

Preparing Women for Pregnancy and Parenthood: A Cross Cultural Study

B. Chalmers and D. Meyer***

* Mount Sinai Hospital, Perinatal Program, University of Toronto, Toronto, Canada

** Dept. of Statistics, University of the Witwatersrand, Johannesburg, South Africa

Abstract

Preparation for parenthood takes place formally and informally. Formal systems include instruction from clinics, doctors and childbirth preparation classes. Informal education may occur from mother to daughter, from books and through the media. How well 221 women in three cultural groups (White, Indian and Mixed origin) in South Africa are prepared for childbirth and parenthood is addressed here. Women were interviewed about their pregnancy and birth experiences at approximately three months postpartum. Findings pertaining to preparation for childbirth indicate that women of different cultures vary in their reliance on one or other source of information. Common to all, however, is a perception of poor preparation for most aspects of their experience of becoming a parent.

Zusammenfassung

Es gibt formelle und informelle Vorbereitungen auf die Elternschaft. Die formelle ist in ein System eingebettet, in welchem man diese Vorbereitung der Eltern durch Kliniken, Ärzte und Unterricht in Vorbereitungskursen durchführt. Die informelle Vorbereitung bzw. Ausbildung geschieht durch Bücher und die Medien. In unserer Studie haben wir die verschiedenen Formen und Ergebnisse der Elternschaft-Vorbereitung in drei kulturellen Gruppen (Weiße, Inder und Gemischte) in Südafrika untersucht. Die Frauen wurden durchschnittlich drei Monate nach der Geburt über ihre Schwangerschafts- und Geburtserlebnisse und -erfahrungen befragt.

Correspondence to: Dr. Beverley Chalmers, Mount Sinai Hospital, Perinatal Program, University of Toronto, Toronto, Ontario M5G 1X5, Canada

Die Resultate, betreffend die Informationsquelle, unterscheiden sich in den drei Kulturgruppen. Das gemeinsame war jedoch das Erleben einer nicht genügenden Vorbereitung, was die meisten Aspekte der Erfahrung des Elternwerdens anbelangt.

Introduction

Possibly of most importance in a system where cultures are changing is the necessity for adequate preparation of families for their transition to parenthood. As traditional birthing systems are lost following contact with Western health care systems, as is occurring amongst Indian and African cultures in South Africa, so replacements for traditional and often inappropriate preparation methods such as maternal instruction, have to be developed.

Preparation systems may be both formal and informal¹. Traditional systems tend to be more informal, although the traditional post-partum seclusion period of Indian and African women may well be classified as formal. On the other hand, Western cultures tend to emphasize the need for more formal systems of instruction such as childbirth education classes. Both are probably needed as cultures merge.

The onus to provide preparation for and education about pregnancy, birth and parenthood, is being placed primarily on nurses in South Africa and, indeed, worldwide. Added to their already considerable workload, this is probably an unreasonable demand to make, even if, on the surface, an apparently obvious line of action. It is also probable that nurses, who are not trained as educators with specialized educational skills and who may find themselves with cross cultural barriers to communication, could prove to be inadequate as childbirth educators.

Alternate sources of education about the transition to parenthood exist such as printed material and the media. To what extent these are relied on by women of differing cultural backgrounds is unknown. In addition, the value of information passed on from generation to generation varies between cultures depending, often, on the similarity between the parents' experiences of birth and those of their children².

To what extent the various sources of information available to women of different cultures are perceived by them to be useful is one concern of this investigation. Women's knowledge about pregnancy, birth and parenthood based on this information is the major focus.

Materials and Methods

Subjects

With the assistance of the Johannesburg City Health authorities, women were randomly selected from each of the city's birth registers of White (N = 72), Mixed cultural origin women (N = 70) and Indian women (N = 79) during the period September 1987 to December 1988. Women were visited at home by Pub-

lic Health Nurses and asked to take part in the project. Participation involved a lengthy interview at about the time their child was three months old.

Of the 194 White women randomly selected from the birth records by the City Health Department, 18 had moved and were untraceable, 53 refused to participate, 2 women's babies had died, 1 woman was receiving intensive psychological treatment and 4 could not be interviewed due to language incompatibility at the time of the community health sister's visit. When approached by the study interviewers later, a further 41 had moved and 1 declined to participate. Three of the final interview schedules were incomplete and were excluded from the data analyses which, therefore, were performed on the responses of 72 women.

City Health authorities randomly selected 180 women of Mixed cultural origin. Of these 24 had moved by the time of the health care worker's visit, 20 refused to participate in the study, two women's babies had died and 1 woman could not be interviewed because of language difficulties. A further 48 could not be traced at the time of the later interview and 1 refused to participate at this point. Five additional records were excluded from the data analysis as too incomplete for inclusion leaving a final sample of 70 women.

Even more difficulties in tracing subjects occurred with the sample of Indian women. City Health authorities selected 153 women from the birth registers of Indian women. At the time of the health worker's visit 30 of these had moved, 39 refused to participate in the study, 1 was experiencing psychological distress and 1 woman's baby had died.

At the time of the interviewer's visit later, 40 additional women were unable to be interviewed. Of these 4 refused to be interviewed as they were working and could not make time available, 5 declined to participate on the grounds of no interest in the study, 5 women's husbands had refused to allow them to participate, 3 lived in areas which proved to be dangerous for the interviewer to visit during evening hours and a further 21 were untraceable. Two additional women agreed to be interviewed but the interviewer was unable to complete these interviews due to the women's emotionality during the interview. A total of 42 of the original randomly selected sample were interviewed.

Additional Indian women were recruited into the sample through community post-natal clinics. Women attending the clinic whose babies were approximately two to three months old were asked to participate in the study. In all 37 women in the final sample were recruited in this manner, yielding a total sample of 79 Indian women.

It must be noted that this additional method of obtaining subjects in the Indian sample could well have incurred bias as these subjects were drawn only from clinic attenders. Nevertheless, it is not certain that those women agreeing to participate from the original randomly selected sample of birth records were not also a biased sample due to the high refusal rate occurring in this group. It is most probable that only women less bound by traditional customs of privacy surrounding birthing experiences and, particularly, family affairs, would have agreed to participate in this study.

In addition many Indian women follow traditional customs of remaining with their mother (in-law) in the months following birth and would have been ex-

cluded from the sample and recorded as “moved” by the city health visitors. This source of bias would have, in all probability, also led to the study of a less traditionally bound sample of Indian women than occurs in the general population.

Cultural Characteristics

The distinctions that can be drawn between peoples commonly termed as “Indian” in South Africa are variable. Based on religious, language and other distinctions there are groups variously termed Hindu, Moslem and Christian in terms of religion, speaking Hindustani, Tamil, Gudjerati, Urdu, Telugu and other languages^{3,4}. According to Rosenthal⁴ approximately half of the Indian population living in the area of the present study group are Moslems, a third Hindu and the remainder following other religions such as the Christian belief. The bulk of the Moslems speak Gudjerati and some Urdu. The Hindus are primarily associated with the Tamil, Hindustani and Telugu languages with a smaller proportion speaking Gudgerati. The majority of Christians are converts from the Tamil Hindu group.

Despite the apparent diversity inherent in these groupings, inter-religious and inter-linguistic marriages as well as the official medium of school instruction being English have led to a decline in traditional language usage and a mingling of customs^{3,4}.

Amongst White groups there are again distinctions that can be drawn on the basis of language (English and Afrikaans being major groupings) and religious bases (primary groups including Catholic, Protestant of various forms and Jewish).

People of Mixed racial or cultural origin may present with any combination of the above distinctions.

From an academic perspective the problem raised by this wide variety of peoples is that of generalizability. Most groups, however, practice rituals to mark or celebrate similar events occurring throughout life. Ceremonies, for example, surrounding infancy, puberty, marriage, childbirth, menopause and death – to name only the major life events – are commonly practiced in most groups and are, in fact, universal ceremonies. It is these major ceremonies with which this project is concerned. Variation in how these events are acknowledged is, however, evident.

While distinctions according to racial groups are unacceptable to the author, the reality of the differing expectations and experiences of birth amongst the various peoples of this country necessitates the use of these categories for the sake of academic comparison.

Questionnaire Development

The questionnaire explored women’s attitudes, knowledge and practices regarding conception, pregnancy, birth and the early months of parenthood. Only data pertaining to knowledge and preparation for pregnancy and parenthood are reported here.

The questionnaire was based on interview schedules used in previous research into African⁵ and Mixed cultural origin^{6,7,8} women’s birth customs. In addi-

tion items were included based on the wealth of literature available on Western birthing experiences. Customs pertaining to Indian women's birth experiences were obtained through in-depth discussions with Indian women, childbirth educators and obstetricians.

The questionnaire was pilot tested for clarity of questions and ease of administration before use.

The final questionnaire used as the basis for the structured interviews contained 334 items. These items yielded approximately 1670 data points per case. Of these items, 38 referred to biographical details, 22 to events surrounding conception, 18 to behaviour during pregnancy, 19 to birth itself, 10 to the immediate post-partum hospital stay, 17 to the time of going home after delivery, 94 to aspects of infant feeding and care, 11 to the mother-infant relationship and 9 to the marital relationship / partnership. A further 24 items explored knowledge about experiences, 28 social support during the period of transition to parenthood and 12 work related issues. An additional 32 items related specifically to Indian customs and beliefs. Copies of the questionnaire are obtainable from the author.

Few items were open ended with almost all subjects' responses falling into preset possible alternatives. Where subject's responses differed from specified categories of response these were recorded as close to verbatim as possible and later coded.

The questionnaires were in English only. The high cost of back-translation of such a lengthy questionnaire rendered translation into many other languages unfeasible. Instead, interviewers were asked to ensure that the meaning or intention of each question was clearly understood by interviewees. To overcome this difficulty, all interviewers were required to be bilingual and to translate questions if and when necessary. It was, partially, for this reason that women highly qualified in areas relating to childbirth were employed as interviewers. The method of interviewing used closely resembled that adopted by Craig and Albino⁹. Interviews took approximately one and a half to two hours to complete.

Interviewers

Two women of the same cultural group interviewed women in each of the three groups. Interviewers were trained on interviewing techniques as well as on the details of the interview schedule itself.

With the exception of one of the White interviewers who was a qualified social worker working in the field of childbirth all interviewers were registered midwives.

Reliability of Interviewers

Interviewers were asked to tape record interviews whenever possible, with women's permission. Almost all women in the Indian and the Mixed cultural origin groups, and many White women, however, while willing to be interviewed did not want the interview to be recorded. The 17 interviews (16 White and 1 Indian) that were recorded were checked by an independent, post-graduate social science student, for errors of transcribing women's statements onto the interview

schedule. Only 10 errors in the transcribing of the 28390 data points involved in these 17 questionnaires were detected in this manner. It appears that the reliability of the two White interviewers in recording data correctly is satisfactory. It was unfortunately not possible to obtain a similar assessment of the Indian and Mixed origin groups' interviewer reliability.

Ethical Approval

The study was approved by the Committee for Research on Human Subjects of the University of the Witwatersrand.

Permission was obtained from City Health authorities for access to birth registers and for recruiting Indian subjects through post-partum clinics.

Statistical Analyses

Most data recorded was categorical in nature: very few items yielded continuous data. All information was, in the first instance, analyzed in terms of measures of central tendency and has been reported as percentages or as means. Percentages in Tables do not always total 100 % as not all response categories given by mothers to questions have been reported here: those with few respondents have usually been omitted for ease of presentation. Categories with few respondents were, however, included in all statistical analyses. Missing data on items may also account for some of the discrepancies in totals presented in Tables. Percentages have been reported on the basis of a total sample of 221 women of whom 72 were White, 70 were of Mixed cultural origin and 79 were Indian.

Cross cultural comparisons of frequencies were obtained by means of the Likelihood Ratio Chi Square test. All p values reported in the text refer to the outcome of this statistical procedure. Because of the complexity of the data set, and for simplicity of presentation, N has not been reported for each chi square analysis. This was not deemed essential to the interpretation of p values as N is subsumed in the calculation of chi square.

When many associations are studied there is an increased likelihood of Type 1 error. Whether or not one corrects statistically for the effect of multiple comparisons is debatable¹⁰. The analyses presented here have not adjusted for multiple tests of comparison. The obvious multiple cultural differences evident in the sample to begin with render differences between groups a logical outcome. Statistically significant differences between groups are therefore, to be expected: of more interest are the comparisons which, in fact, yield evidence of no difference between groups despite the social, economic, educational, religious and cultural differences in the samples.

Results

Findings pertaining to women's knowledge and their sources of information are discussed with reference to (a) Conception, (b) Pregnancy, (c) Birth and (d) Parenthood.

(a) Knowledge about Conception

As can be seen from Table 1 women's knowledge about conception was lacking. Some Mixed cultural origin as well as Indian women reported conception as taking place during a menstrual bleed. Between a quarter and one third of all women also reported pregnancy as occurring at any time in the menstrual cycle other than during menstruation. Many Indian and Mixed cultural origin women, in particular, admitted not actually knowing when conception occurs. Only between a third and a little over a half of the women in the three groups actually knew when conception was possible.

Most women in all groups were aware that babies result from intercourse (81.3%) and that the conceptus resembles a collection of cells that gradually develop into the baby (80.2%). Some women (9.2%) in all groups, however, believed that the fetus begins in the shape of a baby which simply enlarges as the pregnancy progresses.

Table 1. Knowledge about conception (%).

	Total	White	Mixed	Indian	P
<u>Signs of conception:</u>					
Cessation of menstruation	66.2	63.9	72.9	62.2	.04
Nausea	38.5	40.3	34.3	40.8	NS
Breasts enlarged/sore	22.9	30.6	12.9	25.0	.03
Medical confirmation	34.1	32.4	41.4	29.0	NS
Enlarged abdomen	12.4	8.5	11.4	17.1	NS
Tiredness	13.4	12.7	7.1	19.7	NS
<u>Timing of confirmation of pregnancy:</u>					
1 - 3 weeks	12.1	6.1	2.3	3.7	
By 6 weeks	43.1	15.9	8.0	18.2	
By 8 weeks	17.3	6.3	8.8	1.9	.0001
By 12 weeks	14.5	3.3	7.9	3.3	
Later than 12 weeks	14.0	1.4	4.7	8.0	
<u>When conception occurs:</u>					
While bleeding	4.6	0	8.7	5.4	
Anytime not bleeding	25.6	31.9	34.8	10.8	
Around mid cycle	43.8	55.6	31.8	43.3	.0001
Don't know/not sure	19.5	8.3	24.6	25.7	
<u>Intercourse causes conception</u>	81.3	84.5	81.2	78.4	
<u>Fetus is:</u>					
A collection of cells	80.2	84.5	80.0	76.3	NS
A small child that enlarges	9.2	9.9	11.4	6.6	NS

Most women did not learn about conception from their mothers or other close family members (Table 2). Although the percentage of women in this category was small, more Indian women reported learning about how babies are made from their grandmothers or from a traditional teacher than women of other cultural groups. Some Indian and some women of Mixed cultural origin learned about conception from clinic sisters or a doctor. Almost half the women in all groups received their information about conception from other sources which may have included magazines, books, friends or school.

Table 2. Sources of knowledge about conception (%).

Source	Total	White	Mixed	Indian	P
Mother	27.5	37.5	28.6	17.1	
Grandmother	7.8	4.2	5.7	13.2	
Traditional healer	6.4	5.6	2.9	10.5	.0001
Doctor/clinic sister	10.1	0	20.0	10.5	
Father	0.9	2.8	0	0	
Sibling	0.9	2.8	0	0	
Other (friends, books, school magazines)	45.9	47.2	42.9	47.4	

(b) About Pregnancy

Major sources of information during pregnancy are clinics and doctors. White, and to a lesser extent, Indian women receive more information about pregnancy from their doctors than from the clinics (Table 3). Nurses, hospitals, ante-natal teachers and books are also major sources of information on pregnancy and birth for all groups of women. Women's mothers, other family members, and friends are less valuable as sources of information. Husband's, too, are not very helpful in this regard (Table 3).

Private ante-natal classes provide a further source of information about pregnancy, particularly for White and Indian women who attend them. Fewer women of Mixed cultural origin have access to ante-natal classes (Table 3). Of the women who attend ante-natal classes, most receive preparation for parenthood classes (77.5%) while some participate in exercise classes (20.2%).

The value of ante-natal classes as a source of information is, however, open to question. In most instances fewer than a third of the women who attended classes felt that they had learned enough from them about various issues of importance in pregnancy (Table 4). While information may not be gained from classes, women do report feeling reassured, special and satisfied when attending

Table 3. Sources of information about pregnancy (% rated as excellent).

Source	Total	White	Mixed	Indian	P
Doctors	34.4	34.7	33.8	34.7	NS
Nurses	26.2	22.1	26.5	29.7	.003
Ante-natal teachers	24.8	28.2	21.2	24.6	.006
Clinics	24.4	19.1	26.8	25.4	.001
Books	23.2	29.6	16.7	22.2	.0001
Hospitals	20.3	20.6	26.9	13.9	.0001
Mother	18.4	13.9	22.1	19.4	.04
Magazines	14.3	9.9	15.3	17.8	.0001
Friends	12.1	10.0	12.1	14.1	NS
Other relatives	8.3	5.8	7.7	11.3	NS
Husband	7.3	5.6	4.7	11.1	.0001
Grandmother	2.5	1.5	1.6	4.3	.05

Table 4. Topics covered adequately in ante-natal classes (%).

Topic	Total	White	Mixed	Indian	P
Process of birth	26.4	40.3	9.0	30.5	.0001
Development of baby	23.8	35.8	7.5	28.8	.0001
Physical changes in birth	21.9	34.3	6.0	26.4	.0001
Hospital stay	21.2	29.9	4.5	30.5	.0001
Practical aspects of breast feeding	21.2	28.4	7.5	28.8	.0001
Practical aspects of baby care	20.3	25.4	7.5	29.3	.0001
Emotional changes	19.7	26.9	6.0	27.1	.0001
Physical well being post-natally	18.7	29.9	4.5	22.0	.0001
Husband's role	17.6	31.3	4.5	17.0	.0001
Services available eg clinics	16.6	25.9	7.5	17.0	.0001
Practical aspects of bottle feeding	16.1	17.9	6.0	25.4	.0001
Parenthood	15.5	20.9	6.0	20.3	.0001
Emotional reactions in weeks after birth	15.0	22.4	4.5	18.6	.0001
Husband's role after birth	14.5	26.9	3.0	13.6	.0001
Family planning	14.5	14.9	7.5	22.0	.0001
Sex during and after pregnancy	13.0	22.4	4.5	11.9	.0001
Work and motherhood	10.9	11.9	7.5	13.8	.0001
Coping with family/friends	10.9	16.4	7.5	8.5	.0001
Coping with doctors/nurses	9.8	17.9	4.5	6.8	.0001
Coping with older children	7.4	7.9	4.5	10.2	.0001

Table 5. Reactions to ante-natal classes (%).

Reactions	Total	White	Mixed	Indian	P
Satisfied	97.7	96.3	97.5	100.0	NS
Felt special	86.7	83.3	93.8	75.0	NS
Reassured	85.3	100.0	80.6	75.0	.0001
Degraded	85.0	0	87.5	90.9	NS
Depersonalised	54.6	0	66.7	50.0	NS

classes (Table 5). Nevertheless, while White women do not report negative feelings in response to classes both Indian and women of Mixed cultural origin do often report feeling degraded and depersonalized.

Women's ratings of the value of ante-natal classes as a whole reflect their mixed feelings with few women of any group rating exercise classes highly and about a half to two-thirds of women rating preparation for parenthood classes well (Table 6).

Table 6. Ratings of ante-natal classes as valuable (%).

Type of class	Total	White	Mixed	Indian	P
Exercise	14.3	23.6	1.5	37.6	.002
Preparation for parenthood	56.4	44.4	50.0	68.4	NS

On average, about a third of all women report their preparation for pregnancy as derived from all these sources as excellent (34.6 %). Differences between the cultural groups regarding perceived adequacy of their preparation for pregnancy occurred with White women being most satisfied (44.4 %), Mixed origin women being the least happy (20.6 %) and Indian women falling between the two (38 %) ($\chi^2 = 37.5$ (10); $p < 0.0001$).

(c) Knowledge About Birth

Clinics appear to be the major source of information about birth for women of Mixed cultural origin while White women are given this information primarily by their doctors (Table 7).

Most women do not report being well prepared for birth (Table 8) with women of Mixed cultural origin reporting being least prepared for all three stages of delivery and the period of stay in hospital and White women being best prepared.

Women's perceptions of their lack of preparation for birth are supported by the apparent lack of knowledge about some aspects of birth. For example, a num-

Table 7. Sources of knowledge about birth (%).

Source	Total	White	Mixed	Indian	P
Clinic	43.8	27.8	64.3	40.8	.0001
Doctors	36.8	51.4	24.6	34.3	.0001

Table 8. Preparation for birth (% rating as excellent).

Preparation for:	Total	White	Mixed	Indian	P
Labour	22.9	38.0	14.5	16.2	.0001
Delivery of baby	23.3	32.4	13.0	24.0	.05
Delivery of placenta	24.3	31.9	12.5	27.0	.002
Hospital stay	25.2	34.7	16.2	24.3	NS

Table 9. Knowledge about birth interventions.

Not knowing about	Total	White	Mixed	Indian	P
Caesarean section	14.6	0	22.4	21.6	
Induction	26.3	0	53.7	27.0	
Forceps	23.5	1.0	16.4	6.1	
Vacuum extractions	64.3	39.4	89.7	64.9	
Episiotomy	25.8	5.6	39.7	32.9	

ber of women, and in particular Indian and Mixed cultural origin women, did not know what some of the commonly used medical interventions in birth were (Table 9). In general knowledge levels were poorest amongst women of Mixed cultural origin.

(d) Knowledge About Parenthood

As can be expected, women received more information from clinics than from doctors regarding becoming a mother (Table 10). Very few women regard their preparation for their first month of parenthood as excellent. In general, practical aspects of baby care give mothers fewer problems than emotional issues (Table 10).

Women received more information about marriage, parenthood and family planning before marriage than after (Table 11).

Table 10. Sources of information about and ratings of preparation for parenthood (%).

	Total	White	Mixed	Indian	P
<u>Source of information:</u>					
Clinic	37.0	20.0	57.1	34.2	.0001
Doctors	16.0	12.9	18.8	16.4	.0001
<u>Rating of preparation for parenthood tasks:</u>					
Preparation for 1st month	28.2	26.8	22.1	35.2	.04
Changing diapers	68.4	88.6	53.9	62.2	.0001
Day feeds	64.8	87.1	52.4	52.4	.0001
Night feeds	61.2	78.6	55.6	47.6	.003
Financial issues	61.2	83.8	27.9	68.1	.0001
Coping with family	54.5	63.9	34.0	61.5	.002
Pacifying baby	48.8	60.0	46.0	40.5	.006
Coping with own feelings	41.6	48.5	28.3	46.0	.001
Housekeeping	38.8	44.9	21.4	48.5	.02

Table 11. Information on marriage received before and after marriage (%).

Topic		Total	White	Mixed	Indian	P
Marriage	before	42.1	25.8	37.1	61.8	
	after	26.8	13.0	34.8	32.0	
Family planning	before	39.8	25.7	40.0	52.6	
	after	37.1	17.4	50.7	42.7	
Parenthood	before	31.5	14.3	38.6	40.8	
	after	28.6	18.8	37.7	29.3	

Table 12. Ratings of information on marriage as excellent (%).

Topic		Total	White	Mixed	Indian	P
Marriage	before	30.3	7.7	32.0	41.7	
	after	18.3	6.3	18.5	25.0	
Family planning	before	31.2	12.5	40.7	35.7	
	after	33.3	5.6	47.2	33.3	
Parenthood	before	27.6	0	39.3	29.4	
	after	28.8	5.3	39.1	32.5	

Table 12 indicates that information about marriage given after marriage is less valuable than knowledge gained before. Information about family planning and about parenthood is valued whenever it is given by both Indian and Mixed cultural origin women. White women, however, value information given about family planning before marriage and information given about parenthood after marriage.

The major source of information about marriage, family planning and parenthood, both before and after marriage, for all women was the women's friends (Table 13). Of most concern, however, is the high number of women reporting not having received any information at all.

Discussion

Differences emerged between cultural groups regarding the extent of reliance on traditional sources for information about conception, pregnancy, birth and parenthood with Indian women relying on family sources more often than other women. Primary sources for all women, however, were health care professionals either in private practice or in hospital or clinic employment. Women of Mixed cultural origin are particularly dependent on state hospital health care resources for information.

Of more importance is the frequent indication that whatever preparation is being given is not always adequate. The lack of clear understanding of conception in many women of all cultures; the lack of knowledge about some fairly common birth interventions, particularly amongst Indian women and those of Mixed cultural origin; the lack of apparent preparation for the emotional aspects of new parenthood in all women and the perceived absence of much preparation for marriage, family planning and sexuality amongst all women bears testimony to the inadequacy of the current preparation programmes. In fact, a large number of all women report receiving no formal preparation for marriage, contraception or sexual behaviour at all and rely mostly on friends for advice and information on these issues. Given the serious nature of the issues involved it is apparent that much improvement is needed in the provision of formal training for the transition to parenthood.

Whether or not the current health care professionals can provide the educational programmes needed to help prepare couples for parenthood is debatable. Both the nursing and medical professionals view themselves as extended. In addition neither are fully trained as educators and most are not necessarily trained in the cross cultural expectations of the various peoples they serve. Both are often limited in terms of the time and place available to them for patient interaction to the health care consultation time and venue: neither are free to spend much time either in the home or with additional family members. Although a logical solution to the inadequate preparation problem would be to demand of the medical and nursing professions that they assume the teaching mantle – and probably the counselling mantle as well – this is unlikely to successfully resolve the problem in reality.

Table 13. Sources on information before / after marriage (%).

Sources	Total	White	Mixed	Indian	P
<u>Before</u>					
<u>About marriage:</u>					
No information	53.6	63.8	63.2	35.1	
Friends	27.0	20.3	17.7	41.9	
Mothers	11.9	7.3	16.2	12.2	.004
Husband	1.0	1.5	0	1.4	
Doctor/Nurse	1.0	0	1.5	1.4	
<u>About family planning:</u>					
No information	56.4	66.7	58.8	44.6	
Friends	26.5	18.8	22.1	37.8	
Mothers	4.7	4.4	8.6	1.4	NS
Husband	1.0	1.5	0	1.4	
Doctor/Nurse	7.6	5.9	8.8	8.1	
<u>About parenthood:</u>					
No information	66.7	83.8	60.3	56.8	
Friends	16.7	10.3	8.8	29.7	
Mothers	12.4	4.4	26.5	6.8	.0001
Husband	0.5	0	0	1.4	
Doctor/Nurse	1.5	0	3.0	1.4	
<u>After</u>					
<u>About marriage:</u>					
No information	67.3	76.9	61.8	64.0	
Friends	14.9	15.4	8.8	20.0	
Mothers	12.0	1.5	25.0	9.3	.005
Husband	2.4	1.5	1.5	4.0	
Doctor/Nurse	1.0	1.5	1.5	0	
<u>About family planning:</u>					
No information	59.3	76.1	45.6	56.8	
Friends	20.1	13.4	23.5	23.2	
Mothers	2.9	0	7.4	1.4	NS
Husband	1.9	1.5	1.5	2.7	
Doctor/Nurse	11.0	7.5	17.6	10.9	
<u>About parenthood:</u>					
No information	66.7	75.0	57.4	67.6	
Friends	17.6	20.6	10.3	21.6	
Mothers	11.0	0	25.0	8.1	.0001
Husband	1.0	1.5	1.5	0	
Doctor/Nurse	1.5	1.5	3.0	0	

In addition, preparation for birth and parenthood needs to be sensitive to cultural diversities. In an increasingly multicultural world the importance of learning about the needs of culturally diverse women, and incorporating such knowledge into preparation programs, cannot be underestimated. Care needs to be taken not to impose the values for pregnancy, birth and parenthood practices from one culture upon those of other backgrounds. Instead avenues of inter-

change need to be created for the dissemination of a variety of approaches to the birth-parenthood experience with a view to seeking a meeting ground when such practices appear distinctly dissimilar. While it is apparent from the findings of the present study that there are differences in the frequency of exposure to preparation amongst women of differing cultures, it is also apparent that whatever preparation is given needs to be more closely tailored to the needs of each cultural group.

The task of education for pregnancy and parenthood needs to begin long before conception. It is needed from the earliest years in a simple form which is then developed and expanded on in concordance with biological and intellectual growth. To achieve this education programmes need to be introduced into the formal school curriculum and appropriate educators prepared for this task¹¹ neither of which yet occur in Southern Africa.

The emergence of AIDS as a growing problem of considerable potential proportion in Africa, as well as in other parts of the world, and the consequent urgency to provide sexual education to pre and post pubertal children as the major effective preventative technique for the long term spread of the disease makes the appointment of well trained educators in reproductive health a matter of priority. Sadly, this need is not well recognised, in Southern Africa or, indeed, almost worldwide, as yet.

Acknowledgements. The financial assistance of the Institute for Research Development of the Human Sciences Research Council towards this research is hereby acknowledged. Opinions expressed in this publication and conclusions arrived at are those of the author and do not necessarily represent the views of the Institute for Research Development or the Human Sciences Research Council.

The assistance and co-operation of the Johannesburg City Health Department, Johannesburg Hospital, Baragwanath Hospital, Groothoek Hospital, Coronation Hospital, Lenmed Clinic, Morningside Clinic, Dr S Valabh, Dr J McIntyre and Prof G J Hofmeyr, Sr K Hansen and Ms B Opperman in obtaining subjects for this study is gratefully acknowledged. So too is the assistance of Sisters S Oboler, F Malatji, F Judgbhay, A August, N Goolab, M Brown and Ms M Shulman for conducting the interviews.

The computational assistance of Mr M Malele and Ms S J Van Rensburg is gratefully acknowledged.

References

1. Jordan, B. (1983). *Birth in Four Cultures*. Montreal, Eden Press
2. Chalmers, B. (1990). *African Birth: Childbirth in Cultural Transition*. Sandton, Berev Publications
3. Kuppasami, C. (1985). *Religions, Practices and Customs of South African Indians*. Natal, Sunray Publications
4. Rosenthal, L.N. (1976). *Marriage, the Family and Social Change among the Guderati speaking Indians of Johannesburg*. Johannesburg: Unpublished Doctoral Dissertation
5. Chalmers, B. (1987). Black women's birth experiences: Changing traditions. *J. Psychosom. Obstet. Gynaecol.* **6**, 211-224
6. Brindley, M. (1976). *Western Coloured Township*. Johannesburg, Ravan Press
7. Chalmers, B. Ransom, O.J. and Herman, A. (1990). Working while breast feeding in Coloured women. *Psych. Rep.* **67**, 1123-1128

8. Ransom, O.J. Chalmers, B. Herman, A. and Reinach, G. (1988). Infant feeding in a Coloured community. *SAMJ* **74**, 393–395
9. Craig, A.P. and Albino, R.C. (1983). Urban Zulu mothers' views on the health and health care of their infants. *SAMJ* **63**, 571–572
10. Bracken, M.B. (1989). Reporting obstetrical studies. *Br. J. Obstet. Gynaecol.* **96**, 383–388
11. Chalmers, B. and Hofmeyr, G.J. (1989). The gestation of a childbirth education diploma. *J. Psychosom. Obstet. Gynaecol.* **10**, 179–187