Antenatal Education as Perceived by Health Professionals

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ABSTRACT

This article aims to identify the learning needs of expectant and new parents for antenatal education as perceived by health professionals. In Australia, antenatal education programs are predominantly designed by health professionals, and recent research has challenged the efficacy of this approach. The data collected from 73 health professionals, reported here, demonstrates that their perceptions of the concerns and interests of expectant and new parents were divided into three interrelated categories: “need to know. . .what’s happening,” “they won’t listen,” and “balanced information.” The health professional ideas for improving antenatal education were limited and identified a reluctance to change practice.

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Antenatal education is an important component of antenatal care in Australia; however, hospital programs are predominantly restricted to classes that women and their partners attend during the final weeks of pregnancy. Few antenatal educators regard the childbearing year as a time of learning (Humann, Handfield, & Svensson, 2001), or indeed if they do, they do not have the resources to provide programs at other times. They rely on the care provider to meet a woman’s learning needs prior to the third trimester, a situation fraught with difficulties because care providers rarely have the time required to meet the woman’s learning needs. Thus, expectant women are caught in the middle.

A few studies have been undertaken to compare the interests of clients and their health-care pro-

viders. For example, Freda, Andersen, Damus, and Merkatz (1993) interviewed two groups of clients during their first antenatal visit and one group of health-care providers. The researchers found that significant differences existed between the clients’ interests and the providers’ perceptions of their clients’ interests. An older study by Levenson, Smith, and Morrow (1986), which compared physician-patient views of the information required by pregnant teenagers, found that significant differences existed between the two groups in the topics considered to be important. Smedley (1999) found discrepancy in the relative importance of topics as reported by couples attending Childbirth Education Association sessions in Sydney, Australia, and by the educators. Pinkosky (1997) found that providers

underestimate their clients' desire for information. From the literature, it would seem that, in many situations, the needs and/or interests of the clients appear to have been subsumed by the health-care providers' perceptions of their clients' needs and interests (e.g., see Maestas, 2003; Sullivan, 1993).

The aim of this study was to describe the interests and concerns of expectant and new parents as perceived by health professionals and to determine processes by which the health professionals thought needs could be met. The data gained from the expectant and new parents is reported elsewhere (Svensson, Barclay, & Cooke, 2006).

METHODS

A multiple-source, multiple-methods needs assessment was used to collect the data. The multiple sources were first-time expectant and new parents, primary maternity-care providers of the parents, and antenatal education program documentation from the hospitals the women attended. Data collection methods were repeated in-depth interviews, focus groups, participant observation, surveys, and a review of program documentation. Only data from care providers are described in this article. Details of data collection methods are presented elsewhere (Svensson, 2005).

Ethics approval was obtained from hospital and university ethics committees prior to commencement of the research. Informed written consent was obtained from all participants.

Sample and Recruitment

Health professionals who cared for, or had contact with, expectant and new parents attending two hospitals were informed of the study through in-service education programs. They were invited to participate in 1 of 7 focus groups. The samples and professional backgrounds are listed in the Table.

Data were also collected from a random sample of 20 experienced antenatal educators who were external to the two hospitals and drawn from a list of parent education coordinators obtained from the New South Wales Parent Educators Network and the National Association of Childbirth Educators. The sample included educators from New South Wales, Victoria, South Australia, and Queensland.

Setting

Two large, metropolitan referral hospitals in Sydney were the basis for the majority of the sample selected for the current study. The departments, services, annual birth rate, and antenatal education programs of hospitals were similar.

Data Collection

A total of 53 midwives, nurses, and educators participated in 7 focus groups. The focus groups were conducted at a time and place accessible to each group and lasted for approximately 1.5 hours each. The questioning route required identifying frequent questions and comments made by expectant and new parents to the health professionals in their practice. The professionals were asked to describe apparent anxieties and concerns of parents and how they thought opportunities for learning and support could be provided.

The survey administered to a random sample of 20 experienced educators asked questions similar to those used in the focus groups. For example, "How do you think parenting and baby-care issues should be provided to expectant couples during the child-bearing year?" Open-ended questions were used to encourage an expression of the health professionals' own ideas.

Data Analysis

The researcher transcribed all audiotapes from the focus groups verbatim. The text was examined for

For detailed information about the data collection methods, see Svensson, Barclay, and Cooke's article, "The Concerns and Interests of Expectant and New Parents: Assessing Learning Needs," published in *The Journal of Perinatal Education* (2006), Vol. 15, No. 4, (pp. 18–27).

TABLE
The Health Professionals: Data Collection Methods and Samples

Data Collection Method	Sample	Number and % of Total Population
Focus Groups	Antenatal educators at Hospital #1	7 (70%)
	Antenatal educators at Hospital #2	7 (75%)
	Antenatal clinic midwives	6 (90%)
	Birth center midwives	7 (90%)
	Birth suite midwives	7 (60%)
	Postnatal midwives	7 (60%)
	Child and family health nurses	12 (80%)
	Antenatal educators outside participating hospitals	20
Surveys		
Total Number of Participants		73

M Content analysis is a qualitative analysis technique used to classify words in a text into a few categories chosen because of their theoretical importance.

recurring themes, with significant words and phrases highlighted. The highlighted words and phrases were then examined more closely for related patterns and the development of subthemes. The themes and subthemes were allocated a code, and combinations of codes were retrieved and cross-linked. Content analysis was also used on survey data.

RESULTS

The actual words used by participants have been retained and identified here in italics. Parentheses that enclose a pseudonym follow longer comments and questions. Codes are used to identify data collection method: focus group (FG) and survey (S). Codes are also used to identify the source: educator (Ed), midwife (MW), and child and family health nurse (CFHN).

Concerns and Interests of Expectant and New Parents as Perceived by the Health Professionals

The concerns and interests of expectant and new parents as perceived by the health professionals were divided into three interrelated categories: 1) *need to know*. . .*what's happening*; 2) *they won't listen*; and 3) *balanced information*.

***Need to know*. . .*what's happening*.** The health professionals recognized that expectant and new parents were interested in knowing *the milestones in pregnancy and after birth*, and they were *happy to go through them with the women*. As Jill (MW) said, "Every visit, she comes along with a printout from the Web and wants to check that the milestones listed are actually right." It appeared, however, that focused training, specialization, and delineation of clinical practice limited the health professionals' range of knowledge of parental concerns at different stages of pregnancy and, subsequently, their ability to discuss those concerns. For example, antenatal-clinic midwives felt comfortable addressing questions about *what's happening* in pregnancy; delivery-suite staff could easily address labor issues; postnatal midwives were able to discuss the immediate postnatal period; and child and family health nurses were confident about topics concerning the mother and the growth and development of the baby. The majority in each group described that they felt *uncomfortable* when they were asked questions related to another area of expertise. It took them out of their *comfort zone*.

Participants perceived that expectant and new parents had an interest in knowing *what happens*

in relation to practice issues so they could make informed decisions. However, probing revealed that the *practice issues* the health professionals believed were important during the childbearing year differed from those described by parents to the researcher. Indeed, the health professionals' comments indicated that they placed an emphasis on policy and procedure of the service or the institution. They believed the parents needed to know *when to come to hospital, what they can eat and drink in labor, that they will have a catheter if they have an epidural, that the midwife will not be with them throughout labor, and that they should ring the hospital before they come in*. There appeared to be two reasons for the health professionals' perception of the parents' *need to know*. One reason was to provide guidelines and direction to women and their partners, and the second, covert reason was to help the staff meet institutional requirements.

***They won't listen*.** An overwhelming belief existed among the health professionals that expectant and new parents *really need to know about how to care for their baby*, but *they won't listen* during pregnancy. For example, *they won't listen to anything about the baby* (MW, FG), *about what it's really like to be a mum and a dad* (Ed, FG), or *about breastfeeding* (CFHN, FG). The reason proposed was that *they are too focused on the birth*. Again, the health professionals' perceptions contrasted strongly with information derived from expectant parents (Svensson et al., 2006).

Within and between groups of health professionals, an underlying impression existed that pregnant women had *tunnel vision* and were *incapable of thinking beyond the birth* (MW, FG). However, this viewpoint was challenged by the women interviewed in another study, in which they felt some *midwives and doctors* appeared to *separate the uterus, developing baby, and the breasts from the body of an employed, confident woman with a personal life and cared for the physical body not the whole person* (Svensson et al., 2006).

Further questioning by the researcher about the notion that *they won't listen* revealed the argument posed by the health professionals lacked justification.

The *practice issues* the health professionals believed were important during the childbearing year differed from those described by parents.

For example, the antenatal educators said they had women and men in recent programs who did ask questions about topics such as breastfeeding, settling techniques, controlled crying, and developing a routine for their baby. However, the educators hastened to add:

Well, maybe they are interested, but we don't have time to discuss them in detail. . . by the time we get through labor. (Emma: Ed).

Two of the seven sessions are now on life after the birth. Maybe we should do three, but it would be hard to fit it all in. They need to know all of the birth stuff. (Judy: Ed)

The *time issue*, as it became known, was of importance to the antenatal educators because they felt they were not *doing [their] job* if they did not cover all of the labor and birth information. Similarly, the antenatal-clinic midwives felt they were not doing their job if they did not *conduct a thorough physical examination* during an antenatal visit. However, lack of time appeared to provide another excuse for not changing their practice.

Indeed, through probing, it became apparent by the language and gestures used that each group of health professionals was in a position of authority, because they knew what expectant and new parents needed from their practice and, as such, their practice did not need to change. Participant observation of programs during the childbearing year reinforced that there was an apparent unwillingness to change and broaden the focus of the information they currently provided.

Balanced information. The health professionals' rhetoric portrayed a commitment to providing women and men with *balanced information so they can make decisions*. However, inconsistency existed between their commitment and what they told women. For example, when asked how they addressed infant feeding and circumcision—two topics on which their state government had policies—they said they followed their state's policy. The researcher challenged the health professionals by pointing out that, in following policy, they were contradicting their earlier comment, because policy limits the options available to expectant and new parents, and so the professional is not giving balanced information. The participants' response was *but policy is policy—after all, it is best for the couple* (MW).

Personal bias was also evident in the practice of some of the health professionals. For example, midwives had a tendency to say,

Well, we all know midwifery-based care is the best. I tell women that it is better to go through the midwives clinic rather than the doctors. (Suzanne: MW)

The Health Professionals' Ideas for Improving Antenatal Education

One of the most significant findings was discovered when the health professionals revisited current programs and structure after being asked for their recommendations for providing effective antenatal education. No one was able to come up with suggestions for innovation or improvement. Although they said current programs were *most appropriate for couples*, the underlying reluctance and apprehension to change from a structure that was familiar became evident again. For example, the following statements reflect the reluctance to change:

I can't think of how else to do it, . . . the 7-week program is the best. (Ed)

I'm really reluctant to move from a structure I know. What we are doing is OK. (Ed)

Three themes were identified from the health professionals' antenatal education recommendations: *maybe we could*, *networking is important*, and *getting them involved*.

Maybe we could. To encourage creativity and new thinking within focus groups, the researcher asked participants the following question: "If you had unlimited resources, how would you provide expectant and new parents with the information and skills they require during the childbearing year?" The participants' responses—which appeared tentative, because each group preceded their recommendations with a phrase such as *well, maybe we could*—are listed below.

- **Pregnancy, birth, and beyond sessions in schools.** "Well, I think we really need to educate children because they're not exposed to pregnancy as they were years ago. They don't see their mums breastfeeding. I think we need to get in well before they become pregnant." (Sue: Ed, FG)
- **Television health updates.** "During peak viewing times, you could have a quick health update on

pregnancy, birth, feeding, or any of the related issues. It only needs a minute or two.” (Emma: MW, FG)

- **Preconception workshops.** “We could cover many topics, such as how to maximize your chance of becoming pregnant, environmental factors, diet, tests...the list goes on.” (Anne: Ed, FG)
- **Basic pregnancy package to be distributed by general practitioners.** “Some GPs give women the New South Wales health booklets. Others just say, ‘Well, the test is positive.’ It is no wonder couples head straight to the bookshop.” (Judith: MW, FG)
- **Early pregnancy programs.** “I know we have tried them, and we could not get the numbers. . . . If only GPs told women about them. There is so much they need to know about diet, alcohol, caffeine, exercise, and antenatal tests.” (Jane: Ed, FG)
- **Coffee mornings for pregnant women.** “Like an ABA [Australian Breastfeeding Association] meeting, so women can just chat.” (Carol: Ed FG)
- **A 7-week program in the third trimester of pregnancy.** “I know it is what we already have, but it seems the best.” (Kylie: Ed FG)

The difficulty participants had in *think[ing] outside the box*, beyond programs that were already available, was in stark contrast to the wide variety of suggestions for programs and strategies provided by the expectant and new parents, which are presented elsewhere (Svensson, Barclay, & Cooke, in press).

Networking is important. Although the antenatal educators and child and family health nurses recognized that *pregnant women, mums, and dads need a support network*, the other health professionals gave the idea minimal consideration. The *time issue* appeared problematic again, because the health professionals reported they “*simply do not have the time to think about anything except what is required [physical care] during the visit*” (Sarah: MW).

The antenatal educators said it was *imperative that the hospital provide a 6- or 7-week antenatal program* so women and their partners could *form friendships, . . . form a network*. Some recognized that, with many women employed and a reduction in the size of family networks, developing a support network before the birth was important for women and their partners. Liz’s (Ed, FG) comment typified

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those of the other educators: “*Couples need a 6- or 7-week program like we have. . . . They need the support.*” The comment agrees with the expectant and new parents’ perceptions, in which they viewed the support and relationship-building with other parents as important factors in antenatal education.

Getting them involved. The educators displayed a commitment to have both women and men *involved in their learning*. Their view of getting the parents involved was to *have an agenda-setting exercise at the beginning of each program, have frequent small-group discussions in the program, and use the games we have learned in workshops*.

The learning activities the health professionals believed expectant and new parents preferred were predominantly practices they themselves had learned from childbirth education books or training. Card activities—frequently called “games”—and videos were their favored strategies. The explanations they provided were that card activities *involve the group and encourage decision-making by couples* (Margaret: Ed, FG). Videos *show the couples what can happen, and they give a sense of reality*. As far as birth videos were concerned, *they need to be seen so they understand what may happen. . . . then they can discuss what they would do* (Anne: Ed).

When questioned further on their opinions, the health professionals’ responses revealed two important issues. First, it appeared that the educators believed that card games, which required the women and men to sort cards into a correct sequence, were problem-solving activities. When the researcher highlighted their incorrect perception, the educators responded *well, the group may not know the answer so we should give them some prompts*. Second, in relation to the videos, the health professionals all seemed to think couples should see the videos; however, they accepted the researcher’s comment that some groups and participants might think otherwise. Once again, the health professionals believed they knew what the expectant parents needed and, being in a position of power, they were reluctant to change their practice.

Only one of the educators had incorporated innovative strategies into her practice in relation to

baby care and parenting activities. Indeed, including a postnatal couple in a class—one of the recommended strategies—had been and remained contentious. The following comments demonstrate the opposing views of the educators:

Learning from peers is a great idea, but who would decide who should attend...? Maybe it should be more than one couple? (Judy: Ed, FG)

The [postnatal] couple could offload all their bad experiences and feelings. It could be a nightmare. (Annette: Ed, FG)

I'm not mad on the idea of new parents attending a class. I find it hard enough to get through the hundreds of topics we already need as it is. The idea may be a good one, but I don't think it will achieve much in practice. (Gail: Ed, FG)

Asking a couple with their baby to a class would be great, as they [the participants] could learn from their experience. (Kim: Ed, FG).

As far as the midwives and child and family health nurses were concerned, *getting them involved* translated into “*I recommend that they all go to antenatal classes, as that is where they can learn all they have to*” (Michelle: MW, FG). Although this recommendation appeared to be an appropriate action, with the hospitals only providing antenatal education programs in the final weeks of pregnancy and with the limited time allocated for antenatal clinic consultations, it meant that a significant gap existed in the antenatal education accessible to women and men during the childbearing year.

DISCUSSION

The aim of this article is to present the learning needs of expectant and new parents as perceived by health professionals. In doing so, several significant findings require further exploration: the reluctance of the health professionals to change their practice, the apparent control they maintain over expectant and new parents learning under their care, and the lack of coordination between services.

Although lack of time was the explanation given for a reluctance to change their practice, the health professionals' training, specialization, and delineation of clinical practice appeared to be more significant reasons for their reluctance. Each group had their distinct *comfort zone*, which, for the midwives and child and family health nurses, corresponded to a gestational stage of the childbearing year. Indeed,

only the antenatal educators' practice bridged gestational stages; even then, their preferred focus was on pregnancy and only the first couple of weeks after the birth. The delineation was counter to that required by the expectant and new parents of the needs assessment. It meant that if antenatal education was to be effective during the childbearing year, health professionals might require further training, as proposed by Svensson and Handfield (2001).

Underlying all of the data was the health professionals' sense of power over the expectant and new parents under their care. They did not agree with this notion when it was presented; however, their language and gestures confirmed its presence. They constantly said a *need-to-know practice* issue existed so the expectant parents could conform to the institution. Although some rationale is apparent for this belief, the way the information is preached to the parents hinders its translation into practice. When the hindrance was highlighted to the health professionals, their limited comfort zones became apparent again. It appears that their training, specialization, and delineation of practice are significant issues in the attempt to provide effective antenatal education. The health professionals use their educational resources and activities in an instrumental fashion, rather than as tools for learning and enlightenment, which is a trend found in many areas in Australia (Humann et al., 2001).

With the exception of the antenatal educators, the health professionals were unable to spontaneously make recommendations for improving antenatal education. It appeared that they wanted parents to attend conventional antenatal classes to learn about institutional requirements and policies (Gilkison, 1991; Svensson & Handfield, 2001). Although this information was also of interest to parents, it was not the primary focus of their learning during the childbearing year (Svensson et al., 2006).

CONCLUSION

This study's findings demonstrate that many underlying reasons exist for a mismatch in the information needs of expectant and new parents. For antenatal education to be effective, it is not sufficient for educators to be provided with a list of topics to be covered, because they may not have the knowledge or expertise to cover the topics. Indeed, the topics selected by the health professionals may not be the ones required by expectant and new parents. Training is required, along with support and guidance.

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