A Descriptive Survey of the Educational Preparation and Practices of Antenatal Educators in Ireland

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ABSTRACT

Antenatal education is recommended to prospective parents, yet little is known about the educational preparation of the facilitators of this education, or of the educational practices they use. The aim of this study was to investigate the educational preparation and practices of antenatal educators in Ireland. Data were collected using a questionnaire structured on the three components (abilities, opportunities, and means) of Stamler’s theoretical framework of enablement. Eighty-four of the 120 antenatal educators responded (70%), and this included midwives, public health nurses, physiotherapists, and private antenatal educators. Findings describe a picture of varied educational preparation for the antenatal educator with a range of educational practices being used. Within public antenatal classes, large class size was a barrier to providing a participatory educational approach.

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LITERATURE REVIEW

Although antenatal education programs are recommended to prepare parents for birth and parenthood (Gagnon & Sandall, 2007), available programs do not always meet parents’ needs (Barlow, Coe, Underdown, & Redshaw, 2009; Svensson, Barclay, & Cooke, 2006). Many studies have been undertaken on women’s experiences or expectations of antenatal education programs (Ahlden, Ahlehaugen, Dahlgren, & Josefsson, 2012; Bondas, 2002; Holroyd, Twinn, & Ip Wan, 2011; Koehn, 2008;

Svensson, Barclay, & Cooke, 2008), but less information is available from the perspective of those who deliver them (Barlow et al., 2009; Svensson, Barclay, & Cooke, 2007; Wiener & Rogers, 2008).

In Ireland, antenatal education is provided through the public and private sector. Antenatal classes within the health services system are facilitated by midwives, public health nurses, and physiotherapists. Antenatal educators in the private sector are not required to have a professional qualification but may undertake extensive training before

assuming this role (Kelly, 2011). The purpose of this study was to explore the educational preparation and practices of antenatal educators, to ascertain if participatory and facilitative approaches were used, and to get a national picture of class size and availability of educational resources. Prior to undertaking the study, a literature review was conducted using Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System Online (MEDLINE), Scopus, and Maternity and Infant Health (formerly Midwifery Information and Resource Service [MIDIRS]) databases. Keywords included antenatal education, parentcraft education, prenatal education, and childbirth education. The search was not limited other than being restricted to studies in English.

Educational Preparation of Antenatal Educators

The prevalence of both formal and informal preparation for the role of antenatal educator has been identified previously (Collington, 1998). *Formal preparation* includes attendance at parent education training courses, whereas *informal preparation* refers to the educators developing skills through alternative methods such as observation of colleagues giving classes and reading relevant literature. More recently, it has been recommended that the educational preparation for antenatal educators needs to include the principles of adult learning (Kelly, 2011; Nolan, 2009), experiential learning methods (Svensson, Barclay, & Cooke, 2009), and group facilitation skills (Prendiville, 2004; Weiner & Rogers, 2008). These authors argue that a facilitative approach to antenatal education enables women to discuss fears and anxieties not just about labor and birth but also about the transition to parenthood.

Within the health services system in Ireland, midwives and public health nurses may be required to provide antenatal education, yet it has been reported that midwifery training may be insufficient to prepare midwives for a structured teaching role (Barlow et al., 2009). Wiener and Rogers (2008) found that midwives who attended additional antenatal education courses offered more holistic programs, which went beyond labor and birth and included a focus

on parenthood. Midwives who did not have such training believed that parents only wanted to focus on labor and birth.

A systematic review by Koehn (2002) reported differences between parents' and educators' priorities in terms of educational topics; parents wanted information on parenting, whereas educators perceived that a tour of the maternity unit was the most important component of programs. In terms of teaching styles, facilitative approaches and interactive learning, with good interpersonal and presentation skills, are valued by parents (Tighe, 2010), but antenatal educators focus largely on providing parents with information (Svensson et al., 2007). Where parents are asked to set their own learning agenda, they will frequently ask for a balance of birth and parenting topics (Barlow et al., 2009; Nolan & Hicks, 1997), and where nonparticipatory approaches are used, parents are unlikely to have their personal concerns addressed. Svensson et al. (2007) critiqued the educational preparation of antenatal educators and highlighted a reluctance to change their practice.

Another concern that arises is the size of publicly provided antenatal classes (Barlow et al., 2009). Where the class sizes are large, it is likely that teaching will be more didactic and learning for parents less effective (Holroyd et al., 2011; Lee & Holroyd, 2009). Women like to attend antenatal education sessions in small groups where there are opportunities to interact with and support each other (Kelly, 2011; Nolan, 2009; Schrader McMillan, Barlow, & Redshaw, 2009). A class size of 8–10 couples is considered ideal (Barlow et al., 2009; Kelly, 2011; Svensson et al., 2008). This facilitates interaction, encourages sharing of information, and promotes social support, which may continue after childbirth (Schrader McMillan et al., 2009). In the United Kingdom, within the National Health Service (NHS), antenatal classes may be for groups of up to 30 participants, whereas National Childbirth Trust (NCT) classes are capped at 10 couples or 8 couples in private classes (Barlow et al., 2009).

METHOD

A self-report questionnaire was designed using, with permission, Stamler's (1998) enablement framework for patient education, which was developed from a concept analysis of enablement in patient education and was used originally to evaluate antenatal education programs (Stamler, 1996).

A class size of 8–10 couples is considered ideal. This facilitates interaction, encourages sharing of information, and promotes social support, which may continue after childbirth.

In this context, Stamler (1996) defined enablement as “assisting the patient to acquire or expand the means, abilities and opportunities to fulfill a role or complete a task, to the patient’s perceived satisfaction” (p. 339). By examining the “abilities,” “opportunities,” and “means” available to antenatal educators in preparing for their role and delivering their education programs, it was anticipated that a picture would emerge of how these educators are enabled to work toward meeting the needs of prospective parents.

Questions were designed under the headings “Abilities,” “Opportunities,” and “Means.” “Abilities” included information on the educational preparation of antenatal educators and their perceived educational needs. Questions on “Opportunities” related to the practices used by the educators to meet the learning needs of prospective parents. A list of teaching and learning strategies was provided, and respondents were asked to identify the strategies they used. The “Means” section sought information on the resources available to participants such as teaching aids, funds to attend courses and to buy teaching aids, and the availability of journals. Where appropriate, open questions were included to facilitate participants’ elaboration on responses.

The questionnaire was reviewed for content validity by two experts in antenatal education and five experienced midwife educators. A pilot study was undertaken with seven antenatal educators not currently in practice. From feedback received, minor amendments were made to the questionnaire for ease of answering. Ethical approval was obtained from the local joint University/Health Service Research Ethics Committee and also from individual maternity hospitals where this was required.

Data Collection

All directors of midwifery, directors of public health nursing, and representatives from private antenatal education educators’ groups in Ireland were contacted for details of any known antenatal educators. The names of 120 educators were obtained including 56 midwives, 25 public health nurses, 14 physiotherapists, and 25 private antenatal educators. The questionnaire was sent to all, and a reminder was sent 2 weeks later.

Analysis

The data were analyzed with Statistical Package for the Social Sciences (SPSS), and descriptive

statistics were used to describe and summarize the data. The responses to open questions were categorized to reflect the thematic area of the content provided.

RESULTS

Eighty-four antenatal educators returned the questionnaire giving a response rate of 70%. This consisted of 44 midwives, 16 public health nurses (all of whom were registered midwives), 12 physiotherapists, and 12 private antenatal education educators (2 midwives and 10 lay educators).

Seventeen percent of respondents ($n = 14$) worked alone, whereas 83% ($n = 70$) worked as part of a team. Eight percent ($n = 7$) worked as antenatal educators full time, 66% ($n = 55$) facilitated antenatal classes as part of their job, and 26% ($n = 22$) gave classes occasionally. The midwives and physiotherapists held classes in hospital settings, whereas the public health nurses offered courses in health centers. Private antenatal educators mostly offered classes in their own homes.

Class size revealed notable differences with a mean class size of 22 ($SD = 13.75$, range 1 to 80). Smaller group sizes were common for private antenatal classes. For the public classes, 27 participants reported class sizes of 25 or greater with 15 participants reporting class sizes of 35 or greater.

The remaining findings are presented using the headings from Stamler’s (1996) concept of enablement.

Abilities

Fifty-one percent ($n = 38$) of the health professionals ($n = 74$) stated that antenatal education had been included as part of their professional education program. As students, these midwives, public health nurses, and physiotherapists had “observed antenatal classes” (68%, $n = 50$), “gave classes under supervision” (42%, $n = 31$), and “received lectures on antenatal education” (34%, $n = 25$). Physiotherapists were the only group (16%, $n = 12$) that had undertaken a specific module on antenatal education as part of their preregistration program. Twenty-three percent ($n = 17$) of health professionals (midwives and public health nurses) had received no formal preparation for the role. This group stated that they had learned how to deliver classes by “observing classes provided by colleagues” and by “reading books.” The 10 lay educators undertook a 2- to 3-year diploma

TABLE 1
Courses Undertaken by Antenatal Educators ($n = 60$)

	(%) Number
Birth from within level 1 2-day course with Pam England (USA)	37.0 ($n = 22$)
Birth from within levels 2 and 3 Course by Pam England (USA)	3.5 ($n = 2$)
Hospital/health service executive courses 5-day course including one day facilitated by Mary Nolan (U.K.)	30.0 ($n = 18$)
Irish nurses and midwives organization parent education course 2-day course	28.0 ($n = 17$)
Birth international courses 2-day course by Andrea Robertson (Australia)	25.0 ($n = 15$)
Diploma in antenatal education national childbirth trust (NCT) 2–3 year distance learning course	17.0 ($n = 10$)
Physiotherapy programs Module on antenatal education	12.0 ($n = 7$)
Lactation consultants' course Breastfeeding	12.0 ($n = 7$)
Royal College of Midwives U.K. Course Antenatal education	7.0 ($n = 4$)
Other	7.0 ($n = 4$)

in antenatal education by distance learning from a U.K. university.

At the time of the study, a range of short courses on antenatal education facilitation were available in Ireland, and 71% ($n = 60$) of respondents had attended at least one course. These were typically short courses of 1–5 days (Table 1). Thirty-two percent ($n = 27$) attended one course only, 21% ($n = 18$) attended two courses, 10% ($n = 8$) attended three courses, and 8% ($n = 7$) attended four or more courses (Table 2). Twenty-nine percent ($n = 24$) of respondents stated that they had never attended a specialist course. On occasion, employers funded attendance at courses; however, 33% ($n = 24$) of the employed health professionals ($n = 72$) stated that courses were self-funded. The most frequently reported reasons for attending courses were “to enhance existing skills,” “increase self-confidence,” “meet with other antenatal educators,” and “build confidence in the role as antenatal educator.” Infor-

mation on current educational needs was gathered from an open question. A wide range of topics was identified including facilitative teaching strategies and updates on childbirth practices. These are categorized in Table 3 to reflect the material provided by the participants.

Opportunities

This section focused on the opportunities used by antenatal educators to meet the learning needs of prospective parents. This included information on the teaching and learning strategies and participatory techniques used by the educators. The strategies are presented in rank order from the most frequently cited to those used least (Table 4). Results indicate various teaching strategies used including “drawing on the experiences of clients” (96%, $n = 80$), “grouped discussion” (72%, $n = 60$), and “leading clients in practical skills/activities for labor” (73%, $n = 61$). Eighty-six ($n = 72$) participants used the “modified

TABLE 2
Number of Courses Attended ($n = 84$)

	No course	1 course	2 courses	3 courses	4 courses	5 courses
Midwives	10	6	8	4	5	1
Public health nurses	9	2	5	—	—	—
Physiotherapists	5	3	3	1	—	—
Private	—	6	2	3	—	1

TABLE 3
Current Educational Needs (*n* = 84)

Introduction to teaching methods and the use of teaching/learning aids
Relaxation and breathing techniques
Update on pregnancy, labor, and the postnatal issues
Observation of current midwifery practice
Interactive strategies (use of ice melters, small group work, involving parents in setting a learning agenda)
Adult learning methods
Group dynamics and the facilitation of learning within groups
Dealing with emotional issues
Evaluation procedures
Evidence-based practice
Teaching and learning about parenting
Meeting fathers' needs
Meeting the learning needs of non-Irish nationals
Teenage pregnancy

lecture—some discussion included,” whereas the “lecture (information giving only)” was said to be used by 36% (*n* = 30) of respondents.

Means

Antenatal educators used a range of resources for their classes (Table 5). Flip charts (92.5%, *n* = 77), DVDs (91.5%, *n* = 76), posters (91.4%, *n* = 76), and baby models (91.4%, *n* = 76) were generally available.

TABLE 4
Ranking of Frequency of Teaching and Learning Strategies Used (*n* = 84)

Teaching and Learning Strategies	Always/ Sometimes	Rarely/ Never
	% (<i>n</i>)	% (<i>n</i>)
Drawing on the experiences of clients during classes	96 (80)	4 (4)
Visual aids	93 (78)	7 (6)
Practical demonstration—educator demonstrates and clients watch	89 (75)	11 (9)
Modified lecture—some discussion included	86 (72)	14 (12)
Educator-led discussion	78 (76)	22 (8)
Leading clients in practical skills/activities for labor	73 (61)	27 (23)
Group-led discussion	72 (60)	28 (24)
Brainstorming	63 (53)	37 (31)
Games/ice melters	60 (50)	40 (34)
Visit to the labor ward/birthing suite	59 (49)	41 (35)
Small group work	54 (45)	46 (39)
Team teaching	38 (32)	62 (52)
Pure lecture (information giving only)	36 (30)	64 (54)
Role play	31 (26)	69 (58)

TABLE 5
Resources Available to Antenatal Educators (*n* = 84)

Resources	Always/ Sometimes	Rarely/ Never
	% (<i>n</i>)	% (<i>n</i>)
Flip chart	92.5 (77)	7.5 (7)
Television/DVD	91.5 (76)	8.5 (8)
Childbirth posters	91.4 (76)	8.6 (8)
Doll (baby models)	91.4 (76)	8.6 (8)
Obstetric pelvis	85.0 (72)	15 (12)
Midwifery journals/childbirth education journals	74.0 (70)	26.0 (14)
Other childbirth preparation models	71.0 (69)	29.0 (15)
Money to replace broken equipment	38.0 (32)	62.0 (52)

Of the antenatal educators working within the health services system, 38% (*n* = 32) had problems accessing or replacing educational resources. Many of these respondents wrote additional comments about the lengthy bureaucratic process required to replace equipment or to order new teaching aids.

DISCUSSION

This is the first national survey of antenatal educators in Ireland, and it reveals considerable diversity in the educational preparation of those who deliver classes to prospective parents. Antenatal education is provided both by health-care providers and private antenatal educators. At the time of this study, apart from the physiotherapists, few midwives and public health nurses had been adequately prepared for this role as part of their professional education. As students, most had received lectures or had observed or participated in some classes; however, it has been reported that this is insufficient for a structured teaching role (Barlow et al., 2009). Although respondents had attended a range of specialist education courses, there were a number of midwives and public health nurses who did not have any additional preparation for their teaching role. Those who did attend specialist courses often attended more than one course and some self-funded their attendance.

It has been reported that the lack of training of educators affects the quality of antenatal education programs within the health service (Kelly, 2011;

Although respondents had attended a range of specialist education courses, there were a number of midwives and public health nurses who did not have any additional preparation for their teaching role.

Training on facilitative teaching and learning strategies can give educators the skills and confidence to ensure that their own classes are participant-led and reflect best practices for antenatal education.

Schrader McMillan et al., 2009). If classes are to meet the needs of parents, there is a need to ensure that all antenatal educators are adequately prepared for undertaking this educational role. Antenatal education facilitation should be a core component of midwifery and public health nurse education programs, but to keep abreast of new knowledge and teaching and learning strategies, continuing education should be available for those involved in providing classes (O'Sullivan & O'Connell, 2010). This needs to be supported by health service employers.

Information on the current educational needs of educators identified a range of topics, including facilitative teaching strategies and updates on childbirth practices. Training on facilitative teaching and learning strategies can give educators the skills and confidence to ensure that their own classes are participant-led and reflect best practices for antenatal education (National Institute for Health and Clinical Excellence [NICE], 2008).

In this study, the variation in class size was a significant issue, with one participant reporting up to 80 participants. Where class size is large, participatory teaching strategies are difficult to implement, and this may be reflected in the number of respondents who reported that they used a lecture or modified lecture format. A focus on solely providing information has been critiqued by Svensson et al. (2007) who suggested that midwives are reluctant to adopt new strategies. However, it must be acknowledged that it is difficult to use participatory approaches where the class size is so large. Nevertheless, antenatal education is ineffective without meaningful interaction, and large groups provide little opportunity for forging friendships or developing a support network (Nolan, 2009). It is surprising that the U.K. reports (Barlow et al., 2009; Schrader McMillan et al., 2009) did not recommend a limit on class size. Many of the problems identified in these reports could be addressed if class size was limited to a maximum of 10–20 couples (Nolan, 2009). This may require that additional classes be provided, which is challenging during the current economic constraints and may lead to an increasing number of couples resorting to private antenatal classes because of a lack of capacity

within the public health services system, or receiving no antenatal education at all.

A lack of funding for teaching resources was also identified as a problem. New resources are increasingly available to support antenatal education programs, yet the health professionals who responded to this study highlighted the difficulties in obtaining supplies or replacing equipment. There is a need to update resources and equipment to support practice.

The U.K. review of antenatal education programs reported that the provision of antenatal education did not address the needs of couples adequately in terms of access, contact time and timing, and content (Barlow et al., 2009). It is recommended that antenatal education should address issues around the transition to parenthood, changing relationships, and adaptation to new roles. This is seen as a “golden opportunity” to support families as they approach this important period in their lives (Barlow et al., 2009, p. 26). In particular, the needs of fathers are often not addressed (Schrader McMillan et al., 2009). Without adequately prepared antenatal educators who have access to appropriate teaching and learning resources, it is difficult to see how health professionals will meet the learning needs of prospective parents.

CONCLUSION

In Ireland, antenatal education is provided within maternity hospitals by midwives and physiotherapists and in community settings by public health nurses, most of whom have a midwifery qualification. Private classes are available and, in this study, where these were provided by nonhealth professionals, lay educators had an appropriate qualification.

The findings reveal a varied picture of antenatal education. Although many of the health professionals had received appropriate educational preparation for this role, others, mainly the midwives and public health nurses, learned “on the job.” The concern here is that, although midwives and public health nurses have the requisite knowledge of childbirth to provide appropriate information to couples, they may not have the knowledge or skills to use participative approaches in their classes. A more positive finding was that most participants had attended at least one course for providers of antenatal education with many attending two or three courses. This was often self-funded. Reasons given for attending courses were to increase their confidence and skills and to meet other antenatal educators.

The educators in the public sector reported a lack of support for the provision of antenatal education, and class size was a concern. They also reported that they often had limited educational resources available to them. Large classes reduce the opportunity for couples to participate and ensure that their learning needs are met (Barlow et al., 2009) and may lead to educators focusing on the provision of information on labor and birth rather than preparing parents for parenting (Svensson et al., 2007). The strategies used by the educators reflected their educational skills and the class size.

There was a good response rate to this national survey, and we are confident that the findings reveal an accurate picture of the educational preparation and self-reported practices of antenatal educators in Ireland. This is the first study that explored these issues, and we were pleased that most educators identified that facilitation skills and adult learning approaches were important in the provision of classes and that many had attended a number of courses to help them develop these skills. This was a self-report questionnaire, and there was no objective assessment of their performance; however, as the focus was more on the educational needs of the educators and the resources available to them, this self-report was useful. Since this study has been completed, the findings have informed the development of a program on antenatal education for health professionals, and antenatal education skills are also now included as part of midwifery education programs.

Implications for Practice

Antenatal educators need formal educational preparation to prepare parents realistically for birth and the transition to parenthood. Various teaching and learning strategies are required to maintain parents' attention during antenatal classes and to ensure that learning is relevant, understandable, and memorable. Adequate resources of varied teaching aids to use a participatory approach to learning are also important. Programs to prepare antenatal educators for their role should include group facilitation skills, adult learning theory, and evidence-based information on childbirth practices. Educators must be able to present information in such a way that parents feel empowered to make informed decisions about their maternity care and in their role as parents. The facilitation of antenatal education needs to be incorporated into all midwifery education programs. Continuing education is also required so that edu-

cators are encouraged and supported to maintain a participative approach to learning in antenatal classes and keep up-to-date with developing trends in antenatal education provision.

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