UNDERSTANDING CHILDBIRTH EDUCATION:
A PHENOMENOLOGICAL CASE STUDY

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MASTER BY RESEARCH DECLARATION

"I, Elvira Brown, declare that the Master by Research thesis entitled "Childbirth education by osmosis: a phenomenological case study" is no more than 60,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work."

Signed: Date:

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ABSTRACT

This study investigated childbirth education programs in Victoria from the perspective of the educators themselves. Prior to the study the Ministerial Review of Birthing Services in Victoria (1990) entitled "Having a Baby in Victoria" identified shortcomings in the childbirth education programs offered to expectant women and their partners. The study sought to interpret the experiences of the childbirth educators with regard to the development, implementation, delivery and evaluation of their programs.

Using phenomenology and case study approach fourteen childbirth educators were recruited to participate in the study. These participants were from public and private hospitals in Melbourne and regional Victoria. Data were collected using in-depth interviews which were recorded and then transcribed. Due to the length of time since data collection, analysis was placed in the context of the Ministerial reviews of the 1990s and 2000s, however, the resultant phenomenon remained unchanged. The collective experiences of the participants was conceptualised as the phenomenon *education by osmosis*.

The phenomenon represents the manner in which childbirth educators developed and delivered education to their clients. The three major themes High pressure of osmosis: Varied motivations, Semi-permeable membrane of osmosis: Obstacles, struggles and progress, and Low pressure (equalisation) of osmosis: Establish roles and status represent how the childbirth educators located themselves in the role, how they dealt with the often difficult situation of pleasing employers, clients and colleagues with limited resources, and ultimately, growing within themselves.

The study findings highlighted the ongoing difficulties experienced within the area of childbirth education in Victoria. In spite of several reports recommending changes to service-provision, there remains dissatisfaction with this service. Recommendations are suggested and implications for midwifery education are also outlined.

KEY TO THE STUDY

In the presentation of this thesis the following conventions have been used.

pseudonyms   all study participants were allocated a pseudonym to ensure anonymity

normal type and "…"   citation of quotes from the literature

Italics   citation of participants' words

…   material edited out

[square brackets]   researcher's comments, added to clarify or explain

CHAPTER ONE
INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 INTRODUCTION

In Victoria, antenatal/childbirth education usually refers to teaching sessions or classes for pregnant women and their partners (Hancock, 1994). The purported aim of these classes is to prepare the pregnant woman for childbirth and parenting, and in so doing, enable the woman to understand the nature of maternal health and wellbeing during pregnancy and to acquire the confidence to take charge of her childbearing experiences. Through interaction with the other participants the expectant woman may also find the classes a means of peer support throughout the later stages of pregnancy (Williams & Booth, 1985; Eisenberg, Murkoff, & Hathaway, 1991). The content of childbirth education programs in Victoria is similar to those of British childbirth education programs, which were informed by the recommendations of a report titled "Changing Childbirth." This report was commissioned by the British Government in 1993 to investigate the provision of midwifery services in Britain (Department of Health, Report of the Expert Maternity Group, 1994). "Changing Childbirth" stated that maternity care must focus on the pregnant woman and empower her to take part in the decision-making process regarding her care. The report specified the topics that were to be addressed in childbirth education classes in Britain. These topics included adaptation to the role of parent; knowledge regarding the development and care of an infant; and the emotional and physical preparation of the woman for labour, birth and the post-partum period (Simkin, 1996).

The importance of educating prospective parents, particularly in parenting skills, was made in the Review of Victoria's Child Protection System (1988), a review initiated in response to the growing incidence of child abuse in this state, and in the Report of the Ministerial Review of Birthing Services in Victoria (1990). The outcomes of these reports indicated that childbirth education classes were not meeting the needs of the pregnant women undertaking them. Gaining an understanding of how childbirth education programs were developed, implemented and evaluated in Victoria, was a strategy that could provide valuable insight into why childbirth education classes were not meeting the needs of their consumers. Thus it seemed that an investigation of how

childbirth education programs were developed, implemented and evaluated was necessary.

This thesis is concerned with the experience of childbirth educators in Victoria in the 1990's and their educational preparation set in the political context of then and from 2000 onwards. Childbirth education involves the provision of information about pregnancy, childbirth and parenting to pregnant women and their partners. The information can include the teaching of practical skills required in labour, that is, relaxation and breathing techniques and the preparation for parenthood. This education is usually provided by another person or group of people perceived to be experts in these fields. The providers of childbirth education information may be qualified in the area of childbirth, that is, midwifery, but not specifically childbirth education. They may be non-professional childbirth education practitioners who have no formal training in the areas of pregnancy and childbirth, apart from that gained through personal experiences (Ministerial Review, 1990) and without educational expertise, or they may be professionals in another discipline, for example, physiotherapy, with a particular interest in childbirth education.

Interest in the development of childbirth education programs arose from my involvement as a mother, midwife and educator in hospital antenatal and labour wards, and as a lecturer in a higher education-based School of Nursing and Midwifery. The publication of both the Report of the Review of Victoria's Child Protection System (1988) and then Ministerial Review of Birthing Services in Victoria (1990) further heightened my interest in childbirth education (a discussion of the findings of both these reports is provided in Section 1.3). In order to explore how childbirth education programs were developed, implemented and evaluated, 14 midwives who were conducting childbirth education programs in Victoria were interviewed, with the aim of understanding their lived experience as childbirth educators.

1.2   AIM OF THE STUDY

This qualitative study uses phenomenological methodology and a case study approach in order to answer the research question, "What is the lived experience of childbirth educators?" Thus, it is the aim of this study to provide

an understanding of the lived experience of childbirth educators in Victoria in the years immediately following the Ministerial Review (1990). The research question which guided the study was framed as "What does childbirth education mean to you?"

Using van Manen's methodical structure of human science research and case study approach to guide this study, participants' responses were gained through in-depth interviews and these responses provided the information about the lived experience of childbirth education of those practitioners. The following section provides an overview of both the Ministerial Review (1990) and the Review of Victoria's Child Protection System (1988) and why their findings are important to the development of future childbirth education programs. It also demonstrates their relevance to this study as a catalyst for investigating current childbirth education programs.

1.3   FINDINGS OF THE MINISTERIAL REVIEW ON BIRTHING SERVICES IN VICTORIA

The Minister for Health commissioned the Ministerial Review on Birthing Services in Victoria in 1988. It sought "... to review all aspects of birthing services with outcomes aimed at giving women greater freedom and range of choice in deciding how they wanted to have children" (Ministerial Review, 1990, p4). The Ministerial Review (1990) was based on a range of written submissions provided by expert health practitioners (192 in total) such as obstetricians, general practitioners, midwives, lactation consultants and physiotherapists. Consumers, that is, pregnant women and women who recently had given birth, were part of the consultation process.

The Ministerial Review (1990) highlighted several problematic areas in childbirth education provision which were deemed to require investigation in the clinical field; for example, disagreement between childbirth education providers regarding program content and principles; the size and format of classes; and, the lack of any formalized training or education for childbirth educators. An outline of the issues of concern to both consumers and providers of childbirth education follows in order to provide the background information of the status of childbirth education programs in Victoria.

The provider criticisms related primarily to the educational soundness of programs; specifically, a lack of quality control and evaluation methods; the validity of some classes; the lack of objectives for programs; variation in course length; the inappropriateness of some program content for women of cultural and language diversity, and aboriginal and young women.

Consumer criticisms related to dissonance between program content and their experience of childbirth education specifically: the lack of integration of adult learning methods in the teaching processes; the failure of some programs to address the requirements of many diverse cultural groups; the standard of some programs; a discrepancy between the program content and reality of the birthing suite experience of the pregnant woman and the overwhelming proportion of class time spent on preparation for labour at the expense of preparation for parenthood. In addition, there was dissatisfaction with large class sizes and with some programs, for failing to provide a midwife who could answer questions regarding hospital procedure.

In summary, the Ministerial Review (1990) identified the major areas of dissatisfaction with childbirth education programs from both the providers' and consumers' viewpoint. The providers' dissatisfaction highlighted discrepancies in program content and length, evaluation and their appropriateness for consumers other than English-speaking women. Consumer dissatisfaction lay predominantly with varying standards of programs and the discrepancy between what was taught in the classes and the reality of the childbirth experience. On a positive note, some consumers found the classes to be informative and relaxing, fostering their confidence in their ability to deal with the impending birth and to be a source of friendship and moral support with midwives being seen to be welcoming and knowledgeable.

The Ministerial Review (1990) detailed recommendations for change to the provision of birthing services, including childbirth education with regard to program content, principles and the size and format of classes. Other areas identified as needing attention were the development of: tertiary based childbirth education programs for childbirth education providers; culturally appropriate programs for women from diverse cultural backgrounds, and the development of literature and audiovisual aids in various languages.

1.4 THE REVIEW OF VICTORIA'S CHILD PROTECTION SYSTEM

The report entitled the Review of Victoria's Child Protection System (1988) was initiated in response to the growing incidence of child abuse in this state. This review made particular reference to the importance of educating prospective parents in parenting skills. The introduction in 1993 of legislation, which requires mandatory reporting by health professionals of suspected child abuse cases, was a direct result of this review. A deficit identified in this review, a lack of parenting knowledge and skills (Health & Community Services, 1995a), was seen as a direct contributing factor in the occurrence of child abuse. The review recommended that antenatal education was to be an integral part of the primary prevention strategies against child abuse (Health & Community Services, 1995b). This lack of parenting knowledge and skills was also identified by consumers in the Ministerial Review (1990). A review of antenatal education literature by Schneider (1989) supported the Ministerial Review's (1990) finding that parents were ill prepared for the parenting role. Schneider (1989) states that childbirth education has the potential to influence the type of parenting and childrearing in which parents will engage. The implication is that all prospective parents should be afforded the best education about childbirth and subsequent parenting. The findings of the above reviews and Schneider's paper give rise to the question of the effectiveness of childbirth education programs in meeting the needs of prospective parents.

The deficiencies and recommendations identified by both the Review of Victoria's Child Protection System (1988) and the Ministerial Review (1990) in relation to childbirth education, coupled with my interest in this topic as outlined earlier in this chapter, were the driving factors to conduct this study. The following section details the rationale for this study and draws on the literature which affirmed the need for investigation of childbirth education programs.

In the 1980's childbirth education programs in Victoria were provided as part of public hospitals' maternity services. Non-government funded hospitals offered programs on a fee-paying basis. Questions that might arise as a result of either type of arrangement include: What opportunities exist for free exchange of information between the providers and the consumers? Is the information presented perceived as beneficial by those attending the classes? Are programs formally evaluated? Are trans-cultural issues addressed in the

program? Finally, how is the content and its development decided upon? Thus, irrespective of whether the programs are offered on a free or fee-for-service basis, the issue of the accountability of service providers in light of the dissatisfaction of consumers with these programs (Ministerial Review, 1990) suggests that an investigation of these questions would be appropriate. Various documents and stakeholder groups have engaged in ongoing evaluation of childbirth education. Conducting research into these programs from the point of view of the educators will provide insight into the questions raised above. The findings may provide the direction for the development of future childbirth education programs that would specifically address the needs of the consumers. However, it is the intention of this study to track the progress of childbirth education programs in the decade following the Ministerial Review (1990) from the perspective of the educators themselves.

Taking the above into account and given the findings and recommendations of the Ministerial Review of Birthing Services in Victoria (1990) and the Review of Victoria's Child Protection System (1988), there was clearly a need for further investigation of childbirth education programs from the point of view of the educator. This, then, would assist the future development of educationally sound childbirth education programs.

1.5   STRUCTURE OF THE THESIS

This thesis consists of six chapters. The second chapter presents a review of the literature relevant to childbirth education both locally and abroad, an historical overview of childbirth education from the 1970s to the present day, and a discussion of the theories of teaching and learning relevant to education at the time of data collection. The study methodology is described and justified in Chapter Three. A discussion of the phenomenological movement is presented which includes the use of phenomenology in nursing and midwifery research. The evolution of case study as a research approach is explored and its use in this study is explained.

The design and method used for this study is presented in Chapter Four. The description of the participants, data analysis using 's methodical structure of human science research and the resolution of ethical issues pertinent to this

study are discussed in Chapter Four. The management of the data is also presented in this chapter.

In Chapter Five the findings are presented. These findings describe the lived experience of fourteen childbirth educators, particularly, the implementation of their programs, their educative processes and their educational status.

In Chapter Six, a discussion of the findings of the study, the phenomenon 'education by osmosis,' and its limitations are presented. The implications for midwifery practice and recommendations for future research and education are also presented in this chapter.

CHAPTER TWO
THE LITERATURE REVIEW

2.1 INTRODUCTION

There are three distinct sections to this chapter. The first section presents the historical context of childbirth education. Following this is a review of the literature on childbirth education. Finally, an overview of literature about the theories of teaching and learning is outlined to provide the background to, and illustrate how, childbirth educators teach and how it pertains to this study.

As qualitative researchers share different views regarding the extent to which literature should guide qualitative research (Field & Morse, 1995, p.45-46), it is therefore important to raise this issue and the approach taken in this study. According to these authors, there are three particular views in relation to when the literature should be reviewed. Thus, in qualitative research, the stage at which the literature is reviewed varies according to particular researchers and the particular research tradition. Several phenomenological exponents (Speigelberg, 1971; Oiler, 1981 and Omery, 1983) concur that the literature should be delayed until such time that all data collection has been completed. This approach is used so that the researcher can utilise the phenomenological concept of bracketing in order to interpret the participants' experiences with fresh eyes. This concept is explained in greater detail in Chapter Three. However, another viewpoint espouses that the researcher critically examines all previous research on the topic and uses it as a guide in order to locate the present study in the context of previous research. Given that each research setting will differ and may have changed over time (Morse & Field, 1995, p. 46), it remains possible for the researcher to retain an open-minded approach to the study. Accordingly, literature related to childbirth education has been reviewed prior to commencing the study and particular studies have been used to further explore the research question and the phenomenon derived from the study.

The current chapter reviews literature from the early 1980's to the present time. Most of the pertinent literature comes from Northern America and Britain. Overseas material was included as firstly, interest in childbirth education was generated outside Australia and was followed by research both in North America and Great Britain in the early 1980's and secondly, there was a paucity

of published research in Australia in relation to the content, design and evaluation of childbirth education programs. However, all available Australian research has been incorporated in this background material.

2.2   THE HISTORICAL CONTEXT OF CHILDBIRTH EDUCATION

The conduct of childbirth has, over the last 150 years, come full circle. Childbirth prior to the second half of the twentieth century was seen as the women's domain and hence women giving birth were assisted by midwives. In conjunction with an increase in the extent of medical intervention and use of technology during pregnancy and childbirth, as well as loss of close contact with the extended family unit, there has been a steady surge in antenatal/childbirth education available to the expectant woman. A century ago the extended family provided a learning experience in pregnancy management and parenting skills, but today's pregnant women and their partners look to doctors, nurses and others within the health system as their source of information (O'Meara, 1993a).

The gradual decline in the involvement of the extended family and the effects of the Industrial Revolution, coupled with the development of various obstetric practices and drugs, designed to deal with the pain of childbirth (Lindell, 1988), saw childbirth move into community based care with male obstetricians (predominantly) taking over the care of the pregnant woman. One aim of this medical care was to optimise the safety of both mother and foetus during pregnancy and labour (O'Meara, 1993a). An adverse effect of the medicalisation of birth was that women felt that they were no longer in charge of what is a natural process (Willis, 1983). Developments in recent years have seen a return of some of that lost control back to those giving birth, particularly in relation to pain management during labour and being able to participate in the decision making process relating to medical interventions (Oakley, 1979).

The need for education gave rise to schools of thought such as Lamaze, Bradley (1951, cited in Williams & Booth, 1985), and Dick-Read (1944) and Balaskas (1983). Dick-Read's method concentrated on the woman managing the pain of childbirth through knowledge of the process of labour and delivery. However, his concept of childbirth education did not extend past the delivery of the infant as did the Soviet method of preparation for childbirth known as

psychoprophylaxis, developed by Velvosky and based on the concept of Pavlovian conditioning (Lindell, 1988). Lamaze's method, accouchement sans douleur (childbirth without pain), derived from Velvosky's teaching, quickly gained popularity in France and Western Europe (Williams et al., 1985). Bradley's teachings placed emphasis on the husband coaching the woman through the labour and delivery (Williams et al., 1985). Balaskas's active birth method builds upon the early work of Caldeyro-Barcia and Odent who believed that shorter, more effective labours resulted if the woman remained active and ambulant during the first stage of labour (Balaskas, 1983). Another early pioneer of childbirth education was Margaret Gamper whose successful preparation of pregnant women for childbirth led to her first formalised childbirth education classes in 1946 in the United States of America. Her method of preparation of her clients became known as the Gamper Method, the theoretical basis of which lay in the writings of the 19th century midwives and physicians. Notably, Dick-Read is acknowledged by Gamper as having been extremely influential in her work (Young, 1986). Dick-Read also influenced physiotherapists interested in obstetrics, and as a result, this group of professionals also became involved in childbirth education. The emphasis of their teaching was on breathing and relaxation techniques during labour (Williams et al., 1985). Midwives became involved in formal childbirth education in Britain during the 1940's and 1950's based on the teachings of Dick-Read. However, it was not until twenty years later that antenatal education became a compulsory component of midwifery courses in Britain (Williams et al., 1985).

These methods of approaching childbirth were termed natural childbirth and occurred when women began to question the technology and medical control involved in pregnancy and birth (O'Meara, 1993a). Women began to demand not only safe, but satisfying childbirthing experiences in which they were actively involved in all decision-making related to their pregnancy, labour, delivery and parenting (Lothian, 1993). In Australia, the demand by women for satisfying and informed birthing experiences led to the formation of groups such as the Childbirth Education Association and Parent Centres Association among others (Barclay, Andre & Glover, 1989).

The return to natural childbirth gained momentum with the introduction of the Lamaze and LeBoyer methods of childbirth whose emphasis lay in returning the

control of the childbirth process to the expectant parents. Control, in this context, refers to the decision making process during labour, in particular, pain management, and ultimately during the birthing process itself. The movement for the restoration of control during childbirth back to women has further been bolstered by the growth of the women's movement with its general advocacy for the empowerment of women. Childbirth classes are now a well established and accepted practice and where available, are attended by approximately seventy-five percent of first time mothers according to a British study by Jacoby (1988).

The emergence of these classes created a new direction for research and evaluation of these preparatory courses. As early as 1984 Kuczynski advocated research in the area of antenatal education in order that future education was based on sound theory resulting from this research (Kuczynski, 1984). Research in this domain demonstrates there to be a wealth of information available to women, but as both Jacoby (1988) and Hillan (1992) found, women wanted more information and felt that what they had been given was not adequate preparation for labour, birth and parenting. British and North American studies conducted in this field do not focus on consumer satisfaction with the classes, but rather determine the effectiveness of the education by measuring obstetric outcomes (Robitaille & Kramer, 1985; Sturrock & Johnson, 1990; Hetherington, 1990). As early as 1975 MacIntyre (1981) found that women were not receiving the information they wanted, yet O'Meara (1993c) in an Australian study discovered that childbirth educators were continuing to teach what they saw as relevant even though women were still dissatisfied with the content. Thus a need exists for further research to determine whether findings of previous research have impacted on current programs or whether there still exists dissatisfaction with current programs.

2.3   CHILDBIRTH EDUCATION

Much of the research conducted about childbirth education has concentrated on evaluating obstetric outcomes in order to determine the effectiveness of antenatal education which is "concerned with the provision of information, guidance, and education for childbirth and parenthood" (Schneider, 1989). Studies conducted along similar lines include those by Robitaille and Kramer (1985), Sturrock and Johnson (1990) and Hetherington (1990). These

predominantly quantitative studies measured outcomes such as analgesic and anaesthetic administration, instrumental (forceps) delivery and the numbers of full term and premature births for a study group and control group. In selecting subjects from those who had attended classes, the researcher eliminated those who had delivered by caesarean section. No reason was given for this decision, yet a comparison of caesarean section rates is directly relevant when measuring obstetric outcomes. Statements were also made where no direct evidence was available to support them. One such statement was " ... these data reflect the increased pushing ability of the subjects attributable to their education." (Hetherington, 1990, p. 88). Another area of concern with this particular study is that the only criterion for the control group was that they had not attended preparation classes. No efforts were made to discover whether the control group had used other methods of preparation. This information was not asked of the study group either. Furthermore, the education classes attended by the study subjects were developed by the research team. The content was based on a model of Lamaze classes and included content specifically designed to reduce analgesic use. Medical and nursing staff of the delivery and postnatal wards attended in-service sessions to prepare them for the care of the study group. Thus it appears that measures were taken which may have contributed to the study producing the desired results and therefore raises questions of validity.

In Jacoby's study (1988), 75% of first time mothers attended antenatal/childbirth classes, but only 6% rated them as the most useful source of information. This study (n = 1508) was based on a previous, similar study conducted in 1975 and was used to compare results. Jacoby (1988) found that in the case of childbirth education, dissatisfaction had, in fact, increased amongst first time mothers. In the original study (1975), of the approximately 66% of first time mothers that attended classes, 42% reported them as being the most useful source of information. In stark contrast, Jacoby's (1988) study found that of the 75% of attendees, only 6% rated classes as useful. Jacoby's (1988) study also researched what other sources of information participants had accessed and their degree of usefulness.

Crowe and von Baeyer (1989) conducted a study of primigravidae (n=30) to determine what factors influence whether a woman describes her birthing

experience as positive or not. All participants attended a course of classes ranging from four to six weeks during the last trimester of pregnancy. This study used self-reported measures which, the researchers acknowledged, are open to distortion. They concluded that there are components of classes that lead to a positive experience. These were knowledge of childbirth and confidence in the ability to control pain. The issue of feeling prepared was not discussed with the participants even though the researchers cited research (Knight & Thirkettle, 1987) which indicated that if the birth experience was not as expected, women were more likely to report it as negative.

A qualitative study by Beaton and Gupton (1990) concentrated on elucidating the expectations women have about birth. The results determined that it was important for childbirth educators to prepare women for the realities of the birthing experience and that women have preconceived notions about this experience. Although using a small cohort (n=11), this study raised some very important issues for childbirth educators, some of which this study will address.

One study that tried to determine how women prepare for the childbirth experience was conducted by Mackey (1990). Women (n = 61) who attended a series of Lamaze classes were interviewed about their birth preparation. In this study, preparation was defined as " ... specifying the ideal labour and delivery experience, reviewing past childbirth experiences, gathering information and planning labour and delivery" (p. 144). The women themselves described preparation as being prepared " ...for doing a good job during labour and delivery" (p. 170). A good job meant using Lamaze techniques correctly, avoiding undesirable behaviour (such as screaming, being unable to perform Lamaze techniques and unable to comply with staff instructions), working hard and feeling that they had done a good job. One important conclusion that Mackey draws in relation to childbirth education is that educators may be teaching what they think is acceptable behaviour during labour and delivery and this is not necessarily realistic or what women want. O'Meara (1993b) found supporting evidence of this in her interviews with childbirth educators. The class content was based on what the educators believed was relevant to the clients' needs.

A study that focused on satisfaction with services, was that conducted by Hillan (1992) who compared a study group (n=50) of low-risk primigravidae delivered by caesarean section with a control group (n=50) of primigravidae who delivered vaginally. Seventy-six percent of the participants had attended a class on at least one occasion. This quantitative-qualitative study found that 28% of women who attended classes criticised them on the basis that these classes did not prepare them adequately for the birthing experience and subsequent parenthood.

Other research with similar focus was that conducted by O'Meara (1993c). This was a two-part study in which she evaluated childbirth education from both the consumer and provider viewpoint in order to develop a model for evaluating childbirth education. Eleven childbirth educators were interviewed. They represented both the public and private sector and included midwives and physiotherapists. The educators generally understood their aim to be to provide information, which in their opinion they judged to be relevant, to women and their families. The study found that none attempted to tailor their course to their clients' needs. A questionnaire was used to collect data from 207 families as part of the consumer group. Within the sample there were 87 women who were currently attending classes and 120 who had attended a course and had already delivered. Each group completed a slightly different questionnaire to take this into consideration. The findings indicated that the subjects did not achieve the level of skills and confidence they expected, an unreported number found classes to be disorganised, disjointed and incomprehensive and overall, classes were ranked third on a list of key sources of information (books and magazines ranked higher). The researcher concluded that the attitudes and views of the consumers indicated quite clearly ways in which education and services could be improved.

Research conducted by Rolls and Cutts (2001) was based on the premise that antenatal education programs were ineffective according to their review of the literature, a finding not dissimilar to earlier studies. The intention of the study was to compare the outcomes of antenatal education of two groups of women and their partners. Both study groups attended four two-hour sessions each. An experimental design was used with pre-and post-test self-administered questionnaires used at the first and last program session. Study participants

(n=70) were also surveyed three months post-birth. The experimental group attended a specially prepared antenatal education program delivered by experienced midwives which was focussed on areas that participants wanted discussed. On the other hand, the control group attended a traditional childbirth education program conducted jointly by a midwife and physiotherapist with traditional content. In other words, participant input was not sought. The questionnaires assessed the participants' level of knowledge regarding set topics ranging from lifestyle aspects during pregnancy to labour processes through to post-birth issues with regard to the woman, her partner and their baby (Rolls et al., 2001). The study findings demonstrated that women in the experimental group felt better prepared for the experience of pregnancy and how to care for themselves after the birth than the control group. Interestingly, neither group felt better prepared for the journey through labour, the birth or indeed, how to care for their babies post-birth (Rolls et al., 2001). These findings support earlier studies' findings with regard to satisfaction and effectiveness of childbirth education programs. On a positive note, this study demonstrated a significant level of satisfaction of the experimental group with program content and its delivery as opposed to the control group. In the researcher's opinion, it reinforces the need for a review of childbirth education programs in existence currently.

A study conducted by Ho and Holroyd (2002) to investigate the effectiveness of antenatal education in preparing Hong Kong Chinese women for motherhood, particularly the first month post-birth, returned similar findings to others discussed earlier. This study differed from that of Rolls et al. (2001) in that a qualitative approach was used. Data were collected using observation and focus group interviews. The study participants included all those that would normally attend childbirth education classes and these ranged from 48 to 95 women (and their partners in many instances). However, a total of 11 women participated in the two focus groups held. Interestingly, the researcher conducted each focus group. This may have impacted, in the researcher's opinion [myself], on the participants' willingness to speak freely. Findings from this study revealed dissatisfaction along similar lines to those conducted in Australia and elsewhere. These included the lack of culturally relevant material, large class size, insufficient preparation for parenting and conflicting information

being given (Ho and Holroyd, 2002). As with the study by Rolls and Cutts (2001), this study also had a small number of women participating (focus group numbers of 11) with all study participants sought from the one public hospital. This was also the case with the study reported by Rolls et al. (2001). This could be seen as not being representative of all women attending childbirth education classes in Hong Kong. Given that Ho et al's. (2002) focus group participants were of a higher income than the average Hong Kong population, this could also be seen to be a limitation.

Svensson, Barclay and Cooke (2007) conducted a study using a "multiple-source, multiple-methods needs assessment" (p. 10) to collect data. The aim of their study was to ascertain what information health professionals thought expectant and new parents wanted or needed and concerns that they may have. The study participants included first time expectant and new parents, their primary maternity-care providers (which ranged from midwives, nurses and childbirth educators), and antenatal education program documentation (Svensson et al., 2007). A variety of data collection methods was used ranging from in-depth interviews, focus groups, participant observation, surveys, and the review of program documentation. Some of the findings were as follows: study participants (health professionals) had the perception that expectant and new parents wanted information regarding their pregnancy and the period after the birth of their baby; however, they were of the view that despite their best efforts, expectant and new parents did not listen to information regarding parenting, they were purportedly more interested in the birthing issues (Svensson et al., 2007). This is in direct contrast to those of Ho et al. (2002) whereby participants in that study claimed a paucity of relevant information being provided to them. Another finding of Svensson et al.'s (2007) study revealed that study participants' (health professionals) were of the view that expectant and new parents wanted information that enabled them to make informed decisions regarding their care, termed "practice issues" in the study (2007, p. 11). However, the researchers discovered that the health professionals' understanding of practice issues (the practicalities related to labour, when to come into hospital, the use of urinary catheters during epidurals, what to eat and drink in labour) was at odds with that of the expectant and new parents' understanding of the term "practice issues" (Svensson et al., 2007). Another

important study finding was that in spite of the health professionals' perception that expectant and new parents needed parenting information but "did not listen," (p. 11), they [health professionals] were reluctant to change aspects of their practice and indeed, displayed a sense of power and control over the expectant and new parents (Svensson et al., 2007), a fact with which they did not agree.   The researchers recommended that health professionals require training, support and guidance with regard to program content (Svensson et al., 2007).   A particular strength of this study is that it not only examined the consumer of childbirth education, that is, the expectant and new parents, but also the provider, that is, the health professionals.   It would have been further strengthened if the study researchers had examined how the antenatal programs had been developed rather than only reviewing program content.

The need for a review of the status and relevance of childbirth education programs in the twenty-first century is the topic of discussion by De Vries and De Vries (2007).   Whilst not research-based, the authors never-the-less have called for a realignment of childbirth education programs with the expectations and needs of today's expectant women and their partners.   They claim that childbirth education "has lost its way in recent years" (De Vries et al., 2007, p. 38).   Indeed, the authors propose that the term childbirth educator should be replaced with "birth coach" (p. 38) as this would imply a broader role than the former term.   Their call for this change is premised on their belief that the landscape of birthing and birthing women has changed since the mid-twentieth century and that it is necessary to adapt to this change.   Whilst the landscape they refer to is situated in North America, it has implications for the Australian landscape also.   De Vries et al. (2007) argue that "In creating a fresh model of childbirth education ... we learn in new ways to walk the walk as well as to talk the talk as we journey alongside each other to create new possibilities for birthing families" (p. 47).   The authors' views are supported by Lothian (2008) who acknowledges that it is time to review the content of childbirth education classes as the delivery of maternity care has undergone changes, whilst the content of classes has not.   The researcher is also of the opinion that the role of the childbirth educator needs to be expanded from what is has been traditionally to one of empowering women through the provision of " ...accurate, up-to-date, evidence-based information..." (p. 47).   Concomitant with this is the need for the

childbirth educator in helping expectant women and their partners make sense of the information provided. Lothian (2008) believes that the childbirth educator's expanded role means that she journeys alongside the woman through the pregnancy. The childbirth educator is "not just an expert who comes on the scene in the last two months of their pregnancy" (p. 48). In fact, Lothian (2008) believes that the role of the childbirth educator is as a facilitator rather than the expert. In so doing Lothian (2008) argues that women will be empowered to drive the necessary changes in the provision of maternity services. In the researcher's opinion, the discussions by De Vries et al. (2007) and Lothian (2008) present very powerful arguments for change in childbirth education abroad and locally and which fit well with the recommendations of the Ministerial Review (1990).

Given the nature of the findings from the literature, further study is warranted to determine whether previous findings are supported, or whether the situation in childbirth education has improved. Thus it became apparent from reviewing the literature that research into the experiences of childbirth educators was necessary as many of the articles demonstrated that the prospective parents were not satisfied with the information presented in the classes they attended. The following section provides a discussion of the teaching and learning theories.

2.4   THEORIES OF LEARNING AND TEACHING

In order to locate the study in the context of accepted, traditional models of teaching and learning, it was worthy to explore the various theories of learning and teaching. The significant teaching and learning theories at the time of data collection have been included in the discussion that follows.

According to Huckabay (1980, p.171), a model in its simplest terms "is a simplification of reality. It is not reality itself." For childbirth educators, a model provides them with the strategies and means by which they present their program content.

Huckabay (1980, p. vii) based her work on the premise that "…theories of learning and instruction provide the [midwife]-teacher with a cognitive map to improve learning and to facilitate instruction." Inherent in this statement is the

belief that any planned teaching must adhere to an accepted, deliberate method or plan of instruction, that is, the teaching is not a haphazard occurrence.

Huckabay (p. VII, 1980) presents four basic assumptions in her work. She argues that teaching skills are acquired behaviours, that is, this requires deliberate learning by teachers, in this case, by the childbirth educators, of these skills; there must be an understanding of how humans learn as this will allow the teacher to create appropriate teaching strategies; learning will result in a change of behaviour [for the childbirth educator]; and lastly, theory seems to indicate that effective teaching can occur with or without an in-depth knowledge of the subject matter. This means that childbirth educators might become effective teachers if they possess sound teaching strategies even if they have no experience of birth, midwifery or parenting.

There are many accepted models of instruction. Examples of these are: Bloom's mastery-learning model, Carroll, Skinner, Gagne and Bruner's Model of instruction. All advocate specific conditions and strategies in order to produce effective teaching, which contribute to effective learning. The following provides a brief overview of each of the above theorists' models of instruction.

Carroll's model (Huckabay, 1980, p.172) identifies five main concepts, based on the time factor, which he has categorized into two distinct headings. They are: determinants of time needed for learning and determinants of time spent in learning. In relation to the former, the variables related to this are: aptitude, which refers to the amount of time needed for learning under optimal conditions; a learner's ability to understand instruction and the quality of the instruction. The concepts related to the determinants of time spent in learning are opportunity, that is, time allowed for learning and perseverance which refers to the amount of time that the particular learner is prepared to devote to the task to be learnt. For nurses and midwives, Carroll's model of instruction is particularly useful as it can be applied to the practice context, that is, for patient/client-teaching activities. A nurse or midwife instructor can use this model since learners [patients/clients] learn at a different pace and each learner presents with their own level of prior knowledge. The main premise of Carroll's model is that any learner can learn a particular task if she/he is provided with the necessary time and appropriate instruction (Huckabay, 1980). A drawback of

using this particular model for childbirth education is the nature of the program itself, that is, the length of each course would not allow the opportunity for women/clients wanting/needing repeated exposure for each new skill or task.

The premise that most students can master what task is set to them underlies Bloom's model of instruction, which he called mastery learning. Mastery learning, in its embryonic stage, first surfaced in the 1920's at the University of Chicago but slid into obscurity until its re-emergence in the late 1950's, early 1960's, under the new name of programmed instruction, which incorporated some of Skinner's studies. Bloom formulated his strategy for mastery learning on what he saw as the shortcomings of the educational system of his time. Bloom retained Carroll's conceptual model but redefined the concepts (Huckabay, 1980).

The major premises of Bloom's model are that all students can achieve mastery, learning is greater and more efficient if given sufficient time and that mastery also promotes student interest [motivation] (Huckabay (1980). Bloom believes that in order for mastery to be attained, objectives need to be set for not only the overall conceptual model, but for each variable within it. If the summative evaluation shows that these objectives have been met, then mastery in that task has been attained. Before implementing a mastery-learning program, Bloom argues that there are certain conditions that need to be met. Firstly, objectives for both the teacher and learner are required and secondly, measurement of progress towards these objectives in the form of formative evaluation is necessary. This form of evaluation, which is done throughout the learning process, is a guide to the learner's progress, as well as a means of feedback for both the learner and teacher. This type of evaluation is especially useful in mastery learning since the task to be learned can be broken down into stages. Each stage learned to mastery level with formative evaluation is used as an indicator of the students' readiness to progress toward the next stage, and also as an indication of the need for other resources (Huckabay, 1980).

Finally, Huckabay (1980), states that two major outcomes are evident from use of Bloom's mastery learning model. These are, firstly, the student will have mastered the task set (measured by summative evaluation) and secondly, the student will have an enhanced self-image because of her/his achievement.

This particular model is more suited for use in childbirth education programs in the researcher's opinion. This is because there is a clearly stated need for learning objectives and periodic evaluation for both educator and learner. This would provide the childbirth educator with a measure of the quality of instruction and the degree of learning evident.

The principles of operant conditioning underlie the model of instruction developed by Skinner. Operant conditioning is a form of learning used in behaviour therapy to produce a desirable behaviour that is then rewarded. Similarly, a reward is withheld for undesirable behaviours (Walker, Burnham & Borland, 1994). Broadly speaking, these principles are that "… learning is a function of change in overt behaviour. Changes in behaviour are the result of an individual's response to events (stimuli) that occur in the environment. A response produces a consequence" (Kearsley, 2005, p.1). Central to Skinner's Stimulus-Response theory is the concept of reinforcement, which can be anything that strengthens the desired behaviour. These can be both positive and negative (Skinner, 1968).

The concepts central to Skinner's model of instruction are as follows: identifying the terminal behaviour [that is, the objectives that the learner is expected to achieve by the end of the teaching session]; ensuring that work towards achieving the terminal behaviour is initiated [demonstration by the teacher followed by a return demonstration by the learner can be used to commence this process]; encouraging the desired behaviour which can be done by the provision of appropriate cues [known as primes] by the teacher. Furthermore, the programming of more complex behaviour, that is, information presented should be in small segments which, once learnt, should be reinforced and then built on. The sequencing of the instruction, that is, the task to be learnt should be presented sequentially in order of difficulty and in a manner that ensures that the learner is prepared for the next stage (Huckabay, 1980, pp.212-217).

In comparison to Bloom's mastery learning model, the researcher believes that Skinner's model of instruction, which is underpinned by his Stimulus-Response theory, is less suited for childbirth education programs. This is due to the fact that Skinner's model of instruction advocates that teachers [educators] using this style of teaching practice "stimulus control" which includes, amongst other

practices, a change in the physical environment in order to remove distractions (Brady, 1885, p. 75). Given that childbirth education programs are developed for, and attended by adults, it would not seem an appropriate model of choice in the researcher's opinion.

Another model of instruction is that developed by Gagne, the aim of which is for the learner to achieve productive learning (Huckabay, 1980, p. 222). There are two categories associated with Gagne's theory of productive learning, knowledge and instruction. Variables exist within these two categories and according to Huckabay (1980) Gagne believed that it was important that these be identified. These variables are those subsets of knowledge that must be acquired in increasing difficulty in order to achieve the final desired knowledge/task [the outcome].

In the knowledge category, Gagne surmised that each task to be learned was comprised of several smaller tasks whose achievement could be measured individually. These he referred to as subordinate categories. He theorised that a learner could achieve each subordinate category given the appropriate instruction and provided the learner was able to retain the knowledge acquired from the previous subordinate task achieved (Huckabay, 1980). The second category in Gagne's model is that of instruction. In Gagne's opinion, instruction implies that something of value is communicated to a learner. This is premised on the fact that quality instruction allows the learner to progress from learning a simple task onto more complex tasks.

Gagne's model of instruction requires that instructional/behavioural objectives be provided for the learner. According to Gagne (Huckabay, 1980), a behavioural objective is a statement that defines the goal that the learner is required to achieve by the end of the instruction and the outcome can be measured by the teacher (p. 225). In Gagne's opinion, there are three important reasons for using behavioural objectives in preparation for teaching. These are that they provide the teacher with guidance in the preparation of a teaching session; they enable the teacher to assess a learner's performance against the set objective and that learners will know beforehand what needs to be learnt by the end of the instruction (Huckabay, 1980). As such Gagne's

model can be applied to nursing and midwifery education as well as patient/client instruction, in particular, childbirth education programs.

Whilst Gagne's model differs from Bloom's mastery learning model, it does however, highlight the need for learning objectives as does Bloom's model. Importantly, Gagne's model places emphasis on the teacher [childbirth educator] having an understanding of how learning actually takes place (Gagne, 1985). This then, has implications for the formal education and preparation of the teacher [childbirth educator].

The last theory of teaching and learning presented in this chapter is that of Bruner. His model of instruction is based on constructivist theory, that is, he believes that learning is an active process in which learners construct new ideas or concepts based upon their current or past knowledge (Bruner, 1966, p. 41).

Bruner's early work described two very distinct and differing characteristics between theories of instruction as opposed to learning. These were that the theory of instruction was prescriptive in nature, that is, it provides guidelines for the learner about how to acquire the requisite knowledge and skills. The other differing characteristic is the ability to measure the outcome of the instruction. On the other hand, Bruner labelled the theory of learning as being descriptive, that is, what is expected is stated but not how to reach that level of knowledge or outcome (Huckabay, 1980, p. 254).

There are four major features that should be inherent in a model of instruction in Bruner's view. These are: "… a predisposition to learning; the structure of the body of knowledge which should be in a way that can be easily grasped by the learner; the effective sequencing and presentation of the knowledge for the learner and finally, the nature and pacing of the rewards and punishments" (Bruner, 1966, pp. 40-41). The defining aspects of each of the four features above will be briefly outlined.

 A learner's predisposition towards learning will require a teacher who is able to foster a learner's exploration of knowledge through the mechanisms of "activation, maintenance and direction" (Huckabay, 1980, p. 255). In other words, a teacher must enable the learner to explore knowledge (that is, the teacher commences the learner on the path to learning), use alternative

knowledge-seeking methods (that is, ensures that the learner's behaviour continues) and guide the learner in order to keep them focussed and not venture along incorrect pathways to knowledge (involves giving the learner a goal to work towards).

According to Bruner, when structuring knowledge three aspects must be considered. These are the "… mode of representation ....., its economy, and its effective power" (Bruner, 1966, p. 44). Put simply, the mode of representations refers to the way information or knowledge is presented. It can be in the form of the demonstration and practice of a skill (enactive representation), by the use of diagrams or graphs to name a few (iconic representation) or by the use of formulae or hypotheses (symbolic representations). The economy of representation refers to the amount of information that needs to be retained by the learner in order to achieve the desired outcome, that is, to achieve comprehension (Bruner, 1966, p. 45). The more that needs to be retained, the more steps of processing the learner must use in order to understand the concept at hand. The third and final aspect, effective power, refers to the ability of the learner to connect differing sets of knowledge. This can be facilitated by the ability of the teacher to structure the content so that relationships can be seen between the concepts presented and thus be readily assimilated into already held knowledge by the learner (Huckabay, 1980, p.258).

The third major feature of Bruner's model refers to the sequencing of the material or body of knowledge to be presented or learnt. Bruner (1966) states "…the sequence in which a learner encounters materials within a domain of knowledge affects the difficulty he will have in achieving mastery" (p. 49). The optimal sequencing of material to be learnt will be dependent on several factors: learners' past learning experiences, their stage of development and the speed at which they learn, the degree of difficulty or complexity of the material and of course, differences between learners (Bruner, 1966, & Huckabay, 1980).

The nature and pacing of reinforcements is the final component of Bruner's model. According to Bruner (1966, p. 50), learning is dependent on what he termed, "knowledge of results." This concept refers to a type of reinforcement for the learner and must be given at an appropriate time so that the learner can then use it to make corrective actions towards achieving their end goal. At the

same time, it is imperative that the teacher enables the learner to maintain motivation on the journey to achieving the goal (Huckabay, 1980).

It would seem from the literature, in the researcher's opinion, that Bruner's theory would be especially suited for the development of childbirth education programs. It has the hallmarks of being a more sophisticated theory which is based on the premises that "learning is an active, constructive process" and that "new information is linked to prior knowledge" (Learning Theories Knowledgbase, 2008). In contrast to other theories examined above, it specifically addresses adult learning and life-long learning principles.

In exploring the various significant theories of learning and teaching that existed at the time of data collection, it was the intention of the researcher to demonstrate that the process of teaching needs to be appropriately planned in order for it to be effective and most importantly, useful to the learner. Irrespective of which model or theory of teaching and learning a childbirth educator chooses for her/his program, the particular model/theory should enable the childbirth educator to facilitate the acquisition of knowledge by the learner (women and their partners) and thus achieve their end goal.

2.5   SUMMARY

This chapter has reviewed literature pertaining to the historical context of childbirth education and childbirth education itself. A discussion of the theories of learning and teaching followed. Chapter Three discusses the research methodology and design of the study.

CHAPTER THREE
RESEARCH METHODOLOGY & DESIGN

3.1 INTRODUCTION

In recent years the use of qualitative research methods has grown as increasingly nursing and midwifery researchers strive to understand human experiences in order to give them meaning. As discussed in Chapter One, the aim of the study was to provide an understanding of the lived experience of childbirth educators in Victoria in the years immediately following the Ministerial Review (1990). In order to do this it was necessary to locate the study within the qualitative paradigm. As phenomenology allows the researcher to understand the experiences of the participants (Creswell, 1998), it was deemed to be an appropriate methodology for the study. Coupled with this was the use of case study approach as it enabled the examination of a particular case [the experiences of childbirth educators]. Thus, the methodology of phenomenology and case study design underpin this study. They are seen as a legitimate means of explicating and understanding the experiences of childbirth educators.

In this chapter, a brief historical overview of phenomenology is given with particular reference to van Manen as the particular exponent used in this study. This is followed by a discussion of the case study approach.

3.2 PHENOMENOLOGY

The use of phenomenology is widespread in nursing research (Crotty, 1996). In adopting this methodology it was important to understand how phenomenology as a methodology has evolved. To this end, an overview of key phenomenology proponents, including the 'new' versus the 'traditional' phenomenology (Dowling, 2005) is necessary.

According to Dowling (2005), phenomenology became a part of modern philosophy before World War 1. She acknowledges that whilst several schools of phenomenology exist, there are "… commonalities ….distinct features … and many perspectives of phenomenology" (2005, p. 131).

Immanuel Kant described phenomenology in 1786 as the study of things or phenomena (Cohen, 1987). Kant's work arose as a challenge to the existing

reductionist scientific method of viewing phenomena as individual parts, not as components of a whole. Another philosopher, Franz Brentano (1838-1917), described phenomenology as a philosophy, an approach and a method in 1888 (Cohen, 1987).

However, Edmund Husserl (1859-1938) was credited with being the founding father of the Phenomenological Movement. Husserl developed his view of phenomenology based on Brentano's concept of intentionality, that is, every perception has a meaning. Thus, according to Husserl, knowledge is derived from the study of experiences (epistemological stance).

The emphasis of Husserl's phenomenology was on the essence of the phenomenon being studied (Cohen, 1987). Husserlian phenomenological inquiry is referred to as eidetic phenomenology, or descriptive thought. This involves the description of the meaning of human experience from the individual's perspective (Cohen & Omery, 1994; Giorgi, 1986), giving rise to the phrase the lived experience(s) (Jasper, 1994).

Husserl developed the phenomenological strategy of reduction which aims to address the issue of bias. The researcher does this by examining the phenomenon free of its context and deriving a description of the phenomenon/experience before attaching a meaning to it/reflecting on it. Understanding the concept of reduction is vital to the understanding of Husserlian phenomenology (Dowling, 2005). Other phenomenologists such as Heidegger and Merleau-Ponty also acknowledge that reduction is essential in phenomenological research (Dowling, 2005).

Speigelberg (1971) has written extensively on the phenomenological movement in an attempt to provide its history. He described the tradition of phenomenology as a movement as he believed that phenomenology was not a stationary philosophy because its central tenets had undergone change as the philosophy was developed by scholars of this tradition (Cohen, 1987). He describes the phenomenological movement as having developed through different philosophers and schools of thought: from that of Brentano right through to the North American School.

This belief is borne out by the following:

> … today the pattern of the phenomenological movement seems to resemble that of an unfolding plant more than that of a river. This does not mean that the separate destinations of the various currents of the movement are contradictory, and hence that they cancel each other out. They rather represent the pursuit of definite and essential assignments of the movement in the total pattern of the phenomenological task: the descriptive investigation of the phenomena, both objective and subjective, in their fullest breadth and depth (Spiegelberg, 1971, p.2).

A different view of phenomenology was espoused by Heidegger (1889-1976) who viewed phenomenology as a way of finding a solution to a problem. His work in phenomenology was primarily concerned with ontology, that is, the theory or nature of how something exists, as opposed to Husserl's work which is described as an epistemology or the philosophical theory of knowledge (Ray in Chaska, 1990). This difference is illustrated in Heidegger's work *Being and Time* (1926). Phenomenological researchers refer to Heideggerian phenomenology as hermeneutic phenomenology, or interpretive thought. The goal of hermeneutic phenomenology is to interpret the meaning of human experience (Cohen & Omery, 1994), in other words, it clarifies the reality, or the what, of the participants' experience (Crotty, 1996). According to Dowling (2005), it is Heideggerian phenomenology that has guided research undertaken in the caring professions such as nursing, in particular, that conducted by the likes of Benner and Wrubel.

Merleau-Ponty developed his work based on Husserlian and Heideggerian phenomenology. His premise is that one can rediscover the 'first experience' and by doing this the researcher can look at the phenomenon in a new way (Dowling, 2005). To do this he also used the Husserlian strategy of phenomenological reduction (Dowling, 2005). According to (1990), the work of Merleau-Ponty is particularly suited for nursing research as the key concepts of lived space, lived body, lived time and lived human relation allow the researcher the wherewithal to question, reflect and write about the person(s) experience(s).

Gadamer's view of phenomenology follows on from Heidegger's work. His phenomenology is premised on two central concepts: prejudgment, or the notion that our own prejudices or preconceptions enable understanding of the phenomenon; and universality which is premised on the fact that the person expressing the experience and the person understanding it are connected by

human consciousness which makes understanding possible (Dowling, 2005). Gadamer's phenomenology is interpretive or hermeneutic in nature and requires that participants review transcripts and dialogues (dialogical method) as a necessary part of the process (Dowling, 2005).

Whilst the works of Husserl, Heidegger, Gadamer and others have contributed to phenomenology as a philosophy, the works of Colaizzi, van Kaam and Giorgi have proposed methods for undertaking research using phenomenology. These philosophers belong to the Dusquene School of Psychology and their methods have been used widely by both nurse researchers and theorists. All three have similar methods according to Dowling (2005). A detailed account of 's phenomenological method used for the data analysis in this study is described in Chapter Four.

More recently Crotty (1996), an Australian phenomenological researcher, has challenged the use of Heideggerian phenomenology by many nurse researchers, who he states, have embraced the study of subjective experience of individuals in order to enhance nursing care. His view is that the focus of phenomenology, as understood by philosophers, is the "... study of phenomena, that is, of the objects of human experience" (Crotty, 1996, p.3) as opposed to the focus of phenomenology used in nursing research, which is on elucidating the subjective meaning of people's experience. He states that nursing phenomenological research lacks the required critique as nurses merely provide descriptions of the phenomenon and not the actual essence of it (Dowling, 2005). Thus he claims that nurse researchers' use of phenomenology, which has evolved over the last three decades, has resulted in a new form of phenomenology, derived, he believes, from misreading of Heidegger. He refers to this as the 'new' phenomenology. This view of phenomenology is not unlike that espoused by Noe (p. 238, 2007) who also describes phenomenological research as "understanding the ways in which reality is disclosed in experience thanks to the person's … involvement." Crotty's views are also espoused by Yegdich (2000) and supported by McNamara (2005) who state that research studies have focussed on collecting "naïve accounts of phenomena." (p. 695).

American (Continental) phenomenology or the 'new' phenomenology differs from the traditional (European) phenomenology in that it does not employ the

use of phenomenological reduction (Dowling, 2005). Crotty believes that this is the phenomenology that nurses use, which is a hybrid of the North American tradition (1996). According to Dowling (2005), another distinguishing factor of the 'new' phenomenology is its preoccupation with the context in which it occurs. This is in contrast to both Husserlian and Heideggerian beliefs. In the 'new' phenomenology, reduction is less of an issue, especially for nursing research and what it researches.

In his review of thirty nursing research articles, Crotty (1996) shows that while some authors claim to have researched the object of a selected experience, what emerged was a subjective interpretation of the participants' experiences. Whilst this type of research is not problematic in itself, Crotty believes that nurse researchers must make explicit their use of phenomenology. In other words, nurse researchers must clearly state that their research focuses on the subjectivism of the phenomenon being researched. As a result of this, Crotty (1996) is averse to nurse researchers claiming to use a Husserlian or Heideggerian approach since the 'new' phenomenology is actually what informs their research. Dowling (2005) agrees with Crotty's view that the American tradition is probably more appropriate for nursing research as it allows the understanding of the experience rather than its essence or, in van Manen's view, the "phenomenology of practice" (1990, p.8).

Van Manen is an educationalist and has contributed to modern thought on phenomenology. He attributes his interest in human science and phenomenology as a result of his studies in the Netherlands (1990, p.ix). The European traditions of both interpretive and descriptive phenomenological methodologies have influenced van Manen's work and he uses the term 'human science' interchangeably with the terms 'phenomenology' and 'hermeneutics' in his work. His work is viewed as a definitive means of how to undertake research in education (Vandenberg, 1992, p. 119). Van Manen believes that phenomenology (human science) is the study of how human beings make sense of their world; as such, phenomenology employs description, interpretation, self-reflection and even critical analysis to do this (1990, p.2).

Van Manen's view of phenomenology is that it can only really be understood by undertaking research using it (1990). He believes that it is the study of the lived

experience of "something or someone" (1990, p.5), not how it is intellectualised by the researcher.

Given that van Manen is not a supporter of bracketing, his writings are particularly useful for nurse/midwife researchers because these practitioners already have a prior interest in the research problem/human science that they are engaged in (1990, p.1), and as such, 's phenomenology can be used to guide nursing/midwifery research methodology. This is in direct contrast to the concept of epoche (Creswell, 1998), which purports to suspend any prior belief associated with the writings of many of the early phenomenologists such as Husserl, where the phenomenon is the essence of the experience.

Van Manen proposes that research using hermeneutic phenomenology can be guided by a '…methodical structure' which has six research activities associated with it.

> Reduced to its elemental methodical structure, hermeneutic phenomenological research may be seen as a dynamic interplay among six research activities:
> (1) turning to a phenomenon which seriously interests us and commits us to the world;
> (2) investigating experience as we live it rather than as we conceptualize it;
> (3) reflecting on the essential themes which characterize the phenomenon;
> (4) describing the phenomenon through the art of writing and rewriting;
> (5) maintaining a strong and oriented pedagogical relation to the phenomenon;
> (6) balancing the research context by considering parts and whole.
>
> (1990, pp. 30-31).

According to van Manen (1990), education research with a phenomenological underpinning should be guided by pedagogical standards, so much so that the fundamental underlying principle is pedagogy. Put simply, we view what we are researching from an educational standpoint. However, he stresses that it is the way in which the research question is formulated, asked or understood that is the important issue, rather than the research method used but acknowledges that the research method may shape the way that the question is articulated or expressed (1990, p.2). Furthermore, he strongly believes that there is a relationship between the question posed and the methodology that is used to

explore the question. As such one's methodology should reflect or be in harmony with how the researcher views their world (1990, p.2). (1990) argues that by employing this approach, the researcher is better able to understand the contextual meanings of the experiences of the participants.

Dowling (2005) acknowledges van Manen's contribution to phenomenology and agrees with van Manen's claim that he sits between both the descriptive and interpretive traditions. Van Manen uses the term phenomenon interchangeably with experience (1990).

Phenomenology is particularly suited to nursing and midwifery research as it provides the researcher with a framework to guide the research process in the quest for discovering new nursing/midwifery knowledge. This view is supported by Robertson-Malt (1990, p. 290) who argues that van Manen's six research activities provide the framework for interpreting the experience in question.

As the aim of this study was to provide a rich understanding of the lived experience of childbirth educators, the 'new' phenomenology was seen as an appropriate method to achieve this aim. By using this particular phenomenological perspective, the researcher was able to explore the subjective meaning of childbirth education as explained by the participants. The question, "What does childbirth education mean to you as an educator?" was used in order to elicit the experiences of each participant.

3.3   RESEARCH DESIGN

Case study research is used as one of many approaches in the qualitative tradition. It has been used extensively in the social sciences. Case study as a distinctive research method is commonly used in educational research, as it is very useful in the evaluation of educational programs (Stake, 1995; Merriam, 1998). However, its use in researching nursing and midwifery issues is much less common.

There is a lack of a universal definition of case study; however the most common definitions are given here. Stake (1995, p.xi), defines the case study research method as "…the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances."

Furthermore he argues that it allows the researcher to "look for the detail of interaction with its contexts" (p. xi). In an early definition provided by Merriam (1988, p. 9), she states that "… a case study is an examination of a specific phenomenon such as a program." Yin (2003, p. 4) defines the case study research method as "…the method of choice when the phenomenon under study is not readily distinguishable from its context. Such a phenomenon may be a project or program in an evaluation study." A particularly useful definition of case study, in the researcher's opinion, is that proffered by Gerring (2007, p. 19). He states "Case [study] connotes a spatially delimited phenomenon (a unit) observed at a single point in time or over some period of time. It comprises the type of phenomenon that an inference attempts to explain." Merriam's (1998) later work states that "…the single most defining characteristic of case study research lies in delimiting the object of study, the case." In other words, it is a "single entity … around which there are boundaries" (p. 27). Creswell (1998) provides a succinct overview of case study as "… an exploration of a bounded system or a case over time through detailed, in-depth data collection involving multiple sources of information rich in context. This bounded system is bounded by time and place, and it is the case being studied – a program…" (p. 61).

Other proponents of case study method (Hancock & Algozzine, 2006, p. 9) argue that this method represents another type of qualitative research in itself. They believe that case study differs from other qualitative traditions in that it allows the researcher to gain intensive analyses and descriptions "...bounded by space and time" (2006, pp. 9 & 11). Hamel, Dufour and Fortin (1993, p. 1), put forth the notion that case study "…is an in-depth study of the cases under consideration…" and as case study employs various methods such as participant observation and interviews, the term approach would better describe the tradition. This point of view is also supported by Merriam (1998, pp. 28-29) who argues that employing a case study approach does not limit the researcher to using a specific method of data collection or analysis, as is the case with experimental or survey research. Researchers use this approach because of their interest in gaining an understanding or interpretation of a particular situation and within a specific time frame.

Case study method can be a useful tool in demonstrating a process of change or it can also be revelatory in that it provides insight into the participants' world (Gillham, 2000). According to Gillham (2000, p. 1), case study is challenging to define, however, it "…answers specific research questions …which can only be studied or understood in context." He argues that as case study adopts a naturalistic approach, it is very appropriate in the study of "human phenomena, …as it happens in the real world" (2000, p. 2).

In summary, the common thread in the literature is that case study can accommodate various research methodologies, theoretical perspectives, and data collection methods used by researchers from diverse disciplines. As case study approach would allow the in-depth exploration and understanding of a case [experiences of childbirth educators] using particular methodologies [phenomenology], it was seen as an appropriate manner from which to derive rich, contextual data (Creswell, 1998). In this study Stake's (1995) definition and perspective of case study was used.

3.2.1 Elements of case study

Stake (1995) and Merriam (1998) both state that the qualitative case study is characterised by special elements. Stake (1995) argues that case studies can be of three specific types: intrinsic, instrumental and collective. The term intrinsic is applied to case study when the case itself is of primary interest. It is not the purpose of an intrinsic case study to develop a theory. When an understanding of an issue is required by examining a particular case, this is referred to as an instrumental case study. As the term implies, collective case study involves several cases being investigated within the research project, which may lead to a more in-depth and better understanding of a larger number of cases. For the current study this particular approach allows the researcher to uncover the meaning of the experiences of the case being studied [experiences of childbirth educators].

Merriam (1998, p. 29) describes three distinct approaches to case study: particularistic, descriptive and heuristic. The particularistic case study focuses on a particular situation, event, program, or phenomenon. It is of value when designing research to address practice in the everyday world. The term

descriptive refers to the case study whose end product results in a rich or thick description of the phenomenon being studied (p. 29-30). The third type of case study, that which provides the reader with an understanding of the phenomenon being studied, Merriam (1998) refers to as a heuristic case study. This type of case study can provide the "discovery of new meaning, extend the reader's experience, or confirm what is known" (p. 30). Given that the aim of the current study is to gain an understanding of childbirth educators' experiences, the use of case study as articulated by Stake (1995) was seen as appropriate method of obtaining data rich in contextual meaning.

This qualitative research approach is not without its criticisms. The issue of generalizability has been a major issue for critics of this approach. However, applying the findings of case study research to another similar situation is not the focus of this approach. Many disciplines such as education, sociology, psychology and psychiatry use case study successfully as can be evidenced in the literature reporting studies that investigate pertinent issues and problems in applied research.

As the aim of this study is to provide a rich understanding of the lived experience of childbirth educators the use of case study in conjunction with phenomenology is used as the methodology of choice. A case study approach enables the researcher to examine a particular case [the experiences of childbirth educators], by studying "the particularity and complexity of a single case [the experiences of childbirth educators], coming to understand its activity within important circumstances" (Stake, 1995, p. xi). Case study approach also provides the researcher with the means to "gain intensive analyses & descriptions….bounded by space and time" (Hancock & Algozzine, 2006, pp. 9 & 11). If a label were to be attached to this case study, it could be described as an instrumental case study (Stake, 1995) as it enables the researcher to gain insight into the experiences of childbirth educators.

3.4   SUMMARY

According to van Manen, phenomenological research focuses on discovering how humans perceive their world (1990). For this reason, phenomenology using van Manen's approach was chosen to guide the study into the

experiences of childbirth educators, allowing the participants' voices to be heard as they described their experiences of providing childbirth education in the period following the publication of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990). Nested within this methodology was the use of Stake's (1995) case study research design which enabled the researcher to gain in-depth insight into the participants' experiences. A detailed account of the research methods used in the study is discussed in the following chapter.

CHAPTER FOUR
METHODS

4.1   INTRODUCTION

The method used for a study must reflect the philosophical framework that underpins the research (van Manen, 1990). Thus, it is the methodology within which the study is located that determines the procedures and techniques that are used for the research. In this chapter the recruitment of participants, the processes of data collection and management and analysis are presented in order to address the research question "What is the lived experience of childbirth educators?" The relevant ethical issues and the rigour of the study are also discussed in detail.

4.2   PARTICIPANTS

The individuals who took part in the study were fourteen childbirth educators whose experiences in childbirth education constituted the case study, the approach used in the design of the study. Participants were informed that each would be allocated a pseudonym to ensure anonymity. Each participant was asked to complete a demographic questionnaire and was informed that by so doing, she was giving consent to being interviewed as outlined in the letter of information given to each participant (Appendix B).

4.2.1 Recruitment processes

Childbirth educators were recruited from several different environments in which childbirth education and midwifery were practised. A total of fourteen educators were involved. The work environments from which the educators were drawn included: birthing centres located within hospitals; hospital-based delivery suites; community health centres offering childbirth education programs and independent childbirth education practice. Participants met the criteria of:

- A registered midwife, as defined by the Nurses Board of Victoria;

- Directly involved in childbirth education; and,

- Willing to participate in the study after an explanation of its aims and their involvement.

Sixteen Directors of Nursing (DON) of public and private hospitals were approached by myself, initially by telephone with a follow-up letter explaining the nature of the study and seeking voluntary participants for the study. Each DON agreed to speak to midwives who were involved in childbirth education and to disseminate the follow-up letter. The names of 12 participants were provided by 10 of the DONs and an additional educator volunteered. Hence, the sampling strategies of purposive and snowball sampling were employed. Purposive sampling, according to Morse (1991, p. 121), involves the selection of participants who are considered to be experts in their field "by virtue of their involvement in specific life events." Snowball sampling is a strategy that allows a researcher to access participants who may not otherwise have been accessible (Beanland & Schneider, 1999, p.280). A further independent practitioner was recruited through collegial networking (snowball sampling). Therefore a total number of 14 participants were recruited. The intent of interviewing childbirth educators who practised in different midwifery settings, that is, from the public and private sectors, was to elicit diversity in, and commonality of, experience in order to obtain a rich insight into their experiences. A profile of each participant follows.

4.2.2 Introduction of participants

Ella

Ella was a female childbirth educator aged 46-50 years at the time of the study with hospital-based nursing and midwifery qualifications. She had not undertaken any specific education as a childbirth educator and had 14 years of experience in the field, one of two participants with this degree of experience. The course that she taught was offered in the evenings and she could not remember its exact duration in hours.

Holly

Holly, a 38-year-old woman, had undertaken an 8-week long childbirth education course in addition to her hospital acquired nursing and midwifery

education. Her experience in childbirth education totalled seven years and she offered a 16-hour course to her clients in the evenings.

Siobhan

Siobhan was a hospital-trained nurse and midwife who was not formally qualified in childbirth education. She was in the 36 to 40 year age category and had a total of seven years childbirth education teaching experience. The 10-hour course that she taught was held in the evenings.

Molly

Molly was a woman aged over 50 years with 10 years of childbirth education experience.   Her nursing and midwifery qualifications were obtained in a university; however, she was not formally qualified in childbirth education. Her course was 12.5 hours in duration, offered in the evenings.

Sheila

Aged 25 to 30 years and with university qualifications in both nursing and midwifery, Sheila offered a 12.5 hour course in the evenings and had four years of experience in childbirth education. She had no formal qualification in the field.

Lilly

With 14 years of experience as a childbirth educator, Lilly was educated through the traditional hospital model in both nursing and midwifery and was over 50 years of age at the time of interview. However, she did not hold a formal childbirth education qualification. Her course was 12 hours duration and taught in the evenings.

Lizzie

Lizzie was in the 41 to 45 year age range and had 12 years experience in childbirth education. She had a hospital-based qualification in nursing but had obtained her midwifery qualification at university. However, like the majority of her contemporaries in the study, she did not possess a formal childbirth education qualification. Her course was 18 hours in length and was offered both in the morning and evening.

Peta

Peta was aged 36 to 40 years of age and had acquired her nursing and midwifery qualifications in a hospital. She did not possess a formal childbirth education qualification. Her experience in the field totalled three years and her course was 12 hours in length. Classes were offered in the evenings.

Pippa

Pippa, aged 46 to 50 years, was educated through the traditional hospital model for both her nursing and midwifery qualification. She had not undertaken a childbirth education qualification. With six years of childbirth education experience, her course was 12 hours in duration, offered to clients in the evening.

Noel

Noel, another hospital-trained nurse and midwife, was 36 to 40 years old who also did not have a formal qualification in childbirth education. She had six years of experience in teaching childbirth education and her course was 10 hours in duration. She offered it both mornings and evenings to cater for the needs of the clients.

Pincha

As another hospital-trained nurse and midwife, Pincha, who was 36 to 40 years of age, also had no formal childbirth education qualification. However, she brought with her 12 years of experience to the role. She taught a 12-hour course in the evening.

Millie

As the participant with the least amount of experience in the role, 18 months, Millie, who was a 31 to 35 year old woman, nevertheless brought enthusiasm into the course. She was also hospital trained and offered a 10-hour course in childbirth education in the evening. She was not formally qualified in childbirth education.

Bella

With five years of childbirth education experience and being 46 to 50 years of age, Bella offered a 12-hour course in the evening. Her nursing and midwifery qualifications were obtained in a hospital and she also did not possess a formal childbirth education qualification.

Mannie

As with the majority of her fellow participants, Mannie was hospital trained in both nursing and midwifery without a childbirth education qualification. As a 36 to 40 year old, she had 13 years of experience in childbirth education and her course was offered in the evening. It was of 16 hours duration.

All participants were female with six in the 35-39 age groups. Twelve of the participants had gained their nursing qualifications in hospitals with the remaining two being college diplomates. All were hospital-trained midwives. Of the fourteen participants, only one participant had undertaken a short childbirth education course of eight hours. The majority of the participants, nine, had more than five years experience as childbirth educators with the programs that they taught. Seven of the programs taught by these educators were of 12 hours duration with others ranging from a minimum of 10 hours to a maximum of 18 hours. Twelve of the programs were offered in the evening, one program was offered in the morning and another both morning and evening to cater for working clients.

A summary of the demographic data of the participants is found in Table 1.

Table 1: **Demographic data for the 14 childbirth educators who participated in the study**

Information		Number
Age	Under 25	0
	25 - 30 years	1
	31 -35 years	1
	36 - 40 years	6
	41 - 45 years	1
	46 - 50 years	3
	> 50 years	2
Gender	Male	0
	Female	14
Type of nursing qualification	Hospital	12
	Tertiary institution	1
	Combined (Hosp/Tertiary)	1
Years experience as a childbirth educator	0 - 4 years	3
	5 - 9 years	5
	10 - 14 years	6
Length of childbirth education program	Unknown	1
	10 hours	3
	12 hours	7
	16 hours	2
	18 hours	1
Time of day program offered	Morning	2
	Evening	12
	Both	(2)

4.3   LOCATION, SETTING & TIME OF INTERVIEWS

Participants were interviewed separately after choosing a convenient time and venue for the interview. In all cases participants chose a quiet venue in their workplace, away from distractions and the interviews ranged from one to one

and a half hours. With permission from each participant all interviews were tape-recorded and transcribed verbatim by the researcher.

4.4   DATA COLLECTION

4.4.1 Interviews

Prior to beginning the interview each participant was asked to complete a questionnaire, which provided their names, addresses and telephone numbers. This enabled participants to be contacted when it was required.   Semi-structured in-depth interviews were conducted using a semi-structured interview guide developed by the researcher.   The interview allowed the participant to describe in her own words their experience of childbirth education.

A semi-structured interview guide consists of the general issues that the researcher wishes to explore in the course of the interview. The issues to be explored are not in any given order and are used primarily as prompts for the interviewer (Minichiello, Aroni, Timewell & Alexander, 1995). An interview guide was designed to identify and explore areas of childbirth education that were deemed relevant to the study topic. Data were gathered through conversational in-depth interviews and at the beginning of the interview each participant was asked, "Would you start by telling me what childbirth education means to you?" In order to clarify certain aspects of the interview certain probing questions were asked of the participant. Examples of these were: How is your program based on a particular type of philosophy? Tell me about the background to what you are currently teaching; tell me about the processes that were involved in decision-making about the content; tell me about content in your program. This type of data gathering was concomitant with Minichiello's et al. (1995) method as a way of accessing information that may not otherwise be available to the researcher, that is, as a conversation with a specific purpose in mind. These conversations may take place on more than one occasion, and Taylor and Bogdan (1984) argue that repeated interviews can lead to a more detailed understanding between the interviewer and the participant. In this study follow-up interviews were not required in twelve cases as the use of cues enabled the clarification of issues during the interviews. The participants were informed at the beginning of the interview that the need to contact them for clarification of

the interview material could arise. All participants consented to the possibility of future contact by the researcher. Two participants were contacted during the later stages of data analysis for clarification of the content of the transcripts. An example was the need to ascertain how one of the participants arrived at the decision of what to include in her program.

4.4.2 Transcripts

Each interview was tape-recorded with each participant's permission and transcribed verbatim by the researcher. To facilitate reading and to ensure confidentiality during the writing of the findings, each of the childbirth educators' transcripts was assigned a pseudonym.

Allowing the participant to proceed without interruption so that the element of bias by the researcher is not introduced is part of the phenomenological method of data collection (Giorgi, 1975). Therefore I began the interviewing process as a conversation with each participant (Omery, 1983), allowing the participant to speak freely and unimpeded. Because of my past clinical work in midwifery and present role as a nurse educator, I had the underlying belief that each program would have a guiding philosophy and clearly defined program objectives. It became apparent early in the data gathering that this was not the case and that these established ideas should be put aside. This was not entirely possible as past experience constituted part of the researcher's midwifery experiences. This attempt at putting aside preconceived notions to avoid influencing participants' accounts of their experience is known as bracketing (Giorgi, 1992). However, according to Crotty (1996) the point is made that in many nursing research projects it is used inappropriately and often is the only indicator that the study has a phenomenological leaning.

The participants numbered fourteen in total as this was the point at which data saturation was reached. Saturation is defined by Morse (1994, p. 230) as "repetition in the information obtained and confirmation of previously collected data." Whilst data saturation is commonly associated with the methodology of grounded theory, none-the-less it had relevance, when it became evident that no new insights were coming forth from the data collected in this study. Miles and Huberman (1984) suggest the researcher focus on the emergent themes

from each interview and explore these with each subsequent interview so as to illuminate the richness of the data. This strategy was used prior to conducting each interview. The lengthy interviews, coupled with the use of appropriate cues for example, "Tell me how you became involved in childbirth education?", and the opportunity to ask for further information and clarification of specific issues, enabled me to obtain rich, meaningful descriptions of the participants' experiences.

The transcripts were returned to the participants in order that they could validate the data (Knaack, 1984). It was explained to the participants that they could expand, add or delete information if it more accurately reflected their own experiences. None of the participants did this. The process of data validation by the participants serves to enhance the quality of the data and to ensure its trustworthiness (Holloway & Wheeler, 1996). As no changes were made to the transcripts by the participants, I believe that the data represented exactly what the participants said.

4.4.3 Management of data

The data for the study were comprised of transcripts of the tape-recorded interviews and records made at the time of interview of the participants' facial expressions and other non-verbal body language. To facilitate reading following transcription, the data from the interviews were entered into a computer software program, Non-numerical Unstructured Data Indexing Searching and Theorising (NUD*IST) (Qualitative Solutions and Research, 1995), in order to allow for ease and efficiency of data management (Morse, 1994). NUD*IST is a software program designed specifically for non-numerical data that facilitates the sorting and coding of qualitative data. NUD*IST limits the potential for researcher bias to creep in as all data entered are able to be accounted for (Richards & Richards, 1994).

With the data thus organised, it was possible to search the data for emergent themes. Initially it was anticipated that this program would simplify data management. However, I came to the conclusion that this type of program would be more appropriately used when dealing with large numbers of interviews as becoming familiar and competent with the program took an

inordinate amount of time. With the smaller number of participants I felt immersed and intimately connected to the data without the need for a software management system.

4.5 DATA ANALYSIS AND INTERPRETATIONS

The mode of analysing data in a phenomenological study depends on the philosophical underpinnings of the study. Whilst there is no one accepted formula or strategy for analysing qualitative data, there are many differing sets of guidelines for this purpose. However, the challenge for the qualitative researcher is making sense of the voluminous amounts of data that qualitative research produces. The following discussion centres on the strategy of using thematic analysis as a way forward in analysing phenomenological data.

Pope and Mays (2006), describe thematic analysis as "… the simplest form of analysis and hence its common use in health care research" (p. 69). According to the authors, data are grouped into themes and described as they appear. Analysis is then taken further by looking at how the themes are connected across participants. These themes can be derived inductively from the data according to Pope et al. (2006, p. 67) and Creswell (2009, p. 184).

According to Ezzy (2002, p. 88) thematic analysis involves the identification of themes or concepts directly from the data. He argues that thematic analysis is an inductive process as the emergent themes from the data were not predetermined.

Boyatzis (1998, p. 31) argues that codes or analysis that are data-driven are constructed inductively. This concurs with the writings of Ezzy (2002) and, in part, with Pope et al. (2006). According to Boyatzis, it is the researcher who then interprets the meaning of these codes. He argues further that a good thematic code has five elements to it:

1. A label (i.e., a name)
2. A definition of what the theme concerns (i.e., the characteristic or issue constituting the theme)
3. A description of how to know when the theme occurs (i.e., indicators on how to "flag" the theme)
4. A description of any qualifications or exclusion to the identification of the theme

5.   Examples, both positive and negative, to eliminate possible confusion when looking for the theme (1998, p. 31).

According to Green and Thorogood (2004), thematic analysis is the end result of content analysis of data where recurrent information appears. However, the authors acknowledge that the analysis can be as in-depth as the researcher requires by interrogating the data (for example, looking at relationships between themes).

Creswell (2007, p.159) argues that many phenomenological studies use one of the approaches to data analysis advanced by Moustakas (1994, pp. 121-122) based on a modification of the Stevick-Colaizzi-Keen method which requires the researcher to:

> Describe the meaning of the experience for the researcher.
> Find and list statements of meaning for individuals [participants].
> Group statements into meaning units [themes].
> Develop a textural description, "What happened" [what the participants experienced with the phenomenon].
> Develop a structural description, "How" the phenomenon was experienced.
> Develop an overall description of the experience, [the "what" and 'how"] the "essence" of the experience. (Moustakas, 1994, pp. 121-122)

This has subtle similarities and differences to van Manen's approach in that Moustakas' modification also requires the explication of the meaning of the research to the researcher as does van Manen, however, it does not stipulate the need to maintain a strong pedagogical relationship with that being researched. Furthermore, van Manen believes that the act of writing the results of the research actually allows a deeper understanding of the experiences that have been the subject of the research process.

It would seem that for the most part, the guidelines discussed above concur that thematic analysis involves identifying overriding commonalities in the participants' experiences and presenting the researcher's interpretation of these common experiences. However, guidelines are exactly that and "applying guidelines requires judgement and creativity" (Patton, 2002, p.433).

4.5.1 van Manen's Methical Structure of Human Science Research

Thematic analysis was used to analyse the data from this study following van Manen's Methical Structure of Human Science Research. He proposes that research using hermeneutic phenomenology can be guided by a 'methical structure' which has six research activities associated with it (1990, pp. 30-31). Each of the inter-related activities described by van Manen are explored next to demonstrate the analysis used in this study.

1. Turning to a phenomenon which seriously interests us and commits us to the world

This initial step in van Manen's research activities involved revisiting the phenomenon of interest, namely, how midwives who were also childbirth educators viewed their experience(s) of being childbirth educators. This led to the formulation of the research question. Whilst this was the ultimate goal of the study, I was also interested in their experiences from an educator's perspective of what worked particularly well within their programs. Working as an educator of midwives and having an understanding of the literature on the same, preconceived, established ideas of what childbirth education was or what it was meant to be was not entirely able to be put aside as the concept of phenomenological reduction (bracketing) presupposes. However, van Manen (1990) does not subscribe to this concept and thus the concept of 'bracketing' was not an issue in this study.

2. Investigating experience as we live it rather than as we conceptualize it

The goal of this stage was to investigate the original experience of each participant rather than to conceptualise it. This is achieved by using a phenomenological analysis of the data which does not, for the most part, have prescriptive strategies. It is the attitude of how the researcher looks at the data and how she/he responds to the phenomenon that emerges from the data that provide the interpretive aspect of the analysis. Drawing on the work of van Manen, he believes that if the researcher uses their own experience of the phenomenon in question, then it assists in the data analysis process as it provides a reference point for the commencement of the analysis phase (1990, p. 57). By allowing the participants to speak freely about their respective experiences of being childbirth educators provided a rich source of information.

Along with this rich data source, notes were taken and body language was also noted. This added to the richness of the data.

Each interview was transcribed and read several times by the researcher to get a sense of the whole experience before thematic analysis was undertaken. The identification of themes was assisted by the use of a qualitative computer program, NUD*IST.

3. Reflecting on the essential themes which characterize the phenomenon

This stage of the process involved the actual identification of the themes as they presented in the data. The descriptions of each participant's experience were examined carefully and in detail, and from this process, general themes emerged which when reflected upon, stood out quite distinctively from the interview transcripts. Upon further reflection, it became clear that there were further intricacies at play and the themes were refined by further investigation of the data which resulted in sub-themes, overarched by the three main themes. These are presented in Chapter Five.

4. Describing the phenomenon through the art of writing and rewriting

This phase involved the actual 'writing up' of the findings of the study, that is, presenting the researcher's interpretation of the participants' descriptions of their experiences as childbirth educators.

This is the end result of the reflective process of reviewing the data constantly over a prolonged period of time until such time that the researcher felt that the designated themes (the names of which were drawn from the data) represented the descriptions provided by the participants. This was achieved by the writing and re-writing of each theme until it was felt that it provided an encapsulating view of what the participants actually said. This is supported by van Manen who stated that "Writing fixes thoughts on paper. It externalizes what in some sense is internal. ...to make some aspect of our lived world, of our lived experience, reflectively understandable and intelligible" (1990, pp. 125-126).

5. Maintaining a strong and oriented pedagogical relation to the phenomenon

The concept underpinning the fifth research activity described by van Manen was used in this study by the constant revisiting of the theory underpinning education as described in Chapter Five. Being an educator in a tertiary institution, this role allowed me to retain at the forefront the educational principles that underpin adult learning, in this case, pregnant women and their partners, during the analysis phase. Thus, the principles of the pedagogy of teaching were strongly related to the description and interpretation of the experiences as told by the participants (the childbirth educators in this study). This notion is in keeping with van Manen's beliefs regarding the pedagogical relationship to the phenomenon. He states ' ...the very fact that we write about curriculum, teaching, or education, ...a manifestation of pedagogic orientation ... To be oriented as researchers or theorists means that we do not separate theory from life...' (1990, p. 151).

6. Balancing the research context by considering parts and whole

Balancing the research context by considering the individual experiences and the collective experience was, at times, overwhelming. So many issues arose that one had to constantly bring oneself back to the research question in order to retain the focus of the study. Van Manen (1990, p. 33) aptly describes this as " ...one can get so involved in chasing the *ti esten* [meaning, 'what is it?'] that one gets stuck in the underbrush and fails to arrive at the clearings that give the text its revealing power." The process was assisted to a large extent by consultation with the supervisor who had another perspective on the research and was able to advise on how to remain focused on the data without losing sight of the descriptions of the experiences as told by the study participants.

4.6   RIGOUR OF THE STUDY

It is appropriate to speak of rigour in qualitative research (Patton, 1990). Rigour is defined as "The striving for excellence in research through the use of discipline, scrupulous adherence to detail, and strict accuracy" (Burns & Grove, 1993, p. 779). Sandelowski (1986) and Beck (1993) offer criteria based on Guba and Lincoln's (1981) work with which to evaluate qualitative research.

These criteria are credibility, fittingness, auditability and confirmability. These criteria were used to discuss the issues of rigour in this study and a brief discussion on how these criteria have been addressed follows.

4.6.1 Credibility

Credibility as described by Beck (1993, p. 264) " ... measures how vivid and faithful the description of the phenomenon is." In this study, credibility was achieved by conferring with the participants and obtaining their feedback after reading their transcript. All the participants were in agreement with their transcripts.

4.6.2 Fittingness

Fittingness described by Beck (1993, p. 264) refers to how well the findings of the study can be identified by childbirth educators not involved in this study, as being their experiences of childbirth education. Fittingness was achieved by sharing the findings of the study with other childbirth educators independent of this study.

4.6.3 Auditability

Auditability " ... encompasses all the decisions made by the researchers at every stage of data analysis" (Beck, 1993, p. 264). This criterion was addressed by asking a childbirth educator, independent of this study, to determine whether she was able to follow the decision trail (from data collection through to the explication of the results of the study), used by the researcher in the study.

The written memos (a tool available within the NUD*IST program which allows the researcher to write observations about categories) about codes and themes contribute to the rigour of this study as they create an auditable trail of the logic of the data analysis (Sandelowski, 1986). The tapes, coded transcribed data and computer printouts also provide an audit trail whereby an external auditor could examine the process by which the data were collected and analysed. All are important considerations in establishing the trustworthiness of the data (Guba, 1981).

4.6.4 Confirmability

Confirmability is said to be achieved when the criteria of credibility, fittingness and auditability have been satisfied (Sandelowski, 1986). In each instance the independent childbirth educators concurred that the participants' experiences of childbirth education described in the study closely resembled their experiences of the phenomenon. Participants involved in the study agreed that their narratives were reflected in the study findings.

4.7   ETHICAL ISSUES AND CONSIDERATIONS

The following discussion is centred on the ethical principles of research, the ethical issues associated with this study and the strategies used by the researcher to ensure that the principles of research were adhered to. When undertaking research, whether qualitative or quantitative, there is an implicit understanding that ethical principles will be adhered to during the conduct of the research. Burns and Grove (1995, p. 548) define ethical principles as "principles of respect for persons, beneficence, and justice that are relevant to the conduct of research."

According to Holloway and Wheeler (1996, p. 38) and Johnstone (1999), the four principles that are commonly associated with ethical practice or behaviour with respect to research are: respect for autonomy; beneficence; non-maleficence and justice. Johnstone (1999, p. 88) argues that the concept of respect for autonomy refers to the freedom to make one's own choices.

Beneficence refers to the duty to do good, in other words, to benefit the person. This refers quite simply to the researcher doing good often as a result of the research outcomes (Johnstone, 1999).

Non-maleficence refers to the researcher's duty to not cause harm to the participants. As a rule, this concept is viewed as a separate principle to beneficence (Johnstone, 1999). Lastly, the principle of justice refers to the fairness of the strategies and procedures that are used in the study.

According to Clifford (1997) the researcher has a responsibility to the participants not to infringe these basic rights during the conduct of the study. Furthermore, the existence of potential ethical issues must be outweighed or at

the very least, justified by the outcome(s) of the study and this is the responsibility of the researcher.

This qualitative study involved human participants and thus had the potential for ethical issues to be raised. These issues were: participants' concerns regarding the nature of the study and in particular, their privacy, the examination of their practices, embarrassment at how certain childbirth educators assumed their roles and, in some cases, the lack of formal qualifications. The following section describes the strategies used to address the pertinent ethical issues in the study.

4.7.1 Informed consent

All research participants have the right to be fully informed of the nature of the study in which their participation is sought (Clifford, 2000). In order for participants to be fully informed, two basic conditions of research must be met, that is, participation must be voluntary and there must be full and open disclosure of information related to the study. This includes how the data will be collected and what the researcher will do with it. Consent given freely respects the participants' autonomy.

The participants were not recruited directly by the researcher but were informed of the study in the form of a letter sent to, and disseminated by, the Directors of Nursing of the various agencies as a third party. Willing participants contacted the researcher, thus the decision to participate in the study was made independently by each participant without any coercion.

It was acknowledged that participants could ask questions about the study before deciding to take part and that they were free to refuse without explanation to the researcher. Furthermore they were free to withdraw from the study at any point without prejudice.

Although this study involved human participants, it was not anticipated that the nature of the study, that is, the description of the participants' experiences as childbirth educators, would cause any harm. However, it was acknowledged that in the event that a participant was to become distressed, the researcher would refer the participant to an appropriate counsellor.

4.7.2 Confidentiality, anonymity and privacy

The issues of confidentiality and anonymity in this study were addressed by asking participants not to include their names on the personal information questionnaire. Furthermore, participants were informed that the interview transcripts would be coded and allocated pseudonyms. The computer files of the transcripts were password protected. They were also informed that the final report of the study would not contain any identifying information about the participants or their place of employment.

The interview tapes and the transcripts of the data were kept separate from the written personal information questionnaires (refer Appendix B) in a secure location.   The participants were assured that the information about themselves and the data from the interviews (rendered anonymous by the use of numerical codes) would be accessible to the supervisor and the researcher only and would be kept in storage for the mandated period, as prescribed by the University's Code of Conduct for Research. Thus the issue of confidentiality could be assured.

In all cases participants chose a quiet venue in their workplace at a time of their choosing which ensured their privacy during the interview process. Furthermore, all participants were assured by the researcher that all information, whether of a personal nature or otherwise, would be safeguarded against disclosure to any other party. By securing all information disclosed by participants the construct of privacy was addressed (Clifford, 2000).

Following transcription of the interview tapes, each participant was offered the opportunity to read the transcript of the relevant interview in order to confirm that it reflected what they said. All agreed.

4.7.3 Withdrawal from the study

Prior to the commencement of the interview, participants were given an explanation of the study and the interview procedure. Each participant was also informed that she would be free to withdraw from the study at any time without prejudice to herself or explanation to the researcher. In the case of such withdrawal, participants would have the right to nominate how the interview tape(s) and subsequent transcript of their interview would be dealt with. No participant chose to withdraw from the study.

Ethical clearance to conduct this study was obtained, first, from the Faculty of Nursing Human Research Ethics Sub-Committee and subsequently, the Royal Melbourne Institute of Technology Human Research Ethics Committee (refer Appendix A).

4.8   SUMMARY

This chapter has discussed the methods and design used in this study and the rationale for the use of phenomenology to explore the phenomenon of childbirth education. The study design, the recruitment of participants, how data were collected, managed and analysed and issues of ethical considerations and rigour have also been addressed. The following chapter, Chapter Five, presents the findings of the study.

5.1   INTRODUCTION

Since the 1970s childbirth education has been provided by midwives and independent childbirth educators. Whilst there had been an increase in the demand for knowledge by women and their partners in relation to childbirth and parenting, there did not appear to have been a parallel increase in the formal education of childbirth educators. In the analysis of the data the researcher was extensively engaged with the interview transcripts in order to gain a deep and rich understanding of the experiences of the childbirth educators. Concepts emerging from the data were grouped into themes and it is these that give meaning to the phenomenon of interest labelled as "education by osmosis."

The following chapter is a discussion of the phenomenon. Its nomenclature is a result of the description of the meanings attributed by the researcher to the experiences of the fourteen childbirth educators in relation to the implementation of their programs, their own educative processes and their educational status.   The three central themes are 'varied motivations,' 'obstacles, struggles and progress' and 'establish roles and status-a state of harmony.'   The sub-themes that emerged with each central theme were as follows: a childbirth educator perchance; a childbirth educator by design (theme 1); a state of disharmony; structured madness; modified madness; mended madness (theme 2); the collective experience; claim on the territory; a glimpse of maturity and the evolution of maturity (theme 3).

5.2   THEME ONE: VARIED MOTIVATIONS

'Motivation: Inducement, purpose, drive.' (Delbridge et al. 1992)

Midwives who became childbirth educators in the early days came to the task by a variety of means. Some childbirth educators carefully planned their foray in to childbirth education whilst others 'stumbled' into their various positions.   A snapshot of the plethora of motivational factors which led the childbirth educators taking on their specific role is described in the following discussion.

5.2.1 A childbirth educator perchance?

'Perchance: Maybe, possibly, by chance.' (Delbridge et al. 1992)

Having undertaken midwifery training in England and after a period of time not working while having her own children, Molly was keen to return to midwifery practice. She was required by the employing agency to undergo a refresher course and it was through this program that she was introduced to the birthing centre. This introduction to childbirth education was the impetus for Molly as she realised that this was her ambition, to practise midwifery in a birth centre as it entailed total involvement in the care of women throughout their pregnancy, birthing and childbirth education, including conducting sibling classes. She felt that this was closely aligned to the midwifery model of care to that which she was accustomed.

> .... my big ambition, to work in a birth centre .... having worked in England as a midwife it was very much more in that style, that you had total care of the patient throughout pregnancy and the delivery…. (Molly)

In complete contrast, some found themselves offered a position that, while it offered great social advantages, such as flexible working hours and excellent salary, gave them very little idea of exactly what it was that they were to do and even less about how to go about it. Many were returning to midwifery work after a period of absence, many from maternity leave. In these cases part time work with socially acceptable hours was a high priority for these participants as they juggled family and work commitments.

Pippa described how, on her return to the midwifery workforce, the nursing administrators discovered that [pregnant] women wanted parenting classes and so decided to offer these. As a new staff member it was expected she would be involved with the childbirth education classes.

> ... there was a need of [sic] education, parenting, all that type of thing. ... I wasn't particularly interested, ... they said, well you can take it, so I took it. So basically I've had to rely on my own resources … (Pippa)

Whilst Pippa's entry into childbirth education was not intentional, she described her experiences as being positive and has remained in this role. Wanting to

return to midwifery practice, another responded to an advertised position in an antenatal clinic because of her family commitments. Noel found that it was this opportunity that commenced her on her path in childbirth education and how this became her new career.

> *... and because of the family situation, a job down in the outpatients came, was available and I took it, which started me off on the childbirth education ball. … and I found that I had enjoyed the feeling that I had experienced … I felt quite comfortable with teaching. So that's how I .. I have been teaching down here for five years. (Noel)*

The driving force behind Lilly's entry into childbirth education was the fact that she was the only staff member at the time that held a qualification in adult education. This was seen as an advantage by the hospital administrators. Lilly described how she had been working in various areas of the hospital and how taking a position as a triage nurse/midwife led her to become the parent educator.

> *... drifted into it, because then it was the sort of thing to do to have classes for people. … glamorlarly [sic] called the parent educator in this hospital. (Lilly)*

A background totally removed from formal childbirth education was the way Peta described the development of her interest in childbirth education; in fact, she had been working in doctor's rooms. In that role Peta found that as soon as the women discovered she was a midwife, they would be quite demanding of childbirth information. Upon her return to work following the birth of her own second child a position was available as a childbirth educator and she took this due to the suitability of the hours. Peta stated that although she thoroughly enjoyed conducting childbirth education classes, initially it was not intentional.

> *... actually, I fell into antenatal education in that the job came up as I was coming back after my second baby. ... but the hours suited, they were perfect. They were flexible. (Peta)*

The incentive for two of the participants' entry into childbirth education was primarily employer-driven rather than a particular enthusiasm on their part. In two agencies, the administrators believed it necessary to provide childbirth education, as this would be a good public relations exercise for their hospital. To this end, some staff members were expected to be involved in these

programs, both from the public relations perspective, and also in terms of job security. If midwives had been involved in other areas of nursing education, they were the natural choice to conduct antenatal classes.

> *... my first teaching experience was when I started at the [agency] and I was asked to teach to the midwifery students... . And when I moved to [agency] I was asked to participate in doing parent education classes, ... that's what I've done. (Mannie)*

While her predominant role was that of a delivery suite midwife on her return to work, Pippa explained that she conducted a three-hour childbirth education class each week as the hospital's administration decided that they needed to offer childbirth education classes.

> *…they said [the administrators], "why don't you do it one night?" … and I did go over one night, and then they said "well you can take it" so I took it. (Pippa)*

5.2.2 A childbirth educator by design

'Design: A plan or drawing produced to show the look and function or workings of something before it is built or made; the art or action of conceiving of and producing such a plan or drawing; purpose or planning that exists behind an action or object.' (Delbridge et al. 1992)

In contrast to the above participants, others carefully planned their pathway in the hope that positions would be available to them. They often took positions as midwives while searching for the position they wanted. One had to agree to coordinate the outpatient antenatal clinic if she wished to conduct childbirth education classes. As no resources for childbirth education classes were provided for the educators, a further proviso was imposed; the classes must not be a financial burden to the hospital in question. Thus resources had to found by other means whether from within the unit or by donation from other sources externally if the classes were to be offered.

> *... they said that as long as it didn't cost them anything we could … I really became quite interested from there. (Millie)*

Bella had worked at several different venues as a midwife and was actively involved in established childbirth education programs. The inspiration for developing her own program came as a result of her new employment at an

agency undergoing the accreditation process. One of the recommendations was that the hospital should be providing childbirth education to the community.

> *... and they asked me if I would be interested and I jumped at the chance and said 'I will'. (Bella)*

Wanting to be a childbirth educator Sheila was driven to gain a wide range of midwifery experience at various outer suburban hospitals. Along this path she was exposed to a broad base of midwifery experiences including antenatal education [sic]. Sheila then moved to a major hospital in the delivery suite and then finally to a birthing centre.

> *... my goal was always to work in a family [birth] centre, ... then I came to the midwife [birth] centre. (Sheila)*

Being highly motivated by her own thirst for parenting knowledge during her first pregnancy, Holly, who was employed as a midwife in a small country hospital, decided to develop her own program.

> *... one of the reasons why I chose to become a childbirth educator was because I found that initially, when we had our first child, I was like a sponge - I wanted as much information as I could before I had my first baby. (Holly)*

5.2.3 Summary

Becoming a childbirth educator for some participants required them to be resourceful, especially if they were not prepared for the role. It was a foray into the unknown. In many cases these midwives became childbirth educators because circumstances dictated this and thus they fell into the role. There was a commitment to childbirth education on the part of these particular participants in terms of providing information to their clients, their adoption of the role of childbirth educator and what this entailed such as regular hours and remuneration, however, this was a serendipitous situation for these participants. For several others, the realisation of their efforts, that is actually finding employment in their chosen field, usually occurred via a circuitous route.

5.3   THEME TWO: OBSTACLES, STRUGGLES AND PROGRESS

A disharmonious situation greeted the participants as they entered the workforce as childbirth educators. There were no formal educational pathways to enter the field and few established programs formal or otherwise. While the notion of childbirth education was generally agreed to be 'a good thing' in fact very little thought had been given to just how, where or by whom it would be delivered, although there was general consensus that midwives would be involved. It seemed that even when obstacles were overcome, more arose. Consequently institutions, educators and clients were caught in a confusing and dynamic situation, all searching in different directions for a way forward.

5.3.1   A state of disharmony

'Disharmony: Discord, lack of harmony between persons or things.'
(Delbridge et al. 1992)

The structure, or lack thereof, of some programs and the fact that some programs were client-driven rather than any adherence to a program structure is the focus of attention in this sub-theme. Bella described how even though there was a set content (inherited from a previous educator) for the session she found that often she would be unable to adhere to that content because clients directed the discussion into other areas. Bella stated:

> *… I have an idea of what I'm going to say, but sometimes you get taken off track,…sometimes there might be someone who is going to have a Caesar, so you'll talk a lot more about Caesars than you normally would… (Bella)*

She believed this to be total client involvement. Molly was expected to conduct the childbirth education classes in spite of not having done so before and not having any formal preparation for this role. She described having to operate efficiently from the beginning with what was already being taught.

> *I sat in on a few classes and was then sort of thrown in at the deep end. (Molly)*

In response to probing about input into the course content, Bella responded that basically she added to whatever the physiotherapist had not covered. She remarked that:

> *... the physio is there and she actually talks about whatever she's
> up to in the program and then I have my input. (Bella)*

When asked how she viewed this manner of operating, she did not feel it to be problematic. She commented that:

> *… the physios [sic] and I keep in close contact … … but like I said
> before, I mean I think it's everybody's choice to do whatever …
> (Bella)*

Three participants described their experiences of taking over established programs designed by existing midwives. For example:

> *... and I think [name] set it up, and determined what went in it.
> ...The charge sister worked out the basic structure... (Peta)*

Other experiences were markedly different in terms of the decision making process related to course content. Holly undertook a childbirth educator's course interstate and then proceeded to observe other educators' courses in terms of content and format. She then developed her own course over a period of twelve months and implemented it. Holly remarked:

> *I sat in on two courses up there, two eight-week courses, ... gave
> me some ideas on what I wanted to do…(Holly)*

Other participants described continuing with existing programs as is seen in the next example:

> *It was all up and going and it was established when I got here.
> (Noel)*

5.3.2 Structured madness

'Structured: The quality of being well organized.' (Delbridge et al. 1992)

When interviewing the participants the concept of educational objectives arose with each participant. The following discussion provides insight into the participants' understanding of educational objectives. Although participants described so-called objectives as educational/course objectives, and believed that they provided a structure for their programs, further scrutiny did not support this belief. In fact, the objectives were educator-centred and not client-centred, that is, they reflected what the childbirth educator wished to achieve with the

program. This was the case with Sheila when, exploring the notion of course objectives, Sheila related that:

> *... I always tell them my objectives for the night, which is to have fun, and to meet people and to do some learning and sharing and I ask them what their objectives are, always ... … then everybody will share that. (Sheila)*

As can be seen in the above excerpt, Sheila did ask her clients what their objectives were but it was unclear whether this information directed the program in any way. She also stated that these objectives were on large posters, and thus not able to be reviewed by the researcher.

When probing about objectives during her interview, Peta offered that they did have such objectives for her program but these were not given out to the clients and thus were not explicit. She stated that:

> *... we've got a set, but we don't read them out. (Peta)*

At another agency program objectives were reviewed on a yearly basis. These were developed and/or modified according to what the childbirth educators saw as necessary and important at the time of review.

> *We all work together and work our own set of objectives that suit all of us and that's what we go [sic] for the year. So we all sit down to do the objectives for next year's classes over a couple of weeks. (Noel)*

Millie, who provided childbirth education in a small regional hospital, postulated an interesting interpretation of learning objectives. This particular childbirth educator explained her understanding of objectives as being what she believed the clients should know and have. Millie stated:

> *... what a childbirth educator pretty much says, I want them to be aware of the natural process, that childbirth is a natural process. I want them to have confidence in the natural ability to give birth themselves, they're probably my two objectives. But I want them to have the resources available to cope with whatever happens. (Millie)*

After further probing about modification of her program content based on program evaluation an interesting viewpoint became apparent: the objectives in

the first instance were dependent on the clients' feedback, in other words, they were retrospective.

> *I've tried to formalise them a couple of times and then felt that really, I'll wait until I get some of the questionnaires back and see if, you know, what the feedback is and then I'll formalise them all. (Millie)*

At another small regional hospital, the existence of the set objectives was what contributed to the philosophy of the program offered. There was an objective for each week of the program and the individual weekly objective related, it seemed, to the week's activity rather than a learning objective.

> *We do have some objectives, and from those I should develop you know, just a three-line philosophy about " this is what we are going to learn about." … each week there is an objective, … but it's just a matter of putting those objectives together and just working out an overall, an overall philosophy … (Pincha)*

5.3.3 Modified madness

'Modified: Made partial changes to.' (Delbridge et al. 1992)

Existing childbirth education programs were modified by individual childbirth educators according to their personal beliefs of what should be included in their respective programs. Enmeshed within the process of modification was the concept of the inclusion or exclusion of content dictated by other health professionals, in other words, from outside influences.

Bella expressed feelings of being uncomfortable speaking to women and their partners purely about the complicated issues that arose during childbirth. She needed to convey the message that midwives also worked with women who had normal labours and births, not only caesarean sections. In response to probing about input into the course content, Bella responded that basically she added to whatever the physiotherapist had not covered.   She was clearly not entirely satisfied with the situation.   As a result Bella negotiated with the physiotherapist, who was responsible for the childbirth education classes, to present additional information that she felt the women and their partners should be exposed to. She stated:

…what I talked about was [sic] the variations of the norm which concerned me a lot because I hated to think that people thought the midwives were only associated with the abnormalities … we sort of talked about just the induction and just the Caesars, … and that's why I sort of went back to the physios and said … I would like more input … and also to talk about the role of the midwife. Over a period of time the content has changed. (Bella)

Over time she was able to address other issues such as pain management in labour, which she believed was important.   Bella said:

… you know I really don't feel right, I'm happy to cover those little things, but I would like more input into the pain relief bit which I think is very important…. that was one area I was very keen to talk about. (Bella)

Thus the content of the program was modified based on the participant's view as opposed to any formal evaluation of the program.   At one metropolitan private facility, Peta who also inherited the program, taught what she was handed until she felt confident to make modifications.   However, Peta did concede that for the most part, the content was modified on the basis of which obstetrician(s) the women were attending as seen in the following quote:

… as I said, we've changed it, we've modified it but it is pre-existing so I really taught what was handed to me until I found my feet. …in a private hospital, who are you going to [sic] and that very much determines how, or what you're telling them… (Peta)

For a childbirth educator in private practice, modifications were made on the basis of client feedback on a week-to-week basis rather than an end of course evaluation. Holly stated:

…I've changed it from when I actually organised it…in as much as the feedback…I do change it week to week… (Holly)

Probing revealed that Holly modified areas related to parenting issues according to client requests.   This concurs with the literature that claims that prospective parents desire more information related to parenting issues. Holly remarked:

... I've changed it from when I actually organised it ... and I've added more parenting and baby care ... the feedback was that was what they wanted. Once they got over the birth what was

more important to them was breastfeeding, childcare and parenting issues, ... (Holly)

Pippa provided an interesting insight into how the program offered at her agency was modified according to the type of clientele in the program. Several women and their partners left a particular program at a large city hospital due to the large numbers and attended the program at this particular private hospital. Pippa had attended a class at a metropolitan public hospital and found the clientele less knowledgeable compared to those clients at her own agency. After discussion with colleagues it was decided to modify the content of their program.

> *… the girls here [pregnant women] are very much more capable and they know what they're doing, they can understand what's happening to them… we sat down and thought about the format … we tell [sic] each other, say how about we put this in … we'll integrate and see how it goes. We're open to suggestions. (Pippa)*

A participant whose program was offered at a birthing centre was emphatic in ensuring that program content was midwife-driven and that medical input was not canvassed in any way. Molly declared:

> *… we are in the fortunate position of not having much input from doctors from anywhere … we certainly wouldn't be looking for their input at all. (Molly)*

Molly also was careful to point out that the program was reviewed at regular intervals; however, it became apparent that this evaluation was midwife-driven and not client-focussed. This is evidenced by the following excerpt:

> *… everybody sat down and wrote down how they conducted the class, what they thought was important in the class, … we put all together and reformulated the class format, taking the best of everything. (Molly)*

Whilst Noel inherited the program from a predecessor, in particular the objectives, she was free to include whatever content she thought necessary. She worked with two other childbirth educators, each using the same set of objectives but each developing their own content. Noel commented that the content is dependent on the evaluation conducted at the end of each program. She stated that:

> *The objectives that we're using at the moment are [name of childbirth educator predecessor] … but what we teach is our own … … we do evaluations at the end of class five … that's how we know that they [the women] want more parenting. (Noel)*

Other educators continued with already established programs but made changes according to their clients' wishes following end-of-program surveys. This was the case for Lilly who stated:

> *I do surveys at the end of the whole you know, program, so I pick up what the people say and perhaps change according to some of their ideas.*

Other experiences range from adjusting course content based on current trends in childbirth education programs elsewhere to making an assessment of clients' needs and providing content based on the outcome of that assessment. Three participants described their experiences of taking over established programs and modifying them as they became more familiar, both with the skill of teaching and with the course content. For example:

> *... we've changed it, we've modified it but it was pre-existing so I really taught what was handed to me until I found my feet. (Peta)*

Lizzie stated that program content was modified primarily on the basis of what the midwives felt was necessary even though they had canvassed some clients' views. The following exemplar illustrates Lizzie's statement:

> *… we did a little mini-appraisal … from people who have done the classes … and we sat down with the midwives and talked about what we felt was important. (Lizzie)*

Lizzie also mentioned that she and the other childbirth educators were careful to ensure that content was acceptable to the obstetricians so as to keep them on side. This viewpoint is highlighted in the following statement:

> *… a fear among doctors, that people who go to the classes are going to come up with some awful question …so the biggest thing is actually getting the doctors involved. …you've got to be careful of not giving them [the women] too much information.*

According to Lilly, whose program was located within a public facility, the obstetricians requested to review an audiovisual aid that was proposed to be used in the childbirth education classes. Even though Lilly did not agree with it,

she cooperated and allowed the obstetricians to review the video. She believed that their concern was related to the fear of litigation and the issue of ensuring that what they relayed to their patients [women] was supported by information given at parenting classes and in the video. In Lilly's words:

> *I mean it's a bit ridiculous that it's in every other parent education session around town, but they're a little bit worried … they had a look at the video, and they were a bit critical …they were a bit nervous about it, … they viewed it at one of their meetings and they couldn't say it couldn't go on … (Lilly)*

It was allowed to be used.

A particular participant provided an interesting slant on the influence of other health professionals' input. According to Millie, she asked the attending obstetricians for their input but was not prepared to repeat what they had actually stated. However, Millie did state that because the hospital at which she was employed was a private hospital and the doctors were responsible for referring the patients, the midwives were mindful of asking for the doctors' input. Millie stated:

> *I guess also because we are a private hospital, the doctors are our bread and butter. We must have their input and if they're not on side….. (Millie)*

When pressed further about the content she stated that the midwives had been able to include whatever they felt was necessary and this is seen in the following statement:

> *Well I/we've had virtually open slather, I've been given, [name of midwife] said "go for your life." (Millie)*

Pincha reproduced the content she had used at another rural hospital. However, she did say that she also asked for input from the physiotherapist and of course, other midwives. Pincha stated that the first few classes were a trial run and subsequent classes were modified on the outcome of the evaluation of the trial run.

> *… so we had a meeting…and the physio, and they all had some input… the first lot of classes was [sic] just trial and error …and have since just … modified it according to the evaluation. (Pincha)*

Interestingly Mannie relayed her experience of having to remove an item from her audiovisual presentation due to an obstetrician's demands. This was due to the fact that women purportedly had complained to the particular obstetrician about the content of the video, which was quite explicit with regard to the actual birthing process.   Mannie said:

> *"Look, my patients don't really like it."   And in the end, unfortunately, I had to withdraw it which was a bit of a shame…..(Mannie).*

A different example of extraneous influences was described by Molly who had no formal induction or preparation for the role. She said:

> *I sat in on a few classes and was then sort of thrown in at the deep end. And so I conducted my class like the person I watched and I think you get beyond that after a while. (Molly)*

5.3.4 Mended madness

'Mended: Restored to a sound condition.' (Delbridge et al. 1992)

In many cases, evaluation was not a formal process conducted at periodic intervals or even at the end of a program. It was, for a large part, a way of deciding what content would stay, what might be removed and what might be included next time, whether that was the following week, the next program or even the same class [repeated] within the current program.   The following relates to the evaluation mechanisms that were perceived to be satisfactory in terms of accommodating clients' requests. A common thread throughout is the notion that if the class was uneventful, then it must be satisfactory in terms of teaching and learning.

The educational concept of evaluation highlighted the various understandings that participants had of this mechanism. In one particular program, which was located within a metropolitan private hospital, prospective course content was determined, according to the childbirth educator, on the basis of client feedback. When elaborating further, it became apparent that whilst client feedback may have contributed to prospective program content to a degree, content perceived to be important by the childbirth educators was what contributed largely to the prospective program content. This is evidenced by Lizzie's statement:

... we did a little mini-appraisal or assessment from people who have done the classes, we sought from them what they felt, what they would have liked to have been covered. So basically asked [sic] them and we sat down with the midwives and talked about what we felt was important. That was probably the main thing that we did, so it was a two-sided thing, the midwives and the clients. (Lizzie)

Whilst client input was sought, there was no further follow up to gauge the success of this structure. This type of evaluation was a similar process at another agency, a large public hospital that offered the program in several languages. At the end of each program, a questionnaire was distributed and modifications were made for the next program on the outcome of the questionnaires. The following statement is from Noel who delivered the program in English [programs were delivered in several languages at this hospital]. She stated that:

... we do evaluations at the end of class five ... and that's how we know that they want more parenting. (Noel)

A different understanding of the term evaluation emerged from Mannie who taught childbirth education at a large city private hospital. This particular program emulated another being taught elsewhere which was deemed to be successful as it continued to exist and attract clients. The understanding emerged that if a program was running successfully then its clients must be happy with what was being offered. On this basis it was decided to offer it unchanged at this particular participant's agency. Mannie's response with regard to program evaluation was:

Well, that must be O.K [sic] because it was doing alright.

She elaborated further with:

The good thing is that we do review them at regular intervals ... and for the purposes of that review everybody sat down and wrote how they conducted the class, what they thought was important in the class, and basically introduced their own particular style into the class. (Mannie)

Lizzie recalled how, even though she inherited a previous program, she adopted a democratic approach to reviewing this particular program which

involved asking the other midwives working in the area as well as the clients [pregnant women]. She described democratic as follows:

> *... we did a little mini-appraisal or assessment from people who have done the classes, we sought from them what they felt, what they would have liked to have been covered. So basically asked [sic] them and we sat down with the midwives and talked about what we felt was important. That was probably the main thing that we did, so it was a two-sided thing, the midwives and the clients. (Lizzie)*

At another institution, Noel claimed that the midwives modified the program according to what they [the midwives] believed should be included, but at the same time retaining the original format of the program. Noel also based her modifications on the outcome of the evaluation and on the basis of this, included more time on the parenting issue, which reflects Holly's experience.

> *… we do evaluations at the end of class five and that's how we go over our evaluation, that's how we know what they want. (Noel)*

> *… I've added more parenting and baby care into it actually. The feedback was that was what they wanted. (Holly)*

5.3.5 Summary

Participants delivered childbirth education programs that, for the most part, had been inherited. Discussion about the structure or development of their programs highlighted the fact that, in many cases, the content delivered was client driven at any given time. It also became evident in the course of discussion that where educational learning objectives existed, these were at best, educator centred rather than learner centred.

As participants familiarised themselves both with the art of being childbirth educators and with the existing program content, they appeared to adopt a certain calmness and contentment with their role. This allowed them the confidence to modify their programs and also to question outside influences upon the programs. This led to a more harmonious state within the childbirth education programs in existence at the time of interview. The development of this more harmonious state is the focus of discussion in the next theme.

5.4 THEME THREE: ESTABLISH ROLE AND STATUS – A STATE OF HARMONY

'Harmony: Agreement, accord, harmonious relations; consistent, orderly, or pleasing arrangement of parts; congruity.' (Delbridge et al. 1992)

As participants developed a certain level of confidence in their role, they became more settled in their new career. This had the effect of bringing a more harmonious synergy to the dynamics that existed between the providers, other health professionals with whom they worked and interacted, programs and the institutions within which they were located. How this renewed synergy developed is explored in this theme.

5.4.1 The collective experience

'Collective: Formed by collection, pertaining to a group of individuals taken together, forming a collection or aggregate, combined.' (Delbridge et al. 1992)

This sub-theme addresses the issue of collaboration with other health professionals in the provision of childbirth education. Some participants describe this as a positive experience whilst others see it as a necessary evil in keeping one's job. The term role erosion was used by several participants.

Whilst Peta worked in collaboration with a physiotherapist in delivering childbirth education classes, her comments reflected that it was not an ideal situation in her view. When probed about her views about their presentation, she proffered:

> *...they [physiotherapists] do an hour at the early bird class and exercise, relaxation and pregnancy and they do, it's supposed to be an hour, it always extends, week five on strategies for coping in labour. ...it's the same thing. Sitting there having to go in as a student and sit in on someone who must be getting furious thinking this woman is never in labour ward, how can she know and how can she cover me,...(Peta)*

Pippa, on the other hand, had a more philosophical view of working collaboratively with a physiotherapist in this traditional midwifery domain. She said:

We do have physios and situation [sic] here, basically because the physio has been involved with this hospital since the beginning and when the original classes were started... It's incorporated so we find she does the post natal checkups or exercise classes here. We find it's reasonably well received. But because we are involved with management and not sort of been able to sort of say, hey we don't need this, ...

Lilly's experience was not too dissimilar to the other participants on this aspect. According to Lilly, the physiotherapists were firmly entrenched in childbirth education and would not be easily removed. She said:

... the physiotherapist here, have a fair sort of hold on classes as well, they don't want to be pushed out...

When probed about how the input was decided, Lilly replied that while she had input into the classes for the public sector, she was not able to contribute to the classes for the private sector couples.

Yes but I don't have any input into those [private sector] at all. But I'm not saying that the physio here at the moment isn't interested in having a midwife involved, she would like to actually, but the nursing administration, but they haven't taken it up. (Lilly)

The program that Lilly was associated with also had input from a representative of the Nursing Mothers Association. However, Lilly was not averse to working with the physiotherapist in delivering the content and participated in some of the smaller sessions run by the physiotherapist.

It would seem that whilst midwife input into the private classes was welcome, retaining control of the classes was imperative for the physiotherapist concerned.

Another participant described an entirely different view of collaboration, one that was more collegial and accepting of another's expertise. Whilst she provided the theory component of the classes, the physiotherapist provided the practice component. In response to whose suggestion it was for the particular format, Mannie replied:

Probably the physio and myself when we first set it up. Because, to me, well a lot of midwives feel very threatened by physios, um, I personally don't. ...they have their area of expertise. They've spent, you know, however many years getting their degree. I can

teach a woman all the different positions she needs for labouring and stuff like that, but a physio can do it just as well. And that's her area, I mean that's her area of expertise. She doesn't presume to talk about Caesars and why they're done, or what pain management is in terms of drips and such, she knows that's my area and that's the area that the midwives will deal with. (Mannie)

Mannie felt that the working relationship with the physiotherapists was very healthy as she was able to question them if needed. An example of this is as follows:

I mean, I'll say 'look, hey what are you talking about saying such and such and such,' and they, you know, either didn't say it at all or someone asked a specific question and they sort of had to give an answer to but referred it to [the midwives]. You want to nit pick the best skills from both, and we've got all the best, we're trained in all the medical stuff. Sure we know all the practical stuff, but the physios that's what they're trained for.

Lizzie's experience working with other health professionals was somewhat different to her peers. Her program involved the general practitioners associated with the particular hospital and also the maternal and child health nurses. All had a degree of input into the classes delivered and she believed allowed better integration of the content. She said:

...we're inviting the GPs to come and talk to the couples about the role of the GP, and also maternal child health nurses. So we're trying to get everyone in. ...we have a lot easier way of integrating the whole thing. (Lizzie)

This experience was shared by other participants also. Sheila's program also had content delivered by both an obstetrician and a lactation consultant which in her view, strengthened the program.

We have got the doctors involved now, ...and I think it's been quite worthwhile actually because the ones that come, seem to be quite good at what they do. ...so I've also got [lactation consultant] who's lactation consultant [sic], and she's very good and runs a good session. (Sheila)

Holly, who ran her own program, described how she would be happy to have the involvement of a physiotherapist in her program but only insofar as it did not erode the midwifery role. She stated:

I feel physios have a role, especially with the exercise part, and I would be very happy for physios to do the exercise part of my classes if they were happy with that. I'd do a better job at the education side of that as far as labour goes, basically because of the knowledge and experience. (Holly)

Molly was of the firm view that childbirth education should be provided by the midwife who would be caring for the woman. She stated:

I am still convinced that the midwife is the person to do the childbirth education. I think that physios are fine to teach some pelvic floor exercises, not that midwives can't, but I think that they should confine themselves to their expertise because they are not involved with the women in labour. (Molly)

5.4.2 Claim on the territory

'Claim: Assert that something is the case; an assertion of the truth of something.' (Delbridge et al. 1992)

The following are descriptions of the positive steps [as perceived by the participants] undertaken by various childbirth educators and their colleagues in so-called wresting back traditional midwifery areas away from other health professionals.

Lizzie was employed in an interstate hospital where her primary role was to set up a childbirth education program in a private hospital. Circumstances necessitated a move to Melbourne where she took up a position in a private hospital once again. Her brief was to establish a childbirth education program run by midwives only as the hospital currently had a program coordinated and delivered entirely by physiotherapists. Lizzie felt sufficiently empowered to challenge the status quo and to bring about a change in who would deliver a childbirth education program at that hospital. She stated:

I certainly put on notice then that one of my main aims as unit manager of this unit was to I suppose take back, what I believe to be the midwives, and that is the education of people having babies, their education, for what, childbirth education, that was nothing, and I let it be known from the very beginning, I was probably stunned that the physio had a legal contract to do the classes at this hospital. It had taken me five years, and I've finally done it....we now totally co-ordinate and run our own classes.

However, the process of reclaiming what she firmly believed to be the midwives' domain was not without its difficulties as she expressed in the following statement.

> *I feel awful in some way, because we took away a fair bit of business [sic] from these physios but this is life and they knew three years ago that I was going to do this. ...A lot of animosity, a lot. I'm trying to break that down a little bit now, you know, by involving them in perhaps the pre-pregnancy exercise classes and exercise to music and I'm trying to do that, but it's very, some animosity there. (Lizzie)*

Whilst Lizzie's approach caused difficulties with the physiotherapists, she believed that it enhanced the childbirth educators' workplace. According to Lizzie:

> *They [the childbirth educators] are happy, they like what they're doing and if the midwives are happy, then the class is going to be happy, ... for too long we as midwives have allowed other people to do childbirth education, it's our domain, and I think we have to start taking it back. I know my name's mud around the place, because I'm the one who got rid of the physios and of course that is happening right across the [network] Hospitals.*

5.4.3 A glimpse of maturity

'Maturity: The state of being mature; full development; perfected condition.' (Delbridge et al. 1992)

This sub-theme deals with childbirth educators' perception of how and why they see childbirth education developing further. It addresses their plans for expanding their courses in order to attract clients to their agencies/hospitals. Once again it becomes evident that money is the real issue rather than a real sense of providing women and their partners with expanded options.

Whilst Lizzie was able to reclaim a midwifery area of expertise from the physiotherapists, it was the financial and the positive public relations aspect of the exercise that enticed the hospital management to support Lizzie's plan. Nevertheless, the outcome benefitted both the clients and the hospital which led to long term stability for childbirth education programs in that particular hospital.

> *...the first thing I had to do was to get management to acknowledge that it would be a benefit to the hospital for us to co-*

ordinate the classes. Then I convinced the owner of the hospital that it would benefit the hospital from a financial point of view, and from a public relations point of view. I can honestly say I don't have any restraints. I can reach for the moon and they'll give it to me at the moment. (Lizzie)

Lizzie also described how she and her childbirth education colleagues ran a childbirth education program for local schools in the area as a means of promoting the hospital and its services. The target groups were students in years 9 to 12 as part of students' personal development. It was primarily a public relations and marketing strategy. Lizzie stated:

...we also have a schools program here, schools come in and learn about, have a look, more about what's it about and implications of having a baby nowadays, ... so I suppose that is childbirth education ..anywhere between years 9, 10, 11 and 12 ...they do it under their personal development so that's very successful. Everything from our point of view we also have a look at from a public relations exercise.

Pippa described how she and a colleague worked together with the physiotherapists. This fostered a sense of calm and cooperation which augured well for the program. She said:

...she does the post natal checkups or exercise classes. [Colleague] and I probably do exactly the same thing as [the physiotherapist]. ...[physiotherapist] is really reasonably flexible.

Whilst Pippa did not articulate where she saw childbirth education in the future she expressed the view that all childbirth educators should update their knowledge at regular intervals. She stated:

I update as much as I can on a regular basis and I think the educator should really do refreshers every, at least every couple of years.

Pippa also was of the view that childbirth educators should have a formal, recognised qualification. She said:

We actually haven't got our certificates ... as a recognised sort of educator, but I think it's a good idea if you can get one.

Lilly's expertise allowed her to firmly state that whilst childbirth education had its detractors at the time, she believed that it had a future and was here to stay.

...you sort of know that it's [sic] should be still there and it should be still offered and it's more important than a lot of other people tend to think. ...but I think some of the doctors are beginning to change their minds, once they got involved. ...now they realise that there is a need and they can participate and people appreciate them [the doctors] being there. (Lilly)

Holly described how some of her clients had requested her services as a home birth midwife. She explained that she could not undertake this as she did not believe that the proper supports were in place for this type of birth at the time. However, she stated that she was prepared to provide the childbirth education in the first instance, attend the birth in a hospital for that client and then provide the postnatal care at home. At that point in time Holly did not see her role expanding beyond childbirth education as it was. As she said:

People have asked me if I would do home deliveries, I wouldn't, I don't think I've got the backup. Attend the birth, somebody in a hospital, and then come home and look after them.

5.4.4 The evolution of the vision

'Evolution: Gradual development.' (Delbridge et al. 1992)

The majority of educators describe their positions as having enabled them to further themselves in terms of their education and also see their positions as an avenue in pursuing further education but on closer examination it appears that this educative process is in terms of obtaining short-course certificates rather than focussing on formalised education at diploma level which would be in keeping with some of the recommendations of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990. This sub-theme also highlights the positive and sometimes, less than progressive, influence on childbirth educators and their programs by the findings of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990).

Lizzie did not expand on the future development of her particular program beyond expressing an opinion that whilst midwives had the knowledge of what to teach, they needed to know how to teach. Her view is expressed in the following:

... not so much from the knowledge point of view but more from group dynamics, dealing with things that come up that your life as a midwife doesn't cover. Yes I would like to see some kind of adult education, childbirth education thing. I don't think midwives need to know what to teach.

In response to probing with regard to the qualifications that childbirth educators may or may not have, Peta responded by saying:

I'd like to see a course. And a certificate. ... Yeah, I would like to see an accredited course, because at the moment, you know [name of colleague at another hospital], she was saying that the status of a childbirth educator is quite low at the moment. You know, it's not considered a vital part, whereas if you go and push it up and it is considered a part and people that are involved with it are considered to be fairly important in this profession, but you have to get an accredited course. (Peta)

However, Peta did not qualify whether the qualification should be at a tertiary level.

Holly made mention of the fact that childbirth education classes did not attract rebates from private health insurers and that she often had enquiries from prospective clients with regard to this. She made mention that a colleague who worked as an independent midwife in a regional city was able to attract rebates for her clients as childbirth education was included under the mantle of antenatal care in her practice. She likened this to the fact that clients attending physiotherapists, as professionals, were able to claim for benefits for physiotherapy services.

At the moment if women ring up and they have got private health insurance they'll ask me if they can get a refunds, well they can't. I think maybe a lot of the health insurance people see that also childbirth education is only exercise – they don't understand what's involved. ...there is an independent midwife in [a rural town] ... and her clients get rebates for the postnatal sessions and for the antenatal classes would be antenatal visits [sic] – she incorporates them into one.

Holly ventured the notion that she wanted to see an evolution from conducting a childbirth education program to expanding the service she offered such as an early discharge program. She also stated that she wanted to be able to network with other midwives/childbirth educators with similar views and interests. As she explained:

I have thought of setting up an early discharge system myself, but I wonder ...it is nice to have other people who have that network to chat to or get somebody else to be in a group of people working together or group of midwives ...

Given the findings and recommendations of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990), some participants claimed that this report had not really changed their perception of childbirth education and how they conducted their programs since its release. Lizzie claimed that the report had not influenced the program that she taught saying:

Not us, because I think we were fairly enlightened and down the track anyway, I think actually our hospital was put up as one that was meeting a lot of needs of the community anyway. ...from our point of view, here, our program and our care here, I think it's really just indicating what we're doing.

Noel was of the opinion that whilst the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) had not meant a significant change for her program, it had served to make the childbirth educators more client focussed. In this way, this particular program had evolved from what it was prior to the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990). According to Noel:

Slight, but not a great impact. We're more aware of what the client needed.

This sentiment was echoed by Lilly who believed that her particular view of childbirth education was reflective of some of the recommendations of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990). In response to probing with regard to the report, Lilly said:

I don't really think so because ... I've probably felt that way about things before, anyway, I mean there might have been other people who needed to hear that thing, but I think we were working to that anyway.

Molly's views were not dissimilar to Lilly's. She stated that findings of the report did not greatly influence her program. As she said:

... I think a lot of the criticisms didn't apply to the way we conduct our classes which sounds a bit, you know, but certainly we looked at it and there wasn't a great deal that we needed to change.

This view was quite different from Mannie's perspective. She claimed to have read the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) prior to developing her program taking into account its recommendations.

... I read the review before I set up the program. I was very much influenced by it.... actually the review played quite a part in the setting up of the unit, our philosophy as well.

Millie's experience was also a positive one in that she found information in the review that she was previously ignorant about, particularly about being able to undertake a short course in childbirth education to become an educator. In response to whether the review had had any effect on her, she said:

Very much so, so much so that I've found out about the [course] and that's, I read that and thought, yes, that's exactly what I want to do. I want to be more along that line and felt that there should be a more overall, because we get women coming in totally unprepared and this, that and the other thing. ... You can combat that I think just to give them the information.

Pincha felt that the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) had a direct impact on childbirth education classes being held in her small country hospital.

... it is as a direct result of the recommendation from the birthing service's review that they [management] have set up the classes here. ... one way of providing a good community service.

5.5   Summary

As participants gained more experience this had an effect of making the programs more settled. Participants described how for the most part, they worked collaboratively with obstetricians and physiotherapists. However, some participants wrested back traditional midwifery work, that is, childbirth education, from the physiotherapists. Some described how their programs were a 'promotions and marketing' avenue for their particular institution and in turn,

this was a positive effect for their programs. Another's experience as a private provider of childbirth education fostered in her a need to venture further afield from childbirth education. Other participants expressed the view that childbirth educators needed to be appropriately qualified and current in their knowledge base. For some participants, the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) either directly affected their program positively or at worst, had no effect whatsoever.

CHAPTER SIX
DISCUSSION

6.1   INTRODUCTION

The final chapter consists of two parts. The first part begins with a snapshot of the context of maternity services existing at the time of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) and an overview of maternity services in existence today with particular focus on the similarities and differences of today's maternity context with those at the time of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990).   Following this, a discussion of the concepts of education, osmosis and situated learning is provided as these are central to the understanding of the phenomenon, labelled as 'education by osmosis' by the researcher.

The second part of the chapter provides a discussion of the participants' experiences of childbirth education that is, the phenomenon, which is a representation of the researcher's interpretations of the participants' experiences. These have been grouped under the central themes of 'high pressure of osmosis: varied motivations,' 'semi-permeable membrane of osmosis: obstacles, struggles and progress,' and 'low pressure (equalisation) of osmosis: establish roles and status.'   The limitations of the study, the implications for childbirth education programs and recommendations for further research are also discussed in the final section of the chapter.

6.2   CONTEXT OF MATERNITY SERVICES

In order to fully understand the discussion centred on the phenomenon as it emerged from the data the researcher felt compelled to provide the context of how midwifery services were delivered leading up to the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) at the time of this review (1990), and again how midwifery services are provided in the time since data collection. The resultant discussion centres on these contextual presentations.

6.2.1 The period leading up to the Ministerial Review of Birthing Services (1950-1990)

In order to understand midwifery practices in Victoria at the time of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990), it was necessary to provide an overview of midwifery during the latter half of the twentieth century. The following is that account based on the practices at one of the largest and busiest women's hospitals at the time in question, The Royal Women's Hospital (RWH). The researcher believes that this hospital was representative of midwifery practices in the state of Victoria at the time given its eminence and size.

During the mid-1950s whilst the practice of midwifery at the RWH was considered to be efficient it was seen as lacking in the emotional treatment of the women it cared for (McCalman, 1998). According to McCalman (1998, p. 313), these failings were due to the 'class and gender divisions which persisted in the prosperous 1960s and 1970s.' In fact, the author goes so far as to state that the RWH's rival hospital was in fact, more respectful of its patients as women.

The RWH in the early 1960s was a large and busy institution with 7000 babies born annually. Such was the influence of its medical staff that according to McCalman (1998, p. 315), "… a patient might legitimately make a request, but never a demand or a condition. Their medical authority was absolute and their dedication to healing and preserving life could, in extremis, exempt them from respect for a patient's self-hood and autonomy." She states that given the size and the administrative structure of the RWH midwifery care was also conservative in nature. As a result, this precluded midwives from providing care during childbirth that was relaxed and sensitive to the women's needs. However, the technical aspect of its midwifery care was exemplary.

As late as 1979, according to McCalman (1998, p. 317), an incoming director of nursing was quoted as saying that "The whole atmosphere of the place was like the military … It was controlling. … The whole atmosphere of the place was less than friendly."

It was at this time (1972) that a new RWH was opened, however, it remained, conceptually, grounded in the practices of the 1950s even though societal expectations of labour and childbirth had changed according to McCalman (1998). Recognition of the women's desire for privacy during labour was provided in the form of single accommodation with husbands being able to be present during labour with their wives, however, "nursing/midwifery was still all about control – control of staff and control of patients" according to McCalman (1998, p. 318).

Not all members of the medical staff were as rigid in their practices. At the time of the opening of the new hospital, some more progressive doctors realised this as an opportunity for a shift in the way that nursing shaped the delivery of midwifery practices. In other words, they saw the potential for improvement in the way women were supported emotionally during childbirth (McCalman, 1998).

During this time according to McCalman (1998), a memo to the Honorary Staff at the RWH supported the notion that nursing/midwifery changes had not kept pace with the changes in how medicine was practised. The memo stated:

> … there is no close relationship between the staffs in the labour ward and the antenatal/postnatal complexes. However, there has been no comparable change in the nursing organisation and it is to the nurse who is continually in attendance in the labour ward that the labouring mother looks for emotional support. It is obvious that standards in this respect fall far short of those desirable. Efforts to continue techniques learnt in the relaxation classes have failed because of nursing staff resistance and lack of co-operation with the physiotherapists who have retired dismayed from the labour ward. This situation probably stems from the innate conservatism of the labour ward staff and the fact that sisters remain too long in labour ward and, although becoming technically proficient, develop impersonal attitudes and become cortically deaf to the woman distressed in labour (p. 318).

In other words, there was a serious disconnection between what the women learnt in childbirth education classes and the subsequent care they experienced during labour and after the birth.

A new model of obstetric/midwifery care became evident during 1961 when the funding body for public hospitals, the Hospital and Charities Commission, allowed the RWH to admit women as public patients who could still remain

under the care of their own doctor. This saw firstly, midwives' traditional territory threatened and secondly, an increased presence of medical staff in the labour ward with a resultant increase in the medicalisation of birth overall (McCalman, 1998). This new practice at the RWH led to the eventual establishment of a private wing in 1979 with doctors taking overall responsibility for the type of care their patients/women would receive. Ultimately the growth in private obstetrics at the RWH contributed to the increase in instrumental births.

The catalyst for reform of childbirth practices at the RWH was spurred on by the forward thinking of its closest rival, the Queen Victoria Hospital, which had become part of the Monash University Medical School. This particular School had a different attitude towards childbirth practices, hospital care and women's reproductive health (McCalman, 1998). A family-oriented birthing centre was established at the Queen Victoria Medical Centre (as it had become known) in response to the backlash to the medicalisation of childbirth in 1979.

This midwife-led birth centre essentially returned control of the birthing experience back to the expectant couple and its principles of operation could be said to have emerged from the theories espoused by De Garis, Lamaze and Dick-Read from the mid-twentieth century (McCalman, 1998). Women were empowered to demand what they expected from the childbearing experience and parallel to this midwives were allowed the freedom to advocate for the women they cared for (McCalman, 1998). This 'new-style' midwifery was in part spurred on by the emergence of two particular groups, the Association for Painless Childbirth and the Childbirth Education Association who promoted the respect of women's wishes in childbirth and which obstetricians enabled this (McCalman, 1998). Another development at this time was the increase in women opting for homebirth which, at the time, was frowned upon as being unsafe for both the woman and her baby. Any hard-fought gains for expectant women such as the modification of birth practices were achieved amongst a very dominant force of medical practitioners.

However, even though family birthing centres became popular and continue to this day, practices in the majority of Victorian hospitals continued to operate much as they had leading to women being increasingly dissatisfied with their

birthing experience. The following is a brief account of the midwifery practices at the time of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990).

6.2.2 The period at the time of the Ministerial Review of Birthing Services (circa 1990)

Midwifery practices in Victoria at the time of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) were varied. Whilst the provision of the services provided in each maternity unit were similar, that is; public and private accommodation, the choice of attending childbirth education courses either publicly or privately as a fee-paying client, a traditional delivery-suite birth or a birth in a family birthing unit, it was the actual experience of the women that highlighted the differences in maternity services provision in terms of what was stated would happen and what actually transpired during their childbearing experience.

The review brought to the fore both provider and consumer criticisms and dissatisfaction with maternity services at the time. These are outlined in Chapter One of this study. The Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) outlined its recommendations for birthing services in Victoria. In the view of the researcher, these can be broadly grouped according to the following service provision categories: midwifery; medical; hospital; education (both midwifery and medical); government/ professional bodies and community bodies.

The key recommendations of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) with regard to midwifery services provision were for the development of birth plan forms and the planning and monitoring of a pilot home birth service. A centre was to be established whose function it would be to coordinate information and resources regarding pregnancy, childbirth and related services for the benefit of pregnant women was a key feature of the recommendations also. The Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria,

1990) also recommended that the definition of childbirth be expanded to include not only the labour and birth but all of pregnancy and the subsequent transition to parenthood. Furthermore, existing antenatal classes be reorganised to take the needs of young women and adolescents into consideration and be made available to this cohort as separate classes was stressed and that women from diverse cultural programs be able to access culturally appropriate childbirth education programs. That women were entitled to make their own choice of infant feeding and that this right be respected by all health care providers was a key feature of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) recommendation. Included also in the recommendations was the notion that assistance and advice proffered in the postnatal period to women be consistent with hospital policy and specialist services offered by the hospital and that mental health issues such as postnatal depression be included in discussions in childbirth education programs offered. Two other key recommendations in this category included the provision for continuing education for rural midwives via distance education and that suitably qualified midwives be accredited to practice normal midwifery in both hospital birth centres and labour wards of the time.

Issues related to education comprised a large number of the key recommendations from the report. Some of these included: the transfer of midwifery education to the tertiary sector; a review of midwifery curricula to include issues such as women's health, birthing options, mental health issues, childbirth education; the wider role of the midwife outside of the hospital setting; the inclusion of follow-through of 2-3 women by midwifery students; and that a direct entry university midwifery degree be developed. In relation to childbirth education programs, the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) recommended that all childbirth education programs have established standards of practice and that providers be accredited. Furthermore it stipulated that these be at tertiary level and be based on adult learning principles with all programs required to have explicit aims and objectives and that courses be evaluated.

Medicine was also targeted and recommendations included that the role of the general practitioner be expanded to include the obstetric care of women. This would include a review of the Diploma in Obstetrics in relation to the birthing context. Another key feature was that medical curricula would reflect the practice of normal childbirth and consider a multidisciplinary input and furthermore, that midwifery and medical students share a common multidisciplinary training period in order to fully appreciate the principles of childbirth.

By far the area that seemed to have copious recommendations directed at it was the hospital sector. The majority of the recommendations centred on making the birthing experience a more positive one for the women. Key recommendations included the expansion of hospital-based birth centres and the support for midwife-led clinics and team midwifery care and the continuity of care for women with high-risk pregnancies. A feasibility study to explore the concept of free-standing birth centres and the establishment of more appropriate birthing environments be considered were also key recommendations. Amongst the numerous recommendations was that the needs of women from diverse cultures be taken into consideration through the use of literature and female care givers if required and that improved responsiveness to their needs was essential. It was also recommended that hospitals be explicit about their philosophy of care and the services they provided including childbirth education programs and their rates of intervention to name two aspects. Models of care that monitored birth interventions and their outcomes were recommended.

Of particular interest to the researcher are the recommendations targeted at hospitals with regard to midwives. These were that the role of the midwife as the provider of all aspects of midwifery care to the woman having a normal pregnancy and birth be recognised and acknowledged by hospital policy and practice; and that any hospital who was proposing to allow independent midwives visiting rights to that hospital, establish a committee to accredit such midwives. Furthermore, the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) also suggested that protocols governing the practice of independent midwives in birth centres and labour wards be established. A final key recommendation for hospitals was the development of shared care programs.

The Government and the Australian College of Midwives Inc. (ACMI) also had recommendations directed at them predominantly centred on policy and education. The following are examples of some of the key recommendations. The establishment of an education campaign directed at community awareness of postnatal depression coupled with a postnatal support service was touted and that there be a central register of childbirth education programs that all women were able to access. It was also recommended that the ACMI be responsible for the development of continuing education programs for those midwives who wished to practice either in the community or independently, especially with regard to establishing their practice. There was also an expectation that ACMI, in conjunction with several peak medical bodies, would be responsible for drafting guidelines for clinical privileges for midwives wishing to practice in conjunction with medical colleagues. In relation to policy issues, recommendations were made that Standards for the Practice of Midwifery be adopted; that any Review of the Nurses Act should, in fact, enhance the professional identity of midwives and recognise their capacity as primary care givers; and that ACMI should be the registering authority for midwives wishing to practice independently.

Whilst the majority of recommendations focussed on the categories mentioned above, a few key recommendations focussed on the role that community had to offer. In particular it was recognised that the role of the community health centre could be expanded to include public maternity care. There was encouragement for funded research projects to explore the issue of early discharge with support from community resources; and finally, it was recommended that Health Department Victoria (HDV) commence dialogue with the Commonwealth regarding funding midwifery services provided outside of the traditional hospital model.

In examining the key recommendations in the preceding discussion, what became abundantly clear is that the provision of maternity services was very fragmented. A model for the comprehensive provision of maternity services in the State at the time did not exist. The following section discusses the context of midwifery practice in the decade since the review.

6.2.3 The context of midwifery practice since the Ministerial Review (1990)

The period following the publication of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) has seen several significant reports with regard to the provision of maternity services in Australia. A summary of some key features of the more recent reports follows.

The report of The Midwifery Workforce in Australia 2001-2012 (Australian Health Workforce Advisory Committee, 2002) (AHWAC, 2002) described the state of the midwifery workforce at the time, in particular its adequacy and its ability to meet the requirements of an adequate workforce in the future. It concluded what was already known anecdotally, that there was a shortage in the midwifery workforce at the time (AHWAC, 2002).

There were many aspects of midwifery that the Committee examined, however of particular interest to the researcher were midwifery education and the varying models of care available for women at the time.

Based on the premise that midwifery care should be provided by people with midwifery qualifications (AHWAC, 2002, p. 1), the report found that that there was a wide range of midwifery courses that produced graduates with varying knowledge and skills. Apart from this was the fact that there was "no consistency ... regarding course length, clinical time, structure of clinical placements ..." (AHWAC, 2002, p. 21). The conclusion with regard to the education of midwives was an existence of a disconnection between the industry and those that prepared the graduates for the workplace (AHWAC, 2002, p. 25).

The authors identified the various models of care available to women at the time: private maternity care, public hospital clinic care, public hospital midwives clinic, birth centre care, shared maternity care, combined maternity care, team midwifery care, caseload midwifery care, GP/midwife public care, outreach midwifery care and planned home births. From this it can be seen that the models of care available included having different care providers and different birth settings (AHWAC, 2002, pp. 26-31), and that there had been an expansion of services from those available at the time of the Final Report of the Ministerial

Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990). The authors (AHWAC, 2002, p.26) also stated that women should be enabled to make informed choices during their pregnancy and in order for this to be possible, there needed to be "quality, evidence-based information."

Two overarching recommendations of this report stand out. Firstly, that there was a "need for government, nurses and midwives, the university sector, and public and private health services to work together in order to ensure an adequate midwifery workforce" and secondly, that " information and data on the availability and utilisation of different models of care in each state is fundamental to workforce planning" (AHWAC, 2002, p. 86). It is the researcher's opinion that both of these recommendations have implications for the education of midwives and by association childbirth education.

A state-funded inquiry into the future direction for maternity services in Victoria was undertaken in 2004. The focus of this inquiry was to develop a framework for strategic changes that would guide the development of maternity services in Victoria in the following 5-10 years (Department of Human Services, 2004, p.1) (DHS, 2004). The framework developed as a result of its findings was one which consisted of three levels of care based on the service needs of the woman rather than the facilities available at a given institution (DHS, 2004, p. 2). This framework acknowledged the expertise of midwives across the continuum of pregnancy, labour, birth and parenting, in particular, normal pregnancy and birth. In fact, the findings reiterated that midwives are the best-placed provider of the type of care that women were demanding (DHS, 2004, p.3). This was not dissimilar to findings in the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) that women with normal pregnancies, labours and births are best serviced by midwives as their primary carers.

Of note is the report's summary which acknowledged the midwifery labour workforce shortage and the need to revise how maternity services are provided in the state. To this end they concluded that the proposed new model would provide women with greater choice and control of their birthing experiences and that midwives would be key providers in primary midwifery care (DHS, 2004, p.

18). It would seem that this is one lesson 'unlearned' from the practices at the time of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990). The question of course is, why?

A follow-on report at national level, entitled Improving Maternity Services in Australia. A Discussion Paper from the Australian Government (Department of Health and Ageing, 2008) (DHA, 2008), identified that the preferred model of care is one based on continuity of midwifery care. It was found that this model had many positive outcomes for the woman including reduced interventions in labour, reduced caesarean section rates, enhanced consumer satisfaction, and a reduction in health care costs (AHMAC, 2008, p.9). The concept of continuity of midwifery care or a midwife-led model of care is supported by Hatem et al. (2009, p.2) who state that "... most women should be offered midwife-led models of care, ..." An implicit assumption is that in order for midwives to provide this skilled care their education must be such that they have the requisite knowledge and skills to do so.

The Improving Maternity Services in Australia. The Report of the Maternity Services Review (DHA, 2009) was the result of the Discussion Paper from the Australian Government which investigated the possible development of a National Maternity Services Plan (DHA, 2008).

Of the many significant issues identified by the Improving Maternity Services in Australia. The Report of the Maternity Services Review (DHA, 2009), the ones that were of particular interest to the researcher are as follows: the discord between members of the midwifery and medical professions with regard to how to manage risk and consumer preferences; the changes required in order to allow women a greater choice of available models of care by expanding midwives' roles; and the provision of improved access for women to information with regard to pregnancy, birthing and postnatal care (DHA, 2009, p. 2).

Women who had contributed to the Improving Maternity Services in Australia. The Report of the Maternity Services Review (DHA, 2009) did so out of their own dissatisfaction with or lack of choices that had been available to them. Women cited the differences in their expectations of the chosen model of care and how the care provided impacted on them and the lack or difficulty in

sourcing appropriate information which enabled them to make an informed choice regarding their pregnancy, labour and birth. This has been an ongoing issue for consumers from as far back as the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990). The Improving Maternity Services in Australia. The Report of the Maternity Services Review (DHA, 2009) stipulated that in spite of the challenges facing policy development, the goal should be to enable women to make informed choices.

This Improving Maternity Services in Australia. The Report of the Maternity Services Review (DHA, 2009) acknowledged that pregnancy, labour and birth was a normal process. However, whilst safety and the quality of care in this normal process was not disputed by either midwifery or medical professionals, it was how this care was delivered that caused discord between and amongst its members. The authors stated:

> ... it would be remiss to always use it as an excuse not to change practice. In maternity services, where most pregnancies follow a normal pattern, we must ensure, first, that practice is based on evidence and, second, that we are not allowing our safety and quality concerns to prevent us acting on evidence that supports changes to practice. Risk must always be a carefully monitored balance of safety and informed choice (2009, p. iii).

The Improving Maternity Services in Australia. The Report of the Maternity Services Review (DHA, 2009) recommendation that midwives have a greater role in the provision of maternity services has implications for their education and credentialing. The form that this expanded practice might take is yet to be determined or actioned, however, it may have impacts on existing undergraduate midwifery education across the curricula of existing programs (DHA, 2009, p. 44).

Newnham (2010, p. 245) believes that "Australian midwifery is at a crossroads" and that important, previously obscured issues have been highlighted by the publication of the Improving Maternity Services in Australia. The Report of the Maternity Services Review (DHA, 2009). She claims that whilst there is a government push to expand the available choices of models of care for women, it would seem incongruent for this to occur within a framework of maternity services controlled by medical parameters (2010, p. 245). Newnham draws on

Barclay's (1995) belief that there is an inherent danger for midwives to becoming professionalised as this often means a professional likeness to traditional medical models (Barclay cited in Murphy-Black, 1995 & Newnham, 2010) of engagement with women. From Newnham's perspective, midwives, and therefore midwifery, continue to face complex issues ahead (2010, p. 255).

6.2.4 Summary

The publication of the reports discussed above has highlighted significant issues. The first of these is that despite the time interval that has passed since the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) government reports both at state and federal level, still report consumer dissatisfaction with the choice and type of models of care. Furthermore, midwifery and obstetrical workforce shortages still exist, and there continues to be a push for the better utilisation of the knowledge and skills of midwives as a means to address, in part, some of the workforce shortage. Of particular concern is the identification of the disconnection between the health industry and those that prepared graduates for practice. This, of course, has implications for the higher education sector and of course, the workplace.

On a positive note the second issue reveals that, since the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990), Victoria's maternity service consumers have seen the development and implementation of a greater choice of models of care. Whilst much work remains to be done it is a way forward for the providers of these services. The reports have also identified an opening of the dialogue with regard to midwives' access to the Medical Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) albeit under a collaborative team-based model of care. This will have implications for the education of midwives (DHA, 2009).

Third, in the past two decades there have been several reports into the provision of maternity services at both state and federal levels with the intent of improving services. There are lessons that could have been learned much earlier but with which the health sector is still grappling with. Some

improvements in maternity services provision are evident. However much remains to be done and taking into account the findings and recommendations of the various reports, it is the researcher's opinion that midwives will experience considerable change in the coming decade as recommendations are taken up and actioned.

Finally, there is growing support for a repositioning of maternity services on a national scale. The popularity amongst childbearing women and their partners of midwifery-led models of care has demonstrated the need for their continued growth and availability across the health care services. They have had the flow-on effect of improved outcomes for their consumers, a fact not lost on the providers [health service agencies]. A key feature throughout this period of change and transition has been the recognition of the worth of the midwife as a fundamental provider of primary childbirthing services but also in terms of the cost to the health sector which provide these services (AHMAC, 2008; DHA, 2009 & Hatem et al., 2008). As a consequence, this has had an impact on the education that prepares midwives for practice.

6.3   TEACHING AND LEARNING

Childbirth educators were employed, in the first instance, as midwives, and were in many situations, used as teachers to provide childbirth education to the women who would give birth at the agency at which the childbirth educators/midwives were employed. Concurrently with their teaching role, these childbirth educators were invariably undergoing an intense learning experience themselves as educators. Each educator had a different style of learning, which was dependent on her background and previous education. From this the educator formulated her teaching methods on a largely individual basis.

Given the various models of childbirth education that abounded in the practice context, it was reasonable to examine traditional models of learning and teaching in order to locate those identified in this study in the context of accepted models of teaching, learning and evaluation of the teaching and learning.

The following discussion provides the reader with firstly, the definition and exploration of the meaning of education in the context of the study. This is followed by a discussion of the meaning of osmosis, again in the context of the study. A discussion on Situated Learning Theory will illustrate how the childbirth educators learnt their teaching skills in the context of their workplace. Following this a description of the phenomenon in the context of the participants' experiences is provided and finally, the voices of the participants, literature and my own are drawn together under the metaphor of osmosis.

6.3.1 Education defined

The word 'education' has several meanings according to the Macquarie Dictionary. These include "the act or process of educating; the imparting or acquisition of knowledge, skill, etc. The result produced by instruction, training or study. The science or art of teaching; pedagogics." (1992, p.11) This definition implies that there exists a particular method or framework of acquiring the knowledge and skills to be a teacher as well as to be able to impart the skills and knowledge to another person(s), that is, as teacher. For the purposes of this study it should be understood that the participants' experience of education is a reflection of the above definition to varying degrees. It is also important to note that in the analysis that follows, there are two concurrent practices occurring, that is, the learning of the childbirth educators and the teaching that they conduct (for their clients) putting into practice what they learn themselves (the techniques of which are often divorced from accepted teaching theory).

Behaviourist theory provides one explanation for the process of learning, in this case, that of the participants taking on the educator role. One such theorist, Huckabay (1980) states that learning/education results in a changed behaviour and that this changed behaviour is retained as a permanent feature of the learner (childbirth educator) that cannot be seen. She describes the learning situation as having three distinct components: these are (1) the learner [childbirth educator], (2) the stimulus situation [the expectant woman and her partner's thirst for information] and (3) the resultant behaviour known as the response [the expectant woman and her partner's satisfaction with the information presented as evidenced by course evaluation]. For some of the participants their description of their experiences would suggest that their

particular view of education as being incongruent with that described by Huckabay (1980). It is this snapshot of each participant's experience of educating, underpinned by Huckabay's (1980) educational theory, that is central to the discussion in this chapter.

6.3.2 Situated learning and Community of Practice

Situated Learning Theory has been arbitrarily aligned, by some, with the paradigm of constructivism, which posits that learning is an active, constructive process. Its proponents believe that "…people actively construct or create their own subjective representations of objective reality" (Learning Theories Knowledgebase, 2008). More importantly, especially in the context of this study's participants, learning occurs in a contextualised setting and new information is linked to prior knowledge (Learning Theories Knowledgebase, 2008). It is this particular worldview that underpins the theory of Situated Learning as discussed by Lave and Wenger (1991).

According to Lave and Wenger (1991, p. 35), the act of learning is embedded within a particular activity that is, in turn, situated within a particular context and is informed by the culture of that context. This opposes the traditional view of knowledge acquisition in the classroom as happening out of context, that is, abstractly. This contextual learning is referred to as situated learning. As few of the participants came to their role specifically to undertake childbirth education, the concept of situated learning explains well how many of the participants learnt the role of childbirth educator. The defining characteristic of this learning is a process referred to as legitimate peripheral participation according to Lave and Wenger (1991, p. 29). It is this type of situation that leads a learner to become involved in what the author refers to as a "community of practice (CoP)" described as having three essential components: a domain, a community and a practice. One of the central tenets of this CoP is that as a beginner "… moves from the periphery of a community to its centre, she becomes more active and engaged within the culture and eventually assumes the role of an expert" (Lave & Wenger, 1991, p. 69). In this study this concept is exemplified as the novice childbirth educator joins a midwifery team, assumes her role in the practice of childbirth education, observes her peers in many cases, and as she becomes more experienced, over time she becomes the

expert. Furthermore, Lave and Wenger argue that situated learning is usually not an intentional process, not deliberate. This unintentional learning, the CoP and becoming an expert within the CoP is referred to by Lave and Wenger as the process of "legitimate peripheral participation" (1991). For many of the childbirth educators, this was not intentional but was a means to working in the midwifery team.

The principles that underpin situated learning as a general theory of knowledge acquisition are firstly, knowledge needs to be presented in a contextual setting and secondly, in order for learning to occur, social interaction and collaboration are prerequisites (Lave & Wenger, 1991; Cope, Cuthbertson & Stoddart, 2000; Edwards, 2005). For the childbirth educator their learning was an integral and inseparable aspect of their practice, particularly so in the early part of their childbirth education career. This is legitimated by Lave and Wenger (1991) who argue "legitimate peripheral participation is … a descriptor of engagement in social practice that entails learning as an integral constituent" (p. 35). For the purpose of understanding how some of the participants learnt how to be childbirth educators, the concept of legitimate peripheral participation provides the framework with which to understand the childbirth educator's learning of the skill of how to teach. Embedded within the notion of situated learning are the concepts of implicit and explicit knowledge.

As the phenomenon emerged from the data it became apparent that it did not represent a static situation but rather a changing one. This is discussed within the concept of osmosis. Thus the phenomenon 'education by osmosis' encompasses the analysis, that is, the researcher's interpretation of the documented experiences of fourteen childbirth educators. It provides a snapshot of how they came to be involved in childbirth education, their own preparation for their teaching roles, their teaching processes and how they delivered [the art of teaching] and what they perceived to be, the appropriate content [curriculum development] to their clients, the expectant parents. It also highlights the demands made by the clients, which in turn contributed to the childbirth educators' learning. Furthermore it also describes their collegial working experiences with other health professionals and their hopes for the future of childbirth education. All of this becomes clearer within the discussion of the themes which follows.

6.4   THE PHENOMENON: EDUCATION BY OSMOSIS

Three major themes contribute to the phenomenon labelled as 'education by osmosis: 'High pressure of osmosis: varied motivations' represents the means by which several participants assumed the role of childbirth educator, as in many cases childbirth education was not the primary reason for taking up the position.   'Semi-permeable membrane of osmosis: obstacles, struggles and progress' represents the change in the delivery of course content over time where the change was client-driven. The participants seemed powerless to deliver the set content and thus there was discrepancy and disagreement between what was taught at one point in the course to what was taught at the same point in the next course. The third theme, 'low pressure (equalisation) of osmosis: establish roles and status' is the researcher's interpretation of the experiences of the childbirth educators as they worked alongside other health professionals in the delivery of their programs; this theme also presents the participants' aspirations and hopes for the future of childbirth education programs. Within the three main themes, sub-themes are also presented and discussed, illustrating their link(s) to the major theme and the phenomenon itself.

6.4.1 Osmosis defined

According to the Macquarie Dictionary (1992, p. 1257), the term osmosis is derived from the Greek word osmos meaning a thrusting. It provides several definitions of the word osmosis, one being "the diffusion of fluids through membranes or porous partitions." Another definition is "the tendency of a fluid to pass through a semi permeable membrane into a solution where its concentration is lower, thus equalising the conditions on either side of the membrane." A simplified explanation of osmosis is "the movement of fluid from a high concentration to an area of lower concentration." This definition aptly describes the descriptions of experiences of particular participants because there was movement of knowledge from one area [set course content] to another area [change in course content], which was largely client-driven. This represents the rate of osmosis. Yet the experiences of other participants were suggestive of a selective diffusion process whereby only some information was delivered to clients. This was not an intentional behaviour but rather one that

occurred due to the barrier(s) that existed for the participants such as their own level of education and their own preparation for the teaching role. However, it is a third definition in particular, "a process of interchange or absorption suggestive of osmotic action," that is also used in the context of the following discussion. This particular definition is seen to be an apt description of education described by the participants because it mirrors the meaning of the word osmosis as a thrusting, that is, education [to teach] was thrust upon some of the participants (Kirkpatrick, 1987). Just as osmosis is dependent on several variables for it to occur, for some childbirth educators, learning how to be a childbirth educator occurred as a result of a push-and-pull method of learning. By this it is meant that some childbirth educators learnt unintentionally how to teach by watching peers deliver childbirth education classes [the 'push']; others attended in-service sessions, read about teaching and generally tried to educate themselves how to teach [the 'pull']. This notion of learning was explored in the discussion in 6.3.2 with regard to the concept of situated learning.

6.4.2 High pressure of osmosis: Varied motivations

Through reflective interpretation of the thematic analysis of "A childbirth educator perchance?" and "A childbirth educator by design" the metaphoric imagery of the high pressure state of osmosis evolved. The experience of pregnancy and childbirth is a significant event in any family. The support of women having babies changed during the second half of the twentieth century from having the midwife as the predominant care-giver during the labour and birth, to an increasingly medicalised experience which took advantage of new technologies and interventions that were designed to improve the obstetrical outcomes for both the mother and her baby. Coupled with this was the loss, in many cases, of the support of the extended family to often-fragmented support systems with regard to pregnancy and parenting skills. This led women to look to the health care providers, predominantly doctors, nurses and midwives, for their information needs (O'Meara, 1993c).

The adverse effect of the medicalisation of childbirth resulted in the gradual erosion of the women's decision-making with regard to their labour and birth, which led to the loss of control for the women of their birthing experience

(O'Meara, 1993a; Willis, 1983).   However, the tide began to turn in the latter part of the twentieth century with the gradual return of some of the lost control back to the women giving birth (Oakley, 1979).

In 1990 the then Health Department of Victoria (HDV) released its Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990). As discussed in Chapter One the scope of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) was to review the practices existent in the birthing services in Victoria with the intention of providing expanded freedoms and choices for women with regard to their birthing experiences. At the time of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) changes were already occurring in how childbirth was conducted.

Through extensive consultation the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) perhaps for the first time, provided a medium for both consumers and providers of birthing services with the opportunity to voice their concerns with regard to the services and practices available at the time, as well as the means through which to express their respective needs.   This was not, however, without its criticisms in the Interim Report (2008), particularly from the medical community who felt that allowing the use of direct quotations from stakeholders bestowed a certain sense of negativity about the systems at the time (Health Department Victoria, 1990).

The Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) found that there was overwhelming consumer and to a lesser extent, provider dissatisfaction with childbirth education programs available at the time. This was supported by Kuczynki (1984), Jacoby (1988) and Hillan (1992) who found that whilst there was a plethora of information available to expectant couples, it did not provide adequate preparation for the experience of labour, birth or parenting. Research by Robitaille and Kramer (1985), Sturrock and Johnson (1990) and Hetherington (1990) equated the quality of antenatal education with the

obstetric outcome and of course, this fell short in many instances. An Australian study conducted after The Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) found that despite stated dissatisfaction with the information presented in childbirth education programs, educators continued to deliver the same content (O'Meara, 1993c).

With regard to childbirth education programs, The Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) highlighted the need for programs to be firstly, underpinned by adult learning principles and that these same programs be located in the tertiary education sector. The goal was to have programs that were grounded in sound educational principles with respect to teaching, learning and evaluation. The rationale for soundly developed programs was premised on the notion that they would allow childbirth educators to facilitate the learning of the consumers and as a result, achieve the goal of adequately preparing the woman and her partner for pregnancy, childbirth and parenting.

The first central theme highlighted several gaps with regard to childbirth education programs in existence at the time of data collection. Childbirth educators came to the field with varying levels of midwifery experience, reasons for becoming involved in childbirth education, and preparedness for teaching childbirth education. In many cases each had their own idea of what a childbirth education program entailed and, in some cases, this did not reflect consumers' expectations. This was not inconsistent with research carried out by O'Meara (1993c) and Nolan (1997). Several of the participants were expected to provide childbirth education classes if they wished to return to the midwifery workplace; this did not necessarily provide the consumer with a childbirth educator who was qualified to conduct adult learning classes. The lack of a defined pathway to becoming an appropriately qualified childbirth educator contributed, in the researcher's opinion, to consumer dissatisfaction identified in the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990).

In some cases, childbirth educators had to share their role with other health professionals in educating women for the transition to becoming a parent.

Some childbirth educators saw this as an erosion of their traditional role as midwives. Other childbirth educators had to compromise program content as the obstetricians sought to gain, or maintain, control of what was taught in the childbirth education programs.

The lack of a defined pathway into childbirth education, the varying expertise and motivations of childbirth educators, the erosion of the traditional role of midwife-as-educator, and the controlling obstetricians gave rise to what the researcher has interpreted as the "high pressure of osmosis" within childbirth education at the time.

6.4.3 Semi-permeable membrane of osmosis: Obstacles, struggles and progress

The metaphor 'semi-permeable membrane of osmosis' evolved from the researcher's interpretation of 'A state of disharmony,' 'Structured madness, 'Modified madness,' and 'Mended madness.' These sub-themes, clustered together, emphasised the sense of discord for childbirth educators. Faced with diverse obstacles in delivering program content, many childbirth educators spent considerable time and energy navigating a way forward for both themselves as educators and for the programs they were involved with.

Some childbirth educators remained with the status quo and continued to deliver preset programs even though research by Hillan (1992) indicated ongoing dissatisfaction with programs. Others observed peers and then emulated them. O'Meara's study confirmed that courses were not tailored to meet the clients'' expectations (1993c). This was also mirrored in the study by Beaton and Gupton (1990). Some childbirth educators merely added to what they perceived was missing in childbirth education programs conducted by other health professionals. However, a small number of participants took it upon themselves to undertake formal childbirth education programs interstate. They then developed, implemented and evaluated their own programs. The behaviour of this particular small group of childbirth educators was in keeping with one of the recommendations of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) which espoused that all childbirth education programs be evaluated. This process was not without its struggles as childbirth educators

struggled with peers, employers and colleagues in implementing their programs that were a change from the status quo and that, in some instances, appeared to challenge colleagues, particularly from other disciplines.

The findings from the second theme clearly identified the need for the standardisation of not only childbirth education programs but also the education of the midwives delivering them. Whilst some programs were considered to be well organised, others gave the impression that there was no particular structure to the content. The findings of O'Meara's (1993c) evaluation of childbirth education programs from both consumer and provider viewpoints would support these findings. It found that providers of childbirth education delivered content which they believed women should have and that consumers found to be not useful for their needs, a situation not incongruent with the findings of Ho et al.'s (2002) study.

In spite of the shortcomings of many of the childbirth education programs in existence, there were however, several participants that described efforts to adjust program content to better meet the needs of consumers. This saw an alignment of like-minded childbirth educators making changes to program content based on consumer feedback. Progress was made in some instances however, for the most part, it was haphazard at best. Whilst the most likely goal for these educators was to meet client demand and satisfaction with the respective programs, for others it centred on regaining control of the traditional midwifery role. These particular childbirth educators saw pregnancy, labour, birth and parenting as a natural process, with the woman being the driving factor as to how she would birth. This particular viewpoint should be welcomed by all midwives as a key recommendation of the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) proposed that midwifery education be transferred to the tertiary sector and that a direct entry midwifery degree be developed and implemented in the tertiary sector (p. 151). It would be the cornerstone philosophy underpinning the direct entry Bachelor of Midwifery which was offered for the first time in Australia in 2002. This was the beginning of the move to establish midwifery as a discipline in its own right.

With few resources, a lack of understanding from the employers regarding these shortfalls, a seeming lack of being duly qualified for the role of childbirth educator for some, and interprofessional rivalries evident in many cases, contributed to what the researcher has interpreted as a state of disharmony. However some changes were apparent, such as childbirth educators who undertook to duly qualify themselves for their role; others reflected, amended and improved their programs. These changes in the environment led to the researcher's interpretation of the situation as the semi-permeable membrane of osmosis.

6.4.4 Low pressure (equalization) of osmosis: Establish roles and status

The themes of 'The collective experience,' 'Claim on the territory,' 'A glimpse of maturity,' and 'The evolution of the vision' led to the reflective interpretation of the findings of the last theme as the low pressure (equalisation) of osmosis. This metaphor represents a snapshot of how the childbirth educators settled into their roles. Having overcome obstacles in embedding their programs in many cases and in other cases, struggling with both peers and other health professionals with regard to program content, the childbirth educators were able to establish themselves as legitimate members of the multidisciplinary team with control over their discipline and hence what was taught to consumers. This had the effect of more harmonious working relationships and could be attributed to the fact that as time progressed, they became more experienced and more confident in teaching, a fact that is supported by Bloom's mastery learning model (Huckabay, 1980).

According to several participants, as they became more experienced they felt empowered to become more assertive in their roles. This had the flow-on benefit of providing, in some cases, programs that were entirely under the control of the childbirth educator but without impinging on the roles of their interdisciplinary colleagues. This change in the childbirth educators' behaviour is supported by Carroll's model of instruction which ascertains that time is needed for a learner to learn (Huckabay, 1980). It also had the added benefit of lowering the tensions that existed previously. The working dynamics of the relationship between the childbirth educators and their colleagues from other

disciplines also seemed to undergo changes, with a more collegial working relationship fostered.

Participants saw the need for their own formal education and acknowledged that childbirth education was, in fact, a necessary component of the childbearing journey. Several recognised that being involved in childbirth education had in fact, enabled them to further themselves in terms of education and in some cases, their positions as midwives. This kind of progression towards taking control comes from the perspective of maturity, that is, the childbirth educators' experience and confidence within the role.

As discussed above, the struggles and progress evident in the "semi-permeable membrane of osmosis" eventually settled as childbirth educators established themselves in their roles and amongst colleagues and peers. This process, albeit many years apart, was legitimised in Improving Maternity Services in Australia: A Discussion Paper from the Australian Government (2008) (Improving Maternity Services, 2008). This paper sought to identify the types of services available to expectant women and their families throughout the childbearing journey including six weeks post birth. An underlying premise of the final report of this discussion paper, the Maternity Services Review (2009) was that:

> Women and their babies must be the focus of maternity care. They should be able to feel they are in control of what is happening during pregnancy, childbirth and the postnatal period, ... we must recognise that pregnancy and childbirth, while requiring quick and highly specialised responses to complications, are normal physiological processes, not an illness or disease. (p. 1)

By acknowledging the process of birth as a normal life-event, the Maternity Services Review (2009) gave credence to those childbirth educators who strove to regain aspects of childbirth education that had been taken on board by other disciplines.

The Maternity Services Review (2009) identified the need to expand the scope of maternity services for women, in particular, the option to be able "to choose, where clinically appropriate, a midwife-led service" (p. 14,) and the involvement of the tertiary education sector in supporting education and training to enhance

midwifery services (Maternity Services Review, 2009). This endorsement of the worth of midwives, and childbirth educators by association, reflects societal shifts in the recognition of midwives as the primary carers of women during their childbearing journey.

Of note also is the development of formal childbirth education courses which indicates professional and community acceptance and confirmation of both childbirth education programs and childbirth educators. Whilst the reform agenda acknowledges that improvements in CBE were required, it nonetheless does not get near as much attention compared to the larger reform agenda. However, there remains room for improvement.

The Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) recommended that all midwifery curricula have childbirth education as part of core content, in addition to the follow-through of women by student midwives and the introduction of a direct entry midwifery degree. It took another eleven years for the latter two components to eventuate. However, whilst the amount of content with regard to these differs in the various curricula within the state, it has, in the researcher's opinion, strengthened midwifery curricula and the status of its practitioners. Midwifery is now largely leading its own discipline.

Peer acceptance of the childbirth educator as a professional had the effect of fostering more harmonious and collegial working relationships. As childbirth educators gained experience they became empowered and assertive and the notion of gaining formal childbirth education qualifications blossomed amongst some participants. Others witnessed their own personal and professional growth as midwives. The inclusion of childbirth education as core content in the new midwifery curricula served to strengthen midwifery as a discipline in its own right and by association, the legitimacy of the childbirth educator. It is these transitions that are reflected in the metaphoric imagery of the "low pressure (equalisation) of osmosis.'

6.4.5 Summary

The phenomenon termed as 'education by osmosis' by the researcher overarches three themes: 'high pressure of osmosis: varied motivations;' 'semi-

permeable membrane of osmosis: obstacles, struggles and progress;' and 'low pressure of osmosis: establish roles and progress.' These have depicted the experiences of a group of fourteen childbirth educators.

Their experiences ranged from their arrival into the forum of childbirth education through undefined pathways, navigating through a maze of often unstructured programs and delivery methods, through to their dealings with peers and colleagues whose ideas of childbirth education did not always reflect their own. Childbirth educators dealt with many shortcomings in their respective positions including interprofessional rivalries which gave rise to disharmonious working relationships.

In spite of difficulties encountered there were changes in the area. Childbirth educators gained formal qualifications in childbirth education and this had a flow-on effect for the quality of programs. Time also saw the inclusion of childbirth education as core midwifery curricula content. A richer knowledge of childbirth education and their proponents has been gained through the exploration and discussion of the themes that evolved from the experiences of the study participants. A discussion of the limitations follows.

6.5   LIMITATIONS OF THE STUDY

Whilst the aim of this study was to provide an understanding of the lived experiences of childbirth educators in Victoria in the years immediately following the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990), limitations exist.

As this study was a qualitative study it cannot be replicated or generalised but it can be verified. It was a deliberate attempt to gain the insights of the participants in the context of their practice. As a result it was a snapshot of the experiences of a particular group of childbirth educators at a particular time.

The second limitation relates to the size of the sample. It could be claimed that the size of the sample may have presented biased viewpoints but the researcher attempted to overcome this by ensuring that participants were not from the same employment institution. The participants represented diversity in

years of practice as well as work contexts. The study did not gauge consumer experiences, however this was not the intention of the study.

The third limitation is that of the length of time since data collection. The researcher's progression was hampered due to circumstances beyond her control. However, the data has been set against the historical movement of childbirth education from 'then' to 'now.' Hence this study now is poised to take advantage in progressing the understanding of current childbirth education as outlined in the recommendations.

6.6 RECOMMENDATIONS AND IMPLICATIONS FOR CHILDBIRTH EDUCATIONS PROGRAMS AND MIDWIFERY

There exists the potential for further research into how well expectant women and their partners feel they are prepared for the parenting role. This concept is not new. A study conducted by Lovie (1999) identified a discrepancy in parents' preparedness for parenting. This study recommended a change in the format of childbirth education programs. There is therefore, a need to further research the status of childbirth education programs in existence at the present time. The next study will focus on the contemporary experiences of childbirth educators and examined in the light of data presented here as a way to reveal from childbirth educators themselves the movement of midwifery as a discipline in relation to childbirth education. Research that considers the viewpoints of consumers of childbirth education programs in the changing landscape of maternity services at the present time could also be conducted.

Given the recommendations of the various reports into maternity services provision both at the state and national level, there are implications for further education of midwives with regard to childbirth education programs and education in general. This education would be directed at preparing midwives for expanded practice in the first instance but also to continue as advocates for the childbearing women and couples as well as for the discipline of midwifery itself.

6.7 CONCLUSION

This study examined the experiences of childbirth educators with the view to understanding how their programs were developed, implemented and evaluated. A phenomenological framework and case study approach to obtain rich data from the study participants was used which allowed the researcher to gain insight into childbirth education programs at the time.

The phenomenon 'education by osmosis' reflects the participants' journey of entering the field of childbirth education by various means, familiarisation with the art of being childbirth educators, and finally settling into their roles. The experiences demonstrated to the researcher that the childbirth educators considered their journey one of personal learning and growth albeit fraught with difficulties at times.

The time since the Final Report of the Ministerial Review of Birthing Services in Victoria: Having a Baby in Victoria (Health Department Victoria, 1990) has seen the publication of various reports with regard to the provision of maternity services in Australia. There is a call in these reports for an expanded role for the midwife which would entail further education and by association, further research into the educational preparation of Australia's midwives.

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APPENDIX A

15th September, 1995

Ms V Brown
PO Box 132
WOODEND, Vic. 3442

Dear Ms Brown,

RE: Project No. 25/95 Childbirth Education Programs in One Australian
State: A Phenomenological Study

I am writing to confirm that the RMIT Human Research Ethics Committee at its
meeting on 13th September, 1995 considered and approved the above named
project.

As you may be aware there is a reporting requirement associated with the
granting of approval. If the project is less than a year a final report is required; if
the project is more than a year annual reports are required.

A copy of the report form is enclosed for your information and use.

M D Knight
Secretary
RMIT Human Research Ethics Committee

Encl: 1

cc   Dr Z Schneider, Faculty of Nursing
Dr P Miller, Faculty of Social Sciences & Communication
Dr N Bruni, Chair, Faculty of Nursing Human Research Ethics Committee

MDK:vsa

APPENDIX B

THE LIVED EXPERIENCES OF VICTORIAN

CHILDBIRTH EDUCATORS

The following questionnaire has been designed to explore various aspects of childbirth education.

Participation is voluntary and confidentiality will be strictly maintained throughout the project, **for this reason I ask you not to write your name on this questionnaire.**

There will be no identifying reference to the institution or the individual in the final report.

Your consent will be deemed to have been given by completion of this questionnaire. You may withdraw at any time from the project.

Thank you for your participation in my research project.

Vera Brown.

INSTRUCTIONS TO PARTICIPANTS

Please read each statement carefully.
Tick the appropriate box.
Where requested give brief explanations.

1. Please indicate your age group.

   under 25   ☐
   25 - 30   ☐
   31 -35   ☐
   36 - 40   ☐
   41 - 45   ☐
   46 - 50   ☐
   50 and over   ☐

2. Please indicate where you obtained your initial nursing qualification.

   Hospital based course   ☐
   College based course   ☐
   Other   ☐ Please specify _____

   _____

   _____

3. Years of experience as a childbirth educator. _____

4. Define "childbirth education" (i.e. what it means to you)._____

   _____

   _____

   _____

   _____

5. Length of the childbirth education course that you teach._____

6. How was the **length** of the course that you teach determined?_____

_____

_____

_____

7. How do clients join the course? _____

_____

_____

8. Time of day that course is held:

_____

_____

9. Who developed the current program? _____

_____

10. How was the **content** of the course determined? _____

_____

_____

_____

_____

11. Are you free to add or delete content to/from the course?

yes ☐
no ☐

Please comment on your answer _____

_____

_____

12. Are you satisfied with the content that you are teaching?

yes ☐
no ☐ Please specify _____

_____

_____

_____

13. What type of resource materials are used in conjunction with the teaching?

audio ☐
audiovisual ☐
other ☐ Please specify _____

_____

_____

14. How many clients are in the class? _____

APPENDIX C

1. Explanation to interviewee re consent, confidentiality, non-identifying information & right to withdraw.

   Are there handouts associated with the course?

   Would I be able to have a copy of any of these handouts, please?

2. What is CBE?

3. How do you see yourself in relation to CBE?

4. What is in your course?

5. Length of course.

6. How do the clients go about joining the course?

7. At what time of the day/evening is the course held?

8. Who developed your current program?

   Depending on answer:
   eg: Charge nurse - why? experience? qualifications?
       Physiotherapist
       Clinician - input from others?

9. Do you have a choice in what you teach?

10. Are you happy with the content that you are teaching?

    Depending on answer:

11. If you had the choice, what would you add or take out of the program that you are involved with?

    If yes, what and why?

12. What steps would you need to follow if you wanted to change aspects of your course?

13. To what extent have you been involved in the development of the program that you are teaching?

14. How was the length of the course determined?

15. What type of AV material is used in conjunction with the teaching?

16. What type of material is created specifically for the course by yourselves?

17. What variety of clients do you get?
    ? reproductive biology clients
    ?ethnic groups
    ?Arab women

18. Do there seem to be any problems that are specific to
    these particular groups?

    If so: ask for clarification.

19. Do you vary the content of your course according to the
    clients that enrol?

20. What do you think of client program evaluation?

21. How do you know that the clients have learnt?

22. How do you know that your teaching has been successful?

23. Do you have any means of getting feedback fom your
    clients?

    Depending on answer:

24. Have you had any direct experience with program evaluation
    made by clients?

    Depending on answer:

25. What is the general response of these clients to the
    program?

26. Are any changes made to the content based on what your
    clients tell you in the evaluation?

    If yes: can you tell me about some of the changes that you
    have made based on the findings of this feedback?

27. Could you tell me about the most "exciting" class that
    you've held?

    What made it exciting?

28. Have you had any "disastrous" experiences with a class or
    in a class?

    If yes: what happened?

29. Have you rejected the idea of getting feedback from your
    clients?

    Depending on answer ask why.

30. Post- registration qualifications.
    Length of time as CBE educator.