Preparing for birth and parenthood
Report on first-time mothers and fathers attending NCT antenatal courses
Authors’ contributions
The questionnaires were piloted by Cristina Augood in 2008; Cristina then left NCT and has not had further involvement. Caroline Muller and Mary Newburn developed the questionnaires for the study in 2009. Caroline was responsible for managing the longitudinal study, data entry, quantitative analysis and report drafting up to June 2010. Sarah Taylor carried out analysis and report drafting from June 2010. Mary Newburn carried out most of the qualitative and policy-related analysis, drawing on her experience of NCT and knowledge of maternity research and policy. Cristina, Caroline and Sarah were employed by NCT as researchers. Cristina is a medical doctor with training in public health. Caroline and Sarah have social science backgrounds and had no prior involvement with NCT. Mary is head of research and information at NCT, and has been employed by NCT for over 20 years. Prior to that she trained and practised as an NCT antenatal teacher. Her background is in sociology and public health.
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NCT is grateful to the parents who attended an antenatal course at St Georges Hospital taught by NCT’s antenatal teacher Gail Werkmeister for the use of this photograph.

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Executive Summary

In 2009 a longitudinal study was carried out to explore the experiences, feelings and views of parents attending NCT antenatal courses across the United Kingdom (UK). The aim was to evaluate NCT courses as a model of preparation for birth, breastfeeding and becoming a parent. We wanted to explore how well parents’ needs were met. The study also provided an opportunity to learn about parents’ experiences of birth, the maternity services and life with a new baby. Eligible women and men were asked to complete an online questionnaire at the end of their antenatal course (mean 38 weeks of pregnancy) and a follow-up questionnaire when their baby was around three months old. The questionnaires included structured questions and questions respondents could answer in their own words.

- Approximately 4,200 individuals, pregnant women and their partners, were booked onto NCT antenatal courses ending in May 2009. Of these 75% were eligible for inclusion in a survey, having consented to future contact.

- NCT contacted 1,584 women, inviting them and their partner, or other birth companion who had attended the course, to participate. Altogether, 47% of pregnant women (738/1584) and 12% of male partners (190/1560) responded. All course attendees except three couples whose baby had died were contacted again when their baby was around three months old. Post-birth, 24% of mothers (380/1581) and 4% of fathers (65/1557) responded. There were linked data for 213 mothers and 20 fathers. Over 95% of parents were expecting their first baby. The findings reported are for first-time mothers and first-time fathers.

- Antenatal courses provided up to 12-20 hours of teacher/breastfeeding counsellor contact time.

The summary findings are presented here in five main sections: reasons for booking an NCT course; findings about NCT courses; plans and preferences for labour and birth; women’s experiences of labour, birth and maternity care; men’s experiences of birth; experiences of the early weeks of parenthood; and experiences of breastfeeding. These are followed by a summary of recommendations.

Reasons for booking an NCT course

- The most common reasons women gave for booking an NCT course were to meet other parents (97%) and to prepare for becoming a parent (96%).

- Nine in 10 came to NCT to get ‘evidence-based information from a reliable source’ (91%), to find out about different methods of pain relief (87%) and prepare for breastfeeding (92%).

- Two thirds of first-time mothers said that they wanted ‘a great deal’ of information about pregnancy and birth (68%).

- First-time mothers’ attitudes towards and preferences for birth preparation were varied:
  - Around half indicated that they wanted to prepare for a ‘natural’ birth and to find out about hospital procedures (51%).
  - A third (34%) wanted to find out about hospital procedures and did not want to prepare for a ‘natural’ birth.
6% wanted to prepare for a 'natural' birth and did not want to find out about hospital procedures.

8% indicated that they came to NCT neither to find out about hospital procedures nor to prepare for a 'natural' birth.

**Findings about NCT courses**

**Meeting other new parents**

- Virtually all expectant parents (women 97%; men 100%) said their NCT course provided a useful opportunity to meet other parents.

**Information**

- After the course, 80% of first-time mothers and 91% of first-time fathers felt that their NCT course provided evidence-based information from a reliable source.

- Men valued having information about the birth process, a structured process to help them think through decision making, preparation for supporting their partner, and the opportunity to be part of a participative group with other expectant parents.

**Confidence about birth**

- The confidence of first-time mothers and fathers about birth rose significantly after attending the course (women: before the course 3%, after the course 48%; men: before the course 1%, after the course 55%).

- First-time mothers who had attended a full-length 'standard' NCT antenatal course (16-20 hours teaching time over several weeks) reported a higher level of confidence about birth than those who had attended an 'intensive' NCT course (12-15 contact hours, often two six-hour birth preparation sessions, plus a breastfeeding preparation session).

- Reflecting after birth, three quarters of first-time mothers said that they had felt prepared for their experience of birth (51% quite prepared, 26% very prepared) and four in five felt either fairly confident (58%) or confident (19%) during birth.

- First-time mothers who strongly agreed that their midwife had supported them were more likely to feel confident, as were those who gave birth at home or in a birth centre, and those who had a spontaneous birth.

- Attending an NCT course may therefore have a positive impact on first-time mothers’ confidence during childbirth. However, as many factors influence feelings during labour and birth in order to be sure a randomised controlled trial is needed.

- Reflecting after birth, four out of five first-time fathers said they had felt prepared for their experience of birth (51% quite prepared, 30% very prepared) and three quarters either fairly confident (60%) or confident (25%) when their partner was in labour and giving birth.

**Becoming parents**

- At the end of their course, six out of 10 women and around half of the men said they knew all they needed to about where to turn to for help, where to meet other parents, and how tired they might be in the early weeks with a new baby.
Considerably fewer women and men indicated that ‘they knew all they needed to’ about looking after their baby (21%; 18%), such as babies’ crying and sleeping (28%; 27%). However, in written comments some acknowledged that participating in the facilitated antenatal group had encouraged them to become a confident parent, using their own resources and believing in their own abilities.

For men, the NCT course gave a real sense of the demands on women of having a new baby, modelled infant care as a shared activity, and addressed changes in couple relationships.

Reflecting after birth, 83% of men said that ideas discussed on the NCT course about how to support their partner had been useful.

**Confidence about becoming a mother or father**

Around one third of first-time mothers (36%) and nearly half of first-time fathers (48%) said they felt confident about becoming a mother or father respectively after the course, compared with a small minority (10% and 15% respectively) before the course.

Three months after birth, there was no difference between how prepared women or men said they had felt according to the length of their antenatal course, but more women who had attended full-length courses reported feeling confident about life with their new baby compared with those who had attended intensive courses.

**Preparation for breastfeeding**

At the end of the course, 91% of both women and men felt that their course had provided a good preparation for breastfeeding, though almost two thirds of parents (65%) wanted more information about baby feeding in general, and 57% of mothers and 49% of partners wanted more information about breastfeeding.

Post-course, first-time mothers who had attended a full-length course more often reported feeling confident about feeding than women completing intensive courses and this difference remained at three months.

Reflecting after birth, 80% of women and 87% of men felt the information on breastfeeding provided on the NCT course had been useful. One in five women (20%) and one in eight men felt the information had been either ‘not very useful’ or ‘not at all useful’.

One in three first-time mothers (32%) and 15% of first-time fathers who had been on an NCT antenatal course (n=960) contacted an NCT breastfeeding counsellor for help and support after the birth.

**Overall assessments**

19 out of 20 first-time mothers (95%) and first-time fathers (94%) agreed or strongly agreed their teacher ‘did a good job’, and would recommend the course to other parents.

97% of first-time mothers and 91% of fathers felt their needs were met by the course.
Plans and preferences for labour and birth

- 53% of first-time mothers planned to have their baby in a hospital labour ward; 36% planned to go to a birth centre (28% alongside a hospital, 8% a free-standing birth centre) and 11% planned a home birth.

- 99% planned to have their partner with them to provide emotional support when giving birth, and 11% were also thinking about having a female family member with them in addition to their partner. One woman was planning to give birth without a companion and 15% were planning to have a female companion, mainly in addition to their life partner. Thirteen had employed a doula.

- Two thirds of first-time mothers (67%) said they wanted ‘a minimum quantity of drugs to keep the pain manageable’; around a quarter (23%) said they would be willing ‘to put up with quite a lot of pain in order to have a completely drug-free labour’, and 6% said that they wanted ‘the most pain-free labour that drugs could give them’.

- Over nine in 10 women said they would like to use ‘natural ways to help cope with contractions’ (96%), including both movement and different positions (97%) and focused breathing (97%). Most wanted to use a birth ball (82%) and around two thirds also wanted to use a TENS machine (71%) or a birth pool (71%).

- Two thirds of women ‘strongly agreed’ that they expected midwives to ‘fully support’ (66%) and ‘fully involve’ (69%) them during the birth. Rather fewer expected this would be the case during their postnatal care (54% and 61% respectively).

Women’s experiences of labour, birth and maternity care

- 85% gave birth in a hospital labour ward, 9% gave birth in a birth centre, either alongside a hospital (7%) or in a free-standing unit (2%) and 6% had a home birth.

- 45% had a spontaneous vaginal birth, 24% had assistance with forceps or ventouse and 31% had a caesarean birth (25% emergency and 6% planned).

- 67% of first-time mothers who gave birth vaginally did so lying on their back (48% in stirrups), 14% were standing, squatting or kneeling, 8% were sitting or supported by pillows and 6% gave birth in a pool.

- 60% of first-time mothers who had attended an NCT course said their birth was not how they had expected it to be, including a third (33%) who felt this ‘strongly’.

- More than half did not have the kind of birth they had wanted (56%).

- Although 60% of women said that their birth was not how they had expected it to be, 64% agreed with the statement ‘my birth was a positive experience’.

- Most first-time mothers used a variety of self-help approaches for coping with pain in labour: 89% used focused breathing, 81% used movement; 78% used ‘other’ low-tech, non-invasive approaches such as massage, rocking and relaxation, 57% used a birth ball and 26% used a birth pool.

- Only one third of women who would have liked to use a birth pool were able to use one during labour.
• Fewer than half were encouraged by a midwife to use a birth ball (44%) and only a quarter (23%) were encouraged to use a birth pool.

• First-time mothers who gave birth spontaneously received different levels of midwifery support for working with pain during labour depending on where they had their baby. A high level of support from midwives* was more often reported from women who gave birth at home (56%) or in a birth centre (64%) compared with a hospital labour ward (31%).

(* Indicted by encouragement to use four or more of the following non-invasive approaches: birth ball, birth pool, movement and different positions, massage, rocking, relaxation and focused breathing.)

• 21% of women were left alone during labour, birth or shortly afterwards when it worried them, including 16% who were left alone and worried at some time during labour.

• 75% of first-time mothers who had a caesarean agreed or strongly agreed that the obstetrician fully involved them during the birth. Over half (54%) said they were given options about procedures such as having the screen lowered, holding their baby skin-to-skin, or finding out their baby’s sex themselves.

• Around half of those who commented about their caesarean birth expressed positive views about the quality of care they had received. Around one in six who commented expressed negative comments from disappointment to frustration or shock.

Men’s experiences of labour and birth

• 98% of first-time fathers were present at their baby’s birth and 85% felt the birth had been a positive experience.

Preparation for life with a new baby

• Late pregnancy was a time of anticipation and uncertainty for women and for men. They anticipated that life with their new baby would involve lack of sleep, a major life change, changes for them as a couple, and changed relationships with friends and family.

Life with a new baby

• Three months after the birth, four major themes emerged from the women’s and men’s comments about how their life had changed: a complete change to a baby-focused lifestyle, feelings of joy and fulfilment, lack of time for things other than looking after the baby, and lack of sleep.

• Using a scale of 0-5, where 0 represented ‘no problem’ and 5 ‘major problems’, 11% of first-time mothers and 5% of first-time fathers indicated that feeling low or depressed was or had been a problem (score 4 or 5). Six percent of first-time mothers and 2% of first-time fathers said boredom was or had been a problem (score 4 or 5).

• None of the men talked about feeling worried, anxious or depressed themselves, though a few mentioned stress, or arguments with their partner, and financial pressures or the importance of ‘job security’. Almost half of the men (48%) had been worried about their partner’s health since their baby’s birth.

• First-time parents often find the first week particularly challenging and they need to be prepared for this.
Some first-time mothers and fathers said they felt ‘best prepared’ for breastfeeding their baby, practical babycare and coping with the reality of their new role. However, a significant group of first-time mothers and fathers wanted better preparation for a range of issues including: the reality of breastfeeding in the early days and ways of responding to breastfeeding difficulties; using bottles and formula milk, practical babycare, and coping with the reality of motherhood or fatherhood, such as coping with their baby’s persistent crying.

At three months, six in 10 first-time mothers and fathers described themselves as ‘confident’ (rather than ‘fairly confident’ or ‘not very confident’) about life with their new baby.

Only 3% of first-time mothers and no first-time fathers said they felt ‘not very confident’ about life with their new baby at three months.

**Baby feeding**

Almost all of the first-time mothers were intending to breastfeed in the first three months (99%): 92% said they planned to breastfeed exclusively, and 7% planned to mixed feed, combining breastfeeding with giving formula milk.

Of those who said during pregnancy that they planned to exclusively breastfeed their baby for the first three months, two thirds (67%) said they had done so, 31% had breastfed and introduced bottle-feeding with formula milk at some stage, and 2% formula fed exclusively. There is no information available on patterns of mixed feeding.

**Summary of recommendations**

Parents’ suggestions for improving NCT courses should be actively considered by NCT and other antenatal education providers, including:

- Make more use of web-based information and offer access to it for parents while on the course.
- Provide access to other parents’ anonymised reports about birth, feeding and the early weeks with a new baby, to get a better understanding of the range of experiences, a taste of the lived reality and ways to tackle common challenges before the baby comes.
- Focus more on what to expect in the days after birth and the following early weeks, including more on practical babycare (how to change a nappy, bath, feed and wind a baby, possible illnesses, colic and nappy rash) and breastfeeding difficulties.

Ensure that courses of similar format provide a similar standard of opportunity for participative parent-to-parent learning and support, e.g. invite first-time parents to attend courses with their new baby and provide a reunion session.

Information should be available for parents prior to booking a course to let them know that longer courses tend to be associated with greater knowledge about birth and feeding, and increased confidence.

Maternity services and children’s centres in England developing provision of antenatal education, in the light of the Department of Health *Preparing for pregnancy, birth and beyond* recommendations,
should offer parent-centred, participative courses and factor in this dose-response relationship.

- Parents booking shorter courses should be particularly encouraged to consider participating in NCT branch activities and Early Days postnatal courses, so they can access additional opportunities for informal support and structured discussion.

Labour and birth

- NCT teachers and activists should encourage midwifery managers and their local maternity services liaison committee to actively review the use of supine positions and stirrups for birth.
- Parents should be told about local hospital practices and the advantages and disadvantages of different birth settings.
- Most women planning birth in hospital who wanted to use a birth pool were not able to do so during labour, so maternity services should review their provision to increase opportunities. Fortunately, this was not the case for women who gave birth at home or in a birth centre.

Motherhood and fatherhood

- The findings suggest that NCT needs to review antenatal course objectives, taking account of the needs identified by parents in this report. In addition to the curriculum content and time allocated to postnatal issues, consideration should be given to the availability of relevant written information and access to support, including breastfeeding support, in the early days after the birth.

Baby feeding

- Women and their partners should be able to access relevant information and support about a range of feeding approaches and to feel that support is available to them regardless of feeding method, particularly in the early weeks after birth.

Future research

- To increase opportunities for participation in NCT research and increase the response rate for pregnant women’s partners, NCT should develop its IT system to enable email addresses for all course attendees to be recorded, not just the person booking the course. This would make it possible for both partners to be contacted directly.
- Further research is needed to explore the finding that a high proportion of women found labour and birth different from what they had expected, with one in four feeling unprepared, and over half not having the kind of birth they wanted.
- Further research is also needed on parents’ experiences of looking after a newborn baby, particularly the first week of motherhood and fatherhood, and what kinds of preparation are helpful.
Background

In the United Kingdom (UK), antenatal classes or ‘parentcraft’ sessions are attended by around two thirds of first-time mothers and most welcome and involve expectant fathers to some degree in a number of the sessions. Courses are provided by the National Health Service (NHS), either in a maternity unit or a local health setting, and by others including voluntary sector organisations and independent practitioners, who either charge a fee for their courses or have a contract with a health service provider.

Courses are generally aimed at preparing parents for birth and becoming a parent, though the specific aims, objectives and methods are rarely made explicit. The curriculum, the teaching approaches and training of the facilitators, are many and varied. The format and number of sessions offered is another point of difference. There has been relatively little research or evaluation of the different kinds of courses and the extent to which they are effective or valued by parents.

A recent review questioned the focus and adequacy of current provision in supporting parents with ‘the psychological and biologically-driven processes that both men and women face as part of what has been defined as the transition to parenthood’. The authors found little evidence that the techniques taught in ‘traditional childbirth classes’ can reduce pain in labour and limited evidence of an association with a higher incidence of vaginal birth or a reduction in the use of epidurals. However, they reported that ‘antenatal education is associated with higher levels of satisfaction with the birth experience’ and that ‘antenatal group work with an interactive component (involving) local experienced breastfeeders as volunteers; and the combination of multimodal education/local support programmes combined with media campaigns’ is an effective intervention in supporting initiation and continuation of breastfeeding.

Another review by the same team concluded that the evidence for ‘antenatal group-based parenting programmes’ showed limited effectiveness, but suggested that the sessions may ‘improve a range of outcomes such as dyadic adjustment, maternal psychological well-being, parental confidence, and satisfaction with the couple and parent-infant’.

NCT antenatal services

Courses focus on preparing for labour and birth, baby feeding and life with a new baby. During their training, each NCT practitioner develops objectives for the courses and sessions they lead, which must be approved by NCT tutors. There are no standardised aims and as a result there may be considerable variation between courses. The first NCT preparation for birth courses, established in the 1950s, were based on the work of Grantly Dick Read who believed that women and their partners should understand the physiological process of birth and that relaxation skills could help to break the fear-tension-pain cycle. Approaches have evolved and changed since then, influenced at different times by psychoprophylaxis, feminism, childbirth activism, consumerism, sociology, anthropology, epidemiology and adult learning theory.
NCT offers antenatal courses throughout the UK for small groups of parents with up to 20 hours of facilitated contact time. This model is based on parents booking a course and paying to attend, with reductions for those in receipt of means-tested benefits. The courses come in a variety of formats:

1. Traditional format antenatal courses with a total length of 16-20 hours teaching time over several weeks, usually including one dedicated breastfeeding preparation session, and a ‘class reunion’ afterwards when parents meet up again with the teacher, bringing their babies with them. Sessions usually last for around two hours, so there may be 7-9 sessions before the birth.

2. ‘Intensive’ courses involving 12-15 contact hours during pregnancy. Sessions usually involve two medium length days (of around six hours) plus a separate breastfeeding session.

3. ‘NCT Yoga for pregnancy’ and ‘Relax, stretch and breathe’ courses can be organised either using a ‘pay as you go’ drop-in format or as a course with a set number of sessions. Some women pay in advance for a course with a fixed number of sessions and then continue to drop-in to sessions after their course has finished if spaces are available. Teachers who lead both of these types of course have undertaken extra training. Teachers who have completed the full NCT Yoga for pregnancy course may call their classes ‘NCT Yoga for pregnancy’. Both types of course include yoga-based relaxation, breathing, stretching and body awareness. Sessions usually last from 1.5-2 hours. Fixed length courses may be either full-length or intensive (as above). One woman participating in the survey said that she had attended an NCT yoga for pregnancy course.

4. ‘Perinatal’ courses involve a total of 26-30 hours, made up of around 18 hours of antenatal preparation including a breastfeeding session and six sessions (or 12 hours) including a ‘reunion’ and postnatal discussion sessions after birth.

The most common course formats are full length and intensive courses. Both of these formats usually involve some women-only and some partner-only group work, either within a session attended by both women and men or as separate single gender sessions. Most NCT antenatal courses include a two-hour breastfeeding session led by an NCT breastfeeding counsellor. These are usually designed as mixed gender sessions attended by both women and men.

In England, NCT has service delivery contracts with the NHS and children’s centres, where sessions are available free of charge. These courses may include three or four two-hour sessions. The longest-standing contract is with Birmingham Women’s Hospital, where NCT has carried out an evaluation of parents’ experiences of the course. In addition, numerous NCT-trained teachers and breastfeeding counsellors are employed by NHS trusts and boards and by local authorities, or hired on a sessional basis, to deliver drop-in antenatal preparation sessions or courses to parents. NCT also runs drop-in antenatal sessions in Styal Prison.
Most antenatal sessions on a course are led by an NCT-trained antenatal teacher. The breastfeeding session is usually led by an NCT-trained breastfeeding counsellor. NCT also offers postnatal courses facilitated by NCT-trained postnatal leaders. A key component of the NCT model is the development of a mutually supportive group of women and couples, as well as encouragement to join and contribute to a wider community support network centred on the local NCT branch. NCT branches are run by parent volunteers working alongside the NCT-trained practitioners (antenatal teachers, breastfeeding counsellors and postnatal leaders). Some of these parents, both trained practitioners and others, become active in advising local maternity services.

NCT research suggests that women and men value meeting other parents-to-be, gaining information about labour and birth, and being able to discuss issues of common concern.\(^8,9\) Paid-for classes, attended by around 9% of first-time parents who responded to a recent large representative survey in England,\(^2\) tend to include more sessions in a course and involve fewer parents, so there is more opportunity for discussion and small group work. An earlier study showed that parents attending NCT classes have very high rates of satisfaction with the amount of factual information provided (men, 94%; women, 96%) and an increase in confidence about giving birth as a result of attending the course (men, 92%; women, 93%).\(^9,8\) However, there is also evidence that parents would like more opportunity to focus on the impact of becoming a parent and responding to the practical and emotional demands of looking after a new baby.\(^9,10\)

In recent years, developments to NCT services have included ‘integrated’ perinatal courses which run from pregnancy into the postnatal period, rollout of postnatal Early Days courses,\(^11,12\) and the development of telephone helplines.\(^13\) Another innovation has been ‘NCT Yoga for pregnancy’ and ‘Relax, stretch and breathe’ courses.\(^14,15\)

It is important for NCT to gain feedback from parents on how they regard the services provided. A decade after the last major evaluation,\(^8,7\) it was agreed that there should be another nation-wide survey of parents attending NCT antenatal courses.

This report describes the aims and objectives, the research methodology and results, as well as making recommendations. Two articles have already reported some findings of the survey.\(^16,10\)
Aims and objectives

The study on which this report is based was designed to research the interests, aspirations and experiences of a group of first-time mothers and first-time fathers around the time of birth, and to evaluate NCT’s model of antenatal preparation for birth, becoming a parent and breastfeeding. NCT antenatal courses represent one of the most recognisable public faces of NCT and the study was aimed to enable the charity to assess the acceptability and usefulness of the courses in relation to parents’ perceived needs and experiences. The findings will inform the development of NCT services and provide evidence for managers, researchers and policy makers comparing and contrasting different models of antenatal preparation. They will be particularly relevant for commissioners of antenatal preparation services who want to understand NCT’s approach and impact.

In more detail, the objectives were to explore and evaluate:

- what women and men expecting their first baby wanted from an NCT course, including their self-reported information and support needs and their reasons for booking;
- their perceptions of their level of knowledge and confidence about labour and birth, and life with a new baby, including feeding their baby;
- their experiences and views about birth, the early weeks of new motherhood and fatherhood and feeding their baby;
- how well, and in what ways, they felt the NCT courses met their needs in preparing for birth, parenthood and breastfeeding, including what was valued and any criticisms;
- how attendance at different models of course (full-length or intensive courses) affected outcomes;
- the extent to which participants continued to meet parents from the course.

The report findings are structured chronologically, starting in chapter 4 with why expectant parents chose to book an NCT course, their plans and preferences for labour and birth, the support they anticipated receiving from midwives, the perceived usefulness of the course as a means of preparation, and their own assessment of their confidence before and after attending the course. Chapter 5 reports on women’s experiences of labour and birth, aspects of maternity care and the perceived usefulness of antenatal classes. Chapter 6 addresses the needs, roles and experiences of men as expectant and new fathers. Chapters 7 and 8 discuss preparation for life with a new baby, and expectations and experiences of the earliest weeks of new parenthood, including the opportunities NCT antenatal courses provide for meeting and making friends with other parents at the same life.
stage. Chapter 9 discusses baby feeding in terms of preparation, experiences and feelings of confidence after the course and at three months. The final findings chapter covers satisfaction with the style, format and content of NCT antenatal courses. The report finishes with discussion, conclusions and recommendations based on the study findings.
Methodology

The study was designed to provide a contextualised service evaluation discussing parents’ experience of their course in the context of how they experienced labour and birth, the care and support provided by NHS maternity services and the early weeks of becoming a mother or a father.

It describes and critically assesses NCT’s model of antenatal preparation in relation to expectant parents’ aspirations, preferences and expectations.

3.1 Study design

A longitudinal study was designed with data collected using self-completed questionnaires at two time points: after women and men had completed their NCT antenatal course and again after the birth. Course attendees were contacted just before their antenatal course finished, at a mean gestational age of 38 weeks, and asked to participate in the first survey after the last session. They were informed that they would be contacted again and asked to complete another questionnaire when their baby would be around three months old. Parents who completed both the post-course and post-birth questionnaires became part of the longitudinal sample. A unique self-created reference code was used to link the two questionnaires. This consisted of the first two letters of respondents’ mothers’ forenames and maiden name plus their year of birth.

All women and men who attended an NCT antenatal course ending in May 2009, and who had given their consent to be contacted by NCT, were eligible to take part in the study. This included pregnant women, male and female partners, and birth companions who were not life partners. Where an email address was provided, pregnant women (and subsequently birth mothers) were sent an embedded link to the questionnaire, and also asked to forward a link to their partner or birth companion so that they could also complete a questionnaire online. Mostly email addresses were women’s, but some were partners’ personal addresses or were joint couple addresses. A small number of parents with no active email address were sent a questionnaire by post (8% for the post-course questionnaire and 13% for the follow-up post-birth questionnaire). One and three weeks after dispatching the questionnaire first and second reminders were sent. Parents were given the opportunity to decline to participate if they did not wish to take part.

3.2 Focus of the evaluation

The key focus of the evaluation was parents’ perceptions of how well NCT antenatal courses prepared them for labour and birth, baby feeding, and life with a new baby. The longitudinal design enabled the research team to compare parents’ views and evaluations of the usefulness of the course both immediately after attending and after they had experienced birth and several weeks of life with their new baby. The post-course questionnaires were very similar for pregnant women and their partners. They included questions on the following:
• Preparation for labour and birth, including views on information, perceived levels of knowledge and preferences.

• Plans for childbirth, including planned place of birth and birth companion(s), and expectations of midwives.

• Preparation for becoming a mother or father, including caring for and feeding their baby.

• Self-assessed levels of pre-course and post-course confidence in relation to birth, parenthood and baby feeding.

• How well parents/birth companions felt the course had prepared them.

• Reasons for booking an NCT course.

• Course organisation and curriculum.

• Type of course and attendance.

• Overall evaluation of the course, including value for money.

• Socio-demographic information.

A modified questionnaire was developed for non-parent birth companions. It excluded questions about preparation for becoming a mother or father and reasons for booking an NCT course, but was otherwise similar.

The post-birth questionnaire for women and men covered:

• How well prepared they had felt for becoming a mother or father.

• The usefulness of the NCT course in preparing for becoming a mother or father.

• Life with a new baby, including aspects of change, feelings of confidence, method of baby feeding and experience of any health, social or economic problems.

• Birth experiences, including place and mode of birth, experiences of labour and of caesarean section, and support from midwives.

• Views on how experiences compared with expectations and preferences.

• Self-assessed levels of confidence during birth, and about parenthood and baby feeding.

• Views on the usefulness of NCT preparation.

• Postnatal contact with other new parents and services for families, including NCT services.
• Overall evaluation of courses, including value for money and suggestions for improving courses.

Questions were repeated in case of any missing data, on:

• Type of course and attendance.
• Socio-demographic information.

Both questionnaires also included open-ended questions which allowed the respondent to add comments in their own words.

All questionnaires were piloted and modified before being used in the main data collection phase. A post-birth questionnaire was not developed for non-partner birth companions as no birth companions responded to the post-course survey.

The data were stored securely with password protected access to the database. All responses were anonymised and where written comments are quoted in the report, these are not attributed.

As almost all of those responding to the surveys were having their first baby (women: post-course 99%, post-birth 100%; men: post-course 95%, post-birth 100%), the authors decided to focus the analysis exclusively on them. The results reported in all chapters are for first-time mothers and first-time fathers only, unless otherwise stated.

3.3 Analysis

Data were analysed using SPSS18. Descriptive data are presented for women and men separately. Differences between women and men were tested using t-test or Mann-Whitney and are reported when significant. Changes over time were tested using Wilcoxon signed-rank test or Friedman’s ANOVA as appropriate. Spearman’s correlation coefficients are reported for correlation between variables. For all tests, p values of less than 0.05 are reported as statistically significant. Throughout, percentages may not sum to 100 due to rounding.

All three researchers read the free-text responses to the open questions and discussions were held regarding how to group and analyse the data. The free-text responses to open questions were coded paying close attention to the words and phrases used by the women and men. The number of cases for each code was counted. Codes were then grouped into a smaller number of emerging themes. Each of the authors reviewed comments independently. There was agreement regarding the themes identified. For some questions considered to be central to the future development of NCT preparation courses, and those where there appeared to be a wide range of different comments, all responses were coded and counted. For other questions the first 100 comments were coded and counted as it appeared that saturation in terms of key themes was reached using 100 cases. In these instances, while quotes to illustrate a particular
theme were mainly taken from the first 100 cases, other quotes were sometimes selected if they expressed a theme especially well.

### 3.4 Sample

#### Response rate

Across the UK, around 4,200 individuals; pregnant women and their partners, were booked onto NCT courses ending in May 2009. Of these, 3,144 (75%) had consented to future contact by NCT. All course bookings data are stored electronically on Intrabiz, a bespoke IT package developed for NCT. Using these data of those who had consented to further contact, 1,584 women were posted a questionnaire or sent an email with embedded links to the online questionnaires for pregnant women and their partners (including non-parent birth companions). They were asked to pass the email on to their partner or birth companion. At this time, email details for women’s partners were not collected routinely so they could not be contacted directly.

Of 3,144 parents eligible to take part, 928 completed the post-course questionnaire. The response rate for pregnant women (47%; 738/1584) was considerably higher than for partners (12%; 190/1560).

Sadly, the babies of three couples died and so they were not included in the follow-up post-birth survey. Of 3,138 parents eligible to participate in the post-birth survey, 445 responded. The response rate for mothers (24%; 380/1581) was again considerably higher than for partners (4%; 65/1557).

Linked data from the post-course and post-birth surveys were available for 213 mothers and 20 fathers, these two groups form the ‘longitudinal’ samples. Some 167 women and 45 men responded to the post-birth survey having not responded to the post-course survey.

As 25% of course attendees were not eligible to take part, having not given permission for further contact from NCT, and fewer than half of those eligible to participate responded the results are not necessarily representative, though nothing is known about the responding parents to suggest that they are different from non-eligible and non-responding parents.

#### Socio-demographic characteristics

Nearly all women responding were first-time mothers (post-course: 99% (n=690/698); follow-up: 99% (n=366/368); longitudinal: 100% (n=212/213)). All partners who responded were men and almost all of those who specified were first-time fathers (post-course: 98% (n=168/172); follow-up: 95% (n=60/63); longitudinal: 100% (n=20/20)).

All results reported are for first-time mothers and first-time fathers, excluding women and men who had a baby previously, unless stated otherwise. While it is recognised that some first-time mothers and fathers have a partner who are already a parent, this analysis does not include anyone who said they had previously had a baby.
Around half of women who responded were in their early 30s at the end of the course. Fathers were slightly older, mainly in their early or late 30s (see table 1). There was no significant difference in terms of age between the sample of parents who only completed the post-course questionnaire and those who completed both. In comparison with official statistics for England and Wales, mothers between 30 and 39 years old were over-represented in this study.¹⁷

### Table 1: Age of participants

<table>
<thead>
<tr>
<th>Age</th>
<th>Post-course mothers (n=682)</th>
<th>Post-course fathers (n=167)</th>
<th>Post-birth mothers (n=360)</th>
<th>Post-birth fathers (n=60)</th>
<th>Longitudinal mothers (n=205)</th>
<th>Longitudinal fathers (n=19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 or under</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>25-29</td>
<td>16%</td>
<td>13%</td>
<td>15%</td>
<td>5%</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>30-34</td>
<td>53%</td>
<td>43%</td>
<td>50%</td>
<td>38%</td>
<td>51%</td>
<td>32%</td>
</tr>
<tr>
<td>35-39</td>
<td>25%</td>
<td>27%</td>
<td>29%</td>
<td>44%</td>
<td>28%</td>
<td>32%</td>
</tr>
<tr>
<td>40+</td>
<td>5%</td>
<td>17%</td>
<td>5%</td>
<td>13%</td>
<td>4%</td>
<td>21%</td>
</tr>
</tbody>
</table>

Ninety four percent of mothers and a similar percentage of fathers classified themselves as White (see table 2). Parents from Black and Minority Ethnic groups were slightly under-represented in the study in comparison with the UK population.¹⁸

### Table 2: Ethnicity of participants

<table>
<thead>
<tr>
<th></th>
<th>Post-course mothers (n=677)</th>
<th>Post-course fathers (n=164)</th>
<th>Post-birth mothers (n=362)</th>
<th>Post-birth fathers (n=62)</th>
<th>Longitudinal mothers (n=203)</th>
<th>Longitudinal fathers (n=19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>94%</td>
<td>93%</td>
<td>93%</td>
<td>97%</td>
<td>94%</td>
<td>100%</td>
</tr>
<tr>
<td>Other ethnic groups*</td>
<td>6%</td>
<td>7%</td>
<td>7%</td>
<td>3%</td>
<td>6%</td>
<td>0%</td>
</tr>
</tbody>
</table>

* Other ethnic groups in the post-course sample included mixed/multiple ethnic groups (mothers and fathers: 2%), Asian or Asian British (mothers: 3%, fathers: 2%), Black or Black British (mothers: 0%, fathers: 1%), other ethnic groups (mothers and fathers: 1%). The post-birth and longitudinal samples were similar.

Some 86% of mothers and 76% of fathers who completed the post-course questionnaire had a higher education degree (see table 3). The profile of respondents to the post-birth questionnaire was similar. Parents with degree level education were slightly more likely to complete both questionnaires but this difference was not significant.
### Table 3  Education of participants

<table>
<thead>
<tr>
<th></th>
<th>Post-course</th>
<th>Post-birth</th>
<th>Longitudinal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mothers</td>
<td>Fathers</td>
<td>Mothers</td>
</tr>
<tr>
<td></td>
<td>(n=682)</td>
<td>(n=166)</td>
<td>(n=363)</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>No formal education</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>GCSE, A-level</td>
<td>13%</td>
<td>22%</td>
<td>12%</td>
</tr>
<tr>
<td>Degree/postgraduate</td>
<td>86%</td>
<td>76%</td>
<td>88%</td>
</tr>
</tbody>
</table>

The socio-demographic characteristics of this sample are broadly similar to those for parents responding to an ongoing online parents’ feedback audit of NCT antenatal courses, initiated with a pilot study in August 2010, to which 54% of eligible pregnant women and partners responded.19

### Course formats

Most of those responding had attended a full length course (see table 4). The average size of the group was 6-7 couples, with three quarters of the courses (76%, n=522) attended by 6-8 couples.

### Table 4  Course formats

<table>
<thead>
<tr>
<th></th>
<th>Post-course</th>
<th>Post-birth</th>
<th>Longitudinal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mothers</td>
<td>Fathers</td>
<td>Mothers</td>
</tr>
<tr>
<td></td>
<td>(n=681)</td>
<td>(n=167)</td>
<td>(n=357)</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Full-length course</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Intensive course</td>
<td>25%</td>
<td>27%</td>
<td>20%</td>
</tr>
<tr>
<td>Other course format*</td>
<td>1%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3%</td>
<td>3%</td>
<td>0%</td>
</tr>
</tbody>
</table>

*Yoga for pregnancy’, ‘Relax stretch and breathe’, ‘Perinatal’ and ‘other’

Most respondents in each wave of the survey attended a full-length course (table 4). Among those attending traditional full-length courses offering around 7-9 antenatal sessions, on average first-time mothers said that they had attended six sessions (mean=5.7, SD=1.88) with a minimum of one session and a maximum of 18 sessions. Partners reported attended significantly fewer sessions; the average was five sessions (mean=4.8, SD=1.76) with a minimum of one and a maximum of 12 sessions.
Birth plans, preparation and preferences

This chapter focuses first on the reasons first-time mothers gave for booking an NCT antenatal course. It then describes women’s and men’s plans and expectations for birth, including anticipated place of birth and women’s selection of birth companions. It covers attitudes and preferences in relation to: self-help approaches to preparing for labour, pain in labour and pain relief, medical procedures and monitoring, and the acquisition of information as a method of preparation. Women were also asked about their expectations regarding midwifery care during birth and in the postnatal period. Women and men were asked to indicate their level of confidence before the course and afterwards.

4.1 Reasons for booking the course

The most common reason given by women for booking an NCT antenatal course was a desire to meet other parents having a baby. This motivation was expressed by almost all of those who responded to the post-course survey (97%). Other key reasons from a list of options (see table 5) included a desire to prepare for becoming a parent (96%) and to prepare for breastfeeding (92%). Parents were not asked a similar overall question about preparing for labour and/or birth. More specific questions were asked about a range of aspects of preparation. High proportions said they were motivated to attend the course to ‘get evidence-based information from a reliable source’ (91%), to ‘find out about pain and different methods of pain relief’ (87%), and to find out about hospital procedures, ‘such as induction, epidural, monitoring and assisted birth’ (86%). Over half said they wanted to ‘prepare for a ‘natural’ birth’ (57%).

Most of those responding had had NCT antenatal classes recommended to them by someone who had previously attended a course (88%). A third had their NCT course recommended to them by a healthcare professional (see table 5).

Around half of the first-time mothers indicated that that they booked the course to find out about hospital procedures and to prepare for a ‘natural’ birth, 51% either agreed these were reasons for attending the course or strongly agreed. A small group, six percent of women, wanted to prepare for a ‘natural’ birth and did not want to find out about hospital procedures, while a third (34%) came to the course to find out about hospital procedures but did not want to prepare for a ‘natural’ birth. Eight percent of first-time mothers indicated that neither finding out about hospital procedures nor preparing for a natural birth had been reasons for booking the course.

Almost all of the women, not just those wanting a ‘natural’ birth, indicated that they were interested in using or finding out more about non-invasive self-help approaches for working with pain in labour,20,21 such as using movement and different positions (see table 6).
Table 5  Reasons first-time mothers gave for booking an NCT course

<table>
<thead>
<tr>
<th>Reason</th>
<th>Agree or strongly agree %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>To meet other parents having a baby</td>
<td>97%</td>
<td>680</td>
</tr>
<tr>
<td>To prepare for becoming a parent</td>
<td>96%</td>
<td>680</td>
</tr>
<tr>
<td>To prepare for breastfeeding</td>
<td>92%</td>
<td>675</td>
</tr>
<tr>
<td>To get evidence-based information from a reliable source</td>
<td>91%</td>
<td>676</td>
</tr>
<tr>
<td>Recommendation of someone who had been to NCT classes</td>
<td>88%</td>
<td>680</td>
</tr>
<tr>
<td>To find out about pain and different methods of pain relief</td>
<td>87%</td>
<td>676</td>
</tr>
<tr>
<td>To find out about hospital procedures like induction, epidural,</td>
<td>86%</td>
<td>675</td>
</tr>
<tr>
<td>monitoring, assisted birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To find out about or prepare for a caesarean birth</td>
<td>63%</td>
<td>671</td>
</tr>
<tr>
<td>To prepare for a 'natural' birth</td>
<td>57%</td>
<td>676</td>
</tr>
<tr>
<td>To find out things I need to know about my hospital</td>
<td>49%</td>
<td>670</td>
</tr>
<tr>
<td>To get involved with NCT</td>
<td>48%</td>
<td>674</td>
</tr>
<tr>
<td>Recommendation of a midwife or other health professional</td>
<td>32%</td>
<td>650</td>
</tr>
</tbody>
</table>

Note: question reads "Please think back to when you were first pregnant, what were your reasons for booking an NCT antenatal course?"

4.2  Intended place of birth and birth companions

Around half of women having a first baby planned to have their baby in a hospital labour ward (53%). Around a third (36%) planned to give birth in a birth centre, either in a birth centre alongside a hospital (28%) or in a free-standing unit (8%), and 11% planned a home birth. The proportions planning an 'out of hospital' birth are probably higher than for first-time mothers in the general population, though most national data are for actual place of birth, rather than planned place of birth, and a considerable proportion of women change their plans, usually for clinical reasons late in pregnancy or during labour.

Nearly all women who answered the question about who they planned to have with them to provide support when giving birth planned to have their partner with them (99%; n=640/644). Of these, 11% (n=70/644) were also thinking about having a female family member with them in addition to their partner, 15 planned to have a friend with them and 13 planned to have a doula as an additional supporter during labour and birth. One woman was still undecided about whom to have with her. Three women were not planning to have their partner with them when giving birth; two were planning to have a female companion (one a friend, one a female family member) and one was planning not to have a companion with her. Thus, in total, 15% of women (98) were planning to have a female birth companion, mainly in addition to their partner.

Most women said that their plans in relation to place of birth (71%) and labour supporters (85%) had not been influenced by attending the course. Women were not asked whether they had any risk factors affecting their pregnancy, so it is not known how many would have felt they had a full range of choices open to them. However, some women indicated in their comments that there were aspects of their pregnancy affecting their
options for care. This included expecting twins, gestational diabetes, a low-lying placenta, a heart condition, and the chance of a baby with Down’s syndrome. One said:

‘I had already decided to have my baby in hospital as I thought it was the best place. NCT classes have confirmed I have made the right decision.’

Around a quarter had given further thought to where they would like to give birth:

‘Home birth went from not even being anywhere near the agenda to right at the top. Not because the teacher was especially pro-home birth but because (the course) made us consider it as a possibility. In the end, after weighing up the pros and cons, we decided to go for it.

‘I hadn’t considered a midwife-led unit or water birth before the classes.’

‘(Our teacher) helped made me decide to have the baby in a birthing centre because I wanted to have a water birth and she pointed out that we had to maximise the chances of this by finding out how often people deliver in water at each place and find out their policies on water births.’

And some said that they would aim to stay home for longer during early labour:

‘We had always planned to have a hospital delivery (It is the place I will feel most comfortable), but since the course I do feel that I will want to stay at home as long as possible in early labour before going to the hospital, whereas beforehand I think I would have been tempted to perhaps go in too early.’

Some women commented that they had not been aware prior to attending the course that they could have more than one person with them to provide support during labour.

4.3 Preferences and plans for labour and birth

Women and their partners were asked about their preferences for labour and birth, including their interest in using low-tech, non-invasive, self-help ways to work with contractions and cope with pain. They were asked to indicate their attitudes towards pain in labour, use of drugs for pain relief, and a number of medical procedures and methods of monitoring. They were also asked about their attitude towards obtaining information as part of the preparation process.

Self-help approaches to working with contractions

NCT was interested to know what percentage of parents booking on NCT paid-for courses were coming to learn about and practice self-help approaches to working with contractions. Women and their partners were asked about their knowledge and their preferences for using ‘natural ways’ to help cope with contractions, as well as being asked about specific techniques and approaches. Other research has used the phrase ‘natural
methods, and terms such as this seem to be most easily understood within UK culture. For example, Miriam Stoppard’s book for parents says ‘Most women would like childbirth to be as natural as possible’ (p 106). Nolan has emphasised that instinctive approaches to easing discomfort and pain in early labour are similar to those used in everyday situations and parents should be encouraged to think about what they usually find helpful and adapt those approaches for labour.

Using a rating scale from ‘very much like to avoid’ through ‘avoid if possible’, ‘don’t mind’, ‘would like to have’ and ‘very much like to have’, almost all of these first-time mothers and fathers expressed an interest in using ‘natural ways to help cope with contractions’. Of four different non-invasive approaches presented for consideration, there was most interest in ‘using movement and different positions’, and ‘focused breathing’. Over 95% of the women in the study said they would like or very much like to use these approaches. A large majority also said they would like or very much like to use a birth ball (71%) or a birth pool (71%) (see table 6).

Table 6 Preferences for using self-help approaches for coping with pain during labour and birth among women and men expecting their first baby

<table>
<thead>
<tr>
<th>Would like or very much like to use...</th>
<th>Women %</th>
<th>n</th>
<th>Men %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>movement and different positions*</td>
<td>97%</td>
<td>668</td>
<td>93%</td>
<td>155</td>
</tr>
<tr>
<td>focused breathing**</td>
<td>97%</td>
<td>662</td>
<td>89%</td>
<td>148</td>
</tr>
<tr>
<td>natural ways to help cope**</td>
<td>96%</td>
<td>657</td>
<td>89%</td>
<td>148</td>
</tr>
<tr>
<td>birth ball**</td>
<td>82%</td>
<td>562</td>
<td>72%</td>
<td>119</td>
</tr>
<tr>
<td>birth pool</td>
<td>71%</td>
<td>489</td>
<td>65%</td>
<td>108</td>
</tr>
<tr>
<td>TENS (transcutaneous electrical nerve stimulation)*</td>
<td>71%</td>
<td>480</td>
<td>63%</td>
<td>104</td>
</tr>
</tbody>
</table>

* Significant difference between women and men (t-test, p≤0.05)  
** Significant difference between women and men (t-test, p≤0.01)

The partners’ questionnaire stated ‘You may feel that decisions during labour and birth are mainly for your partner to make, depending on the circumstances. However, if you have clear views on the following, please say whether you would like your partner to have — or to try to avoid — these things during childbirth’. As table 6 shows, men’s attitudes towards self-help ways of coping with pain were generally similar to those of their partner, showing the same ordering of preferences. Generally, women were more likely to express a strong preference than men.

Attitudes towards pain in labour and drugs for pain relief

To explore the attitudes of first-time mothers attending NCT classes towards pain in labour and the use of pharmaceutical methods for alleviating pain or altering perceptions of pain, NCT used questions developed and validated by Green and colleagues. Women were asked to indicate which of three options about pain and the use of drugs for pain relief they would prefer. In addition, an ‘other’ category was provided where they could specify an alternative response.
Two thirds of first-time mothers said they wanted to have ‘a minimum quantity of drugs to keep the pain manageable’ (67%; n=457/687). Another 23% (n=157/687) said they would be willing ‘to put up with quite a lot of pain in order to have a completely drug-free labour’. This is a comparatively high percentage. Among the women expecting a first baby in the Green study, 13% said they were willing to experience pain in order to have a completely drug-free labour.\(^{25}\)

In contrast, for a small group in NCT’s sample, it was an explicit priority to minimise any pain experienced during labour. One in 16 women (6%; n=42/687) anticipating labour for the first time wanted ‘the most pain-free labour that drugs could give them’, This was much lower than the percentage for first-time mothers in Green’s study (21%).\(^{25}\)

Four percent of women in the NCT study (n=31/733) indicated that none of these three statements represented their attitude towards pain in labour and pain relief. Instead they selected the ‘other’ option. Of these, eight first-time mothers explained that they planned to use self-hypnosis or planned a ‘hypnobirth’, eight reported that they would need to wait to see what labour was like in reality before they would know how they felt about coping with pain and using pain relief. Finally, eight commented that they were approaching pain in a more positive or active light, rather than thinking they would need to ‘put up with it’.

Medical procedures and monitoring

Woman and their partners were also asked their preferences with regard to a range of procedures that may be used during labour and birth. The baby’s heart can be monitored during labour in a variety of ways, including using a pinard, which is a simple non-electronic device, used intermittently, which conducts sound to the midwife’s ear; a hand-held electronic monitor, which is used intermittently, and shows the heart rate on a visual display; and a CTG (cardiotocography) monitor designed for making a continuous recording of the pressure and length of contractions and of the baby’s heart rate.

The National Institute for Health and Clinical Excellence (NICE) recommends that women without pregnancy complications or risks (‘low risk’) have intermittent auscultation (IA) throughout their labour. Even a ‘20 minute admission trace’, which some NHS maternity units suggest to low risk women, has been shown to result in more subsequent medical procedures, such as forceps and emergency caesarean section, for no demonstrable benefit in terms of babies’ health and wellbeing.

The Intrapartum Care guideline states:

‘There is high-level evidence that women who had routine admission CTGs were more likely to have interventions during labour, although there were no statistical differences in neonatal outcomes’ (p144).\(^{26}\) It continues:

‘The use of admission cardiotocography (CTG) in low-risk pregnancy is not recommended in any birth setting’ (p145) and states that ‘Women should
be informed that continuous fetal monitoring will restrict their mobility’ (p218).26

Most women 54% (n=363/678) who had attended an NCT course said that they would prefer (‘like’ or ‘very much like’) hand-held monitoring (IA) to electronic monitoring with a belt (continuous CTG). One in 10 preferred to have electronic monitoring (10%; n=68/677), but it was not clear whether these were all women with known risk factors in their pregnancy as no attempt was made to identify risk status.

Women and their partners were asked how they felt about medical induction to start labour, and about acceleration of labour (having ‘labour speeded up’). Both of these procedures involve the use of pharmaceutically manufactured hormonal agents (prostaglandins and/or oxytocin) that mimic aspects of naturally occurring hormones to stimulate the uterus. They were asked about their attitudes towards the use of pethidine or diamorphine (opioid drugs) and about epidural anaesthetic for pain relief. They were also asked how they felt about having an operative birth (forceps, ventouse or caesarean section).

Most women wanted to avoid their labour being induced or speeded up. Similarly an overwhelming majority said they would prefer to avoid a forceps, ventouse or caesarean birth, if possible. Smaller percentages but still large majorities also wanted to avoid opioid drugs (85%) or having an epidural (77%) if possible (see table 7).

A small minority of women said they ‘did not mind’ if they had a caesarean (9%) and eight women said that they would like or very much like to have one (1%). Again, the risk status of these women is not known. About one in eight women said they did not mind whether they had an epidural (14%) and nine percent said they would like to have one.

<table>
<thead>
<tr>
<th>Would like or very much like to have or try</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical induction of labour</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Acceleration</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Pethidine/ diamorphine</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Epidural</td>
<td>9%</td>
<td>11%</td>
</tr>
<tr>
<td>Forceps or ventouse delivery</td>
<td>0.1%</td>
<td>1%</td>
</tr>
<tr>
<td>Caesarean section</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Generally women’s and men’s preferences were similar (see tables 7 and 8). Though men tended to express less strong views than women, they generally shared a preference for using a minimum of drugs and avoiding operative births if possible.
Table 8  Avoidance preferences regarding medical procedures during labour and birth

| Would like or very much like to avoid... | Women | | Men | |
|---------------------------------------|-------|-------|-------|
|                                       | %     | n     | %     | n     |
| Medical induction of labour**         | 92%   | 630   | 83%   | 136   |
| Acceleration**                        | 81%   | 550   | 73%   | 116   |
| Pethidine/ Diamorphine**              | 85%   | 586   | 70%   | 115   |
| Epidural                              | 77%   | 530   | 70%   | 116   |
| Forceps or ventouse delivery**       | 95%   | 651   | 88%   | 146   |
| Caesarean section                     | 90%   | 618   | 87%   | 144   |

* Significant difference between women and men (t-test, p≤0.05)
** Significant difference between women and men (t-test, p≤0.01)

4.4 Information about pregnancy and birth

In recent decades attending an antenatal course has been a vital means of finding out about aspects of pregnancy, the process of labour and birth, and what the options might be in different circumstances. However, now there is information widely available in books, leaflets, on the internet and in mobile phone apps. Yet demand for antenatal courses indicates that expectant parents still feel a need to discuss aspects of childbirth and looking after the coming baby with other parents and a knowledgeable facilitator. NCT antenatal teachers and breastfeeding counsellors are trained to work in a parent-centred way, responding to questions with reliable, evidence-based information without being prescriptive.

NCT qualitative research and earlier survey work has shown that parents vary in the amount of information they want in preparation for labour and the extent to which they need reassurance and assistance in finding answers to their questions. At one end of the spectrum, some women want ‘to know everything’, whereas at the other some prefer to ‘wait and see’, particularly about medical procedures and the circumstances in which they might be needed. Surveys of a representative sample of pregnant women and their partners showed that first-time parents, young parents, and those from minority ethnic groups had the greatest unmet information needs.

In the current study, women and men were asked at the end of the NCT course to think back to before they started the course and say how much information they had been seeking at that time. Around six in 10 women (58%) and almost half of the men said they had wanted to know ‘a great deal’ about pregnancy and birth (see table 9).
Table 9  
Amount of information sought about pregnancy and birth by first-time parents

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th></th>
<th>Men</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A great deal</td>
<td>58%</td>
<td>394</td>
<td>47%</td>
<td>78</td>
</tr>
<tr>
<td>Quite a lot</td>
<td>33%</td>
<td>226</td>
<td>38%</td>
<td>63</td>
</tr>
<tr>
<td>Some</td>
<td>7%</td>
<td>45</td>
<td>14%</td>
<td>23</td>
</tr>
<tr>
<td>Not much</td>
<td>2%</td>
<td>10</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Very little</td>
<td>1%</td>
<td>5</td>
<td>1%</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: question reads "Thinking back to before you started the course, how much information did you want about pregnancy and birth?"

After the course 97% (n=671/690) of first-time mothers agreed or strongly agreed that they knew what to expect at birth. A similar proportion of 98% (n=672/689) also said they knew the kind of birth they wanted. Nearly all women and men agreed that the course provided information about pain and pain relief, the importance of mobility, using water and trying different positions during labour, and hospital procedures like induction, epidural, monitoring, assisted delivery and caesarean birth. Almost all expectant parents (94%), felt that they had been given evidence-based information from a reliable source (table 10).

Many NCT teachers provide the mnemonic of BRAIN to help parents make decisions that feel right for them. When parents are told that a particular course of action is planned or recommended or they are given options to consider, they are encouraged to think about (or ask about) the ‘benefits’, ‘risks’, ‘alternatives’, what their ‘instincts’ are telling them and what would happen if they did ‘nothing’ for a while. Nine out of 10 women and men said this approach had been discussed on their course (table 10).

Table 10  
Course evaluations

<table>
<thead>
<tr>
<th>Now that you have finished the NCT course, what do you think the course provided?</th>
<th>Agree or strongly agree</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Good preparation for a ‘natural’ birth</td>
<td>95%</td>
<td>681</td>
<td>96%</td>
</tr>
<tr>
<td>Evidence-based information from a reliable source</td>
<td>80%</td>
<td>680</td>
<td>91%</td>
</tr>
<tr>
<td>Information about pain and different methods of pain relief</td>
<td>99%</td>
<td>681</td>
<td>97%</td>
</tr>
<tr>
<td>Good preparation for breastfeeding</td>
<td>90%</td>
<td>680</td>
<td>91%</td>
</tr>
<tr>
<td>Information about my hospital</td>
<td>56%</td>
<td>674</td>
<td>57%</td>
</tr>
<tr>
<td>Information about hospital procedures like induction, epidural, monitoring, assisted delivery</td>
<td>96%</td>
<td>682</td>
<td>93%</td>
</tr>
<tr>
<td>Information or preparation for a caesarean birth</td>
<td>89%</td>
<td>679</td>
<td>93%</td>
</tr>
<tr>
<td>Strategy to consider benefits, risks, alternatives, intuition, doing nothing</td>
<td>90%</td>
<td>680</td>
<td>94%</td>
</tr>
<tr>
<td>Information on the importance of mobility and water in labour and trying different positions</td>
<td>96%</td>
<td>680</td>
<td>94%</td>
</tr>
</tbody>
</table>

At the end of the course over 70% of first-time mothers felt that they knew all they needed to about different self-help ways to cope with contractions, with the exception of focused breathing (see table 11), about which 43%
said that they would have liked to know more. Around half felt information had been provided about their local hospital (table 10).

Table 11 First-time parents’ knowledge about natural ways to cope with pain

<table>
<thead>
<tr>
<th></th>
<th>Women: n=684-688</th>
<th>Women</th>
<th>Men</th>
<th>Know all I need</th>
<th>Know a lot but want more</th>
<th>Know a little and want more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>TENS</td>
<td></td>
<td>83%</td>
<td>74%</td>
<td>12%</td>
<td>16%</td>
<td>5%</td>
</tr>
<tr>
<td>Movement and positions</td>
<td></td>
<td>77%</td>
<td>80%</td>
<td>18%</td>
<td>16%</td>
<td>5%</td>
</tr>
<tr>
<td>Using a birth ball</td>
<td></td>
<td>71%</td>
<td>71%</td>
<td>20%</td>
<td>19%</td>
<td>9%</td>
</tr>
<tr>
<td>Using a birth pool</td>
<td></td>
<td>71%</td>
<td>74%</td>
<td>21%</td>
<td>18%</td>
<td>8%</td>
</tr>
<tr>
<td>Natural ways to cope</td>
<td></td>
<td>71%</td>
<td>68%</td>
<td>23%</td>
<td>23%</td>
<td>10%</td>
</tr>
<tr>
<td>Focused breathing</td>
<td></td>
<td>57%</td>
<td>63%</td>
<td>27%</td>
<td>24%</td>
<td>16%</td>
</tr>
</tbody>
</table>

The majority of women and men reported that they knew all they needed to about hand-held monitoring (women: 61%, n=414/681; men: 52%, n=84/162) and electronic monitoring (women: 64%, n=435/678; men: 52%, n=84/163).

Additionally the vast majority of women and men felt that they knew all they needed to after the course about medical procedures such as epidural, pethidine (or diamorphine), instrumental birth and induction. Interestingly, patterns of response for women and for men were very similar, though the men were more likely to say at the end of the course that they still wanted more information (see table 12).

Table 12 The extent to which first-time parents’ desire for information about medical procedures were met

<table>
<thead>
<tr>
<th></th>
<th>Women: n=676-686</th>
<th>Women</th>
<th>Men</th>
<th>Know all I need</th>
<th>Know a lot but want more</th>
<th>Know a little and want more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Epidural *</td>
<td></td>
<td>88%</td>
<td>81%</td>
<td>10%</td>
<td>15%</td>
<td>2%</td>
</tr>
<tr>
<td>Pethidine/ diamorphine</td>
<td></td>
<td>86%</td>
<td>75%</td>
<td>11%</td>
<td>19%</td>
<td>3%</td>
</tr>
<tr>
<td>Forceps or ventouse</td>
<td></td>
<td>81%</td>
<td>71%</td>
<td>13%</td>
<td>20%</td>
<td>6%</td>
</tr>
<tr>
<td>Caesarean section</td>
<td></td>
<td>79%</td>
<td>74%</td>
<td>16%</td>
<td>21%</td>
<td>5%</td>
</tr>
<tr>
<td>Medical induction **</td>
<td></td>
<td>74%</td>
<td>63%</td>
<td>19%</td>
<td>27%</td>
<td>7%</td>
</tr>
<tr>
<td>Acceleration</td>
<td></td>
<td>59%</td>
<td>52%</td>
<td>25%</td>
<td>34%</td>
<td>16%</td>
</tr>
</tbody>
</table>

* Significant difference between women and men (Mann-Whitney, p<0.05)
** Significant difference between women and men (Mann-Whitney, p<0.01)

Other arrangements to prepare for a natural birth

Women were asked whether, in addition to attending their NCT course, they had made any other arrangements to prepare for a ‘natural birth’, with prompts such as attending a hypnotherapy course or preparing using a CD or DVD. A third of women (34%) said that they had made other arrangements. Free text comments about other kinds of preparation
showed that almost all of these were women practicing either yoga or self hypnosis ('hypnotherapy' or 'hynobirthing'), or they referred to both. Some were introduced to these approaches on other courses, and many had bought CDs, DVDs or books. Some were continuing a long-standing practice of yoga. One said:

'I have practiced yoga throughout pregnancy (as well as long before) and hope this will help, but I'm not fixed on the idea of 'natural birth.'

A small number said explicitly that they were encouraged to do this by their NCT teacher, and it was effectively an extension of their NCT course:

'(I used a) hypnotherapy CD which I bought which is as a direct result of the course.'

'(I used) hypnobirthing and practised breathing techniques and positions learnt on the course.'

However, this was not universal. One woman said:

'I bought a CD which I found out about at a baby show. It was not really mentioned on our NCT course, and although we did a relaxation exercise I wasn't aware of hypnotherapy.'

One woman explicitly compared her hypnotherapy course with her NCT course and said it had been more useful as a means of preparing for a natural birth:

'I've attended a Hynobirthing course which was fantastic and was much more beneficial in terms of preparation for a 'natural birth.' It covered more options and gave more facts with regards to the natural approach to labour and birth.'

Another emphasised how, despite having an interest in yoga and self-hypnosis, she found her NCT teacher’s valuing of all kinds of birth to be a positive strength:

'Yes, I have purchased a hypno-birthing CD and attended pregnancy yoga classes. That said, I am not fixated on the idea of a 'natural' birth and appreciated that our NCT teacher did not devalue 'non-natural' birthing.'

Other forms of preparation, each mentioned by small numbers of women, included buying, borrowing or hiring a birth ball, a birthing poll or a TENS machine. Some individuals mentioned hiring a doula, using massage, perineal massage, acupuncture, aromatherapy or reflexology, taking raspberry leaf tea or having a homeopathic remedy kit. It was not uncommon for women to refer to more than one kind of preparation, and some were using several:

'(I do) some basic yoga, aromatherapy. I’ve tried to stay active and mobile as much as possible, I’ve talked through birth positions / activities and practised them with my husband.'
‘Natal hypnotherapy CD, perineal massage, yoga and stretching, breathing practice, raspberry leaf tea, bought a ball, hiring a tens machine!’

4.5  Expectations about care and support during and after birth

Having expressed their preferences for the kind of birth experience they would prefer, women were asked to indicate the extent to which they expected the midwife providing them with care to support and involve them fully both during their birth and afterwards. Most had quite positive expectations; around two thirds of women agreed strongly that they expected to be fully supported and involved during the birth. A smaller proportion felt confident that they would be fully supported and involved during their postnatal care (Wilcoxon, p≤0.01) (see table 13).

| I expect the midwife... | Strongly agree | | Agree | | Disagree |
|-------------------------|----------------|---|---|---|
| ... to support me fully during birth | 66% | 451 | 32% | 217 | 2% | 16 |
| ... to involve me fully during birth | 69% | 475 | 29% | 196 | 2% | 13 |
| ... to support me fully after birth | 54% | 370 | 42% | 283 | 4% | 28 |
| ... to involve me fully after birth | 61% | 415 | 36% | 244 | 3% | 23 |

4.6  Confidence about labour and birth

Women and men were asked to think back to before they started the course and indicate their level of confidence about childbirth then and also to assess their confidence after the course. Both first-time mothers and their partners reported a significant increase in their sense of confidence about birth; after the course around half said they felt confident compared to three percent of mothers and one percent of partners before the course (Wilcoxon, p≤0.01) (see table 14).

<table>
<thead>
<tr>
<th>Before the course</th>
<th>After the course</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Not very confident</td>
<td>55%</td>
</tr>
<tr>
<td>Fairly confident</td>
<td>42%</td>
</tr>
<tr>
<td>Confident</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

A comparison was made of the confidence reported by women attending longer, ‘full-length’, courses offering a total length of 16-20 hours of antenatal teaching time over several (7-9) weeks, with shorter, ‘intensive’ courses offering 12-15 hours, usually held over two days. This showed that women who had attended a full-length antenatal course reported a similar level of confidence before the course to women who had attended an intensive course, but a significantly higher level after the course (Mann-
Whitney, p≤0.01). After a full-length course, most women (52%) felt ‘confident’, but after an intensive course only 38% felt confident; most women (60%) felt only ‘fairly confident’. There were no significant differences in terms of confidence about birth between antenatal courses of different lengths among the men, but the sample size was considerable smaller.

A detailed analysis was made of 100 of the 491 comments made by women after their course but before the birth in response to a request to ‘please explain what has affected your level of confidence’. In the next chapter the free-text responses provided by men are analysed. Of these, most first-time mothers said that they felt more confident (90), some made neutral comments or had mixed feelings (5) and a few were critical of the course or had suggestions for things they feel would have increased their confidence more (5).

Of those who felt more confident, most put this down to having gained more knowledge (17) from their NCT course, more information, including evidence-based information (15), and greater understanding about available options during labour and the possible effects or associated outcomes (12). Frequently, comments referred generally to having a better understanding of what to expect or being forewarned: ‘Having knowledge removes a lot of uncertainty and hence anxiety’. Others cited particular examples of information that they had gained referring to pain relief (3), emergency caesarean section (2) and information about the local hospital and what to expect (1). For example:

‘I have learned a lot in the course. Didn't realise I had so many choices throughout. I’m glad I learned about TENS and the effects of drugs during labour (and) I didn't know about the third stage of labour.’

‘I had read a lot already before the course started so much of it was a repeat, although still useful. The course made me aware I needed to give things like medication and c-section more thought. Although I don’t want any of it I may need it.’

‘(Our teacher) had a lot of local knowledge about what the hospital was like which the community midwives didn’t seem to talk about that much.’

Many women explained how the course had affected their confidence in some detail:

‘I found the course extraordinarily useful. I had been leaning towards the idea of as natural a birth as possible but feeling quite nervous and frightened. I found the course enormously reassuring and it transformed my confidence. After the course we decided to have a home birth which is something that I had secretly wanted but not had the confidence to push for. [The teacher] was fantastically clear and articulate and I was very very impressed with the amount of information she had and how thoroughly she covered things. The information we got about local services really helped our decision and her ability to be clear about all the choices available left us feeling much more able to make an informed decision about how we wanted to approach it.’
A doctor and a nurse also felt their confidence was increased:

'I have increased in confidence but couldn't say I am now fully confident. As a doctor having seen many deliveries I already know maybe too much of what can go wrong. I found the course very reassuring in terms of learning methods (and) being able to help steer the birth towards my preferences, while accepting the best laid plans need room for manoeuvre where necessary!'  

'Being a nurse, I do know a lot of the 'horror' stories that come from birth - my main fear is that something will be wrong with my baby due to something like a birth asphyxia for example, but at least now I have the confidence to speak up if I'm not happy about something, and am armed with a little more knowledge!'  

Many of the comments emphasised having a better understanding of the birth process and what to expect (11), including gaining reassurance that it 'is a natural process' (2). For one women, the course and the style of teaching had helped her to process some of the information she already had.

'Before the course I had read a lot of books on childbirth, but felt weighted down by all the information. This course, especially the teacher, was able to get the detail across, but in a concise manner, which helped me concentrate on what was important, which in turn has made me feel confident about the birth of my baby.'  

The second aspect of the course on which women focused to explain feeling more confident was the value of being part of a group with women going through the same process. They liked having the opportunity to learn and manage their feelings of uncertainty and anxiety by comparing experiences with others on the course:

'Meeting people who are also worried about birth and also being able to discuss openly worries that are on your mind.'  

'Sharing stories and anxieties with other mothers-to-be.'  

'Talking about birth and what happens helped me to understand what to expect. What also helped is taking to other people about their experiences and expectations.'  

Some described how forming an emotional connection with the other women and being able to laugh together relieved tension.

'Group discussions, sharing concerns, realising we each had different knowledge and experience but the same queries and worries. Having some sessions just with 'the girls' was good. And having a laugh - humour always helps!'  

One woman explained how it was helpful reading the birth stories of parents who had been on her teacher’s courses previously:
The tutor had a book in which previous groups had written their experiences - it was reassuring to hear that, despite good and not so good labours, they were all OK.

Attending the course, which involves considerable interaction with other parents, made having a baby very much a shared social experience, shared with other women and with the woman’s partner:

‘The chance to talk about it and learn more normalises it a bit. Joining a group starts to make it a positive experience (that) I’ll look forward to going through at the same time as new friends. Doing the classes with my husband has made us both more relaxed about what to expect and look forward to going through the experience together.’

The third most commonly cited reason for feeling more confident related to physical and psychological preparation for the physiological process of labour and ways of working with pain or coping with contractions. Some women emphasised that their teacher normalised childbirth by telling stories to make it familiar and framing it as something that women have been doing for centuries.

‘The NCT teacher provided stories of what had happened with her and others’ labours.’

‘(I felt more confident) knowing that billions of babies have been born before mine!’

There is clearly an overlap here with gaining knowledge and having a better understanding of the birth process, so no hard and fast distinction can be made in terms of how many women found this aspect of the courses positive. However, some comments referred specifically to women experiencing a shift in thinking towards seeing birth as a normal process, having their existing beliefs affirmed or the teacher embodying a positive attitude to birth (2).

‘In the early stages you don’t want to think about the pain. Now that I have done the class, (I feel) you almost have to embrace it.’

Some said their confidence was increased by practising relaxation and useful positions for labour and birth, and other aspects of body awareness and physical skills (8).

‘In particular I found the hypno-birthing CD that our NCT teacher played us VERY useful, it inspired me to buy my own copy which has been very confidence building. We also had a useful session on the course about massage that the birth partner can do. I would have appreciated more guidance about breathing and birthing positions though e.g. using a ball and pool.’

One women who responded to the antenatal questionnaire after the birth of her baby said that she had learnt more on an NCT Yoga for pregnancy
course but the couples course had been useful too because her partner was able to attend.

'I had been going to an NCT backed antenatal yoga course as well which to be honest prepared me more for breathing/dealing with contractions. The point of this course for me was to make sure my husband knew what I knew! Doing both courses certainly paid off - totally drug free labour at home for my first baby. Amazing!' The fourth most frequent reason given by these first-time mothers for an increase in confidence was the course having prepared their partner for labour and birth. As most women were planning to have their partner as their main provider of emotional support, alongside a midwife, their preparation was important.

'Our teacher very much focused on ensuring our birth partners knew as much as we did - now my birth feels like a shared responsibility which will give me more confidence.'

'What has most increased my levels of confidence is the knowledge that my husband is confident now; given that he will be my birthing partner, it means a lot to me.'

Some commented on how the course resulted in them being closer, having a shared understanding and an agreed approach:

'Spending time with my husband on the course ... means that we both know more about what we want and how to support each other and manage things.'

A fifth reason given for increased confidence related to the style of the course, the method and quality of the teaching, including the interactive, participative activities used during the sessions and the teacher’s knowledge and non-prescriptive approach.

'Being able to discuss and ask questions as well as being with others in the same situation. I liked that everything was very informal, no question felt too silly to ask, and our facilitator gave knowledgeable and also ‘neutral’ answers (i.e. acknowledging that everyone is different, with different needs and wishes).'

'Excellent, informative, interactive and fun teaching from NCT teacher.'

Many also appreciated the supportive relationship that they had with their NCT teacher at this uncertain time of great significance in their lives:

'Our instructor was fabulous and gave her own experiences to ease concerns and gave feelings of confidence and empowerment.'

'The teacher was the most supportive, caring, knowledgeable person I could ever have met.'
'Our NCT teacher was also very good at putting us at ease and making us feel comfortable asking any question however silly it seemed.'

Finally, some women said that they felt more confident as they would be able to communicate more effectively with health professionals during labour; to be able to express their wishes and the reasons for them.

'The course made me feel that I actually had a more realistic view of what might happen than I thought I did. I also have more confidence to know what I might request during labour and feel more comfortable about being able to communicate this.'

In terms of expectations, a few women specifically indicated that the teacher had given them the message that labour was unpredictable and had prepared them emotionally for things happening that they would not choose. Two phrases they used were 'rolling with it is not failing' and you can 'go with the flow'.

In contrast to those who explained why they felt more confident, five out of the first 100 comments explained that they were still not very confident because labour remained an unknown quantity and circumstances were beyond their control:

'Knowledge is useful but I tend not to feel confident about something until I have experienced it.'

'I am still nervous! If I was to give birth in the birthing centre I would be much more confident, but the hospital wards are very bleak ... It's as much to do with the surroundings as the knowledge.'

Of the five negative comments in the first 100 comments made about confidence, one woman simply said that she was 'still petrified'. A few others indicated that knowing more about the birth process had made them feel more anxious, because of 'knowing too much about what can go wrong!'. As NCT is particularly interested to receive any negative feedback so as to be able to learn from it, all negative comments were coded and counted. Overall, just three percent of the comments were negative (14/491).

Two women said that there was too little information provided. Several others specified too little time was spent on 'natural options', use of hypnotherapy or practical preparation. For example:

'I do not feel that the course helped my confidence with childbirth as I feel I gained very little information on natural ways to relieve pain. We did not practise many breathing techniques and I did not finish the course with a particularly good understanding of what was going to happen during labour. I was left with the impression that I would be able to breeze through labour with all the natural techniques and I do not believe this to be true.'

One woman said there had been too much focus on medical procedures:

'I felt that we focused on medical intervention, drugs and pain too much!'
Four women felt that there was a bias against medical procedures or pain relief. One said:

‘Information (was) directed at normal pregnancies and normal deliveries. (The course) has an anti-intervention perspective which could prove to be extremely unhelpful if this is required. It ignores the fact that medical intervention is intended to protect mum or baby or both. It could leave a mother having little trust in the professionals who are looking after her.’

One women with more complex pregnancy had felt marginalised:

‘I have a heart condition which means that my labour had to have a great deal of medical intervention. I felt that the course slightly ‘frowned’ upon births with a high degree of planned medical intervention and pain relief.’

Fortunately, there were contrasting positive reports from women with medical conditions, such as:

‘(My teacher) is a very good instructor and since my baby has to be induced due to a cardiac defect I was concerned I may feel a little left out on the course. This couldn’t be further from the truth. Both (my teacher) and the other parents were very supportive and I am looking forward to the birth (as much as you can!!)’

4.7 Summary

There was a strong preference for obtaining considerable information about pregnancy and birth. Women tended to emphasise that gaining information had been an aspect of the NCT course that they felt had been helpful. The participative style of courses, which involve many opportunities to discuss the birth process and to share their experiences with others, also helped women feel supported.

Asked to rate their level of confidence before and after attending the course, both women and men indicated a substantial increase in confidence after having been on the course, with greater confidence reported by women who had attended a full-length course compared with those attending a shorter course. Increased confidence was attributed to feeling better informed and prepared for birth, focussing on birth as a normal physiological process, being part of an interactive learning group whose members were all going through a similar process, and feeling better prepared to discuss options with health professionals.

Women and men generally expressed similar preferences and attitudes. Attitudes towards pain in labour and drugs for pain relief showed that over nine in 10 of the women were keen to use a minimum of drugs and were keen to prepare using ‘natural ways to help cope with contractions’, however the priority for the others was avoiding pain.
Women’s experiences of labour, birth and maternity care

‘By the end of 2009 and women and their partners will have opportunities to make well informed decisions about their care throughout pregnancy, birth and postnatally.’

When their babies were around three months old, eligible parents were invited to take part in a follow-up survey, asking about their experiences of birth and life with their new baby, how prepared they had felt and how well the NCT course helped to prepare them. A little under a quarter of eligible women (366/1581; 23%) responded, including 154 women who had not responded to the post-course survey. This chapter focuses mainly on women’s experiences of labour and birth, with men’s comments included where relevant. Chapter 6 reports more fully on men’s experiences and reflections, with some further comparative data for both women and men.

NCT aims to create a learning environment in antenatal courses in which women and their partners increase their confidence in human reproductive and nurturing abilities, and the capacity of individual women to give birth and to breastfeed. This is interwoven with opportunities for both parents to think about ways of empathising with and responding to their babies’ needs. Teachers are also aware that for many women and their partners there are unexpected and often unwanted challenges, including clinical complications, lack of support, and intense emotional and physical demands. They therefore aim to achieve a balance between a positive focus on normality, resourcefulness in the face of the unexpected and acceptance that there is wide diversity of experience. However, one study found that some women feel NCT creates an unrealistic ‘rosy’ view of labour and feeding which leaves them feeling poorly prepared and emotionally isolated if they are unable to have a straightforward birth and establish breastfeeding.

One way in which teachers work with parents in preparing for birth is to encourage them to think about the kind of environments and circumstances where they will feel more relaxed and at ease. Objectives include enabling them to work out ways of helping themselves and seek services offering optimal professional support and clinical care. However, by the time parents come to an NCT course they have generally decided where they plan to give birth and to a considerable extent NCT teachers work with these beliefs and preferences.

NCT teachers are aware that the environment for birth and the quality of care and support provided by midwives and obstetricians has a major impact on the birth experiences of women and their partners. This is something over which NCT has no direct control though does influence locally through work with health professionals planning and reviewing services, and nationally through involvement with government in developing maternity policies, and with research and professional bodies in carrying out research and developing clinical guidance. The post-birth questionnaire asked about aspects of maternity care to enable parents’ experiences of labour and birth to be put in context.
Expectations and experiences

In the post-birth questionnaire, women were asked to compare their expectations for labour and birth during pregnancy with their experience of birth. Sixty percent of responding first-time mothers said that their birth was not how they had expected it to be, including a third (33%) who felt this 'strongly'. Furthermore, more than half of women felt they had not had the kind of birth they had wanted (56%) (see table 15).

Table 15 Women's birth expectations and experiences

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>The birth was how I expected it to be</td>
<td>6%</td>
<td>34%</td>
<td>27%</td>
<td>33%</td>
</tr>
<tr>
<td>I had the kind of birth I wanted</td>
<td>17%</td>
<td>27%</td>
<td>23%</td>
<td>33%</td>
</tr>
</tbody>
</table>

It is possible that course format has an impact on the extent to which women have the kind of birth they want, but the question remains unanswered. Although more women who attended full-length courses said they had the kind of birth they wanted (47% vs. 36% attending an intensive course), the difference was not significant (p=0.75). More detailed research, preferably a randomised controlled trial, would be needed to demonstrate whether this has an influence independent of other factors.

5.1 Place of birth

Among first-time mothers who responded to the post-birth survey, 85% gave birth in a hospital labour ward (n=306/362), 9% (n=34/362) gave birth in a birth centre, either alongside a hospital (7%; n=25/362) or in a free-standing unit (2%; n=9/362) and 6% (n=20/362) had a home birth.

In 2007, overall 5% of births in England were in birth centres (3% alongside, 2% freestanding) and the home birth rate for the England was around 3%.\(^1\)\(^{34}\) However, out of hospital birth is less common for women having their first baby. A survey by the National Perinatal Epidemiology Unit in 2010 found that 38% of women felt that home birth ‘had been a possible option’ compared with just 18% of women in 1995, indicating that opportunities to have a choice of place of birth had increased. However, only one percent of first time mothers and five percent of other mothers gave birth at home, and around one percent and two percent, respectively, said they had their baby in ‘a birth centre separate from a hospital’\(^2\)\(^{,35}\)

The longitudinal sample of 212 first-time mothers, made up of those women who responded to both surveys, allows direct comparisons between plans for birth at around the time that their NCT course ended and their actual place of birth. Of the 23 women who intended to give birth at home (11% 23/206), 11 had a home birth. Of the 64 women who were planning to use a birth centre (31% 64/206), most (81%) transferred either before or during labour to give birth in a hospital labour ward. Of 119 women who said during pregnancy that they planned to go to hospital for
their birth, three had a home birth (3%) and five had their baby in a birth centre (5%) (see figure 1). At least one of the home births was unplanned, occurring after labour progressed rapidly and the baby was born without a midwife present:

In contrast, some of those who planned a home birth but gave birth in hospital had spent the greater part of their labour at home but transferred for additional care in response to changing needs:

‘It was intended to be a home birth until 2 hours before delivery (6 hours into labour) then we found out it was breeched so we went to hospital.’ (father)

‘I laboured at home. I transferred close to birth due to exhaustion.’ (mother)

Figure 1 Comparison of 206 first-time mothers’ intended and actual place of birth

Women who gave birth at home or in a midwife-led birth centre were more likely to report having felt fairly confident or confident during birth than women who gave birth in a hospital labour ward ($\chi^2=9.895, p<0.01$). Recognising that hospital births are sometimes more complex clinically and that interventions can be challenging for women, a further comparison was made including only women giving birth in hospital whose labour ended with a spontaneous birth (see table 16) and the difference, though reduced, still remained ($\chi^2=27.138, p<0.01$). Numbers in the sample were too small for further analysis, such as controlling for induction of labour. The differences in confidence may reflect differences in the women choosing different settings for birth and differences in interventions experienced, as well as differences in the birth environment and care provided.

A large prospective study of alternative settings for birth is currently addressing many of these issues.36
<table>
<thead>
<tr>
<th>Place of birth</th>
<th>% Not very confident</th>
<th>% Fairly confident or confident</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital labour ward</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All births</td>
<td>24%</td>
<td>76%</td>
<td>331</td>
</tr>
<tr>
<td>Spontaneous vaginal</td>
<td>17%</td>
<td>83%</td>
<td>136</td>
</tr>
<tr>
<td>Midwife-led birth centre</td>
<td>5%</td>
<td>95%</td>
<td>40</td>
</tr>
<tr>
<td>At home</td>
<td>9%</td>
<td>91%</td>
<td>22</td>
</tr>
<tr>
<td>Total sample</td>
<td>21%</td>
<td>79%</td>
<td>393</td>
</tr>
</tbody>
</table>

5.2 Mode of birth

Forty five percent of women (164/363) had a spontaneous vaginal birth. One in four (24%; 88/363) had assistance with forceps or ventouse, and three in ten women had a caesarean birth (31%). Four in five of the caesarean births were planned vaginal births with the decision about a caesarean made during labour (25%; 89/363); around one in five of the caesarean births were planned in advance (6% of all births; 22/363). These findings show higher levels of intervention than those reported for all first time mothers in England in a recent large ONS survey. Redshaw et al reported a spontaneous birth rate of 52%, a combined forceps and ventouse rate of 21% and a caesarean rate of 26%. This NCT sample may be representative of all women attending an NCT course who, being older than average, would be expected to have rather higher intervention rates, or there may be self-selection bias, or both of these.

The National Service Frameworks for England and Wales and Maternity Matters, the implementation plan for England, specified that maternity services should ‘promote the normality of childbirth’ by among other things, ensuring that ‘staff have up-to-date skills and knowledge to support women who choose to labour without pharmacological intervention, including the use of birthing pools, and in their position of choice’ (see Box 1). NCT was interested to know what the experiences had been of the women in this study in this regard.

All women who had a vaginal birth were asked in what position they gave birth. Of the 250 respondents who had a vaginal birth, a very high proportion, two thirds, said that they gave birth in a supine position (67% 167/250) (table 17). Of these women, almost three quarters had their legs in stirrups (71%; 119/167). Within the total sample, 48% gave birth with their legs in stirrups (see table 15). One woman commented:

‘I didn't get the birth I chose – I was in stirrups and on my back (prior to having a c-section) - but this was entirely to poor midwifery skills and being told I couldn't try another position with no explanation of why. ... The second stage of labour lasted three hours prior to the final decision (about having a caesarean) being made.’
Table 17 Positions for birth among first-time mothers having a vaginal birth

<table>
<thead>
<tr>
<th>Position</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lying on my back with my legs in stirrups</td>
<td>48%</td>
<td>119</td>
</tr>
<tr>
<td>Lying on my back</td>
<td>19%</td>
<td>48</td>
</tr>
<tr>
<td>Standing, squatting or kneeling</td>
<td>14%</td>
<td>34</td>
</tr>
<tr>
<td>Sitting/supported by pillows</td>
<td>8%</td>
<td>19</td>
</tr>
<tr>
<td>In the birth pool</td>
<td>6%</td>
<td>16</td>
</tr>
<tr>
<td>On my side</td>
<td>3%</td>
<td>9</td>
</tr>
<tr>
<td>Other*</td>
<td>2%</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>250</td>
</tr>
</tbody>
</table>

* 'I lay on my tummy on a beanbag', 'Kneeling until needed episiotomy so had to lie on back', 'Lying on bed with back up and end of bed down', 'Sitting on the loo' and 'Sitting with my legs in stirrups'.

This does not reflect the aspirations of the policy frameworks, nor those of the women who had said that they had wanted to use movement and different positions during labour, and conflicts with recommendations.\textsuperscript{28} It also compares unfavourably with results from the 2007 Healthcare Commission study of almost 45,000 primiparous and multiparous women in which 27% said they gave birth ‘lying with my legs in stirrups’ and a further 30% said they gave birth lying down.\textsuperscript{39} The Healthcare Commission follow-up survey reported an increase in women giving birth in stirrups, up 3% to 30%.\textsuperscript{34} The high percentage of women who were supine for birth in that study surprised NCT and BirthchoiceUK.\textsuperscript{40}

5.3 Use of self-help approaches during labour and birth

Movement, such as walking and rocking, can ease discomfort and help labour to progress\textsuperscript{41} so, wherever possible, women should have the space and encouragement to stay mobile. Women who experienced labour were asked how they coped with pain and to what extent they were encouraged by midwives to use self-help methods of coping, such as moving around and changing positions. Nearly half of first-time mothers (45%, n=144/324) in the study said they were able to move around during labour and choose the position that made them feel most comfortable ‘most of the time’. Another 42% (n=137/324) could do so ‘some of the time’ during labour and 13% (n=43/324) ‘not at all’.

In terms of self-help ways to cope with pain during labour, a large majority used focused breathing (89%) and movement (81%); around three quarters used other low-tech, non-invasive approaches such as massage, rocking and relaxation. More than half used a birth ball (57%) and around a quarter a birth pool (26%) (see table 18).

Table 18 Use of self-help approaches to cope with pain

<table>
<thead>
<tr>
<th>Approach</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focused breathing</td>
<td>89%</td>
<td>284</td>
</tr>
<tr>
<td>Moving around and try different positions</td>
<td>81%</td>
<td>257</td>
</tr>
<tr>
<td>Other natural ways (e.g. massage, rocking, relaxation)</td>
<td>78%</td>
<td>246</td>
</tr>
<tr>
<td>Birth ball</td>
<td>57%</td>
<td>174</td>
</tr>
<tr>
<td>Birth pool</td>
<td>26%</td>
<td>78</td>
</tr>
</tbody>
</table>
Maternity services guidance for England, Scotland and Wales

**England** - The National Service Framework for maternity services in England said:

- all maternity services (should) have policies and procedures which reflect an individualised, flexible, woman-focused approach to care and support, and
- seek to engage fathers.

The policy framework specified that:

‘All staff (should) have up-to-date skills and knowledge to support women who choose to labour without pharmacological intervention, including the use of birthing pools, and in their position of choice.’

It further stated that: ‘All NHS maternity care providers and Primary Care Trusts (should) ensure that birth environments in all settings:

- promote the normality of childbirth i.e. they replicate a home-like ambience;
- can have furniture easily re-arranged to allow for mobility and different birth positions;
- wherever possible, allow access to a birthing pool with staff competent in facilitating water births; and
- (be) welcoming to fathers and other birthing partners.’

Maternity Matters made a choice of place of birth ‘guarantee’ that, ‘depending on their circumstances, women and their partners will be able to choose where they wish to give birth. ... The options for place of birth are:

- Birth supported by a midwife at home.
- Birth supported by a midwife in a local midwifery facility such as a designated local midwifery unit or birth centre. The unit might be based in the community, or in a hospital; patterns of care vary across the country to reflect different local needs. These units promote a philosophy of normal and natural labour and childbirth. Women will be able to choose any other available midwifery unit in England.
- Birth supported by a maternity team in a hospital. The team may include midwives, obstetricians, paediatricians and anaesthetists. For some women, this type of care will be the safest option but they too should have a choice of hospital. All women will be able to choose any available hospital in England’

Recently the coalition government has said that ‘Women would be able to make choices about the type of care and support they receive during pregnancy, labour and birth, and after they have given birth, and where they access that care and support.’

**Wales** - The national service framework for maternity services in Wales set a target that within 10 years:

‘Birth environments are regularly audited to ensure they optimize normality, privacy and dignity during labour and birth for the mother and birth partner(s).’

**Scotland** - In 2005, agreed clinical standards for maternity services in Scotland highlighted that:

Studies have shown that women who are supported during labour need to have fewer pain killers, experience fewer interventions and give birth to stronger babies. After their babies are born, supported women feel better about themselves, their labour and their babies.
The study showed that over 80% of women who wanted to use focused breathing, movement and different positions and other natural ways to cope with pain did so during labour and birth. However, only one third of women who said during pregnancy that they would have liked to use a birth pool actually used one in labour (see figure 2). And only a quarter said that their midwife had encouraged them to try immersion in water (23%).

Among this small sample, all the women who gave birth at home said that they were able to move around in labour most of the time (15/15) and this was the case for three quarters of those who had their baby in a birth centre (13/17). In contrast, less than half (37%) of first-time mothers who experienced labour and birth in hospital reported this (98/266; p<0.01). The proportion for women giving birth in hospital remained lower when only those whose labour started naturally and who had a spontaneous birth were considered (54%, 62/114). One in nine of those whose labour started naturally and who had a spontaneous vaginal birth in hospital (11%; 13/114) said that they had not been able to move around ‘at all’. As the whole hospital sample will have included women with obstetric and medical factors making their pregnancy and labour more complex, and many were known to have had continuous electronic monitoring, it is not surprising that the extent of their mobility was reduced. However, measures can be taken to facilitate greater freedom of movement for women with risk factors and those undergoing medical procedures.44

Figure 2 Intention to use and actual use of self-help approaches for coping with pain during labour and birth

<table>
<thead>
<tr>
<th>Approach</th>
<th>Intended to Use</th>
<th>Used During Labour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focused breathing</td>
<td>89%</td>
<td>11%</td>
</tr>
<tr>
<td>Movement</td>
<td>81%</td>
<td>19%</td>
</tr>
<tr>
<td>Other natural ways</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Birth ball</td>
<td>61%</td>
<td>39%</td>
</tr>
<tr>
<td>Birth pool</td>
<td>37%</td>
<td>63%</td>
</tr>
</tbody>
</table>

5.4 Care and support during labour and birth

The midwife’s relationship with the woman and her approach to providing care can affect how a woman’s labour is managed, the way it progresses and how she feels.45-47 Generally, the first-time mothers in this sample reported high levels of support from the midwives caring for them and a sense of being involved in decisions about their care: 87% agreed or strongly agreed that they felt supported by midwives during birth and 80% felt supported after birth. However, for a minority this was not the case with a small group disagreeing strongly (see table 19).
Women were asked to indicate how much they felt they had been able to maintain their autonomy, including whether they had felt able to ask for things they wanted and say no if they didn’t want something. Generally, most reported feeling they had been able to express their wishes. Over 90% agreed or strongly agreed that they were not afraid to say no if they didn’t want something, and said they felt able ask for things they wanted during birth (see table 19). However, other reports, particularly reports of limited access to birth pools and birth balls, and a lack of encouragement to use them, suggests that there are a number of barriers preventing women from getting the kind of care and opportunity to use low-tech facilities that they might both value and benefit from.

Table 19  Support, communication and involvement during and after birth

<table>
<thead>
<tr>
<th>First-time mothers</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The midwives:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>fully supported me during</td>
<td>56%</td>
<td>31%</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>fully involved me in decisions</td>
<td>49%</td>
<td>36%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>fully supported me after birth</td>
<td>42%</td>
<td>38%</td>
<td>13%</td>
<td>7%</td>
</tr>
<tr>
<td>fully involved me after birth</td>
<td>40%</td>
<td>42%</td>
<td>12%</td>
<td>7%</td>
</tr>
<tr>
<td>I said no if I didn’t want something</td>
<td>44%</td>
<td>49%</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>I wasn’t afraid to ask if I wanted something</td>
<td>52%</td>
<td>39%</td>
<td>7%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Women were shown a list of approaches to working with pain and asked which ones their midwife had encouraged them to try during labour. The list included: a birth ball, a birth pool, movement and different positions, massage, rocking, relaxation and focused breathing.

Table 20  Percentage of first-time mothers who said their midwives encouraged them to use of self-help approaches to coping with pain during labour

<table>
<thead>
<tr>
<th></th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focused breathing</td>
<td>68%</td>
<td>182</td>
</tr>
<tr>
<td>Movement and different positions</td>
<td>68%</td>
<td>183</td>
</tr>
<tr>
<td>At least one other natural way (e.g. massage, rocking, relaxation)</td>
<td>45%</td>
<td>177</td>
</tr>
<tr>
<td>Birth ball</td>
<td>39%</td>
<td>180</td>
</tr>
<tr>
<td>Birth pool</td>
<td>25%</td>
<td>182</td>
</tr>
</tbody>
</table>

Over two thirds of mothers who experienced labour reported that the midwife encouraged them to use focused breathing as well as movement and different positions to cope with pain. However, fewer than half were encouraged by a midwife to use a birth ball and only a quarter were encouraged to use a birth pool (table 20). While only one in four women were encouraged by midwives to use a birth pool (table 20), a large majority of those who did use one reported that they were encouraged to do so by midwives (figure 3).
First-time mothers who felt they were encouraged by midwives to use a greater number of ways to cope with pain also reported feeling that their midwives had ‘fully supported’ them during birth ($r=0.18$, $p<0.01$; see figure 4). It may be that midwives who make more different practical suggestions are more engaged and emotionally supportive. It may also be helpful for women to use a number of different approaches to working with pain sequentially, to help them pace themselves through labour.

All those who had a spontaneous birth were selected in order to compare the experiences of a broadly similar group of first-time mothers giving birth in different settings. Among women who gave birth spontaneously, those who gave birth at home or in a birth centre were more likely than those who gave birth in a hospital labour ward to be encouraged to use different approaches to working with pain ($\chi^2=11.736$, $p<0.01$). More than half of women who gave birth at home (56%) or in a birth centre (64%) were
encouraged to try four or more ways of working with pain, whereas this was only the case for 31% of women who gave birth vaginally without assistance in a hospital labour ward.

Table 21 Encouragement by midwives to use self-help ways of working with pain by place of birth

<table>
<thead>
<tr>
<th>Place of birth</th>
<th>Encouraged to use 4+ ways of working with pain</th>
<th>Encouraged to use 0-3 ways of working with pain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Hospital labour ward</td>
<td>31%</td>
<td>69%</td>
</tr>
<tr>
<td>Midwife-led centre</td>
<td>64%</td>
<td>36%</td>
</tr>
<tr>
<td>At home</td>
<td>56%</td>
<td>44%</td>
</tr>
<tr>
<td>Total</td>
<td>39%</td>
<td>61%</td>
</tr>
</tbody>
</table>

Midwives working in different settings seemed to have a different approach to encouraging self-help techniques for working with contractions (table 21). First-time mothers who gave birth in a birth centre reported that midwives encouraged them to use more non-invasive ways to cope with pain compared with those who gave birth in hospital (Games-Howell test, p<0.01).

One woman who had a hospital birth commented:

‘My midwife experience in the birthing pool was amazing but the midwife support in the first couple of hours was dreadful and could easily have lead to me requesting an epidural if I hadn’t been so determined to use the birthing pool, having fought so hard against induction. Next time I will be opting for a midwife-led birthing centre or a home birth as I feel strongly that good midwife support can make or break a positive birthing experience.’

Women who said they had been offered more ways of coping with pain (at least four ways) more often reported having felt confident or fairly confident, compared to women offered three or fewer ways of working with pain ($\chi^2=5.779$, p=0.01). The importance of midwifery-led care and continuous support during labour is are becoming well established. Yet the authors of the Cochrane systematic review concluded that ‘in hospitals worldwide continuous support during labour has become the exception rather than the routine’. Continuous support is said to include ‘emotional support … advice regarding coping techniques, comfort measures … and advocacy’ (p3). Results from the review of high quality trials show that ‘women who received continuous support were more likely to give birth spontaneously, to use pain medication less frequently, to be more satisfied and to have slightly shorter labours. Their babies were also less likely to have low Apgar scores at 5-minutes post-birth, an indicator of wellbeing. Specifically, an environment which offers access to facilities for soothing and working with labour, and midwifery support including firm practical suggestions about ways of pacing oneself through labour were identified as important from observation and women’s accounts in another study. There was a positive correlation between the extent to which women felt that their midwives had supported them and the number of self-help ways
of working with pain their midwives encouraged them to try \( r^2=0.314, p<0.01 \).

Respondents were asked whether they were left alone during labour or shortly after birth by midwives or doctors at a time when it worried them. Asked in several large maternity surveys, this question has shown that around one in five women have been left alone and worried at this time, with considerable variation between hospitals. Most recent surveys in England show an improvement, with fewer women left alone at a time that caused them anxiety.35,52,54

Most first-time parents who had been to NCT classes said that they were not left alone at a time when it worried them. However, one in six women who experienced labour (16%) had been left alone and worried at some time during labour. In addition, five percent were left alone at a time when it worried them shortly after birth. In the small sample of men, only one said that he and his partner had been left alone at a time that worried them (see table 22).

The post-birth questionnaire did not ask for comments specifically about midwifery support, but two women made unprompted comments on what continuous support from a known midwife had meant to them during labour:

‘I was lucky enough to be able to give birth at (name) Hospital where a friend of mine is a midwife. She stayed with us for the duration and was very familiar with my birth plan. I therefore had a slightly unfair advantage in terms of continuity of care and a very positive experience.’

‘I had such a positive experience with continuous support from a midwife I got to know before the birth. I expected the birth to be a dreadful experience but it was nothing like I expected and indeed it was a very positive and amazing - the happiest day of my life.’

<table>
<thead>
<tr>
<th>Table 22</th>
<th>Were you left alone by midwives and doctors during labour or shortly after birth at a time when it worried you?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
</tr>
<tr>
<td>----------</td>
<td>-------</td>
</tr>
<tr>
<td>No, not at all</td>
<td>78%</td>
</tr>
<tr>
<td>Yes, during labour</td>
<td>13%</td>
</tr>
<tr>
<td>Yes, shortly after birth</td>
<td>5%</td>
</tr>
<tr>
<td>Yes, during labour and shortly after birth</td>
<td>3%</td>
</tr>
</tbody>
</table>

First-time mothers who had a spontaneous birth were less likely to report being left alone at a time when it worried them than those who had an assisted birth (see Figure 5). Those who had given birth in hospital also more often reported that they were left alone when it worried them, though numbers in the sample are small and the difference is not statistically significant.
Figure 5  
First-time mothers who reported being left alone during labour and/or shortly after birth at a time when it worried them

<table>
<thead>
<tr>
<th>Mode of Birth</th>
<th>Percentage</th>
<th>Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous vaginal birth</td>
<td>19%</td>
<td>(n=31/164)</td>
</tr>
<tr>
<td>Assisted vaginal birth</td>
<td>28%</td>
<td>(n=25/88)</td>
</tr>
<tr>
<td>Emergency caesarean</td>
<td>25%</td>
<td>(n=22/88)</td>
</tr>
</tbody>
</table>

5.5  
Medical procedures and monitoring during labour and birth

As noted earlier in this chapter, a high proportion of first-time mothers had their baby in a hospital labour ward, including some who transferred there having previously planned for a home birth or birth in a birth centre, and many experienced medical procedures of various kinds. The women were asked how their baby’s heartbeat had been monitored during labour. As many as three quarters of all first-time mothers in the study said they had some period of continuous electronic monitoring with a belt monitor during their labour (72%, n=132/183). Those who said they would very much like to have hand-held monitoring were more likely (62%, n=43/64) to report having this during labour than women who had not expressed a strong preference for this kind of monitoring (29%, n=30/102).

One third of the first-time mothers in this sample who went into labour (34%) had their labour induced, and almost one in four had their labour accelerated (38%) (table 23). About half of first-time mothers who experienced labour had an epidural or spinal anaesthesia (47%; n=159/317) (see table 24). There was a strong association between induction and acceleration and the use of epidural or spinal anaesthesia. Most (71%) of those who had one or both of these procedures (n=91) also had an epidural or spinal anaesthesia. Among those who had an epidural or spinal, 43% (n=68/159) had an emergency caesarean, 37% (n=59/159) an assisted vaginal delivery and 20% (n=32/159) a spontaneous vaginal birth.

While the sudden onset of painful contractions following induction of labour is known to make it more difficult for women to adjust and cope without pharmacological pain relief, it cannot be said that the association between acceleration of labour and use of regional anaesthesia is a causal one as a number of factors may be at play confounding the relationship. For example, if the progress of labour is slower than average this may lead to both acceleration and epidural; and labour may be slower because the baby is awkwardly positioned, for example starting in an occipito-posterior position or with a poorly flexed head, or because the physical environment or emotional support are not optimal, or because the woman is distracted or tense and fearful, or a combination of these and other factors.  

55,56
Table 23  Procedures during labour

<table>
<thead>
<tr>
<th></th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction</td>
<td>34%</td>
<td>313</td>
</tr>
<tr>
<td>Acceleration</td>
<td>38%</td>
<td>312</td>
</tr>
<tr>
<td>Either induction or acceleration</td>
<td>47%</td>
<td>306</td>
</tr>
<tr>
<td>Epidural or spinal</td>
<td>49%</td>
<td>323</td>
</tr>
</tbody>
</table>

For the longitudinal sample, the group of first-time mothers for whom we have post-course and post-birth data, it is possible to compare expressed preferences during pregnancy with labour and birth experiences. After the course, most (91%; n=686) had expressed a preference to avoid an epidural, yet over 40% reported after birth that they had had one (figure 6).

There was also a strong preference to avoid induction (99% n=689) or acceleration (96% n=679), but in the small follow-up sample half (52%, n=91/174) had had their labour either induced or accelerated (see table 23). Among the group whose labour was either induced or accelerated the epidural rate was 71% compared with 24% (n=22/91) for those who did not have induction or acceleration of labour.

Thus, although most of this group of first-time mothers would have preferred to avoid medical procedures, a large minority experienced them. However, women frequently stated that if there was a need for medical treatment in their baby’s interest or their own, they were willing to be flexible.

Figure 6  Preferences to avoid medical procedures as expressed during pregnancy and experiences during labour

5.6  Caesarean birth

NCT particularly wanted to know about the experiences of women who had a caesarean birth. Questions included what having a caesarean birth meant to women. We wanted to know how well prepared women had felt for the operation and the period of recovery afterwards. The aim was to hear from first-time mothers about their experiences of planned caesarean birth and of having an unplanned caesarean during labour.
First, women were asked to what extent they agreed or disagreed with a series of three statements (see table 24). In addition, there was an opportunity to comment about any aspect of caesarean birth, prompted by the following request: ‘Please add any further comments about your caesarean section if you would like to’.

Of the 113 first-time mothers who responded to the survey who had had a caesarean birth, 81% (91/113) had had an unplanned caesarean during labour, rather more than Redshaw et al recently reported for first-time mothers (72%).

Nearly all of the first-time mothers who had had a caesarean said that they were given sufficient information about why their caesarean was advised. Three quarters (74%) felt that the obstetrician fully involved them during birth, but only half (53%) said they were given options about procedures such as having the screen lowered, holding their baby skin-to-skin, or finding out their baby’s sex themselves (see table 24).

Women who had a planned caesarean were more likely than women who had an emergency caesarean to feel that they were given sufficient information (100% n=22/22 vs. 91% n=78/86), were fully involved by their obstetrician (100% n=22/22 vs. 67% 51/76) and given options about procedures (76% n=16/21 vs. 47% n=35/74).

| Table 24 Information and choices during caesarean birth |
|---------------------------------|--------|--------|--------|--------|
| I feel I was given sufficient information about why my caesarean was advised | Strongly agree | Agree | Disagree | Strongly disagree |
| | % | % | % | % |
| | 61% | 32% | 2% | 6% |
| | | | | |
| The obstetrician fully involved me during birth | | | | |
| | 47% | 28% | 18% | 7% |
| | | | | |
| I was given options about procedures (e.g. having the screen lowered, holding my baby skin-to-skin, finding out the baby’s sex myself) | | | | |
| | 32% | 22% | 22% | 24% |

Sixty nine first-time mothers added comments in their own words. The largest group of comments were from women who wrote positively about the experience (n=33), commenting in particular on the quality of care from the obstetricians, anaesthetists and midwives. This included both women who had a planned caesarean and some who had an emergency operation.

‘The caesarean was a very positive experience, the staff were very kind and upbeat and although I was nervous I felt in very safe hands.’

‘I was very pleased with the care I received from the obstetrician, and very comfortable with all her decision-making.’
‘The team that performed my c-section were fabulous. They talked me through everything and involved me fully.’

‘The team were fantastic. It was an emergency but I felt very safe.’

This included positive comments from women who expressed mixed feelings, some difficult experiences or relief that the outcome was positive despite some anxiety (15). For example, one woman said:

‘The hospital care was excellent as was the after care, the operation did not affect my bonding with baby at all.’

Some in this group expressed regret that they had not had a vaginal birth but felt that the birth had been a positive experience:

‘My baby was breech and unable to be turned so we had a planned section, I was disappointed not to have a natural birth but the caesarean went so well the feelings of disappointment were gone in [an] instant.’

One described how her experience of traumatic complications had been compensated for by the quality of care from staff:

‘The team in the delivery suite were fantastic and I felt very well looked after even though I had a traumatic experience given that my epidural would not work despite being done four times. I ended up with two spinal blocks and then as this started to wear off whilst they were putting in my stitches I had to be given a general anaesthetic. I then lost three pints of blood and had to be given a transfusion that evening. Whilst it was not a good experience I don’t feel bad about it as the staff were so good to me.’

A smaller group of women expressed negative comments about having a caesarean (11). These included a wide range of emotions including disappointment, regret, frustration and shock.

‘I was very sad to have to have it. (I am) quite shocked at the high percentage of people needing (a caesarean) nowadays.’

‘I was disappointed to end up with c-section; frustrated not to complete the ‘job’ myself.’

Two women expressed complex mixed emotions. The first described a sense of loss on having missed out on something that mattered to her and also a sense that it was in some way her fault:

‘I felt guilty and disappointed I had not delivered naturally after going through labour.’

The second expressed a sense of loss, concern that her caesarean may not have been necessary and felt that she wasn’t fully involved in the decision making:

‘I felt hard done by. I am not sure if it was fully necessary, I feel like it was pushed upon me.’
One new mother described how the birth had affected the way she related to her baby:

‘I found the experience isolating and unnatural. My baby didn’t feel like mine for a good few hours.’

Some women talked about the process of their caesarean birth (5) and how their care, or communication with them, could have been improved. In several cases women expressed a desire for the care provided to be made more personal and individualised.

‘My C-section was a complete nightmare. I wasn’t given enough epidural, the obstetrician didn’t communicate to the anaesthetist, and I had a traumatic time.’

‘I was given a lot of info prior to the caesarean but none whatsoever during it which would have been very useful. They didn’t even tell me when the baby came out and I had to ask my husband to look over the screen to see what sex the baby was. They then whisked baby away (there were no problems with him at all) and didn’t tell me anything while they stitched me up. I then lost a lot of blood and no-one told me anything.’

‘My birth plan notes were completely ignored e.g. (my) baby was cleaned before being handed to me, the cord blood was not donated.’

‘We were offered the screen lowered but nothing else. I didn’t know these options (e.g. holding my baby skin-to-skin, finding out the baby’s sex myself) were available so I didn’t ask.’

Six first-time mothers specifically commented on opportunities to hold their baby skin to skin. Two were pleased that this had been possible. One said:

‘Unfortunately I ended up with a general (anaesthetic), so was not awake when my daughter was born, (but) I had skin to skin contact in the recovery room and breast fed her there.’

Others were sorry that there was a delay before they were able to hold their baby skin to skin. One said:

‘I was never given the option to hold my baby skin to skin straight away so would ask for this if having a c section again.’

Women’s experiences of the physical and emotional aspects of a caesarean birth, recovery and adjustment afterwards varied widely. Some woman’s comments indicated that the experience had been straightforward and uncomplicated:

‘It all went very smoothly. I had good pain relief afterwards and for the days following. The dissolvable sutures healed well without any infection.’

‘It was a very positive experience, very little pain, very mobile early on.’
‘I had no pain, during or after and was up and about the next morning.’

Others experienced unexpected symptoms or side effects, anaesthetic difficulties or heavy blood loss requiring a transfusion. One said:

‘I had a very complicated c-section and we felt we were very messed about.’

For one woman the operation had a profound affect that was still a cause of regret and sadness three months later.

‘I found the caesarean awful - totally traumatic. I was not given any options (no skin to skin contact, the screen was not allowed to be lowered, etc) about the procedure. In fact, for several weeks, I felt like I had not really given birth - I hadn't heard, seen or felt the birth of my child. In addition, as it was performed in the middle of the night, as soon as I was put on the post-natal ward, my husband was ordered to leave the hospital - it was awful. It makes me cry every time I think about it.’

Three women said that they felt their NCT class had not provided sufficient information on what to expect during a caesarean birth or afterwards. Comments included:

‘The antenatal class did cover aspects of what to expect in a caesarean in terms of who would most likely be in the theatre, etc. (which was very helpful), but it did not cover possible side effects for the mother from the epidural (severe shivering, fever, etc.) and what to expect in the recovery period (inability to get out of bed on your own, inability to lift or carry anything for 6 weeks, etc.). Mentally, it would have been less of a shock if I had known this was a possibility.’

‘The NCT class could have covered more about what happens during caesarean such as getting the shakes/vomiting as that was totally unexpected. Would also have been good to have information on what you can/cannot do for up to three months after a caesarean.’

However, the challenge of achieving a reasonable balance of information is not inconsiderable, as attitudes, experiences and feelings about a caesarean birth vary so widely, as the comments above have indicated. One woman said:

‘I find most of the literature on C-secs biased towards a C-sec being a failed labour and a traumatic experience. Mine was great and saved my baby's life.’ She added: ‘I would like to see more literature on medium-term recovery (i.e. after the first few days and weeks).’

Finally, one woman sang the praises of the preparation on the NCT course:

‘Although I had no intention of having a caesarean I could feel no movement so went to hospital, they advised an emergency c section as he was not moving ... Although my birth plans went out the window ... and I did not experience labour, I was fully prepared and felt that this was due to the excellent information received on the NCT course.’
5.7 Confidence during birth

The follow-up questionnaire asked how confident women had felt during birth. Most of these first-time mothers said that they had felt fairly confident. However, 23% said they had felt ‘not very confident’ (table 25).

<table>
<thead>
<tr>
<th></th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not very confident</td>
<td>23%</td>
<td>80</td>
</tr>
<tr>
<td>Fairly confident</td>
<td>58%</td>
<td>208</td>
</tr>
<tr>
<td>Confident</td>
<td>19%</td>
<td>68</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>356</td>
</tr>
</tbody>
</table>

Women who had attended a full-length antenatal course reported feeling more confident during birth than women who had attended an intensive course (Mann-Whitney, p<0.01).

A longitudinal analysis of the reports from first-time mothers who took part in both waves of the survey showed that confidence about birth was at its highest after the course, compared with both before the course and during birth (Friedmann Anova, p<0.01), see figure 7.

The role of the midwife during labour is a key factor affecting women’s experiences of birth. Women who strongly agreed that their midwife had fully supported them were more likely to recall feeling confident, rather than fairly confident or not very confident, during birth ($\chi^2=6.408$, p<0.01) (table 26).

<table>
<thead>
<tr>
<th>n=337</th>
<th>Reported level of midwifery support and reported confidence during birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘The midwives fully supported me during birth’</td>
<td>Confidence during birth</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>Confident or fairly confident</td>
</tr>
<tr>
<td>Agree</td>
<td>Not very confident</td>
</tr>
<tr>
<td>Disagree/strongly disagree</td>
<td>43%</td>
</tr>
<tr>
<td>Total</td>
<td>77%</td>
</tr>
</tbody>
</table>
Figure 7  First-time mothers’ confidence about birth pre-course, post-course, and at three months

As reported earlier, there was a large reported increase in confidence after attending the NCT course compared with women’s reflections on how they had felt before the start of their course. Women who reported that they had felt confident before the course were more likely to feel confident after the course ($r=0.346$, $p<0.01$).

Results for the longitudinal study sample show that there was a positive correlation between reported post-course confidence and reported confidence during birth ($r=0.211$, $p<0.01$). However, reported confidence was lower during birth than immediately after the course. Most often, women felt only ‘fairly confident’ during birth (58%, table 25). Those who felt ‘confident’ after their course (50%) were more likely than others to feel confident during birth (see table 27) ($\chi^2=9.160$, $p<0.01$). Women who reported feeling ‘confident’ during birth were more likely to agree that their birth had been a positive experience ($\chi^2=21.118$, $p<0.01$) and more likely to agree that the birth had been as they expected ($\chi^2=38.922$, $p<0.01$).

These findings suggest that attending an NCT course may have had a positive impact on first-time mothers’ sense of confidence that lasted and helped to sustain them during childbirth. However, there are limitations to retrospective reports of confidence, and confidence may vary during labour and birth depending on changing circumstances. In order to know whether an NCT course has an independent impact on a woman’s confidence during labour or her overall experience of birth, a larger, more detailed cohort study or a randomised controlled trial would be needed. A cohort study with a sample of sufficient size to enable multiple regression analysis would make it possible to control for possible confounding factors such as length of labour, obstetric interventions, and extent of labour support.
Table 27 First-time mothers’ confidence during birth and at the end of the course

<table>
<thead>
<tr>
<th>Longitudinal sample</th>
<th>Level of confidence during birth</th>
<th>All</th>
<th>Column</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Confident</td>
<td>Not very confident or fairly confident</td>
<td>%</td>
</tr>
<tr>
<td>Confident</td>
<td>31%</td>
<td>69%</td>
<td>100%</td>
</tr>
<tr>
<td>Not confident</td>
<td>13%</td>
<td>87%</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>22%</td>
<td>78%</td>
<td>100%</td>
</tr>
</tbody>
</table>

\[ r = .346, p < .01 \]

**fairly** or **not very confident**

5.8 Women’s feedback on preparation for labour and birth

The findings in this section of the report provide more quantitative and qualitative evidence to show what the women had to say about their experiences of birth and the preparation NCT had provided. Overall, looking back after they had had their baby, a quarter of women reported that they had felt very prepared for the birth (26%). A further half (51%) said that they had felt quite prepared. Men’s views were broadly similar (see Figure 8).

Figure 8 Postnatal reflections on preparedness for birth

As with self-assessed confidence during birth, women who attended a full-length course also reported feeling better prepared than those who attended an intensive course which provided fewer hours of contact time and fewer individual sessions (Mann-Whitney, \( p < .05 \)) (figure 9).
The post-birth data show a positive correlation between women reporting feeling that they had been ‘very prepared’ for birth and agreeing strongly that ‘overall I feel my birth was a positive experience’ ($r=.39$, $p<0.01$). However, it is not possible to claim any kind of causal relationship. It may be that women whose labour went smoothly subjectively felt better prepared because there were no unforeseen surprises, whereas those women who had assistance with forceps or an emergency caesarean, which would not have been their preference, felt their experience had been physically and emotionally especially demanding.

Women who gave birth spontaneously felt better prepared for birth than women who had a vaginal birth with assistance and (especially) more so than women who had an unplanned (emergency) caesarean ($\chi^2=14.440$, $p<0.025$) (table 28). These were not dramatic differences; most women, regardless of their mode of birth, reported having felt only somewhat prepared.
Table 28  First-time mothers’ mode of birth and views about level of preparedness

<table>
<thead>
<tr>
<th>Mode of birth</th>
<th>Thinking back, how prepared did you feel for the birth?</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all or only a little prepared</td>
<td>Quite prepared</td>
</tr>
<tr>
<td>Spontaneous birth</td>
<td>16%</td>
<td>54%</td>
</tr>
<tr>
<td>Forceps birth</td>
<td>24%</td>
<td>57%</td>
</tr>
<tr>
<td>Ventouse birth</td>
<td>26%</td>
<td>53%</td>
</tr>
<tr>
<td>Emergency caesarean birth</td>
<td>36%</td>
<td>41%</td>
</tr>
<tr>
<td>Planned caesarean birth</td>
<td>19%</td>
<td>42%</td>
</tr>
<tr>
<td>Total</td>
<td>24%</td>
<td>51%</td>
</tr>
</tbody>
</table>

5.9 Women’s own reflections and interpretations

Women were asked two open-ended questions about which aspects of birth they had felt best and least well prepared for. Some 326 women responded about what they felt ‘best prepared’ for. All responses were read and the first 100 responses from first-time mothers were analysed in detail. Quotes used to illustrate the ways in which women felt well prepared have been selected from all responses.

Best prepared

Of the first 100 responses, 39 women said that having knowledge and feeling able to use self-help approaches to coping with contractions had been the way they felt best prepared. This included women who specifically referred to using breathing awareness or particular patterns of breathing (13). Few explained very much about how this worked for them. Examples include:

‘Breathing through early contractions.’

‘Breathing and controlling pain naturally.’

These included women who specifically referred to using yoga or hypnotherapy (7), and women who talked about having a calm state of mind (3) or a positive visualisation of contractions being like waves (1). For example:

‘My mental state was probably the best prepared thing about the birth. I went into it believing it was a natural process that my body would handle.’
Some women described several things as having been 'best preparation':

'Relaxation exercises and different positions to adopt from the NCT classes were very useful and also ... it was explained that things might not to plan which was what happened.'

'(I was able to) use yoga, breathing and meditation.'

'Focusing on the future, trying to stay relaxed by creating a relaxed atmosphere and breathing.'

'How to use movement, breathing, massage etc. to speed up the labour and ease pain.'

Several women who had practised hypnotherapy or yoga techniques during pregnancy emphasised that it was useful preparation:

'I went to pregnancy yoga so that really helped me with concentrating on my breathing whilst having contractions.'

It is interesting that the aspects of preparation for birth that women tended to emphasise most commonly as having increased their confidence were to do with knowledge and information. In practice, the aspects of birth that women most frequently mentioned in terms of being 'best prepared' were to do with their way of thinking about birth and having physical skills and comfort techniques that they felt able to use.

The joint second most frequently mentioned ways in which women felt 'best prepared' were understanding the process of labour and what might affect its progress (16) and knowing about pain relief options (16). One woman also mentioned the effects of different types of pain relief. Examples of how women found it helpful to understand the birth process include:

'Knowing the stages of labour and not seeing it as an endless process.'

'(Knowing about the) progression of labour (stages), how external stimuli affects labour.'

In terms of pain relief, on the whole women did not go into much detail. (They made comments like:

'(Knowing about) pain relief/the effects of pain relief available.'

Other ways in which women said that they felt 'best prepared' for birth included knowing what to expect with a caesarean birth (9) including the number of people and roles of those in the room, having met the obstetrician in advance of the operation and having been well prepared for an operative birth by the midwife:

'I was prepared for how many people would be present for a c-section.'
Women also mentioned the value of feeling confident in the midwives and doctors looking after them (6) and being open-minded about how their labour and birth would unfold (2). For example:

'I felt really informed about all types of birth, so I felt confident when I had to discuss induction, pain relief and preparation for assisted delivery.'

'(Knowing) that birth was different for every person and so to trust the midwife and go with it.'

Other aspects of preparation women felt were useful were ‘being prepared for pain’ (4) and ‘feeling educated about different options’ and confident to be involved in decisions (4), having arranged to use a TENS machine (3), having their house well prepared or their hospital bag well packed with aids for labour (2), knowing technical birth language (1) having arranged to be in a peaceful environment (home) (1), and ‘knowing it could last a while!’ (1).

Least prepared

Some 315 women responded to the open-ended question about what they had felt least ‘prepared for about the birth’. Responses from 100 first-time mothers were analysed in detail, however quotes used to illustrate the ways in which women felt least prepared have been selected from all of the responses.

The single most frequently mentioned aspect of birth that women said that they had felt least prepared for was the extent of the pain (23). This was flagged by around a quarter of women, for whom it had made a significant impact:

'The pain and the length of time you're in pain! Not getting a break between contractions.'

'The sheer brutality of the pain! I was very shocked for several days after that my own body would do that to me!'

'The pain, especially in my legs and how fast the contractions became - how quickly they got closer together.'

'The pain of the head crowning and final pushes!'

'Extreme pain of pushing baby out.'

No other single comment came close in number. Other related aspects of birth that women felt least prepared for were the length of their labour (6) and the speed, intensity or frequency of contractions (5). Counting these together with the 23 who explicitly referred to pain, there were comments on pain or closely related aspects of labour from 34 women out of the 100 respondents whose comments were analysed in detail. Pain was thus not mentioned by around two thirds of the first 100 respondents. In addition, for example, four women spoke about being unprepared for the second
stage of labour without referring directly to pain. None of these women had had an epidural. Comments included:

‘Pushing during the 2nd stage.’

‘The length of 2nd stage, ventouse, forceps.’

‘The pushing stage was so difficult with a big baby!’

Other women spoke about losing control (1) or becoming very tired in labour (1) without referring explicitly to pain:

‘Being taken to theatre and how my husband would cope with this. Also I felt out of control and quite delirious and did not expect this.’

A large range of other aspects were mentioned, demonstrating how widely experiences of labour and birth can vary in objective ways and in terms of individual perceptions. The most common themes were labour not going as expected, experiencing induction of labour, and being afraid or disappointed with aspects of care. Women also referred to aspects of labour or the period immediately after the birth as shocking, or surprising, or not knowing how best to cope. Further information is provided regarding the number of times each theme was mentioned with illustrative quotes for each:

Labour not going as expected (10) – this included labour ending with an unplanned caesarean (4) and the process of birth involving more interventions than women wanted or expected:

‘(I) had planned (hoped) for natural home birth. Ended up with long labour, lots of inductions, drugs and caesarean section - didn’t plan for that!’

‘I was not realistic about my labour. I thought I could (control) things but at the end of the day your body will do what it wants.’

‘The possibility of having a caesarean hadn’t crossed my mind.’

‘Losing my focus when plans changed and forgetting what I really wanted. Also, I didn’t really plan for not liking using water, birthing ball and TENS machine - which I always wanted to.’

Experiencing induction of labour (6) – this included the shock of needing to be induced, the practical process, different methods, the speed of onset of labour, and the slowness of onset of labour:

‘Being induced - the different methods and how slow it can be. We had been told that usually you go into labour and deliver very quickly if you’re induced. It took 3 days!’

‘I wasn’t aware how quickly the contractions could occur after the gel was applied after being induced.’
Being afraid or disappointed with aspects of care (9) – this included feeling afraid in the operating theatre (3), having an unkind midwife or finding it difficult to communicate with the midwife or doctor (3), lack of staff (2) and not being able to use a birth pool.

‘(I felt least prepared) for an emergency C-section. I didn’t realise how understaffed and overworked the midwives were and how little attention would be given to me.’

‘I feel that the [hospital] wants mothers to have C-sections. Out of five of us, one had a C-section, three of us were threatened with one and the other had been induced early.’

‘How frightened I’d be going into the operating theatre.’

Feeling drained, unwell, struggling or shocked immediately after the birth (9) – this included how women felt after a vaginal birth (5), how women said they felt in the first 24 hours after a caesarean (4) and coping with the first feed and with going home.

‘I was in slow labour for five days and found that I felt terrible afterwards as just so drained and tired.’

‘How physically and mentally exhausted I’d feel afterwards and incapable of comforting my baby.’

‘(I was least prepared for the) impact of C-section – i.e. my inability to move afterwards and care for my baby in the next 24 hours.’

‘(I was least prepared for the) bit after birth when holding baby and trying to feed.’

Features of labour that were shocking or surprising (5) – this theme included an unplanned precipitate home birth, the baby being born early, having a baby with a brow presentation, the amount of blood and the extent of the waters when they ruptured.

Coping with aspects of early labour (3) – this theme included the length of the latent phase, knowing when you are in labour and deciding when to go into hospital; and not knowing what to do when labour slowed down (3):

‘What my options were and what I could do and expect when things didn’t go according to plan and contractions weren’t progressing.’

Some of the more notable comments reflecting themes that did not come up in the 100 comments analysed in detail included not being prepared for the sensation of the having the epidural administered and not being prepared for the epidural not working:

‘(I was least prepared for) having an epidural - the sensation you feel during its administration. (I) was scared of getting paralysed.’
'The pain that I would be in because of the drugs I was given to speed up my labour and the fact that the epidural didn't work - this never crossed my mind I just expected it to take the pain away and when it didn't it was a big shock.'

Several women talked about pushing technique and feeling unprepared for the pushing their baby out:

‘Pushing - If someone had told me that you are supposed to push as though you want to have a poo I am sure that my baby would have come out much sooner. ...If it wasn't for the intervention of a very forceful midwife over an hour into the pushing stage who told me to push like I was pooing I am sure I would have had to have intervention with forceps as they were about to take me down the theatre. I am slightly angry that no one told me this as it would have saved a lot of pain.’

5.10 Summary

The results serve to highlight a number of important issues about the birth expectations and experiences of first-time mothers who have attended NCT courses and their preparation for labour and birth.

The realities of birth were different from what many first-time mothers expected and more than half did not achieve the kind of birth they had wanted. These outcomes are likely to be the result of numerous factors, including the way maternity services are organised and managed, including the extent and quality of midwifery support provided, clinical factors in the pregnancy and the influence of the NCT course.

Most women had their baby in a hospital labour ward, including many of those who had planned to use a birth centre or to give birth at home. Among this sample, only 45% had a spontaneous vaginal birth. Rates of assistance with forceps or ventouse (24%) and caesarean birth (31%; 25% emergency and 6% planned) were higher than the national averages for first-time mothers, but the population was also older. Similarly the higher than average rate of induction may reflect higher intervention rates for older mothers. However, the small numbers in the sample and low response rate also leaves open the question of whether the sample is representative of first-time mothers attending NCT classes.

Among those who had a caesarean birth, women mostly commented about feeling safe at the time of the operation and well supported by the medical staff. Around a third reported a range of more mixed or negative feelings, mainly to do with the quality of communication with them. Some commented on their bonding with their baby, physical recovery or emotional adjustment after birth.
Men’s experiences of labour and birth

There is relatively little published research on men’s experiences of labour and birth or, more specifically, what they find useful preparation for supporting their partner through labour or being present at their baby’s birth. However, over the last 20 years an increasing number of studies have explored men’s perspectives of childbirth, and some have questioned how well midwives and childbirth educators have responded to their needs. Recent reviews of evidence have concluded that there is an urgent need for further research about the best methods to use during the antenatal period for preparing fathers for birth and for their new role as father. Findings from observational and intervention studies suggest that the qualities of effective antenatal support for fathers are flexibility of approach and of the syllabus in order to be responsive to the needs of the particular men attending, combined with a participative style of group work. Courses that provide ‘adjunctive’ men-only sessions alongside couple sessions or women-only sessions have been well received, as well as sessions run with a particular focus on fathers’ perspectives and concerns, sessions run by men and involving opportunities to learn from other more experienced fathers.

A longitudinal study carried out by NCT at the end of the 1990s recruited a broadly representative sample of fathers whose partner was pregnant and followed them up when their baby a few months old. The extent of the men’s engagement with pregnancy issues and involvement in birth was considerable. Large proportions wanted information on a wide range of topics during pregnancy and most were with their partner during labour and/or present for their baby’s birth (vaginal births 96%, planned and unplanned caesarean births 89%). Two thirds or more described their experience of childbirth variously as emotional (80%), exciting (72%) and wonderful (65%). Large proportions also felt distressed by seeing their partner in pain (66%) and were frightened at some stage in the process (41%). This degree of involvement is consistent with an historical trend towards fathers taking on a more nurturant role, involving greater sensitivity towards their baby’s needs and development of practical nurturing skills and confidence gained through caring for their baby. It is also supported by fatherhood advocacy organisations. Burgess has argued that services should draw fathers into perinatal education as a matter of routine, reinforcing the idea that they will be involved as an equal ‘parenting partner’, providing day to day care alongside the child’s mother.

The current study of first-time fathers who had attended an NCT course adds to what is known, focusing on the experiences and views of a particular group of men in the UK. This chapter presents feedback from men at the end of the course and after birth, adds some comparative data about men’s and women’s preparation for labour and birth, their perceived information needs and the extent to which these were met by the NCT course attended. Although the response rate was low, the number of men participating and the free text responses provide a rich source of data. After the course, 168 first-time fathers responded, and 65 participated in the follow-up survey including 20 who responded to both questionnaires who made up the longitudinal sample.
6.1 Participation during labour and birth

All but one of the men who responded when their baby was around three months old had been present with their partner during labour (54 out of 55, excluding those having a planned caesarean) and birth (59 out of 60). Comments indicated that men of this generation and background considered it ‘normal’ to be present for their baby’s birth, and many also indicated that it was extremely important for them to be able to participate in this unique and significant event. The main reasons given by men for being with their partner during birth were to support her, to be present for their baby’s first moments of life outside the womb, and to experience the birth of their baby together:

‘It’s normal - the natural place to be.’

‘It was inconceivable that I wouldn’t be there, both to be a part of my baby’s arrival in the world and to support my wife through her labour and delivery.’

‘I wanted to be there as this was a tremendous occasion for both of us. I wanted to support my wife but I also wanted to share in the excitement of those first moments.’

‘It was my birth as well (even though I wasn’t physically doing it) so I wanted to be there.’

A large majority of these first-time fathers felt that overall their baby’s birth had been a positive experience (85%), while 15% reported that this was not the case. However, for many the birth was not as they had anticipated, and one in 10 indicated that their experience had been very different from what they had expected. On a positive note, most reported that they had felt able to ask for things that they or their partner wanted, and to support their partner in her decisions (see table 29).

Table 29 Men’s birth experiences

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was able to support my partner in her decisions</td>
<td>58%</td>
<td>38%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>I wasn’t afraid to ask if I or my partner wanted</td>
<td>48%</td>
<td>47%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Overall, I feel the birth was a positive experience</td>
<td>40%</td>
<td>43%</td>
<td>15%</td>
<td>0%</td>
</tr>
<tr>
<td>The birth was how I expected it to be</td>
<td>10%</td>
<td>30%</td>
<td>35%</td>
<td>10%</td>
</tr>
</tbody>
</table>

n: 60, 59, 59, 60
6.2 Feelings during labour and birth

Of the 40 men who responded to the question about how they felt being with their partner during birth, a range of emotions were expressed. Over half described the experience wholly positively (23) using words like ‘wonderful’, ‘amazing’, ‘fantastic’, ‘priceless’ or ‘great’.

Another group made mixed comments, describing having felt anxious or distressed to see their partner in pain but also feeling excited or pleased that they were able to support their partner (12). For example, one man said he had been ‘nervous but excited’ and another ‘nervous, happy, overwhelmed’. Other comments included:

'I've never been more worried, frightened, amazed and gobsmacked at the same time.’

'It was very tough emotionally seeing my partner in pain, but I was able to provide support and encouragement.’

One of these men described experiencing the ambivalent feelings of believing that it was good to have been present, but at the time not feeling sure what part he could play:

'I felt like I was in the right place but a bit of spare part. Also nervous!’

Another said:

'At times I felt a bit powerless as I couldn’t help her with the pain, however she has since told me she was very grateful I was there.’

One in 10 of the men who commented described only negative feelings (4), expressing how difficult it had been to see or hear their partner in pain, or to be excluded at a time when their partner was in pain:

'I felt guilty that she did all that pain on her own.’

'It was overwhelmingly tough to see the one I love in constant pain.’

'I was very unhappy! I was required to wait in the room next door — hearing screams as my wife underwent contractions with no pain relief (as they were attempting to get a spinal block to work), beeps of equipment, and with very little in the way of communication from midwives, nurses or doctors. Having been at my wife’s side every moment up until then, this was very distressing and still causes me to get upset when thinking/talking about it!’

6.3 Confidence during birth

The post-birth follow-up survey also asked partners how confident they had felt during the birth. The majority said that they had felt fairly confident. When compared with the responses from women about their confidence during birth it is interesting to note that generally fewer men reported a low
level of confidence than was the case for woman (see table 30), though this difference is not statistically significant (p=0.3).

### Table 30  First-time parents’ confidence during birth, reported three months after birth

<table>
<thead>
<tr>
<th>Confidence during birth</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Not very confident</td>
<td>15%</td>
<td>9</td>
</tr>
<tr>
<td>Fairly confident</td>
<td>60%</td>
<td>36</td>
</tr>
<tr>
<td>Confident</td>
<td>25%</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100%</td>
<td>60</td>
</tr>
</tbody>
</table>

Unlike the women, there was no significant difference in self-assessed confidence according to the length of NCT course attended, though this may be explained by the small size of the sample.

### 6.4 Men’s feedback on preparation for labour and birth

After their baby had been born, men, like women, were asked how they rated particular aspects of preparation provided in the antenatal course. After the course nearly all women (95%, n=647/681) and men (96%, n=160/166) had agreed or strongly agreed that the course provided a good preparation for a natural birth. Nearly all women (89%, 606/679) and men (87%, 145/167) had said they felt that the course provided information and preparation for a caesarean birth (section 4.4).

In the follow-up survey, new fathers were asked ‘how useful did you find the NCT course, in preparing you for the birth?’ A similar question was asked of women and the responses are provided together below (table 31).

Once again, these aspects of preparation were rated positively. Men particularly valued the information they had been able to explore about different kinds of labour and birth, and approaches to decision making. The BRAIN mnemonic to prompt consideration of benefits, risks, alternatives, ones’ instincts and the option of doing nothing before making decisions was rated as ‘very useful’ or ‘fairly useful’ by nine out of 10 men and women. Relaxation skills and techniques practised on the course were rated as ‘very useful’ or ‘fairly useful’ by 78% of women and 67% of men (see table 31). As the numbers of responding men were small, these findings may be less reliable than those for women.
Table 31 Perceived usefulness of different aspects of the antenatal course

<table>
<thead>
<tr>
<th></th>
<th>Men Very or fairly useful</th>
<th></th>
<th>Women Very or fairly useful</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Information about different kinds of labour and birth</td>
<td>93%</td>
<td>56</td>
<td></td>
<td>94%</td>
</tr>
<tr>
<td>Considering the benefits, risks and alternatives before making decisions</td>
<td>90%</td>
<td>54</td>
<td></td>
<td>92%</td>
</tr>
<tr>
<td>Information about using movement and water during labour *</td>
<td>82%</td>
<td>49</td>
<td></td>
<td>89%</td>
</tr>
<tr>
<td>Ideas to support my partner</td>
<td>80%</td>
<td>48</td>
<td></td>
<td>--</td>
</tr>
<tr>
<td>Practical ways to help me cope during labour/birth</td>
<td>--</td>
<td>--</td>
<td></td>
<td>85%</td>
</tr>
<tr>
<td>Ideas to help me have the type of birth I wanted</td>
<td>--</td>
<td>--</td>
<td></td>
<td>88%</td>
</tr>
<tr>
<td>Relaxation skills and techniques</td>
<td>67%</td>
<td>40</td>
<td></td>
<td>78%</td>
</tr>
</tbody>
</table>

* Significant difference between men and women (Mann-Whitney, p<0.05)

Best prepared

Men were asked to explain what they had felt best and least prepared for about the birth. Fifty-four men provided comments on what they had felt best prepared for. The main themes to emerge related to providing support during labour (10), the process of labour and what would happen when (9) and practical preparation including knowing when to go to hospital, having bags packed and change for car parking (8). Comments about the process of labour and knowing what to expect reflected the men having been prepared for the unpredictable nature of labour and birth, and having talked things through as a couple in advance:

‘I was well prepared as a result of NCT classes having talked through the chronology of events and how things might take different paths at each point.’

‘I knew that all our best laid plans may well go awry, so we were not completely thrown by the sudden urgent need for an emergency c-section after many hours of normal labour.’

‘Talking in depth with my wife about all aspects of the whole process.’

Several men emphasised being prepared for their support role or developing knowledge and confidence to communicate more effectively with the staff:

‘I knew my wife would be in a lot of pain and need my FULL support.’

‘Coping with my partner’s pain and the things I could do to help.’
‘Having the confidence to challenge and query if we needed to (although in the end we didn’t, as our midwife was star)’

Other themes included knowing about options for pain relief and medical procedures (6) and the extent of the pain (5).

**Least prepared**

Fifty-two men responded to the question about what they were least prepared for, though of these four replied ‘nothing’. Many different issues were mentioned with three leading themes. The first theme related to the reality of labour and providing support (12), including coping with ‘false alarms’ and when to go into hospital, irregular contractions, the speed of labour and the (long) length of labour and consequent tiredness. Within this group, coping with pain was mentioned explicitly several times (6):

‘(I was least prepared for) the feeling of helplessness over my wife’s pain.’

Another said:

‘How quickly my wife changed her mind from a midwife-led water birth (plan A) to an epidural (plan B), when she arrived at the hospital 5cm dilated.’

In contrast one man said:

‘I wasn’t prepared for how strong my wife could be without painkillers.’

Induction of labour was another specific theme mentioned by several men (7). One felt unclear about the induction procedure, another was surprised by how long the process took. Another commented on ‘the speed and severity of the pain which this seemed to cause’. The development of complications (6), including the need for an emergency caesarean (2) was another concern. Two men commented:

‘(I was least prepared for) when it went wrong! Even though we knew what to expect, we hadn’t really thought about it.’ (Baby born by an emergency caesarean)

‘The whole C-section experience - theatre, preparation by the anaesthetist, and concern for baby in first few minutes.’

Several men highlighted having felt unprepared for aspects of the immediate post-birth period (5) or highlighted practical issues including being too cold in hospital having expected the delivery suite to be very warm, and the discomfort of a long labour wearing uncomfortable shoes! One man referred to ‘over-stretched staff’ resulting in a ‘lack of support during labour and after birth’.

**Father-focus and partners’ sessions**

It is often suggested that transition to parenthood courses tend to focus on the needs of women rather than addressing issues that matter to men. A series of questions were included in the post-birth survey to find out more
specifically about men’s needs and preferences. Men were asked whether their course had addressed the issues that they wanted to cover and also what they felt about the separate sessions for partners. Single-gender or partner-only sessions provide an opportunity for men and same-sex partners to ask questions or raise their worries without having to be concerned about how their own partner or other pregnant women might react.

Informal feedback has suggested that these sessions are highly valued. In this study, the questionnaire defined a session as ‘any period of time during a class or a whole class’. Two thirds of men who responded to the post-birth survey said that there had been men-only sessions (68%). Of those who indicated that their course had included some separate sessions for the pregnant women and some for partners, around four in five men felt there was an appropriate balance of mixed gender sessions and men-only sessions with the remainder split between wanting more or fewer men-only sessions.

A third of first-time fathers said that the course had addressed all or most of the issues affecting them in becoming a father (32%), half felt some things had been adequately addressed and one in seven (15%) felt that ‘none of my issues’ had been adequately addressed.

A free-text question in the post-birth questionnaire asked the men to comment on ‘what aspects of the course did you get the most benefit from?’ In particular they rated highly having the opportunity to get to know others going through the same experience and to be able to share experiences and concerns:

‘(What did I get most benefit from?) All of it. Before the course I found it hard to get interested, but meeting others going through the same thing at a similar time was excellent in sharing worries and experiences.’

‘Getting to know other people in the same situation. To hear that other women’s concerns/questions were the same as my wife’s.’

Several men particularly highlighted the opportunity to prepare for labour and birth:

‘How the birth process works – the movement of the head, twisting down the pelvis etc. was fascinating.’

‘Getting a clear idea of the various options for labour and technical information was very helpful.’

‘Different approaches to minimising labour pain and the pros and cons. Different types of intervention - the pros and cons.’

Preparing together, as a couple, and as part of a participatory group of parents was also clearly valued:

‘It allowed my wife and I time to focus on the future together.’
'Group sessions were good for learning as well as letting off steam with other similar individuals. Close friends without kids find it difficult to relate to what is changing in our lives.'  

'Hearing other people in the same situation - their hopes, fears, worries and ambitions about the birth and early stages of parenthood, and realising they are similar to your own.'

In response to a free text question about how the course could be improved, two men commented on dedicated partners’ sessions:

'I think a ‘dad’s only’ session may have been useful to discuss what was likely to happen at the delivery and shortly after, without the mums being there, to allow us to be better prepared (but without scaring us!)

'Men-only sessions sound interesting, but we did not have the option.'

Some of women also commented on separate sessions for pregnant women and for partners. There was a feeling that separate sessions enabled women and men to speak more freely about sensitive topics, but also concern that separate sessions could lead to the absent partners missing out on discussion that might be useful for one or both of them:

'It was good to cover things such as tearing etc in a more relaxed environment with just ‘the girls.’ Perhaps the men could have benefited from their own session too.'

'It would have been more helpful to have partners there for the breastfeeding session as this also covered how we might be feeling after the birth.'

Most of the men’s responses about how the course could be improved called for a greater focus on postnatal issues and preparation for looking after a new baby including aspects of infant feeding; these are discussed in chapter 8. Men’s comments specifically related to labour and birth included a call for more preparation on induction of labour (3) on labour pain (2) the latent phase of labour (1) epidural anaesthesia (1) and (unplanned) caesarean birth (1). Two men commented that there was too much of an emphasis on natural birth, including one father expecting twins:

'(There was) too much emphasis on the joys of a natural birth and breastfeeding. ...We could not have (a) natural birth as our presenting twin was breech. ...It was always as if we were to miss out on a magical moment which was extremely unfair and could have led to affecting the well being of a sensitive couple.’

The comments on pain and preparation for birth ranged from men who felt a greater realism was required, through ambivalence about what was the best way to prepare people for labour, to a man who felt that the course he attended got the preparation about right:

'(The course should have been) more realistic/honest about the level of pain that will be experienced by the mother.’
'I do get the feeling that we were never actually told the truth - Whilst being an amazing thing, birth is horrifically painful, even for the Dad! (Or is this one of those things best not spoken about?! Ultimately a thoroughly excellent course and course leader.)'

'Could the course be improved? Not particularly - although what happened to us was about as far removed from what we had planned as it was possible to get, we felt that the course had prepared us to deal with it as well as could be expected.'

There is further discussion in chapter 8 about issues that men felt were important during the transition to fatherhood.

6.5 Summary

Of the 60 first-time fathers who participated in the follow-up post-birth survey, all but one had been with their partner for their labour or the birth of their baby. Among this group who had been to an NCT antenatal course there was a widespread desire to support their partner during labour and to be present and actively involved in their baby’s birth.

Despite the birth being different from what they expected in many cases, 85% felt that their involvement in their baby’s birth had been a positive experience and a similar percentage reported feeling confident or fairly confident during the birth.

The men particularly valued the information they had been able to explore during the antenatal course about different kinds of labour and birth, and approaches to decision making. The BRAIN mnemonic to prompt consideration of benefits, risks, alternatives, alternatives, ones’ instincts and the option of doing nothing before making decisions was considered useful by nine out of 10 men and women. Around half of men commented on the value of getting to know other parents. They found preparing for birth and becoming parents together as part of a group who were all going through similar experiences had been especially valuable. However, the father expecting twins and preparing for a planned caesarean birth felt his needs and those of his partner had been less well met.
Preparation for life with a new baby

Antenatal education that models infant care as a shared activity, addresses couple-relationships and sensitises men to the demands for women of having a new baby is correlated with better mental health outcomes for both women and men postpartum.65

Most NCT antenatal courses are designed to prepare women and men for the kinds of changes in their lives that having a new baby will bring, though some short courses, such as ‘labour days’ are limited to preparation for labour and birth. Information on NCT website (course reference 2B/C301; accessed 11 May 2011) indicates that on a standard full-length course ‘Subjects covered will usually include:

- Pregnancy and birth choices
- Choosing where to have your baby
- Body awareness, relaxation, breathing and massage
- Home births and water births
- Pain relief – natural and medical methods
- Your labour and the role of the partner in labour
- What complications might arise – e.g. caesarean birth
- Looking after a newborn and feeding your baby
- Early parenting, lifestyle changes.’

Another full length course is also advertised as including ‘Practical babycare for both mums-to-be and dads-to-be’ and ‘parenting choices’ (course reference 4D/C347). This variation demonstrates that the curriculum offered on NCT courses differs, and it seems to suggest that there may be less focus on preparing for life with a new baby than on preparing for labour and birth.

There has been considerable debate over many years about how best to prepare for life with a new baby, and the extent to which expectant parents are receptive at a time when the birth itself is a preoccupation.68,69,70 In this chapter we report what women and men had to say about preparation for life with a baby immediately after their NCT course had been completed and also how well they rated the course in preparing them when they reflected back several months later, when they had become parents and knew first-hand about the reality of looking after a new baby.

Every parent’s experience of birth and becoming a mum or a dad is different. As the earlier chapters have shown, some start their new lives with their baby having a generally positive experience of birth, others feel shocked or exhausted and are having to cope with the aftermath. A woman’s physical recovery and recuperation after birth may take some time, particularly if she has a perineal or abdominal wound that needs to heal. Babies’ behaviour differs and so do parents’ expectations and their resourcefulness and adaptability. Each person’s upbringing and experience of relationships and expressions of love and nurturing in childhood will vary. Those with a close and supportive extended family who are able to provide practical support are in a different position from those who live a long way from the baby’s grandparents and those who find family members interfering or critical.
The extent of variation makes it challenging to prepare first-time mothers and fathers. NCT teachers therefore tend to aim for raising awareness about how the early weeks will be very different from life as women and men have known it, with the baby’s needs taking up most of their time. Various activities are organised to contribute towards this objective. In one, the ‘24 hour clock’ activity, women and men each shade in portions of time in clock faces, anticipating how their time may be spent during the early weeks with their new baby. This is designed to encourage them to anticipate how their time will be spent and then to discuss their assumptions with their partner and the wider group.

Another activity, used by teachers leading most full-length courses, involves them inviting a couple from a previous course to come into the session with their new baby to talk about what the early weeks have been like for them. This provides an opportunity for expectant parents to see a new family together, to see the new baby being handled and be able to ask questions, and get a first-hand impression of how it is to be a new mother and a new father. Literature suggests that this kind of opportunity for embodied learning can have a powerful positive impact.

Another strategy that teachers use is to encourage expectant parents to think about who they might consult or ask for support if they should need it after the birth, so that they have a ‘toolkit’ of potential contacts and resources to call upon. They are positively encouraged to develop a mutual support network with other new parents who will be going through a similar process of disruption, uncertainty, anxieties, tiredness and gradual adjustment. Expectant parents on the course often form a strongly cohesive group and there are other opportunities via the wider NCT and local community activities to meet new families in their neighbourhood. Contact with other new parents experiencing the same kinds of trials and tribulations can serve to normalise the process. At their best, these networks provide an informal opportunity to share doubts and frustrations as well as practical ideas about what they find works for them, enabling new mums and new dads to feel encouraged and cared about by the wider group while they adjust to their new roles.

These objectives and ways of working form the background to the questions that the parents were asked at the end of the course about preparation for their baby’s arrival and the changes they were anticipating. The next chapter specifically addresses preparation for and experiences of infant feeding.

7.1 Preparation and anticipating change

As with pregnancy and birth, women and men were asked as part of the end of course survey to think back to before they started their course and indicate how much information they had wanted about becoming a parent, feeding and looking after their baby (see table 32). After the course, reported demand by women and men for information about becoming a parent and baby care was greater than the demand for information about pregnancy and birth (see table 9). This may be influenced by how parents felt about unmet informational needs at the end of the course.
Table 32  
Amount of information sought about becoming a parent, feeding and looking after a baby by first-time mothers and fathers

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th></th>
<th>Men</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>A great deal</td>
<td>68%</td>
<td>469</td>
<td>93%</td>
<td>56</td>
</tr>
<tr>
<td>Quite a lot</td>
<td>24%</td>
<td>168</td>
<td>52%</td>
<td>31</td>
</tr>
<tr>
<td>Some</td>
<td>5%</td>
<td>36</td>
<td>20%</td>
<td>12</td>
</tr>
<tr>
<td>Not much</td>
<td>2%</td>
<td>8</td>
<td>2%</td>
<td>1</td>
</tr>
<tr>
<td>Very little</td>
<td>0.3%</td>
<td>2</td>
<td>0%</td>
<td>0</td>
</tr>
</tbody>
</table>

The post-course questionnaire asked women and men to respond to questions about various aspects of life with a new baby and sources of informal and formal support. The questions were posed in terms of 'knowledge' rather than anything more complex, such as having had an opportunity to anticipate changes, to discuss them or to reflect on preferred personal styles or expectations. Respondents were asked 'Now that you have completed the NCT course, how much do you feel you know about the following?' and a list of topics was presented. This is a fairly basic indicator of some of the aspects of life that are important when adjusting after birth and some of the areas of awareness that may ease the transition.

Table 33  
First-time parents’ knowledge about life with a new baby

<table>
<thead>
<tr>
<th></th>
<th>Know all I need to</th>
<th>Know a lot but want more</th>
<th>Know a little and want more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>Where to turn to get help **</td>
<td>63%</td>
<td>45%</td>
<td>27%</td>
</tr>
<tr>
<td>Where to meet other mums and dads</td>
<td>62%</td>
<td>58%</td>
<td>31%</td>
</tr>
<tr>
<td>How tired you might be *</td>
<td>62%</td>
<td>51%</td>
<td>31%</td>
</tr>
<tr>
<td>Sex after childbirth</td>
<td>50%</td>
<td>40%</td>
<td>31%</td>
</tr>
<tr>
<td>Changes in relationship **</td>
<td>49%</td>
<td>38%</td>
<td>38%</td>
</tr>
<tr>
<td>The realities of life with a new baby *</td>
<td>44%</td>
<td>36%</td>
<td>44%</td>
</tr>
<tr>
<td>Crying and sleeping</td>
<td>28%</td>
<td>27%</td>
<td>54%</td>
</tr>
<tr>
<td>Looking after your baby</td>
<td>21%</td>
<td>18%</td>
<td>60%</td>
</tr>
</tbody>
</table>

* Significant difference between women and men (Mann-Whitney, p<0.05)
** Significant difference between women and men (Mann-Whitney, p<0.01)

As Table 33 shows, over 60% of women and around half of men reported that they knew all they needed to about where to turn to get help, where to meet other parents, and how tired they might be in the early weeks with a new baby. Considerably fewer women and men indicated that 'they knew all they needed to' about looking after their baby (21%; 18%) or about crying...
and sleeping (28%; 27%). There were also questions about baby feeding which are reported in chapter 9.

Overall, men’s responses showed a broadly similar profile to those of women (tables 33 and 34), but they were generally less likely to indicate that they knew all they needed to. There were differences for five of the eight listed topics, particularly so for changes in their relationship and people and places they could turn to for help after their baby is born.

Table 34 Preparation for parenthood provided in courses

<table>
<thead>
<tr>
<th>Agreed or strongly agreed</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Opportunity to meet other parents having a baby</td>
<td>99%</td>
<td>682</td>
</tr>
<tr>
<td>Opportunity to get involved with NCT</td>
<td>85%</td>
<td>677</td>
</tr>
<tr>
<td>Good preparation about becoming a parent</td>
<td>88%</td>
<td>681</td>
</tr>
</tbody>
</table>

Expected changes

An open question asked respondents how they felt that becoming a parent might affect them. They were asked to: ‘Please tell us how you expect your life to change when your baby is born. In your own words, please describe up to three aspects of life that you anticipate may be different during the first three months’. The reactions suggested that most had a given this thought, and had a sense of what the reality of being the parents of a new baby might be like. They were expecting to have to give things up and make considerable adjustments in their domestic, social and emotional lives.

- Lack of sleep

Both women and men were most likely to refer to a practical issue, lack of sleep or tiredness as their first response to the question. Six in 10 women and five in 10 men referred to ‘sleep deprivation’ or ‘lack of sleep’ before anything else. It was also a common second or third response. A few mentioned tactics for coping with disrupted nights:

‘Less sleep at night and lots of catch up naps during the day’

- Major life change

Many expectant parents who responded expected a major life change involving new responsibilities and priorities, restrictions of their freedom and the need to put another person first. A minority of women were apprehensive and expressed their feelings explicitly in terms of loss, suggesting that life centred on the new baby’s needs would mean:

“(A loss of) freedom and independence to do what I want!”

“I’ll be spending more time at home – the world narrows down!”
'My sex life – I’m afraid that this will go on the decline and my husband won’t feel the same about me as before having a baby.’

‘Lack of control over what happens - I expect the baby to dictate what I do on an hourly basis.’

‘(Changes will include) missing the accomplishment and challenge of an extremely rewarding career.’

Though these kinds of comments were less often made by men, some also talked about entering this phase of their lives in terms of major loss. One man simply said:

‘Sacrifice - sleep, social life, relationship with wife, financial.

‘I don’t expect to see my friends as much or be organising weekend trips as frequently to watch rugby or football.’

‘No more nights out/cinema/gigs etc.’

‘(We’ll have) less time for our own relationship.’

Both the women and the men provided repeated comments about being more home-based, more involved with their family and having less time for themselves and social activities designed with adults in mind. A number of the women seemed almost to be holding their breath for the impact:

‘(I expect) complete life change - EVERYTHING!’

‘(I think) feeling or being in control may take a while to re-establish.’

‘(I expect) a sudden huge responsibility for the health and survival of the most helpless and most important human being in my life.’

‘(I may be) feeling out of control for the first time in a long time.’

Women tended to express the changes they were facing in terms of coping with the demands of the baby and how their own life and opportunities would be affected by it. For men there was a distinct dimension on how they would need to respond to both the demands of the baby and supporting their partner:

‘(I’m expecting) having to make sacrifices to ensure my wife and baby are OK.’

‘I will have to support my wife more than ever!’

‘(I expect it will mean) coping with my partner’s worries (normally unnecessary).’

‘Most of my time will be spent supporting my wife to look after the baby.’
New responsibilities came up as a theme. Some men raised taking on new additional financial responsibilities: ‘My wallet will be much lighter’. Both the women and the men felt the weight of responsibility of looking after another human being, anticipating:

‘The sudden huge responsibility for the health and survival of the most helpless and most important human being in my life.’ (woman)

‘Having someone totally reliant on me’ (man)

The women were more likely than the men to talk about feelings of anxiety, feeling overwhelmed, isolated, bored or depressed. Their comments included:

‘(I expect to feel) unconditional love and immense amounts of worry and self-doubt!’

‘I hope I am not isolated - as a single parent.’

‘I shall be stuck at home and will get lonely and bored.’

‘I feel nervous I will not cope well with the demands.’

‘I feel terrified.’

‘I’m depressed because I live far away from my family and friends. I am worried that my partner will not be able to cope.’

In contrast to these worries about loss and new unfamiliar demands and challenges, parents also talked about eagerly anticipating changes that they felt would give their life greater meaning and happiness. Those who focused more on ‘family fulfilment’ sometimes talked about the prospect of a ‘proper’ family phase in their lives. Some of the women said:

‘(I expect) greater meaning, focus and purpose.’

‘(I expect it to be) lots of fun and more fulfilling.’

‘(I look forward) to really becoming a proper family - Mum, Dad, and baby.’

‘(I feel) ready to take challenges on and to enjoy the changes. We are ready for a new chapter in our lives and to share our lives.’

There was also a group of men who emphasised feeling ready for becoming a father, and some expressed excitement and delight about entering this new phase in their lives:

‘(I’ll get) a greater feeling of purpose and responsibility.’

‘It will be brilliant and I can't wait!’

‘Joy from fathering a new baby.’
’Excitement. Fundamentally the birth of a child is very exciting!’

- **Changes for us as a couple**

One of the specific aspects of change that first-time mothers and fathers both raised was changes in their relationship with their partner, partly as a result of having less time together as a couple. This was a key theme, raised by a quarter of women:

’(I think there will be) less quality time with my husband.’

’(Our) relationship, I have no doubt our routine will be turned upside down and I hope that we will not bite each other’s heads off.’

’Potentially more conflicts with partner.’

The focus of comments included lack of time and tiredness, one or both partners having a different focus for their attention, and changing roles with one parent being home with the baby after the birth. Women and men recognised the potential for the new demands and pressures to divide rather than unite them. Some comments from women included:

’Our daily routines will be very different and we’ll need to support each other and understand that.’

’Tension, perhaps stress of lack of sleep for both of us. I hope my partner and I can ensure we understand each other’s different situations. One at home with baby, the other at work. We need to remember to work together on the baby!’

’Having to work harder at my partnership with my husband than ever before!’

’I may not be able to give my husband the appreciation he needs, and will need to watch this carefully.’

Comments from men also showed awareness of the changing dynamics in the couple relationship and the potential for conflict if they didn’t offer to do more of the domestic work:

’I’ll be taking on more of my partner’s chores.’

’I will have to make sacrifices and compromises I may not be used to.’

’(One change may be) managing my relationship with my partner.’

The men also talked about ways of looking after themselves and their partner as a couple:

’Having to make sure myself and my wife make time for just us, when the baby has gone for a sleep.’
A number of first-time mothers expected their relationship to improve when they had the baby to focus on together, despite the additional demands:

‘My relationship with my partner, although it is strong I expect it to be stronger still.’

‘(I expect) changes to my relationship with my partner - largely for the better but also more restrictions.’

‘My boyfriend and my relationship will change, it will deepen and we will be closer, but we will also face challenges.’

Some of the men made similar comments about co-parenting.

‘Working as a team with my partner - and supporting each other’

Conspicuous by its absence from the comments about how women and men expected their lives to change was much reference to sex. None of the men mentioned sex explicitly in a total of 478 comments on expected changes from 168 men. One man’s veiled remark hinted at changing attitudes and feelings:

‘My wife will become ‘my wife and the mother of my child’ - I expect this will change our relationship.’

Four woman mentioned sex. It seems probable that the topics raised frequently and those that were seldom mentioned reflect, at least to some extent, the kinds of changes discussed during the course sessions. Both women and men seem fully mindful about sleep disturbance and the amount of time the baby’s demands would take, but changes in how they will relate to each other sexually were seldom mentioned, as if there had been little or no discussion about this on the course. Comments included references to ‘challenges’ and ‘less quality time’ but, with few exceptions, nothing else was said. There were no comments, for example, about changes in libido, fewer opportunities to make love, possible pain, physical differences or the impact of breastfeeding on physical intimacy.

- **Family and friends**

Changes in relation to the role played by family and friends were commented on by women and men. Part of the ‘family phase’ they were entering involved a different relationship with their own parents, as well as making new friends with young children and turning to them for support. Women said:

‘(I expect to be) much more family oriented - us and the baby plus extended family.’

‘Friends and family, I will have to learn to involve people more in doing things for me, and accept other people's help.’

‘Different friends — i.e. friends without babies may ‘drop off the scene.”’
The men also anticipated more leisure time spent at home and in friends’ homes with the baby, with fewer opportunities to go off spontaneously and more people coming into their domestic lives:

’Social life will change i.e. more BBQ’s and round people’s houses with the baby rather than off to the pub.’

‘Our lives will be much more open to scrutiny from family/friends who will want to visit us and the baby.’

Anticipation and uncertainty

These comments demonstrate that in late pregnancy first-time mothers and fathers are poised on the brink of a life-changing event, and the period is a highly charged with a mixture of anticipation and uncertainty. Wariness was demonstrated by comments such as ‘I am sure I will do my best’ and ‘It’s the unknown.’ Asked how they felt about the changes they anticipated, a majority of first-time mothers expressed feelings of both excitement and nervousness:

‘I’m very excited and looking forward to it, and a tiny bit scared of what’s to come and how we’ll cope.’

‘Excited about meeting my baby, anxious about changes to things I enjoy - like working.’

‘I’m excited and nervous in equal measure.’

Many of the first-time fathers expressed similarly mixed emotions, such as this dad who said:

‘(I feel) excited - and daunted. It’s almost like being born again myself. I know everything will be completely different, challenging and rewarding in lots of new ways. I’ve done as much preparation as is possible, and it feels inadequate - how can you prepare for something unimaginable.’

7.2 Confidence about being a parent

Women and men were asked to rate their level of confidence about being a mother or father after the course and, thinking back, to indicate how confident they had felt before the start of the course. Few said they had felt confident before the start of the course, however around one third of first-time mothers’ and nearly half of first-time fathers said they felt confident about being a mother or father, respectively, after the course (p≤0.01) (see table 35).
Table 35  
First-time parents’ self-reported confidence about being a mother or father before and after the course

<table>
<thead>
<tr>
<th>Level of confidence</th>
<th>Women</th>
<th>Men</th>
<th>After the course**</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Not very confident</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27%</td>
<td>188</td>
<td>23%</td>
<td>38</td>
<td>4%</td>
<td>29</td>
</tr>
<tr>
<td>62%</td>
<td>424</td>
<td>62%</td>
<td>103</td>
<td>60%</td>
<td>405</td>
</tr>
<tr>
<td>10%</td>
<td>68</td>
<td>15%</td>
<td>24</td>
<td>36%</td>
<td>245</td>
</tr>
<tr>
<td>100%</td>
<td>680</td>
<td>100%</td>
<td>165</td>
<td>100%</td>
<td>679</td>
</tr>
<tr>
<td>Fairly confident</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>96%</td>
<td>1%</td>
<td></td>
<td>3%</td>
<td>0.5%</td>
<td>100%</td>
</tr>
<tr>
<td>39%</td>
<td>60%</td>
<td></td>
<td>0.5%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>13%</td>
<td>79%</td>
<td></td>
<td>8%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36%</td>
<td>60%</td>
<td></td>
<td>4%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

** Significant difference between women and men (Mann-Whitney, p≤0.01)

A comparison between the two most common course formats showed that women and men who had attended a full-length course were no more likely to say that they felt confident about being a mother or father than those attending an intensive course. The self reported rates of confidence at the start of the course were similar for women and men attending both intensive and full-length courses.

Among first-time mothers, of those who recalled having felt not very confident about being a mother before their course (n=188), most (79%) said they felt fairly confident at the end of their course (table 36). A minority remained not very confident (13%) and another small group described themselves as confident (8%). Among the majority who recalled having felt ‘fairly’ confident about approaching motherhood before their course (n=424), most remained fairly confident (60%) though a substantial minority (39%) indicated an increase in confidence from ‘fairly confident’ to ‘confident’. Thus, the greatest impact of the course on confidence about impending motherhood seems to have among those who did not feel confident pre-course, rather than among already moderately confident women.

Table 36  
First-time mothers’ confidence about being a mother before and after the course

<table>
<thead>
<tr>
<th>Level of confidence</th>
<th>Women</th>
<th>Men</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of confidence</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Confident</td>
<td>96%</td>
<td>1%</td>
<td>10%</td>
</tr>
<tr>
<td>Fairly confident</td>
<td>39%</td>
<td>60%</td>
<td>62%</td>
</tr>
<tr>
<td>Not very confident</td>
<td>13%</td>
<td>79%</td>
<td>28%</td>
</tr>
<tr>
<td>Total</td>
<td>36%</td>
<td>60%</td>
<td>100%</td>
</tr>
</tbody>
</table>
confident (8%); others described themselves as confident (21%). Among the majority who recalled having felt ‘fairly’ confident about approaching fatherhood before their course (n=103), most remained fairly confident (53%) though a substantial minority (47%) indicated an increase in confidence from ‘fairly confident’ to ‘confident’. Thus, the greatest impact of the course on confidence about becoming a father seems to have been among those who did not feel confident pre-course, rather than among men who were already moderately confident.

Despite the small percentages who felt that they had sufficient information about looking after their baby, relatively few offered comments specifically on this topic. Of 75 first-time fathers who responded, only two commented on this explicitly:

‘I feel we could have spent a great deal longer on parenting, and less time on labour.’

‘NCT barely touched on parenting which was disappointing.’

Others acknowledged that becoming a confident parent was about using their own resources and believing in their own abilities:

‘I think I will be OK! I trust my instincts.’

‘The fact that by attending classes you learn that perhaps you know more than you think.’

Many also appreciated that the process of getting to know other parents and going through the period of anticipation and uncertainty together as a group, discussing questions and sharing concerns and plans, itself helped to develop their confidence. Comments acknowledging that this had affected their confidence included:

‘Meeting people in same situation and realising everybody feels the same.’

‘A great deal of people do it; we cope; (getting) confidence from the group.’

‘At the end of the course I feel better equipped to deal with the pressure and responsibility that comes with parenthood and after discussing impending fatherhood with the other expectant dads I realised that my worries are quite common!’

Developing this theme, one man also referred to knowing that if they needed specific help when the baby came they would be able to access it.

‘Understanding that it’s a learning curve for every one, and there is support out there if needed.’

In addition to the group process, several men also highlighted practical aspects of the course that had enabled them to feel more confident. Having a knowledgeable, responsive course leader was highlighted again:

‘Being able to ask questions and get straight answers, and more importantly...’
being able to get answers to follow up questions, which you cannot do with books or online.’

Some men indicated that their course had covered practical babycare in some detail:

‘The course helped my confidence because I now know how to do a lot of the practical tasks associated with taking care of a baby - changing nappies, bathing, etc.’

‘The course was excellent preparation both in terms of what to expect and practical aspects when baby arrives.’

Like men, some women would clearly have liked to find out more about practical babycare and felt that the course was weaker on this than on preparation for birth:

‘I would of liked the courses to cover more aspects of 'life with baby'-swaddling, bathing, burping, etc.’

‘The NCT classes spent very little time talking about what to do with a newborn baby.’

Whereas others felt they had covered practical babycare in some detail, indicating that there may be quite a wide variation between courses and the approaches of different course leaders:

‘Know a lot more about feeding and what to expect from the baby on a day to day basis.’

The women also found the group process helpful and valued getting to know a network of friends who they could share things with, including parents who were a little further along and had already had their baby:

‘Discussing with others how normal it is to feel unsure (increased my confidence).’

‘Talking through various scenarios with others ... It also helped when a couple came to visit one of our NCT sessions with their 3 week old.’

And, like men, women commented on their teacher’s reassuring philosophy. The course leaders’ approach to preparing first-time mothers and fathers sometimes drew on broader historical and wider cultural evidence of parenting, encouraging them to get to know their newborn baby and develop ways of looking after him or her that work for them as individuals and as a family:

‘The info presented in the course - especially the knowledge that everyone is different and women have been doing this for centuries.’

‘Knowing that there are other people in exactly the same situation, and that there have been people in exactly the same situation who have done it successfully!’
The teachers encouraged parents to trust their instincts and to recognise their unique role in relation to their own baby.

‘The concept that I am the best person for taking care of my baby and the fact that you have to reconnect with your instinct to better respond to his-her needs.’

I don't doubt my ability to cope with the baby, but the course focused on the fact that we all have the ability to be great parents and that we must rely on our instinct, rather than turning to books and baby gurus.

‘I realised there are no rules and you can only make the best job of it that you can - it's entirely up to you and with a few NCT pointers on the way and with the help of my now new group of new mum friends, I think we'll be OK!’

7.3 Summary

NCT courses, particularly full-length courses, encourage both women and men to think about the kinds of changes that may affect them when they are caring for their new baby, using a range of participative activities. There is clear evidence from comments that first-time parents were anticipating having to cope with interrupted sleep and tiredness, and with big changes in terms of responsibilities and day-to-day freedoms and opportunities. They recognised that this would affect their couple relationship as well as each of them as individuals. This suggests that these kinds of changes had been well explored in most antenatal courses.

One of the challenges of providing an opportunity for parents to explore what the reality of life with a new baby may be like is that in the short-term, rather than feeling more confident, they may feel anxious due to uncertainty about how much things will change and how well they will cope with the new demands. Generally, first-time mothers expressed more ambivalent feelings than first-time fathers.

In terms of increasing first-time mothers’ and fathers’ confidence in their new roles, parents’ assessments indicate that there was greatest positive impact for those women and men who remembered feeling ‘not very confident’ before the course.

The results suggest that NCT courses meet the criteria of antenatal education recommended by Burgess. They ‘sensitise men to the demands for women of having a new baby’, model infant care as a shared activity and address couple-relationships. While there appeared to be an unmet demand from women and men to find out more about looking after their new baby, many first-time parents acknowledged positively that the process of getting to know other parents on the course, the information that had been covered, and the resource of an experienced teacher, had helped most to feel more prepared and confident in their abilities and resourcefulness.
Life with a new baby

*The first minutes of their baby’s life are for parents an exciting, awesome, exhilarating and exhausting experience. In these moments, all their dreams, hopes and plans come together.* (p9)

Once their baby has been born, the parents’ relationship with their baby intensifies. They know the baby’s gender and what he or she looks like. They begin to interact directly and to see how the baby responds. Right from the start, as well as the characteristics of the individuals in the family, the interaction between the mother and baby and how the parents feel is influenced by the kind of birth they have experienced, the environment in the maternity unit and the care provided. A range of broader cultural factors including social class, ethnic, religious and family influences help to determine how the next few hours and weeks will unfold. The formal postnatal care provided in the UK is often inadequate to meet the full range of clinical, emotional and informational needs of woman, babies and partners. Women who have had a caesarean birth are more likely to report that their needs have not been fully met and many women say that they would have liked more support with feeding their baby.

Parents need a range of knowledge and skills in order to care for their baby as well as confidence in their own abilities. Receiving support and encouragement to focus on looking after their baby and themselves during the early weeks are important particularly in circumstances where many rituals of parturition have been weakened. A key part of the task for new parents in the early weeks is ‘working it out’. Through interacting with their babies and learning iteratively what seems to work in caring for them, parents develop affectional bonds, becoming increasingly confident and more deeply attached. However, the literature shows that as well as being rewarding, adjustment to early motherhood is frequently accompanied by feelings of exhaustion, stress and isolation and for new fathers there is both a huge personal adjustment to make as well as a demanding new role in supporting their partner.

Stern and Bruschweiler-Stern make the case that an important part of the process of adjustment for women is that of reconciling the idealised imagined baby with the real baby, and changing their mental image for themselves from the perfect mother to the mother they are able to be. This process of adjustment, it has been suggested, takes women around three months of mothering on a daily basis, by which time they begin to feel that they know their baby as an individual and feel like a mother. The literature on fatherhood emphasises a desire among men for greater involvement in their children’s day to day lives and emotional needs than their own fathers had, but suggests that their opportunities are limited. The constraints include a lack of positive nurturant role models and a lack of wider social support for more participative fathering, such as lack of support from education and employment, limited opportunities to spend time with their young children which undermines their competence and confidence in carrying out practical childcare tasks, and active exclusion at times by mothers. Miller’s recent qualitative study adds to what is known about contemporary fatherhood in the UK, reinforcing previous
findings that men want to be ‘nurturing’ and ‘involved’ but find that their worker/breadwinner role soon becomes predominant. 82

8.1 Motherhood and fatherhood - How it feels

In the follow-up survey, carried out when their babies were around three months old, first-time mothers and fathers were asked to give up to three responses to an open-ended question about ‘how your life has changed since your baby was born’. Altogether 356 first-time mothers and 55 first-time fathers responded.

Four major themes emerged from women’s comments. These were a complete change to a baby-focused lifestyle, feelings of joy and fulfilment, lack of time for things other than looking after the baby, and lack of sleep. Other important themes were the extent of planning and preparation required for doing things with a baby, and a shift away from going out with friends in the evenings towards making new friends with babies and socialising with them during the day. At this stage, around three months after the birth, relatively few of these first-time mothers (6%) overtly reported feelings of isolation, anxiety, depression, boredom or low mood in the free-text comments about how their lives had changed.

The same four themes emerged from men’s comments. They too commented to a lesser extent on the planning required before going out with a baby and changes in their social life which included spending more time with other parents of young babies and time with the grandparents. None of the men talked about feeling worried, anxious or depressed themselves, though a few individuals in a small sample mentioned stress or arguments with their partner, and financial pressures or the importance of ‘job security’.

It is notable how accurately parents predicted these changes in the post-course survey (see section 7.1).

A baby-focused lifestyle

The women described how their lifestyle had changed from being centred on work and on their own wishes, or doing things as a couple, to being almost exclusively baby-focused. Around one in eight women referred to this directly but many more made comments that were consistent with there having been a major change in their day to day way of life as a result of having a baby.

‘My days revolve around my baby now.’

‘My priorities have completely changed.’

‘Being baby-centred, i.e. satisfy their needs first.’

‘How difficult it is to do anything apart from looking after baby.’

‘Everything revolves around this little person.’
This affected how they spent their time, their thoughts and concerns, what they spent time doing and who they spent time with. Most of the women seemed comfortable with this change, willing to go with the flow of their baby’s demands:

‘I have given up all control of my life - he sets the timetable now.’

‘I have a beautiful little boy who has become my highest priority, everything needs to be organised around him.’

Some of these first-time mothers referred to having become more patient, more relaxed, more confident or more resourceful as part of becoming a mother.

‘You learn to cope and my patience has improved.’

‘(I like) being able to spend time cuddling and talking to my baby without feeling the need to rush out or make plans.’

‘(What has changed?) My ability to multi-task constantly.’

‘(What has changed?) My personality – I’m surprised at my protectiveness and strength when it comes to taking care of or protecting/defending my baby.’

Others commented on the weight of the responsibility they had felt in the early days – or still felt - and the isolation or being a new mother or the relentlessness of attending to their baby:

‘(I feel) overwhelmed at the responsibility of another person to care for.’

‘Loneliness – I felt trapped in house in the early days as it took so long to get myself and the baby ready when my husband was back at work.’

‘Worrying - I constantly worry about someone other than myself and can't stop fretting whether the baby is too hot, too cold, needs a nappy change, is still breathing etc.’

Though one mother described how the daunting demands were eased by the connection she felt to her baby which helped her to cope:

‘Sometimes I feel so overwhelmed and very scared, but I look at him and my heart melts.’

A few found the demands of motherhood a serious restriction for them personally:

‘(I’m) not working, I don't have regular adult contact and am not intellectually stretched.’

‘(I find the) loss of any independence very frustrating and depressing.’
The first-time fathers made very similar comments. More frequently than the women, they couched this in terms of having more responsibilities, a development about which they tended to feel positive. Some expressed this change in terms of personal growth, that previously they had been doing things that were less worthwhile, or in terms of feeling a sense of achievement or pride:

‘Everything now must be based around him first and us second.’

‘Responsibility - constantly having (and wanting!) to think about the wee one.’

‘Before the baby, I now realised how much time I wasted doing trivial things.’

Several fathers, as well as focusing on their babies’ needs, made reference to their partner and the baby together, as if mindful at this stage that the two were very much bound up with each other and their role as father was to support them both. The men frequently referred to their partner as ‘mum’, reflecting the importance of her new role for the whole family:

‘(There’s been a) shift of priorities - baby and mum over everything.’

‘Mum has to be on hand at all times.’

One father commented specifically on the gendered impact of having a baby:

‘Greater definition of our female/male roles in the family, all of a sudden I am the bread winner and (my partner)’s a house wife.’

One mother similarly commented:

‘(Changes for me include) being at home most of the time as opposed to work - whereas my partner’s professional life has continued more or less the same.’

**Joy and fulfilment**

First-time mothers frequently commented on the joy they felt in spending time with their new baby. Around one in eight women made a direct reference to feeling a sense of fulfilment in spending time with their daughter or son and/or in their new role as a mother:

‘The daily joy of my gorgeous baby.’

‘The overwhelming love I feel for my daughter.’

‘(I feel) besotted! I delight at watching him developing in new ways each day.’

‘I get a beautiful smile every morning when I go in to my baby’s bedroom!’
The pre-occupation of these mothers with their babies, and the strength of feeling they expressed, reflects the overwhelming power of the baby to evoke a response in the mother who has had positive childhood experiences herself.75,91

‘I can’t believe how much love you feel for your baby, it’s so overwhelming I was in shock.’

These kinds of comments included: ‘Loving the daughter’ or ‘really loving being a mum’. The following comment illustrates a sense that the power of these feelings for the baby could be stronger than feelings about losing independence:

‘(I feel) total devotion to the baby and do not feel remotely resentful about it!’

The arrival of their baby changed their status, cementing the transition which started when they became pregnant, from being part of a couple or a single person to having created a family. This act of creating a new family with their partner and their child, for many of the women and men participating in this survey, had wide ramifications. It could affect how they felt about themselves and about their partner:

‘(I feel) like a different person - amazed by the love I feel for him and how he has changed our family.’

‘It is nice to now feel like a ‘proper’ family.’

‘(I feel a) special bond with my husband.’

‘(My) relationship with my husband - feeling like a family so an even stronger unit.’

Some expressed how it affected their feelings about their own parents and their standing in their extended family:

‘(I feel a) greater appreciation for my parents.’

‘(I am) even more close to my mum now - it makes the bond very special.’

‘At last I am not the only member of the family and my group of friends who is childless.’

Interestingly a few women also described getting to know their neighbours since having their baby and being more home-based, and also having an opportunity to participate in events in their local community. As so many aspects of life had changed, from their interior sense of self, their relationship with their partner, to their working life and personal freedoms, taking time to mention their neighbours, locality and new contacts is all the more significant:

‘(I’ve) met new friends and had more time to chat to neighbours.’
‘I am more involved in my village.’

‘(Now I) appreciate where we live and the things (there are) to do.’

‘I have made a lot of new friends and discovered a whole different world out there.’

First-time fathers also expressed delight in their new baby and pride in establishing a family:

‘(I have) an overwhelming feeling of pride.’

‘What a great and happy feeling it is to be a dad.’

‘(We) feel complete as a family.’

Some of the men expressed the changes they were experiencing in emotional language, demonstrating that a strong new bond had been formed:

‘(I feel) absolute joy at spending time every day with our little girl.’

Others expressed their warm and engaged feelings for the baby using somewhat less intense language than many of the women:

‘He is a bundle of fun and it’s very rewarding watching him develop.’

‘The new experience of watching an infant develop and react to me is great.’

Lack of time

The third major theme was lack of time. This was referred to by one in five women and was the most common theme in comments from men, mentioned by almost one in four. It came up as lack of personal time for women to do things for themselves, from the basics of going to the loo or getting their hair cut through to opportunities to express themselves in ways they were used to, to take exercise or to go out with friends without the baby or to do any other kind of work than babycare. Both men and women made comments about lack of time for housework or getting ordinary domestic things done. They both commented on fewer opportunities to things alone or with their partner as a couple, including opportunities for sex and emotional intimacy.

‘How difficult it is to do anything apart from looking after baby.’

‘Time for me is hard to come by.’

‘(I have) difficulty getting things done - even using the bathroom.’

‘Getting everyday tasks done is difficult, e.g. a large shopping run.’

‘(I feel) frustrated at times about not getting anything done.’
‘The availability of time to do normal chores. The state of my house - such a mess!’

As well as this affecting them personally and in terms of running the household, women commented on there being less time for them as a couple:

‘I spend much less time with, and attention on, my husband.’

However, some women indicated that the effects of having very little time when they were not looking after the baby were really getting them down:

‘(I feel a) loss of self esteem as I have no time for my physical appearance.’

‘Lack of control - I never have a moment to do anything, the house is a mess, I am a mess, nothing ever seems to get finished!’

Some described the change they experienced in terms of ways of responding to the pressures, and needing to learn to juggle, to accept help and to adapt:

‘(I’m) learning to let things go... accept help, when it is offered and learning to juggle baby’s needs with daily tasks - feeding myself for example... but we are getting better at it!’

Lack of sleep

Mirroring their anticipation of the change in their lives that their new baby would bring, both women and men frequently referred to lack of sleep and tiredness as a major change in their lives. In comparison to the pre-birth questionnaire, lack of sleep was referred to less frequently. Around one in eight of the comments from women referred to tiredness and broken sleep, and for a significant number lack of sleep and exhaustion were having had a major impact on their lives:

‘(I am) tired all the time.’

‘Extreme tiredness - no one really explained how tired I would be.’

‘Exhaustion - have not slept for more than 3 hours at a time since the birth.’

‘Lack of sleep is impairing my mental capacity.’

Planning and preparing

A less frequently cited change in their lives, but nevertheless a commonly mentioned consequence of having a baby, was a diminution of spontaneity. Both women and men referred to the need to plan activities in advance and to prepare for leaving the house, making sure that they had all that the baby would need while they were out.

‘(What has changed?) Not having the freedom to go out or do things spontaneously.’
‘I have to plan ahead for any walk or trip out, and pack for every eventuality.’

“Getting about takes a lot more planning!”

New friends

One other effect for first-time parents of having a new baby was that they went out much less in the evening as a couple. For women in particular there was a shift towards a different kind of social life centred around other mothers with babies meeting during the day while their partners were at work. For women who lived close to other new mothers whom they had come to know locally, through the NCT course, NCT branch activities or other contacts, this was a positive development that many valued and enjoyed:

‘Social life is now during the day with mums and babies - I don't go out in the evening.’

‘I have met lots of new mums and have a better social life than before!’

‘Getting to know new mums and having a great network of new friends.’

‘(My) social life is now during the day with mums and babies - I don't go out in the evening’

‘I've made a) good group of (NCT) friends and we chat together.’

Women’s other comments included references to them carrying out more housework, and to differences in the impact of parenthood for mothers and fathers. Housework had not emerged as a theme in post-course comments on expected changes.

‘(Changes for me include) being at home most of the time as opposed to work - whereas my partner's professional life has continued more or less the same.’

‘My life (as a mum) changes significantly more than (his life as a) dad.’

A few women referred to specifically to changes in their sex life, mainly to there being less frequent sex or fewer opportunities for sex. One said:

‘My sexual relationship with my partner (has changed) – (I'm) much more reluctant and nervous about this now, though he is completely understanding and gentle.’

Almost as common were references to having less time to oneself, less time to spend with one’s partner, or less time for ‘everything.’ Interestingly, the pace of life seemed to have increased for some and decreased for others; and while some said that their baby required them to make more plans, rather than act spontaneously, others said they were no longer being able to plan ahead.
8.2 Experiences of problems and worries

As well as collecting feedback from parents in their own words, from neutral open-ended questions that enabled them to say what they wanted to, the post-birth questionnaire included a range of closed questions enabling NCT to get the reaction of all first-time mothers and fathers to a range of previously identified topics and questions. Previous literature has identified the pressures that mothers feel conform to an idealised image of a mother who is happy and coping. NCT research has identified that many mothers and fathers with a new baby, of all ages, class and cultural backgrounds, experience stress and worries during the postnatal period. The birth of a wanted baby is culturally defined as a positive transition, and it can be difficult for women and men to admit to themselves or to others that they often feel angry, worried, disappointed, depressed or at their wits end.

The study aimed to give parents permission to express the negative aspects of how their lives had changed, by asking about the problems and worries they had experienced. Both women and men were asked to rate the extent of any problems and worries since their baby had been born on a scale from zero (no problems) to five (major problems) (table 37). Tiredness was the most frequently reported problem for both new mothers (36% rated it four or more) and new fathers (25% rated it four or more) (table 37). The next most common concerns for both genders were never getting a break, worries about their baby’s health, and worries related to sex. The questionnaire for men included fewer questions about potential post-birth problems. They were asked about feeling low or depressed but not about their physical health, isolation or loneliness, nor about whether they felt less valued as a person since the birth of their baby. These were included for the women as these have previously been reported as important dimensions of women’s experiences of becoming a mother and postnatal recovery. Similarly, men were asked about their partner’s health but women were not. About one in five men indicated that they had been worried about their partner’s health since their babies’ birth (22% rated it four or more; mean=2.27, SD=1.38).
Table 37  First-time parents’ problems and worries three months after birth

<table>
<thead>
<tr>
<th>Problem</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Tiredness *</td>
<td>36%</td>
<td>358</td>
</tr>
<tr>
<td>Never getting a break **</td>
<td>24%</td>
<td>357</td>
</tr>
<tr>
<td>Worries about my baby’s health **</td>
<td>20%</td>
<td>359</td>
</tr>
<tr>
<td>Worries about starting having sex/lack of sex/painful sex</td>
<td>23%</td>
<td>359</td>
</tr>
<tr>
<td>Going back to work/childcare</td>
<td>16%</td>
<td>359</td>
</tr>
<tr>
<td>Worries about my own health</td>
<td>12%</td>
<td>358</td>
</tr>
<tr>
<td>Disagreement with my partner</td>
<td>11%</td>
<td>359</td>
</tr>
<tr>
<td>Feeling low or depressed **</td>
<td>11%</td>
<td>358</td>
</tr>
<tr>
<td>Worries about money/benefits</td>
<td>10%</td>
<td>359</td>
</tr>
<tr>
<td>Isolation or loneliness</td>
<td>5%</td>
<td>355</td>
</tr>
<tr>
<td>Worries about the effects of the current recession</td>
<td>9%</td>
<td>359</td>
</tr>
<tr>
<td>Boredom **</td>
<td>6%</td>
<td>359</td>
</tr>
<tr>
<td>Feeling like a less valued person</td>
<td>6%</td>
<td>354</td>
</tr>
<tr>
<td>Getting to know my baby</td>
<td>3%</td>
<td>359</td>
</tr>
<tr>
<td>Housing</td>
<td>3%</td>
<td>359</td>
</tr>
<tr>
<td>Worries about my partner’s health</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

* Significant difference between women and men (t-test, p ≤ 0.05)
** Significant difference between women and men (t-test, p ≤ 0.01)

There was a significant difference in the extent to which women and men reported feeling low or depressed, represented by mean scores (women’s mean=1.60; men’s mean=0.92, p ≤ 0.01). While feelings of depression were not often reported as more than a minor or moderate issue, 11% of first-time mothers and 5% of first-time fathers indicated that feeling low or depressed was or had been a major problem (score 4 or 5), and 5% of first-time fathers. Both genders were asked about feelings of boredom. This was also more of an issue for women than for men at three months post-birth. Six percent of first-time mothers indicated boredom was or had been a major problem (score 4 or 5), and 2% of first-time fathers.

8.3  Usefulness of the NCT course

The new parents were asked to think back and consider ‘how useful did you find the course in preparing you for being a parent’ and then respond to 10 topics about caring for their baby, tiredness and the ‘realities’ of life with a new baby, changes in their relationship with their partner and ideas about supporting their partner, as well as questions about sources of help and getting to know other new mothers and fathers. A substantial 84% of men reported that ideas discussed on the NCT course about how to support their partner had been useful. This provides further evidence to support Burgess’s conclusions about the benefit for families of men being given the opportunity, as part of a transition to parenthood course, to explore the demands faced by new mothers, and to be encouraged to view care of the baby as a shared activity.65
In addition, both women and men rated discussing ‘information about where to turn to get help’ as one of the most helpful aspects of preparing for parenthood. This was rated by 85% of women and two thirds of men as ‘fairly useful’ or ‘very useful’. Preparation for change was also rated highly: ideas about the realities of life with a new baby, and changes in couple relationships, were rated as useful by two thirds of women. Fewer women and men felt that they had received useful information about having sex after childbirth or useful ideas on coping with tiredness (see table 38). Around half of the women and men said they had found discussion about sex after childbirth useful. This may reflect the amount of time spent discussing this subject or the quality of the discussion and information provided.

### Table 38 Aspects of NCT course preparation rated as very or fairly useful in preparation for becoming a parent

<table>
<thead>
<tr>
<th>Mothers: n=240-358</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Ideas about supporting your partner</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Information about where to turn to get help *</td>
<td>85%</td>
<td>295</td>
</tr>
<tr>
<td>Ideas about the realities of life with a new baby</td>
<td>69%</td>
<td>238</td>
</tr>
<tr>
<td>Ideas about changes in your relationship</td>
<td>69%</td>
<td>200</td>
</tr>
<tr>
<td>Practical ways to handle your baby’s crying and sleeping</td>
<td>61%</td>
<td>195</td>
</tr>
<tr>
<td>Information about having sex after childbirth</td>
<td>52%</td>
<td>124</td>
</tr>
<tr>
<td>Ideas on coping with tiredness</td>
<td>51%</td>
<td>149</td>
</tr>
</tbody>
</table>

* Significant difference between women and men (Mann-Whitney, p≤0.05)

The way that subjects are introduced and explored on a course varies for several reasons. NCT antenatal teachers each plan their own course curriculum and some aspects of what each teacher plans to cover will vary. In addition, within some pre-determined limits, all teachers aim to respond to what the particular group of parents attending want to cover during the course. In addition, longer courses offer more scope for discussion as there are more hours available. Generally, teachers may have tended to focus more on parents’ role changes, making adjustments, and the social and emotional impact of having a baby rather than on practical aspects of babycare such as bathing and nappy changing in NCT courses. One of the reasons for this was that many parents also used to attend an NHS ‘parentcraft’ course and these practical skills-based topics were covered in those sessions. However, NCT tutor Mary Nolan has suggested that this assumption can no longer be made with confidence.98

Overall, around three months after birth, ‘thinking back to the first month’ with their new baby, six in 10 first-time mothers and a similar proportion of first-time fathers said that they had felt ‘very’ or ‘quite’ prepared for life with their new baby. Around one in 20 of the women and one in 30 of the men said they had felt not at all prepared (see figure 10). When comparing
courses of different lengths, traditional full length courses and intensive courses, no significant difference was found in the extent to which either women or men said they felt prepared.

First-time mothers and fathers were asked to comment in response to a question on what they had felt best and least prepared for ‘about looking after a new baby’. These were open questions allowing parents to comment on any aspect they chose to highlight. Interestingly, three out of four main themes on which women indicated they had been ‘best prepared’ were also themes on which feedback indicated women felt ‘least prepared’. These were breastfeeding, practical babycare, and the reality of motherhood. The findings seem to suggest that these three topic areas are important. While the question was not phrased specifically in terms of how the NCT course prepared them, the findings raise the question of whether there is considerable variation between different NCT courses in terms of what the curriculum includes. Alternatively, it may be that some women have significant alternative means of preparing for life with their new baby, such as personal experience of babies, or connections with a network of family members and friends.

**Best prepared**

Altogether 341 first-time mothers commented on what they had felt best prepared for. All the comments were read and 100 were analysed in detail. Some women made more than one comment (115). Four main themes emerged. There is a degree of overlap between the categories, and some are more specific than others, so the distinction is not absolute. However, coding into categories followed the different kinds of emphasis made. The themes were feeling best prepared for: breastfeeding (28), practical babycare (25), the reality of motherhood (18), including practical coping and emotional support strategies, and feeling unprepared (10). Quotes are mainly taken from the 100 comments analysed in detail, with others included where they illustrate a theme especially well.

- **Breastfeeding**

Approximately a third of women commented on being best prepared for breastfeeding, including those who referred simply to ‘feeding’ in a context implying breastfeeding (32). Comments made by the first 100 women included:
'(I felt best prepared for) feeding - I knew that I wanted to breastfeed and info that I received from NCT and other NHS sessions was very useful.'

'Breastfeeding - that was the best session of the course by far.'

'The amount of time the baby would be feeding, didn't realise it was so frequent before doing NCT!'

This included some comments from women who said they had had difficulties but felt equipped to address them and find support:

'Breastfeeding - although this turned out to be more difficult than I had thought.'

'Feeding. Was able to call on someone when I was struggling.'

Some further comments indicating what women especially valued in preparation for breastfeeding included:

'Literature that made me able to feel more rational about why my baby needed to feed so frequently - it felt like he was almost permanently latched on but I just kept reminding myself his tummy was the size of a chickpea.'

'Breastfeeding and the need for support from family/friends.'

- **Babycare**

The second most frequently mentioned theme was preparation for practical babycare (25); the kinds of knowledge and skills that used to be referred to collectively as 'parentcraft'. Some first-time mothers felt well prepared and some specifically indicated that this was partly as a result of their NCT course:

'It was very hot after he was born so keeping his temperature comfortable and (reducing) his bedding I remembered from the information sheets we were given.'

'(I felt best prepared as a result of) the tick list of what to check when the baby cried, i.e. nappy, food, colic, etc.'

Others did not mention the course but indicated that they had adequate information and felt reasonably confident:

'(I felt best prepared for) sleeping - what baby should be wearing and what to cover them with. Moses basket, etc. Nappies/changing.'

'Knowing how to feed and bath my baby, what I needed for her and knowing there was support nearby from others going through the same experiences.'

'(I felt best prepared for) trying to work out my babies needs when crying.'
'I was prepared with the physical side of it like changing, bathing etc.’

‘Changing nappies and what the poo should look like. Sleeping patterns. Where to turn to in case of breastfeeding problems. Spotting tongue tie.’

- The reality of motherhood

The third theme was the reality of motherhood (18) including comments on ‘how it feels’ and strategies for coping. It was apparent from the feedback that this group of mothers felt they had been prepared for the impact their new baby would have on their day to day, whether this came from their NCT course, chatting informally to friends or new parent contacts, from another source.

’I felt best prepared for the sleepless nights and the breastfeeding.’

’(I felt best prepared for) the disruption to everyday life - learning how to deal with that was/has been more ‘on the job.”

’The fact that you couldn’t plan a day - things would always crop up.’

’(I was best prepared for) how life changing it would be, e.g. (what to expect in) a typical 24 hour period.’

’(I was best prepared for) how time would be taken up with my baby.’

Women seemed to find it useful when the first weeks after the birth were identified as a time of transition, which would be much more challenging than later weeks when the new family was more established and a relationship with the new baby had been forged:

’(I felt best prepared) being forewarned re the difficulties of the first couple of weeks (e.g. the third day when (you might get) baby blues and the milk coming, or how to cope with visitors etc) made it easier to cope. It helps to know that any difficulties are ‘to be expected’ and not only experienced by you alone.’

One of the things these women talked about as a strategy for coping was being flexible, focusing on their baby’s needs (rather than housework, visitors or other demands) and a willingness to ‘go with the flow:

’(I felt best prepared) to go with the flow rather than planning to stick to a regimented schedule.’

’(I felt best prepared for) understanding how things will change and you cannot predict a routine and must go with the flow.’

’(I was prepared to) sleep when he sleeps (and) don’t do housework!’

’I had been reading a lot and had attended my NCT courses. We bought all the necessities and had the baby gear. I was planning to breastfeed, and I
knew that we would instinctively figure it out eventually. I knew that I needed to take things one day at a time.’

In terms of getting the hang of their new role, three women in the 100 responses analysed referred to having or developing ‘a routine’ and a similar number talked about trusting their instincts, as the examples above and below illustrate.

‘(I felt) that looking after our baby would just come naturally, and it did. Reading books and taking classes was helpful, but having the confidence to do things yourself is the key.’

Others referred specifically to having discussed the need for practical and emotional support during preparation and therefore having been able to make arrangements for support:

‘(I felt best prepared by) discussing the need for support in the first days/weeks.’

‘(I was prepared for needing) the support of family to help through the crying, tiredness and breastfeeding.’

Two other women, not counted in the ‘reality of motherhood’ group, said they felt well prepared because of their own state of readiness for motherhood or their own experience of family life:

‘I felt prepared for motherhood in general. It was something I had wanted for a long time.’

‘(I feel prepared because of my previous) experience (from my family) and (my) instincts.’

- Feeling unprepared

Finally, the fourth theme, which reflected the views of one in 10 of the women who responded, was a rejection of the question: they had felt unprepared for life with their new baby (10). They felt that the course they had attended had been unhelpful in getting them ready for looking after their baby or what to expect of the transition to motherhood generally. The comments included:

‘The antenatal classes covered mostly a natural birth and the complications and impact of interventions. There was little time spent on looking after the baby.’

‘Breastfeeding - this was a major focus of NCT. It left me feeling that if we cracked breastfeeding the rest was easy. This was not the case - there was so much I was left to teach myself from a book and I felt very unprepared and alone.’

‘(I’m) not sure I felt prepared for anything!’
'I did not feel prepared at all.... (there was) too much focus on birth and that was the easiest despite complications.’

‘From the classes - breastfeeding was the only part of looking after a new baby that was covered.’

Some of those who made these criticisms had attended an intensive course, some of which are presented as ‘labour days’, but others had attended a full length course and found the coverage of the days after birth insufficient.

Among other positive comments about feeling prepared there were also references to having a support group of other parents in place (8), and having the necessary babycare equipment (6): ‘The class gave me lots of ideas on the types of things I might need’. Five first-time mothers referred to preparing for, and being prepared for, changes in their relationship with their partner:

‘(I felt best prepared for) changes in (our) relationship and arguments (and finding ways of) getting in touch with other.’

- Fathers’ feedback

Some men felt very positive about their efficacy in their new role and indicated that they were well prepared for all aspects of becoming a father (8). Among responses from the 58 first-time fathers who responded to the question about what they had felt best prepared for, two common themes were babycare (14) and breastfeeding (7), including preparation for supporting their partner with breastfeeding. Their comments also referred to tiredness and disturbed sleep (6) and feeling poorly prepared (8). Positive comments about feeling prepared for becoming a father included:

‘(What do I feel best prepared for?) Most things actually! Generally having the belief that being a dad was something I could actually do well.’

‘I felt prepared for all aspects of looking after our baby.’

In addition, men highlighted how useful it was to have practical preparation about what to expect, in terms of the amount of time the baby’s care would take and especially the challenges and changes in the first week. Many NCT teachers use the 24 clock activity as described in chapter 7 and provide a tear-off NCT information sheet called ‘What’s in a nappy?’ Their comments included:

‘(The) routine of sleep/feed/change and the info on the first week, like the pamphlet on babies’ poo colour and consistency.’

‘The circle of a baby’s clock for sleeping, changing nappies, winding etc.’

‘Supporting my partner to breastfeed.’

‘(I was best prepared having been made) aware of how difficult and tiring it is for my wife on a day to day basis.’
Some, but not all, of those who felt that their course had not covered enough about looking after a new baby or role changes, had attended an intensive course:

'I did not feel prepared in any aspect.' (Intensive course)

'I don't feel we really covered looking after a baby in any detail.' (Full length course)

Least prepared

The free-text responses to the question about what first-time mothers had felt least prepared for are particularly important, as they provide an indication of the ways in which women might have benefited from different opportunities during their NCT course. Four major themes emerged from the 100 comments that were analysed in detail, of 344 comments made. These were baby feeding (34), practical babycare (22), the reality of motherhood (27) and tiredness and lack of sleep (18). Some women commented on more than one theme.

- Baby feeding

Well over half of the women made references to being 'least prepared' for aspects of feeding their baby; some commented about feeding issues on their own (34) and others mentioned feeding as one aspect of uncertainties and new challenges in working out how to look after their baby. Of the 34 who focused particularly on feeling unprepared for aspects of feeding their baby, 23 referred to breastfeeding of which 13 comments were explicitly about breastfeeding difficulties.

'Didn't realise how difficult breastfeeding would be - I thought it would be easy.'

'Getting going with breastfeeding was a struggle and harder than I thought it would be.'

'How painful and brutal breastfeeding can be! Despite all the information about positioning etc. no one had mentioned how much it can hurt and how long it can take to get sorted. It took me 3-4 weeks before it all went smoothly.'

Experience of difficulties was sometimes made in the context of a lack of support from midwives and being prepared for how to manage if this turned out to be the case:

'Breastfeeding - I had massive problems. I had very poor midwife support postnatally.'

'(The course) did not really cover the realities of an over stretched midwife service with little interest in encouraging breastfeeding and an enthusiasm for mixed/formula feeding. Also, I would have been useful to cover common issues such as colic, reflux etc.'
In contrast to the many positive comments above about how the NCT course had been a helpful preparation for breastfeeding, some women specifically identified that they felt that the NCT breastfeeding session had misled them regarding what to expect and that this had been unhelpful:

‘The NCT course gave the impression that it is both natural and easy for mother and baby and did not cover the potential problems or give any reassurance that it can be difficult at first. I therefore felt a complete failure when my baby would not feed at birth and assumed there was something wrong with me. On the basis of the NCT advice I would have given up but I persevered with the help of an excellent health visitor and NHS lactation specialist.’

The other comments were about ‘becoming a breastfeeding mother’ (10), in other words learning how to breastfeed and what breastfeeding entailed.

‘I was breastfeeding and I didn't really know that the baby just needs to be fed ALL THE TIME.’

Eleven feeding comments were about a lack of information about introducing or using formula, bottle feeding, sterilising equipment or mixed feeding:

‘I felt least prepared about breastfeeding and in particular what to do if after attending clinics etc the baby would still not latch on. What are the alternatives expressing, formula and how to do each of these.’

‘I had significant difficulties with breastfeeding and had to supplement with formula at short notice on the health visitor's advice. I did not know anything about formula feeding and found it very stressful to have to learn at my lowest ebb.’

‘(I felt least prepared for feeding because I had no) information about bottle feeding. How much they should take, how often, sterilising. If you do not breastfeed, you get very little info. Not everyone wants to breastfeed!’

- Babycare

Around a third of women said that they felt ‘least prepared’ generally for mothering their baby (22); they lacked a sense of self efficacy. They were unsure and anxious about what to do and how to do it. This included practical tasks and a sense of a positive belief in themselves as mothers. Women now often leave hospital or birth centres within 24 hours of giving birth, so they have had very little experience of handling, feeding, changing and soothing their baby.

‘Looking after a baby - the reality - sleeping patterns, crying, feeding, choking, etc. What to do when, who to turn to when.’

‘What to do when we got home from the hospital. We had no idea if we should wake up the baby for a feed or when to feed.’
’(I felt least prepared for) practical issues e.g. bathing, changing, dressing and the number of blankets to use in bed, feeding in public, etc.’

Winding a baby was mentioned by several women responding to the post-birth survey. These first-time mothers highlighted winding their baby as a main aspect of life with their new baby that they had felt least prepared for:

’(I did not know) the tricks of how to burp or settle my baby for sleep.’

’Feeding - burping was not even mentioned.’

One or two first-time mothers also made specific mention of feeling a need for guidance on health and illness in babies, including colds, first aid, a chance to explore their baby’s sleep patterns and associations, and avoiding over-stimulation:

’No advice was given on sleep cycles which meant that it took us a while to realise the crying wasn’t for food but tiredness. By then sleep associations had set in i.e. falling asleep on the breast!’

’Helping her to cope with the world around her e.g. understanding overtiredness and overstimulation and helping her to settle.’

- The reality of motherhood

Another key theme which encompasses other more specific experiences has been identified as the reality of motherhood (18). This relates to a changed way of life and a woman’s reaction to it, often involving strong emotional elements. It reflects experiences of the reality as opposed to the fantasy of what life with a new baby would be like. Exhaustion and lack of sleep often feature as significant characteristics of life with a new baby. This was often commented on specifically as something first-time parents felt unprepared for and has been given a separate category. Some first-time mothers talked about feeling shocked, anxious or overwhelmed by the impact of motherhood.

’(I was unprepared for) the initial shock and trying to cope with lack of sleep, emotions and learning to breastfeed.’

’The exhaustion - not knowing why she was crying - the sheer amount of time taken by feeding.’

’The overwhelming feeling of anxiety!’

’(I was unprepared for the) emotional side; how scary it would be the first time I took the baby out for a walk.’

’(I was unprepared for) the effect on our relationship.’

Nine women referred to coping with persistent crying or colic (‘a baby crying in pain’) and how helpless and frustrated it made them feel:
'I was not prepared for) the baby crying for extended periods and coping with the emotion I felt when he cried.'

'I was unprepared for) how to cope with the seemingly endless crying and the utter irritation I felt because I couldn't calm him down.'

- **Tiredness and lack of sleep**

Tiredness and lack of sleep (18), was commented upon frequently, even though it also featured strongly as something both women and men anticipated during pregnancy would be a characteristic of life with a new baby. It was mentioned specifically by many women as something they felt 'least prepared' for:

'No matter what courses you attend or all the books you read I think nothing can prepare you for the sleep deprivation and how this effects you both personally and as a couple.'

Other issues raised that women have felt least prepared for included physical recovery after the birth (5), and the need to limit the number of visitors (2).

- **Fathers’ feedback**

The comments from the 58 men about what they felt least prepared for covered similar themes to women: particularly aspects of feeding (13), persistent crying (9), tiredness (4), and partners’ physical recovery (4). Comments included:

'The first two weeks is relentless - only way to get through it is to go on auto-pilot and deal with whatever happens as it happens.’

'Just how to handle him physically - how to pack him up, how to carry him, hand him between us - we weren't really shown anything on that.’

'Dealing with the realities of crying and how to pacify.’

'Coping with my wife’s feelings/sadness and struggling with the breastfeeding.’

'I was least prepared for) feeding – (the course) only covered breastfeeding - my wife produced milk but my son never worked it out. My wife felt like she had failed and we had no information about what formulas to use/different types of bottles/how their feeding times & routines differ etc.’

Many new parents felt that they needed to know more in advance of having their baby about what to expect, as well as thinking about who might be available to turn to for encouragement, guidance and practical help in the first weeks with their new baby. However, there was also recognition that the way an experience is lived out in real time, involving all the senses, is likely to be qualitatively different from attempts to visualise what it will be like in advance. As one mother said:
‘Although I knew and was told so, (I was unprepared for) the huge effect (a baby) has on your life; as it takes over completely.’

Confidence

In addition to asking parents about how prepared they had felt for life with a new baby, the follow-up questionnaire asked women and men to assess their level of confidence once more. As discussed in previous chapters, confidence is affected by many factors. Rogan and Barclay, who carried out a qualitative study of 55 first-time mothers, identified three factors that influence the transition: previous experience with babies, social support, and baby’s behaviour. Levels of self-reported confidence may reflect differences in an individual’s personality, and their particular experiences and needs, as well as the potential for a course to provide fulfillment of needs. Three months after birth around 60% of mothers and fathers felt confident about life with their new baby. Three percent of mothers and no fathers indicated that they still felt ‘not very confident’ (see table 39).

Table 39  First-time parents’ confidence about life with a new baby three months after birth

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<tr>
<td>Not very confident</td>
<td>3%</td>
<td>9</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Fairly confident</td>
<td>39%</td>
<td>141</td>
<td>38%</td>
<td>23</td>
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<tr>
<td>Confident</td>
<td>59%</td>
<td>212</td>
<td>62%</td>
<td>37</td>
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<td>Total</td>
<td>100%</td>
<td>362</td>
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Figure 11 shows that over time there was an increase in confidence, with a large reduction in the proportion feeling ‘not very confident’ and a major increase in those feeling confident.

Figure 11  First-time mothers’ confidence about being a mother before and after the course and confidence about life with a new baby at three months

(n=207-209)
The longitudinal sample enables comparisons to be made between women’s reported confidence in anticipation of having their first baby and their feelings once they had experienced motherhood and caring for their baby for around three months. At the end of the course, the majority of the longitudinal sample had felt fairly confident about being a mother, but a small group had still felt not very confident. Of the latter group, most of those who responded at three months (80%) said at that stage that they felt fairly confident about life with a new baby (n=10). Thus, experience and the passage of time had increased their confidence from a low level to a moderate level.

By the time their baby was three months old most felt ‘confident’ (58%) about life with a new baby, though a substantial minority (42%) remained only fairly confident or not very confident (table 40). Of those who had felt confident about being a mother antenatally (n=77), most also felt confident about life with a new baby at three months (69%) though quite a large number (31%, n=24) reported that their level of confidence had fallen, reporting only feeling fairly confident or not very confident.

Some women consistently reported feeling confident. There is a significant correlation between recalled feelings of confidence about being a mother before the course, after the course, and reports about confidence about life with a new baby three months after birth. Women who felt confident before the course were more likely to feel confident after the course (r=.544, p<0.01) and mothers who felt confident after the course were more likely to feel confident three months after birth (r=.194, p<0.01).

While there was no difference between how prepared women or men said they had felt according to the length of their antenatal course, more women who had attended a full-length course reported feeling confident about life with their new baby three months after birth than women who had attended an intensive course (Mann-Whitney, p<.01).

### 8.4 Parent to parent support

A key component of the NCT model is the development of a mutually supportive group. Antenatal teachers work with parents in a participative way throughout the course. They facilitate discussions among the whole group and plan small group activities and encourage informal chat and
social contact between women and their partners. This encourages parents to get to know one another and to develop trusting, confiding and supportive relationships and a mutual support network. Some or all of the parents on the course also often form a close social group that continues to meet after the course ends. Parents are also introduced to local NCT branch activities including coffee groups, nearly new sales, and activities such as picnics, swimming, walks and barbeques. Both women and men rated the opportunity to meet other mums and dads as one of the most useful aspects of attending an NCT course: 97% of women and 100% of men rated this as ‘fairly useful’ or ‘very useful’ in the post-course survey.

Teachers usually organise a postnatal reunion after the last baby of the group has been born, to which all parents are invited to attend with their babies. Seventy one percent of all mothers (n=242) and two thirds of all partners (n=41) who attended a full-length or intensive course attended a reunion. A further 8% of mothers and 12% of partners said that a reunion had been available but they had not attended.

When asked which aspects of the antenatal course they had got the most benefit from, overwhelmingly both women and men said that meeting, forming a group with, and ultimately becoming friends with other parents attending their course had been enormously important for them. Of 345 comments from women, more than half (241) included this theme. For example,

‘Meeting other people in a structured environment that has led to me becoming great friends - mums and dads alike.’

‘(It’s been) good to meet people in same situation at the same time as me.’

‘Making friends as we have supported one another after our births.’

‘The social network has been invaluable.’

Frequently women made multiple comments, of which one related to meeting other local parents. For example:

‘(I got most benefit from) meeting other couples in my area (and from discussing) different types of pain relief.’

‘The course was most useful in terms of preparing for the birth and for meeting new friends. It was useful that the course leader suggested a date for us all to meet afterwards.’

‘What happens physiologically during labour and its stages. Pain control options. ‘24 hours’ looking after a baby description. Socialising with other new parents.’

Similarly, respondents found it helpful to hear from parents who had been on previous NCT courses who had had their babies a few weeks earlier, as they could provide a first-hand account of what birth, feeding, and looking after their baby was really like for them. One woman who attended a shorter course commented:
“We did the weekend intensive course, so missed out on having a couple come to the class who had recently had a baby.”

The men also frequently referred to the value of getting to know other parents:

‘Group sessions were good for learning as well as letting off steam with other similar individuals. Close friends without kids find it difficult to relate to what is changing in our lives.’

Since their course had finished, 89% of women and 62% of men said that they had had informal meetings with members of their NCT antenatal class. Smaller percentages had been along to other kinds of groups that provide contact with other new parents: a health centre drop-in (38% women, 13% men); a drop-in at a children’s centre (28%, 5% men), an NCT branch drop-in (11% of women, and one man) or an NCT facilitated postnatal ‘Early Days’ course (six women, 2%).

One father of twins born by caesarean felt that his course had not helped him prepare well for what to expect after the birth, but found the network of support from other parents valuable:

‘(I needed to know about) practical help - rather than aimless massage, breathing and relaxation. ... Following the birth I was completely unprepared for the actual help that we would need. ... The actual level of care that I have to give is just staggering. None of this was covered in the course. ... Apart from meeting other first time parents who now provide a massive network of support, without sounding too grumpy, I may as well have stayed at home and watched the football.’

8.5 Issues of importance to men in becoming a father

In order to find out more about what men’s experience of the transition to fatherhood, the fathers’ post-birth questionnaire included the question: ‘please let us know which issues have been especially important for you in becoming a father’. All respondents answered and the vast majority of comments related to looking after their baby, changes in their relationship with their partner, and working out their new role in relation to their baby, their partner, themselves as a person and their work. Financial responsibilities also featured among responses.

‘Trying to gain a balance between working hours and helping my wife is difficult as I have a very demanding job but also feel I should be at home as much as possible to help (I am still wrestling with this - and probably will be for a while yet).’

‘Simply being a dad. Financial support/spending time with family - the balance of showing you still love them when having to work.’

‘Financial stability, and lots of interaction with baby’
‘(Having) less time to myself, and being down to a single income.’

‘How to bond with my baby in the early days, and how to support my wife fully when I am at work all day.’

Several highlighted that a key issue for them was working out how to be supportive to their partner:

‘Knowing how and when I can actually be useful and support actively.’

‘How to be supportive, and not let tiredness get on top of me.’

Many of the comments about work resonate with the findings from Miller’s research on fathers, other comments reinforce the findings of Nystrom K, Ohrling and Lewis that, far from nurturant fathering being positively reinforced during the early months of fatherhood, it was sometimes undermined or difficult for fathers to achieve, as illustrated here:

‘The understanding that I will be given a mountain of completely contradictory advice. The understanding that the medical profession still only vaguely understands that males are involved in child care.’

‘It was important for me to feel a part of the whole process and not feel an outcast.’

Societal ambivalence about men’s role as a father and men’s attempts to reconcile the mixed messages about what it is to be a good dad are illustrated by use of phrases such as professionals having only a ‘vague understanding’ of a father’s involvement and words like ‘outcast’. The comment below is another example. The man says that as a father he recognises that he is in a ‘supporting role’, and as part of this must accommodate socialising with people and in ways that he wouldn’t previously have done.

‘Accepting I am in a supporting role and trying to help make childcare easier and help my partner to make new friends by not sulking when asked to go to lame social gatherings!’

So, during the early weeks after the birth, while undergoing the transition into fatherhood, men are working out how to embody their new role both in the private sphere of their home-life and the public settings of work, healthcare services and their (changing) social networks.

8.5 Summary

Four key themes emerged about women’s and men’s experiences of becoming parents for the first time. First, and most commonly mentioned, this meant a change to a baby-focused lifestyle, involving changes in their personal, social and (particularly for women) working lives. Second, for many in this sample, the change was immensely positive, as the baby created new feelings of love, joy and fulfilment, which for some women appeared to compensate for losing freedoms they had previously valued and enjoyed. Third, there was a lack of time for things other than looking
after the baby. The fourth key theme, reflecting what parents had anticipated, was tiredness and lack of sleep.

Feelings of low mood, depression, anxiety and boredom were all reported as problems. Six percent of women described negative feelings about motherhood in comments. A larger percentage of first-time mothers (11%) indicated in response to specific questions that feeling low or depressed was or had been a major problem for them, and this was also reported by 5% of first-time fathers. Six percent of first-time mothers and 2% of first-time fathers said boredom was a major problem for them. A number of men described how combining their working role and financial responsibilities with supporting their partner and developing their fathering relationship was an issue for them. None of the men talked about feeling worried, anxious or depressed themselves but almost half of those who responded (48%) indicated that they had been worried about their partner’s health since their baby’s birth and a large majority (83%) had welcomed the ways in which their NCT course had prepared them for supporting their partner.

First-time mothers who had attended an NCT course were most likely to report feeling best prepared for breastfeeding, practical baby care and the reality of motherhood, including practical coping and emotional support strategies. However, a significant group also felt they needed better preparation for the reality of breastfeeding in the early days and ways of responding to breastfeeding difficulties; they wanted information about using bottles and formula milk, more on practical babycare and coping with the reality of motherhood, including coping with persistent crying.

Comments from men also indicated that some highlighted being well prepared for breastfeeding and practical babycare while others felt poorly prepared for looking after their baby, including responding to feeding challenges. At least one in 10 women and men felt very poorly prepared for life with their new baby, making no positive comment at all. Those who did provide feedback suggested that the main gaps concerned looking after their baby, changes in their relationship with their partner and the demands on their time. For men, becoming a father involves working out what kind of a dad they are going to be and that this is done in the context of multiple demands and often conflicting messages.

While there was no difference between how prepared parents said they had felt according to the length of their antenatal course, women who had attended a full-length course more often reported feeling confident about life with their new baby three months after birth than women who had attended an intensive course.

This study reinforces earlier findings on the protective effect of social support. The growing body of evidence about the transition to motherhood and fatherhood suggests that being part of a parent support network in which confiding relationships can develop is very valuable. NCT courses and branch social activities facilitate and help to maintain and develop these kinds of opportunities.
Baby feeding

‘Baby feeding is one of the most rewarding and often challenging aspects of parenting. When feeding goes smoothly it provides pleasure, a sense of fulfilment and closeness. However, feeding difficulties can be painful and deeply distressing. The NCT believes it is important for parents to have every opportunity for positive feeding experiences.’

This chapter looks in detail at infant feeding issues and the part that an NCT course plays in helping as women and men prepare for feeding their baby. Three quarters of women in the UK breastfeed their baby at least once (76%) and the proportion is greater for mothers aged over 30 and with more years of full-time education. However, many women switch to mixed feeding, combining breastfeeding with formula feeding, or stop breastfeeding completely within a few weeks. The UK Infant feeding Survey shows that at six weeks fewer than half of babies (48%) are being breastfed and just one in five are exclusively breastfed (21%). Almost all of the women who stop breastfeeding during the early weeks say that they would have liked to carry on breastfeeding for longer, suggesting that breastfeeding presents challenges to many women.

There is now a large infant feeding literature including considerable qualitative research in women’s experiences of becoming a mother and feeding their baby, support for establishing breastfeeding during postnatal care, factors affecting the initiation of breastfeeding, and interventions intended to facilitate breastfeeding.71,100-106

There has been less of a focus on initiatives designed primarily to achieve positive feeding experiences for women within the context of developing a breastfeeding-friendly culture.107 Some studies have looked into the attitudes and experiences of new fathers108,109 though generally the literature on fathers involvement with their babies, and in infant-care specifically, has been limited.64

Klaus and Kennell emphasised the need to ‘mother the mother’, both during birth and afterwards.110 They highlighted similarities between doula studies and bonding studies. Both kinds of ‘intervention’ - continuous social and emotional support of mothers by a female carer and early and sustained close contact between mothers and their newborn infants - resulted in either a demonstrated or reported increased in affection and attention by mothers towards their babies, and an increased desire to care for their babies in the first few weeks, responsiveness when their baby cried and more frequent and longer breastfeeds (p112).110 They state that ‘It is often difficult for a new mother to recognize her needs and feelings and give herself permission to ask for help’ at a time when ‘meeting the never-ending demands of a young infant is a momentous change’ from having the freedom to live as an independent person’.

The NCT Baby Feeding Policy states that ‘Baby feeding is one of the most rewarding and often challenging aspects of parenting. When feeding goes smoothly it provides pleasure, a sense of fulfilment and closeness. However, feeding difficulties can be painful and deeply distressing.’111 NCT
believes it is important for parents to have every opportunity for positive feeding experiences and has a long track record of influencing policy, supporting breastfeeding women and publishing evidence-based information. In the 1970s and 1980s it could be difficult for women who wanted to breastfeed to find books and health professionals with commitment and useful knowledge. NCT trained breastfeeding counsellors and published information to meet this need, as well as starting decades of lobbying for more enlightened policies. In recent years, emphasis has included evidence-based information on the use of formula milk, introducing solid foods, and use of dummies as well as breastfeeding issues.

In addition to antenatal teachers, NCT practitioners include breastfeeding counsellors and postnatal leaders. Breastfeeding counsellors are training to diploma level on a course developed by NCT and validated by the University of Bedfordshire. They have all had personal experience of breastfeeding a child for at least six months and are taught to provide active listening within a non-judgemental, non-directive, person-centred model which aims to enable individuals to make decisions which they feel are right for them. Most full-length NCT antenatal courses offer at least one dedicated breastfeeding session led by a breastfeeding counsellor; some offer two sessions.

The breastfeeding sessions provide an opportunity for women and men to talk about their feeding plans, share knowledge, and raise questions and concerns with other first-time parents and an experienced facilitator. Breastfeeding counsellors explore expectant parents’ attitudes and beliefs around feeding a baby and their anxieties. They ensure that those attending understand the relationship between demand and supply and discuss the importance of positioning at the breast to create a good latch; this ensures efficient transfer of milk and minimises trauma to the nipple. Sessions are designed to be responsive to those attending, but they also vary from one breastfeeding counsellor to another, as all NCT practitioners design their own curriculum within a generally agreed framework of aims, content and methods. Common topics covered include the value of skin to skin contact, putting the baby to the breast soon after the birth, avoiding damage to the nipple, responding to any pain early, and the importance of support. NCT believes that having had a preparation session with a breastfeeding counsellor, and being invited to contact her after the birth makes it more likely that parents will be in touch if they have concerns or need support once their baby has been born. It is hoped that the breastfeeding counsellor will be seen as approachable, knowledgeable and readily available for consultation by telephone or in a local mother and baby group or drop-in facility.

There has been less focus on formula feeding and on mixed feeding in NCT courses. Some of the reasons for this include a historical demand from parents for support, information and practical help with breastfeeding, NCT’s advocacy for breastfeeding as part of its public policy work, and breastfeeding counsellors’ training and expertise in breastfeeding. Though breastfeeding is the physiological norm for infant feeding, as a practice it has been vulnerable to the commercial promotion of formula milk and changing social norms. The health impact of reduced rates of
breastfeeding has been a major international concern. Thus developing good practice in supporting breastfeeding has been a high priority. However, as a parent-centred charity, NCT intends to be responsive to all parents’ needs. The *NCT Baby Feeding Policy* states: ‘Parents should be encouraged to make feeding choices that are right for them and their baby.’

Breastfeeding counsellors emphasise that the practice of breastfeeding can easily be undermined because it is an unfamiliar skill that needs to be learned. In the early days women may experience pain, engorgement, and doubts about their milk supply which can usually be overcome with patience, reassurance and guidance. Many women, men and wider family members experience a psycho-social challenge in adjusting to breastfeeding. In contrast, the challenges for formula feeding parents are seen as important but less complex. Traditionally, midwives and health visitors have been better equipped to support formula feeding families than breastfeeding mothers. NCT’s recent review of baby feeding concluded that all families need to feel valued and supported with feeding issues and that feelings of guilt and disappointment for those who stop breastfeeding earlier than they had intended to need to be addressed.

An earlier longitudinal cohort study of NCT course attendees showed that that 97% of women who had attended an NCT full-length course had breastfed their baby at some stage and 84% reported exclusive breastfeeding throughout the first six weeks. Nine in 10 of these women were expecting their first baby, so the samples are not directly comparable. Around a quarter of women (28%) said they had had ‘minor’ problems and around a quarter (27%) had had ‘major’ problems.

Asked to identify the kinds of problems they had experienced from a list of 11 topics with the option to add other problems, the most common problems had been sore or cracked nipples (60%), the baby feeding constantly (50%) extreme tiredness (40%) and always having to do the feeding (40%). Women sought help from many sources, including midwives and health visitors, their partner, friends and NCT breastfeeding counsellors. The survey was carried out alongside a much larger longitudinal cohort study in which the women having a baby were broadly representative of childbearing women in the UK in terms of their age, socio-economic status and ethnicity. Among those who breastfed their baby, the same four problems were most frequently reported, though the order was different: the baby feeding constantly was most commonly reported as a problem by the national sample. When their babies were around four months old, NCT’s sample of women and men also reported wanting to spend more time during the antenatal course on combining breastfeeding and bottle feeding (44%, 44% respectively) and on using bottles (28% and 35%).

### 9.1 Feeding intentions and preparation for baby feeding

In the current study, the end of course questionnaire asked: ‘How are you planning to feed your baby during the first three months?’ Almost all 677 first-time mothers were intending to breastfeed (99%); 92% (n=620) said
they planned ‘breastfeeding only (including expressed breastmilk)’ in the first three months, and 7% to use a ‘mixture of breastfeeding and formula’.

Responses to a number of different questions indicate how useful women and men found the breastfeeding session and the whole course in preparing them for feeding their baby during the early days and weeks. The post-course survey asked some specific questions about ‘breastfeeding’ and more general questions about ‘feeding your baby’. Unlike the study 10 years earlier, which used longer questionnaires, there were no explicit questions about using formula milk or bottles. After the course, nine out of 10 women (91%; 620/680) and men (91%; 150/165) agreed or strongly agreed that overall the course provided a good preparation for breastfeeding.

Responses to a question about knowledge, however, indicted that a many prospective parents wanted to find out more about breastfeeding and other aspects of feeding. Thirty five percent of first-time mothers and first-time fathers felt that they knew all they needed to about feeding their baby and almost two thirds said they wanted to know more. More women (43%) and men (51%) felt that they knew all they needed to about breastfeeding. However, around six out of 10 women and half of men still wanted to know more about breastfeeding (see table 41). As reported in table 10, 90% of women and 91% of men thought the course provided a good preparation for breastfeeding.

<table>
<thead>
<tr>
<th>Table 41 First-time parents’ knowledge about baby feeding and breastfeeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>First-time mothers, n=680</td>
</tr>
<tr>
<td>First-time fathers, n=163-164</td>
</tr>
<tr>
<td>Know all I need to</td>
</tr>
<tr>
<td>Know a lot but want more</td>
</tr>
<tr>
<td>Know a little and want more</td>
</tr>
<tr>
<td>Women %</td>
</tr>
<tr>
<td>Feeding your baby</td>
</tr>
<tr>
<td>Breastfeeding</td>
</tr>
</tbody>
</table>

### 9.2 Feeding experiences

Of 362 first-time mothers who responded to the follow-up survey, including some who, though eligible, had not responded to the post-course survey, 62% (n=223) reported that they had exclusively breastfed their baby for the first three months. Although, this rate is much higher than the rate for the whole of the UK (13%) it is significantly lower than the proportion in the post-course sample who said they were planning to only give breastmilk (92%). Around a third of women (36%; 126/362) had combined breastfeeding with bottle-feeding using formula milk, and 3% (n=10/362) had only used formula milk.

Women in the longitudinal sample, who responded to both surveys, had a similar rate of exclusive breastfeeding in the first three months. Of those who said during pregnancy that they planned to exclusively breastfeed their baby for the first three months, two thirds said they had done so (67%, 125/188); 31% combined breastfeeding with bottle-feeding using formula milk.
milk, and 2% formula fed exclusively. Among the 13 women who had said that they intended to mixed feed, around a third of the group (4/11) changed their plans and exclusively breastfed (see figure 12).

**Figure 12** Baby feeding intentions and behaviour during the first three months

![Graph showing breastfeeding intentions and behaviour](chart)

*First-time mothers, n=202*

After the birth, mothers and fathers were asked how useful they had found the information provided in the course. The information provided on breastfeeding was rated as ‘very useful’ by 36% of women and men and ‘fairly useful’ by 44% and 51% respectively (see figure 13).

**Figure 13** Usefulness of information on breastfeeding provided in the course

![Bar chart showing usefulness of breastfeeding information](chart)

*First-time mothers: n=359, first-time fathers: n=59*

One in five women (20%) felt the information had been either ‘not very useful’ or ‘not at all useful’ and one in eight men gave this response (see figure 13). Information on baby feeding in general was rated mainly as ‘fairly useful’ and less often as ‘very useful’ (see figure 14).
Figure 14  Usefulness of information on baby feeding provided in the course

<table>
<thead>
<tr>
<th></th>
<th>Not at all useful</th>
<th>Not very useful</th>
<th>Fairly useful</th>
<th>Very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>5%</td>
<td>16%</td>
<td>55%</td>
<td>24%</td>
</tr>
<tr>
<td>Women</td>
<td>5%</td>
<td>16%</td>
<td>49%</td>
<td>29%</td>
</tr>
</tbody>
</table>

first-time mothers: n=353, first-time fathers: n=58

Around one in five of the comments in the post-birth survey about what women felt best and least prepared for related to experiences during the early days and weeks of feeding, including the challenges experienced. There was desire for more information about the reality of breastfeeding, how it feels physically and emotionally, and how to respond to breastfeeding difficulties or a lack of professional support.

Altogether, 36 comments from first-time mothers who said they had been ‘least prepared’ for aspects of breastfeeding included reference to difficulties latching the baby on and getting breastfeeding started, feeling unprepared for how time-consuming breastfeeding can be, experiencing pain, mastitis, hand expressing and negative emotions associated with breastfeeding such as guilt and anxiety.

The 31 comments on other aspects of baby feeding that the first-time mothers felt ‘least prepared’ for related to bottle feeding or mixed feeding. More specifically, one or more women referred to being unprepared for sterilisation, using bottles and teats, washing and preparing bottles, quantities of formula needed and frequency of feeds, winding their baby, combining bottle feeding and breastfeeding, the effects of formula milk on the baby’s digestive system, e.g. lactose problems, refusing the breast, and babies’ weight-loss after birth. These were, women wrote, not covered at all or were not covered in sufficient depth in NCT courses, leading to a feeling of being unprepared or under-prepared.

Generally, some men felt well prepared for their role in supporting breastfeeding, as this comment illustrates:

'It was good to be able to have enough information to be helpful and supportive with the breastfeeding and also to know that being tired was to be expected!'

Others felt they were poorly prepared for aspects of feeding their baby and, as previously discussed, a common complaint was that postnatal issues
were accorded too little time. Around one in five comments on what men felt least prepared for were feeding-related, including coping with difficulties in establishing and maintaining breastfeeding, being unprepared for bottle-feeding, and bottle-feeding expressed breast milk (22%, 13/58).

Though one, whose partner was fully breastfeeding at three months also commented:

’The reality of how tough the first few weeks are was something that I don’t think was ever conveyed.’

Two others said:

’Sterilisation of equipment and bottle feeding were not discussed which I found disappointing. The over emphasis of breastfeeding, coupled with the fact that it sometimes is impossible... can have very bad mental health consequences for vulnerable mothers.’

’That breastfeeding is not something which all mothers and babies can manage, even with a huge amount of effort from the parents (predominantly mother but also father supporting) and what if you need to turn to formula to get enough food into the baby.’

9.3 Confidence about baby feeding during pregnancy

Immediately after the course, attendees were asked to rate their level of confidence about feeding their baby, and to say how confident they recalled feeling before the course started. Few recalled feeling confident before the course. After the course, three in 10 women and four in 10 men felt confident about feeding (see table 42). Both mothers’ and fathers’ confidence about feeding increased significantly compared with how they said they had felt before the course (Wilcoxon, p≤0.01).

<table>
<thead>
<tr>
<th></th>
<th>Before the course</th>
<th>After the course**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>Not very confident</td>
<td>49%</td>
<td>40%</td>
</tr>
<tr>
<td>Fairly confident</td>
<td>45%</td>
<td>55%</td>
</tr>
<tr>
<td>Confident</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

** Significant difference between mothers and fathers (Mann-Whitney, p≤0.01)

More detailed analysis shows the kind of changes in confidence that first-time mothers experienced. The course seems to have had greatest impact on women who reported low confidence before the course started. The largest group of first-time mothers (n=337) said they had been ‘not very confident’ about baby feeding before their course. Of these ‘low confidence’ women, 89% reported an increase in their confidence (‘fairly confident’ 70%; ‘confident’ 19%). The remainder had unchanged confidence (11%). In comparison, of those who recalled feeling ‘fairly confident’ before the course (n=309), around two thirds still reported...
feeling fairly confident (63%) and a third indicated that their confidence had increased during their course (33%).

Most of the small number of women who recalled feeling confident before their course (n=37) remained confident (78%). The others (22%) reported feeling only ‘fairly confident’ after the course. Review of their comments about how their confidence had been affected suggests that generally this shift represents women having a more realistic understanding of what to expect.

Several explained that the course had made them aware, or more aware, of possible breastfeeding difficulties. The comment below is fairly typical of this group:

‘Perhaps I now have a more realistic view.’

However, another said:

‘The breastfeeding course made me feel under much more pressure to be able to breastfeed than I previously felt which has actually made me more anxious.’

Altogether 364 first-time mothers responded to a question after their course about what had influenced their level of confidence about baby feeding. All responses were read and 100 were analysed in detail. Three main themes emerged as having a positive influence on confidence: having greater knowledge about the process of breastfeeding (41), feeling that there was help available and knowing where to go to find it (14) and feeling inspired by the breastfeeding counsellor (11). Others indicated that attending the NCT course had been helpful but they did not explain how it had affected their confidence (10). Most quotes used to illustrate these themes are taken from these 100 cases. The numbers in brackets refer to the number of relevant cases in the first 100. Some additional quotes have been selected where they seem to provide a useful insight into a particular experience or view.

Greater knowledge

Women valued detailed information about how the process of breastfeeding works, and practical information such as how to position their baby at the breast and tactics to try if they experienced difficulties:

‘(It was an) excellent session — it really educated me about what to do.’

‘The breastfeeding class helped to explain the process, making it less ‘scary.’”

‘Knowing different ways of coping if the baby doesn’t immediately appear to take to the breast.’

‘I already planned to breastfeed before attending the course, however I did not know what to expect. The breastfeeding class during the NCT course was a revelation. And I now feel confident.’
They especially valued being able to ask questions and receiving answers that satisfied them as being helpful and reliable.

‘(Having a) chance to ask lots of questions in the course and discuss common problems.’

‘Having the realities of breastfeeding explained fully and having my questions answered.’

One women commented on there being sufficient time in the class to process the information:

‘Although we were given very similar information at NHS antenatal classes, the extra time taken at the NCT class means we feel we have ‘taken in’ the information more.’

Another would have preferred more visual information to demonstrate aspects of breastfeeding:

‘I feel a bit more confident having talked through some of the issues and problems that arise but I think more practical advice and demonstrations on things like positions for holding baby in feeding, expressing, etc would have been useful. Maybe using a demo video or something.’

In contrast, when their questions were not answered, this was felt to be most unhelpful:

‘I was disappointed with the breastfeeding element of the class. The tutor did not cover problems even though this was discussed as a learning need at the beginning. She said that she did not want to go into problems at the end and leave on a bad note. She left me feeling that the baby would know instinctively what to do and that as long as I did it properly there would be no major issues. However, no mothers that I have spoken to - either breastfeeding or otherwise - have had a problem-free beginning.’

‘The breastfeeding course was very useful but I feel it did not cover in enough detail the problems women may encounter with breastfeeding. I have inverted nipples and asked the counsellor privately about this at the course. I feel this should be already included as a topic as a lot of women have this condition and may be embarrassed to ask.’

Another woman made a similar comment:

‘I expected the course to discuss issues that may arise and possible solutions. I specifically asked about breastfeeding with flat/inverted nipples and (session leader) didn’t seem to know much about it and couldn’t offer any advice. As this is a fairly embarrassing subject, it was hard enough to ask about it in front of everyone, but then to not even receive any information or advice about it once I did ask, left me very disappointed.’

Sources of support
Many women felt more confident as a result of hearing about places to get support including being invited to contact the NCT breastfeeding counsellor:

‘Knowing where there is support if required; both NCT, NHS and other mums.’

‘I think breastfeeding will be one of the biggest challenges and I didn’t realise before the course that there were quite a lot of potential difficulties. The NCT breastfeeding counsellor raised awareness of these but also made me feel confident that help is available.’

**NCT breastfeeding counsellors**

Some women particularly commented that the breastfeeding counsellor had inspired them:

‘The breastfeeding counsellor was really helpful and supportive.’

‘The breastfeeding session with the NCT counsellor was excellent and confidence inspiring.’

**Other responses**

A number of women indicated no particular anxieties but felt they needed to wait and see how things worked out; until then they could not be more than fairly confident (8).

‘It’s hard to feel entirely confident as I don’t know what my body and baby have in store.’

‘I think you can only say you are truly confident once you’ve had a go!’

Another group indicated that they felt quite worried or concerned about how difficult or demanding breastfeeding might be (7):

‘The breastfeeding component of the course wasn’t as helpful as the rest of the course, I found it daunting to think about the first 6 months of feeding and would prefer to just think about the first week initially and then build from there. I don’t feel too confident at the moment but I am going to try my best and am glad there are breast feeding support groups run at my local health centre and hope that with support I will be able to persevere.’

‘I’m still a little nervous about how well I’ll be able to manage.’

‘When talking to other people you discover it’s not as natural and second nature as people lead you to believe.’

‘I’m quite apprehensive about how easy it will be now whereas previously [...] I was happy to take it in my stride.’

Some women (3) commented that their confidence about feeding their baby had been adversely affected by a lack of opportunity to discuss
formula feeding (see also section 8.3).

’I thought that the NCT should offer more advice on formula feeding in the course - a leaflet was available but the NCT instructor said that she wasn’t allowed to hand it out, we had to collect it from the table if we wanted it. This seemed very silly to me!’

’I have decided to bottle feed. NCT courses do not provide much support for bottle feeding mums. I find this irresponsible as there is a lot involved in bottle feeding and expected some information or help or advice.’

’Unfortunately the focus on everything I see and read is on breastfeeding including a whole NCT session; as someone who is unable to breastfeed due to medication I felt a little let down. I was not given really any pointers on formula feeding and I would have liked to have some guidance on this.’

9.4 Confidence and feeding behaviour at three months

At the time of the follow-up survey, when most parents had three months’ experience of caring for their baby on a daily basis, two thirds of mothers and around nine in 10 fathers reported feeling confident about feeding their baby (see table 43). The most common experience affecting about a quarter of first-time mothers (23%, 44/195) was to recall having felt ‘not very confident’ before a course, then ‘fairly confident’ after a course, and then ‘confident’ at three months. Figure 15 shows the increase in self-reported confidence for the longitudinal sample of mothers (Friedmann Anova, $p \leq 0.01$).

Table 43 First-time parents’ confidence about baby feeding three months after birth **

<table>
<thead>
<tr>
<th></th>
<th>Mothers</th>
<th></th>
<th>Fathers</th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Not very confident</td>
<td>3%</td>
<td>12</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Fairly confident</td>
<td>30%</td>
<td>108</td>
<td>13%</td>
<td>8</td>
</tr>
<tr>
<td>Confident</td>
<td>67%</td>
<td>239</td>
<td>87%</td>
<td>52</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>359</td>
<td>100%</td>
<td>60</td>
</tr>
</tbody>
</table>

** Significant difference between mothers and fathers (Mann-Whitney, $p \leq 0.01$)
A comparison between the two most common course formats showed that, post-course, women who had attended a full-length course more often felt confident about feeding than women completing intensive courses (Mann-Whitney, \( p < .05 \)) and this difference remained three months after birth (Mann-Whitney, \( p < .01 \)). No differences were found for men’s confidence about feeding related to length of course.

**Does confidence before birth predict positive feeding experiences?**

Most women in this sample (92%) said they planned to breastfeeding their baby exclusively for at least the first three months. We wanted to know whether those who reported feeling confident after their course were more likely to fulfil this aim. Among first-time mothers who planned to exclusively breastfeed for the first three months, 30% said they felt confident after their course, 63% fairly confident, and 6% not very confident about baby feeding. There was little difference in the way these women’s babies were fed in practice: 67% of the ‘confident’ women were exclusively breastfeeding at three months as against 70% of ‘fairly confident’ women. The rate for women who were ‘not very confident’ was lower (50%), though numbers are small and this difference is not statistically significant.

**9.5 Contact with a breastfeeding counsellor**

Parents who attend an NCT antenatal course are invited to contact a breastfeeding counsellor after they birth if they need support with feeding their baby. NCT breastfeeding counsellors provide one-to-one support for mothers at drop-in groups in local community settings and by telephone or email. Many counsellors regard meeting parents before the birth as a means of introducing themselves and becoming known as a familiar and trusted person to turn to if questions or difficulties arise. The comments above on what affected women’s confidence bear out the positive effect it had for them to meet a breastfeeding counsellor during pregnancy. In the
follow-up survey, first-time mothers and fathers were asked if they had had contact with an NCT breastfeeding counsellor since birth. One in three mothers (32%, \( n=116/363 \)) and 15% of fathers (\( n=9/60 \)) reported having had at least one contact.

An open question asked respondents to describe what had prompted them to contact the breastfeeding counsellor. Reasons included concerns over latching on, mastitis, sore or flat nipples, the use of formula milk, expressing milk, pain, thrush, blocked milk ducts, the feeding behaviour and pattern of babies, and a desire for ‘general encouragement’. For example:

‘I found breastfeeding very painful and almost gave up - I rang the counsellor for moral support and advice. (She was) very helpful.’

‘I did not seem to be producing enough milk and my confidence dipped. I needed some advice and support that I could still breastfeed and that my baby was getting enough.’

‘To ask for advice on technique as I really struggled with sore breasts at the start - the advice really helped me to persevere.’

‘To get advice on expressing because my baby was in special care and the hospital wasn’t providing any guidance.’

‘NHS breastfeeding counsellors scared me about mastitis so I went to the NCT one for reassurance.’

Among the women who planned to exclusively breastfeed for the first three months, those who introduced formula were more likely than those who exclusively breastfeed to have contacted an NCT breastfeeding counsellor (36% vs. 27%, \( x^2=3.335, p<0.05 \)), however almost two thirds of them had not done so. No data were collected in the current study on the extent of breastfeeding problems experienced, nor how easy or difficult it had been for women or their partners to contact an NCT breastfeeding counsellor.

9.6 Summary

NCT courses place considerable emphasis on preparing women and their partners for breastfeeding. Generally the feedback about this is positive; a high proportion of women coming to full-length and intensive NCT courses plan to breastfeed and they generally find the NCT a source of helpful information. Attending a course provides informal mother-to-mother support which plays a crucial role in normalising the experience of breastfeeding and providing encouragement, as well as access to the expertise of a mother-centred breastfeeding counsellor. Women and men coming to the courses have varying previous experiences, expectations and desires. Antenatal teachers and breastfeeding counsellors need to build women’s confidence and sense of self efficacy about breastfeeding while at the same time preparing them for the kinds of usual experiences that women and their partners so frequently face when getting breastfeeding established in the early weeks.

Of those who said during pregnancy that they planned to exclusively
breastfeed their baby for the first three months, two thirds said they had done so (67%), a third (31%) had breastfed and introduced bottle-feeding with formula milk at some stage, and 2% formula fed exclusively. No information was collected on the timing of introducing formula milk or on patterns of mixed feeding.

Commenting when their babies were around three months old on the preparation their course provided, 80% of women and 87% of men felt the information on breastfeeding provided on the NCT course had been useful. One in five women and one in eight men felt the information had been either ‘not very useful’ or ‘not at all useful’.

Women valued having their questions answered, particularly those about potential difficulties. Two women who had flat or inverted nipples felt that their questions had not been well answered and the small group of women and men who planned to formula feed also felt that their information needs had not been met. Some parents anticipating that their baby would be breastfed also wanted information on formula and bottles.

It is important to note that during pregnancy first-time mothers who had attended a full-length course more often reported feeling confident about feeding than women completing an intensive course and that this difference remained when their baby was three months old.
Customer service

NCT wants to provide a high quality of customer service as well as courses that meet parents’ needs in preparing for birth and the transition to parenthood. Parents were asked their views about the booking process, the comfort and convenience of the venue, and asked to provide feedback on how they perceived aspects of the teaching on the course. They were also asked what if any improvements they felt could be made to the course.

10.1 Booking process

First-time mothers were asked whether the booking process was clear and easy to follow. Most agreed or strongly agreed that this was the case, with only 7% disagreeing (table 44).

Table 44 The booking process was clear and easy to follow

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>49%</td>
<td>44%</td>
<td>6%</td>
<td>1%</td>
<td>100%</td>
</tr>
</tbody>
</table>

10.2 Venue

Course attendees generally found courses comfortable and convenient for them to reach from their home. Over nine in 10 first-time parents (92% of women and 93% of men) agreed that the course location was convenient for where they lived (table 45). Proximity to home is important in terms of developing a support network with other local parents who it will be easy to meet up with after the baby has been born. Fewer thought the course location was convenient for their place of work. Approximately half of women and men indicated that the course venue was not convenient to reach from work (table 45). It may be that the course location is no more difficult for parents to access than their place of work but, particularly while pregnant women are still working, having a long journey can mean being tired before a session starts.

Table 45 Convenience of the course location

<table>
<thead>
<tr>
<th>The course location was convenient for where I work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>%</td>
</tr>
<tr>
<td>Women</td>
</tr>
<tr>
<td>Men</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>The course location was convenient for where I live</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
</tr>
<tr>
<td>%</td>
</tr>
<tr>
<td>Women</td>
</tr>
<tr>
<td>Men</td>
</tr>
</tbody>
</table>

A large majority of women and men felt that the room where their course
was held was comfortable and spacious (table 46). However, one in seven pregnant women (14%) did not find the room comfortable.

Table 46 Comfortableness of the course venue

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree %</th>
<th>Agree %</th>
<th>Disagree %</th>
<th>Strongly disagree %</th>
<th>Total %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was enough space in the room</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>46</td>
<td>47</td>
<td>6</td>
<td>1</td>
<td>100</td>
<td>457</td>
</tr>
<tr>
<td>Men</td>
<td>41</td>
<td>55</td>
<td>3</td>
<td>1</td>
<td>100</td>
<td>167</td>
</tr>
<tr>
<td>The room where the course was held was comfortable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>38</td>
<td>48</td>
<td>13</td>
<td>1</td>
<td>100</td>
<td>457</td>
</tr>
<tr>
<td>Men</td>
<td>31</td>
<td>61</td>
<td>6</td>
<td>1</td>
<td>100</td>
<td>167</td>
</tr>
</tbody>
</table>

10.3 Teaching style

One of the features of NCT courses is the intention to work using a collaborative parent-centred approach. One aspect of this is to ask parents at the start of the course what they would like to cover and to purposively find out whether they have any particular questions or concerns. Almost all of the parents agreed that their teacher had asked them what topics they wished to cover in antenatal classes; 96% of women and 93% of partners (table 47).

Table 47 Satisfaction with course teachers

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree %</th>
<th>Agree %</th>
<th>Disagree %</th>
<th>Strongly disagree %</th>
<th>Total %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>The teacher asked what topics I wanted her to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>64</td>
<td>32</td>
<td>3</td>
<td>1</td>
<td>100</td>
<td>457</td>
</tr>
<tr>
<td>Men</td>
<td>56</td>
<td>37</td>
<td>6</td>
<td>1</td>
<td>100</td>
<td>142</td>
</tr>
<tr>
<td>I think the teacher did a good job</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>69</td>
<td>26</td>
<td>4</td>
<td>1</td>
<td>100</td>
<td>457</td>
</tr>
<tr>
<td>Men</td>
<td>70</td>
<td>24</td>
<td>4</td>
<td>2</td>
<td>100</td>
<td>142</td>
</tr>
</tbody>
</table>

An especially positive finding concerned antenatal teachers. A large majority of first-time parents thought their course teacher did a good job (table 47) and nine in 10 first-time parents would recommend their course to someone else (table 48). Only 4% of women and 6% of partners would not recommend the course to someone else.

Though not prompted to comment on their teacher, in response to a question inviting any further feedback on their course, more than 100 women and men used the opportunity to praise their teacher. Parents used words and phrases like ‘fantastic’, ‘friendly’, ‘excellent’, ‘knowledgeable’, ‘brilliant, very helpful and informative’, ‘sympathetic, supportive, and informative’ and ‘open minded’. Some typical comments include:

‘(We had an) excellent teacher — (she) never made anyone feel stupid or ignorant despite a huge variety in knowledge within the class.’

‘I can only say good things — I really support the NCT — I was really pleased’
with NCT classes - teacher fantastic!’

‘Fabulous teacher. I felt able to ask anything. She had good presentation skills and made us feel comfortable.’

Only four comments were negative about antenatal teacher’s qualities. For example;

‘Whilst our course leader was very pleasant and I really enjoyed meeting other expectant parents ... I didn’t feel any great sense of confidence in the teacher’s advice.’

<table>
<thead>
<tr>
<th>Table 48</th>
<th>Satisfaction with the course</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly agree</td>
</tr>
<tr>
<td>The course met my needs</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>55%</td>
</tr>
<tr>
<td>Men</td>
<td>56%</td>
</tr>
</tbody>
</table>

I would recommend the course to someone

| Women     | 67% | 28% | 3% | 1% | 100 | 457 |
| Men       | 70% | 24% | 5% | 1% | 100 | 142 |

Three women (1%) strongly disagreed when asked whether the course had met their needs. They explained their view in comments. One was disappointed with the emphasis on labour at the expense of time spent on parenthood. The second woman sought a more structured and informative course, and the third felt her course had been too focused on the difficulties of childbirth and parenting rather than the joys.

10.4 Course structure

Most first-time parents were satisfied with the length and pace of their course (table 49). A somewhat higher proportion of full length course attendees (14%) felt their course was too slow compared with those attending an intensive course (6%). Those attending intensive courses were more likely to find their course too short than full length course attendees. This was so for around one in five first-time mothers. These differences between course types in terms of pace and length were statistically significant (p<0.05).

<table>
<thead>
<tr>
<th>Table 49</th>
<th>Satisfaction with course pace and length</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course type</td>
<td>%</td>
</tr>
<tr>
<td>Pace</td>
<td></td>
</tr>
<tr>
<td>Full length</td>
<td>14%</td>
</tr>
<tr>
<td>Intensive</td>
<td>6%</td>
</tr>
<tr>
<td>Length</td>
<td></td>
</tr>
<tr>
<td>Full length</td>
<td>9%</td>
</tr>
<tr>
<td>Intensive</td>
<td>18%</td>
</tr>
</tbody>
</table>

Pace: n=568, x²=8.094, p=0.017. Length: n=599, x²=9.005, p=0.011.
First-time mothers were asked whether the timing of their course was suitable for their baby’s due date. Most agreed or strongly agreed that the timing had been suitable, and less than 5%, or one in 20, disagreed or strongly disagreed (table 50).

<table>
<thead>
<tr>
<th>Table 50</th>
<th>Suitability of course timing for due dates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly agree</td>
</tr>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>50%</td>
</tr>
</tbody>
</table>

10.5 Value for money

First-time mothers and fathers were asked after their babies had been born, ‘do you feel that the NCT antenatal course was good value for money?’ Most felt their course had been good or very good value for money (table 51). Women and men tended to have similar views. There was no difference in views between those attending a full length course and those attending an intensive course.

<table>
<thead>
<tr>
<th>Table 51</th>
<th>Value for money</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First-time mothers</td>
</tr>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>27%</td>
</tr>
</tbody>
</table>

10.6 Satisfaction and suggestions for improvement

Overall, there was a high level of satisfaction expressed with NCT courses attended. Almost all women (97%) and 91% of men said that they felt their needs were met by their course, with over half agreeing strongly. After the course, some comments particularly praised the participative style of the teaching:

‘I thought the NCT teacher was brilliant - really creative in her facilitation of exercises. It was very validating - generally it was us (the trainees) who arrived at answers ourselves, with her help.’

‘Plenty of chance to discuss things. Good ‘adult learner’ model i.e. not too didactic. Teacher warm and friendly, great calm presence too.’

At the end of the post-birth questionnaire women and men were asked ‘Do you feel any aspect of the antenatal course needs to be improved or is there anything about preparing for labour, birth and parenting that you would have liked the antenatal course to cover?’ Of 307 responses from first-time mothers, 100 were analysed in detail. Over half requested more on postnatal issues (56), including what to expect in the first hours and weeks after birth, practical aspects of babycare and babies’ behaviour (47), women’s physical recovery (4), women’s emotions (3) what the baby would look like when born (1) and the support that new mothers need (1).
'It would have been useful to include more about aspects following the birth, particularly around problems with feeding and what to expect in the first 6 weeks.'

Specific examples were given of the kinds of topics that the women felt they would have benefited from discussing prior to having their baby:

'(I would like there to be) more on the first 24-48 hrs at home e.g. your baby won't settle without being held.'

'(I wanted to know more about) how to handle a crying baby --- how to help get my baby into a routine...I feel the course could have been more practical and hands on.'

'(It would be helpful to) cover more about taking care of baby when you get home e.g. bathing, sterilising, pumping, sleeping, dos and don'ts etc.'

'(I would like) more realism e.g. coping with crying, breastfeeding difficulties, purpose of health visitors, bottle (feeding) practicalities.'

As well as practical aspects of babycare, several women requested more focus on the kinds of emotional changes to expect and how to cope with them:

'Need much more about how it feels to have a new baby.'

'Whilst I realise you don't want to scare people, I think there could be more emphasis on what to expect emotionally after the birth. The changes in relationships, isolation etc.'

'I think there are not enough details given on the effects of birth traumas and possible issues. Although we spent a couple of hours talking about depression, postnatal anxiety was never even mentioned even though it is more common than depression.'

One women found the stay in hospital especially difficult and felt further support on communicating with staff would be helpful:

'I think more needs to be covered on coping in hospital and when you get home. ... Some coping strategies for if the birth does not go to plan and you have a longer stay (in hospital). I was in hospital for 3 nights and could not wait to get home. It's such an alien environment I think this can really have an effect on new mums.'

In relation to women’s physical recovery, women particularly highlighted the need for more information on lochia and on perinatal trauma and recovery:

'Post natal information e.g. how long you bleed for, the amount of time it takes for uterus etc to go back into place (and therefore the length of time you still look pregnant) as this really affected my morale in the first few weeks.'
‘I would have liked to know more about the after birth — i.e. coping with stitches, tears, infections, prolapses etc so I didn’t feel so afraid or alone.’

In addition, there were 37 comments specifically on aspects of preparation for feeding that the women felt needed to be improved. These were reported in chapter 9. A smaller number made comments or suggestions about the way aspects of preparation for labour and birth were covered (18) or how the course was planned and organised (6). Three responded to say nothing needed to be improved. Some women made more than one suggestion.

Comments about course organisation included:

‘It would have been helpful to me to have had handouts each week on what we had covered as I was not always able to remember all the details.’

‘I would have also liked us to wear badges for the first few weeks until everyone had got to know names. It would also have been helpful to collect email addresses and mobile numbers at the booking stage and then for the teacher to email everyone and introduce herself before the first class.’

Like the women, almost half of the 54 men who responded requested a greater focus on postnatal issues, mainly looking after a newborn baby:

‘(There was) nowhere near enough preparation for the first few weeks after birth.’

‘Post birth stresses and strains - obviously this is very different for everyone so could lead to ‘scare-mongering’ but at times I have been taken to the limit of my endurance ‘physically and mentally’ - which was a complete shock to me.’

‘I would have liked more about parenting skills and techniques to deal with ‘first few weeks’ with baby.’

There were also a small number of negative comments about course reunions which were planned but did not take place. Parents felt a real loss when they did not have an opportunity to meet up with the group and their course teacher after the birth, when this was anticipated.

10.7 Summary

This chapter shows that parents feel positive about the booking system, the venues and locations of NCT antenatal courses. They also value the quality of teaching and most feel that the courses represent good value for money. Feedback from women and from men about how the courses could be improved mainly focused on spending more of the course on preparing for the postnatal period. There was a general consensus that more focus was needed on what to expect and how to manage during the first week after birth including preventing feeding problems and how to respond if difficulties arise. Parents wanted more on practical aspects of babycare and how breastfeeding feels, physically and emotionally.
Discussion and conclusions

This longitudinal cohort study of women and men attending NCT antenatal courses with up to 20 hours of contact time highlights the importance of this kind of service in preparing expectant parents for birth and the first weeks of parenthood. NCT antenatal courses provided an opportunity for women and men to meet others going through the same experience, to share ideas and concerns, and discuss questions of common interest. Expectant parents valued the opportunity to learn in groups, drawing on the teacher’s knowledge.

NCT antenatal courses were found to increase women’s and men’s self-reported confidence about birth and baby feeding. They provided an opportunity for parents to say what they wanted the course to cover, and to acquire and discuss evidence-based information and how it might be relevant in practice. Throughout the course, sessions are led by teachers and counsellors whose training encourages person-centred learning. Women and men emphasised the value of finding out about what midwives and health visitors and can offer and where guidance and support is available with feeding and parenthood issues after the birth. This signposting and encouragement to seek help is especially important given the evidence that women’s needs for support, information and clinical care during the postnatal period are often not being met.

NCT attracts parents with a range of different aspirations. Higher proportions of women attending NCT courses were planning to give birth in a birth centre or at home, compared with national statistics, and similarly high proportions wanted to give birth with a minimum of drugs or medical procedures. In contrast, one in 10 were planning to have an epidural. There was a high demand among parents to find out about medical procedures as well as low-tech and self-help approaches to preparing for labour and birth.

Around half of those who had been planning a home birth at the time their NCT course ended gave birth at home. Only one in five of those planning to have their baby in a midwife-led birth centre actually gave birth there. The research did not explore the timing or reasons for transfer. However, antenatal teachers may find it useful to note that such a large proportion of women’s plans for birth are changed by developments during the last weeks of pregnancy or during labour. Further research is needed on women attending NCT courses to see whether these results are replicated and to find out the reasons for transfer.

In practice the use of low-tech approaches for working with pain during labour was fairly low and rates of medical interventions and transfers to the hospital labour ward for birth were high. Especially striking was the finding that only one third of those women who would have liked to use a birth pool were able to do so during labour. Provision of basic equipment such as a birth ball was often lacking. Emergency caesareans were disproportionately common (25%) and half of women had an epidural (49%), including 43% of those who would have liked to avoid one. Almost half (47%) had their labour induced and/or accelerated. Therefore on this evidence, there remains a
large gap between the preferred type of birth for women attending NCT antenatal courses and their actual birth experiences. It is possible that the low response rates mean that the samples of women and men are not representative of all parents attending NCT courses.

Other disturbing results include the finding that around a fifth of women reported having been left alone during labour or shortly after birth at a time when it worried them. This level of support is not consistent with national maternity policy. Being left alone was less common for those who had their baby at home or in a birth centre.

Another notable finding is that two thirds of those who gave birth vaginally did so lying on their back, including 48% who were in stirrups, despite policy frameworks to support woman-centred care, to prevent women’s freedoms from being restricted and to encourage more upright postures. NCT teachers should be aware of how widespread this practice still is and discuss it with parents in classes as well as with midwifery managers in their locality.

In terms of preparation for life with their new baby, many parents bring their baby home from the maternity unit within 24 hours of birth and have had very little experience of handling, feeding, changing or soothing their baby. Many find the first week extremely challenging and need to be better prepared for this. Comments from women and men suggest that it is helpful when the first few weeks after the birth are identified as a time of transition which will be more challenging than later weeks when the new family is better established and the initial learning and adjustment phase has passed. This aspect of preparation and parents’ experiences of the transition to parenthood merit further detailed attention.

A very high proportion of those attending the course planned to breastfeed, including a number who anticipated combining breastfeeding with bottle feeding. Many first-time mothers and fathers found caring for their baby enormously demanding; breastfeeding difficulties in the early weeks were common and often distressing, especially if not anticipated. Generally the NCT breastfeeding sessions were felt to be very useful, particularly when they responded to participants’ questions, provided guidance, and suggested strategies for coping with pain or other problems.

There is a constant challenge for all NCT practitioners delivering services to find an appropriate balance in the language they use and the messages they convey. They want to encourage parents to have respect for and confidence in the normal physiological process of birth and breastfeeding; simultaneously they need to show respect for parents’ personal preferences, highlight possible deviations from normal and acknowledge the very real emotional and social challenges that first-time parents face. Generally, these findings indicate that most parents came away from their course with a positive outlook, prepared for a range of possible eventualities, and not feeling that they would be personally responsible if things do not work out as they would have liked. However, some parents did feel let down or left out.

NCT antenatal courses are designed to prepare parents for what to expect, to provide some practical strategies, and increase confidence. Yet the teacher has no direct control over the care that the maternity services will
provide. The culture of the maternity services in different NHS trusts and birth settings, and the care provided during late pregnancy, labour, birth and postnatally has a major impact on the experiences of women and their partners. The findings show that hospital practices are frequently not consistent with encouragement of freedom of movement, use of gravity and non-invasive methods of working with pain and continuous one-to-one midwifery support. Earlier NCT research has shown that women feel the birth environment, particularly in hospital, can make coping during labour more difficult. So findings about women’s and men’s experiences and views about how well their NCT course prepared them need to be considered with this in mind. NCT needs to continue to work locally, nationally and UK-wide to raise awareness about the women’s and men’s experiences of maternity services and to influence strategies for change.

**Impact of different course formats**

At the end of their antenatal course, first-time mothers who attended a full-length course were significantly more likely to report feeling better informed and more confident about labour and birth and about feeding their baby than those attending intensive courses. These differences were also apparent in responses to the follow-up survey. Women who had attended longer courses were both more likely to report that they had felt confident while giving birth, and to report feeling confident about feeding their baby, than other mothers. This finding is important. It shows that the shorter courses, with fewer contact hours and involving fewer individual sessions, are not a direct equivalent in terms of preparation for either birth or breastfeeding.

In this context, it should be noted that NCT ‘intensive’ courses generally provide significantly more contact time than many NHS based courses. There was no difference between courses of different length in terms of confidence about anticipating motherhood. This probably reflects the more focused preparation for birth and breastfeeding offered on NCT courses. The size of the sample of first-time fathers was too small to expect measurable differences in confidence. However, there were some differences favouring longer courses in relation to fathers feeling well informed.

The parents in the sample differed from the general population of first-time parents. As well as choosing to attend an NCT course, they were older and most were university educated. Although the findings are therefore not generalisable, they contribute to what is known about experiences of the transition to first-time parenthood in the UK. Alongside other research, they are relevant for the development of maternity policies and planning of services, setting out in detail many of the aspirations, experiences and needs expressed by both mothers and fathers.

It is important to emphasise that this study did not employ a before and after design in relation to course attendance, and this is a limitation. It would be useful in a future study to have baseline measures, before parents start a course, of their knowledge and confidence, their interests and aspirations. In order to address some of the unanswered questions about associations between interventions and outcomes, it would be useful to
conduct a larger cohort study, or a randomised controlled trial to
demonstrate causality. It would be useful to compare the effects of NCT
antenatal courses with other preparation courses in women and men of
different ages and social backgrounds. On the basis of this study, suggested
outcomes of importance would include: place and mode of birth, mode of
feeding, positive birth, feeding and transition to parenthood experiences,
knowledge, confidence and sense of self-efficacy, and access to parent-to-
parent mutual support networks. As recent reviews of evidence have
concluded, more research is needed on antenatal course objectives,
content, contact hours, formats and the skills and approach of course
leaders.

In 2010, NCT began an audit of parents’ feedback to collect information
routinely on all those attending an NCT-managed course. Results are being
fed back anonymously to individual NCT practitioners and managers, so
inconsistencies in the quality of courses can be addressed.

11.1 Recommendations

We would recommend the following:

• Parents’ suggestions for improving NCT courses should be
  actively considered by NCT and other antenatal education
  providers, including:

  Make more use of web-based information and offer
  access to it for parents while on the course.

  Provide access to other parents’ anonymised reports about
  birth, feeding and the early weeks with a new baby, to get a
  better understanding of the range of experiences, a taste of
  the lived reality and ways to tackle common challenges
  before the baby comes.

  Focus more on what to expect in the days after birth and the
  following early weeks, including more on practical babycare
  (how to change a nappy, bath, feed and wind the baby,
  possible illnesses, colic and nappy rash) and breastfeeding
  difficulties.

• Ensure that courses of similar format provide a similar standard of
  opportunity for participative parent-to-parent learning and support,
  e.g. invite first-time parents to attend courses with their new baby
  and provide a reunion session.

• Information should be available for parents prior to booking a course
to let them know that longer courses tend to be associated with
greater knowledge about birth and feeding, and increased
confidence.

• Maternity services and children’s centres in England developing
  provision of antenatal education in the light of Department of Health
  Preparing for pregnancy, birth and beyond recommendations126
  should offer parent-centred, participative courses and factor in this
dose-response relationship.
Parents booking shorter courses should be particularly encouraged to consider participating in NCT branch activities and Early Days postnatal courses, so they can access additional opportunities for informal support and structured discussion.

Labour and birth

- NCT teachers and activists should encourage midwifery managers to actively review the use of supine positions and stirrups for birth. Actions to facilitate change could include: user involvement, leadership, training, audit and feedback.
- Parents should be told about local hospital practices and advantages and disadvantages of different birth settings.
- This report adds to the evidence behind recent calls for greater access to birthing pools. Most of the women in this study planning to give birth in hospital who wanted to use a birth pool were not able to do so during labour, so maternity services should review their provision to increase opportunities. Fortunately, this was not the case for women who planned to give birth at home or in a birth centre.

Motherhood and fatherhood

- The findings suggest that NCT needs to review antenatal course objectives, taking account of the needs identified by parents in this report. In addition to the curriculum content and time allocated to postnatal issues, consideration should be given to the availability of relevant written information and access to support, including breastfeeding support, in the early days after the birth.

Baby feeding

- Women and their partners to be able to access relevant information and support about a range of feeding approaches and to feel that support is available to them unconditionally, particularly in the early weeks after birth.

Future research

- To increase opportunities for participation in NCT research and increase the response rate for pregnant women’s partners, NCT should develop its IT system to enable email addresses for all course attendees to be recorded, not just the person booking the course. This would make it possible for both partners to be contacted directly.
- Further research is needed to explore the finding that a high proportion of women found labour and birth different from what they had expected, with one in four feeling unprepared, and over half not having the kind of birth they wanted.
- Further research is also needed on parents’ experiences of looking after a newborn baby, particularly the first week of motherhood and fatherhood, and what kinds of preparation are helpful.
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For further information about ways that NCT can work with you to deliver services for parents in your area, or to find out more about training options, please contact:

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