Original Article

Mothers' Perceptions About Childbirth Preparation Classes: A Qualitative Study

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Abstract

Background: Childbirth preparation classes are designed for better adaptation of couples to physiological and psychological changes related to pregnancy and childbirth. Therefore, we aimed to explore the mothers' perceptions about childbirth preparation classes.
Methods: A qualitative study was conducted using the conventional qualitative content analysis method from May to August 2022. Eighteen women who had given birth in the last six months in one of the hospitals in Tehran and at least 20 days had passed since their delivery were included in the study; also, five husbands, two midwives, and two obstetricians were interviewed. The participants were purposefully selected according to the inclusion criteria. Sampling continued until data saturation. Data were collected through individual, in-depth, and semi-structured interviews and analyzed by the MAXQDA version 10 software.
Results: Mothers' age ranged from 17 to 37 years. 128 primary codes, 7 sub-sub themes, 3 sub-themes, and one theme were extracted. The sub-themes included satisfaction from the choice (perception forming for better choices, common consent), making the wait pleasant (dignity-oriented professional care, adaptation to change, feeling of empowerment), and good termination (free and conscious choice for birth mode, self-control during delivery process). Finally, a theme called "making motherhood pleasant" was extracted.
Conclusion: Making motherhood pleasant can be a meaningful achievement of childbirth preparation classes. Paying more attention to improving the quality of these classes can help improve family health. Therefore, policymakers should implement strategies to facilitate women's access to these classes.

Keywords: Childbirth, Mothers, Cesarean section, Qualitative research

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Introduction

Physiological and psychological changes induced by pregnancy and childbirth make this process one of the most different events in marital life.[1] This experience is generally accompanied by experiencing negative emotions such as fear and anxiety in couples.[2, 3] The presence of stress and anxiety resulting from labor pain during pregnancy leads to unsatisfactory complications in the fetus, disrupts the progression of childbirth and the possibility of needing unnecessary interventions, and increases the cost of pregnancy and childbirth services.[4] According to the World Health Organization (WHO) 2016, a Cesarean section prevalence rate of more than 10% in the country will increase both the maternal and neonatal mortality index and their morbidity.[5, 6] Although there is evidence of an appropriate agreement between integrated programs in maternal health care with International Guidelines, in recent years, the increase in Cesarean section rates in the world (18.6%) and in Iran (53.6%) has turned this issue into a health problem.[7, 8] This difference rate can be caused by cultural differences in countries and the implementation of different programs in this field. Therefore, the WHO announced three groups of recommendations for reducing the rate of Cesarean sections in countries, including general recommendations, context-specific recommendations, and no recommendation (this option should not be implemented.). Recommendations included interventions based on women's group, based on service providing group, and finally interventions based on health organizations and systems.[9] Studies have confirmed the role of childbirth preparation classes in line with the WHO program in improving pregnancy outcomes, reducing Cesarean section rates, and maternal well-being.[10, 11] The childbirth preparation classes called "Physiological Childbirth Preparation" by the Ministry of Health and Medical Education in Iran have been held in selected hospitals and health centers since 2008. These classes provide services to couples in three sections: counseling, evidence-based education, and skill-based training. The subjects discussed in the class include the calculation of gestational age, reproductive system, nutrition, breathing and relaxation techniques, identifying risk signs, benefits of vaginal delivery, pain reduction techniques, and neonatal nursing.[12] This class is being held with the aim of empowering mothers and reducing the fear of natural childbirth in Iran. Studies with a qualitative approach to investigate Iranian women's experiences of participating in these classes are limited.[13, 14] Also, in these studies, more attention has been paid to the biological aspects of pregnancy and childbirth. In contrast, other aspects of motherhood, including its psychological aspect, are less highlighted in the themes. Therefore, we aimed to explore the mothers' perception about childbirth preparation classes.

Materials and Methods

This qualitative study was conducted using conventional content analysis method in Tehran, Iran, from May to August 2022. After approval of the Ethics Committee of Shahid Beheshti University of Medical Sciences, informed consent was obtained verbally from the mothers and written by midwives and obstetricians, and then the telephone conversations were recorded. The target population was Iranian women who had participated in birth preparation classes (18 peoples, their husbands (5 peoples), midwives (2 peoples), and obstetricians (2 peoples). The inclusion criteria included the women who had given birth in the last six months and at least 20 days had passed since their delivery in the public and private sectors, had interest in participation, and participate at least in three or more class sessions. Also, midwives and obstetricians who had more than 5 years of work experience in the delivery sector were included. Those participants who were not willing to participate after the interview were excluded from the study. According to the executive protocol of the Ministry of Health and Medical Education in Iran, classes are held by trained midwives from the 20th week of pregnancy in 8 sessions of 90 minutes. In this way, a list of midwifery centers

(these centers are organized by midwives) in Tehran, capital of Iran, was prepared and selected randomly (about 19 centers). A list of centers was prepared along with their contact numbers. After contacting the officials, a list of eligible women with contact numbers was prepared. They were selected purposefully and with maximum variation in terms of age, socioeconomic level, type of delivery, and delivery in public or private center. After we called the mothers and explained the study objectives (21 people), about 86 percent (18 people) of those invited participated in the interview. The reasons for lack of participation in the study were being involved with the baby, not having enough time, and having work problems.

Midwives and obstetricians were interviewed face-to-face, and mothers and their husbands due to the fear of contracting Covid-19 were interviewed by phone using a semi-structured individual interview. The purposeful sampling was done based on the inclusion criteria. All interviews were conducted by a reproductive health specialist in a separate room at the Men's Health and Reproductive Health Research Center of Shohaday-e-Tajrish Hospital. The participants were contacted by phone to schedule an interview time. To ensure that the issues were covered as thoroughly as possible, an interview guide with open-ended questions was designed. The probing questions were asked to understand the participants' views better. For example, questions like "What do you mean by this?", "How?", and "Why?" At the end of the interviews, the participants were informed about the potential need for more interviews and requested to allow the interviewer to contact them in case of any possible questions. Three pilot interviews were conducted to develop the questions (Table 1). The interview lasted for 35-60 minutes based on the mothers' conditions. All interviews were recorded with an audio recorder and, if necessary, tone and sound emphasis was noted. After each interview, the recordings were transcribed into Microsoft Office Word, and analysis and concurrent coding were done. The process included recounting direct quotes from the participants, text labeling, and categorizing, resulting in the extraction of new themes.[15, 16] The interviews continued until data saturation was obtained. This means that no new data could be found in the interview.

In qualitative studies, the aim is to obtain an image of a natural phenomenon and clarify its various dimensions.[17] Conventional content analysis was used for data analysis in this study. The process of data analysis was performed based on the steps proposed by Graneheim and Lundman.[18] Therefore, the researchers transcribed the interview verbatim and performed data analysis after conducting the interview. Then, they read the total text several times to get a general sense of the content of the interview. The total text was considered as the unit of analysis, and shorter parts such as phrases, sentences, or paragraphs, which had a concept related to the research question, were considered as a meaning unit. Each meaning unit was converted into condensed meaning units by keeping its original concept, and these units were then coded. The codes were categorized into sub-subcategories and subcategories based on their similarities and differences. Finally, with regard to the hidden meanings of the categories, the themes emerged from them. The data analysis was done using MAXQDA software version 10.

Table 1: Examples of interview guide questions

Opening questions	Probing questions
Please tell us your experiences of attending childbirth preparation classes	Compared to before participating in the classes, explain more differences in how you feel or look at pregnancy?
How effective were the classes in persuading you to choose the type of delivery?	Please more explain about its effect on your awareness, attitude, and practice?
What did you expect from the classes?	Please explain more
What suggestions do you have to improve the conditions and make the classroom more effective?	Why?

The accuracy of the study data was accessed through four criteria: dependability, credibility, conformability, and transferability based on Lincoln and Guba's approach.[19] To ensure dependability, two experts who were faculty members familiar with qualitative research and reproductive health conducted the external checking. The credibility was established through the prolonged engagement with the data, member checking, and maximum variation when selecting the participants. As to conformability, all the study steps were recorded and reported in detail for future research. Finally, transferability was enhanced through the thick description which means all steps were described in detail, so that the findings could be generalized to other populations with similar characteristics.

The present study is in accordance with the Declaration of Helsinki and is extracted from the research project approved by the ethics committee of Shahid Beheshti University of Medical Sciences with the code of ethics IR.SBMU.RETECH.REC.1401.018. After explaining the objectives of the study and ensuring the confidentiality of participants' information, we obtained a verbal and written informed consent and permission to audio-record the interviews. Participants were assured that the interviews would be deleted after the data extraction. Participants' right to withdraw from the study without consequences was considered. Ethical principles related to the confidentiality of the participants' information were also considered.

Results

After interview with 27 people including 18 mothers, 5 husbands, and 2 midwives and 2 obstetricians, the data were saturated. The mothers' age ranged from 17 to 37 years. Six mothers (33.3%) had delivered through Cesarean section and 12 (66.6%) had given birth naturally. Of the 12 mothers with normal vaginal delivery, two (16.6%) had a history of cesarean section delivery in the previous 4-6 years (Table 2). 128 primary codes were extracted; by analyzing the participants' experiences, gradually 7 sub-sub themes and 3 sub-themes including satisfaction from the choice (perception forming for better choices, common consent), making the wait pleasant (dignity-oriented professional care, adaptation to change, feeling of empowerment), and good termination (freely and conscious choice for birth mode, and self-control during delivery process) were extracted. Finally, a theme entitled "making motherhood pleasant" was obtained (Table 3).

Most participants' conversations revealed that the content and class process should ultimately make motherhood process pleasant for them. This theme is extracted from the sub-themes and sub-sub-themes that will be discussed in the following section.

1. Satisfaction from the Choice

This category means that the couple is satisfied with beginning the parenting process. Changes in attitude increase the likelihood of expected behaviors. The couples stated that attending the class made us feel more satisfied with our choices because it made us focus more on our mutual desires. It also facilitates the acceptance of difficult conditions. This sub-theme consisted of two sub-sub-theme: perception forming for better choices and common consent.

1.a. Perception Forming for Better Choices

This concept refers to the fact that participants' choice is influenced by their perception of the conditions and physical and mental preparation. This concept is better formed with the help of the classes held. A mother said, *"It's ridiculous that we, women, can't make decisions about our own bodies, and other people have to decide when we should become pregnant, or how to give birth"*. She continued, *"Who can give me a better opinion about the readiness of my body and mind for pregnancy and delivery than myself?"* (P2). It seems that the feeling and perception of being prepared to choose and make decision was one of the psychological effects of the class.

Table 2: Characteristics of the participants (N=27)

Participant Number	Age (Year)	Sex	Role	Education level	Job	Type of birth	OB History
P1	27	Female	Mother	Diploma	Housekeeper	VD[a]	G[b]1/P[c]1
P2	33	Female	Mother	Pre-Diploma	Housekeeper	VD	G2/P2
P3	22	Female	Mother	Bachelor's degree	Self-employment	VD	G1/P1
P4	34	Female	Mother	Pre-Diploma	Housekeeper	VD	G3/P3
P5	33	Female	Mother	Bachelor's degree	Employment	VD	G2/P2
P6	21	Female	Mother	Diploma	Self-employment	VD	G1/P1
P7	22	Female	Mother	Diploma	Housekeeper	VD	G1/P1
P8	17	Female	Mother	Diploma	Housekeeper	VD	G1/P1
P9	37	Female	Mother	Bachelor's degree	Housekeeper	VD	G2/P2
P10	27	Female	Mother	Bachelor's degree	Housekeeper	VD	G1/P1
P11	33	Female	Mother	Master's degree	Housekeeper	VD	G2/P2
P12	29	Female	Mother	Diploma	Self-employment	CS[d]	G2/P1
P13	18	Female	Mother	Pre-Diploma	Housekeeper	CS	G1/P1
P14	28	Female	Mother	PhD[e]	Self-employment	VD	G3/P2
P15	31	Female	Mother	Bachelor's degree	Employment	CS	G1/P1
P16	37	Female	Mother	Diploma	Worker	CS	G1/P1
P17	19	Female	Mother	Pre-Diploma	Self-employment	CS	G1/P1
P18	28	Female	Mother	Diploma	Housekeeper	CS	G1/P1
P19	32	Male	Husband	Master's degree	Self-employment	-	-
P20	41	Male	Husband	Pre-Diploma	Self-employment	-	-
P21	29	Male	Husband	Diploma	Self-employment	-	-
P22	23	Male	Husband	Pre-Diploma	Worker	-	-
P23	32	Male	Husband	PhD	Employment	-	-
P24	45	Female	Health provider	Master's degree	Midwife	-	-
P25	29	Female	Health provider	Master's degree	Midwife	-	-
P26	39	Female	Health provider	MD[f]	Obstetrician	-	-
P27	42	Female	Health provider	MD	Obstetrician	-	-

[a]Vaginal Delivery; [b]Gravida; [c]Parity; [d]Cesarean Section; [e]Doctor of philosophy; [f]Medical doctor

Table 3: Extracted sub-sub-themes, sub-themes, and themes from the data analysis

Sub-sub Themes	Sub-Themes	Theme
Perception forming for better choices Common consent	Satisfaction from the choice	Making motherhood pleasant
Dignity-oriented professional care Adapting to change Feeling of empowerment	Making the wait pleasant	
Freely and conscious choice for birth mode Self-control during delivery process	Good termination	

1.b. Common Consent

According to the participants, the classes helped the couple to come closer to each other and make joint decisions. A mother said: *"I was less stressed because I shared my problems with my husband more easily, and he also tried to cooperate more"* (P1).

One of the mothers said, *"My husband's presence in the class made him understand my fears better and get along more with my decision-making."* (P3).

2. Making the Wait Pleasant

Most of the participants believed that

dignity-oriented professional care, adaptation to change, and feeling of empowerment from participation at childbirth preparation classes made the waiting time from pregnancy to childbirth pleasant.

2.a. Dignity-oriented Professional Care

Some participants stated that "It is true that prenatal and perinatal care is specialized care, but we need more to respect our wishes and needs." Therefore, the dignity-oriented professional care sub-sub-theme was extracted. In this regard, a mother said, *"I needed to be seen either in the clinic or in the delivery room, that is, to see what I want. It's not that routine work will be done for me; maybe, my needs are different, I felt this in class."* (P4).

Another mother said happily, *"The class lessons gave me a good feeling that I am important and I need to be treated with respect under all conditions"*(P7).

2.b. Adaptation to Change

Pregnancy is associated with physical and psychological changes. Helping couples to adapt to these changes was mentioned by the participants as one of the most important achievements of the class. A mother stated: *"Participating in childbirth preparation classes increased my husband's participation in care, and it helped me a lot compared to my first childbirth."* (P5) One of husbands implied: *"The classes taught my wife how to cope with her new conditions, and her satisfaction made me calm."* (P19) Another one told: *"When my wife got pregnant, I was very scared because we both had little knowledge. The classes reduced our fears, and my wife had a good delivery."* (P22)

2.c. Feeling of Empowerment

This concept was mentioned by most of the participants. They emphasized that the classes increased their empowerment feelings to pass prenatal and delivery process. A mother said: *"I was able to find out in time when my contractions indicate the time of delivery, and I went to the hospital on time; neither me nor the staff was bothered. The staff themselves said, it's good for everyone to come like you."* (P6). Another mother stated: *" Because I knew what to do in time, I compared myself to another person; I felt how peaceful, and that's why the staff treated me with more respect."* (P7). A midwife who had a lot of experience in childbirth said: *"The control of the situation by the mothers who attended the classes showed how they were empowered."* (P25)

3. Good Termination

Good feelings in the final days of pregnancy and during childbirth were among the topics frequently recounted by the participants. Therefore, this sub-theme was revealed with two sub-sub- themes: freely and conscious choice for birth mode and self-control during delivery process.

3.a. Free and Conscious Choice for Birth Mode

Regarding the conscious choice of some participants, they emphasized that attending the class led to a decision that was less regrettable. In this regard, one mother stated: "*I chose to give birth myself because I learned the types of births and their complications.*" (P11) A midwife said: "*Mothers participated in the birth preparation class because they had a greater role in choosing the type of delivery, so they and the staff were more relaxed*." (P24). Another mother explained: *"Cesarean section wasn't my choice; I felt so good when I was able to have my second birth naturally because I believe that God is closer to a person during childbirth."* (P11) A mother said: *"I really wanted to give birth on the first day of the New Year; that's why I wanted to have a Cesarean section, but my baby's health was more important to me. Having a birth that would ensure the health of me and my baby caused me to choose normal delivery."* (P13).

3.b. Self-control During Delivery Process

Being aware of the labor and birth process caused the mothers to have better control over their conditions. A mother stated: *"I used to*

do breathing techniques and acupressure medicine all the time during labor pain; I felt that I could control the situation." (P9) Another mother told: *"Since I knew how to control my pain with the techniques which I had learned, I felt good and my fear decreased."* (P10)

Discussion

This qualitative study was conducted in Iran to explain women's perceptions of childbirth preparation classes. According to the results of this study, women's experiences were classified into one theme "making motherhood pleasant", and three sub-themes including "Satisfaction from the choice", "Making the wait pleasant", and "Good termination". The results of this study are consistent with those of other studies, showing that socio-cultural and psychological factors play an important role in making motherhood pleasant and choosing the method of delivery easily.[20, 21] The theme of making mothers pleasant is the result of merging categories, which contains most of the psychological concepts such as self-control, free choice, and adaptation to change. In general, it can be inferred from the results of this study that a change in mothers' attitudes through dignity-based care that can be provided in childbirth preparation classes increases the possibility of choosing normal delivery by affecting their beliefs about safe childbirth. Therefore, paying attention to the mother's request can be effective in her choice of the type of delivery. In line with the results of the present study, other studies also reported these outputs from childbirth preparation classes.[13, 22]

The results of the study show that the perception forming for better choices and common consent can help to reach satisfaction from the choice. The results of the study carried out by Morid et al. showed that satisfaction with pregnancy and making the childbirth process pleasant were positive results of these classes. These results enhance the validity of the findings of the present study.[13]

The results of the present study revealed that dignity-oriented professional care, adaptation to change, and a feeling of empowerment can make waiting during pregnancy pleasant. These results are consistent with those of Taheri et al.'s study. In this study, the mothers' empowerment, good behavior of the caregivers, and reconstruction of the structures were among the concepts extracted from the study.[23]

In a study, women's experiences of vaginal delivery in Iran included pain, the essence of vaginal delivery, immersion in stress, and strategies for situation management.[24] In the present study, making positive attitudes about normal delivery and correcting false beliefs were important outputs of the class. It should be noted that some of these results can help promote community health and positive attitude toward childbearing in the long term. Studies reported positive relationships, participation in decision-making, and professional skills and opinions of experts in choosing effective vaginal delivery.[25, 26]

Finally, the good termination of pregnancy marks the beginning of a new chapter of successful motherhood. These sub-themes have been reported with different categories in the studies. Receiving quality care led to a free and conscious choice that ultimately resulted in mothers' satisfaction. The concepts extracted from the present study could confirm the theory of the relationship between the mother and midwife. This theory also considers socio-cultural contexts to be effective in relation to the mother's understanding of her ability and sense of well-being.[27] It seems that the educational and cognitive strategies used in childbirth preparation classes can influence the mothers' views on choosing a safe delivery. In this way, this care model of continuous midwifery care has been confirmed as a pleasant experience for mothers in various studies.[13, 28] On the other hand, self-control during the delivery process is another important concept that leads to good termination. However, based on studies, women who did not have access to childbirth preparation classes taught

by midwives or could not have midwife-accompanied births complained about negative birth experiences.[13, 23, 26]

According to the results of the study, preparation classes for childbirth should be considered a recommended standard of prenatal care. Therefore, by making motherhood pleasant from the process of pregnancy to childbirth, the women's attitude towards this important process should be changed.

Sampling from the private and public sectors, as well as interviews with key informants including mothers, husbands, and healthcare providers were the strengths of this study. Also, the psychological aspect affecting the choice of mothers was further revealed. One of the limitations of this study was that the interviews with mothers and husbands were done by telephone; therefore, part of the qualitative concepts derived from body language was not available.

Conclusion

Based on what the mothers expressed, making motherhood pleasant was one of the important achievements of childbirth preparation classes and played an important role in the decision of the choice of the type of delivery. This decision-making occurred under the influence of cognitive and behavioral changes that the classes created by empowering mothers, perception forming for better choices, and adaptation to change. The women's experiences and desires should be given more attention by the policymakers of the health system in order to ensure the health of the family. Health policymakers should implement strategies to reduce limitations and make these birth preparation classes accessible to all pregnant women in Iran. Strategies such as the implementation of midwife-led care models, support for accompanying midwives, and quality improvement of childbirth preparation classes need to be attended.

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