Does Childbirth Education Make a Difference?

Judith Lothian, PhD, RN, LCCE, FACCE, FAAN

ABSTRACT

Childbirth education is designed to help women access accurate and up to date information about childbirth and make informed decisions about their care. Exposure to evidence based information about maternity care practices should assist women to make informed decisions that are based on that evidence. Evidence based childbirth education should ultimately affect outcomes but there is a dearth of research that looks at the outcomes of childbirth education. This editorial suggests that this research is long overdue.

Judith Lothian
Associate Editor

The Journal of Perinatal Education, 25(3), 139–141, http://dx.doi.org/10.1891/1058-1243.25.3.139
Keywords: childbirth, childbirth education, childbirth outcomes, maternity care practices, normal birth, healthy birth practices, childbirth education research

Since the formalization of childbirth education in the 1960s, the goal of childbirth education has been to provide women and their families with knowledge about labor and birth, and ways to deal with the challenges of labor. With this knowledge women are able to make informed decisions, and advocate for themselves in the maternity care system. Women who attended childbirth class in the 1960s and 1970s did so in order to avoid medication and have a support person, usually their husbands, with them in labor. Women who attended classes back then were more likely to have natural births. Does childbirth education still affect outcomes?

Almost 60 years later, the goals of childbirth education remain the same, however, there is now a solid foundation of research support for both the value of the normal physiologic process of labor and birth and the care practices that facilitate that process. In excellent childbirth education classes, women learn not only about the process of labor and birth but the evidence based maternity care practices that facilitate the physiologic processes. There is substantial research support for the value of six maternity care practices that facilitate the physiologic processes of labor and birth: letting labor begin on its own (Amis, 2014), freedom of movement in labor (Ondeck, 2014), labor support (Green & Hotelling, 2014), avoiding routine interventions like continuous electronic fetal monitoring, intravenous and restrictions on eating and drinking, routine use of epidurals and liberal use of episiotomy (Lothian, 2014), avoiding the supine position for birth and the value of physiologic pushing (DiFranco & Curl, 2014), and keeping mother and baby together (Crenshaw, 2014). These six evidence based maternity care practices are an important part of the curriculum of excellent childbirth education classes. If women have an understanding of the physiology of

Surprisingly, since the 1970s there has been almost no research that looks at the outcomes of childbirth education.

labor as well as the evidence based care practices that facilitate that process it seems logical that women who attend childbirth classes would be more likely to let labor start on its own, move freely in labor, keep birth in upright positions, have fewer routine interventions, keep their babies with them, and ultimately be less likely to have a cesarean compared to women who do not attend childbirth classes.

Surprisingly, since the 1970s there has been almost no research that looks at the outcomes of childbirth education. The only recent research that has looked at outcomes, demonstrated a relationship between attendance at childbirth classes and the elective induction (Simpson, 2010). The women who attended childbirth class with an expanded, evidence based, curriculum on induction were less likely to be induced than the women who gave birth in the same hospital but did not attend childbirth education classes. Further research is critical.

Not unlike the 1960s, childbirth takes place in hospitals and the maternity care system itself exerts a powerful influence on whether and to what extent women are able to make informed decisions about their births. Maternity care in the US is far from evidence based. To what extent does this thwart women's efforts to have the safest, healthiest birth possible? Excellent childbirth education today, like in the 1960s, must prepare women to advocate for themselves. We need to do research that looks at the ways in which women's plans for their births are ignored or sabotaged in a maternity care system that is not evidence based.

It is time to test our hypotheses. Does childbirth education make a difference in women's experience of birth? Does it make a difference in women's ability to find comfort (other than the epidural) as labor progresses? Can childbirth education affect not just the rates of elective induction, but the cesarean rate? Are women who attend evidence based childbirth classes less likely to need an epidural? How do women who attend childbirth classes describe their births? What memories of birth do they pass on to their friends, their families, their children? Are women who attend childbirth classes more effective in navigating the maze of the current maternity care system?

Does childbirth education make a difference? Let's find out.

It is well past time to methodically research the outcomes of childbirth education. Does childbirth education make a difference? Let's find out.

IN THIS ISSUE

In this issue of the Journal of Perinatal Education our feature article titled "Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health," authors Strauss, Sakala and Corry discuss how continuous labor support by a trained doula has proven benefits and is recognized as an effective strategy to improve maternal and infant health, enhance engagement and satisfaction with maternity care, and reduce spending. They advocate for community-based doula programs which can also reduce or eliminate health disparities by providing support to women most at risk of poor outcomes. They argue the most effective way to increase utilization of this evidence-based service would be to eliminate cost barriers. Key recommendations identify numerous pathways to pursue Medicaid and private insurance coverage of doula care. This comprehensive and up-to-date inventory of reimbursement options provides the doula, childbirth, and quality communities, as well as policy makers, with many approaches to increasing access to this high-value form of care.

In this issue's "Celebrate Birth" column, Timothy J. Dolan, describes how after seeing a copy of the JPE that passed his desk, he felt compelled to share his memories of the births of his three children, back in 1975, 1977 and 1979. He describes how participating in their children's various births, he and his wife became strong proponents of taking charge of their health and medical treatments. They believe to this day that a well-informed patient working with health care professionals can result in the best outcome for all parties.

In a descriptive study that examined factors associated with exclusive breastfeeding through 4 weeks postpartum in Thai adolescent mothers, Kanhadilok, McCain, McGrath, Jallo, Price, and Chiaranai, explored personal, social, cultural, and infant factors that explain and predict breastfeeding initiation and maintenance. Findings revealed breastfeeding attitudes, social support, and cultural beliefs about "being a good mother" were positively correlated with breastfeeding initiation. Furthermore, breastfeeding attitudes and social support were significant

positive predictors of exclusive breastfeeding (both $p > 0.01$) continuation through 4 weeks, while infant temperament was a significant negative predictor ($p > 0.04$). Maternal competence at 4 weeks postpartum was also positively correlated with exclusive breastfeeding continuation.

Hauck, Fisher, Byrne, and Bayes discuss mindfulness based childbirth education by incorporating adult and experiential learning with mindfulness based stress reduction in childbirth education. These authors provide both historical and current evidence around childbirth education models including the introduction of mindfulness to parent education. The curriculum of their mindfulness based childbirth education eight week program is shared with corresponding learning objectives for each session along with examples of educational materials that demonstrate how adult and experiential learning are embedded in the curriculum.

Gilliland presents the results of her descriptive survey identifying motivations for attending a birth doula training workshop. Participants selected a variety of reasons; but only 30% chose "become a professional doula" as their main reason. The author proposes that besides career training, these workshops are filling a cultural gap in childbirth education for people who are not expectant parents, and who intend to utilize this knowledge in unanticipated ways.

In an interesting article on principles, mechanisms and benefits of perinatal music therapy and antenatal music classes, Wolfgang Mastnak, a professor at the University of Music and Performing Arts in Munich, Germany discussed the multifaceted effects of music in pre- and perinatal care.

Finally, Stevenson, Trotter, Bergh, and Sloane present the results of their mixed-methods study to determine pregnancy related anxiety in women who conceive via in-vitro fertilization. The researcher administered the Pregnancy-Related Anxiety Measure to 144 women during their second trimester. Anxiety scores were slightly higher among IVF- compared to non-IVF pregnant women. Thirty-one participants provided narrative data about their pregnancy-specific anxiety. Themes emerged from qualitative analysis related to anxiety about the health of their baby(ies), perception of maternal health and safety, and perception of their abilities to fulfill the role of mother. The authors suggested that because of their relationship with patients during pregnancy, nurses and perinatal educators play a critical role in identification of women with pregnancy-specific anxieties and providing relevant care to address these anxieties.

REFERENCES

Amis, D. (2014). Healthy birth practice #1: Let labor begin on its own. *Journal of Perinatal Education, 23(4),* 178–187.

Crenshaw, J. (2014). Healthy birth practice #6: Keep mother and baby together—It's best for mother, baby and breastfeeding. *Journal of Perinatal Education, 23*(4), 211–217.

Difranco, J., & Curl, M. (2014). Healthy birth practice #5: Avoid giving birth on your back and follow your body's urge to push. *Journal of Perinatal Education, 23*(4), 207–210.

Green, J., & Hotelling, B. (2014). Healthy birth practice #3: Bring loved one, friend, or doula for continuous support. *Journal of Perinatal Education, 23*(4), 194–197.

Lothian, J. (2014). Avoid interventions unless they are medically necessary. *Journal of Perinatal Education, 23*(4), 198–206

Ondeck, M. (2014). Healthy birth practice #2: Walk, move around, and change positions throughout labor. *Journal of Perinatal Education, 23*(4), 188–193.

Simpson, K. R., Newman, G., & Chirino, O. (2010). Parent education to reduce elective labor inductions. *MCN, 35*(4), 118–194.

JUDITH LOTHIAN *is the associate editor of* The Journal of Perinatal Education*. She is also a professor of Nursing at Seton Hall University. She is a fellow in the American College of Childbirth Educators and the American Academy of Nursing and is chair of the Lamaze International Certification Council.*