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Birthing process preparedness of first-time mothers at the Nelson Mandela Bay Municipality in South African: A qualitative research study

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Abstract

Pregnancy or birthing brings with it hope of a new life. A woman who was well-prepared antenatally and who has a low-risk pregnancy has the possibility of enjoying her labour and birth. First-time mothers are at times deprived of this experience due to limited preparation for the birth. A qualitative research design using an exploratory, descriptive, and contextual approach was used to understand how first-time mothers experience birthing process preparedness. Data was collected from July to August 2020 by means of semi-structured interviews from sixteen purposively selected participants. Results revealed that participants are having varied experiences from factors that had influenced their birthing -process preparedness and thus provided suggestions for midwives to facilitate birthing process preparedness of first-time mothers in future. In conclusion the based on the results it is envisaged that a well-prepared pregnant woman is more likely to be less anxious during the birthing process. *(Afr J Reprod Health 2023; 27 [5]: 72-80).*

Keywords: Birthing, first-time, mothers, preparedness

La grossesse ou l'accouchement apporte avec elle l'espoir d'une nouvelle vie. Une femme qui a été bien préparée avant la naissance et qui a une grossesse à faible risque a la possibilité de profiter de son travail et de son accouchement. Les mères pour la première fois sont parfois privées de cette expérience en raison d'une préparation limitée à la naissance. Une conception de recherche qualitative utilisant une approche exploratoire, descriptive et contextuelle a été utilisée pour comprendre comment les mères pour la première fois vivent la préparation au processus d'accouchement. Les données ont été recueillies de juillet à août 2020 au moyen d'entretiens semi-structurés auprès de seize participants sélectionnés à dessein. Les résultats ont révélé que les participants avaient des expériences variées à partir de facteurs qui avaient influencé leur préparation au processus d'accouchement et ont donc fourni des suggestions aux sages-femmes pour faciliter la préparation au processus d'accouchement des mères pour la première fois à l'avenir. En conclusion, sur la base des résultats, il est envisagé qu'une femme enceinte bien préparée est plus susceptible d'être moins anxieuse pendant le processus d'accouchement. *(Afr J Reprod Health 2023; 27 [5]: 72-80).*

Mots-clés: Naissance, première fois, mères, préparation

Introduction

The birthing process and birth are filled with emotions of either joy or apprehension for the woman in labour. The apprehension, especially for the first-time mothers, is usually due to limited background in giving birth and the birthing process. The antenatal care period is an important stage in birthing preparedness as the midwives at that stage of the pregnancy share crucial information with the women about the pregnancy and birth, and what to look out for until the birthing stage[1-2]. Women are thus encouraged to book at antenatal-care clinics (ANC) as soon as possible in their pregnancy and attend regularly.

Birth preparedness is one of the strategies developed by WHO to curb the rate of maternal and neonatal deaths and morbidity. It involves teaching and empowerment strategies such as health education and explanations about pregnancy and birth inclusive of complications that may occur while also organising some opportunities for the mothers to meet with clinical psychologists and counsellors. In the context of this article, the birthing process preparedness is concerned about the psychological status of the woman from

pregnancy until six hours after delivery hence the emphasis on the help from clinical psychologists and counsellors. Birth preparedness is currently adopted by many countries as it assists with education and knowledge of women about matters that could expose pregnancy and birthing to risk and thus increase the possibility of morbidity and mortality[3]. These classes which are formally organised support but not part of the ANC session are already known to take place successfully in many developed countries such as USA and Australia[4-5]. Primiparous women are sometimes said to have attested that antenatal education as useful and significant particularly for expectant women to gain the knowledge required for them to manage the birthing process successfully[6-7]. As the focus globally is currently towards the Sustainable Development Goals (SDGs), safe motherhood which encompasses birth, and birthing-process preparedness becomes an important aspect.

Some studies present results that concur that birthing complications are sometimes a result of ignorance and limited information culminating in undesirable behaviour during labour which is at times termed as non-co-operation of the woman[8]. Some of these women would have read books and magazines, listened to media announcements and programmes, searched the internet for information and thus become confused as some of the material they read might have needed some explanation and clarity which was not possible[9].

Many first-time mothers will be told stories of their own experiences by their mothers or sisters which at times are not positive experiences, leaving the first-time mother apprehensive of the birthing process[9-10]. Midwives on the other hand in executing their role perform certain assessments and examinations to ascertain the safety of the woman and child while estimating the progress of labour. These assessments are frightening to some of the women as they are experienced as an intrusion of privacy while exacerbating uterine contractions and pain to some of them[11]. With professional prio-explanation and education these assessments could become meaningful and tolerable. The labouring woman would have been given the necessary information of the nature and need for the assessment in terms of the birthing process. The birthing process classes would assist as there will be time set aside for the explanation and demonstration to the pregnant woman. classes There is limited knowledge about birth and birthing preparedness among first-time mothers in the sub-Saharan countries though this is a safe motherhood strategy promoted by WHO and ICM[12-13.] South Africa is one of the countries in this region where many of the maternal mortalities and birth complications occur[14]. Results in a narrative review of cross-sectional studies on factors influencing knowledge and practice of birth preparedness and complication readiness in sub-Saharan Africa which involved countries likes Nigeria, Tanzania, Ethiopia, Ghana, Guinea, Uganda and Malawi, the findings indicated that knowledge of birth preparedness was higher than knowledge of pregnancy danger signs or complications in many studies[15]. However, the implementation of childbirth preparedness interventions was lower than the level of knowledge in all these studies.

This study was directed through the assumptions of the Health Promotion Model (Pender 1996). The concept of health promotion is about increasing the well-being of an individual and thus the Health Promotion Model (HPM) describes the multidimensional nature of individuals as they interact within their environment towards achieving health[16]. The model encourages an engagement in behaviours and interactions of individuals with their physical immediate environments. Persons are to take responsibility to initiate and sustain these health-promoting interactions in a conducive environment. The model is founded on eight behaviours and specific beliefs which are, namely, perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity-related affect, interpersonal influences, situational influences, commitment to plan of action and immediate competing demands and preferences. In the context of this study it was envisaged that the first -time mothers with a clear understanding of the birthing process will probably behave and co-operate better with the midwives for the benefit of a positive birthing process and outcome than those with inadequate preparation. Several strategies have been developed by many countries, South Africa included, and policies implemented to curb the increasing maternal mortality rate; but there is less specific focus on birth and birthing- process preparedness especially for the first-time mothers[17]. This study was based on the premise that

it will help to gather information that will assist with a strategy towards raising awareness and implementing the concept of birth preparedness in South Africa. The purpose of the study was to understand how the birthing process preparedness of first-time mothers in the public obstetric units of the NMBHD was.

Methods

This study which was conducted in the Nelson Mandela Bay Municipality (NMBM) in South Africa, at the public midwife's obstetric delivery units (MOU's) located in the various suburbs (two) and townships (three) employed a qualitative research design and the data -collection method was audio-recorded one-on-one semi-structured interviews while the researcher who was the data collector was jotting down fieldnotes, capturing participant non-verbal cues and communication used during the interview. The interviews were conducted in English. The delivery registers in each of (MOUs) were reviewed to identify suitable candidates for participation. 22 women who were first -time mothers, of 18 to 30 years of age, had had vaginal deliveries of live and healthy babies and were at list six hours post-delivery, were recruited, purposively and privately selected from the various low-risk public maternity units as this was the selection criteria for the study. The participants were identified in these units before being discharged. Interviews commenced after the informed consent form had been signed, giving permission for voluntary participation and use of the audio-recorder. The participants were to respond to one main question and some follow-up probing questions from a predetermined schedule. The main question was: "*Can you tell me how ready you were for your birthing process?".*

The interviews were conducted in a private room at the hospital. The interviews took an average of 60 minutes each and discontinued when evidence of data saturation had been observed. 16 participants were interviewed; but only 15 interviews were useful for data analysis as one of them was from a high-risk participant, a fact that was found only during the interview session. The remaining 6 mothers were informed of completed data collection but thanked for agreeing to be participants. The profiles of the participants who took part in the study are presented in Table 1.

Data analysis was continuous with data collection and discontinued after data saturation had been reached[18]. Interview transcripts were collated and transcribed verbatim before the manual data analysis. Thermatic data-analysis method was used, and the recommended 6 steps implemented, namely, to familiarise the researcher with the transcribed data, generate preliminary codes to data to describe the content, further search for patterns and themes in assigned codes across all the interviews, review themes, define and name the themes and finally produce the report[19]. The results were finalised in a meeting with the independent coder and later with the research supervisor.

A pilot study was conducted using 3 participants and that data formed part of the main study.

Trustworthiness

To ensure trustworthiness of the study criteria, proposed in Lincoln and Guba's Model of Trustworthiness which are credibility, transferability, dependability and confirmability were used[20].

Credibility was ensured by using *triangulation,* meaning that a variety of literature sources was consulted, the findings discussed with an independent coder and later with the supervisor. *Prolonged engagement* and interview verification at the end of the interview with participants was also used to collect as much useful data as possible. This principle of transferability was ensured through a *thick description* of the methodology of the study while confirmability was achieved by the researcher using an independent coder to verify and code the data, exclude biases and confirm data as a true reflection of information provided by the participants[21].

Results

Three main themes which emerged are presented in table 2.

Theme 1: *Participants shared their experiences regarding the birthing process and their birthing -process preparedness*

Participants shared personal experiences of the birthing process as a painful and difficult period to

Table 1: Demographic profile of participants

Pseud onym	Age	Ethnic group	Religion	Highest level of education	Occupation	Gestation al age
Miss A	18	Coloured	Christian	Grade 08	Scholar	37
Miss B	18	African	Christian	Grade 11	Scholar	36
Miss C	30	African	Christian	Diploma	Facilitator	39
Miss D	21	African	None	Grade 12	Scholar	36
Miss E	20	African	Christian	Grade 11	None	38
Miss F	21	African	Christian	Grade 10	Scholar	36
Miss G	30	African	Christian	Diploma	None	38
Miss H	18	African	Christian	Grade 11	Scholar	41
Miss I	22	African	Christian	Grade 12	Waiter	36
Miss J	18	African	Christian	Grade 12	Scholar	40
Miss K	18	African	Christian	Grade 11	Scholar	41
Miss L	19	African	Christian	Grade 12	Scholar	39
Miss N	22	Coloured	Christian	Grade 11	Machine operator	37
Miss O	25	African	Christian	Grade 12	Administrative clerk	37
Miss P	23	African	Christian	Grade 12	Scholar	

Table 2: Identified themes and subthemes related to birthing -process preparedness of first-time mothers

Main themes	**Subthemes**
1. Participants shared their experiences regarding their birthing process and their birthing -process preparedness.	**Participants experienced:** 1.1 fears associated with their birthing process and 1.2 feeling mainly unprepared for their birthing process.
2. Participants reported having had varied experiences from factors that had influenced their birthing -process preparedness.	**Participants reported:** 2.1 limited information shared by midwives regarding their birthing process, 2.2 ineffectiveness of pain- relief strategies and 2.3 birthing -process preparation had been received from varied sources.
3. Participants provided suggestions for midwives to facilitate their birthing process preparedness	**Participants suggested:** 3.1 birthing -process preparation classes, 3.2 birthing -process preparation through counselling sessions and 3.2 detailed information mainly about the birthing process.

go through. Exacerbating the difficulty were the cumulative birthing pains and other associated unavoidable procedures conducted during their birthing process. For instance, one participant in this regard had the following to say:

…each time midwife was inserting fingers, it would feel like it is worse than the first time as if ***[fingers]*** *are inserted deep now, the wish was that the midwife could just stop. Even that machine* ***[CTG]*** *for the heartbeat, each time you are put there it feels like it is worse than before. Each time you are called for that machine you would feel like not going. You want to turn it away, you want to turn it away, seriously.* (Miss G, L382-390)

Some participants expressed the fact that they were ignorant about the birthing process, hence experiencing a lot of fear. For example, some participants said:

…I was scared because I didn't know what I was experiencing at that time, I thought there is something bad you see, … or like maybe I will have miscarriage since I was seeing blood, so I was very scared. (Miss L, L73-75)

"You are scared to toilet ***[for bowel action]****. You do not know whether the baby will come out or not. You are just not sure…." (*Miss C, L512-515*)*

Even though the birthing process was experienced as severely fearful and painful some participants acknowledged it as purposeful and worthy for the awaited outcome. Some of the experiences were expressed as follows:

"I asked that nurse ***[midwife]*** *who was helping me, what was happening, she said, '****now the baby is descending, you see that is why you are feeling more pains****. I could also see that my abdomen is flat here on top* ***[pointing]*** *and it moved to the*

bottom. Then she told me that it is the reason why I am in so much pain and my bones are opening up ***[pointing to the pelvis]****, that was what she told me. I was hopeful"* (Miss M, L327-333)

Feeling mainly unprepared for their birthing process

In retrospect some of the participants commented that they soon realised that they were not

completely prepared when the birthing occurred as initially thought; but they acknowledged the role played by ANC. In this regard participants had the following to say:

"I wasn't mostly prepared but my mother told me what is going to happen ***[and]*** *what I must do."* (Miss C, L17-18)

"I was not fully prepared, nhe! because I didn't know other things….Then with regard to birthing process preparation they ***[the midwives]*** *were not more specific about it. Because I didn't know like when there was that jelly that was coming out I didn't know what did it mean, you see. So, I was not prepared enough."* (Miss M, L17-24)

Theme 2: Participants reported having had varied experiences from factors that had influenced their birthing preparedness

The participants acknowledged consulting varied sources about pregnancy and birth which in the end had caused some confusion. Sources consulted were, for example, the midwives themselves, family and the media. The acknowledgement was expressed as follows:

"...as I said that, for me I had to hear it ***[birthing process]*** *from someone who had experienced* ***[it]*** *to understand what is going to happen."* (Miss O, L118-119)

"*I was googling* ***[Google search]*** *whatever I was not sure about*." (Miss C, L292)

Participants reported that limited formal information had affected their understanding of pain management methods used, leaving them frustrated. The following responses illustrate these feelings:

"Ever since I had been dragging and doing the same thing, I had been doing the breathing in and breathing out, it did not help me anyway." (Miss J, L-231-234)

"*…when I came here* ***[in the hospital]*** *then they injected me* ***[pethidine]*** *to reduce pains and that I sleep but nothing happened, instead the pains increased."* (Miss D, L238-240)

Theme 3: Participants provided suggestions for midwives to facilitate their birthing-process preparedness

In this study it has been largely noted that, though at times attempts had been made to assist with birthing-process preparedness, it had not been optimum which caused concern. Participants voiced their concerns as well as some suggestions to aid in facilitating future birthing -process preparedness. Some of the suggestions were as follows:

…and they ***[midwives]*** *do not group us. If you have two months you do exactly the same thing as the person who is nine months, you see we are all doing the same thing. We are not grouped…The discussion is forever about pregnancy, from one month till nine* ***[months]*** *…* (Miss G, L347-350)

"It was supposed that at least a person ***[pregnant woman]*** *receive counselling once in a while because nine months is very long….''* (Miss N, L385-395)

Detailed information about the birthing process

"It was never explained under what circumstances a person is stitched, under what circumstances a person is cut ***[an episiotomy]*** *You see? I only felt it on me when I was giving birth, that if you sustain tear you need to be stitched* ***[sutured]****, you will not heal on your own. And if the baby the head is not delivered, you will have to be cut eventually"* (Miss H, L111-117)

To prevent the prevalence of the focus on the baby only during ANC, participants suggested a detailed guide with information that would include needs for birthing- process preparation. The participants shared the following suggestions:

*"Like .... as I am attending here at the clinic it is preferable that you should know what is it that you going to do here when you are in labour so that you will not be surprised when you get here **[labour ward]**, it shouldn't be like that."* (Miss E, L283-288)

*Oh! and the way of labour, how is it, what pain are you going to feel, what are the things that will come out, how are your waters going to break at certain time. I feel that those things should be discussed with first-time **[mothers]**....* (Miss G, L513-525).

Birthing process preparedness has benefits not only for the first-time mother but also for the midwife.

Discussion and implications

Pregnancy is one of the highlights of any woman's life and for her family as the birth of the baby is awaited with eager anticipation. Midwives on the other hand are also working hard to safeguard the pregnancy for a positive birthing process. Pregnancy and birth bring with them a multitude of emotions; therefore, birthing process preparedness is critical. The WHO has approved an ideal process for birthing-process preparation during ANC period[22]. Despite this approval, as reported in literature birthing-process preparation in many countries, especially the developing countries, is of a limited scale or not done at all and thus not much is reported about it in these countries[23], South Africa included. Participants in this study were fearful of birth as they had experienced being poorly prepared for the birthing process. The fear of the birthing process seems to be a shared phenomenon among birthing women, regardless of their parity[24]. Results from another study highlight the fact that fear of the birthing process among first-time mothers is mainly linked to the unknown as there is no previous experience of the birthing process[25].

Pain and harm to the baby are feared most of all; but, owing to expectations of the birth of the baby, some women are willing to endure the pain and fear of the birthing process. Some authors maintain that, although labour pain is a universal feeling, women respond to it differently[26]. The difference and tolerance lie with the fact that women find the pain of the birthing process as purposeful when it is associated with the birth of a live child[26-27].

Birthing-preparedness experience is multidimensional, subjective and depends on the individual woman's experience[23]. Fear of the birthing process is prevalent and escalates particularly among poorly prepared first-time mothers[28], and those who lack knowledge of the birthing process[29]. Primiporous women with inadequate childbirth preparation who become exposed to shortcomings during the birthing process get shocked when these unfamiliar aspects take place[30]. Some of the participants had experienced inadequate preparedness for the birthing process despite attending ANC as the information gained from the ANC was not very helpful. Some research results from another study concur with this finding and add that this experience depends on how the information was shared and received[31].

Owing to not gaining much information and knowledge about the birthing process participants had been consulting multiple sources in search of information. It is argued and noted that birthing-process information enhances acceptable health behaviour, self-care and empowerment for birthing women, empowering them with the knowledge to know and identify risks and seek assistance from relevant persons and places as soon as possible[32]. However, some participants appreciated the care and information shared by midwives during ANC.

Participants shared some recommendations of care for future first-time mothers. Midwives work in a partnership with women for the purpose of giving support, care and advice during pregnancy, birth and postpartum period[33]. According to some authors midwives are supposed to cover pregnancy-related lifestyle and health needs and even psycho-social health education needs in their health education sessions[34]. Participants in this study felt that their needs had been neglected as the focus was that of the baby's well-being. Participants proposed that time should be dedicated to birthing-process preparedness for the first -time mothers to be fully prepared. Many countries such as Sweden (67%) and Kenya have dedicated time for birthing process preparedness in their ANC period[35]. In Kenya it was observed that 91% of women had reported having experienced a positive labour process owing to dedicated birthing-process preparation during the ANC period[36]. Participants were

therefore recommending that some time should be dedicated just to education about the birthing process and this request is supported and viewed as valid[23]. More explicit communication by the midwife was recommended by the participants. Consequently, relevant to birthing-process preparation, substandard communication for birthing women was also reported by midwives[37]. Participants also raised the need for counselling during the birthing -process preparation. According to some authors birthing-process preparation with counselling sessions would encourage women to express their feelings and help them engage with distressing components of the birthing process[38]. Stress prevalence during birthing women is estimated to be 5.5- 78% among birthing women while prevalence of depression is 20-26% in low-to-middle income countries[39]. Consequently, it has been reported that 99% of mortalities that occur in developing countries are a result of expectant mothers' deficiency in preparedness for their birthing process[40].

Conclusion

Birthing-process preparedness has a critical role to play in facilitating the reaching of the Sustainable Development Goals. A well-prepared woman is more likely to have a positive birthing experience and outcome thus assisting with decreasing the rate of maternal morbidity and mortality. Midwives have a pivotal role to play and are expected to cope with the formidable task of educating and counselling women during the antenatal period using sessions dedicated specifically to this purpose.

Ethical considerations

The researcher maintained the ethical strategies that uphold the principles prescribed by the Belmont Report. Permission for the study was granted by the Nelson Mandela University (Ref: **H18-HEA-NUR-021**), Department of Health Eastern Cape (Ref: EC_201905_012), unit managers and written informed consent was given by all the participants. The rights of the participants were respected and as such participants were informed of the right to voluntary participation and withdrawal at any stage of the study without a penalty. Privacy and confidentiality were protected by keeping all personal details anonymous and data collected confidential.

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Authors' contribution

The corresponding author of this article was the main supervisor of the study, conceptualised the draft article, finalised it and submitted to the journal. The second author collected and analysed data for the study, read and approved the final manuscript.

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