

# PRENATAL EDUCATION IN ONTARIO

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## BETTER PRACTICES



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Ontario's maternal, newborn and early  
child development resource centre

Centre de ressources sur la maternité,  
les nouveau-nés et le développement  
des jeunes enfants de l'Ontario

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### PRENATAL CURRICULA REVIEWED

*Canada Prenatal Nutrition Program – Facilitators’ Guide.* Toronto Public Health (2006)

*Early Pregnancy Manual.* Central East Reproductive Health Network – Public Health (1998)

*Early Prenatal.* Eastern Ontario Health Unit (2003)

*Growing Babies... Growing Parents: An evidence-based perinatal education resource.* Children’s & Women’s Health Centre of British Columbia – Provincial Health Services Authority (2003)

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*Prenatal Class Curriculum.* Peterborough County-City Health Unit (2006)

*Prenatal Instruction for Newcomers to Canada – P.I.N.C. Curriculum.* Region of Peel (2005)

*Prenatal Health Education Program.* Victorian Order of Nurses Windsor-Essex County Branch (2006)

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# 1. INTRODUCTION

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## PURPOSE

This manual is designed for prenatal educators and prenatal program managers. It is intended to disseminate current research and promising effective practices used by other prenatal educators. The manual is not a prenatal education curriculum but can provide guidance to organizations wishing to review, assess or update their curricula or create a new curriculum for a specific population. It will also be useful to prenatal educators who wish to stay current in their practice.

It is important to note that group prenatal education programs are only one component of the care and support necessary through pregnancy, birth and the postpartum period. Comprehensive health promotion practices encourage a blend of strategies with inter-sectoral collaboration. Other strategies that complement group prenatal education include:

- one-on-one prenatal care provided by health care providers;
- policy development;
- prenatal health fairs;
- public media and health promotion campaigns;
- community and workplace supports and resources;
- school programs, etc.

It is not intended that one group or agency take on all the components influencing the preparation of pregnant women and their partners for labour and parenting. It is important however, to position group prenatal education programs within a comprehensive framework. This document focuses specifically on group prenatal education and does not address other components of prenatal education.

## CONTENT

This manual can be reviewed from beginning to end, chapter by chapter, or by specific area of program content. The manual includes information about the types of group prenatal education, documented effectiveness of prenatal education, topics and key messages, effective practices and relevant resources.

This resource is not a comprehensive or exhaustive review of literature, curricula, programs or resources. It should be seen as a snapshot that represents the status of prenatal education in Ontario. There are many high calibre programs available throughout Ontario that may not have been highlighted in this manual.

Programs and resources cited throughout this document do not imply endorsement by the Best Start Resource Centre. Any changes in programs, products, suppliers, website addresses, etc. subsequent to the printing of this resource are inevitable, and are beyond the control of the Best Start Resource Centre.



## 2. TYPES OF PRENATAL EDUCATION

### DEFINITION OF PRENATAL EDUCATION

Prenatal education, in the context of this manual, is defined as a series of classes, either online or in person, provided for groups of pregnant women and their partners or support people. The goals of these classes are to:

- provide participants with the information and skills they need to improve pregnancy and birth outcomes;
- help participants have a positive birthing experience; and
- prepare participants for early parenting.

Prenatal education has evolved over time in Ontario. Historically, expectant women were prepared for pregnancy, birth and parenting through the transmission of information from one woman to another. Birth was part of family life and women received some of their education on birthing by attending the births of other women. In industrialized countries, birth is now generally performed in a hospital setting and the healthcare system has taken on the role of preparing parents for the birth as well as the transition to parenting. In addition, there is still a range of cultural beliefs surrounding pregnancy, labour and delivery, birth and early parenting in Ontario. For example, in some Aboriginal populations, the grandmother may continue to have a significant role in sharing her knowledge about pregnancy and early parenting, as well as in providing support after the birth.

### PRENATAL EDUCATION PROVIDERS IN ONTARIO

Prenatal education is currently offered in Ontario by a variety of organizations: public health units, hospitals, community health centers, non-profit organizations and private businesses. The programs are generally open to pregnant women and their

support people. The support person may be the woman's partner (male or female) or it may be a close relative or friend.

The 1997 Mandatory Health Programs and Service Guidelines ([www.health.gov.on.ca/english/providers/pub/pubhealth/manprog/mhp.pdf](http://www.health.gov.on.ca/english/providers/pub/pubhealth/manprog/mhp.pdf)) shape the content of the programs offered by public health units in Ontario (the guidelines are currently under review). Public health programs focus on supporting pregnant women and their partners to achieve a healthy birth outcome and prepare for parenting.

Some hospitals in Ontario offer prenatal education programs. Hospital programs generally cover the topics related to healthy behaviours, signs and stages of labour, comfort measures during labour, medical interventions, postpartum recovery, breastfeeding and baby care. Hospital programs include a tour of the birthing centre and help parents become more comfortable with the technology of pain control. The information offered by hospitals usually reflects the level of obstetrical service offered.

Some Community Health Centres ([www.health.gov.on.ca/english/public/contact/chc/chc\\_mn.html](http://www.health.gov.on.ca/english/public/contact/chc/chc_mn.html)) offer prenatal education programs and these may be directed at a more specific group such as Francophones, teens, Aboriginal people or specific cultural groups.

Expectant parents in larger cities have additional choices of programs. Some are run by non-profit organizations such as the Victorian Order of Nurses ([www.von.ca](http://www.von.ca)) or by private, for-profit educators with specific approaches such as Lamaze ([www.lamaze.org](http://www.lamaze.org)), Bradley Method ([www.bradleybirth.com](http://www.bradleybirth.com)), Birthing from Within ([www.birthingfromwithin.com](http://www.birthingfromwithin.com)) or by midwives ([www.aom.on.ca](http://www.aom.on.ca)) who may combine various program elements. In some cases, private

educators are part of a non-profit association, e.g., Childbirth and Postpartum Professional Association of Canada ([www.cappacanada.ca](http://www.cappacanada.ca)).

The program delivery setting may vary greatly: public health unit office, hospital, workplace, school, community centre, public library or private place of business.

### GENERIC PRENATAL PROGRAMS

A large number of expectant parents take part in a “generic” series of classes, which provide an overview of a wide array of topics over a number of consecutive weeks during the pregnancy.

Across Ontario, agencies offer a wide range of generic series. They are many different schedule options, to accommodate busy schedules. The duration normally ranges from approximately 10 to 14 hours and classes are generally offered over four to seven sessions or during one to three weekends.

Topics may include: prenatal care and healthy lifestyles, labour and delivery, role of the support person, breastfeeding, newborn care, postpartum care, adjustment to parenting and community resources. Many programs incorporate a hospital tour often provided as a collaborative effort between agencies. In some cases, a post-delivery session is also offered. Some programs offer optional stand-alone modules, in addition to the series provided.

If a public health unit, community health centre, hospital or non-profit organization provides the program, the cost ranges from no charge to approximately \$120/pregnant woman, with subsidies available in many areas. The cost of programs offered by private agencies is higher. Classes are sometimes included as part of a midwifery service.

### PRENATAL PROGRAMS SPECIFIC TO THE STAGE OF PREGNANCY

In Ontario, some organizations divide the series into an early pregnancy mini-series that focuses on having a healthy pregnancy, and a late pregnancy mini-series covering labour and delivery, and early parenting. The cost is similar to that of a generic series and parents have the option of attending either or both mini-series.

In some areas, agencies will share teaching components: one agency offers the early pregnancy program and another offers the late pregnancy program. In other areas, the program is offered in collaboration, with one of the classes in a different location, such as a hospital.

A recent trend in Ontario has been to offer Prenatal Health Fairs. In some areas, these have replaced the early pregnancy series of classes. These public events are provided collaboratively by a number of organizations that have an interest in maternal and family health.

Additional options exist outside Ontario. For example, the British Columbia Women’s Hospital & Health Centre ([www.bcwomens.ca](http://www.bcwomens.ca)) offers a 10-week program split into four stages:

- The first stage (0-18 weeks of pregnancy) consists of two classes focusing on changes of early pregnancy, fetal development, making lifestyle choices, and informed, shared decision-making.
- The second stage (19-28 weeks) offers three classes with an emphasis on changes of mid-pregnancy, baby care and parenting the newborn.
- The third stage (29 weeks to birth) focuses on changes of late pregnancy, labour and birth and breastfeeding. A hospital orientation is included during this stage.
- The fourth stage is one final class after the baby’s birth which focuses on the newborn and adjusting to parenthood.

## REFRESHER PRENATAL PROGRAMS

These programs are offered to parents who may have taken prenatal education for a previous birth and wish to obtain current and/or review information, especially if a few years have elapsed since the last birth. These programs may also be relevant for couples in blended families, where the pregnant woman has experienced birth before but the partner hasn't. Topics include: labour and birth, preparing children for the baby's arrival and sibling rivalry. Ottawa Hospital offers such a course ([www.ottawahospital.on.ca](http://www.ottawahospital.on.ca)).

Some organizations offer specific sessions to assist parents in preparing siblings for the arrival of a new baby, e.g., Sunnybrook Health Sciences ([www.sunnybrook.ca/prenatalclasses](http://www.sunnybrook.ca/prenatalclasses)).

Some agencies offer sessions exclusively on breastfeeding, e.g., hospitals, La Leche League. The content of this program is generally integrated into the generic series and may also be provided separately as a refresher class for parents who did not breastfeed their first child and who wish to do so with a subsequent child.

## PRENATAL PROGRAMS FOR SPECIFIC GROUPS

### Adolescents/Young Adults

A large number of agencies, including public health and community health centres, offer programs specifically for pregnant women who are adolescent or young adults. The maximum age of the participants in these programs varies from 20 to 25.

The program content is generally adapted from a generic series with more emphasis on healthy behaviours during pregnancy and adjustment to parenting. In most cases, additional incentives to participate are offered, e.g., free transportation, provision of food and elimination of a registration fee. These programs are sometimes provided at a

high school after regular classes or in a community centre. They may also be blended into the classroom curriculum and provided during the school day. In rural communities, these programs may be offered on a one-to-one basis, as required.

### Cultural Groups

Some agencies provide prenatal education in English to pregnant women who have a limited understanding of the English language. Topics covered are similar to those in a generic series with additional visual aids and techniques appropriate for English as Second Language classes. An example of this is available at Peel Region Public Health ([www.pregnantinpeel.ca](http://www.pregnantinpeel.ca)).

Programs are also offered in languages other than English when the numbers and resources permit, e.g., French, Farsi, Tamil, and Cantonese. The program may also be culturally adapted to reflect specific practices and beliefs.

Reaching deaf and hard-of-hearing expectant parents is important and some agencies provide one-on-one classes with the assistance of an interpreter. Information and assistance is available through the Canadian Hearing Society ([www.chs.ca](http://www.chs.ca)).

### Multiple Pregnancy

Multiple birth prenatal programs are specifically geared for parents expecting multiples. These programs are sometimes provided in addition to or instead of a generic series. They focus on pregnancy difficulties common to multiple pregnancies such as caesarean sections, care of preterm and low birth weight babies, signs of preterm labour, familiarization with neonatal intensive care units and the role of family supports. Some larger cities have programs for parents expecting multiples and a listing is available on the Multiple Birth Canada website: [www.multiplebirthscanada.org](http://www.multiplebirthscanada.org).

### **Diverse Family Structures**

Prenatal programs that are adapted for pregnant women of diverse family structures and sexual / gender identities are available in large cities. The topics are similar to those in a generic series and include adapting to co-parenting in a diverse family structure. An example of this program is available at The 519 Community Centre in Toronto ([www.the519.org](http://www.the519.org)).

### **ONLINE PRENATAL PROGRAMS**

Some organizations have started to offer online prenatal education. Currently, these programs have limited interactive capabilities and no evaluation information is available. However, systems are rapidly evolving. In Ontario, Grey Bruce Health Unit ([www.publichealthgreybruce.on.ca](http://www.publichealthgreybruce.on.ca)) offers an online program to accommodate people living in rural areas, particularly during the winter months. The online program may be used as a complement to or instead of face-to-face sessions. There is no fee for this online program and no registration is needed. Participants in the health unit's catchment area may contact a Public Health Nurse if they have questions.

Online fact sheets are also widely available.

### **BLENDED PRENATAL PROGRAMS**

"Blended programs" using a combination of online information and face-to-face meetings are emerging. In the United States, the East Health Care System from Minnesota ([www.healtheast.org](http://www.healtheast.org)) has an online program that offers the same content as the in-class series. This is followed by one face-to-face session where breathing techniques are facilitated and participants' questions are answered.

In Canada, Invest-in-Kids ([www.investinkids.ca](http://www.investinkids.ca)) has embarked on a program called The Parenting Partnership. This program uses a combination of face-to-face sessions and interactive online learning and is designed to support the parents for the duration of the pregnancy and until the child is

two years old. The program is currently being piloted on a large scale and will be evaluated for short and long term outcomes (follow up continues to the child's 5th birthday), with the final report targeted for 2011.

### **DROP-IN PRENATAL PROGRAMS**

Some agencies offer prenatal education drop-in programs on an on-going basis. These are often provided in the context of the Canadian Prenatal Nutrition Program (CPNP) and focus on reaching pregnant women who may be at risk for poor birth outcomes due to poverty, isolation, lack of education, etc. Drop-in programs are also occasionally provided for specific groups, such as pregnant women with substance use problems.

The structure of drop-in programs varies across the province with some areas following a set curriculum that is repeated every few months and others adapting topics according to the needs of the participants. Program facilitators may also incorporate local opportunities such as presentations by physicians or midwives. The classes include a facilitated session on a given topic, followed by information sharing and networking. Drop-in programs are sometimes provided as a complement to a generic prenatal program.

### **ONE-TO-ONE PRENATAL PROGRAMS**

In some cases, pregnant women and their support person may take a one-to-one program with a prenatal educator. This may be due to a variety of reasons, e.g., geographic isolation, medical condition including hospitalization, prior loss of a baby, language issues, incarceration, or a complex work schedule.

Private businesses and some hospitals offer one-to-one programs, covering similar topics as the generic series, with adaptations as needed. This option is generally much more costly. However, depending on the specific situation, some of the costs may be covered through a social agency.

## OTHER

A large number of organizations offer parenting programs and there is sometimes an overlap between prenatal and parenting program content. For example, the Transition to Parenting Program ([www.ottawa.ca](http://www.ottawa.ca)) is generally started in late pregnancy and provides the opportunity to develop parenting skills, to meet and connect with other parents and to find out about services and resources available in the community.

Adoptive parents may also find these programs of interest, as they can benefit from knowledge and skill development related to newborn care and transition to parenting.

A new model combining prenatal care and education called “Centering Pregnancy” is emerging. Women receive their regular obstetric care in a clinical setting and then join other women/couples/teens with similar due dates for an education session. The groups generally form at the end of the first trimester and continue through the early postpartum period. The model has been used in the United States ([www.centeringpregnancy.com](http://www.centeringpregnancy.com)) and also in British Columbia.

Some prenatal programs are offered for parents who have experienced the loss of a baby in a prior pregnancy. Perinatal Bereavement Services Ontario ([www.pbso.ca](http://www.pbso.ca)) provides information on available programs.





### 3. LITERATURE ON PRENATAL EDUCATION

#### INTRODUCTION

Service providers want their prenatal education strategies to be as effective as possible. This section presents a summary of the literature regarding the effectiveness of prenatal classes.

The review was primarily focused on whether or not prenatal education classes are effective in improving health awareness, knowledge, behaviour or health outcomes for parents and babies. In addition, the review also considered the following:

- What teaching strategies have parents identified as being more effective?
- What teaching strategies are more effective in reaching specific population groups?
- Are certain delivery channels more effective?
- Which groups of expectant parents are less likely to receive prenatal education?

The published literature included in the review was obtained through a search of the following databases from 1996 to 2006:

- Cumulative Index of Nursing and Allied Health Literature (CINAHL);
- Medline;
- Academic Search Premier;
- Evidence Based Medicine Reviews (Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, Database of Abstracts of Review of Effects, American College of Physicians Journal Club); and
- Health Source – Nursing/Academic Edition.

These databases cover a very large number of journals. Journal articles prior to 1996 were used if they were recently referenced. Also included in the review are reports from various Canadian organizations and statistical data found on the Internet.

Keywords used in database searches included the following: prenatal education, effectiveness,

prenatal classes, childbirth classes, childbirth education, classes, outcomes, sleep positions, SIDS, shaken baby syndrome, newborn safety, crying, car seat, lesbian, informed consent, PPMD, postpartum mood disorders and online.

The literature search was not systematically rated according to the methodology used (i.e., randomized controlled trials, quasi-experimental designs). Prenatal education program elements were extracted in order to provide suggestions to service providers. Comments on the quality of the evidence are provided where relevant.

The findings from this summary are limited due to a number of critical factors:

- There is not a large amount of research on the effectiveness of prenatal education;
- It is difficult to isolate the impact of prenatal education from the other sources of prenatal information and care;
- Most prenatal education studies do not control for the socio-demographic differences between attenders and non-attenders, making it difficult to draw conclusions; and
- A selection bias exists, as women are more likely to attend prenatal education classes if they are older, have a higher level of education, are married or have a steady partner, and visit a health care provider<sup>1</sup>.

The literature search focused mainly on providing an overview of the effectiveness of prenatal education and should not be considered an exhaustive search of all research published on the topic. All types of group prenatal education (community-based and privately provided) were included in this review. Research on the effectiveness of prenatal care (e.g., clinical care of pregnant women) was excluded.

There is a need for additional, carefully designed research on this topic, to help guide work in prenatal education.

## EVIDENCE OF THE EFFECTIVENESS OF PRENATAL CLASSES

### Historical Background

Over the past century, the need for formal prenatal education services has emerged due to the institutionalization of birthing<sup>2</sup>. In the first half of the 20th century, prenatal education programs were developed to educate women about pregnancy, nutrition and health care during pregnancy and by the 1950s, also included preparation for birth. At that time, hospitals were generally sedating women for childbirth and encouraging little maternal input. From 1960 to 1980, the philosophy of birthing and prenatal education changed and birth was seen as a healthy process and consumers were given choices related to this process. The movement changed towards natural and less medicated childbirth and over time, gradually evolved to an approach that blended the medical model and natural options. Following society's changing values, prenatal education evolved to meet the needs of pregnant women and to also include partners in the process.

In the latter part of the 20<sup>th</sup> century, expectant women became increasingly involved in the workforce and this reduced the time they had to inform themselves about childbirth. In the 1990s, a dichotomy emerged in maternal-newborn care between the “high-tech” and “high-touch” approaches. Physicians became more concerned about risk management and this resulted in an increase in medical interventions, including tests and pain relief procedures. These topics are now generally part of the prenatal curriculum. At the same time, changes in the area of social support, including the introduction of birthing rooms to create a home-like environment and the use of midwives and doulas to assist in the birthing event, occurred.

Women are discharged from the hospitals as early as 24 hours after giving birth, making it important for prenatal curricula to cover topics related to breastfeeding, postpartum adjustment, and newborn care.

### General

It is important to identify what outcomes are anticipated through prenatal education:

- Lower rates of infant mortality, low birth weight and preterm birth?
- Improved maternal health and reducing maternal risks?
- Increased ability of the mother to cope with the stress and pain of labour?
- Increased parental knowledge so they can make informed decisions?
- Increased ability of the parents to care for their infants?

Since all of these outcomes are important, prenatal education covers a wide array of topics. Therefore the supporting literature is very broad.

According to a 2006 Cochrane Systematic Review, the effects of general antenatal education for childbirth and/or parenthood are uncertain<sup>3</sup>. Six trials, involving 1443 women, were included in the review. There was a lack of consistency in the results largely due to the fact that the content, approach, and populations served varied. There were also methodology shortcomings in some of the studies, preventing solid results. Previous studies had similar findings<sup>4,5</sup>. What women are taught in prenatal classes often varies dramatically depending on the educator's philosophy of childbearing and the type of prenatal classes<sup>6</sup>.

It is important to note that research does not indicate that prenatal education is ineffective. A British study<sup>7</sup> concluded that 93 % of women who attend prenatal classes find them useful; however, it is simply not possible to affirm that it is a unique positive element in the preparation of expecting parents. Some of the outcomes of prenatal classes may seem unrelated and may not be evaluated, such as expanding the social network of parents<sup>8</sup>, which may assist the mother during postpartum.



A 1993 study<sup>9</sup> published in the *Canadian Nurse* indicates that the primary sources of information for pregnant women are their friends and colleagues. According to the 2002 National Survey of Parents of Young Children<sup>10</sup>, the major sources of information for parents are: physicians, partners, friends, mother, books and magazines. It becomes difficult to distinguish the added value of group prenatal education.

As indicated previously, research studies on prenatal education often have a selection bias that limits the findings. For example, a 1993 Australian postnatal survey<sup>11</sup> of 1193 women showed significant behavioural differences between mothers attending prenatal classes and those not attending, particularly regarding tobacco use, missed prenatal care appointments, breastfeeding and alcohol consumption. Those who did not attend were significantly more likely to have the following characteristics: under age 25, not completed secondary education, single, low family income, no health insurance, and public hospital clinic patients. The prenatal education was therefore not the only factor in changing their

behaviour, given other determinants of health. A similar American study from 2003 found that attendance at childbirth classes was associated with a 75% increase in the odds that a child will be breastfed. Once again, in this research, significant socio-demographic disparities existed between the attenders and non-attenders.

#### **Evidence on changing specific behaviour**

Some studies have examined the impact of prenatal education on behaviours related to childbirth and infant care: breastfeeding, pain management, etc.

##### **Breastfeeding**

The initiation of breastfeeding is correlated with prenatal education in specific population groups<sup>13,14</sup>. Participants who attend prenatal education are more likely to breastfeed than non-attenders. A Systematic Evidence Review and Meta-Analysis for the US Preventive Services Task Force<sup>15</sup> concluded that educational programs had the greatest effect of any single intervention on both initiation and short-term duration of breastfeeding. However this review was not limited to group prenatal



education programs and included all types of one-on-one education (e.g., physician, nurse, or lactation consultant). Thirty randomized and nonrandomized controlled trials and five systematic reviews of breastfeeding counselling were included. Educational sessions that review the benefits of breastfeeding, principles of lactation, myths, common problems, solutions, and skills training appear to have the greatest single effect. Interventions have larger effects in populations with low baseline rates of breastfeeding. This systematic review also stated that the continuation of breastfeeding beyond the short term (defined as more than two to four months, depending on the specific research) is not related to prenatal education but is associated with additional supports such as telephone, in-person clinics or home visits by lactation consultants, nurses or peer counsellors.

### **Pain Management**

Some research is available on the topic of pain management during labour. Most prenatal education programs explain pharmacological options and are designed to enable women and their partners to draw upon their own resources for coping with pain during labour.

In some cases, prenatal education focusing on the pharmacological options for pain relief may increase the likelihood of these options being requested during labour<sup>8</sup>. Another study demonstrated that couples taking childbirth education were more likely to receive little or no pain medication and less conduction anaesthesia than controls<sup>16</sup>.

Nolan<sup>17</sup> references a large number of studies on the association between use of pain relief options in labour with attendance at prenatal classes. No clear conclusion can be drawn.

The author indicates that this may be due to variation in content and teaching approaches, and self-selection bias regarding the type of class taken. She concludes that men and women have generally made up their minds about pain control prior to attending prenatal classes.

### **Vaginal Delivery**

Women are generally encouraged to attempt vaginal delivery in prenatal education.

A systematic review<sup>18</sup> of the research was completed to ascertain if prenatal education had an impact on vaginal delivery. Two randomized controlled trials involving 1451 women met the inclusion criteria for the review. The evidence is inconclusive due to shortcomings in study design.

### **Identifying Onset of Labour**

Prenatal education often includes information on identifying the onset of labour. A systematic review<sup>19</sup> was completed to determine if prenatal classes help reduce the number of “false alarms”. Only one antenatal education program was part of the review and it had some design flaws. The program was associated with a reduction in the mean number of visits to the hospital before the onset of labour. Due to the design issues, the systematic review authors concluded there is not enough evidence to evaluate the use of a specific set of criteria for self-diagnosis of active labour.

### **Toxoplasmosis**

Prenatal education is effective in changing specific health behaviours such as hygiene practices designed to prevent congenital toxoplasmosis<sup>20</sup>. A 10-minute education program delivered early in the pregnancy was effective at changing pet hygiene behaviour and cooking methods for roast beef and hamburger.

### Sickle Cell

The effect of prenatal sickle cell screening education on the follow-up rates of infants with sickle cell trait was assessed<sup>21</sup>. Parents whose prenatal education included sickle cell information were more likely to comply with follow-up if their infant had sickle cell trait and they retained significantly more of the information given during the postnatal education than did controls.

#### Summary of research on specific behaviours

- Prenatal education has shown some effectiveness in increasing the initiation of breastfeeding.
- Prenatal education has shown some effectiveness in improving specific health behaviours such as hygiene practices to reduce toxoplasmosis and follow-up sickle cell screening.
- Research linking prenatal education to other health behaviours is inconclusive due to selection bias or limited evidence.

### Evidence on health outcomes

One of the goals of prenatal education is to improve birth outcomes. Very few studies specifically examined the effect of prenatal education on birth outcome. An early study (1990) on the relationship between childbirth education classes and obstetric outcome<sup>22</sup> found no difference in outcome between a study group who attended two classes focusing on labour and delivery preparation and a control group who did not take prenatal classes or took only one prenatal class.

Other specific aspects of health outcomes include the following:

#### Preterm Birth

In a Canadian study<sup>23</sup>, the same information was given to pregnant women on preterm labour from two sources. It was given through

an early-series prenatal class and through their health care provider at their 18 to 20 week prenatal visits. The authors conclude that such a standardized approach can help improve preventive practice for preterm labour.

### Low Birth Weight

Babies born with a birth weight below 2,500 grams are identified as low birth weight (World Health Organization, 1990) and are at higher risk for various negative health outcomes. According to a systematic review<sup>24</sup> completed by the Public Health Research, Education & Development Program (PHRED), prenatal education classes, on their own, have not been shown to be a factor in reducing low birth weight for adolescents. One of the studies reviewed included both intervention and control groups receiving home visiting, with only one group receiving prenatal education classes. The use of prenatal classes did not produce a significant effect on low birth weight but the mean birth weight of both groups receiving home visiting improved 50% over the national average. Five (of 13) studies reviewed showed a statistically significant increase in birth weight. Interventions providing multiple strategies such as transportation to appointments, health teaching, social/peer support, referrals to community services, telephone contact, and coordination of prenatal appointments were more effective than single strategies.

A 1990 American study of 60 first-time mothers found no difference in infant birth weight following childbirth education classes, even if significant differences occurred in health promotion behaviour<sup>25</sup>. The very small sample size in this study makes it difficult to draw conclusions related to birth weight.

To date, inadequate research methodology prevents a general conclusion to be drawn regarding the effect of prenatal education, as an isolated intervention, on low birth weight prevention<sup>25</sup>.

## WHAT PARENTS HAVE SAID

Do parents feel that prenatal education prepares them for the birth of their baby, for caring for their newborn and to be ready for parenthood? The literature provides insight into what parents would like to receive from a prenatal education program in order to feel well-prepared.

### Personal control

A 2004 American study<sup>26</sup> examined the association of various factors with components of childbirth satisfaction and with the total childbirth experience. Personal control and having expectations met during childbirth were important factors related to the women's satisfaction with the childbirth experience. Helping women have realistic expectations and strategies to increase their personal control during labour and birth may increase the women's childbirth satisfaction. This confirmed findings from previous research<sup>27</sup>. Assessment and discussion of the woman's wishes

and expectations regarding childbirth should occur throughout pregnancy, resulting in a plan for labour and delivery.

### Preparation for unexpected outcomes

Another American study completed in 1995 investigated couples' evaluation of their labour and delivery after attendance at prenatal education classes<sup>28</sup>. The couples had experienced a representative sample of common labour and delivery situations. Using a standardized labour and delivery evaluation scale, both partners reported low satisfaction regarding the total labour experience. In the case of deliveries assisted by vacuum or forceps, the satisfaction level of both partners was even lower and it was lowest for caesarean deliveries. The author indicated that if caesarean deliveries continue to be a major method of delivery, childbirth educators and health care providers need to explore mechanisms to make this a positive experience.



A small study was undertaken in Ontario with seven women attending two different prenatal education programs<sup>29</sup>. The participants were interviewed three times: after registration yet before attendance at classes, approximately one-third into the classes and within a week after the birth of the baby. At the third interview, women indicated they had felt prepared for a normal vaginal delivery; however, many of the participants indicated they were not prepared for what actually happened (three caesarean-sections and one prolonged preterm delivery). Even the three term vaginal deliveries had unexpected problems and the women did not feel prepared for such situations. In addition to the lack of preparation for the unexpected, the mothers identified the perceived failure of labour and delivery nurses to reinforce the knowledge gained from attending prenatal education class. Mothers also identified the failure to debrief or discuss the implications of audio-visual aids such as the birth videos during the prenatal education sessions, leaving them with many unanswered questions and some misconceptions prior to delivery.

#### **Timing of the information**

A Canadian study<sup>9</sup> was based on interviews with 71 expectant women. Women identified what they would like to learn about at different stages of pregnancy. In the first trimester, women identified an interest in simply being with other pregnant women and wanting to learn about the average pregnancy, labour and birth. Second-trimester participants had a wide variety of interests: changes during pregnancy, breathing exercises, labour and birth, postnatal exercise, baby feeding and care. In the third trimester, women valued content about labour and delivery. Women who had already had a baby found that breathing

exercises and physical preparation for labour and birth were the most valuable aspects of prenatal classes. Participants felt they learned best in the mornings but were all working outside the home, and the study suggests that weekend mornings may meet their needs more effectively. Participants also indicated that they would like to receive brief yet substantive reading materials before the classes, so they would not feel ignorant during class. Women wanted the opportunity to take part in class discussion. They also expressed an interest in accessing videotapes for home viewing.

The learning needs of parents at different stages of the pregnancy have been the subject of other research<sup>30,31</sup> and suggestions are integrated in Chapter 4.

Interviews completed with public health staff that offer prenatal education from ten Ontario health units<sup>32</sup> indicate early (< 20 weeks) prenatal classes have low attendance. According to the report, the low attendance is probably due to the public's expectations of the purpose for prenatal classes: labour and birth information is the main reason for attendance.

#### **Parenting confidence and skills**

According to a 2002 National Survey of Parents of Young Children<sup>10</sup>, only 44% of parents felt prepared for parenthood before their first baby was born. Once their baby was born, their confidence plummeted to 15%. Older first-time parents, most notably those over 35 years of age, were more likely than younger first-time parents to report low confidence in the parenting role. Research on the effectiveness of prenatal education for older pregnant women was not found.

An Australian postnatal survey also noted that eight months after the birth, mothers who had

attended prenatal classes were not more confident than non-attenders in caring for their infant or less likely to be depressed than non-attenders, even if the non-attenders tended to have a lower socio-economic status<sup>11</sup>.

Other postnatal research<sup>33</sup> highlighted mothers' comments about the "conspiracy of silence" that appeared to exist regarding the realities of motherhood. Mothers commented that no one had prepared them for the unrelenting demands of infant care, the level of fatigue they would experience, the loss of personal time and space, and the realities of 24 hour-a-day infant care.

Such information becomes very relevant when determining when to assess parents' satisfaction following a prenatal education program. If an evaluation is performed towards the end of the pregnancy, the parents may feel quite satisfied with the knowledge they have acquired about parenting during prenatal classes. The real test comes during labour and delivery and after the baby is at home. Comprehensive evaluations may need to be done at different times, to evaluate different aspects, such as:

- the impact on health behaviours in pregnancy;
- the impact on maternal health and infant outcome; and
- the participant satisfaction with prenatal, labour and delivery and infant care information.

Most parents and professionals express a desire for interventions that foster the autonomy of the future parents, in order to help them remain confident in their decisions both during and after the perinatal period<sup>34,35</sup>. The concept of an empowerment model of care best describes their desires. Participants frequently indicate that the

education should focus on the parents' needs and, as such, groups should evolve according to changing learning needs.

An Australian evaluation<sup>36</sup> of a pilot program focusing on parenting skills and relationship issues, as well as preparation of birth, significantly increased the women's positive experience of parenthood when interviewed 10 weeks after the baby was born. A similar trend was found in the men's evaluation of parenthood, although the difference was not statistically significant. A key strategy of the pilot program was to provide gender-specific discussion groups that were led separately by a midwife and a male facilitator. These groups were conducted three times, and encouraged couples to explore personal issues as individuals, separate from their partners.

### Fathers

While a pregnant woman's life partner may be either female or male, this subsection focuses on research regarding the impact of prenatal education on male partners.

In an Australian study<sup>37</sup>, fathers reported that the prenatal classes had prepared them for childbirth but not for lifestyle and relationship changes after the birth. Additionally, fathers were less familiar than mothers with the family-related services in their region. A Japanese study<sup>38</sup> had similar findings: the fathers felt satisfied with the birth experiences but found themselves unprepared for postnatal life.

There is a need for prenatal classes that include information that is specific to the concerns of male partners. Some prenatal classes offer father-focused discussion groups, teach coping skills and provide social support. Fathers attending a father-focused class had less psychological symptoms of stress

and showed a significant improvement in spousal relationships than those in traditional classes<sup>39</sup>. The classes offered father-focused discussion groups and emphasized coping skills and increasing social network support. The fathers were not separated from the mothers and the educators directed questions and comments to the fathers to motivate involvement and communication on feelings and caring. It is important to note that the post-test was done prior to childbirth.

An Ontario study<sup>40</sup> reviewed feedback from fathers, mothers and service providers regarding the provision of services to fathers. Recommendations support father-only programs, offered in the evenings or on weekends, in non-structured settings.

#### Summary of what parents have said

Studies conclude that parents find the following strategies beneficial:

- Programs that help to set realistic expectations of the birth and offer ways to increase personal control during the birth event.
- Programs that prepare parents for unexpected outcomes.
- Programs that offer information at the relevant stage of the pregnancy.
- Program that aim to increase the parents' confidence in decision-making.
- Programs that involve fathers.



## EFFECTIVENESS OF SPECIFIC DELIVERY SETTINGS

### Online

Online prenatal education is a relatively new approach to prenatal education. While it is promising in reaching a potentially large audience, especially those who may find it difficult to attend formal classes, evidence of effectiveness has yet to be determined.

### Worksite

Worksites are occasionally used to deliver prenatal programs, particularly in the United States. Studies have compared groups taking prenatal education programs offered in worksite settings with control groups not taking a prenatal education program<sup>41,42</sup>. Benefits of increased knowledge were noted with the groups enrolled in a program. However, this could be expected of programs in any setting and the association was not made specifically to the worksite setting. These studies found that offering a worksite prenatal program also had a positive impact on employee retention and absenteeism. Unfortunately, no studies compared groups taking a program in a worksite setting with groups in another setting (such as a hospital or community-based program).

### School

According to Dieterich, school-based pregnancy programs offer a promising setting to improve health behaviours and outcomes of the pregnant adolescent<sup>43</sup>. This is particularly true when the program employs a prenatal educator and is implemented within the curriculum. The author adds that when the prenatal educators can work as consultants within the school setting, they can be instrumental in developing not only interdisciplinary but also interagency collaborative relationships. Some of the barriers such as cost and transportation can be eliminated, and the allocation of school credits is an incentive for some.

## EFFECTIVENESS FOR SPECIFIC GROUPS

### Adolescents

The effectiveness of comprehensive prenatal programs (i.e., beyond group prenatal education programs) for adolescents is well-documented<sup>43,44,45</sup>. Program participants are less likely to have inadequate prenatal care and are less likely to have low birth-weight births<sup>44,45</sup>.

A study<sup>45</sup> completed in New Mexico included a total of 48 prenatal and parenting programs. Unfortunately, the data provided cannot isolate the influence of prenatal classes. Some of the positive contributing factors identified were: one-on-one attention, follow-up discussion groups and home visits, peer interaction, ongoing education in birth control choices and counselling as needed. Other services considered to be important include transportation to medical visits, advocacy by program staff and health providers and the inclusion of the whole family in home visits and counselling sessions.

Research on multidisciplinary approaches is beyond the scope of this manual; however, program planners need to examine the benefits of multidisciplinary partnerships.

A British study<sup>46</sup> clearly advocates for prenatal classes specifically designed for adolescents to reduce stigmatization and increase attendance. Classes should be offered at a time and venue suitable to their circumstances and the content should incorporate issues such as sexual health and contraception. Teenagers indicated they would have been more likely to attend prenatal classes if classes coincided with their prenatal care visits.

Lakehead University<sup>47</sup> used a literature review to categorize the needs of the pregnant adolescents and further identified the strategies that would best meet these needs. Proposed strategies that go beyond the provision of a prenatal education series were identified. Multidisciplinary prenatal

programs that have the following characteristics are more likely to be successful in meeting the prenatal needs of this population:

- collaboratively involve pregnant adolescents, their families and peers, as well as the community;
- are located in a familiar setting;
- are congruent with the adolescents' stage of cognitive and psychosocial development;
- offer individual support and counselling incentives for healthy behaviours, participatory planning; and
- offer a flexible class agenda.

Other initiatives have been successful in engaging adolescents in prenatal classes. In an American study<sup>48</sup>, student nurses delivered prenatal curricula to teenagers. The author indicates that the program was well received by the adolescent clients who may have regarded some of the nursing students as peers and role models. Teaching strategies that actively involved the teenagers, such as group discussion, games and demonstrations were often used.

An older study<sup>49</sup> (1988) focused on the benefits of prenatal classes for adolescent fathers. Findings suggest significant gains in knowledge for the experimental group with regard to pregnancy, prenatal care, infant development and parenting. Fathers who participated in the prenatal classes tended to report more supportive behaviours toward the mother and the infant.

### **Aboriginal**

Aboriginal people in Canada are often confronted by conditions putting them at higher risk for health problems. In rural communities, they may have limited access to health care and face environmental constraints such as the lack of appropriate solid waste disposal and a safe water supply, as well as adverse climatic conditions. In urban areas, they may lack extended family and community support and have difficulty maintaining

or learning traditional practices. These situations may put women at higher risk for some pregnancy complications and adverse outcomes. Given the underlying context of health concerns in many Aboriginal populations, and the Aboriginal holistic approach to health care, Aboriginal prenatal education services are often linked to services that address determinants of health, including food security, prenatal health care, etc.

The only literature found on prenatal education classes in the context of Aboriginal health is the adaptation of a model developed for adolescents<sup>47</sup>. The model was assessed to see if it could be successfully used with adolescent Aboriginal women living in an isolated northern Canada community. This model focuses on multidisciplinary programs and community involvement and therefore goes well beyond offering a generic prenatal education series. Although an actual program was not delivered within the scope of this study, the model was seen as useful in developing a prenatal program that would take local needs and resources into account.

### **Multi-cultural**

In 2001, 27% of Ontarians were born outside Canada<sup>50</sup>. Newcomers to Canada may come from cultures where pre and postnatal support is handled very differently than in Canada. In addition to this, newcomers to Canada may be isolated from their extended families and may have additional challenges around language, employment and income. An evaluation report of the Canada Prenatal Nutrition Program<sup>51</sup> points out that being a recent immigrant is not a high-risk prenatal factor in itself. Whether an immigrant woman is considered at risk depends on her country of origin, circumstances of immigration and personal health history.

Prenatal classes for these populations may need to focus on information about Canadian services and practices during pregnancy, delivery and parenting, in addition to linking families to services that can

help to meet basic needs and settlement concerns such as food, employment and housing. There is very little research regarding prenatal education for immigrant women in the Canadian context.

Program planning research from British Columbia<sup>52</sup> revealed that regular prenatal classes would not meet the needs of Punjabi women, even if those were delivered in Punjabi. Immigrant women are often so focussed on primary needs, such as employment, that they cannot take time to seek prenatal health information. There is need for a mobilization strategy to communicate with health care providers about prenatal education, create “buy-in” from the health care providers serving the women of the community and provide prenatal sessions that build on the existing knowledge and

concerns of the women. According to this research, a long-term perspective is also necessary as these partnerships often take a long time to build.

Limited research is available on culturally appropriate childbirth classes. A Canadian study focused specifically on meeting the needs of Chinese women<sup>53</sup>. The author offers some suggestions: orient the couples to the health care system, give information on patient’s rights, bridge similarities and differences in cultural practices, incorporate culturally appropriate food to the nutrition information provided, and provide participants with the vocabulary they need to communicate with service providers throughout the perinatal period.



### Other

A study regarding prenatal education for women with disabilities<sup>54</sup> was completed in northeastern Ontario. Some positive supports were provided (e.g., providing brochures on prenatal care associated with their disability, encouragement to develop good communication and supportive relationships with family members). In general, however, women reported they received insufficient and inappropriate information, especially about their pregnancy and chronic illnesses. The pregnant women in this study thought that nurses doubted their ability to be decision-makers or parents. There is a need for prenatal educators to provide increased advocacy for pregnant women with chronic illness and increased educational resources related to mothering with a disability.

Prenatal education for parents expecting multiples is available in larger cities and there is a growing demand for this service. A multidisciplinary team of nurses and a dietician delivered prenatal classes for multiple pregnancies in the Ottawa area<sup>55</sup>. Evaluation results indicated that the program met the needs of the participants and provided them with the opportunity to network. Emerging themes in the evaluation were the quality of the information received, the quality of educators, the value of sharing with others, the value of the neonatal intensive care unit tour and a sense of increased coping abilities.

Another Canadian study on the preparation for parenting multiple birth children<sup>56</sup> emphasized the special needs of parents expecting multiples and recommends that multiple birth prenatal education start at about 24 weeks gestation.

Very few studies provide information on prenatal education classes for women with substance use issues (beyond tobacco). An American study conducted in the mid-90s<sup>57</sup> found that substance-using pregnant women expressed a preference for content that focused on labour and birth, that they preferred to ask questions individually and in the privacy of the examining room, and that they showed negligible interest in breastfeeding.

### Summary of effectiveness for specific groups

- Pregnant adolescents and their partners can benefit from comprehensive prenatal support programs but the specific impact of group prenatal education programs has not been established.
- Insufficient research has been done to assess the effectiveness of prenatal education for people with diverse cultural identities.
- Prenatal education for parents expecting multiples has shown some effectiveness when delivered by a multidisciplinary team.

### WHO ARE WE MISSING?

In Ontario, statistics on attendance at prenatal education programs is not tracked on a provincial level. Some health units have tracked data following the birth of children and from these, we know that the percentage of pregnant women taking a prenatal program at least once varies widely, e.g., 30% for Eastern Ontario Health Unit<sup>58</sup>, an average of 48% in the eight northern health units<sup>59</sup>, 72% in York Region<sup>60</sup>. These statistics do not include all health units and the range may be even wider.

Studies from other countries provide some clues to explain the absence of some women in prenatal education programs. An American study done in 2003<sup>12</sup> found that 66% of mothers with children 4 to 35 months had never attended childbirth classes. Mothers who are Caucasian were twice as likely to have attended prenatal classes as compared to mothers who are African American. Attendance was also lower for mothers with less education, with a lower household income and who were never married.

A Swedish study<sup>61</sup> found that childbirth education programs reached the majority of pregnant women. Non-attendees had lower education and income and had more negative feelings about the approaching birth.

An Australian study offers a few additional specifics<sup>62</sup>. First-time pregnant women did not attend prenatal education because they felt that classes would not help, judged the time to be inconvenient or experienced problems with transportation, child care or cost of classes. Some did not attend because they did not know that classes were available.

## CONCLUSION

Isolating the effectiveness of prenatal classes is very difficult due to the amount of information available to pregnant women and their partners throughout their life prior to the birth of the baby. Prenatal education programs are varied and prenatal educators have personalized approaches that make comparisons difficult. In addition, through application of adult education principles, each program is customized to the needs of the participants, making each program delivery unique.

It would be unethical to deprive a specific group of expectant parents of prenatal classes to serve as a control group in order to complete a randomized controlled trial on the effectiveness of prenatal classes. At best, the effectiveness of different prenatal education programs can be compared for specific groups of parents.

There is some evidence that prenatal education can influence knowledge, health behaviours and outcomes. Despite the limitations of the current literature in establishing a clear link between prenatal education and specific outcomes, parents and service providers report a range of benefits. Some benefits may be difficult to measure, such as increased confidence and increased partner involvement. Other benefits may result from a number of combined interventions such as a social marketing campaign on a topic that is reinforced by a health care provider and further reinforced through prenatal classes.

Some of the elements that can strengthen prenatal education are:

- Partnerships with services that have complementary mandates (i.e., health care providers, home visitors, social workers, schools, etc.);
- Program evaluation, including postnatal outcome evaluations;
- Program flexibility to meet the needs of a range of learners; and
- Integration of learning activities designed to increase skills and confidence in decision-making.

### Additional research needed

Data on the demographics of the women taking prenatal education classes in Ontario could be useful, particularly if tracked across the province. The lack of information relevant to the Canadian context was particularly noticeable in the following areas:

- Aboriginal;
- Multi-cultural;
- School-based (for adolescents);
- Worksite;
- Women with disabilities;
- Women who have delayed pregnancy (over 35); and
- Online programs.

Additional research would help to identify specific success indicators, for example:

- Reduction in postpartum mood disorders;
- Correct use of car seats;
- Reduction in the incidence of shaken baby syndrome;
- Use of proper infant sleep positions;
- General adjustment to parenting; and
- Other prenatal, maternal, fetal, newborn and parenting issues.



## 4. COURSE CONTENTS

### GOALS AND OBJECTIVES

The goals of prenatal education programs are to:

1. provide expecting parents with the information and skills they need to improve pregnancy and birth outcomes;
2. help participants have a positive birthing experience; and
3. prepare them for early parenting.

The content of prenatal curricula differs depending on each agency's mandate. Some agencies specialize in providing health information during early pregnancy to improve birth outcomes. Other agencies have the mandate of ensuring parents are knowledgeable regarding comfort measures during labour and helping them make informed decisions regarding childbirth, newborn care, breastfeeding and transition to parenting. Alternatively, some agencies focus on teaching a specific delivery method.

The following is a compilation of the objectives of prenatal education, as expressed by key informants, and identified in the sample of prenatal curricula reviewed. The objectives cover the full continuum of prenatal education, from conception to early childhood:

- To enable parents to make and maintain positive lifestyle changes that support the growth and development of a healthy baby and family;
- To help parents understand the growth, development and needs of the newborn baby and be able to respond to those needs;
- To help parents recognize and respond to the physical, social and emotional changes of the prenatal period;
- To increase parents' knowledge, confidence and ability to cope, allowing them to make informed decisions through the birth experience and during the early parenting experience;
- To create realistic expectations of the birth event and the transition to parenthood; and
- To increase parents' knowledge of prenatal and postnatal community resources.

### HOW TO USE THE CHART

The following chart is a collection of topics and key messages from the curricula reviewed and obtained through key informant interviews. The chart assumes that the facilitator has access to detailed content information. Specific curriculum details are not included, as that was beyond the scope of this manual.

The menu of topics is not intended to be exhaustive nor is it prescriptive. It would be impossible to cover all of the topics identified in a typical 12-hour generic class. The chart provides facilitators and program managers with the range of potential topics that may be raised by participants.

Given the variations in participants' knowledge, and given specific agency mandates, content of prenatal programs will differ. Facilitators can focus on elements they identify as essential to participants. Facilitators should, however, be prepared for discussion on a wide variety of topics and therefore ensure they have access to additional resources and sources of information.

The sub-topics have been listed in the chronological order thought to be most useful to participants. As a general rule, topics requiring some form of

decision-making by the participants (e.g., breastfeeding, options during labour, and circumcision) can be discussed earlier, to provide participants with additional time to support decision-making.

Some topics may be presented over time (e.g., decision-making about breastfeeding discussed at one session followed by troubleshooting regarding breastfeeding at a subsequent session). Other topics may be repeated over several sessions to support skill development (e.g., practise of comfort measures during a number of sessions). The next chapter shares a selection of strategies that can be used to deliver this course content.

The key messages have been written from the point of view of the participants: if they were to give some advice to a pregnant friend, what would they tell them? The word “you” in the key messages refers to the pregnant friend. The word “both” refers to the pregnant friend and her support person.

The suggested timing for discussion of each topic is provided as a guide. Evidence supports the time periods noted in meeting the learning needs of participants<sup>4,9</sup>. However, depending on participants’ specific learning needs, timelines may need to be adjusted.



# TOPICS AND KEY MESSAGES FOR GENERAL POPULATION

**SUGGESTED TIME TO DISCUSS:**  
Weeks 0-24 and reinforced  
throughout pregnancy

## PRENATAL HEALTH

### TOPICS

### KEY MESSAGES

#### GENERAL:

Prenatal care guidelines. Facts on prevention of low birth weight babies. Tips for communicating with a health care provider. Starting to plan for parenting.

- Make sure you have a health care provider you trust and make sure you feel comfortable communicating your needs with him/her.

#### PHYSIOLOGY:

Normal anatomy and physiology of female reproductive system. Fertilization and implantation, cellular growth, development of body systems and placenta. Anatomical changes of mother during pregnancy. Weight gain during pregnancy. Patterns and distribution of weight gain. Body image changes. Fetal development through pregnancy. Fetal environment. Common physical discomforts: constipation, heartburn, leg cramps, ligament pain, nausea and vomiting, backache, fatigue, stress incontinence, swelling, varicosities, haemorrhoids, etc. Additional problems that should be reported to health care provider: fever, vision disturbances, bleeding, swelling, depression, etc. Sexuality during pregnancy.

- Your body will go through a number of physical changes during pregnancy.
- Know which symptoms are cause for concern and should be reported to your health care professional.
- Physical and emotional changes may influence both partners' desire for sexual expression; open communication and mutual understanding of changes are important.
- You can have intercourse during pregnancy if both partners feel comfortable with it and there are no specific medical contraindications.
- You should gain approximately 25-35 pounds during your pregnancy, depending on your pre-pregnancy weight.

#### NUTRITION:

Food groups, vitamins, minerals and dietary needs during pregnancy. Nutrients to highlight: folic acid, iron, calcium, zinc, protein, vitamins A, C & D, fatty acids, fibre and water. Food additives. Methyl mercury in various types of fish.

- Follow Canada's Food Guide to Healthy Eating through pregnancy and throughout entire life; allow your appetite to guide your food intake.

#### PHYSICAL ACTIVITY:

Importance of physical activity during pregnancy and after. Contraindications to physical activity during pregnancy. Tips for everyday movements: bending, lifting, getting up, etc. Par Med X for Pregnancy. Prenatal exercises. Ergonomic factors. Posture and body awareness.

- Follow Canada's Physical Activity Guide to Healthy Active Living through pregnancy and throughout entire life. Check with your health care provider for specific contraindications.
- As pregnancy progresses, the increase in weight, the shift in the centre of gravity, and the changes in joints and ligaments will affect your coordination and balance.

#### STRESS:

Physiology of stress. Define stress-positives and negatives. Common stressors in pregnancy. Healthy ways to cope with stress.

- Use relaxation techniques that work for you when you feel stressed.

**SUGGESTED TIME TO DISCUSS:**  
Weeks 0-24 and reinforced  
throughout pregnancy

## PRENATAL HEALTH (CONT)

TOPICS	KEY MESSAGES
<b>SUBSTANCE CONSUMPTION:</b>	
Alcohol, tobacco, caffeine, herbal products. Over-the-counter, prescription and illicit drugs. Other harmful substances and chemicals. Partner and community supports regarding substance consumption.	<ul style="list-style-type: none"> <li>• No amount of alcohol is safe during all stages of pregnancy.</li> <li>• Check with your health care provider regarding contraindications for any prescription and over-the-counter drugs you may be taking during pregnancy. Natural and herbal medicines should be treated the same way as prescription drugs.</li> </ul>
<b>ENVIRONMENT:</b>	
Exposure to contaminants (teratogens) in the environment, in the workplace and in the home. Known reproductive toxins: second-hand smoke, pesticides, lead, paints, solvents, cleaning products, electromagnetic fields, plastics, asbestos, mercury. Toxoplasmosis. X-rays and radiation. Hot tubs and saunas. Communicable diseases including HIV and AIDS. Infections. Immunization. Travel.	<ul style="list-style-type: none"> <li>• Tobacco smoke (it's never too late to quit smoking), exposure to environmental tobacco smoke, illegal drugs, radiation and many chemicals are harmful to you and your baby throughout the pregnancy and should be avoided. Partner and community supports are available.</li> </ul>
<b>OTHERS:</b>	
Dental care. Tests and technology used in pregnancy. Violence and abuse issues and available community resources.	<ul style="list-style-type: none"> <li>• Abuse can escalate during pregnancy; violence is associated with miscarriage, prenatal complications, preterm labour and low birth weight.</li> <li>• You should know where to go for help if you experience family violence.</li> </ul>

**SUGGESTED TIME  
TO DISCUSS:  
Weeks 20-36**

## PHYSICAL AND EMOTIONAL PREPARATION FOR CHILDBIRTH

### TOPICS

### KEY MESSAGES

#### PHYSICAL PREPARATION:

Identification of muscles used during labour and birth. Common fetal uterine positions. Signs and symptoms of preterm labour, approaching labour and true labour. Rupture of the membrane. Contractions. Dilatation and effacement. Stages of labour and birth.

- You should both be aware of the physical changes that will take place through the pregnancy.
- Practicing prenatal toning exercises is important to help in delivery.
- It is important to be able to recognize the signs of preterm labour, early signs of labour and true or false signs of labour.
- You should both understand the process of birth and know the four stages of labour.

#### EMOTIONAL PREPARATION:

Possible psychological issues of expectant parents: mood changes and disorders, feelings about partner, self-image, feelings about parenthood, fears and anxieties, dreams. Communications skills. Preparing psychologically for the unexpected.

- Major hormonal changes in pregnancy affect the brain chemicals that regulate mood; feelings of anxiety are normal.
- Approaching parenting responsibilities, changing body shape, family pressure or fear related to labour may all contribute to fluctuating emotions.
- Consider using coping skills and relaxation techniques to help deal with other life stressors.
- The childbirth event may not happen as you would like and you both need to be psychologically prepared for that.

#### PRACTICAL & TECHNICAL ISSUES:

Combining career and parenthood. Prenatal testing: amniocentesis, ultrasound and others. Potential problems: miscarriage, placenta previa, abruptio placentae, ectopic pregnancy, preeclampsia, gestational diabetes, etc. Items to discuss with your health care provider. Birth plan / preferences for birth. Decisions on immediate postpartum (i.e. skin-to-skin, breastfeeding, medical procedures). Fetal movement counting procedure. How to time a contraction. Preparation for labour & delivery – packing suitcase and kit. Hospital pre-registration and admission procedure. Cord blood registry. Tour of local hospital: labour and delivery unit, postpartum unit, and neonatal intensive care unit - as applicable. List of community resources associated with prenatal services.

- You should both have agreed on a written birth plan, and discussed it with your health care provider.
- You should both be familiar with hospital procedures and community supports.

**SUGGESTED TIME  
TO DISCUSS:**  
Weeks 24-36

## INTERVENTIONS TO SUPPORT, COMFORT AND PROVIDE PAIN MANAGEMENT DURING LABOUR AND BIRTH

### TOPICS

#### NON-MEDICAL COMFORT MEASURES:

Role of labour support (physical and emotional). Labour doulas. Acupressure/acupuncture. Aromatherapy, baths and showers. Hypnosis. Relaxation exercises. Paced breathing techniques: deep breathing, shallow breathing, modified shallow breathing, panting and pushing. Pressure and counter pressure. Touch and massage. Attention focusing and distraction techniques. Heat/cold. Music. Walking. Birth ball. Birthing positions including squatting.

### KEY MESSAGES

- It is important for both parents to know a variety of comfort methods and to practice those ahead of the birth.
- You should listen to your body and breathe at a rhythm that feels comfortable.
- You should clearly indicate the supports you would like to have and may want to consider a labour doula or a friend/relative to assist.

#### MEDICAL INTERVENTIONS/PAIN MANAGEMENT:

Common anaesthetics: local epidural anaesthesia, spinal anaesthesia, nitrous oxide, general. Other pain relief measures: analgesics, sedatives, transcutaneous electrical nerve stimulation (TENS), intracutaneous injections. Induction of labour - risks and benefits. Augmentation of labour. Use of forceps and vacuum extraction. Episiotomy. Fetal health surveillance. Birth by caesarean section-risks & benefits. Vaginal birth after caesarean.

*Note: Some of these medical interventions may not be available locally.*

- The birth process may take unexpected turns and you both need to have the knowledge necessary to make informed decisions along the way.
- You both need to know what a caesarean section is, why it may be needed and the risks and benefits it entails.

**SUGGESTED TIME  
TO DISCUSS:**  
Weeks 26-36

## PHYSICAL, EMOTIONAL AND SOCIAL NEEDS OF THE NEW FAMILY

### TOPICS

#### PHYSICAL:

How to relieve pain and discomfort after childbirth. Postpartum hormone level changes, involution, vaginal discharge, breast changes, haemorrhoids, episiotomy healing. Diet, rest relaxation, postnatal fitness, birth control, sexual changes. Variations following caesarean birth. Weight management. Strategies to cope with fatigue.

### KEY MESSAGES

- The mother will experience some physical discomforts after birth and you both need to know which symptoms are cause for concern and should be reported to a health care professional.

**SUGGESTED TIME  
TO DISCUSS:  
Weeks 26-36**

## PHYSICAL, EMOTIONAL AND SOCIAL NEEDS OF THE NEW FAMILY (CONT)

### TOPICS

### KEY MESSAGES

#### EMOTIONAL:

How a mother may feel after childbirth. Partner's feelings. Postpartum blues, postpartum mood disorders, postpartum psychosis. Parental expectations and adjustments.

- Postpartum mood disorders can happen to any new mother. You both need to know how to help prevent it and be ready to get help if needed.

#### SOCIAL:

Roles and relationships. Communication. Changing and adapting lifestyle. Sexuality after childbirth. Setting priorities to assist with time management. Importance of partner involvement. Home support after birth.

- Prior to hospitalization, it is important to agree on a realistic postnatal plan regarding parental responsibilities, support systems, childrearing styles and financial issues.
- As a partner, it is important to develop your own relationship with the baby. For example, the positive involvement of fathers is a key factor in the healthy development of children.
- Raising children is a demanding but vitally important job that will take a large amount of your time and requires good communication between you.
- It is normal for interest in sex to change after the birth of the baby. Sexual intercourse can resume after the baby's birth when both partners feel ready and are comfortable with the birth control method chosen. In the meantime, you may be able to express your love and emotions in other ways.
- It is important for parents to support each other in maintaining some personal interests and in ensuring some couple time.

#### PRACTICAL & TECHNICAL:

Hospital postpartum routines. Rooming-in options. Length of hospital stay. List of community resources associated with family needs: help lines, hospitals, breastfeeding services, children with special needs, community centres, counselling, Early Years Centers and other family resource centres, food banks, home visiting services, local public health unit, libraries, mothers' groups, newcomers services, parenting classes, postnatal services, safety associations, parent support groups, postpartum doulas. Maternity and parental leave benefits. Child tax credits. Health insurance.

- There are many community services available and both parents need to know where to get support.
- If you have special needs for your hospital stay, you may need to negotiate arrangements with the hospital, ideally in advance (e.g.: comfort measures, partner staying overnight, disabilities, diet).

**SUGGESTED TIME  
TO DISCUSS:**  
Prior to 32 weeks

## BREASTFEEDING

### TOPICS

### KEY MESSAGES

#### RESEARCH:

Research findings of the advantages of breastfeeding vs formula feeding infants. Decision-making regarding breastfeeding.

- Breast milk is the normal food for babies. In special circumstances artificial baby milk (formula) may be recommended for medical reasons.

#### PHYSICAL ASPECTS:

How a breast functions. Anatomy & physiology of the breast. Breast milk composition. Breast changes during pregnancy. Vitamin D supplementation and risk factors for vitamin D deficiency.

- Your breasts will produce all the food your baby needs for the first six months of life. Offering anything else to your baby is not recommended.
- Health Canada recommends vitamin D supplementation for all exclusively breastfed babies.

#### PRACTICAL INFORMATION:

Prenatal preparation for breastfeeding. Strategies to promote successful initiation (importance of early skin-to-skin contact, common positions, proper latch, suck and swallow patterns, letdown reflex, collecting and offering colostrum, hand expression to relieve engorgement). Factors interfering with successful initiation (difficulty to latch, engorgement, unnecessary supplementation using formula and rubber nipples, flat and inverted nipples). Complications due to problematic breastfeeding and milk removal (plugged ducts and mastitis, sore nipples, yeast infections, insufficient breast milk, overactive letdown, difficulties resulting from birth complications and what to do). How to burp your baby. Infant feeding patterns.

- If you are experiencing breastfeeding problems, seek help as there are many community resources available and most problems can be solved.
- It is normal for the newborn to lose some weight after birth.

**SUGGESTED TIME  
TO DISCUSS:  
Prior to 32 weeks**

## BREASTFEEDING (CONT)

### TOPICS

#### PRACTICAL INFORMATION TO CONTINUE:

How to tell if baby is removing enough milk. Nutrition for the breastfeeding mother. Contraception and breastfeeding. Care of breasts during breastfeeding. Medication, alcohol and food sensitivities during breastfeeding. How to express and store breast milk, hand expression. When, where and why to call for help when experiencing breastfeeding problems. Lactational amenorrhea. How long to breastfeed. Age of introduction of complementary foods. Importance and reasons for exclusive breastfeeding to six months. Access to additional breast milk. Increasing your milk supply.

*Note: If an agency wants to design a prenatal curriculum as outlined in the WHO/UNICEF Baby-Friendly™ Initiative, there are evidence-based guidelines to be considered within the curriculum. For example, all formula feeding information is given on a one-to-one basis only to those who plan to formula feed, and handouts about formula need to be separate from breastfeeding information.*

### KEY MESSAGES

- You can enjoy a healthy variety of foods while you are breastfeeding. Rest will help you recover from birth.
- What you eat and drink will get passed on to the baby including medication, alcohol and nicotine. Check with your health care provider about taking medications, including contraceptives, while breastfeeding.
- You will want to resume your normal activities while breastfeeding. Find places in your community where you can breastfeed easily.
- As a partner, you can help by supporting breastfeeding and making it the easier choice.

**SUGGESTED TIME  
TO DISCUSS:  
Weeks 28-36**

## THE NEWBORN

### TOPICS

#### CHARACTERISTICS:

Normal characteristics of a newborn: reflexes, skin conditions, sense, foreskin, meconium, eyes (colour, muscles), head moulding. Newborn behaviours. Growth and development of the newborn.

#### HEALTH ISSUES:

Newborn tests and procedures. Apgar scoring. Jaundice. Colic. Group B streptococcus infection. Allergies. Diaper rash. Facial rash. Cradle cap. Weight gain. Fever management. Sudden infant death syndrome. Health issues specific to premature infants. Immunizations. Infant hearing screening. Common infant illnesses. Symptoms prompting medical attention.

### KEY MESSAGES

- You both need to have an understanding of the characteristics of the newborn.
- You both need to be aware of the suggested follow-up medical care required for newborns regarding immunization and visits to health care providers.
- As parents, you should know some guidelines and also follow your instincts if you feel the baby is not well and promptly get medical attention.
- Do not give babies and children under 2 years of age Aspirin™ or medication containing acetylsalicylic acid.

## THE NEWBORN (CONT)

### TOPICS

### KEY MESSAGES

#### BASIC NEEDS:

Sleep patterns & position, feeding, hygiene, warmth, comfort, love. Attachment. Umbilical cord care. Baby's sleep environment, bed sharing.

- You both need to know how to hold, feed, diaper, dress and bathe your new baby.
- It is by caring for your baby that both of you will develop a bond with your baby.
- Put your baby on its back to sleep, with no pillow or soft bedding, in a smoke-free environment, to reduce risks of sudden infant death syndrome.
- The Canadian Paediatric Society recommends that babies sleep in their own crib, in the parent's room, for the first six months.
- Never give cow's milk to a baby or infant before at least 9 months of age.

#### PRACTICAL & TECHNICAL:

Circumcision and pain relief alternatives. Various holds for infants. Interpreting infant states (quiet and active alert, drowsy, crying, active and quiet sleep). Infant cues and behaviour to promote parent infant attachment. Crying identification.

Baby supplies and clothing required. Baby equipment safety: car seat – including installation, crib, playpen, walkers, strollers, high chairs, gates, change table, toys. Sun safety. Insect repellents. Poisoning. Childproofing the home. Household pet interactions. Birth registration. Working with a physician/paediatrician. Child care options. Strategies to cope with inconsolable crying and information on Shaken Baby Syndrome.

- The newborn will have a wide range of needs but limited ways to express them.
- Never shake a baby.
- If either of you are feeling frustrated and can't cope or are losing control, place the baby in his crib or in a safe environment to regain your cool or get help.
- You both need to decide ahead of the birth if you want your son to be circumcised. At this point, the Canadian Paediatric Society does not recommend circumcision as a routine procedure for newborns.
- You should both know the safety hazards for young children and childproof your house accordingly.
- The infant car seat should be rear facing and it should be properly installed before your baby is born.
- If you are going to entrust the baby to someone else's care, make sure the care provider is reputable, trustworthy and knowledgeable about infant care.
- The birth event is only one day in the long journey of parenthood and life-long learning.

## ADDITIONAL TOPICS AND KEY MESSAGES FOR SPECIFIC POPULATIONS

**SUGGESTED TIME TO DISCUSS:**  
Specific classes for multiple births should start immediately upon diagnosis

### MULTIPLE BIRTHS

#### TOPICS

*Note: All the topics for the general population should be covered. The topics below should be adapted to multiple births.*

- Prenatal medical care and tests.
- Physical adjustments: maternal nutrition, patterns of maternal weight gain, rest, reduction in strenuous physical activity.
- Emotional adjustments.
- Fetal growth of multiples.
- Zygosity testing - timing and purpose.
- Early problem recognition (e.g., preterm labour).
- Unexpected and possible outcomes: low birth weight babies, infants with special needs, loss of a baby or more.
- Building a support network and effective communication amongst the people assisting with newborn care.
- Labour and delivery options: caesarean section, epidurals, fetal heart monitoring, and pain medication.
- Hospital procedures: neonatal intensive care unit environment, number of staff in delivery room, room sharing options (co-sleeping of babies, mother and babies), staggered discharge.
- The increased role of the partner.
- Postpartum mood disorders.
- Stress management.
- Financial and employment issues.
- Breastfeeding multiples: logistics, positioning, nutritional requirements.
- Postpartum sleep issues.
- Care of older siblings.
- Contact information for local and national support organizations for parents of multiples.

#### KEY MESSAGES

- When you are pregnant with multiples, you need to make sure you listen to your body and drink, eat and rest as needed.
- Many of the usual discomforts of pregnancy may be exaggerated and usually occur much sooner in a twin gestation and even sooner when expecting triplets or more.
- Babies from multiple pregnancies are at a higher risk for health issues and you both need to be emotionally ready for a variety of possible birth outcomes.
- Plan some family and community supports to assist with household chores, sibling needs and newborn care before the birth of the babies.
- Plan post-birth sleeping arrangements that will work for your situation and will enable you to get the rest needed.
- As a partner, you will likely have an increased role and should be well prepared in all aspects of newborn care.
- It is possible to breastfeed multiples. You will need additional supports to assist with other household tasks and newborn care.
- There are many organizations as well as support groups which offer specialized services for parents of multiples. It is important to know how to access these.

**SUGGESTED TIME TO DISCUSS:**  
As soon as pregnancy  
is confirmed

## ADOLESCENTS & YOUNG PARENTS

### TOPICS

*Note: All the topics for the general population should be covered. The following topics may need additional emphasis.*

- Importance of prenatal care. Types of health care providers. Description of prenatal visit.
- Healthy eating on a limited budget. Safe food preparation. Reading nutrition labels.
- Effects of substance use on the fetus, FASD.
- Importance of breastfeeding.
- Coping with stress.
- Budgeting.
- Family abuse.
- Safer sex practices.
- HIV testing.
- Prenatal and postpartum depression.
- Preterm labour.
- Choice of labour support person.
- Comfort measures during labour.
- Contraception after birth.
- Role of the partner.
- Solo parenting for mother and for partner.
- Community resources, including help lines, and how to access them.

### KEY MESSAGES

- It is important for you to see a health care provider on a regular basis throughout your pregnancy to help improve your health and that of your baby.
- Breastfeeding is not only best for your baby but it is also less expensive and more convenient.
- There are many community services to support young parents. Know what they are and know how to get help when you need it.
- Alcohol, tobacco, tobacco smoke and illegal drugs are harmful to both you and your baby throughout your pregnancy and should be avoided.
- You can prevent Fetal Alcohol Spectrum Disorder.
- Try to reduce the risk of having a low birth weight baby, as there are negative health consequences for the baby.

**SUGGESTED TIME TO DISCUSS:**

Any stage of the pregnancy – may vary according to topic

## CULTURAL GROUPS

### TOPICS

*Note: All the topics for the general population should be covered. The following topics may need additional emphasis, depending on cultural background. If a language barrier exists, please consult the section on literacy and language barriers in chapter 5.*

- Community resources, ideally in the first language of the participants, and information on how to access these. Interpretation services.
- Health care system and procedures: prenatal care, hospital procedures and staff roles.
- Possible birth outcomes: sex of child not as anticipated, medical interventions needed, etc.
- Effects of substance use on the fetus, FASD.
- Baby equipment safety: car seat – including proper installation, crib, playpen, walkers, strollers, high chairs, gates, toys.
- Postpartum blues, postpartum mood disorders, postpartum psychosis.
- Childproofing the home.
- The role of the father.
- Identifying symptoms of a sick child and steps to take.
- Immunization schedules for newborns.
- Circumcision.
- Cultural beliefs about infant care.
- Birth control methods.
- Canadian laws that relate to parenting.

### KEY MESSAGES

- As parents, you have a right to be provided with the information you need before making a decision that may impact on the health of the mother or child.
- It is important to develop a support system of family, friends and agencies during the pregnancy to help you through the postpartum period.
- Alcohol, tobacco, illegal drugs are harmful to the baby throughout the pregnancy and should be avoided.
- You may have been raised in an environment that is very different from the one in which you will raise your child. There are resource people and agencies that may help you with the transition.

**SUGGESTED TIME TO DISCUSS:**  
Any stage of the pregnancy

## DIVERSE FAMILY STRUCTURES

### TOPICS

*Note: All the topics for the general population should be covered*

- Advocating for non-discriminatory medical and social services.
- Legal issues regarding family identity (birth certificate, adoption).
- Medical history of egg / sperm donor.
- Access to breast milk.
- Solo parenting.

### KEY MESSAGES

- You need to assert your needs and ensure you are treated without discrimination by the medical and legal system.
- Families can define themselves.

**SUGGESTED TIME TO DISCUSS:**  
Weeks 24-36

## REFRESHER CLASSES

### TOPICS

*Note: It is assumed that participants have already taken prenatal education and are familiar with most topics. They will need to be able to have access to information on a wide selection of topics. Written materials to take home may be most appropriate.*

#### LABOUR AND DELIVERY

- Signs of labour.
- Stages of labour and coping strategies.
- Tips for the labour supporter.
- Breathing techniques.
- Positions for labour and birth.
- Non-medical comfort measures.
- Medical interventions.
- Hospital procedures that have changed since previous baby.
- Vaginal birth after caesarean.

#### PARENTING

- Bringing the new baby home.
- Sibling rivalry.
- Parenting resources.

### KEY MESSAGES

- Use your previous pregnancies as a guide to determine what areas you need more information in.
- You should trust your gut feelings throughout the pregnancy, labour and birth.
- Don't hesitate to contact your health care provider or the hospital if you need assistance during the pregnancy.
- You can benefit from a variety of comfort measures through the labour and delivery and both partners should be familiar with these.
- Older siblings may need your help in adjusting to a new baby coming home.





## 5. EFFECTIVE PRACTICES

This chapter provides program suggestions for prenatal educators. The information was collected through key informant interviews, topic experts and review of a sample of the curricula in use across Ontario and Canada. The list is a compilation of ideas that have been field-tested and may help facilitators improve their program. This is not an inclusive list and the ideas have not been subjected to a formal evaluation.

### RECRUITING AND RETAINING PARTICIPANTS

In order to be as healthy as possible, it is important that pregnant women and their partners receive information early in pregnancy. Once participants are engaged in the prenatal program, it is important to meet their needs and to retain them for the duration of the program. This section offers suggestions regarding partnerships, promotion and participant retention.

#### Partnerships

The woman's first point of contact with the health care system is generally with her primary health care provider (e.g., family physician, obstetrician, nurse practitioner or midwife) to confirm the pregnancy. Ideally, the pregnant woman will then be referred to a prenatal education program. A good partnership with local health care providers is key to reaching women early in their pregnancy. Local health care providers will need to have a clear understanding of the course content in order to promote prenatal education programs to their patients.

Different methods are used across Ontario to engage women in early pregnancy. Some public health departments distribute a basic first trimester information kit to pregnant women through health care providers. In addition, some health departments provide health care providers with consent forms that can be completed by the pregnant women at the clinic and then faxed to the health unit. Consent forms give the woman's permission to the health department to contact her regarding prenatal programs.

In some areas, the initial contact with the pregnant women takes the form of a one-on-one consultation where health issues are discussed. At this time, women may be referred to programs that meet their individual needs such as a local Canada Prenatal Nutrition Program (CPNP), the Healthy Babies – Healthy Children (HBHC) prenatal program, a smoking cessation program or a generic prenatal education series.

Referrals to prenatal education series may also come from CPNP and HBHC program coordinators and other community partners such as food banks, social services, community health centres. A good partnership with other agencies is important in recruiting participants.

#### Promotion

Promotion of prenatal education through health care providers is seen as an effective way to reach a large number of pregnant women. Specific methods of promotion to health care providers include tear-off pads, posters, newsletters, site visits, attending office staff luncheons and providing program updates. In addition, promotion through family resource centres, Ontario Early Years Centres and community groups can be accomplished through site visits, and distribution of posters and pamphlets, etc.

Regular updates on the websites of agencies providing prenatal education is another method to promote classes directly to the general public. These promotions can include a section on upcoming classes, frequently asked questions and on-line registration.

Prenatal education providers who offer a specialized, private service may also wish to consider offering information sessions, advertising in prenatal and parenting magazines, linking with local media, and providing direct mailings.

Additional promotion may be required to reach newcomers to the community who may not yet have a family physician. Newcomers may have moved from a different area of Canada or have recently immigrated to Canada. Connecting with

immigration and settlement organizations, cultural associations and religious organizations can help reach the immigrant population. A relationship of trust may need to be built with cultural and religious leaders, as they can have a strong influence on the participation of their members. Organizations such as Welcome Wagon offer another way to reach new people in the community.

Offering programs in a variety of languages can help increase participation of newcomers. Some agencies in Ontario offer programs in languages other than English and French. If this is not possible, consider providing print material in language(s) understood by newcomers. This is also useful when one parent may be comfortable in English but the other one is not. When possible, choose or develop promotional materials that are as inclusive as possible, i.e., with images and wording that reflect a range of family structures, sexual orientations and ethno-cultural affinities.

Cost is often a factor for women considering participation in a prenatal education program. It is helpful to build in flexibility regarding payment options for participants. Some public health programs are free and some publicly funded programs will subsidize participants in need. State clearly information about costs and subsidies on promotional materials.

In many areas of the province, Prenatal Health Fairs are offered on a regular basis. These fairs provide information and opportunities for consultation with a range of local health professionals and service providers in a self-directed environment. They are also a good way to promote prenatal education programs. Typically offered to women early in pregnancy, Prenatal Health Fairs can augment topics and key messages that are covered in classes but the timing may be better, especially on topics such as nutrition and substance use.

When participants register for a program, collect demographic information to assist in program planning. A question regarding previous pregnancies may help identify special concerns regarding miscarriages and loss of a baby.

Screening can be used to determine the related concerns of participants. In the Healthy Babies Healthy Children program, Boards of Health are mandated to use the Larson Screen ([www.health.gov.on.ca/english/providers/pub/child/hbabies/policy\\_statement.html](http://www.health.gov.on.ca/english/providers/pub/child/hbabies/policy_statement.html)). Women can then be referred to other programs addressing their specific needs.

## TIPS:

### **Pregnant? Who You Gonna Call? Campaign.**

A comprehensive social marketing campaign can have much more impact than single advertisements. The reach is greater and the message is reinforced through the various channels. Thunder Bay District Health Unit embarked on a 3-year early prenatal campaign to increase the number of registrants attending their program. They developed billboards, transit shelters, tear-off sheet posters, newspaper ads, a roll-up display, information pamphlets, interior bus cards and a pregnancy memories keepsake that the participants receive at the first class. The theme of the campaign was to make the public health unit the second phone call made by women as soon as they find out they are pregnant. *(From Lyne Soramaki – Thunder Bay District Health Unit).*

 **TIPS:**

**English as Second Language.** The Region of Peel has an innovative prenatal program called Prenatal Instruction for Newcomers to Canada. It is delivered by English-speaking facilitators in a format appropriate for participants learning English as Second Language (ESL). As part of delivery, the facilitators spend additional time explaining medical terms, utilize more visual supports and incorporate role-playing, simulating interactions with health care providers. This program has the advantage of being able to reach participants with a variety of first languages. *(From Judy Buchan – Region of Peel).*

**Getting Them Hooked.** Peterborough County-City Health Unit has developed six interactive stations that are used in the first prenatal class to help future parents realize where they may have some skill or knowledge gaps. Each station has a specific infant care topic and a corresponding activity for parents: i.e., adjusting parent interactions to match infant's temperament style, assessing a baby's

fever, positioning a baby in various situations, bathing and diapering a baby, buckling up an infant in a car seat and installing the seat in a vehicle, and massaging a baby. Additional interactive activities include "Bed-in-a-Bag." During this activity, support persons are given a number of items occasionally found in baby cribs and must select those needed to make a safe bed and adequately clothe a baby for bed. By having this highly interactive session at the first class, the support persons feel very involved and interested in coming back. *(From Helen Ames, Public Health Nurse, Peterborough County-City Health Unit).*

**What are we doing next?** At the end of each class, the facilitator lists the topics for the upcoming session on a flipchart. Participants put checkmarks on the topics that interest them the most. The facilitator then tailors the following session's agenda to meet the group's needs. *(From Kathy Crowe – City of Ottawa Public Health).*

### Retaining Participants

If participants feel the prenatal program is meeting their needs, they will continue to attend. Some facilitators start the first class in a series by asking participants what they are most interested in learning. They then make sure that time is spent on these topic areas, helping to ensure that the content meets the needs of participants.

It can be difficult to meet the needs of everyone in the program. Participants come with different levels of knowledge and are often at varied stages of pregnancy. It can be useful to provide written materials for participants to "catch-up" between classes as this will keep the class content more challenging and interactive. Informing participants about what topics will be covered in the next session can encourage them to attend.

Some agencies, such as Peterborough County-City Health Unit (see Tip) – have chosen to discuss newborn care during the first session, as it has relevance to both partners and supports continued participation in the program.

If participation drops, it is useful to determine the underlying reason(s). It may be because participants have moved, have changed work hours, are experiencing illness or transportation issues. It could also be because the program is not meeting their needs and it would be helpful to know how the program could be improved. Research indicates that prenatal education topics match the pregnant women's interest in those topics less than 50% of the time<sup>30</sup>. Occasionally, the drop in participation may be due to abuse and a sensitive approach is needed if/when the prenatal educator follows up with the woman.

## LOGISTICS

As discussed in chapter 2, there are wide variations in the delivery of prenatal education across Ontario. In most areas, partnerships between organizations with complementary mandates help to ensure coverage of the key topics. The following are general considerations that may assist in program planning:

- The duration of most generic prenatal education ranges from approximately 10 to 14 hours, spread over four to seven evening classes. The sessions generally last two hours, with a short break after one hour. There is a trend to reduce the total number of program sessions, as participant retention is sometimes an issue. A reduction in program and transportation time can benefit working parents, however, reduced time is challenging for the facilitator in ensuring all key topics are covered.
- Many agencies also offer generic programs over one to three weekends, generally on Saturdays. This accommodates working parents, particularly pregnant women, who are generally quite tired in the evening.
- Many agencies offer a menu of classes for which parents can sign up separately: early prenatal, labour and delivery, breastfeeding, newborn care, couple communication, prenatal refresher, etc. This method may meet the specific needs of the participants in a timely manner but does not guarantee that an important topic such as the impact of alcohol during pregnancy will be covered.



**Dream & Nightmare.** It is helpful for parents to express their fears about childbirth and to develop realistic expectations. One way to do this is through a “dream vs. nightmare” activity. Each person has three slips of paper labelled A, B and C. On slip A, participants write their “ideal dream labour”. On slip B, they describe “the type of labour they would rather not have”. On slip C, they indicate “their worst fear”. When completed, the facilitator says: “We all like labour A and no one wants labour C. It certainly could happen, but probably won’t.” The facilitator then says that most women will experience Labour B. The participants exchange their B slip with someone else in the group and discuss the coping skills needed to deal with this labour. *(From Helen Ames, Public Health Nurse, Peterborough County-City Health Unit).*

**Environmental Impacts.** The facilitator prepares a “grab bag” containing items that may affect the fetus (these may be put in a series of smaller bags to facilitate handling). Suggested items include: beer can, coffee, pop, cigarette package, picture of a marijuana joint, syringe, over-the-counter prescriptions, empty bottle of oven cleaner, can of tuna, bottle of nail polish, kitty litter, food models, hair dye, herbal tea, etc. If an item is not available, a picture can be substituted. Each person or couple takes an item and identifies the effect it may have or how it is linked, and this is discussed with the group. *(From multiple sources combined).*

## GROUP FACILITATION STRATEGIES

### Principles of Adult Education

By using the principles of adult learning, the prenatal class facilitator can improve the participants' learning experience. There are many resources and courses specifically on adult education.

Basic principles of adult education emphasize that the facilitator use the knowledge and skills of the participants and create an atmosphere that supports the exchange of information between the participants. The adult learner should be an active participant in the learning process. Each learner has unique needs and can contribute in a unique way to the process.

The facilitator's role is to ensure the information is relevant, practical and meets the needs of the participants. Recognizing the diversity of participant needs, the timing and depth of content may need to be adjusted.

In addition to providing information, program activities can assist parents with decision-making and taking control of the experience of becoming parents<sup>34</sup>. Ideally, activities will enable the exchange of ideas, feelings, interests, solidarity and development of supportive relationships sustained beyond the program duration.

### Involving Partners and Support Persons

Everyone involved plays a role in a healthy birth outcome. The involvement of partners and other family members needs to be valued throughout the prenatal education program. As discussed in chapter 3, partners often need information to develop the confidence and skills to support family development. The prenatal education program must go beyond encouraging partners to be supportive of the pregnant woman or new mother and demonstrate how the partner can bond with the new baby and the importance of one-on-one.

In some cases, the partner is not the biological father of the baby but is a person who is supporting the woman through the pregnancy, birth and



**Thinking Outside the Box.** As a discussion starter, ask a question that has no correct or obvious answer and lets participants express their thoughts or feelings. For example: What color is birth? Are some of you having scary dreams? This will help participants vocalize some of the anxieties they may have and help them realize they are not alone. *(From Deana Midmer – Department of Family & Community Medicine, University of Toronto).*

**Squeezing the Knee.** This short activity can be done as a complement to the topic of preterm birth and/or labour and delivery, to simulate a contraction. The pregnant woman is sitting on a chair, with the support person beside her. The support person is asked to grab the pregnant woman's knee and slowly start squeezing the knee gradually, as if they were climbing a mountain. Once they are at the top of the mountain, they need to be squeezing harder and hold for a bit (this represents the peak of the contraction) then gradually decrease pressure to the knee and visualize going down the mountain (this represents the end of the contraction). This can be repeated with length of squeezes longer or shorter to simulate time in between each contraction. *(From Lyne Soramaki – Thunder Bay District Health Unit).*

postpartum. In other cases, the partner does not accompany the pregnant woman to prenatal classes. It is important that language and activities utilized offer the flexibility necessary to accommodate diverse family structures: grandmother and mother, sister and mother, single mother, lesbian couple, etc.

The role of the partner can be emphasized throughout the prenatal education sessions in the following ways:

 **TIPS:**

**Who Are Your Support People?** The facilitator prepares a sheet for participants to complete during class or as a take-away activity. The sheet has headings in various categories of potential support people: Extended family members, friends, neighbours and community resources. The participants make a specific list of 3-4 supports in each category and indicate how these people or organizations could help them. If they have not been able to find adequate supports, the facilitator can try to help them. *(From Manitoba Health. Maternal & Child Health. Perinatal Resource Manual. A Guide for Educators).*

**Name Recall.** This is used to demonstrate the tension participants may have upon arrival to hospital when labour starts. Have everyone form a circle and hold hands. The facilitator starts by saying her name. The person next to her will say the facilitator's name and then her own and so on. The last person will say everyone's name. Participants will likely have sweaty hands, forget their own names or their partners' and will get a sense of what stress can do. *(Teaching Tips from the International Childbirth Education Association, PO Box 20048, Minneapolis, Minnesota 55420 USA, 952/854-8660, [www.icea.org](http://www.icea.org)).*

- Engage the partners by asking them about their opinions on various issues such as their expectations of the birth and include partners in activities and demonstrations such as relaxation techniques, comfort measures and newborn care.
  - Provide suggestions for the partner's role in pregnancy, labour and delivery.
  - Provide suggestions to help partners bond with the baby: holding the baby even when he is not crying, using a baby carrier on walks, performing routine care for the baby (e.g., bathe, dress, diaper).
  - Suggest other ways the partner can play a role by: being a role-model, creating a smoke-free environment, playing, reading and spending time with the baby, learning to recognize infant cues, being aware of the developmental milestones and of the baby's progress, supporting breastfeeding, etc.
  - In general, male participants prefer a variety of hands-on, problem-solving tasks. They also prefer facts to "discussing feelings".
- General Facilitation Suggestions:**
- Set up a climate where participants can feel comfortable to opt out of certain activities if they choose (including physical discomforts, emotional issues, religious or cultural restrictions, etc.). When introducing an activity, ensure that participants have an idea of what they are getting into and let them decide if they want to take part.
  - Be responsive to the group's needs, interests, temperament and energy level. An activity that was very successful with one group may not be appropriate for another group.
  - Icebreakers are helpful at the beginning of each program and can also be useful each time the group meets. Icebreakers can be linked to the program content. For example, an opener for a breastfeeding session could involve participants interviewing other participants on their concerns regarding breastfeeding their baby. Many websites offer ideas for icebreakers that can be adapted to prenatal education.
  - People learn much more from what they do than from what they see or hear. To teach skills, start by demonstrating the skill, and then have participants practice while moving around the class to assist. As much as possible, integrate hands-on opportunities into the learning.

- Using art may help some participants express their feelings and thoughts. For example, to introduce the topic of postpartum mood disorders, ask participants to draw how they imagine life after having their baby.
- Facilitate discussions after showing video segments. Direct questions to both partners. What information was new to you? Did anything surprise you? Are there elements you disagree with?
- Instead of simply presenting information from Canada's Food Guide to Healthy Eating, provide the information in the form of a quiz: offer two sample meals and have participants indicate which one has more fat or more nutritional value, etc. Ask participants to write down what they have eaten in the past 24 hours and have them determine how closely they have met Canada Food Guide's requirements.
- Facilitators won't always have all the answers. Seeking out the information and bringing it to the next class models problem solving. Referring participants to other information sources and asking a group member to report back to the group demonstrates utilization of community resources.
- Provide the group with "take-away activities" such as interviewing a new parent, practicing fetal movement counting, practicing relaxation and breathing techniques, creating a list of "things to do before birth", etc. Do not expect participants to perform the activity but present it as a way to enhance the learning for those who are interested.
- Use case studies. Describe a situation (e.g., health issues during pregnancy, labour discomforts, postpartum problems) and prompt the group with a few questions: What is happening here? Why is it happening? What can the partner do to help? What community services may be helpful to this person? Case studies are helpful because participants can react to the behaviour of the people in the case study, not necessarily their partner's behaviour in a similar situation.



**Parenting Discussion Starters.** The facilitator distributes questions to couples or small groups of individuals, which they discuss together, and then share with the larger group. The facilitator can then build on the class knowledge base. Some suggested questions:

- Should you give your baby a pacifier?  
Discuss your reasons or considerations regarding this decision.
- What toys, games and activities do you think are appropriate for a 2-month old baby?  
What are important things to consider when choosing toys for your children?
- What are some reasons for a baby to cry? How long should a 3-week old baby be left crying?
- How often should you bathe a new baby?  
What equipment and materials will you need?  
What safety precautions should you take?
- What do you feel are important things to look for when choosing child care?
- Your baby has a cold and his fever is 101 F (38.3 C). What should you do to care for your baby?

*(From Early Pregnancy Manual – Central East Reproductive Health Network – 1998)*

- To increase interactions between participants, have one couple or one person interview another on a specific topic. This will help them get a different perspective on the topic and know each other better, which may help them build a support network.
- Depending on the group, role-playing may help participants gain confidence in dealing with certain situations.

- Make use of all senses: show a sample labour kit, have participants bathe a doll, use an audio tape containing various baby cries, have participants taste new foods through a pot-luck session or an invitation to bring healthy snacks, etc.

## TIPS:

**Who's Having a Baby?** This exercise can be done at the end of the program, to reinforce comfort techniques. First, have participants do a “labour rehearsal”, going through the various stages of labour, practicing various breathing techniques, massage, visualization and other comfort measures. Then, reverse the roles and have the pregnant women assist their support person, going through similar exercises, from a different point of view. (*Teaching Tips from the International Childbirth Education Association, PO Box 20048, Minneapolis, Minnesota 55420 USA, 952/854-8660, [www.icea.org](http://www.icea.org)*).

**Crying Baby Tape.** The facilitator plays an audiotape of a crying baby for approximately four minutes. A baby doll is passed around and the participants can demonstrate ways they might use to calm or soothe the baby. After turning off the tape, ask the participants for suggestions on ways to soothe the baby and discuss concerns new parents may have about their baby. Encourage participants to share feelings about coping with a crying baby and to discuss ways to provide parental support. This can lead to a discussion on preventing Shaken Baby Syndrome. (*From Early Pregnancy Manual – Central East Reproductive Health Network – 1998*).

- Create a welcoming atmosphere through the set up of the room and the position of the chairs, the use of music and name tags. Greet the participants at the door, etc.
- Create an environment that reflects the topic. For example, use low-lighting and relaxing music when practicing relaxation techniques.
- If an activity may make some participants uncomfortable due to personal or cultural reasons (e.g., massage session, birthing video), indicate you will be doing it at the beginning of the next session. Participants can choose to arrive a little later for that session if they prefer, as it is less obvious to arrive late than to leave early or to sit out an activity.
- Include a field trip in the program. Many programs include a tour of the labour and delivery unit of the local hospital. Depending on the group and the logistics involved, a tour of an Ontario Early Years Centre or a supermarket tour may be beneficial.
- As an educator, try to find an opportunity to attend a birth as a support person or as an observer. The experiences of having a baby, of being the health care provider assisting in delivering the baby, of being the support person and of being an observer are all very different and learning by experience can provide a different perspective.
- Consider having a peer attend one of the sessions, as co-facilitator or observer, and afterwards, discuss possible improvements to the program.

## ADOLESCENT PARENTS

### Program Planning

The expectant adolescent is neither a typical teenager nor a typical adult. Teenagers generally have a less developed knowledge base about pregnancy and parenting due to their shorter life experience. Chapter 4 provides information on some of the topics requiring additional emphasis for teens/young adults.

Adolescents tend to have higher levels of anxiety about pregnancy and birth and may need additional information about the birth event. Programs for adolescents should foster self-directed, long-term health promotion behaviours<sup>47</sup>. Adolescents have higher risk of unhealthy behaviours prior to conception and during pregnancy. They may use substances prior to conception and during pregnancy to cope with challenging issues in their lives. They require information about their health choices, about the possible consequences, and support to improve their health. The facilitator must also recognize the underlying factors for health risk behaviours, i.e., poor nutrition may be due to lack of money, and smoking may be due to stress. Where possible, the facilitator should be ready to address these underlying factors, rather than focusing directly on the risk behaviours.

A harm-reduction approach may be the best option for the facilitator to ensure repeat attendance.

It is important for agencies to offer programs specifically for teens, as pregnant teens generally feel more comfortable when they are with a group of other pregnant teens<sup>46</sup>. It is also valuable to give teens a choice regarding which type of class they prefer to attend, as some prefer to interact with adults older than themselves.

As indicated in Chapter 3, prenatal programs that involve young parents, their families, their peers and local community resources are more likely to be successful. It is also important to offer individual support, counselling for healthy behaviours, a flexible class agenda, and to involve the participants in the planning and content of the program.



**Young Parents Connection.** This free, ongoing drop-in program targets expectant and new parents under the age of 22. Registrants meet at the local YMCA for education, fitness, community kitchens and social activities. The evening begins with a light supper for all participants, after which, everyone breaks out into their particular groups: prenatal classes, “After the Baby” class, toddler parenting programs, and dads-only sessions. Once a month, guest speakers are invited to present on topics such as smoking cessation, nutrition, and safety to the entire group. After the formal classes, participants are encouraged to use the fitness centre, gym, or pool for some guided physical fitness activities, with or without their children. Child care is provided. Numerous local agencies have partnered to provide programming for this project. *(From Jennifer Miller – Algoma Health Unit).*

### Recruiting Participants

Public health nurses in high schools may be the teen’s first contact with the health care system. It is important to promote prenatal services to students. Health departments can make use of bulletin boards in high schools to promote the prenatal education program. A good partnership with the high school guidance departments will assist in early recruitment. Many youth are also involved in adult education centres and this becomes another venue to reach them.



## TIPS:

**Prenatal Pedometer Program.** Pregnant women and their partners can join a walking program by signing up at the first prenatal class. They are then loaned a pedometer for the next four weeks to encourage them to increase or maintain their physical activity level. An information package is also provided. Each week they participate, their names are included in a draw. *(From Lyne Soromaki – Thunder Bay District Health Unit).*

**Managing Your Time.** In a prenatal class for couples, have each participant draw a circle representing 24 hours in a day. The participants indicate separately how they wish to use that time after the baby is born. Then the couples come together and work out a balance that is manageable for each person as well as for the couple. *(From Ed Bader – Focus on Fathers – Catholic Community Services of York Region).*

**Climbing a Mountain – (“Preparing your Backpack”).** Give the participants the analogy of preparing to climb a mountain when preparing for the birth. Before climbing a mountain, what do you need to know? What will you bring? Who will you take with you? What environmental factors should you be aware of (cold, loneliness, rain)? Are there some physical, mental or genetic factors you need to take into consideration? How can you mentally and physically prepare for it? Such an analogy may help participants understand the importance of various aspects of the preparation. The instructor can also help explore the concept of flexibility, as not all the items/ideas for mountain climbing preparation are always used; just as we cannot predict what will be needed during birth. *(From Carolyn Thompson – Childbirth, and Post Partum Professional Association of Canada).*

## Retaining Participants

Keeping the program interesting and free of barriers is essential to retaining young participants in prenatal education programs. Here are some effective delivery practices for pregnant adolescents:

- School-based prenatal programs are effective at keeping pregnant students in school while providing a social support network. The timing of classes is important. Many agencies have found that offering programs right after school, in the school, works well.
- Ideally, the programs should be free and transportation provided.
- Additional incentives such as food and baby care items have been shown to increase attendance.
- If possible, have the prenatal class attendance counted toward the community volunteer hours required for high school graduation, or as a parenting class credit.
- Reinforcing the benefits of prenatal education and care during the program is critical to ensuring continued participation.
- Teens prefer experiential teaching strategies to lectures and discussions. They also like games, videos and field trips to the obstetric unit.
- Teens respond well to guest speakers such as physicians, dietitians, midwives, early childhood educators and social workers. Presentations may help the participants connect with these professionals later.
- If possible, invite teenagers who have already given birth to take part in discussions on newborn care and postpartum mood disorders.
- Offer simple, self-scoring quizzes that the participants can take home. These can be on a variety of topics such as nutrition, self-care during pregnancy, comfort measures, breastfeeding myths, newborn care, etc.
- Have the participants fill out a diary throughout their pregnancy, including a section on nutritional intake.

- Use food models, pictures or fast food menus, to show how some choices and substitutions can improve the nutritional value of the meal.
- Offering a prenatal education program in conjunction with prenatal care appointments works well due to the transportation barriers youth often face.
- The size of the group may vary and agencies may need to be flexible in their requirements. In rural communities, the programs occasionally need to be delivered one-on-one, to ensure timely access to information.
- Some adolescent programs include the fathers and some don't. If the program includes the fathers, find meaningful ways to involve them in the discussions and activities. Discuss tips for solo parenting.

Here are some activities from the Toronto Public Health's Canada Prenatal Nutrition Program Facilitators' Guide that may be useful in working with pregnant women, including teens:

- Create a role-play scenario where the primary health care provider is rushing through a routine visit or is not providing enough information. Ask for volunteers to role-play in front of the group, or have clients role-play in small groups. Have the scenario demonstrate positive, assertive communication strategies to manage the situation. Have a group discussion on feelings elicited and strategies to cope. Discuss informed consent and a client's right to have their questions answered.
- Divide the participants into small groups of two or three and distribute a "Breastfeeding True or False" card to each group. Ask participants to decide if the statement on their card is true or false and give reasons why. Have small groups reassemble into one large group. Have groups report back and ask the large group if anyone felt they would answer differently and why. Clarify any myths that may arise.
- Invite a women assault worker from your community to talk with your group.

## TIPS:

**What is Happening to My Body?** This activity can be used as an icebreaker when discussing changes that happen throughout pregnancy. Each pregnant woman writes down the three most notable changes (emotional and physical) she has experienced since pregnancy as well as any changes (emotional and physical) noticed in her supporting person. Have the supporting persons write down the three most notable changes noticed in their pregnant partner since pregnancy and what they have experienced themselves. Gather the papers and write down on a flip chart what the pregnant women are experiencing and, in a different category, what their support persons are saying. For each comment, explain and discuss with the group the changes and ways women and support person can reduce the discomforts. *(From Carolyn Thompson – Childbirth, and Post Partum Professional Association of Canada).*

**How Heavy is This?** If you do not have a pregnancy simulator, make one using a backpack. Have a support person volunteer to carry the backpack towards the front. Add the required weight in sand, beans or rice, explaining as you are going along (i.e., 2 lbs: uterus, 1 lb: placenta, 7 lbs: baby, etc.). Pass the backpack around so all the support persons can try it. They are usually surprised by the weight. *(Teaching Tips from the International Childbirth Education Association, PO Box 20048, Minneapolis, Minnesota 55420 USA, 952/854-8660, [www.icea.org](http://www.icea.org))*

- In small groups, distribute and discuss case scenarios involving women experiencing postpartum mood disorders. It could be helpful to try to group people from similar cultural or language backgrounds together. Have the participants identify the signs of postpartum mood disorders and possible actions to deal with the situation.
- Have participants organize food models or pictures of food items in various ways: by food groups, by foods high in calcium, iron or protein, etc.
- Have participants align different brands of one type of food (e.g., breads, yogurt, cheese, beans, juice, cereal) from most expensive to least expensive. Have a taste panel to evaluate the taste vs. the cost of food samples. Discuss which food may be worth the cost because of its high nutrient value.
- Help participants find ways to live on a limited budget by discussing community resources and programs that assist with housing difficulties. Explain how social services such as food banks work.

## TIPS:

**Popular Movies.** To introduce a discussion topic, use a clip from a rented popular movie that participants may have seen, e.g., *Three Men and a Baby*, which can help integrate humour to the program. You may need to check the legalities of using video clips. *(From Margaret Wilson).*

## TIPS:

**Myths of Pregnancy.** This activity is done in a large group setting and aims to debunk various myths associated with pregnancy and infant care. Participants are given laminated cards with some possible myths, and actual true statements and they need to figure out what is true and what is a myth, e.g.: A pregnant woman who drinks dark colour drinks will have a baby with darker skin colour, a pregnant woman should not be living in a house where renovations are performed, a pregnant woman should not raise both arms above her head, a woman should not have a bath one week after delivering a baby for fear of having rheumatoid arthritis when she gets older, women with smaller breast may not produce enough milk to breastfeed, etc. *(From Lyne Soramaki – Thunder Bay District Health Unit and Heidi Sin – The Regional Municipality of York).*

- Divide participants in groups and provide each group with a grocery list and a budget for one month. Post grocery store flyers and “shop” for groceries.
- Arrange to tour a local grocery store with a small group of participants. Prearrange a tour date and time with your local grocery store manager and a dietitian. Topics of discussion could include: the nutritional value of foods; marketing of foods; reading food labels; brand name vs. generic label foods.

## CULTURAL ADAPTATIONS

Ontario is comprised of a large number of cultural groups and it is important to meet the specific needs of participants from a variety of backgrounds. Most cultures have strong traditions and beliefs regarding childbirth and infant care. Facilitators must tactfully acknowledge these, while providing current and evidence-based information to the participants. In classes designed for specific populations, prenatal educators may also want to incorporate traditional cultural teachings.

**Here are some suggestions:**

- The attitudes and beliefs of participants from different cultural origins will vary widely depending on their country of origin and the amount of time they have spent in Canada. Adapt to the group and tailor the information and facilitation method used, as with all adult learners.
- Use educational materials that depict a wide variety of people, so that participants can relate better to the “messenger”.
- Newcomers to Canada will need information on using the health care system including its terminology. Also provide them with information on how to cope with or handle a sick infant.
- Use current educational materials that have been culturally adapted in the language of the participants. For example, the Nutrition Resource Centre ([www.nutritionrc.ca](http://www.nutritionrc.ca)) has developed seven different cultural adaptations of Canada’s Food Guide to Healthy Eating.
- Encourage participants to share some of the beliefs they have regarding pregnancy, labour and delivery and discuss these, bringing in additional information about the culture in which the child will be raised. Debunk the myths as necessary but stay flexible on issues with minor impact.
- In some cases, the influence of the mother or mother-in-law of the pregnant woman is very strong. Consider inviting that relative to the class, so information can be transmitted more directly and discussed.
- Respect the participants’ right to choose what they feel is appropriate to participate in, given their upbringing. Examples of sensitive areas include: men not viewing birth videos, women not participating in mixed classes, ice not being given to a woman in labour, etc.
- Provide women with additional strategies to breastfeed when they are not in the privacy of their homes.
- In some cultures, particularly Asiatic ones, participants are accustomed to learning through lectures and may not be as receptive to discussions, ice-breakers and role-plays. They may learn better through handouts, ideally in their own language, and will generally appreciate detailed ones, including a summary of the session. Adjust the facilitation style accordingly.

## SPECIAL SESSIONS

Many prenatal programs offer special sessions as part of the program, or in addition to the program. The following list contains the most common topics addressed.

### Hospital Tours

Some hospitals provide prenatal tours for the pregnant woman and her support person. These tours are designed to help participants know what to expect and the policies of the hospitals. The tours usually cover the admission process, early assessment, birthing unit and postpartum stay. The best time to attend a tour is between 32 and 36 weeks of pregnancy. This gives expectant parents enough time to think about any questions or concerns that they may have and prepare for the birth of their baby. Tours are generally arranged through the prenatal education program and hospitals have specific procedures regarding tours.

### Multiples

In some areas of Ontario, specialized prenatal education programs for parents expecting multiples (twins, triplets, quadruplets or quintuplets) are offered. These classes are sometimes taken in addition to regular prenatal classes.

Ideally, the facilitation of these classes is done by multidisciplinary teams (nurse, dietician, social worker, neonatal intensive care unit nurse, etc.), who can provide coordinated services for multiple birth families. There are many advantages to such sessions. Information can be tailored to the needs and concerns of those expecting multiples. Supports can be found within the group and parents generally find it useful to share contact information with other participants for use after the babies are born. Special sessions for fathers of multiples can be valuable, especially if fathers of multiples can attend and share their experiences. Partners expecting multiples may have questions and concerns that they may be reluctant to discuss in front of their pregnant partners.

The content of a prenatal class for a multiple pregnancy follows the same general guidelines as for a family expecting a singleton baby but there are some differences. The following are suggestions for adaptation, provided by Leonard and Denton<sup>63</sup> and by Lynda P. Haddon (Multiple Birth Educator, Multiple Births: Prenatal Education & Bereavement Support, [www.multiplebirthsfamilies.com](http://www.multiplebirthsfamilies.com)):

- The woman expecting multiples may need to undergo additional testing and screening and couples will likely need more specialized information to help them make informed decisions along the way, particularly if problems develop.
- Help to build a prenatal and postnatal support network is an essential element and needs to be done well ahead. It is important that support people, such as extended family members, communicate with each other, in order to reduce the coordinating role for the parents.
- It is possible to breastfeed multiples exclusively. The parents will need help to develop a breastfeeding plan that is practical and based on their breastfeeding goals. It becomes more important for mothers to get the best advice

possible if they are breastfeeding multiple infants. Obtaining assistance from a knowledgeable health service provider can support successful breastfeeding. Sufficient home help is also critical to breastfeeding success<sup>64</sup>.

- Parents need to be able to make informed decisions regarding the postnatal environment. Ideally, there should be minimal separation of a mother from her infants and the infants from each other. This will assist with breastfeeding and attachment. Separation may be necessary if one or more of the infants is placed in a neonatal intensive care unit, or if infants are discharged at different times.
- Setting priorities is critical to parents of multiples and facilitated activities to assist with this task can be very useful during prenatal classes.



- The emotional attachment process is more complex when multiple infants are involved. Strategies to foster prenatal attachment include sharing information from ultrasound testing and fetal monitoring, being sensitive to positive and negative comments about the babies, and encouraging the expectant woman to keep a pregnancy journal.
- Health professionals can promote parent-infant attachment by helping the parents think about how they will identify similarities and differences between each baby, recognise preferences of each infant, and by encouraging parent-infant skin-to-skin contact.
- Babies from multiple pregnancies are at a higher risk for health issues and parents will need additional emotional preparation for a variety of possible birth outcomes. In the case of stillbirth or loss soon after birth, parents need to be sensitively counselled. Additional information is available in the section on “Prior Miscarriages, Loss of a Baby or Elective Termination”.
- As with all pregnancies, a comprehensive list of community supports, specific services and appropriate reading for parents of multiples is necessary.

### Fathers

Fathers are increasingly involved in the care and nurturing of their children. Both parents need help in ensuring the father’s role is valued and integrated into family life. While a pregnant woman’s partner may be male or female, this section is specific to the role of new fathers, i.e., biological or non-biological fathers that take on a support role in pregnancy, and a parenting role after delivery.

Special prenatal classes for fathers are occasionally offered as part of a generic series. In most cases, the women and the men will be in separate rooms for one or more classes, with different instructors. During that time, the women will also be discussing similar topics and strategies to engage the father in active parenting. Ideally, a male facilitator should

## TIPS:

**What Can I do With This Baby?** The intent of this activity is to find ways for the partner to interact with the newborn. This activity can be done with partners only or with the full group. Have the participants imagine a day with the newborn and brainstorm some of the things they can do with him/her.

Prompt as needed. Suggestions: change the baby’s diaper, give a bath, bring the baby to the mother for feeding, spend time with the baby on your bare chest, cuddle and walk around with a fussy baby, talk and sing to the baby, give your baby a massage, etc.

Write this out onto a flip chart, and discuss each option. A variation within this activity is to choose an option or options (i.e., diapering, swaddling, holding), practice these within the group, and then the support person brings the “baby” to the mom. The support group can then teach the moms the learned techniques. *(From Carolyn Thompson - Childbirth, and Post Partum Professional Association of Canada).*

lead the men’s group; however this isn’t always possible. If a second facilitator is not available, it may still be possible to have some gender-specific discussions with the facilitator moving between groups and with groups collecting their responses on worksheets or flipcharts and reporting their findings to one another as appropriate.

Health Canada funded a study of the needs of new fathers<sup>40</sup> that concluded fathers want prenatal education to address these topics:

- the validation of the dad’s role and presence at birth;

- the life changes that occur after the baby's birth;
- how to balance "child/baby time" with "couple time"; and
- how to spend more time with their child.

Topics on postpartum mood disorders, repercussions of an absent father, anger management, family violence, and Shaken Baby Syndrome can also be included in fathers' classes.

#### **Couple Communication**

Some agencies offer a series of classes specifically on couple communication. These are offered to new and expectant parents and are offered in addition to a generic prenatal education program. The focus is on preparing both parents emotionally for the birth event and for the changes that follow. Topics such as sharing of responsibilities, time management, work-family balance, postpartum

mood disorders, anger management, sexuality and parenting styles are addressed.

#### **Child Emergencies and First Aid**

Some agencies, mainly hospitals and non-government organizations, offer an additional seminar, during pregnancy, about first aid for infants and children. Topics may include choking, bleeding, falls and head injuries, rescue breathing and cardio-pulmonary resuscitation.

#### **Post-birth Sessions**

Some prenatal education programs offer one session after the birth of the baby. This may take the form of a friendly reunion where participants share birth stories or a more educational format where discussion on certain topics (e.g., postpartum mood disorders, breastfeeding difficulties, attachment, adjustment to parenting, etc.) is facilitated.



## USING ADDITIONAL RESOURCES

Chapter 6 contains a list of handouts and teaching aids that facilitators may wish to integrate in their program delivery. Using teaching aids can enhance the information provided by the facilitator, and meet the needs of a variety of learning styles.

When selecting or creating additional resources, incorporate a variety of ethnic backgrounds and family structures, so that participants can identify with what they are seeing. Ensure fathers are included and modeling positive behaviours. Each resource may only depict a limited number of people but a set of resources should strive for a good balance.

### Handouts/Print Material

Many agencies produce one handout covering all content in the prenatal education program. This is a comprehensive method to ensure parents have needed information, instead of having to sort through a number of handouts on a variety of topics. An alternative is to use a generic resource produced by another organization such as Healthy Beginnings from the Society of Obstetricians and Gynaecologists.

Handouts need to be reviewed on a regular basis to ensure they are current. If translations or adaptations of the handouts have been developed, consider making them available, even if distribution will be limited. For example, a handout on infant feeding may be brought home to a grandparent who does not speak English or French.

Handouts should look professional and should not be used if the reproduction quality is poor. Offering the handouts on a website allows clients to download them at their leisure and reduce overhead costs. The handouts can be stored electronically as watermarked PDF files to preserve any reproduction rights.

Participants have indicated that they prefer to have reading materials before participating in class because they do not want to go into a group feeling

ignorant<sup>9</sup>. They want the reading materials to be brief yet to contain the level of detail they need. Given limited classroom time, it is efficient to provide information through handouts and use meeting time for interaction through discussion, role-plays, guest speakers, practice of skills and case studies.

### Visual Aids

There are educational resources that are specifically designed as prenatal visual aids, such as fetal models, models of placenta & umbilical cord, pregnancy simulator, etc. You can also use a variety of props to illustrate a point:

- Create a grab bag of items related to a topic: newborn health, breastfeeding, environmental toxins, comfort measures, etc. Have participants discuss why items have been included. For example, a grab bag on breastfeeding may have a thermometer to show breast milk is always at the right temperature, a mini-car to show it is easily transportable, a pacifier to discuss “nipple confusion”, a cute stuffed animal to elicit the “warm and fuzzy” aspects of breastfeeding, a nursing pad to discuss the let-down reflex, etc.
- Create a sample labour and delivery kit and have participants explain how they would use the items during delivery. The kit can include a relaxation tape, a stopwatch to time contractions, a set of favourite pictures, a massage lotion, etc.
- Create an electronic presentation (i.e., PowerPoint). Slides on a large screen can be powerful visual tools. When the group is large it may be difficult for participants to see the detail on posters. Overhead lighting can create a glare that compounds this problem further. Slides are easier to execute and see than overhead transparencies. They are simpler to edit and update and are more cost effective than having a set of overhead transparencies for each educator.
- Create your own model using household items: use an inflated balloon with a ping-pong ball in the opening to represent the uterus and

mucus plug or use play-dough to create the shape of a cervix and demonstrate effacement, etc. Note that balloons cannot be used in a hospital setting and that some people have an allergy to latex products.

- Show pictures of unsafe equipment to illustrate the dangers.
- Use elastic bands of different strengths to show dilatation and effacement.
- Ensure the equipment is kept clean and in good working order. It can be very distressing and can undermine confidence when an educational tool breaks in a participant's hands.

#### Videos/DVDs

There are many useful prenatal education videos. Cost is often a factor, particularly for agencies with multiple sites. Therefore, to be cost effective, videos should meet a number of learning objectives.

Prior to showing the video segment, identify

highlights for participants to note and observe.

This makes video viewing more of an active rather than a passive experience.

By adding a discussion before and after the video, additional learning can be gained. For example, prior to showing a video on postpartum mood disorders, ask the parents what they already know about the topic. After the video, foster a discussion on prevention, family supports and local resources. Put their finding into context.

Keep in mind that some videos, particularly birth ones, may be overwhelming for some participants. It may be helpful to debrief these and give an opportunity for participants to express their feelings.

Most educational videos are designed to be shown in short segments, so participants have an opportunity to ask questions and reinforce their learning. Preview videos ahead of time and look for opportunities to integrate the various segments into the program. Previewing the videos will also ensure some consistency and reduce potential duplication.



## SENSITIVE TOPICS

### General

Some participants come from difficult situations and may have been victims of traumatic events, of war, of challenged socio-economic conditions, of family abuse, of illness or of genetic handicaps. Their current situations may involve abuse, substance use, isolation, unemployment, poverty or mental illness. They may also have a different racial and cultural background, a different family structure or different values from the prenatal educator.

It is important for prenatal educators to examine their own values and their own comfort level in assisting participants' progress in a way that is meaningful, given their cultural context and the determinants of health. Talking with another professional can support increasing understanding of participants' beliefs. As well, the document *"Reducing the Impact - Working with Pregnant Women Who Live in Difficult Life Situations"* from the Best Start Resource Centre contains research information, feedback from pregnant women and effective strategies to apply to a variety of sensitive issues.

It is important to set a tone of tolerance and acceptance in the prenatal group setting. Respect of participant confidentiality is imperative. This is true for both the facilitator and between program participants. Bear in mind that you have the obligation to report suspected and known child abuse, neglect or exposure to abuse to child protection services, according to Ontario's Child and Family Services Act.

The prenatal educator should be aware of the local services and referral process available to people encountering a variety of difficulties: financial, mental, physical, social, etc. The prenatal educator can make participants aware of options available but the participants need to consent to receive the services.

### Substance Use

The negative effects of alcohol, drugs, tobacco and environmental tobacco smoke during pregnancy are well documented.

Quitting substance use may take more than information and personal willpower. As facilitator, you don't want to increase the potential guilt and shame. People use substances for a variety of reasons: to cope with an undiagnosed mental health condition, due to dependence, to cope with difficult life situations, etc. Some people can quit if provided with needed information about the risks, or brief interventions. Others may require treatment or comprehensive supports that address the underlying factors for the substance use.

Although the message should always be "no substance is the healthiest choice", as a general strategy, try to emphasize behaviours participants can do to "move in a healthy direction". Smokers may be unable to quit smoking; however encouraging them to reduce their smoking will help the fetus<sup>65</sup>. Similarly, so will improved nutrition and moderate exercise. Identify that some people find it very difficult to stop, and that help is available. Provide information about substance use services to all participants in a way that doesn't stigmatize or cause guilt or shame or require a disclosure.

The general emphasis should be on "mother and the future family", and should incorporate information designed to discuss and prevent postpartum relapse. It is also a good opportunity to discuss environmental tobacco smoke and the negative impact of marijuana.

Evaluation results of the Kingston, Frontenac and Lennox & Addington Public Health prenatal program<sup>66</sup> suggest the need to spend less time on the dangers of smoking during pregnancy. Instead, the facilitator should offer resources and referrals to help smokers quit and stress the importance of avoiding environmental tobacco smoke. By acknowledging the difficulty in quitting, and reminding participants of community programs

that can help them stop smoking, prenatal educators can avoid alienating smokers who may feel judged, as well as preventing boredom in the majority of participants who don't smoke.

In a similar vein, this evaluation report also recommends reducing the time spent on discussing the dangers of drinking during pregnancy and focus on common questions, such as “Is there a safe amount of alcohol in pregnancy?”, “Is there a safe kind of alcohol?” and “Is there a safe time to drink in pregnancy?”. The facilitator should also be cognizant of the fact that many women consume a small amount of alcohol before they realize that they are pregnant. There may be questions and fears about this early alcohol use and possible risks to the baby. In addition, remind partners of the importance of supporting their partner in not drinking.

Information on addiction services should be given to all participants for the following reasons:

- The facilitator may not know who could benefit from information;
- Participants who have a substance use problem may not feel comfortable asking for help; and
- Participants may be able to pass the information on to a friend or relative.

#### **Diseases Transmitted to the Fetus**

There are some diseases that can be transmitted to the fetus, e.g., Human Immunodeficiency Virus (HIV), Cytomegalovirus (CMV), Gonorrhoea, Chlamydia, Group B Streptococcus (BGS), Hepatitis B, Herpes, Rubella, Syphilis, Toxoplasmosis, etc. The impact of the transmission varies greatly depending on the specific disease: it may be minimal or it may cause the death of the fetus.

It is important to discuss communicable diseases in classes offered in early pregnancy. Since there are so many diseases to be considered, provision of a handout can augment verbal information. In

later pregnancy classes, communicable diseases and their effects can be incorporated in the context of labour and birth. For example, Group B Streptococcus can be discussed under the premature rupture of membranes and Herpes can be discussed under factors that influence labour or a caesarean section.

Discussion about communicable diseases may feel awkward for the facilitator or participants due to the inclusion of information about past sexual history and current sexual activity. The facilitator may want to set up the delivery of the content in a way that disclosure is not encouraged. Place an emphasis on the association of high-risk behaviour and cervical-vaginal infection from sexually transmitted disease with the dangers to pregnancy and reproductive function. The prenatal educators' role is to provide factual information and to strongly encourage prenatal care as early as possible in the pregnancy.

#### **Abuse**

Abuse is the topic most often mentioned by prenatal educators as a “difficult topic”.

The prenatal educator should only raise the topic of abuse if she is comfortable with it and familiar with the resources available. It is not the educator's responsibility to solicit a disclosure, particularly in a group setting. It is useful to factually state that abuse is common, that it is not the woman's fault, and that help is available. Consider inviting a local guest speaker who is an expert in the area of woman abuse.

It is recommended that educators discreetly display pamphlets regarding abuse and have referral lists of available support services, agencies and counsellors dealing specifically with childhood sexual abuse. A women's washroom is a good location for such information.

A pregnant woman who has been the victim of abuse may be particularly stressed about the

potential for abuse toward her child-to-be. She may also have strong feelings about who should be present in the delivery room and have negative feelings about breastfeeding.

Educators may find that abuse survivors will need more extensive education about the physical aspect of pregnancy and childbirth since many are alienated from their bodies as well as ambivalent or negative about their reproductive capacity. More detail may be needed in class content.

There is a strong association between a history of abuse and the client who refuses or quits prenatal classes<sup>68</sup>. Telephone follow-up to assess those who miss or quit classes may assist in referral or one-to-one support can be made, if desired.

Since disclosure of abuse may not occur in the prenatal period, classes focusing on the transition to parenting should also emphasize the need for all families to have supportive family members and significant others and knowledge of community resources. Coordinated community effort is needed to continue to reach out to women. Home visiting, prenatal and postnatal counselling and paediatric follow-up by compassionate health care providers are effective ways to address potential abuse and neglect.

Additional information on strategies for the prenatal educator can be found in the Best Start Resource Centre document titled “*Abuse in Pregnancy*”.

### **Body Piercing & Tattoos**

There are health risks to body piercing. Infections are common when the piercing has not been properly cared for. Illnesses such as Hepatitis B or C and HIV/AIDS can also occur from the use of non-sterile instruments or supplies. Body piercing or tattooing should not be done during pregnancy or while breastfeeding because of the increased risk of local infection, which can then spread to the bloodstream.

Women should be advised to remove their jewellery if:

- the piercing never healed properly;
- the hole is inflamed, red, irritated or shows a discharge;
- the nipple is pierced and the woman is breastfeeding, as this is an infant choking hazard and increases the risk of infection; or
- the piercing is located near the genitals and could interfere with childbirth.

Women with lower back tattoos should speak with their health care provider about whether their tattoo poses a problem for epidural anaesthesia.

### **Literacy and Language Barriers**

Some participants in prenatal education classes will have language and literacy barriers related to the language that is used in the class, and the literacy level of support resources. For example the woman’s first language may be a language other than that used in the prenatal class, the woman may have difficulty reading and writing (including in her first language), she may have vision or hearing challenges, or she may be taking the program in a different language to accommodate her partner or due to program availability.

It is difficult to meet the needs of a group with mixed language and literacy needs. It is also important to avoid assumptions based on ethnic backgrounds: some visible minorities do not understand or cannot read the language of their country of origin.

The following strategies from the Region of Peel’s Prenatal Instruction for Newcomers to Canada can help:

- Explain key words before starting a new topic.
- Use simple language and emphasize key words.
- Avoid complex sentences and passive verbs.



- Refrain from correcting pronunciation and encourage efforts to speak the language the program is delivered in.
- Give participants more time to answer the questions, as they may need to think out the answer in their first language and then translate into the program language.
- Be aware of the cultural context of language, for example, when saying a “baby shower”, participants may think of rain.
- Make sure print materials are written at a literacy level appropriate to the group.
- As much as possible, offer written materials in the participants’ first language.
- Use posters, models and videos to supplement written materials. Explain key words of a video prior to viewing.
- Offer some take-away activities to reinforce learning.
- Start each lesson with a quick review to reinforce previous learning.
- If many of the participants have difficulty expressing themselves verbally due to language barriers, it may be worthwhile to practice some scenarios where they need to interact with a health care provider. A clear explanation of the roles of the various health care providers may be necessary (e.g., family physician, obstetrician, hospital nurse, public health nurse, paediatrician, lactation consultant).
- If the language or literacy level varies considerably in a prenatal class, consider offering an individual consultation to participants who are having difficulty understanding.

Participants who are visually impaired may need additional supports, such as projecting videos through a projector and having written materials in electronic form so they can magnify them more easily.

## Poverty

Low socio-economic status is one of the most significant factors associated with low birth weight<sup>69</sup>. Stress caused by socio-economic factors can also affect the pregnancy outcome. The stressors caused by socio-economic factors are difficult to eliminate in the short term. While addressing the rate or extent of poverty in the community may be beyond the prenatal educator’s scope, it may be possible to reduce the impact of poverty on pregnant women.

Program planners need to make sure their program is financially accessible and understand the context of people living with economic difficulties. The Canada Prenatal Nutrition Programs are excellent examples of programs providing the environmental supports necessary for pregnant women living in poverty.

Here are some suggestions for general programming:

- Pregnant women living in poverty may have difficulty eating according to Canada’s Food Guide. A specific list of suggestions of low-cost items in the various food groups can be provided to them. Some public health units in Ontario, including Toronto Public Health and Eastern Ontario Health Unit, have created a “Nutrition Matters - Best Buys” handout for each food group.



**Visual translation:** If the facilitator knows the language of the participants, in addition to the language of instruction, she can put key words in both languages on a flipchart for reference. *(From Heidi Sin – The Regional Municipality of York)*

- Inform participants of local programs such as community kitchens, food banks, prenatal nutrition programs, toy libraries and second-hand clothing stores.
- Position breastfeeding as a low-cost infant feeding method.
- Be inclusive in your suggestions about nutrition, exercises, baby equipment, etc.
- Facilitate a brainstorming session of low-cost alternatives for eating healthy, exercising, finding baby supplies, etc.
- Caution participants about purchasing baby equipment (e.g., cribs, car seats) at garage sales and second hand stores. Equipment may not meet current CSA safety standards and vendors (including well-meaning parents) may be liable.
- Help participants build a support network of friends, relatives and community resources.
- Emphasize the importance of loving your baby over buying things for your baby.

#### **Disabilities and Medical Conditions**

Some prenatal education participants may suffer from a physical or mental disability or from a chronic disease. Pregnant women with chronic health problems should receive close monitoring by their primary health care provider. With appropriate care and support, most can deliver healthy babies. Facilitators can assist women in accessing the needed information and services. Encourage the participants to look at pregnancy as a new challenge. Set a supportive atmosphere within the group.

The prenatal educator may be the main source of support regarding pregnancy for some women with disabilities and she may need to establish boundaries regarding her role. The pregnant woman may not have anyone in her life that has experience with pregnancy and disability.

The prenatal educator may need to do some

research to understand the potential impact of a specific medical condition. With the participant's consent, the prenatal educator may also need to contact the woman's health care provider to ensure there are no contraindications to the general recommendations being presented in class.

Disabilities and medical conditions may have an impact on program attendance and it may be necessary to provide additional one-on-one support, in the pregnant woman's home or in another convenient location. E-mail support can also be helpful.

Women with disabilities may be on a fixed income with little or no additional resources available to them. Developing a list of support and services available to them may be beneficial.

#### **Social Isolation**

Many pregnant women have difficulty accessing prenatal classes for geographic, medical or social reasons. If able to attend classes, they may feel somewhat different than other participants. Following are a variety of suggestions that may assist, depending on the source of social isolation:

- If a shy personality is an issue:
  - Provide non-threatening icebreakers that can engage everyone at a level they are comfortable.
  - Make time for fun and socialization that will help participants develop lasting relationships.
  - Find a personality match in the class and pair the participants up to work together on some activities.
- If transportation is an issue:
  - Help participants find ways to ensure transportation to the class and back home. Link them with existing transportation or travel subsidies.

- Consider the location of the program. Is there a way to make it more accessible?
- Consider the timing of the program. Would a weekend program help by reducing the number of trips necessary?
- If isolation is caused by medical reasons:
  - Consider including home visiting, telephone and e-mail support to complement the program.
  - Offer handouts and websites for additional information.

### Family Structure

There are many family situations beyond the traditional “mother-father” dyad. A prenatal class could include people expecting babies in the following situations: single, recently divorced, women whose partners cannot attend for logistical or cultural reasons, same-sex female couples, same-sex male couples with a surrogate mother, a gay and a lesbian friend choosing to raise a child together, etc.

Facilitators may not be aware of the special circumstances of the participants and therefore need to be sensitive about language used and the organization of the activities.

- Create a moment early on where participants can comfortably share and have affirmed their unique family creation story and circumstance.
- Don’t design exercises for “fathers” and “mothers”. As much as possible, use the groupings “person giving birth” and “support person” instead.
- Ensure women who do not have a support person present can take part in the experience in a meaningful way that does not single them out.
- When separating the class for group work, give female support persons the choice of joining either the group with women or men.
- The language used in class needs to be inclusive as there could be participants with varied marital status, sexual orientations and gender identities. Use appropriate terminology so participants feel included, e.g.: single, bisexual, gay, lesbian and transgender.
- Be knowledgeable of assisted reproductive technologies, as these may have been used by some of the class participants.
- If the facilitator’s comfort level is low, don’t hesitate to ask for assistance and suggestions from community agencies and people who service diverse families.

### Prior Miscarriages, Loss of a Baby or Elective Termination

Bereavement is one of the most difficult topics to address in prenatal education. Participants may have already had a pregnancy ending with miscarriage, ectopic pregnancy, medical termination, stillbirth or neonatal death. The parents may have fears of a similar situation recurring or they may feel guilty for wanting another baby. Unfortunately, there are no guarantees in pregnancy and no baby can be replaced.

The following are suggestions for the prenatal facilitator:

- Consider that some of the participants may have suffered a loss. Ensure appropriate and thoughtful word choices during all aspects of the program.
- Let participants talk about their fears and worries, as everyone has probably had negative thoughts at some point and may need to talk about it.
- If some of the participants wish to share their negative experiences, enable them to do so in a supportive environment. It may be more appropriate to discuss logistical aspects rather than emotional ones: “How was your labour?”, “How did the staff at the hospital handle your loss?”, “What did your doctor say about this?”.
- Avoid using religious clichés such as “God probably wanted it that way” as your values and beliefs may be very different from others.

- If another couple has gone through a similar experience and has successfully delivered a healthy baby, it may be beneficial to have the couples be in touch to share experiences.
- Be aware that testing may be a sensitive area for people who have suffered a loss. A test may help to prepare the parents for follow-up with resources (e.g., a support group or a particular physician who specializes in the condition, etc). It is also useful to alert parents to potential future pregnancy issues requiring genetic counselling (e.g., genetic issues they were unaware of that might impact on subsequent pregnancies).
- Encourage all participants to live the pregnancy and postpartum “one day at a time”.
- There may be unresolved issues arising. It may be necessary to let participants know that you will be available at breaks or at the end of the class if there are any particular issues or concerns that need to be discussed.
- If a participant shows a high level of anxiety or the grieving is still very intense, suggest the help of professional counselling services.

Education programs for service providers and brochures for parents are available through organizations such as the Perinatal Bereavement Services of Ontario and March of Dimes. There are also special prenatal classes for bereaved parents available in Ontario.

### Mental Health

Program participants may suffer from a variety of mental health issues, including antenatal depression. It is one of the risk factors for postpartum depression and medical attention should be provided as early as possible.

Depressed pregnant women are less likely to eat and sleep well and more likely to neglect personal hygiene and to smoke and drink alcohol. They are less likely to seek prenatal care or to adhere to medical recommendations<sup>70</sup>.

Symptoms of depression during pregnancy are similar to those at other times of life, but can be more difficult to separate from physical symptoms related to pregnancy such as poor sleep, low energy, and weight changes.

Some anti-depressants have been identified as safe during pregnancy and while breastfeeding, and primary health care providers should be able to assist. Ensure participants are aware of the symptoms of pre and postnatal depression and distribute to everyone a list of local services available.



**Post-Birth Evaluation.** In addition to a post-course evaluation, the Victoria Order of Nurses in Windsor-Essex conducted a post-birth evaluation. A number of short and intermediate outcomes were assessed: maintaining a healthy pregnancy, confidence to cope with labour and birth, knowledge regarding birthing options and medical care, confidence in parenting role and responsibilities, etc. The results indicate that 94% of the participants rated the course as excellent or very good. This organization nevertheless found it difficult to assess the specific long-term benefits and long-term outcomes of taking a prenatal health class prior to the birth. Since there are a large number of service providers involved in the pregnancy, labour and delivery and newborn care, this agency indicated that it would be beneficial to partner with local professionals to provide a more thorough evaluation.  
(From Jan Tutz – VON Windsor-Essex.)

## EVALUATION

As discussed in Chapter 3, the effectiveness of prenatal education programs remains inconclusive, due to a large number of factors: prenatal programs differ in content, prenatal educators' skills and experience differ, parents receive their information from a variety of sources, it is unethical to deprive a group of prenatal education in order to have a control group, etc. Conversely, program funders and managers need to see the effectiveness of their efforts.

Most prenatal education programs have a process evaluation at the end of the program. The participants are asked questions such as: Did you find this course useful? What was more useful? What was less useful? Was the facilitator knowledgeable? etc. In some cases, specific behaviour changes are also collected through self-reports by participants. Did you increase your fruit & vegetable consumption? If you smoked, did you change your smoking habits? Did you create a list of support people? etc.

Outcome evaluation can help improve program content and delivery. Ideally, such a post-program evaluation should be supplemented by a follow-up outcome evaluation completed after the baby is born.

Currently, very few agencies have the time and resources necessary to undertake outcome evaluations. In some areas, prenatal education staff collects anecdotal evaluations through the Healthy Babies Healthy Children program. In smaller communities, new parents may encounter their prenatal educator at a postnatal program or at

a social event. While informal anecdotal feedback may be obtained in these situations, it is very clear that extensive outcome evaluation of the effectiveness of prenatal education classes is needed. There are many factors to be considered: knowledge increase, behaviours during pregnancy, behaviours after pregnancy, attitude changes, increase in confidence.

Current post-program evaluation could be augmented by:

- collection of pre-program baseline health behaviour and knowledge data; and
- follow-up outcome evaluation completed after the baby is born.

If a post-program evaluation is not possible, it may still be beneficial to review literature on the evaluation of other prenatal education programs and reflect on the program currently offered. Does the program cover some of the issues new parents have such as:

- Did the program prepare the fathers for the lifestyle and relationship changes after the birth? Did it provide the information they needed on community services available?<sup>37,38</sup>
- Did it help women increase their personal control during labour and birth?<sup>26</sup>
- Did the parents get sufficient information on breastfeeding, baby feeding/sleeping patterns and behaviour, and self-care?<sup>27</sup>
- Did the mothers feel prepared regarding the realities of motherhood?<sup>33</sup>



## 6. RESOURCES

The following resources were suggested by key informants and are used in prenatal education programs across Ontario. The list only includes resources that are currently available. It does not include publications made by an organization for its own purpose (i.e. handouts made by a health unit for their own prenatal programs). The resources in this list are not necessarily approved or endorsed by the Best Start Resource Centre. The list is in alphabetical order.

The list is far from inclusive of all the resources available but contains the most frequently recommended resources on a variety of topics. As much as possible, the resources provide current information, offer multi-cultural representation and are inclusive of partners.

### HANDOUTS

#### Bereavement

- **Perinatal Bereavement Services Ontario.** Offers booklets and pamphlets to assist parents and caregivers who experience the loss of a child. They also offer telephone support, bereavement groups across the province and subsequent pregnancy prenatal classes. ([www.pbso.ca](http://www.pbso.ca))
- **Bereavement Kit.** March of Dimes. This kit containing five booklets/components is designed especially for parents who experience the loss of a child through miscarriage or during the first month of life. Components can be purchased separately. ([www.marchofdimes.com](http://www.marchofdimes.com))

#### Breastfeeding

- **Breastfeeding Information.** Fact sheets in French, English and other languages on various aspects of breastfeeding. Medela. ([www.medela.com](http://www.medela.com))
  - How to breastfeed
  - Breastmilk collection and storage
  - Breastfeeding problems and solutions
  - Going back to work
  - Etc.
- **Breastfeeding Your Baby.** Canadian Paediatric Society. This brochure answers some of the most common questions about breastfeeding, such as "How do I know when it's time for a feeding?" and "How will I know if my baby is getting enough to eat?" Also provides information about expressing and storing breast milk. French and English. ([www.cps.ca](http://www.cps.ca))
- **Exclusive Breastfeeding Duration.** Health Canada. Pamphlet available in French and English and can be downloaded. ISBN: 0-662-37808-3. ([publications.gc.ca](http://publications.gc.ca))
- **Guidelines for nursing mothers.** Best Start Resource Centre. Magnet provides information on how much breast milk a baby needs by age group. ([www.beststart.org](http://www.beststart.org))

#### Comprehensive

- **Healthy Beginnings – Third Edition.** Developed by the Society of Obstetricians and Gynaecologists in collaboration with the Best Start Resource Centre, the Canadian Paediatric Society and a wide range of expert reviewers. 2005. Available in French and English from the Best Start Resource Centre. ([www.beststart.org](http://www.beststart.org))
- **Baby's Best Chance -Parents' Handbook of Pregnancy and Baby Care – Sixth Edition.** Published by the Government of British Columbia. 2005. Can be purchased from [www.publications.gov.bc.ca](http://www.publications.gov.bc.ca) and downloaded from [www.health.gov.bc.ca/cpa/publications/babybestchance.pdf](http://www.health.gov.bc.ca/cpa/publications/babybestchance.pdf).
- **The Sensible Guide to a Healthy Pregnancy.** Public Health Agency of Canada. 2007. Contains information on lifestyle choices and a ten-month pregnancy calendar. Available in French and English. Can be downloaded or ordered from [www.healthypregnancy.gc.ca](http://www.healthypregnancy.gc.ca).

### Diverse Family Structures

- **Queer Parenting Brochure Series.** Can be downloaded at the Family Service Association of Toronto (under LGBT parents). ([www.fsatoronto.com](http://www.fsatoronto.com))

### Fathers

- **Just for Dad.** Series of downloadable handouts from March of Dimes. ([www.marchofdimes.com](http://www.marchofdimes.com))

### Newborn Safety & Health

- **Back to Sleep.** The Canadian Foundation for the Study of Infant Deaths. Can be downloaded at [www.sidscanada.org/backtosleep.pdf](http://www.sidscanada.org/backtosleep.pdf)
- **Booster Seats and Seat Belts – What You Need to Know.** Downloadable fact sheet from Safe Kids Canada. Available in French and English. ([www.safekidscanada.ca](http://www.safekidscanada.ca))
- **Health Canada – Consumer Product Safety.** A large number of fact sheets and booklets are available in French and English on a large variety of baby safety issues. These can be ordered through the Product Safety Bureau (1-866-662-0666) or downloaded at [www.hc-sc.gc.ca/cps-spc/pubs/cons/index\\_e.html](http://www.hc-sc.gc.ca/cps-spc/pubs/cons/index_e.html). The list includes:
  - Aim for Safety, Target the Label
  - Babies, Children and Sun Safety
  - Baby’s Stationary Activity Centre
  - Blind and Curtain Cords
  - Car Time - Stages 1 to 4
  - Children’s Sleepwear
  - Crib Safety
  - Infant Swings
  - Is Your Child Safe?
  - Suspended Baby Jumpers
  - Toy Safety Tips
- **Immunization.** Many publications on immunization are available in French, English and in a variety of languages from the Ministry of Health and Long-Term Care. ([www.health.gov.on.ca/english/providers/pub/pub\\_menus/pub\\_immun.html](http://www.health.gov.on.ca/english/providers/pub/pub_menus/pub_immun.html))
- **Keeping Your Baby Safe.** Canadian Paediatric Society. Brochure addresses some of the leading safety risks: falls, burns and scalds, drowning, poisoning, choking, suffocation, and motor vehicles. French and English. ([www.cps.ca](http://www.cps.ca))
- **Never Shake a Baby.** Canadian Paediatric Society. Brochure for the prevention of the Shaken Baby Syndrome. Contains practical tips for parents and caregivers on what to do when a baby is crying, and where to go for help when having difficulty caring for a child. French and English. ([www.cps.ca](http://www.cps.ca))
- **Safe Sleeping for Your Baby.** Canadian Paediatric Society. Brochure to help parents create a safe, comfortable sleep environment for their babies. French and English. ([www.cps.ca](http://www.cps.ca))
- **Making a Difference. Ontario Early Years.** Series of 10 pamphlets on milestones and healthy child development from 0 to 6 years in French, English and a wide variety of languages. Can be downloaded at: [www.ontarioearlyyears.ca](http://www.ontarioearlyyears.ca)
- **Newborn Screening: A healthy start leads to a healthier life.** Ministry of Health and Long-Term Care - Ontario Newborn Screening Program. Fact sheet in French, English and 10 other languages on the Newborn Screening program can be downloaded at [www.health.gov.on.ca/english/public/program/child/screening/fact\\_sheets.html](http://www.health.gov.on.ca/english/public/program/child/screening/fact_sheets.html) and ordered from [www.health.gov.on.ca/english/providers/program/child/screening/pdf/nbs\\_orderform.pdf](http://www.health.gov.on.ca/english/providers/program/child/screening/pdf/nbs_orderform.pdf)
- **Playing it Safe: Childproofing for Environmental Health.** The Canadian Partnership for Children’s Health and Environment (CPCHE). ([www.healthyenvironmentforkids.ca](http://www.healthyenvironmentforkids.ca))
- **Reduce the Risks.** A brochure on Sudden Infant Death Syndrome (SIDS). Available from the Saskatchewan Prevention Institute. ([www.preventioninstitute.sk.ca](http://www.preventioninstitute.sk.ca))

- **Safe & Secure – Choosing the right car seat for your child.** Ministry of Transportation. Brochure on the various regulations and installation requirements for car seats. Available in French and English. Can be ordered through Publications Ontario ([pubont.stores.gov.on.ca/pool](http://pubont.stores.gov.on.ca/pool)) or downloaded at [www.mto.gov.on.ca/english/safety/carseat/choose.htm](http://www.mto.gov.on.ca/english/safety/carseat/choose.htm)
- **The First Years Last Forever – I am Your Child.** Canadian Institute of Child Health. This booklet outlines 10 guidelines for parents and caregivers on how they can promote young children's healthy development and school readiness. ([www.cich.ca](http://www.cich.ca))
- **Touch: A Parent's Guide to Infant Massage.** Johnson and Johnson Pediatric Institute ([www.jjpi.com](http://www.jjpi.com))
- **Vaccination and Your Child.** Canadian Paediatric Society. Brochure discusses why children should be immunized, safety issues, and provides a routine child immunization schedule. French and English. ([www.cps.ca](http://www.cps.ca))
- **When Your Baby Can't Stop Crying.** Identifies strategies and suggestions for dealing with a crying infant and validates a caregiver's feelings of frustration and anger. Available from the Saskatchewan Prevention Institute. ([www.preventioninstitute.sk.ca](http://www.preventioninstitute.sk.ca))

#### Nutrition

- **Calcium for life.** Available in French and English From the Dairy Farmers of Canada. ([www.dairygoodness.ca](http://www.dairygoodness.ca))
- **Canada's Food Guide to Healthy Eating.** Guide and complementary documents available for download and ordering in French and English through Health Canada. ([www.hc-sc.gc.ca](http://www.hc-sc.gc.ca)) The guide is also available in seven additional languages from the Nutrition Resource Centre. ([www.nutritionrc.ca](http://www.nutritionrc.ca))
- **Folic Acid – It is never too early.** Brochure and poster available in French and English. ([www.folicacid.ca](http://www.folicacid.ca))
- **For the Health of You and Your Baby.** Dairy Farmers of Canada. Brochure and erasable chart. Available in French and English. ([www.dairygoodness.ca](http://www.dairygoodness.ca))
- **Healthy Eating for a Healthy Baby.** Pamphlet and poster available in French and English from the Best Start Resource Centre. ([www.beststart.org](http://www.beststart.org))
- **The 2005 - 2006 Guide to Eating Ontario Sport Fish.** Ministry of the Environment. Available in French and English. ([www.ene.gov.on.ca/envision/guide/](http://www.ene.gov.on.ca/envision/guide/))
- **Resources on Natural Health Products.** Health Canada. Available in French and English. ([www.hc-sc.gc.ca/dhp-mps/prodnatur/index\\_e.html](http://www.hc-sc.gc.ca/dhp-mps/prodnatur/index_e.html))
- **Teaching Tools for Prenatal Nutrition.** Best Start Resource Centre. A collection of some of the tools and activities from "Healthy Eating for a Healthy Baby". Includes: How Much Weight should I Gain? My Food Diary Rate of Weight Gain. ([www.beststart.org](http://www.beststart.org))

#### Multiples

- **Multiple Births Canada** offers a large selection of fact sheets, pamphlets, booklets and books for parents expecting multiples, some of which are available in French in addition to English. ([www.multiplebirthscanada.org](http://www.multiplebirthscanada.org))

#### Physical Activity

- **Physical Activity Guide to Healthy Active Living.** Public Health Agency of Canada. Guide and complementary documents available for download and ordering in French and English. ([www.paguide.com](http://www.paguide.com))
- **Active Living During Pregnancy: physical activity guidelines for mother and baby.** Canadian Society for Exercise Physiology. Available in French and English. ([www.csep.ca](http://www.csep.ca))

### Pregnancy – Varied Topics

- **Can pregnancy affect my oral health?**

Ministry of Health & Long-Term Care. Ontario Early Years. Fact sheet can be downloaded in French, English and additional languages at [www.health.gov.on.ca/english/providers/pub/pub\\_menus/pub\\_early.html](http://www.health.gov.on.ca/english/providers/pub/pub_menus/pub_early.html)

- **Cord Blood Banking – Turning Waste into Gold.** Alberta Cord Blood Bank (the only public cord blood bank in Canada). ([www.acbb.ca](http://www.acbb.ca))

- **Fact sheets from the Society of Obstetricians and Gynecologists of Canada** (French and English). Can be downloaded at [www.sogc.org](http://www.sogc.org)

- Nausea and Vomiting of Pregnancy
- Group B Streptococcus Infection in Pregnancy
- Herbal Remedies
- HIV Testing in Pregnancy
- Prenatal Diagnosis
- Umbilical Cord Blood
- Vaginal Birth After Caesarean Section (VBAC)

- **Fact Sheets and Key Messages for Pregnancy.** Public Health Agency of Canada (French and English). Can be downloaded at [www.healthypregnancy.gc.ca](http://www.healthypregnancy.gc.ca)

- Smoking and Pregnancy
- Alcohol and Pregnancy
- Folic Acid
- Oral Health
- Physical Activity
- Prenatal Nutrition

- **HIV and AIDS: Prenatal HIV Testing Program.** Ministry of Health & Long-Term Care. Fact sheet can be downloaded in French, English and additional languages at [www.health.gov.on.ca/english/providers/pub/aids/prenatal/catalogue.html](http://www.health.gov.on.ca/english/providers/pub/aids/prenatal/catalogue.html)

- **HIV Testing in Pregnancy.** Society of Obstetricians and Gynaecologists of Canada. Available in French and English. ([www.sogc.org](http://www.sogc.org))

- **How Your Baby Grows: A Monthly Diary of Your Baby's Development** A month-by-month booklet showing the various stages of fetal development and describing the physiological changes that are taking place in the pregnant woman's body. Available in English from March of Dimes. ([www.marchofdimes.com](http://www.marchofdimes.com))

- **Pregnancy & Breastfeeding: Your Rights & Responsibilities.** Available in French and English from the Ontario Human Rights Commission. ([www.ohrc.on.ca](http://www.ohrc.on.ca))

- **Preterm Labour – Signs & Symptoms.** Brochure available in French and English from the Best Start Resource Centre. ([www.beststart.org](http://www.beststart.org))

- **Work & Pregnancy Do Mix!** Brochure available in French and English from the Best Start Resource Centre. ([www.beststart.org](http://www.beststart.org))

- **You and Your Baby Deserve to Be Safe.** Brochure available in French and English from the Best Start Resource Centre ([www.beststart.org](http://www.beststart.org))

### Postpartum Mood Disorders

- **Life with a New Baby is Not Always What You Expect.** Best Start Resource Centre. Brochure available in French and English. Contains information on symptoms for various postpartum mood disorders. Offers suggestions of what the mother, friends and family members can do to help. ([www.beststart.org](http://www.beststart.org))

### Sexuality

- **Sex During Pregnancy.** March of Dimes. Fact sheet can be downloaded in English. ([www.marchofdimes.com](http://www.marchofdimes.com))

- **Sex During Pregnancy and Beyond.** International Childbirth Education Association. Answers common questions expectant couples have regarding sexual relations during pregnancy. Easy-to-read pamphlet available in English. ([www.icea.org](http://www.icea.org))

## Substance Use

- **Be Safe: Have an Alcohol-Free Pregnancy.** Brochure, poster, tear-off pad, static-cling, bookmark. Available in French and English from the Best Start Resource Centre. ([www.beststart.org](http://www.beststart.org))
- **Fetal Alcohol Spectrum Disorder (FASD).** Public Health Agency of Canada. ISBN: 0-662-68619-5. The brochure can be downloaded or ordered in French and English. ([www.phac-aspc.gc.ca](http://www.phac-aspc.gc.ca))
- **Kick Butt for Two.** Brighter Futures for Children of Young Single Parents. A smoking cessation, reduction and prevention support program for pregnant adolescents and young single parents 14 to 24. Available in French and English. ([www.ottawayoungparents.com](http://www.ottawayoungparents.com))
- **Pregnancy Wallet Card.** Motherisk. Contains a list of substances and their possible impact on the fetus. Can be purchased through [www.motherisk.org/documents](http://www.motherisk.org/documents).
- **Your Child is Worth It! Making Your Home Smoke Free.** Pamphlet available in French and English from the Best Start Resource Centre. ([www.beststart.org](http://www.beststart.org))

## VISUAL AIDS

Prenatal educators use a variety of posters, charts and models to share information with the participants. The following list gives an overview of the types of visual supports available. A list of commercial suppliers and distributors is provided further in this chapter.

### Breastfeeding

- Breastfeeding Baby Models
- Breastfeeding charts
- Cloth Breast Model

### Labour & Delivery

- Caesarean Birth Chart
- Comfort Suggestions for Labour
- Labour & Birth Charts

- Ratings of Comfort Measures for Childbirth Chart
- Road Map of Labor
- Positions for Laboring out of Bed
- Birthing Balls

## Pregnancy - Varied Topics

- 12-week foetal model
- Cloth Placenta & Umbilical Cord Model
- Conception to Birth Charts
- Knitted Uterus Models
- Plastic pelvic model (also available in cloth)
- Pre and Post Natal Exercise Poster
- Weight Gain in Pregnancy
- Your Baby Can't Say No

## VIDEOS

There is a large number of videos available on pregnancy, childbirth and postpartum. Many of these are available from a number of distributors and a general list of distributors is included at the end of the chapter. Please note that Best Start has not reviewed these and the list is provided without specific endorsement from Best Start.

It is important for the prenatal educator to view the video before using it in class. Although a variety of points of view may be valuable for the parents to be able to make informed decisions, it is also important for the various videos used to provide a continuum and reduce the confusion they may experience.

### Birth

- **A C-Section Birth Day.** Answer questions about what happens before, during and after a c-section, including the recovery period. 17 min. 2001.
- **Bonjour la vie.** Shows various types of births and discusses interventions. Available in French only. Produced by Denis Boucher Communications Inc. 1998

- **Comfort Measures for Childbirth.** By Penny Simkin. Explanations and demonstrations of physical and psychological comfort measures for women in labour. Shows women in labour and their partners as they use these measures. 40 min. 1995
- **Giving Birth: Challenges & Choices.** Featuring Obstetrician/Gynecologist Christiane Northrup. The video contrasts two different models for birth: the medical model and the midwifery model. 35 min. 1998.
- **Just in Case.** A video about caesarean birth and recovery. 27 min. 1996
- **Open Minds To Birth.** Show expectant parents the importance of staying flexible in their plans for childbirth. 26 min. 2002.
- **Relaxation, Rhythm, Ritual: The 3 R's of Childbirth.** By Penny Simkin. Moments from the labours and births of 10 women. 15 min. 2003.
- **Stages of Labour – A Visual Guide** (Second Edition) Covers signs of pre-labour to delivering the placenta. 30 min. 2006.
- **The Miracle of Birth 2.** Shows five different birth scenarios. Offers a good multi-cultural mix. 58 minutes. 2002.
- **Tried and True.** Shows a collection of comfort measures during labour. Contains 9 chapters on different techniques. 32 minutes. 2000.
- **Understanding Birth: A Comprehensive Guide.** Contains 9 chapters on all the aspects of prenatal education: pregnancy, labour, birth, comfort techniques, interventions, caesarean births, newborn, postpartum and labour preparation exercises. 148 min. 2001.
- **Works of Wonder.** A four-part modular program on labour and delivery. Contains: Three Birth Stories, The Miracle Within, Medical Procedures & Options in Childbirth, A Caesarean Birth Story. 80 min. 2000.

## Breastfeeding

- **Breastfeeding Basics.** 4 Volumes on various aspects of breastfeeding.
  1. The Breastfeeding Game: Why Breastfeed? (22 min.)
  2. Valerie's Diary: How to Breastfeed (23 min.)
  3. Straight Talk from Breastfeeding Moms: Beyond the Newborn (21 min.)
  4. Simple Solutions: Problems, Pumping & Storing Breastmilk (33 min.)
- **Breastfeeding: Why to.** Conveys the message that while breastfeeding may take some patience, it is worth the effort. 24 min.
- **Breastfeeding: How to.** Contains footage showing newborn at the breast within minutes of birth and over the first weeks of learning. Includes a special module on how dads can help with breastfeeding. 31 min.
- **Delivery Self Attachment by Dr. Lennart Righard.** Depicts a newborn's ability at birth to crawl up to a breast and attach himself unassisted. 6 min.
- **Devenir parents... Allaiter bébé.** Sponsored by Le Comité de concertation des groupes d'entraide en allaitement de Québec. Helps demystify breastfeeding and discusses the realities surrounding parenthood. Available in French only. 2004.
- **Dr. Jack Newman's Visual Guide to Breastfeeding.** Topics include: how to know a baby is getting enough milk, breast compressions, avoiding sore nipples, how to get a baby to latch, colicky babies, how to increase intake of breastmilk by the baby, using a lactation aid, risks of formula feeding. 45 min. 2005
- **Follow Me Mum – The Key to Successful Breastfeeding.** Designed to help mothers understand how breastfeeding works, learn how to work with their baby's instinctive behaviour and enjoy their breastfeeding experience. Made in Australia. 20 min. 2000.

- **The Art of Successful Breastfeeding: a Mother's Guide.** British Columbia Reproductive Care Program (distributed by Vancouver Breastfeeding Centre). Describes how to prepare to breastfeed, starting to breastfeed in the hospital, managing common problems at home, and growing with breastfeeding. 58 min.

#### Newborn

- **A Simple Gift: Comforting Your Baby.** Presents information about the importance of the infant's attachment relationship with parents with examples of when and how to respond to an infant's distress in order to promote a baby's trust and confidence to explore the world. Available in French and English. 20 min. 1998.
- **Bringing Baby Home.** General information on baby care from zero to six months. The Liandrea Company. Available in French and English. 71 min. 2005.
- **First days home – Keeping Your Baby Healthy and Happy.** Includes information about car seats, the benefits of breastfeeding, formulas & bottle sterilization, bathing tips, SIDS prevention, safety issues, caesarean recovery and the risk factors for postpartum depression. A diversity of families is shown throughout the video. 60 min. 2003.
- **Hello Parents!** Covers many topics associated with parenting a newborn: exhaustion, coping with crying, schedules, single parent, feelings of inadequacy, relationship changes, financial worries, balancing work and family, father involvement, breastfeeding support, survival tips, attachment. 32 min. 1994.
- **I am Your Child – The First Years Last Forever.** Shares results of research in brain development on the importance of the relationship between care giver and child in the first years of life. Includes information on bonding and attachment, communication, health and nutrition, discipline, self-esteem, child care, and self-awareness. 29 min. 1999.
- **Is Your Child Safe and Secure?** Tips on Car Seats and Booster Seats. Second safety video in a series created by Brampton Fire and Emergency Services with support from the Ontario Ministry of Transportation and the Peel Car Seat Safety Committee. 2005.
- **Kangaroo Mother Care.** Two components: Rediscover the Natural Way to Care for Your Newborn Baby (26 min.) and Restoring the Original Paradigm (51 min.). Kangaroo Mother Care is a method of care for newborns, especially premature babies. The videos describe the method and the evidence behind it.
- **Kids that Click – Keep Your Kids Safe on Every Ride, Tips for using car seats, booster seats, and seat belts safely.** Safe Kids Canada. The DVD is geared towards parents and provides simple step-by-step demonstrations of installations of car seats, booster seats, and safe use of seat belts. A downloadable flyer with the same title complements the DVD. Available in French and English. ([www.safekidscanada.ca](http://www.safekidscanada.ca)). 24 min. 2007.
- **Never Shake A Baby! What Parents and Caregivers Need to Know.** Available from the Saskatchewan Prevention Institute ([www.preventioninstitute.sk.ca](http://www.preventioninstitute.sk.ca)). 18 min. 1998.
- **News About Newborns – A Guide to Newborn Behaviour and Development.** Captures the unique and responsive nature of every new baby and gives expectant parents the encouragement and information they need to appreciate the wonder of newborn talents and temperament. 23 min. 2000.
- **Portrait of Promise: Preventing Shaken Baby Syndrome.** American Academy of Pediatrics. Emphasizes that it is never right to shake a baby. Draws on the experiences of three families with a child injured or killed from violent shaking to describe the nature of injuries resulting from shaking. 11 min. 1995.
- **Starting out Safe and Sound.** Presents information about infant health and safety for the first months of life. 31 min. 2000.

- **The Amazing Talents of Your Newborn.** Johnson & Johnson Pediatric Institute. Presents research on newborn behaviour and attachment to help parents and caregivers broaden their understanding of the development needs of the newborn. 30 min.
- **To be a father.** Information on what fathers can do to help promote and participate in their young children's healthy development. 29 min.

#### Postpartum

- **Diapers & Delirium: Care and Comfort for Parents of Newborns.** Teaches new parents they are not alone in the difficult postpartum times. 27 min. 1987.
- **Life with a New Baby: Dealing with postpartum mood disorders.** Best Start Resource Centre. Introduces the topic of postpartum mood disorders: myths and expectations of parenthood, getting support, symptoms and effects on the family, getting help, risk factors and recovery. Interviews with real mothers and their families. Available in French and English. 17 min. 2006.
- **Postpartum, a bittersweet experience.** Deals with postpartum adjustment with some humour. Combines parenting class and candid discussions with new parents. 27 min. 1988.
- **Postpartum: Caring for Yourself After Delivery.** Information to help new mothers take care of themselves, both physically and emotionally during postpartum. Information on after pains, lochia, sitz baths, episiotomy care, caesarean recovery, breast engorgement, night sweats, changes in hormonal levels, sexual activity, contraception, etc. 16 min.
- **Postpartum: from pregnant to parents.** Provides a postpartum forecast and shows parents how to adjust to the changes. Contains parent interviews, dramatizations and a variety of planning tips. 36 min. 2005.
- **Sex, Love and Babies.** This program reveals to new parents what kinds of changes to expect and healthy ways to keep the marital relationship on track. 30 min. 1993.

#### Pregnancy

- **Baby Time – Baby to Be: The Video Guide to Pregnancy.** Divided into chapters for easy reference. Topics: prenatal care, nutrition, embryonic development, changes to body and mood and implications for partner. 55 min. 2002.
- **Because You're Pregnant.** Covers common aspects and questions related to pregnancy: prenatal visits, medical tests and procedures, month-by-month fetal development, nutrition and exercise, sexuality, signs of preterm labour. 28 min. 2000.
- **Fetal Development: A Nine-Month Journey.** Shows what actually happens from conception to birth. In utero fetoscopy is blended with ultrasound images, drawings and animation sequences. Focuses on how pregnancy affects the mother's body and the importance of keeping the fetus drug free. 15 min.
- **Finding Your Way – The Road to a Healthy Pregnancy.** Kem Murch Productions. Focuses on healthy choices during pregnancy and beyond. 18 min. 2002
- **Have a Healthy Baby: Pregnancy.** Insight on the challenges and joys of pregnancy. Illustrates the changes to mother and fetus during the pregnancy. Includes nutrition, prenatal care, blended families and childbirth preparation. 27 min.
- **Preterm Labour.** Milner-Fenwick. Helps patients understand the consequences of preterm labour. Warning signs and what to do. 7 min.

#### Teens

- **Healthy Steps for Teen Parents.** 3-volume set. Created just for teens. Volume 1 is on prenatal care, Volume 2 is on labour & birth, Volume 3 is on postpartum. Can be purchased separately. 25 min. each volume. 2001.
- **Teen Breastfeeding: The Natural Choice.** 2-volume set. Volume 1: Why Breastfeed? (20 min.). Volume 2: Starting Out Right! (35 min.). 1998

- **Your Pregnancy, Your Plan.** Prenatal care and health during pregnancy, social and emotional issues surrounding pregnancy, role of the young father and needs of a newborn. 46 min.
- **The Stages of Labour – A Visual Guide for Teens.** Features an all-teen cast of parents. 25 min. 1999.

## COMMERCIAL SUPPLIERS & DISTRIBUTORS

The following list of distributors of videos and visual aids is made available for the reader's convenience and should not be construed as an endorsement by the Best Start Resource Centre. Please note that the list is not comprehensive.

### Canadian Distributors:

**Canadian Learning Company** ([www.canlearn.com](http://www.canlearn.com))  
Phone: (800) 267-2977  
(519) 537-2360

**Directional Learning Canada** [dirlearn@albedo.net](mailto:dirlearn@albedo.net)  
Phone: (519) 846-5397

**Maternal Source** ([www.maternalsource.com](http://www.maternalsource.com))  
Phone: (866) 862-4784  
(306) 477-5143

**Superior Medical & Childbirth Care Canada**  
([www.superiormedical.com](http://www.superiormedical.com))  
Phone: (800) 268-7944  
(416) 635-9797

*Note : Representative for Childbirth Graphics in Canada.*

**Visual Education Centre** ([www.visualed.com](http://www.visualed.com))  
Phone: (800) 668-0749 ext. 243  
(416) 252-5907

### American Distributors:

**Childbirth Graphics** ([www.childbirthgraphics.com](http://www.childbirthgraphics.com))  
Phone: (800) 299-3366 ext. 287  
(254) 776-6461 ext. 287

**Geddes Productions** ([www.geddesproduction.com](http://www.geddesproduction.com))  
Phone: (323) 344-8045

**Milner-Fenwick** ([www.milner-fenwick.com](http://www.milner-fenwick.com))  
Phone: (410) 252-1700

**Vida Health Communications**  
([www.vidahealth.org](http://www.vidahealth.org))  
Phone: (800) 550-7047

## PRENATAL EDUCATION TOOLS FOR SERVICE PROVIDERS

There are a wide variety of books, journals and websites that provide information on prenatal care, prenatal education, labour & delivery and newborn care. It is not the purpose of this manual to provide a full list but key informants mentioned the following resources as good, general sources of information for prenatal educators.

### Books & Manuals

- **A Guide to Effective Care in Pregnancy and Childbirth**, Murray Enkin, Marc Keirse, Mary Renfrew and James Neilson. Oxford University Press, 3rd edition, 2000.
- **Birthing from Within: An Extraordinary Guide to Childbirth Preparation**. England P, Horowitz R. Partera Press. 1998.
- **Childbirth Education; Practice, Research and Theory**. Nichols F, Humercik S. W.B. Sanders & Co. 2000.
- **Complete Book of Mother and Baby Care**. Canadian Medical Association. ([www.cma.ca](http://www.cma.ca)). 2002.
- **Family-Centered Maternity and Newborn Care: National Guidelines**. Health Canada. Available from the Minister of Public Works and Government Services. 2001.
- **Innovative Teaching Strategies Handbook for Birth Professionals**. Livingston and Dennedy. 2003.
- **Myles Textbook for Midwives** (14th edition). Diane Fraser, Maggie Cooper. Churchill Livingstone – ISBN: 0443072345. 2003.
- **Parent Making, a Practical Handbook for Teaching Parent Classes about Babies and Toddlers**. Annys Rothenberg. Banster Press. Revised edition 1995.

- **Pregnancy, Childbirth, and the Newborn: The Complete Guide.** Penny Simkin, Janet Whalley & Ann Keppler. Minnetonka, Minnesota: Meadowbrook Press. 2001.
- **Reducing the Impact: Working with Pregnant Women Who Live in Difficult Life Situations.** Best Start Resource Centre. 2002
- **Six Practical lessons for an Easier Childbirth.** Elisabeth Bing. Random House. 1994.
- **The Art of Successful Breastfeeding: A Guide for Health Professionals.** British Columbia Reproductive Care Program - Vancouver Breastfeeding Centre. Video: 75 min. Divided into four chapters designed as a self-study guide for professionals. 1994.
- **The Birth Partner: Everything You Need to Know to Help a Woman Through Childbirth.** Penny Simkin. Harvard Common Press. ISBN: 1558321934. 2001
- **The Complete Book of Pregnancy and Childbirth.** (4th edition). Random House. Sheila Kitzinger.
- **Your Amazing Newborn.** Marshall and Phyllis Klaus. Perseus Books. 1998.
- **Your Baby and Child. Penelope Leach.** Publisher: Knopf. Revised edition 1997

### Staying Current

Key informants indicated using a variety of strategies to stay current in the field of prenatal education including: attending conferences and workshops, reading books and journals, subscribing to listservs, involvement in professional associations, networking with other professionals, taking part in committee work, visiting key websites, analyzing participant evaluation feedback and personal involvement in delivery rooms.

### Best Start Resource Centre

The mission of the Best Start Resource Centre is to support service providers working in the field of maternal, newborn and early child development.

It has a large number of guides, manuals and reference sheets for service providers and most of them can be downloaded from the website or purchased ([www.beststart.org](http://www.beststart.org)). The Best Start Resource Centre coordinates the Maternal, Newborn and Child Health Promotion network, through a free, electronic listserv. Members of the network exchange ideas, resources and information. Other services of the Best Start Resource Centre include training sessions, consultations and an annual conference on maternal, newborn and healthy child development.

### Certifications

Organizations offering prenatal education in Ontario have different certification requirements. In many cases, a Certificate of Competence/License as Registered Nurse in the province of Ontario or a Bachelor of Science in Nursing is required.

The following organizations also provide Childbirth Certifications in Canada

- Childbirth and Postpartum Professional Association of Canada (CAPPAC Canada) ([www.cappacanada.ca](http://www.cappacanada.ca))
- Douglas College in Vancouver ([www.douglas.bc.ca](http://www.douglas.bc.ca))
- Global Birth Institute ([www.globalbirth.org/classroom](http://www.globalbirth.org/classroom))
- Michener Institute offers certification in Lamaze Childbirth Education ([www.michener.ca](http://www.michener.ca))

Additional international organizations offering certifications:

- The International Childbirth Education Association (ICEA) ([www.icea.org](http://www.icea.org))
- Association for Labor Assistants and Childbirth Educators ([www.alace.org](http://www.alace.org))
- Birthing From Within ([www.birthingfromwithin.com](http://www.birthingfromwithin.com))
- Lamaze International ([www.lamaze.org](http://www.lamaze.org))
- The Bradley Method ([www.bradleybirth.com](http://www.bradleybirth.com))





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