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"You are either with me on this or not": A meta-ethnography of the influence birth partners and care-providers have on coping strategies learned in childbirth education and used by women during labour

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ABSTRACT

Background: Childbirth education, which includes providing information and practical techniques to help manage childbirth, aims to support women and their birth partners. It is unknown how birth partners and care providers influence the utilisation of childbirth education information and techniques during women's labour and birth.
Aim: To explore the literature that investigates the influence that birth partners and care-providers have on the application of childbirth education information and techniques used by women during childbirth.
Methods: A meta-ethnography was performed using a systematic synthesis of reciprocal translation and refutational investigation. There were 22 papers included in the final synthesis. Quality appraisal was undertaken using the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBIQARI) quality appraisal tool for qualitative studies.
Findings: An over-arching theme of 'you are either with me on this or not' emerged from the data, which expressed the positive and negative influences on the use of childbirth education information and techniques during labour and birth. The influence of birth partners was captured in the themes 'stepping up to their full potential' and 'a spare part'. The themes 'in alignment with the woman' and 'managed by another' were conceptualised from the data in relation to care-providers' influence. A theme, 'the right fit', described organisational and contextual influences.
Conclusion: Birth partners and care-providers who are present during a woman's labour have significant potential to influence her use of childbirth education strategies in labour, which provides important insights for translation of evidence into practice.

Statement of significance

Problem

The aim of childbirth education is to prepare women and partners for labour, birth and early parenting. However, women's agency and decision making in birth can be impacted by those around her. The influence of birth partners and care-providers on the use of childbirth education strategies is not well understood.

What is already known

Childbirth education has the capacity to change outcomes for birth, but the way in which it is utilised is essential to understand.

What this paper adds

This meta-ethnography provides a unique synthesis of qualitative data to understand how birth partners and care providers influence women's use of childbirth education strategies.

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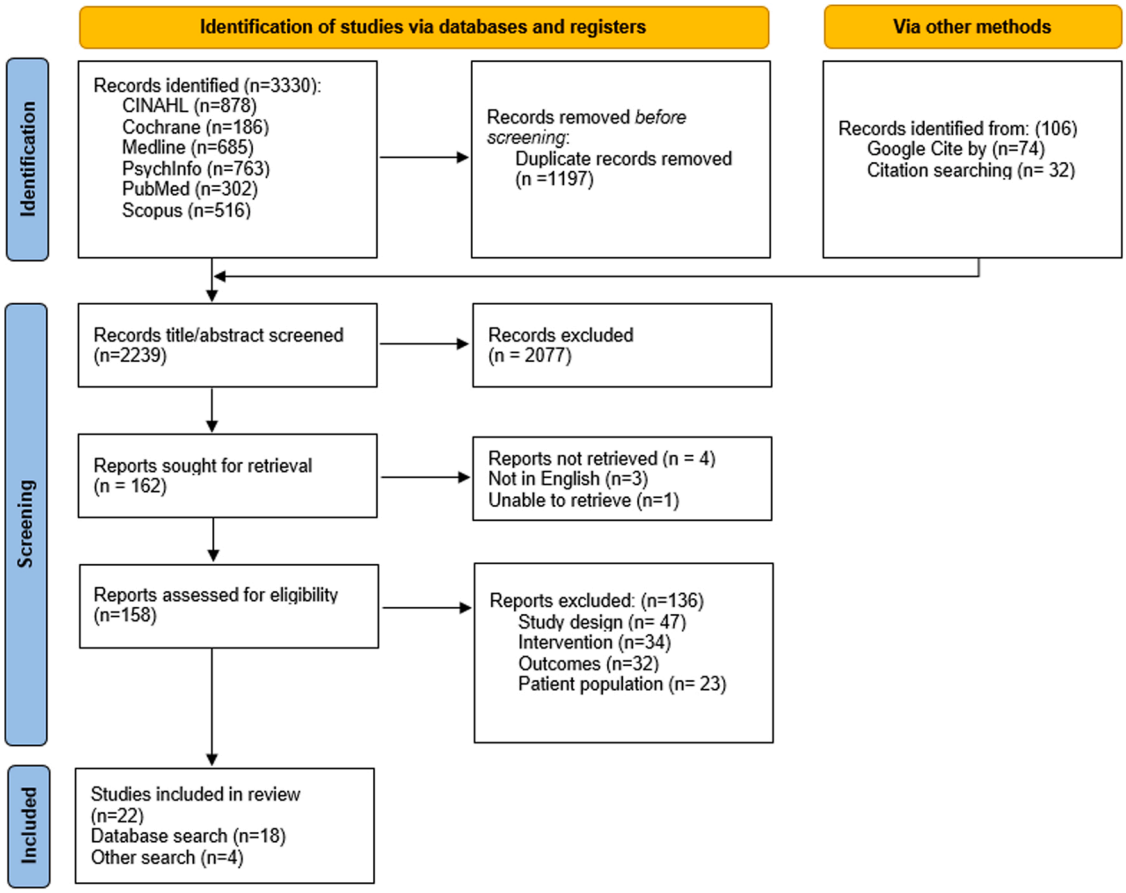

Fig. 1. PRISMA diagram.

1. Introduction

Childbirth education (CBE) was first introduced into Western mainstream health systems in the 1960s and 70s [1] in response to increasing medical interventions, and more women who wanted to actively participate in their hospital-based birth and have their partner present for support [2]. With the rise of the natural birth movement, women sought supportive care tools and techniques to help them manage physiological labour, have agency in their birth, and reduce the use of pharmacological pain medication and medical interventions [3]. Currently, Australian guidelines state that CBE aims to prepare women and partners for childbirth through: generating confidence in their ability to labour and give birth; preparing women for the pain of labour; and supporting their ability to give birth without pain relief [4]. However, there is little evaluation of the effectiveness of CBE, and there continues to be national and international calls to reduce rising rates of routine medical interventions [5,6]. Childbirth education is accessed by the majority of women in Australia [7], with many hospitals offering classes antenatally. Therefore, it is imperative that women are provided with evidence-based strategies in CBE which offer them options and choices for how to prepare for childbirth, including those that support physiological labour and birth and integrate support practices into intrapartum care [8]. Such strategies may include acupressure [9], relaxation and yoga [10], upright posture [11] and breathing [12]. However, the effectiveness of CBE in reducing medical intervention remains uncertain, with some studies emphasising inconsistencies and limitations in outcomes [13,14], while more recent research highlights promising outcomes e.g. reduced caesarean and epidural rates [15] and perineal trauma and resuscitation of the newborn [16]. What is less understood, is the influence that birth partners and care-providers have in the utilisation of the information and tools learned in CBE in the birth itself, along with how maternity system factors impact this.

While there is an increasing expectation for partners to play a more active role in childbirth, it is argued that CBE may not be meeting their needs [17], and that partners or other support people may themselves be in need of support during labour [18]. A systematic review by Smyth et al. (2015), investigating fathers' involvement, found that most fathers want to provide support during labour and birth, however their experience of CBE is not always positive or helpful in preparing them for their role as a birth partner [19].

There is also some question about the capacity of healthcare systems to promote woman-centred care, especially in the recent COVID-19 era [20,21]. To date, much of the health promotion literature is aimed at the individual and their attitudes and behaviours [22], without addressing organisational culture and the demanding workloads of staff [23]. Exploring how care-providers may influence the woman and birth partner is also an important issue in advancing the use of CBE to lower intervention rates. If what is learnt in CBE is incongruent with what occurs in the hospital environment, the usefulness of it may be negated by the influence of intrapartum caregivers [24].

The aim of this meta-ethnography is to explore the influence that birth partners and care-providers have on the utilisation of CBE information and techniques used by women during childbirth. For the purpose of this paper, birth partner refers primarily to the father of the baby, partner or other personal support person such as a doula or family member/friend. Care-provider refers to the staff providing care, such as midwives and obstetricians.

Table 1
Papers identified for inclusion in meta-ethnography.

Paper (REF)	Author, Year, Country	Aim	Methodology	Themes
1 [44]	Hassanzadeh (2021) Iran	To evaluate the perceptions of primiparous women about the effect of childbirth preparation classes on their childbirth experience.	Descriptive qualitative interview part of a parallel convergence mixed method research study. Purposeful sampling method. 13 Iranian women who participated in childbirth preparation classes and had a vaginal delivery were interviewed.	Six main themes: incentive and learning about pregnancy and childbirth; active participation in labour; sense of self-control; use of non- medical pain relief methods during labour; preferring vaginal birth to caesarean section; and positive childbirth experience.
2 [45]	Metinoglu (2021) Turkey	Examine the intrapartum experiences of nulliparous women who participated in childbirth education classes and those only engaged in routine prenatal care.	Qualitative study. Data included semi-structured one-on-one interviews with participants and d Women engaged in routine prenatal care (n = 17) and women participating in childbirth education classes (n = 14) at the maternity unit were included in the study. Purposive sampling method.	Four themes: (1) satisfaction, (2) compliance with birthing positions, (3) intrinsic concentration and (4) participant control of decision-making.
3 [46]	Tabib (2021) UK	Explore the perspectives of expectant parents on the influence of a single antenatal relaxation class.	Fundamental qualitative descriptive methodology and in-depth interviews. Six women and three birth partners.	Four sub-themes of 'different way of thinking', 'deep sense of calmness', 'inspired and motivated' and 'space for relaxation' gave rise to the overarching theme of 'a positive outlook'.
4 [47]	Wennerstrom (2021) Sweden	To interview parents receiving 'psycho-prophylaxis training' during pregnancy and to elucidate their experience of childbirth.	Inductive qualitative method. Interviews with 11 expectant mothers and their partners. Parent couples were recruited from three different midwifery clinics in the south of Sweden. In these clinics the ordinary prenatal education, for the woman and her partner, in groups of 12–14 persons, consisted of two meetings lasting for two hours each.	Three categories in the manifest phase: 'To gain security from knowledge and focus on breathing and relaxation', 'The couple's sense of proximity and the team collaboration with the maternity staff' and 'Meeting pain'. Two themes in the latent analysis: 'Participation gave a sense of security' and 'Manageability'.
5 [48]	Roberts (2020) UK	To explore the perspectives of men who support their partner during early labour.	Semi-structured interviews were audio-recorded and transcribed before thematic analysis. Opportunity sample of fathers (n = 12) in the UK who had been present during their partner's labour in the previous twelve months.	Early labour was described as the 'calm before the storm' during which they carried out practical tasks or rested to ensure they could fulfil their role when labour progressed. However, men frequently felt 'like a spare part' during the later stages of labour.
6 [49]	Tabib (2018) UK	Service evaluation of relaxation workshops for pregnant women.	Class discussion and post workshop questionnaire. 503 women took part in the workshops, experiences collected from 87 of the participants.	Identified themes (a) my own relaxation, (b) confident, and not afraid, (c) proud of myself, (d) unexpected and feeling in control, (e) support.
7[50]	Liu (2017) USA	To examine the birth experience of immigrant and minority women and how 'Centering Pregnancy' influenced that experience.	In-depth interviews and surveys with a sample of racially diverse 'Centering Pregnancy' participants. Interview transcripts were analyzed thematically. Study participants (n = 34) were primarily low-income, Spanish-speaking immigrants.	Many women identified (1) choice regarding medical intervention and (2) their relationship with birth attendants as most important to their overall experience.
8 [51]	Levett (2016) Australia	To gain insight into the experiences of women, partners and midwives who participated in the Complementary Therapies for Labour and Birth Study.	Qualitative in-depth interviews and a focus group as part of the Complementary Therapies for Labour and Birth Study. Thirteen low risk primiparous women and seven partners who had participated in the study, and 12 midwives caring for these women.	The overarching theme was 'making sense of labour and birth'. Women's, partners' and midwives' experience of the course and its use during birth gave rise to supporting themes such as: working for normal; having a toolkit; and finding what works.
9 [52]	Finlayson (2015) UK	To explore views and experiences of using self-hypnosis during labour and birth	Interviews 8–12 weeks after birth. Interviews were conducted alongside the main SHIP Trial, a randomized controlled trial investigating the effect of a childbirth self-hypnosis training programme on rates of epidural use. Thematic Network Analysis approach to qualitative data analysis.	Global theme of 'unexpected consequences', supported by five organising themes, 'calmness in a climate of fear' 'from sceptic to believer', 'finding my space', 'delays and disappointments' and 'personal preferences'.
10 [53]	Spicer (2014) Australia	To inform those working with first-time pregnant women about the effectiveness of childbirth education, with and without hypnosis.	A hermeneutic phenomenological approach, to explore each participant's thoughts, experiences and reflections. Twelve women were recruited, using a purpose sampling technique through advertisements at playgroup venues.	It is suggested that a comprehensive format is worth considering that includes physiology, breathing, relaxation, and education for the support person.
11 [54]	Risisky (2013) USA	To gather information regarding experiences with 'Centering-Pregnancy' related to labor and birth, education and care, and working with midwives.	Qualitative non-experimental thematic analysis on focus group data to gather women's perspectives. Ten women who had recently birthed in the past 3–11 months. Three additional individuals; two were male spouses and one woman's mother also took part.	The findings conveyed three broad themes: program experience, midwife relationship, and support.
12 [55]	Miquelutti (2013) Brazil	To report the experience of labor by women who did and did not participate in a Birth Preparation Program (BPP).	A qualitative phenomenological approach using semi-structured interviews with eleven women who participated in BPP and ten women attending routine prenatal care selected through purposeful sampling.	Women who participated in BPP reported self-control during labor, adopted vertical positions to control pain, and reported satisfaction with their birthing experience.
13 [56]	Fisher (2012) Australia	Explore mothers and birth support partner's experiences of Mindfulness Based Childbirth Education (MBCE).	Generic qualitative approach of focus groups with 12 mothers and seven birth support partners	A sense of both 'empowerment' and 'community' were the essences of the experiences of MBCE both for mothers and their birth support partner

(*continued on next page*)

Table 1 (*continued*)

Paper (REF)	Author, Year, Country	Aim	Methodology	Themes
			were undertaken approximately four months after the completion of MBCE.	and permeated the themes of 'awakening my existing potential' and 'being in a community of like-minded parents'.
14 [57]	Hunter (2012) USA	To examine the mother–doula relationship during the birth experience.	Critical ethnographic methodology. Observations of childbirth classes. Data collected from education and resource materials used by the doulas when interacting with previous or potential clients. Observational data were also collected during the childbirth experience in the hospital. Participants included nine doulas and nine mothers and were not recruited as dyads.	The findings suggest that doulas' conceptualizations of the space of birth were framed in terms of creating/maintaining intimacy and that doulas and women maintained this intimate space even within the institutionalized medical-clinical birth experience.
15 [58]	Longworth (2011) UK	To explore the role, expectations and meanings that individual fathers ascribe to their presence at birth.	A Heideggerian phenomenological approach utilising in-depth interviews at two different time points. Large tertiary maternity unit in the North West of England. 11 first-time fathers accessed through hospital-based parent craft sessions.	Four main themes were evident: fathers' disconnection with pregnancy and labour; fathers on the periphery of events during labour; control; and fatherhood beginning at birth and reconnection. 'Control' was evident both as a distinct and a cross-cutting theme.
16 [59]	Duncan (2010) USA	To elicit descriptions of mindfulness based childbirth and parenting (MBCP) education experiences during the perinatal period.	Used a team-based, interpretive phenomenological approach to analysis. Pregnant women (n = 27) participating in MBCP during their third trimester of pregnancy and thoughts following birth.	Coding of the qualitative descriptions yielded an overarching theme of participant use of formal and informal mindfulness to cope with salient stressful aspects of pregnancy, labor and delivery, and the postpartum experience.
17 [60]	Lee (2009) China	To examine Chinese women's satisfaction with and the perceived effect of childbirth education class on their labour experience.	Mixed-methods Donadedian model as the theoretical framework. 40 women were purposively selected for a semi-structured interview. Thematic analysis was conducted on the interview data.	Three themes emerged from the interview data, namely, 'learning about labour', 'contributing to a smooth labour process' and 'coping with uncertainty and handling anxiety'.
18 [61]	McKinney (2006) USA	To detail the experiences of students and teachers who used The Bradley Method of childbirth education.	The method of qualitative analysis was constant comparison. Fifteen participants for this study, a criterion-based sample, were recruited in stages. Participants responded via email to a set of interview questions, and many shared links to their web pages for their birth stories and philosophies.	Five themes: 1) role of spouses or partners; 2) the concept of "natural" childbirth; 3) the importance of relaxation and preparation; 4) the quality of materials and teachers; and 5) the relationships formed with caregivers such as nurses, midwives, and doctors.
19 [62]	Premberg (2006) Sweden	To describe fathers' experiences of childbirth education.	Phenomenology. Ten fathers were interviewed 2–4 months after the birth of their first child. The current study was carried out in a small, countryside town in the southwest region of Sweden.	For fathers, the essential structure might be described as ''childbirth education takes a secondary role while simultaneously creating preparedness for birth and fatherhood.'' A secondary role meant that childbirth education had no unique position for the fathers.
20 [63]	Segeel (2006) South Africa	To explore and describe how childbirth education contributed to the birthing and breastfeeding experiences of primigravidas.	Qualitative exploratory design using semi-structured, phenomenological interviews. First time mothers who experienced labour, birth and breastfeeding, regardless of mode of birth.	Three themes; (i) physical discomfort experienced during childbirth, (ii) expectations of the labour ward personnel, (iii) application of information received at childbirth education classes during labour, birth and breastfeeding.
21 [64]	Spiby (2003) UK	To describe women's experiences of using, starting, and discontinuing three coping strategies in labor that were taught in childbirth classes.	An exploratory research design involving content analysis. 121 women were interviewed within 72 h of the birth of their first child.	Common aspects of care, changes of environment, and use of pharmacological pain relief affected women's discontinuation of coping strategies.
22 [65]	Schneider (2001) Australia	To analyse the childbirth classes experiences of first time mothers.	Grounded theory. Tape recorded, individual interviews. Thirteen women's experiences in childbirth education classes. Ten women were delivered in private hospitals and three women in public hospitals.	Categories: 'Unprepared' (labour and birth experiences), and 'Vulnerable' (breastfeeding) evolved during the grouping of the concepts.

2. Method

Meta-ethnography is a qualitative research synthesis method introduced by Noblit and Hare in the 1980's [25]. We adopted this approach to synthesising data from qualitative studies, with the aim of constructing a comprehensive understanding of the existing research findings. The phases of a meta-ethnography are: (1) getting started; (2) deciding what is relevant to the initial interest; (3) reading the studies; (4) determining how the studies are related; (5) translating the studies into one another; (6) synthesising translations and (7) expressing the synthesis [25].

2.1. Search methods

We searched the databases CINAHL, Cochrane, Medline, PsychInfo, PubMed, and Scopus for relevant studies (search strategy terms can be found in Appendix A). We included qualitative and mixed methods studies available in full-text and English language, published from 2000 to 2022 to ensure alignment with recent practice. Hand searching reference lists of included papers and Google 'cite by' were used to check for further papers.

2.2. Eligibility criteria

Studies were included if they explored the use of information and techniques learnt from CBE during labour and birth and examined the role that birth partners and care-providers played in its use. The inclusion criteria were (i) original research (ii) exploring the role of birth partners or care providers in the utilisation of CBE information and techniques (iii) during labour and birth (iv) from the perspective of mothers, birth partners or care-providers. Studies were excluded if (i) findings were collected about the experience of CBE prior to birth, (ii)

the use of CBE information and techniques during labour and birth was not included in the findings.

2.3. Search outcomes

The PRISMA flowchart (Fig. 1) illustrates 'getting started' (phase 1) and 'deciding what is relevant to the initial interest' (phase 2) of the meta-ethnography process. We retrieved a total of 3330 studies from the initial database searches. A further 106 studies were found by checking reference lists and using Google 'cited by' function. Once duplicates were removed, 2239 papers remained. These studies then underwent a title-abstract screening process and 2077 were removed. Two reviewers (KS and KL) performed full-text screening (phase 3) of the remaining 162 studies. Differences of opinion were resolved through discussion, or a third reviewer (HD or EN) was available if needed. A total of 22 studies were included in the meta-ethnography.

2.4. Quality appraisal

For critical appraisal of the included 22 papers we used the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI) quality appraisal tool for qualitative studies [26].

2.5. Data abstraction

Data abstraction was performed in two stages (phase 4 and 5). In phase 4, it was determined how the studies were related. Studies were read and re-read to become familiar with the content and theoretical persuasion of the paper. Quotes and explanations of themes from original studies were considered to be data items and were allocated as first and second order interpretations. These interpretations were explored using reciprocal translation (similarities) and refutational translation (discrepancies) to determine where there was convergence and divergence between the studies [25]. Reciprocal and refutational translations required us to work in an iterative way to translate terms from one study to the others (phase 5) [25]. Reciprocal translation involved identifying shared themes from across the studies based on original first and second order constructs. First and second order constructs from included studies were entered into NVivo12 [27], from which new key concepts and metaphors that cut across studies were generated. These became known as third order constructs and provided a new understanding of the phenomena. Refutational investigation explains contradictions in the synthesis of data.

2.6. Synthesis

To 'synthesise translations' (phase 6) we developed new overarching themes from the concepts and metaphors, where themes from the original studies were compared to produce a translation of meaning. From this a new explanation was developed that speaks for the whole rather than what the parts alone imply [25] by creating new meaning out of the existing research data. These are presented in the findings section (phase 7).

2.7. Reflexivity

Reflexivity demonstrates high-quality ethical inquiry and establishes credibility and legitimacy of the research process [28]. To maintain reflexivity, the research team explored and discussed our views and opinions throughout the research process, acknowledging that the beliefs, assumptions and biases that we bring to the research process help to shape thinking. We were mindful of our positions as childbirth educators and/or midwives with existing beliefs relating to how CBE can be implemented to support physiological birth practices. We ensured rigour by staying close to the data, using a reflexive process and intersubjective checks to ensure these influences minimised bias toward the outcomes of the synthesis [29].

Table 2
Table of themes, sub-themes and concepts.

You are either with me on this or not		
Theme	Sub-theme	Concepts
Birth partners		
Stepping up to their full potential	Mindfully present with a common voice	• There for the mother • Advocacy role
	Facilitation and focus	• Doing the techniques together • Providing reminders
	Theory promotes application	• Understanding the theory behind techniques • Motivated to work with the birth process
A spare part	Emotions in the presence of pain	• Feeling of helplessness • Lacking trust in physiology
	The periphery of birth	• On the edge of events • Limited to providing practical tasks
Care-providers		
In alignment with the woman	Supportive alliance	• Teamwork and positive relationships • Following the woman's lead
	Proactive assistance and encouragement	• Helping implement techniques • Essential adjunct to their role
Managed by another	Disruptive encounters	• Lack of understanding • Environmental and routine care disruptors
	Someone else pulling the strings	• Discouraging attitude • Taking over
	Education and practice at odds	• False assumptions about staff support • Dissonance between classes and birth setting
Birth Setting		
The right fit	Lack of integration	• Organisational pressure from the wider maternity system • Fragmented integration with a lack of training
	Contextual awareness	• Birth partner support a novel concept • Desire to follow care-providers instructions

2.8. Findings

Studies originated from nine countries (six from the UK, five from the USA, four from Australia, two from Sweden, and one each from Brazil, China, Iran, South Africa, and Turkey). CBE programs that were included in the studies ranged from single classes to sessions over several weeks. Some involved birth partner participation while others were attended solely by the pregnant woman, but where researchers provided information on the support offered by the birth partner/care-provider. (Table 1).

2.9. You are either with me on this or not

The overarching theme 'you are either with me on this or not', reflects how there are both positive and negative influences on the use of CBE information and techniques during labour and birth. It describes the notion that birth partners and care-providers are either *with* a woman in terms of helping her to use what she has learnt in CBE classes or *not*. Four themes sat underneath this overarching theme representing the positive and negative influence birth partners and care-providers have in women's utilisation of CBE practices; 'stepping up to their full potential', 'a spare part', 'in alignment with the woman', and 'managed by another'. A further theme, 'the right fit', describes issues that permeated through these four themes and considered organisational and contextual factors. The findings are presented in Table 2.

A conceptual model showing the themes and sub-themes is shown in

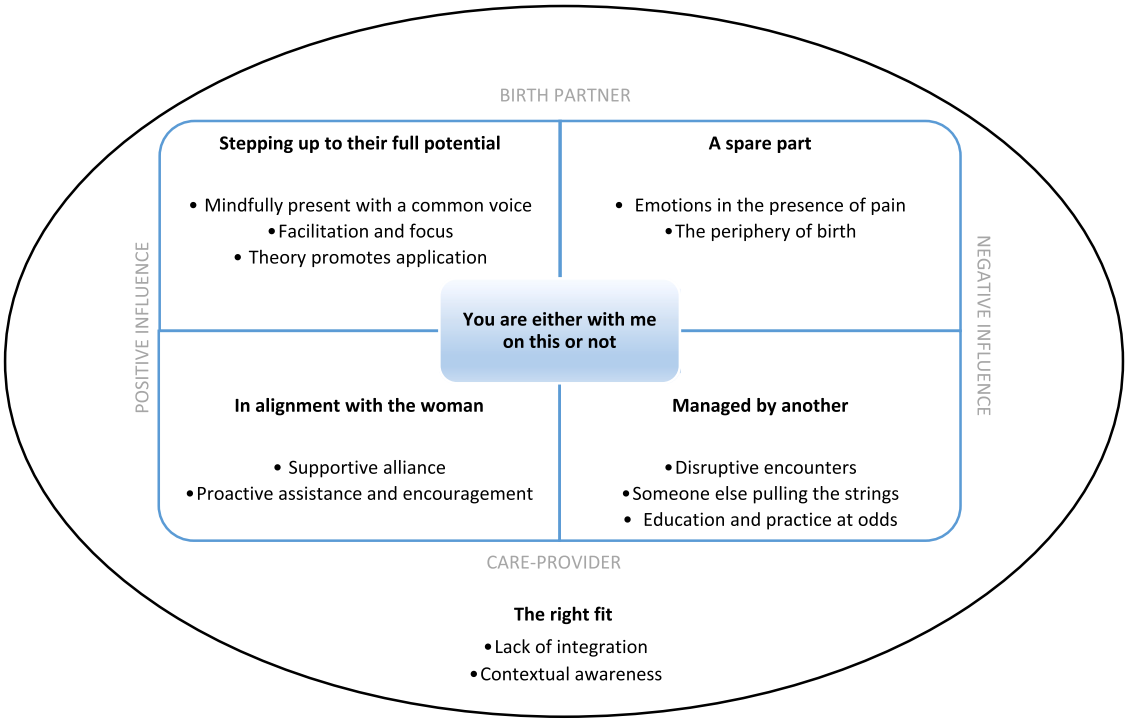

Fig. 2. Conceptual model of 'you are either with me on this or not'.

Fig. 2, and Table 3 shows how each paper is mapped against these.

2.10. Birth partners – stepping up to their full potential

We noted prominent examples of ways the birth partners positively assisted in the use of CBE information and techniques during labour and birth by stepping up to their full potential as a support person.

2.10.1. Mindfully present with a common voice

Birth partners' capacity to be 'there for the mother' was apparent in the way they emotionally held the space so that the mother could utilise the information and techniques learnt in CBE classes.

> "and my mum was with me and was like don't listen to anybody you just keep doing exactly what you're doing, so I stayed really in the zone with myself and my mum and my baby" [p.26, Spicer 2014]

In addition to emotional support, birth partners having an 'advocacy role' also created their positive influence.

> "Luckily [he] was my voice in saying you know what, this isn't gonna happen this way. This is gonna happen this way and this is what we want to do, so, you know, and amazingly they let it happen that way" [p.140, Risisky 2013]

2.10.2. Facilitation and focus

Birth partners often provided support through being practical in nature. This facilitated the use of CBE during labour by 'doing the techniques together' with the birthing woman.

> "My husband was right there and using all of the [techniques], 'cause up until then he was just saying you're doing really well, breath [sic] through it, but now he was like you are feeling really relaxed and touching my head and shoulders and using sort of touch and hypnotic techniques" [p.25, Spicer 2014]

Or if they weren't actively doing the techniques with her, they were fulfilling the function of 'providing reminders' for her to do so.

> "My husband helped me focus on my breath by saying, "Come back to your breath'' at times when the labor got intense" [p.198, Duncan 2010]

2.10.3. Theory promotes application

One of the reasons parents gave for using techniques from CBE was that they had an 'understanding of the theory behind the techniques'. While this appeared a main motivator for women using techniques, when birth partners understood why and how they could be of benefit this also helped them to support their use and be 'motivated to work with the birth process'.

> "So we learnt, and also we talked about the importance of practising. We were also taught breathing techniques. We talked about what was actually physically happening and I think that gave us a good understanding of the actual process of birth and why we were doing what we were doing." [p.27, Spicer 2014]

> "It was the theory that motivated practice of the relaxation exercises, Louise commented, 'without that scientific reasons, I wouldn't have done it, I'm more of an evidence-based camp'." [p.4, Tabib 2021]

2.11. Birth partners – a spare part

The theme of 'a spare part' describes how in contrast to the ways birth partners helped women apply what was learnt in CBE, several studies also highlighted the difficulties birth partners had in supporting CBE practices.

2.11.1. Emotions in the presence of pain

Some birth partners expressed 'feelings of helplessness' when it came to supporting the birthing woman, which also impacted her ability to focus on her CBE techniques: "I was still trying to comfort him [partner] and obviously having a baby' " [p.24, Spicer 2014].

Birth partners' own emotions in the presence of pain could also lead to 'lacking trust in physiology', thus undermining the use of CBE techniques: "Lisa said she 'thought her mom would be too worried if [she]

Table 3
Included studies and how they map onto themes and sub-themes.

	Birth partners					Care-providers					Birth setting	
	Positive Influence			Negative influence		Positive influence		Negative influence				
	Stepping up to their full potential			A spare part		In alignment with woman		Managed by another			The right fit	
	Mindfully present with a common voice	Facilitation and focus	Theory promotes application	Emotions in the presence of pain	The periphery of birth	Supportive alliance	Proactive assistance and encouragement	Disruptive encounters	Someone else pulling the strings	Education and practice at odds	Lack of integration	Contextual awareness
Hassanzadeh (2021)		✓		✓			✓					✓
Metinoglu (2021)	✓	✓				✓		✓				✓
Tabib (2021)			✓			✓		✓	✓		✓	
Wennerstrom (2021)	✓	✓	✓			✓	✓					
Roberts (2020)	✓	✓	✓	✓	✓					✓		
Tabib (2018)		✓				✓	✓		✓	✓	✓	
Liu (2017)			✓			✓	✓	✓	✓		✓	
Levett (2016)		✓	✓			✓	✓			✓	✓	
Finlayson (2015)			✓					✓		✓	✓	
Spicer (2014)	✓	✓	✓	✓		✓		✓	✓			
Risisky (2013)	✓		✓									
Miquelutti (2013)		✓					✓					
Fisher (2012)	✓	✓	✓	✓		✓		✓		✓	✓	
Hunter (2012)	✓	✓		✓			✓	✓	✓		✓	
Longworth (2011)	✓			✓	✓	✓					✓	✓
Duncan (2010)	✓	✓										
Lee (2009)									✓			✓
McKinney (2006)	✓		✓				✓		✓		✓	
Premberg (2006)	✓			✓	✓						✓	
Segeel (2006)	✓	✓				✓			✓	✓	✓	
Spiby (2003)								✓		✓		
Schneider (2001)				✓		✓				✓	✓	

was in a lot of pain and really push having an epidural'." [p.321, Hunter 2012].

2.11.2. The periphery of birth

The idea that birth partners were on the periphery of birth originated from the finding that despite attending CBE classes, some birth partners were still 'on the edge of events', lacking knowledge or motivation regarding their role and how they could provide support. This was often 'limited to providing practical tasks' with little consideration to the usefulness of supporting what else had been learnt in CBE.

> "I have more of a back role as a kind of ferry man essentially, and I knew that, once we'd got there probably my role would sort of change again, but I wasn't sure what that role would be. I had sort of feared being a bit of a third wheel essentially, and, you know, in a way I probably was" [p.493, Roberts 2020]

> "I was more worried about do we have enough stuff in the bag, is the bag in the car, what's the route to the hospital? all the logistical bits were sorted and the rest would just come" [p.493, Roberts 2020]

2.12. Care providers – in alignment with the woman

Care-providers positively influenced the use of CBE when there was an alignment with the woman's needs.

2.12.1. Supportive alliance

When care-providers engaged in 'teamwork and positive relationships' with birthing women this led to greater implementation of CBE techniques.

> "The midwives were totally up for it and the particular midwife I had, she, I think she, had patients that did HypnoBirthing so she knew what to do. She was fantastic." [p.28, Spicer 2014]

This alignment and ability to support the use of CBE information and techniques was further enhanced through the care-providers ability to 'follow the woman's lead' during labour.

> "They weren't offering me an epidural, because, in my birth plan, I had said I didn't want an epidural… they followed it as closely as they could, and that's one thing I really appreciated about the hospital, is that they respected my birth plan… at one point I was like 'well give me anything' and they were like 'well you know we're trying to go according to your birth plan'." [p.419, Liu 2017]

2.12.2. Proactive assistance and encouragement

A number of studies highlighted how some care-providers 'helped to implement techniques' that women had learnt during CBE and that they saw this as an 'essential adjunct to their role'.

> "I had a fantastic midwife during labor who was incredibly supportive; even though I ended up in the labor ward she dimmed the light, and played my CD." [p.15, Tabib 2018]

> "So, you talk about acupressure so they know what the points are and they know what it's going to do." (midwife) [p.129, Levett 2016]

2.13. Care providers – managed by another

We also identified in the next theme incidents where care providers had a negative influence on the use of CBE. This was expressed in the sense that the woman's birth was being 'managed by another'.

2.13.1. Disruptive encounters

When hospital staff had a 'lack of understanding' of CBE techniques and misinterpreted women's needs or behaviours, women became frustrated and lost focus.

> "I found that frustrating that they'd be like, 'oh no, you don't look… you know…sad enough to be in labour', and I'm like, 'I can feel the pain, I'm just smiling', so…I felt like you had to be screaming and shouting. I felt like if you were calm then maybe they didn't think you were in labour" [p.5, Finlayson 2015]

Furthermore, 'environmental and routine care disruptions' caused interruptions to the use of CBE techniques. This highlighted how care-providers' behaviour and disturbance of the birth setting impedes a woman's use of what she has learnt in CBE classes:

> "Rosie described her experience of using relaxation techniques in labour ward as 'quite hard', explaining, 'because there was so much going on, we had so many (people) coming in and out of the room, it was just too overwhelming'." [p.5, Tabib 2021]

2.13.2. Someone else pulling the strings

Interactions with some care-providers highlighted a 'discouraging attitude' towards what was learnt or recommended in CBE classes, identifying more than just disrupting implementation, but directing more toward medical management.

> "I imagined how it looked at sunset, the sounds I would hear while there, and the hammock where I would be lying while taking it all in and got in a rhythm when I was reminded by the midwife that my labour may carry on for significantly more hours. I didn't feel I had the energy to focus on ignoring the pain for that much time and called for an epidural" [p.15, Tabib 2018]

Further to this sense of discouragement, some care-providers exhibited a more obvious 'taking over' persona, or where the focus of care was not woman-centred;.

> "And so they had me in the bed and so when I pushed they said, "no, no push yet! The doctor's not here" And I said, "I want to get her out! I want her out of me" … I pushed and so one of the nurses…said "don't push!" [p.419, Liu 2017]

2.13.3. Education and practice at odds

There can be incongruity between what is taught in classes and what is offered by care-providers in practice. This was reflected in two ways. Firstly, women felt they had received 'false assumptions about the staff support' they would receive in labour.

> "A nice picture was drawn for them and they were not fully equipped on how to handle negative staff. This had a detrimental effect on their ability to cope with the pain. "Well, at first when we just arrived and I sensed the coldness, I immediately started to feel panicky … anxious and worried … and I could feel I was not coping with the pain". [p.68–9, Segeel 2006]

Secondly, there was a 'dissonance between classes and birth setting' resulting in confusion between what is learnt in CBE and the reality of labour in the moment:

> "there were occasions when the midwives reminded the women that what was said in the classes was not necessarily the same in the hospitals. This kind of information and advice may be confusing for some women who want to participate in decisions about their care, particularly since the midwives who are encouraging the women to be assertive are not with them in the hospital situation" [p.19, Schneider 2001]

2.14. The birth setting – the right fit

The original studies showed that as well as the influence that birth partners and care-providers have on the use of childbirth education, there were also wider influences of the birth setting, and the way it

integrates and accommodates CBE practises in the birth room. The theme of 'the right fit' represents the 'lack of integration' of CBE in the wider maternity and socio-cultural systems, and how 'contextually appropriate' the use of CBE strategies to support a physiological birth is deemed.

2.14.1. Lack of integration

We found that in the use of CBE techniques during labour and birth, women, partners and care providers often encounter 'organisational pressures from the wider maternity system' to conform to models of medical management.

> "Participants also suggested the space for relaxation was not necessarily a physical space and a woman could have two different experiences of the same physical space under the care of different midwives. The study highlights the significant role of practitioners as well as the organisational culture in protecting or inadvertently violating such space." [p.6, Tabib 2021]

Additionally, studies reported 'fragmented integration with a lack of training' for staff interested in supporting CBE skills and techniques:

> "Midwives expressed interest in doing courses in a variety of techniques to help build their practice. However, they found that one of the biggest barriers was the cost of the courses; 'it's so expensive but the techniques should be readily available to midwives' (Midwife 2); 'We shouldn't have to pay to do our jobs' (Midwife 1); 'No it should be part of the training' (Midwife 2)." [p.129, Levett 2016]

2.14.2. Contextual awareness

Supporting the use of CBE during labour was dependent on the context and culture of where and with whom it was being applied. Concepts in the data supported the idea that either 'birth partner support was a novel concept' or there was culturally a 'desire to follow care-providers instructions' as the trusted expert, lessening the need for CBE information and techniques to manage one's own labour**:**

> "Insufficient emotional support, however, must be understood in a cultural context. In Turkey, many husbands are not willing to play an active role in the labor process." [p.61, Metinoglu 2021]

> "When Iranian women demonstrate calmness and work along with the care provider, they consider this as a positive achievement" [p.5, Hassanzadeh]

3. Discussion

If CBE is to adequately fulfil its purpose of preparing women for childbirth it is fundamental that what is learnt in programs can be integrated and supported in practice during labour and birth. In this review, we have identified relational aspects between the woman, birth partners, maternity staff and the setting that either upheld the purpose of CBE or obstructed it.

Women benefitted when birth partners were mindfully present and helped them to focus on using their techniques through reminders, performing techniques together or advocating for what they had learnt in CBE. Women have voiced their desire to learn about non-pharmacological techniques for labour and birth [30] and this study has highlighted that a supportive approach from those around them is an important factor in helping them to fully apply these techniques. When birth partners did not, or could not, perform such a role, they were identified as having a negative influence on the use of CBE in the theme 'a spare part'. Some birth partners felt helpless, lacked trust in promoting physiological birth, or had limited awareness of the full support role they could offer. Research has shown that birth partners would welcome the opportunity to focus on their individual needs [19] but there is a lack of targeted information which has led fathers, to be frustrated by the lack of inclusion by maternity care services [31].

Given the fact that integrating evidence-based knowledge within the cultural and organisational hegemony of medical birth practices is problematic [32], the findings from this study identifying the positive influence of staff support in encouraging a woman to use CBE practices is important. Care-providers adversely influenced the use of CBE techniques when women felt their birth was 'managed by another'. These findings bring into question the way in which the attitudes and approaches, which may underpin maternity care more generally, are incongruent with the philosophy behind CBE, which emphasises birth physiology, the role of support, and autonomy and informed consent, all of which remain important whether it is a physiological labour or requires intervention. The midwife-institution relationship may be prioritised above the midwife-woman relationship [33]. This was evident in Newnham et al.'s (2017) ethnographic study on the practices surrounding consent for an epidural juxtaposed against access to water in labour [34]. Their findings highlighted how dominant medical discourse permeates childbirth classes resulting in non-evidence based information and a lack of informed consent for women choosing pain relief options in labour [34]. Childbirth classes merely reflecting hospital policies and culture are cited as barriers to antenatal education and highlight the institutional constraints of midwives and ultimately women in choosing pain relief in labour [34]. Drawing on the notion of 'birth territory' [35] Dahlen et al. (2020) found that women with a physiological birth orientation had to 'run a gauntlet' in birth territories that favoured technocratic ways of managing labour [36]. The study highlighted that proximity of the birth space to the obstetric unit also led to either a more physiological orientation or an increased likelihood of medical interventions [36]. In all settings, midwives were found to either 'buffer the gauntlet' by offering help to enable women to survive it, or resulted in reinforcement of technocratic ways to birth [36]. The present study has highlighted how care-providers 'buffer' the use of CBE; either providing a guardianship for its use or dominating in such a way that its implementation is diminished.

Finally, organisational and contextual factors were identified that created dissonance between CBE and the reality of the setting in which a woman gives birth. Organisational issues included a lack of integration of CBE in the wider maternity system, fragmented support, absence of staff training or support for CBE, and medical dominance. Contextual factors that make redundant the birth partner influence on the use of CBE, included birth partner involvement being a novel or unsupported idea, and a woman's desire to follow care-providers' instructions during birth rather than use her own coping skills. Lack of effective labour support coupled with the fact that some women demonstrate an unhesitating acceptance of the biomedical model of maternity care and hospital birth [37], produces a challenging situation with regard to the implementation of CBE. Care providers managing a multitude of competing demands such as adhering to policies, managing technology, hospital culture, staff sickness and long working hours, have previously been highlighted as having an impact on the ability for staff to provide effective labour support and promote normal birth [18,34,38].

'Systems thinking' suggests looking at the inter-relationship of the whole system and determining how its parts interact with each other, rather than the individuals within it, to find the source of problems [39]. Typically, childbirth educators work independently, signifying a lack of integration with the rest of the maternity service and the reality of the birthing room. This was reflected in this study's findings with issues of dissonance concerning CBE and hospital policy and practice. Furthermore, models of care that foster the translation of CBE skills in labour through appropriate staffing and management styles and ensure education is geared towards expectant parents' needs rather than professional needs [40], could all help to provide a more integrated approach of CBE into maternity systems.

Table 4
Potential ways to promote and encourage the use of childbirth education in labour and birth.

Birth partners	Care-providers	Organisations
Classes to include specific information on birth partner role and participation and the benefits this could offer	Maternity staff familiar with information and techniques taught in classes	Childbirth education to be more formally integrated into maternity systems with an emphasis on a systems approach including management support
Ensure CBE content is meaningful for birth partners and includes the topics of advocacy and strategies for coping if issues arise during the labour	Additional training for staff to learn evidence-based complementary therapies for labour and birth	Classes to include theory behind techniques so women and birth partners understand reasons why they can be helpful to promote use their use
CBE to include practical activities to promote the facilitation of techniques	Care-providers to ascertain woman's preferences for management of labour and how staff can support this	Careful consideration of routine practices that can disturb the use of childbirth education
Be mindful of contextual needs and if the approach to CBE suits the place and people	Acknowledgement and encouragement by staff of the important role birth partners can offer during labour	Models of care to foster the promotion of childbirth education through appropriate staffing, work demands etc.
	Reduce the theory-practice gap through closer working between childbirth educators and maternity unit staff	

4. Strengths and limitations

Meta-ethnography has increasingly been adopted in healthcare research allowing for higher order interpretation of qualitative data [41]. This meta-ethnography contains 22 papers, adding to current knowledge about how people (and settings) help or hinder a woman applying what she has learnt in CBE, to the labour and birth. Despite the extensive literature search, potential papers may still have been missed. The search was based on full-text, English publications only. Inclusion of other languages and cultural backgrounds and those not provided in full-text, could have added different perspectives. As a method to synthesise qualitative research meta-ethnographies have become increasingly popular. [25,42]. Walsh & Downe (2005) argue that it is helpful to think of meta-ethnography as a way of "opening up spaces for new insights and understandings to emerge, rather than one in which totalizing concepts are valued over richness and thickness of description" (p,205) [43]. What constitutes CBE is diverse and included studies were highly varied. The heterogeneity of CBE content is an ongoing discussion and one that makes comparison, both meta-ethnography and meta-analysis, problematic. The standardisation of childbirth classes however, would depend on a multitude of factors which are at present unknown and may not be appropriate. Interpretation of findings are further complicated when considering the additional effect that model of care, care-provider birth philosophy, cultural sensitivities and the couple's relationship factors may have on the application of CBE.

5. Recommendations

Relational aspects between the birthing couple, staff and the environment have been highlighted as important factors in safeguarding the purpose of CBE. Synthesis of the data has emphasised the need for birth partners and care providers to be *with the woman* in her quest to use the information and techniques she has learnt in preparation for the birth of her baby. Failure to do so, can mean that the groundwork and provisions a woman has put in place to assist her during labour are challenging to use, or even completely disregarded. Table 4 contains recommendations we have made based on the findings of this review.

6. Conclusion

This meta-ethnography explored how CBE is translated into practice depending on the support provided by birth partners, care providers and the birth setting. The findings question whether the philosophical underpinnings of CBE and care practices in labour differ, and consequently affect the implementation of childbirth education strategies during birth. There is a paucity of research looking at why coping strategies in labour may be initiated or discontinued by a woman, and even less looking at the influence that others in the room have on these practices. It could be argued that CBE is currently a 'tick-box' exercise that in reality is not well integrated into maternity care, resulting in incongruities between what is taught in class and the reality of being in the birth room. Childbirth education that promotes physiological birth but only focuses on changing the woman's behaviour without gaining support from birth partners, care-providers and organisational culture, is likely to fail due to inadequately addressing external stressors that impede a woman's use of such coping strategies. Until childbirth education strategies that support physiological birth are properly integrated into the wider maternity system, including through guidelines and policies that assist implementation, women and birth partners may not be able to fully utilise these coping techniques during labour, and the true value and benefits of it are likely to remain diminished.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2023.02.001.

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