

Parentcraft?

What's That?

**The views of the
Community of West Central
Halifax**



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Executive Summary

The research outlined in this document was undertaken with the support of the Sure Start Programme Manager, parents and colleagues.

Objectives of the research

1. To identify the community's understanding of Parentcraft sessions.
2. To identify parentcraft needs of the local pregnant population and their families in West Central Halifax via undertaking a qualitative research activity.
3. To identify barriers to the uptake of Parentcraft by the local community.
4. To disseminate information to key service providers and agencies involved in antenatal parenting education with the objective of modifying services in light of research results.
5. Use the research evidence to engage the local target population in antenatal parenting education.

The research was undertaken during April to June 2004 using three Focus groups within the local female community; face-to-face, one to one discussion; and 6 questionnaires for the male population.

Data was collected by facilitator and co-facilitator notes.

Key Findings

1. There was a lack of awareness of parentcraft sessions in the local area.
2. The elder female family members 'passed down' information about childbirth and parenting.
3. Women said they would attend an appointment for parentcraft. An appointment was seen as important.

4. There were cultural issues about timing and fathers attending sessions and the birth.
5. Men wanted more information about labour and their own health facilitated by an Asian male health professional.
6. Language barriers were a large issue.

Areas of development

1. To seek further views from the male community.
2. Investigate the feasibility of a male health worker to work with the male community.
3. Further research to be undertaken with the Bangladeshi community facilitated by a Bangla interpreter.
4. Provision of education for Community Midwives on cultural issues.
5. Investigate training opportunities for a bi-lingual worker to facilitate parentcraft.
6. Advertising needs to be more visible.

Background

A woman's education for childbirth is influenced by the society within which she lives and it's cultural expectations. Kitzinger (2000) has illustrated the ways in which birth is perceived in different cultures and the experiences of these women suggest that there is a large divide between the professional and lay perceptions. MacVicar (1990) also recognised that the information provided and the expectations of women during pregnancy were at odds.

There has been a dearth of research in the last thirty years looking at antenatal education, meeting women's needs and attendance at such sessions. (Clements 1989; Simkin and Enkin 1989; Coombes and Schonveld 1992; Rees 1992; Roch 1992). It was acknowledged that classes suffered from a number of problems

including a low attendance rate and a high drop out rate. Murphy-Black's (1990) review of the literature included the following factors as reasons of poor attendance –

'Clients did not want to go; did not know about them; classes not worthwhile; felt confident without attending; poor timing; transport problems; attended in previous pregnancy; no child-care provision'.

Studies also indicate that, at their best, antenatal classes encourage and develop lasting supportive friendships and that parents want balanced, honest and realistic information so that they know what to expect and can then make informed decisions (Shearer 1993; Cliff and Deary 1997; Nolan 1997,1999).

All the studies illustrated concentrated on the views of the white indigenous community and in 1998 The Audit Commission highlighted that we fail to adequately collect views from ethnic minority groups. The Audit Commission (1998) surveyed a total of 3570 women in England and Wales by sending a questionnaire to them, asking about their experiences of maternity services. Of the 2400 that replied, 35 were Indian, 32 Pakistani, and 8 Bangladeshi. Several studies have suggested that women from different ethnic minority backgrounds have problems completing questionnaires due to illiteracy and even when languages are translated this is often not sufficient. Katbamna's research provides insight into the South Asian women's experiences of managing and negotiating care during pregnancy and childbirth (Katbamna 2000) and also highlights the enormous diversity that exists within the South Asian community.

Access to maternity services remains problematic for some women from minority ethnic groups (Hayes 1995). In many instances, access involves structural barriers that disadvantaged women have to overcome. Language appears to have been a major problem for a long time. The Bangladeshi women in Katbamna's study frequently referred to language as a barrier to communication with health care professionals. Inadequate interpreter services often means that family members are interpreting sensitive issues. Lack of understanding of the socio-cultural aspects of minority ethnic women's sexuality and associated 'taboos' may also provide some explanation for any perceived lack of 'what's on offer'.

Figures from the Office of National Statistics (1999) indicate that women from Pakistan who come to the United Kingdom (UK) but who are born outside the UK

have nearly double the number of stillbirths compared with women from the general population. The number of stillbirth's per 1000 births in England and Wales for the general population is 0.5% while for women born in Pakistan and living in England and Wales it's 0.98%. Locally, the stillbirth rate is much higher at 7.4%. Infant mortality in West Central Halifax is 14.2 % compared with England's average of 5.8%

West Central Halifax population profile

West Central Halifax is a designated urban renewal area within the Metropolitan Borough of Calderdale and has fixed geographical boundaries. The area is densely populated with a population totalling 11,000 and comprises of a high proportion of South Asian residents who have a Pakistani/Mirpuri heritage, a small Bangladeshi community, an indigenous white minority and a few recently arrived asylum-seekers. The area contains a very high percentage of young adults under 30 years old. The birth rate is almost twice the local average. The area has a high rate of unemployment and low income with significant poor housing. It is a mixed residential/commercial area with 400 small and medium sized businesses. There are significant health needs. Women members of the community, in particular, have difficulty in accessing services due to a shortage of bi-lingual staff to compensate for their own lack of English language skills and lack of transport.

The development of Sure Start programmes (Department of Health 1999) has enabled professionals to work in different ways, consult local communities and provide flexibility with services that match local need. Sure Start West Central Halifax local programme held a 'Vision Day' in 2001 during which representatives were asked to give their views about the community's strengths and weaknesses. From this, came a Sure Start 'Vision Statement' that included building a confident and integrated community that:

- Showed mutual respect for the values and cultures of all it's ethnic groupings
- Were well informed about the services that are available to support families and their children
- Enjoyed good health through improved diet, exercise and access to good pre and post-natal care
- Found ways of involving the whole family in child rearing and demonstrating improved understanding of child development.

Methodology

A qualitative research method was required to ascertain the views of parents with regard to offering appropriate parentcraft. Due to the timescale and characteristics of the local community the method chosen was **Focus Group** and some one to one interviews. A few questionnaires were given to fathers as most men who were asked, preferred not to be interviewed in a group with a female facilitator.

Focus group research is an interview design that uses a small group of individuals to explore their experiences, opinions, wishes and concerns (Barbour, Kitzinger 1999). The data is generated by the discussion of the group members and it helps the members to clarify and explore their views in such a way that would not be possible within one to one interviews. Research aimed at ascertaining the views of women about maternity services has been mainly quantitative and evidence suggests that this method of approach fails to adequately collect the views of women from ethnic minority groups (Bowes, Domokos 1996).

Focus group research produces data that is richer and has more depth. It also makes use of the midwife's professional skill of sensitively collecting information through a conversational medium, increasing the range of inclusion in the study. The strengths of interviews in this way far out way those of questionnaires (Polit et al 2001),

- Participation can be gained from a wide range of people including those with literacy problems
- The response rate is usually higher
- Information is immediately available
- The interviewer can reduce misunderstandings
- Participants can feel more in control in semi or unstructured interviews resulting in them feeling valued
- It is particularly relevant in midwifery as it provides the opportunity to pursue a 'women centred approach' to issues and situations

Holloway and Fullbrook (2001) also suggest that it's purpose is to 'hear the voice of participants – to enable understanding of the situation' but the author is also aware that focus groups can put participants on the spot as they may not be used to expressing feelings to others. Stephenson (1999) suggests that in her experience of facilitating focus groups she has always been struck by the member's sense of empowerment simply by being invited, listened to and acknowledged as having

something worthy to contribute. Watts and Ebbuts (1987) noted that group discussions could generate more critical comments than interviews. This is especially useful if the aim is to improve services as in this case.

Sample population

The sample population consisted of three groups of female members:

- Group 1
Female family members (mothers and mothers in law, grandmothers). 6 female members were interviewed with an interpreter.
- Group 2
New mums who had given birth under a year ago. 7 new mums were interviewed.
- Group 3
Pregnant mums. 5 were interviewed in a group with 3 one to ones taking place at home.
- Questionnaire
6 questionnaires were given to fathers by their wives.

A member of the Sure Start Board enhanced access to the sample population particularly with access to the older female population. The research for this group was conducted at the home of an older female member of the community, with verbal invites given out by the Board member. This method was felt appropriate as she was well known and had credibility within her community.

Sure Start records gained access to pregnant mums and newly birthed mums. These women had already registered with Sure Start and therefore ethical approval wasn't considered necessary due to actually signing to say they would be willing to be contacted by a member of the Sure Start team. Women within these two groups were verbally invited to attend a group to discuss their views around pregnancy and parentcraft to find out what their needs were. These two groups were held in the Sure Start building with crèche facilities provided in the room for the new babies if needed.

Questions

The questions included in the focus group differed slightly depending on the type of group interviewed. (Appendix 1) The Midwife, Health Visitor and a bi-lingual support worker facilitated the groups. The facilitator had a list of approximately 20 questions to guide her within the group discussion. Not all the questions needed to be asked as often the group discussion generated and incorporated the facilitator's thoughts and questions.

The main themes included;

1. What do you understand by the term 'Parentcraft'?
2. What knowledge do you think pregnant ladies need to enable them to have a positive birth experience?
3. Where do you think the knowledge needs to come from?
4. Do you think 'special preparation' sessions are necessary?
5. Where should sessions be held?
6. What are the barriers to coming to sessions?
7. Who should facilitate the sessions?
8. What do you think about men/partners/husbands supporting you/their wife/partner in labour?
9. How do you feel about husbands attending parentcraft?
10. Should we have a special session for mothers/in law to keep you/them up to date?

The questionnaire for the men followed the same format to try and find out what they knew about parentcraft and their feelings around attending. The potential disadvantages of the questionnaire were that respondents needed to be able to read

and understand English. The views of the non-English speaking/reading men could not be sought at this time. (Appendix 2)

Experience as a Midwife with counselling knowledge warned the author that emotions could be triggered and heightened, often unexpectedly when focusing on pregnancy, childbirth and previous experiences. Each group was prepared for this possibility and invited to take time out to discuss on a one to one basis at the end of the session if needed. Two women took up this opportunity to 'debrief' about their pregnancy and birth experience. They were followed up at a later date to check on their well-being and neither needed further input or referral.

Although the researcher was introduced as a Midwife, which could have introduced bias, it was also felt that as she was new to the Sure Start area and willing to 'listen' and take the women's views forward, the women could be open and honest.

Ground rules including: confidentiality, equal opportunity, respect for others, time limit and enjoyment were discussed with each group.

Data collection

Co facilitator notes were taken at each focus group meeting.

Validity and Reliability

Researcher bias:

Personal bias as a professional working with parents and delivering parentcraft. Own bias as a parent.

Bi-lingual worker – the potential for questions and answers to be interpreted in a different way or lack of understanding. Quoting out of context.

Respondent validity and bias:

Some of the group members knew each other and felt comfortable to discuss often-sensitive issues but most of the members did not know each other and therefore may have been uncomfortable speaking out in a group. Discussing ground rules and how valued the researchers felt the groups and individuals opinions would be, helped reduce this.

A weakness of the focus groups method lies in not being sure if the group's member's contribution is subject to groups influence (McDougall 1999). Too small or too large groups would also have an effect on this. Three one to one interviews were also conducted and similar responses to the focus groups were recorded; therefore the author feels that the potential of the above bias didn't occur.

Selection bias:

Selection of respondents was restricted to the Sure Start area although the Asian population covers a wider area. The author is aware that many of the women who responded were the more motivated members of the community. The author is also conscious that women from the Bengali community were invited but due to the unavailability of a Bengali interpreter within the Sure Start area, they failed to respond. One English speaking Bengali mum was invited on a one to one and again similar themes emerged.

Ethical considerations

As previously mentioned, Parents who register with Sure Start local programmes are made aware that their views may be sought regarding the needs of the community therefore ethical approval was not sought. Informed consent was sought and confidentiality, anonymity and privacy were discussed on verbal invite and within the ground rules.

Issues raised in focus groups are often reflected upon later, in privacy and may cause distress after the event. Debriefing was offered and group members were left with a contact name and number. Two members used this facility.

Results

Question 1

What do you understand by the term 'Parentcraft'?

Group 1

- *'We've never heard of Parentcraft or preparation classes'*
- *'I am not aware of such classes'*
- *'We didn't have anything like that'*
- *'Tell daughter / daughter in law what to expect'*

Group 2

- *'You are going from one stage to the other'*
- *'What it means to be a parent'*
- *'Someone tells you details of what you want to know but not in deep'*
- *'Before or after birth, how to cope'*

Group 3

- *'I don't know what it is'*
- *'I have never heard about it'*
- *'About birth'*
- *'Support'*

Question 2

What knowledge do you think pregnant ladies need to enable them to have a positive birth experience?

Group 1

- *'When to feed, change and bath the baby'*
- *'Looking after herself'*
- *'Basic knowledge of everything'*
- *'Need information on diet'*

Group 2

- *'How to cope'*
- *'I didn't know what to do if things go wrong'*
- *'Dads need information on what's happening and how to support his wife'*

Group 3

- *'Negatives and positives of labour'*
- *'What happens in labour'*
- *'Pain relief and coping'*

- *'About being a mum'*

Questions 3 and 4

Where/who do you think the knowledge needs to come from? Do you think special preparation sessions are necessary?

Group 1

- *'We give the information to daughter / daughter in law about what will happen'*
- *'We give all the information on baby care'*
- *'If we know about sessions we will send our daughters / in law'*

Group 2

- *'I learned from mum. She gave me full support but if someone hasn't the support I can imagine what they can go through'*
- *'When the midwife did the Birth Plan I was positive about a natural birth'*
- *'I was let down, I didn't get the support'*

Group 3

- *'The midwives need to give the information'*
- *'I have talked to other people'*
- *'Emma's diary'*
- *'Information and books'*

Question 5

Where should the sessions be held?

Group 1

- *'Would attend in the Sure Start building'*
- *'Not Fridays'*
- *'Invite daughter and mother in law. Would like incentive to attend'*
- *'Send an appointment, it's more important for health'*

Group 2

- *'Someone's house or here (Sure Start building)'*
- *'Evening classes for working parents'*
- *'As an informal group in someone's house'*
- *'If held at Sure Start it would be better to send an appointment than an invite as it is more important but you need to invite mother in laws, it would make them feel special or have a special session'*

Group 3

- *'I would be happy coming here (Sure Start)'*

- *'Term time would be better because of the older school children'*
- *'I would like mornings here'*

Question 6

What are the barriers to coming to parentcraft sessions?

Group 1

- *'I would like an incentive providing'*
- *'Not knowing about them'*
- *'Need posters in clothes shops in Urdu and English'*
- *'Don't want to go on own'*

Group 2

- *'Language barrier'*
- *'You need to tell us we have to come'*
- *'Antenatal class and appointment at the same time'*
- *'Parents don't think we need any classes'*
- *'Cultural issues'*
- *'Invite mums and mother in laws to classes'*
- *'Evening classes for working parents'*
- *'Need separate classes for men – don't mix'*

Group 3

- *'Some people work'*
- *'I have college'*
- *'Too tired'*
- *'Want mornings'*

Question 7

Who should facilitate / do the classes?

Group 1

- Didn't come out in the group discussion

Group 2

- *'Mother in law usually gives the information. It should be someone friendly like the midwife'*
- *'Someone who knows'*

Group 3

- *'Midwives should give the information'*
- *'Male trainers need to do men's sessions'*

Question 8

What do you think about men / husbands / partners supporting you / wife / partner in labour?

Group 1

- *'The younger ones want this, we didn't have it'*
- *'It's a woman's thing and women need to support'*
- *'Encourage husbands to support wives'*

Group 2

- *'Husbands should be there'*

(This entire group had their husbands with them during labour and birth)

Group 3

- *'It is our own choice if the husband is to be there'*
- *'It is not in our culture'*
- *'Women know better how to support'*

Question 9

How do you feel about partners / husbands attending parentcraft?

Group 1

- *'No, but it depends on your own up bringing'*
- *'There should be separate evening classes for men and women'*

Group 2

- *'My husband wasn't allowed to stay with me'*
- *'Separate classes for men but they need the information'*
- *'Just with partner, not with anyone else'*

Group 3

- *'There should be male sessions with a male person'*
- *'It's up to us'*
- *'Not sure'*
- *'I want my husband to know'*

Question 10

Should we have special sessions for mothers and mothers in law to keep them up to date?

Group 1

- *'I would like a lunch time get together'*
- *'I would like an invite for daughter / in law and myself'*

- *'I would like a monthly lunch club'*
- *'We would feel valued'*

Group 2

- *'Invite mothers and mother in law to classes'*

Group 3

- Didn't come out in group discussion

The three one to one interviews held in parents homes resulted in similar themes as the focus groups.

Questionnaires

A total of 6 were given to new fathers, as it proved impossible for the author to facilitate a focus group. This was because they were not comfortable talking to a woman about childbirth. The questionnaires were given to newly birthed mums who asked their husbands to complete. If they didn't read English, their partner translated it.

60% of the men questioned had not heard of 'parentcraft classes'. Half said that they had some knowledge of labour and birth from reading their wives books. All were present at the birth of their child. 20% felt that one to one sessions would be appropriate as they felt that many men would feel uncomfortable in a mixed group. 50% would attend sessions with their wives and all agreed it would be nice to have men only sessions to know more about personal problems and that it should be facilitated by a male health professional. The majority wanted to know more about how to support their wife in labour.

Analysis and discussion

The reliability of the questionnaire is limited and should be used with caution, although empirical evidence does suggest that the results need to be investigated further.

There was a mixed response to the meaning of 'parentcraft'. Other terminology was used to explain it i.e. parent education; antenatal classes; birth preparation but two thirds of respondents did not know what they were or that they were able to attend any in the area.

Much of the information about parentcraft is given at the 'booking visit' when newly pregnant women are already overwhelmed with information. These findings suggest that it may be more appropriate to give this information to the local population later in their pregnancy. The issue around the correct terminology and explanation to the pregnant woman and her family around the importance of attendance needs to be addressed. Verbal information via an interpreter would raise awareness and could be backed up by a leaflet in Urdu / English. Culturally appropriate posters in local shops appear to be a popular way to advertise the sessions.

It is clear that different generations have different perceptions on what is needed. The elder female population feel that they are there to give the information and from the other two group discussions it was noticeable that the younger women are happy to have advice from health professionals. There was a clear theme within the groups that at times there was conflict between the elder females information giving to the younger generation, what the younger females felt they wanted and the health professional giving evidence based information. It is suggested that mothers and in laws are invited on a regular basis so that correct information can be discussed with them in a culturally sensitive and respectful way so that they can help pass the correct information on to their daughters and daughters in law.

Some cultural themes were also gained from discussion within the groups. The Asian population of West Central Halifax appear to value an appointment as more important than an invitation. It was also noted that religious sensitivity should be taken into consideration when arranging sessions. Having a separate class for men and women was very much a cultural issue. The older generation considered it more appropriate that women were supported by women but younger generations have mixed views depending on their upbringing. Some mention was made to the culture of arranged marriages and women not feeling very comfortable with their husbands there. In the 'western world' today's culture around childbirth is that men are 'expected' to be present during labour and the birth although not all men are comfortable with this concept. Great sensitivity is needed when discussing this issue with non-western cultures and their wishes respected.

Men are keen to know more about labour and in particular about their own health. The evidence suggests that an Asian male worker would be the most appropriate person to facilitate this for the local population.

The language barrier to attending sessions is significant and needs to be urgently addressed to enable social exclusion to be reduced.

Some of the discussion views were similar to previous research findings regarding parent education sessions i.e. timing. Empirical evidence suggests that timing of such sessions cannot please everyone and that a variety of choices need to be given to encourage greater attendance.

Recommendations

- To seek further views from the male community.
- Investigate the feasibility of a male health worker to work with the male community.
- Further research to be undertaken with the Bangladeshi community with a Bengali interpreter.
- Provision of education for Community Midwives on cultural issues.
- Investigate training opportunities for a bi-lingual worker to facilitate parentcraft.
- Advertising needs to be more visible.
- Implement the current findings and alter the way parentcraft is currently advertised and delivered.
- Involve a Bi-lingual Support Worker at each session to enhance inclusion and understanding.

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