPs and Midwives. There is an identified need for good quality, relevant information to be readily available during pregnancy *and* pre-conceptually and for efficient delivery systems for this information. Other areas of concern that emerged during the research process and may need further attention were the need for parenting education and support.

Conclusions

The challenges faced by this research process and the diversity in the findings only serve as a reminder that antenatal education is not a static unitary concept to be imposed on a receptive homogenous population. Rather it is a series of responses to a set of changing needs varying across individuals and groups who may need to be accessed in diverse ways. In order to achieve its goals and maximize its potential it needs to form part of a supportive empowering framework of service provision from the pre-conceptual stage to early infancy. This study suggests that health and social wellbeing of mothers, babies and families could be greatly enhanced if antenatal health promotion becomes the goal for the NWHB.

The model of antenatal education

An enhanced health promoting role for all health professionals who come in contact with pregnant parents

and

Education sessions that are targeted, needs driven and consumer focused.

Recommendations

The main recommendations in this report are as follows:

- The development of an information resource pack for parents which would include up to date local information. The short-term appointment of an Information Co-Ordinator to take responsibility for this development is recommended.

- The development of a model of antenatal education, using a partnership approach, to be delivered in a variety of settings that can meet the needs of all service-users in the Sligo/Leitrim area, particularly those who do not currently access services

- The appointment of an Antenatal Education Co-Ordinator to facilitate the development of flexible programmes of education in accordance with the needs of various client groups.

- Submission of recommendations, as appropriate, to the NWHB Parenting Strategy group and other relevant groups locally and nationally.

Summary of Other Recommendations

In addition to the main recommendations for action arising directly from this project, a number of other recommendations follow from the findings. Some of these relate to issues that are outside the brief of this project but were priority concerns for study participants. These secondary recommendations include the following:

- Engaging directly with men to gather information on the experiences and needs of fathers
- Provision of antenatal education programmes outside of normal daytime working hours where appropriate to meet the needs of service-users.
- Development of planned Midwives' Clinics with a strong emphasis on a health promoting and educational role of midwives
- Widespread dissemination of good quality information around breastfeeding to ensure this informs the preconceptual attitudes and values towards infant feeding.
- Development of an infant feeding policy in the Board's area to inform the actions of all relevant services.
- Provision of increased support at home for families postnatally .
- Provision of support both in hospital and at home, postnatally, for women who initiate breastfeeding.
- Encouragement of breastfeeding support groups and provision of information about them to mothers.
- As recommended in the NWHB Primary Care Strategy (1999), support initiatives at national level to amend the GP contract and include antenatal education and health promoting activities in it.
- Development of a clear policy on the use of birth plans and support for staff to practice in accordance with the policy once it is in place.

Acknowledgements

The progress of this project through the various stages from its initiation to the production of this final report has been made possible by the co-operation and involvement of a large number of people. We would like to express our gratitude to everybody who has contributed towards the achievements of the project to date.

Sincere thanks are due to the members of the Antenatal Education Project Team who have given so generously of their time and energy throughout the project.

We greatly appreciate the co-operation of NWHB staff members, particularly Sister and staff of the Maternity Ward, Sligo General Hospital, for their commitment to the research process. We also acknowledge with thanks the efforts and co-operation of several other individuals and community-based groups in facilitating this research. We are very grateful to all of the study participants for sharing their views and experiences, which provided very rich sources of information. The results presented here could not have been achieved without the involvement of all of these people.

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Lily Murphy
Joan Mullan **April 2000**