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Space for human connection in antenatal education: Uncovering women's hopes using Participatory Action Research

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ABSTRACT

Objective: the aim of this research was to initiate active consultation with women and antenatal educators in the development and delivery of antenatal education that was mutually relevant.
Design: a Participatory Action Research approach influenced by feminist concerns was used to guide the research. Data were analysed by the researcher and participants using a Voice Centred Relational Method of Analysis.
Setting: an Antenatal Education service in a consultant-led tertiary referral unit in Ireland.
Findings: research findings revealed women's desires to build relationships through ANE to cope with anticipated loneliness and isolation after birth; however, environmental, structural, and organisational factors prohibited opportunity to build space for human connection.

Participating women valued external and authoritative knowledge as truth, but concomitantly sought opportunity and space through classes to learn from the real life experiences of other mothers. Women lacked confidence in embodied knowing and their power to birth and demonstrated unquestioning acceptance of the predetermined nature of hospital birth and biomedical model of maternity care.
Key conclusions: in this research, we envisioned that hospital-based ANE, relevant and grounded in the needs and life experiences of women, could be developed, with a view to supporting women's decision-making processes, and understanding of pregnancy, birth and early motherhood. Participatory Action Research using a Voice Centred Relational Method of Analysis offered an opportunity to foster ethical and dialogic activity between learner and facilitator, underpinned by acknowledgement of the value of women's experiences; however, space for expression of new and useful knowledge in preparation for motherhood was limited by institutional context.

Introduction

Currently, and since their inception, traditional hospital-based Antenatal Education (ANE) programmes are endorsed by the Irish State (Government of Ireland, 2004) and promoted free of charge as an important aspect of the maternity services, as evidenced by their facilitation in every public maternity unit in Ireland (Cuidiú, 2015). Service support for ANE is such that in one Dublin maternity unit alone, two thirds of first time mothers attending for maternity care participated in the hospital-based antenatal education programme (Fitzpatrick, 2012).

Previously acknowledged tensions exist between supporting women in preparation for birth and motherhood and the influence of over-riding institutional and political ethos of place of birth (Kitzinger, 2005; Brixval et al., 2015). Hospital-based antenatal education has been viewed traditionally as a vital accessory to the biomedical model of care (Oakley, 1984; Mason, 1994; Nolan, 1999; Kennedy, 2002; Kitzinger 2005; AIMSI, 2010); however, central to the role of antenatal education is the concept of empowering women to negotiate their birth needs (Kitzinger 2006; Nolan, 2010). Empowering women through discovery and negotiation of individual birth needs is likely to be prohibited by didactic teaching methods to large numbers of women attending classes. The results of a national survey to investigate the educational preparation and practices of antenatal educators in Ireland indicate that public class sizes may on occasion involve up to 80 participants (O'Sullivan et al., 2014).

Prior to the publication of the National Maternity Strategy for Ireland (DOH, 2016); consultation with women in planning and

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developing maternity services in Ireland was virtually non-existent (O'Connor, 2006; Devane et al., 2007). Inclusion of women in progressing services was militated against by the ongoing crisis of increased demands on maternity services in Irish hospitals that were already stretched beyond capacity and resources (Kennedy, 2010; O'Connor, 2007). This is despite government and independent recommendations that consumers be involved in health research, service planning and development to address inequalities within the healthcare system (KPMG 2008; DOHC, 2005, 2001; Kinder, 2001). Women as mothers are largely ignored in this regard and left without voice (Oakley, 1984, 1993; DOH, 1997; Murphy-Lawless 1998; Gray 2000; Edwards, 2005), however, there is evidence to suggest that when offered opportunities to come together, women can, and do, agree prioritised areas of research to develop maternity services (Cheyne et al., 2013).

The aim of this research was to initiate active consultation with women and antenatal educators in the development and delivery of antenatal education that was mutually relevant. The research was designed to challenge traditional hospital based antenatal education processes by encouraging dialogue between pregnant women and healthcare professionals surrounding accepted and assumed needs in preparation for birth and motherhood. In this paper, we present women's needs in preparation for birth and motherhood, as they are shared, using a participatory action research approach; the more detailed perspectives of the antenatal education team will be presented elsewhere.

Methodology

The nature of PAR is a focus on social processes and collaboration with participants to acquire knowledge with a view to changing actual practice (Stringer, 2014; Kemmis and McTaggart, 2005). The process of creating space in PAR makes it possible for participants to represent their worlds through voice by speaking about issues of concern in spaces that may have been previously closed to them (Stringer, 2014; Ospina et al., 2008) with a view to bringing about social change (Brydon-Miller, 2007). The Action Research Cycle described by Coghlan and Brannick (2010), has a pre-step which identifies the context and purpose of the area of inquiry, followed by four phases: constructing, planning action, taking action and evaluating action. In this research, four Action Research Cycles (ARCs) were completed (ARC 1–4). Fig. 1 illustrates operationalisation of the Action Research Cycle.

Data collection

This research was conducted in a consultant led tertiary referral unit in Ireland. Information was gathered over a period of twenty-three months between January 2010 and November 2011, chiefly through individual interviews (n = 5) and group discussions (n = 14). In total, there were 10 antenatal meetings and 8 postnatal meetings. Participants (n = 19) were first time pregnant and postnatal mothers of eighteen years and over, who could speak English, were willing to discuss their views about antenatal classes and were interested in attending antenatal classes at the chosen maternity hospital.

Table 1 provides an overview of women co-researchers, their characteristics and their levels of participation in the research.

Women participating in ARC2, ARC3 and ARC4 were invited to take part in three group meetings over a consecutive period of seven months; in each ARC, the first group meeting took place when women were approximately 24 weeks gestation of pregnancy. The aim of the meeting was to create a space for women to explore and articulate their anticipated needs in preparation for birth and motherhood. The second meeting, otherwise known as Collaborative Inquiry Group (CIG) meetings, with the antenatal educators and postnatal women took place one month later.

The specific aim of the CIG meetings, of which there were three in total, was planning and discussion about implementing change in practice in response to participating women's feedback, as distinct from gathering information exclusively. Interview transcripts and initial data interpretations were shared with participants who determined the nature and significance of research questions and emerging themes and consequently, co-created the research findings (Koch and Kralik, 2006). For this reason, and in keeping with the philosophy of PAR, research participants were referred to as co-researchers.

Actions emerged from our discussions and changes were implemented to the existing ANE programme, in which participating women were invited to take part. Following on from this, women were invited to the postnatal meeting approximately 12 weeks after birth, with their babies, to share their experiences of the ANE programme, pregnancy, birth and early motherhood. One practical example of change arising from our discussions was the introduction of a written exercise to encourage class participation as a mechanism for feedback to antenatal educators on information relevant to women attending classes. This was deemed more successful with couples' classes, as couples could suggest that the facilitator discuss a topic of a potentially sensitive nature that participants may not have had confidence to question about directly themselves.

The majority of participants were involved in one complete ARC (Table 2); however, they were also invited to support a new group of pregnant women by collaborating as postnatal mothers in the ARC that followed. Collaboration with women experienced in childbirth was essential to ensure that any potential power disparity between pregnant women and antenatal educators was minimised and that women receiving care, attending ANE and participating in the Action Research Cycles were supported in negotiating with ANE professionals. The support of more experienced mothers, no longer attending the hospital for care was valuable, as analysis by Kirkham and Stapleton's (2004) suggests that when vulnerable, the likelihood is that women will not speak or confront potential carers in the interests of preserving relationship.

Data analysis

Individual and group interviews were analysed using a voice-centred relational method of analysis (VCRM) known as The Listening Guide (Brown and Gilligan, 1992). This offered a robust analytical framework that paid attention to the depth of the complexities of everyday life for women embarking upon birth and motherhood, set in the context of a medically led, hospital-centred model of care.

VCRM offers a way to encourage discussion about the situation and contexts within which we work and research by placing emphasis on the multi-layered nature of voice; that is, what is said and what is unsaid. In this research, concrete steps to analysis involved a minimum of five readings; 1.reading for the plot and the researcher's responses to the narrative, 2.reading for the personal pronoun or voice of the 'I', 3.reading for relationship (with other) and 4.reading for cultural contexts and social structure (and the institution). In this research, a fifth reading emerged; that of the institution or professional and that of the woman attending the service for care. In this paper, emerging themes from Readings 1–4 will be presented.

Ethical considerations

Ethical approval was granted by the maternity unit involved and the university. PAR is a dynamic and evolving concept in principle and practice; therefore, informed consent was obtained from participants from the outset of the research and prior to each phase within the project.