Childbirth Education at the Crossroads

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ABSTRACT

In this column, a reader expresses concern that attendance at childbirth classes is declining at the same time the cesarean rate is rising. The history of childbirth education is discussed in the context of both access to information and changes in maternity care since the introduction of formal childbirth education. Changing goals and contemporary challenges facing childbirth education are discussed. The need for a new model of educating and empowering women is identified, and ideas for changes are explored.

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READER'S QUESTION

The *Listening to Mothers II* findings suggest that attendance at childbirth classes is declining (Declercq, Sakala, Corry, & Applebaum, 2006). At the same time, the cesarean rate is skyrocketing (Hamilton, Martin, & Ventura, 2007), induction rates are rising (Declercq et al., 2006), and the maternal mortality rate is steadily increasing (Hoyert, 2007). It seems to me that women need childbirth classes more than ever. How can we do a better job getting women to classes and then empowering them to create change in the current maternity care system?

COLUMNIST'S REPLY

Fourteen years ago, we worried that those who attended our classes were predominantly White, middle-class women and that they were suddenly choosing epidural rather than natural births (Lothian, 1994). I argued then that we needed to take a hard look at both reaching more women and evaluating the content of classes so that women developed confidence in their ability to give birth and would chose to give birth naturally. Today, even White,

middle-class women are not attending childbirth classes, even more women are choosing epidurals, and some evidence suggests that there are no differences in outcomes of women who do attend childbirth classes and those who do not (Declercq et al., 2006; Lothian, 2007).

In spite of huge changes in the delivery of maternity care, the basic content of classes has not changed (Morton & Hsu, 2007). Although childbirth educators present information with the understanding that this information forms the foundation for informed decision making, in the current maternity care system, women have very limited choices and lack the autonomy necessary for making decisions about their care (Block, 2007b; Edwards, 2005; Lothian, 2008; Nolan, 2005). Traditional classes are taught in large hospital groups where women and childbirth educators are pressured not to rock the boat (Morton & Hsu, 2007). Respect for women's choices contributes to the childbirth educator's reluctance to challenge women's choices or teach in a way that persuades women to choose normal birth (Block,

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2007b; Morton & Hsu, 2007). One third of the women who want a normal birth end up with interventions, including epidurals (Declercq et al., 2006). Swirling around us is the rising cesarean rate and the increase in maternal mortality and preterm birth. It is safe to say that we are experiencing a crisis in maternity care in the United States. We are also experiencing a crisis in childbirth education. What do we do?

The Birth of Formal Childbirth Education

Formal childbirth education created by Elisabeth Bing and Marjorie Karmel changed the world of birth in 1960. A small number of women wanted to be awake and aware for the birth of their babies. They knew, from Karmel's experience with Dr. Ferdinand Lamaze in France, that to be awake and aware they would need to learn simple relaxation and breathing techniques to cope with pain and would need support and guidance during labor (provided in France by a *monitrice*). Sitting around a dining room table, Bing and Karmel designed something totally different to make that happen—formal childbirth education classes. Women and their partners would learn about birth, relaxation and breathing, and support (coaching) in small group classes outside the hospital. Bing's *Six Practical Lessons for an Easier Childbirth* (1967) outlined the content of classes and became a bible for both women and childbirth educators. In class, women learned what to do to be able to give birth naturally, and they learned specific, practical strategies to convince their obstetricians and hospitals to give them what they wanted. In the beginning, the only women who attended classes were those who knew they wanted to avoid scopolamine and have their husbands with them in labor. Classes started late in pregnancy when, the wisdom of the time suggested, women were ready to think about and prepare for labor and birth. Childbirth educators were

trained by the hundreds to teach classes. In childbirth classes, women developed close relationships with other women and the childbirth educator. Armed with knowledge and confidence, it is not an exaggeration to say that these women changed birth. For the first time in decades, a structure was in place to pass on knowledge and wisdom about labor and birth. It was a momentous change!

Over time, childbirth education became institutionalized. Classes moved into the hospital, and the goal became providing women with information they could use to make informed decisions (too often based only on the choices available in the hospital). Classes began to be promoted as *preparation for birth* rather than *natural childbirth*. Women who did not want a natural birth began to come to classes “for the information.” The idea that classes would provide the knowledge and skills needed to change hospital practice was lost. For the first time, childbirth educators—as hospital employees—faced the dilemma of how to provide accurate, up-to-date information and how to encourage women to choose normal birth and, at the same time, how to avoid getting fired. Large classes did not provide women the opportunity to develop trusting relationships with either the other women in the class or the childbirth educator. Childbirth educators, especially those teaching in hospitals, became increasingly reluctant to persuade women of the value of normal, natural birth.

Unlike 50 years ago, women today come to childbirth classes knowing a great deal about pregnancy and birth. From the beginning of pregnancy, they access information on the Internet, watch *A Baby Story* and other television birth programs, and listen to birth stories of medical, “intervention-intensive” birth from family and friends. In choosing their care provider and place of birth early in pregnancy, women have, unknowingly, made decisions that will affect the care they will receive and the choices they will have during pregnancy and labor and birth. Women are not usually encouraged in childbirth classes to evaluate and reconsider those decisions, mostly because the educator's skill is in providing information and supporting decisions, not in the *art of persuading* women to think differently about birth.

In the past 50 years, pregnancy and birth have become increasingly medicalized. In 1970, the cesarean rate was less than 6% (Centers for Disease Control and Prevention, 1995), compared to today's rate of 31.1% (Hamilton et al., 2007). Fifty

For more information about Dr. Ferdinand Lamaze, Elisabeth Bing, and the history of Lamaze International, read Elaine Zwelling's articles published in earlier issues of the Journal of Perinatal Education (JPE): “Looking Back in Time: An Interview with Madame Blanche Cohen” (Fall 1999, Vol. 8, No. 4), and “The History of Lamaze Continues: An Interview with Elisabeth Bing” (Winter 2000, Vol. 9, Issue 1). These and all other published articles in JPE are available on the journal's Web site (<http://www.ingentaconnect.com/content/lamaze/jpe>). Lamaze members can access the site and download free copies of JPE articles by clicking on the “Members Only” link on the Lamaze Web site (www.lamaze.org).

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years ago, women were not tethered in labor to intravenous lines and electronic fetal monitors. There were no obstetric anesthesiologists reassuring laboring women (wrongly) that epidurals do not affect the baby and that there is no reason to experience pain. The challenges we face today are far different from those faced by Bing and Karmel. The current maternity care system provides routine care that puts mothers and babies at risk, and most women come to pregnancy believing that technology and medical intervention increase safety for mother and baby. The childbirth educator's challenge is to change women's thinking and, in doing so, ultimately change birth. Childbirth education has an important role to play in creating change. What is needed to create change in the 21st century is different from what was needed in 1960.

I think it's time to sit around the table like Bing and Karmel did in 1960. What are appropriate goals of childbirth education today? What model will best achieve those goals? What will the role of the childbirth educator be? Like the founders of formal childbirth education in 1960, we need to figure out what women need to know (not just about pregnancy and birth, but about the dangers inherent in the current maternity care system, and how to create change), where we might best meet them, and when the best time for our encounters might be.

Goals of Contemporary Childbirth Education

The mission of Lamaze International is to promote, support, and protect normal birth. Lamaze envisions a world of confident women choosing normal birth. The goals of Lamaze childbirth education are to promote normal birth, build women's confidence in their ability to give birth, and ultimately to provide the knowledge and skills women need to give birth normally in the current maternity care system. Lofty goals! In order to meet these goals, we need to *persuade* women to choose normal birth and then help them make it possible. Women need to know that there is an optimal way to give birth (Block, 2007a). No woman should leave a childbirth class without being convinced of that.

What needs to happen to achieve these goals? Women certainly need evidence-based information about maternity care practices; they need to know the simple story of normal, natural birth and the care practices that facilitate normal birth; and they need to know the medicalized, routine care practices that make giving birth normally more dif-

ficult. If our goal is confident women choosing normal birth, we need to take things further. We need to actively and passionately *persuade* the women in our classes, even the women who come to classes wanting something different, that there is an optimal way to give birth. We need to influence women's decision making, not just fill their heads with facts and opinions. We need to help women untangle and make sense of the profusion of often conflicting and inaccurate information that is available everywhere, and we need to stay with them every step of the way. Our goal, one that we have been extremely reluctant to embrace, is to *persuade* women of the value and importance of normal birth for them and their babies. We persuade best by sharing stories, by being passionate in our trust of normal birth and women's ability to grow, birth, and breastfeed their babies, and by being shockingly honest and direct. But persuasion is not enough. We need to ensure that women have the knowledge and skills they will need to actually be able to have a normal birth.

Developing a New Model of Childbirth Education

If we are to persuade women to choose normal birth, and then help women make that happen, formal childbirth education will have to change. What do women need to know? Where will childbirth education take place? When will it start? These are just a few questions to consider as we move forward. Here are some thoughts—the beginning conversation at the dining room table.

What Do Women Need to Know? Women are overloaded with information about pregnancy and birth (very different from 50 years ago). What women need now is not more information but accurate, up-to-date, evidence-based information, and they need help making sense of it. Childbirth educators will need to resist the pressure to withhold information or present information in ways that suggest that restrictive hospital policies make sense or that “one choice is as good as another.” We need to make sure that women know that “there is such a thing as optimal maternity care, and they're not likely to have it in this country unless they work hard to find the right provider or start demanding better practices from the ones they've got” (Block, 2007a, p. 8). Women need to know how to find excellent books and Web sites and how to access accurate information outside of their encounters with us. They need to hear stories

To view Lamaze International's Six Core Practices That Support Normal Birth and to read about the evidence that supports these practices, click on the “Lamaze Institute for Normal Birth” link on the Lamaze Web site (www.lamaze.org).

of normal birth and see normal births, not just in hospitals but also in birthing centers and at home.

Where Should Childbirth Education Take Place?

Women today access information on the Internet and through books and television (Declercq et al., 2006). We need to be there. It's time to develop online classes. I am excited about the idea of an online early pregnancy class that helps women make decisions about their care provider and place of birth. Women can now sign up for a 40-week pregnancy e-newsletter program from the Lamaze Institute for Normal Birth. Each week during pregnancy, women will receive an e-mail message with confidence-building, evidence-based information about their pregnancy, childbirth, breastfeeding, and early parenting. Lamaze is also developing an interactive Web-based birth planner for women. It's time to think about creating online social networks to get our message to women and to provide an opportunity for ongoing dialogue.

I think it's worth considering going back to small, individualized, community-based classes. It has probably always been unrealistic to think that teaching Lamaze classes in a hospital is possible without compromising standards and creating conflicts of interests for the childbirth educator. If formal classes are seen in the context of ongoing childbirth education in a variety of ways and in a variety of settings throughout pregnancy, mandates related to the number of classes and the number of hours required in Lamaze classes will no longer be necessary or useful.

It makes sense to think more about how we might collaborate with others who are already working with pregnant women. Yoga and prenatal fitness classes are filled to capacity with women from early in their pregnancies. Group prenatal care is a natural fit with childbirth education.

When Should Childbirth Education Begin? Persuasion takes a long time; therefore, we need to engage women early. The good news is that women start looking for information as soon as they find out they are pregnant. The first place they look is online. What about an early pregnancy class online? What about including information regarding online resources and Lamaze's 40-week pregnancy e-newsletter program in at-home pregnancy tests? Lamaze has launched a consumer Web site, and the Lamaze Institute for Normal Birth's 40-week pregnancy e-newsletter program for pregnant women will be

promoted in obstetricians' and midwives' offices. Childbirth education needs to be an integral part of pregnancy from the moment a woman learns she is pregnant.

Role of the Childbirth Educator

I see today's childbirth educator with an expanded role. She is with women throughout their journey through pregnancy, not just an expert who comes on the scene in the last 2 months of their pregnancy. I have visions of childbirth educators working side by side with midwives and nurses in group prenatal care settings, teaming up with yoga and prenatal fitness instructors, giving lectures in baby stores, and meeting with pregnant women in settings that I can't even imagine (perhaps in the women's homes) to grapple with the hard issues that confront every woman making the journey to motherhood. I also see childbirth educators writing and teaching online courses, presenting Webinars, and developing interactive Web sites.

We need to let go of our fear of offending, of making women feel guilty about their choices, of worrying about women having bad birth memories. Our fears dishonor women. We need to be honest. We also need to be gentle and understanding. We need to confront ourselves so that we can meet women honestly and truly empower them to confront and change the maternity care system. When we are honest, we honor women's wisdom and, in doing so, increase their autonomy and ability to make decisions.

No matter where we meet women, our role should be that of facilitator, not expert. Wherever we meet women, we should encourage them to share their stories of normal birth. In doing so, we help women understand birth by living vicariously through other strong, powerful women's experiences. We have to keep reminding ourselves that we must persuade women to think differently about birth because normal birth is best for them and their babies.

Childbirth Education at a Crossroads

We are at a defining moment. We are at a crossroads. Elisabeth Bing and Marjorie Karmel gave birth to something totally different in 1960. It's a different world today. Let's build on the momentous change that they inspired and let childbirth education evolve to meet the needs of 21st century women and, at the same time, confront the 21st century crisis in maternity care. We *can* change the world of birth. Again.

For more information on expectant women's current use of the Internet, see Amy Romano's article "A Changing Landscape: Implications of Pregnant Women's Internet Use for Childbirth Educators" in the Fall 2007 issue of JPE (Vol. 16, No. 4).

To read more about group prenatal care settings, see Charlotte and Raymond De Vries's article "Childbirth Education in the 21st Century: An Immodest Proposal" in the Fall 2007 issue of JPE (Vol. 16, No. 4) and Deborah Walker and Renee Worrell's article "Promoting Healthy Pregnancies Through Perinatal Groups" in the Winter 2008 issue of JPE (Vol. 17, No. 1).

View Lamaze International's consumer Web site at <http://magazine.lamaze.org/>

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EVIDENCE-BASED NURSING CARE: LABOR SUPPORT SKILLS

Lamaze International's Evidence-Based Nursing Care: Labor Support Skills workshop provides evidence-based education, training and support for labor nurses to promote normal birth, and to increase labor support skills and the use of non-pharmacological pain management strategies.

Nurses who complete this workshop will increase their confidence in labor support skills, increase client/patient satisfaction, improve maternal-child well-being and reduce incidence of adverse outcomes.

“The evidence-based information presented gives me the confidence to teach what I know.”

-- Workshop Participant, September 2007

Visit www.lamaze.org to find a workshop in your area. Don't see a workshop near you? Contact workshops@lamaze.org to learn how to purchase the curriculum or host a workshop in your community.