Information Giving and Education in Pregnancy: A Review of Qualitative Studies

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ABSTRACT

Studies of childbirth education have universally failed to take into account the quality of the education provided to women and their families and whether its style of delivery meets women's preferences and needs. The present study sought to determine which educational approaches are most welcomed by women and most helpful to them in learning about labor, birth, and early parenting. A systematic survey of peer-reviewed studies on antenatal education, published in English from 1996–2006 and which sought women's views and experiences, was conducted. Findings confirm women's preference for a small-group learning environment in which they can talk to each other as well as the educator and can relate information to their individual circumstances.

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In recent years in the United Kingdom, there has been a considerable cutback in the provision of antenatal education by the National Health Service. This is of concern not only to midwives and to childbirth educators trained by the National Childbirth Trust, the largest charitable organization in Europe providing prenatal and postnatal education to parents, but also to parents themselves. A recent documentary on British television (Ahmad, 2007) interviewed women who expressed disappointment and concern that they had not been offered any antenatal classes in their first pregnancies, although the U.K.'s prestigious National Perinatal Epidemiology Unit claimed that 88.5% of primiparous women were offered classes at their local hospital or clinic in 2006 (Redshaw, Rowe, Hockley, & Brocklehurst, 2007). Anecdotal evidence from private providers and from the National Childbirth Trust suggests that demand for classes has escalated in response to their increasingly limited availability through the National Health Service.

In a climate of evidence-based practice, and one in which the definition of what might constitute "evidence" is a narrow one (Walsh, 2007), it is not difficult to justify withdrawing antenatal education on the basis that it has never been proved to be effective. However, experienced childbirth educators have observed that it is impossible to assess the effectiveness of an antenatal education intervention solely in terms of events in the delivery room (Nolan, 2005; Shearer, 1990). The multiple variables that determine what happens to a woman during labor, including the uniqueness of her own physiology and psychology, the flexibility of hospital protocols or lack of it, and the substantial influence of the personal philosophy of birth of the midwife who

cares for her make it very unwise to lay any outcomes of labor at the door of the antenatal classes the woman attended.

Research has nevertheless persisted in investigating such outcomes and has been consistently inconclusive (Copstick, Hayes, Taylor, & Morris, 1985; Gunn, Fisher, Lloyd, & O'Donnell, 1983; Hetherington, 1990; Qureshi, Schofield, Papaioannou, Ramsden, & Fear, 1996; Redman, Oak, Booth, Jensen, & Saxton, 1991; Spiby, Henderson, Slade, Escott, & Fraser, 1999). The fact remains that many women who are pregnant for the first time will seek to attend antenatal classes (Redshaw et al., 2007) and will possibly be distressed if not offered them. Some women who can afford it will seek classes in the voluntary or increasingly visible private sector (Singh, Newburn, Smith, & Wiggins, 2002). Others will receive no antenatal education and will approach labor ignorant of what is to come, frightened, and unable to make their own informed choices about their treatment. This situation conflicts with U.K. government policy to ensure that women are able to make decisions about their own care, based on information and understanding (Department of Health, 1993, 2004, 2007).

Studies of childbirth education have universally failed to take into account the *quality* of the education provided to women and their families and whether its content and style of delivery meet women's preferences and needs. My extensive involvement with childbirth education for more than 25 years leads me to believe that the work of theorists and practitioners in adult education has been largely ignored in relation to the delivery of antenatal education.

STUDY AIMS

In the present study, I sought to determine not what should be the *content* of antenatal classes—there is a body of evidence around this (Camiletti & Alder, 1999; Nolan, 1999b; O'Meara, 1993; Schneider, 2002), on which childbirth educators who wish to meet women's agendas can usefully base their practice—but which *educational approaches* are most welcomed by women and most helpful to them in learning about labor, birth, and early parenting. My study considers not just antenatal classes, but also other encounters between midwives and pregnant women where key information must be transmitted. Because the study is about *how* to communicate information to pregnant women, rather than about content, it has relevance to midwives wherever in the world they are working to help women acquire, understand, and utilize information.

SEARCH METHODS

A review of studies on antenatal education was conducted. The inclusion criteria were as follows:

- studies written in English;
- studies published in 1996–2006 (in the 10 years prior to when the present investigation began);
- peer-reviewed studies;
- studies carried out in developed countries; and
- studies that included a qualitative element, seeking women's views and experiences.

Following consultation with midwives and university librarians, the keywords "pregnancy," "antenatal," "prenatal," "information," "education," "classes," "communication," and "qualitative" were selected as likely to capture the relevant literature. Medline, MIDIRS, and CINAHL databases were searched, looking for the keywords in titles and abstracts. Because it is notoriously difficult to identify relevant qualitative research with precision, the key terms were used in a variety of permutations to increase sensitivity. References in articles thus identified were scanned for other studies that might be relevant. This strategy yielded 19 studies that included a qualitative element, published in a variety of journals. Of these, 12 fulfilled the requirement in that they consider women's views on and experiences of receiving information during pregnancy, as well as health professionals' views on how best to communicate with and teach women. The Table lists the studies, highlighting details relevant to the present review. A thirteenth study, which involved a quantitative analysis of questionnaires, was included because of the relevance of its focus on women's communication preferences in antenatal clinics (Risica & Phipps, 2006; listed as Study Number 1 in the Table). In this article, references to each of the 13 studies are followed by the study's identifying number listed in the Table.

Not all of the identified studies related specifically to antenatal classes in preparation for birth; however, all of the studies were concerned, either wholly or in part, with how information and skills are transmitted to women during pregnancy. Some of the studies examined information giving and communication related to breastfeeding, early parenting, smoking cessation, and screening for fetal abnormality. Some explored one-on-one educational interactions between mothers and midwives,

TABLE
Information Giving and Education in Pregnancy: A Review of Qualitative Studies Published in 1996–2006

Study Number	Title	Author(s) and Year of Publication	Methodology / Methods/ Sampling	Participants	Country of Study	Findings
1	Educational preferences in a prenatal clinic	Risica & Phipps (2006)	Descriptive research; convenience sample; questionnaires (completed in Spanish or English)	139 pregnant women	United States	Majority of participants preferred to receive prenatal information from a provider compared with other media.
2	Some lessons from Swedish midwives' experiences of approaching women smokers in antenatal care	Abrahamsson, Springett, Karlsson, Hakansson, & Ottosson (2005)	Phenomenological research; purposive sample	24 midwives working in antenatal care	Sweden	Cooperation and dialogue with women promotes effective health education.
3	Perceptions of effective advice in pregnancy – The case of activity	Gross & Bee (2004)	Multimethods research; convenience sampling; interviews and questionnaires	57 women with low-risk pregnancy	United Kingdom	Response to advice extremely varied; clear and consistent messages must be provided by all healthcare providers involved in antenatal care.
4	Presenting and discussing nuchal translucency screening for fetal abnormality in the UK	Pilnick, Fraser, & James (2004)	Qualitative study; women eligible for nuchal translucency screening at time of recruitment; interviews	14 women eligible for nuchal translucency screening at time of recruitment	United Kingdom	A large amount of interactional work is required by midwives before and after screening to ensure that women understand information given.
5	Qualitative study of evidence-based leaflets in maternity care	Stapleton, Kirkham, & Thomas (2002)	Grounded theory, convenience sample; interviews	163 childbearing women, 177 midwives, 28 obstetricians, 12 obstetric ultrasonographers, 3 obstetric anesthetists	United Kingdom	Evidence-based leaflets promoting informed choice did not promote informed choice in childbearing women; pregnant women usually complied with professionally defined choices instead of making their own.
6	What constitutes ''balanced'' information in the practitioners' portrayals of Down's syndrome?	Williams, Alderson, & Farsides (2002)	Qualitative study; practitioners at inner-city teaching hospital and district general hospital in South East England; interviews; multidisciplinary discussion groups	70 practitioners whose work related directly or indirectly to perinatal care	United Kingdom	Midwives and others involved in prenatal screening need to be aware of their own feelings about screening and disability.

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Study Number	Title	Author(s) and Year of Publication	Methodology / Methods/ Sampling	Participants	Country of Study	Findings
7	An Australian study of women's experiences of their first pregnancy	Schneider (2002)	Phenomenological research; convenience sample; interviews	13 primiparous women	Australia	Teaching in the ward or childbirth/parenting programs should not be compromised by midwives who believe that pregnant women cannot learn.
8	Chinese women's perceptions of the effectiveness of antenatal education in the preparation for motherhood	Ho & Holroyd (2002)	Qualitative study; women who had attended antenatal classes observed by researchers; focus groups	5 antenatal classes observed for between 48 and 95 women; 11 women who had attended antenatal classes interviewed in 2 focus groups	Hong Kong	Large class sizes and didactic mode of teaching inhibited learning. Childbirth educators did not seek appropriate feedback from participants, and personal problems were not addressed.
9	Strategies for coping with labor: Does antenatal education translate into practice?	Spiby, Henderson, Slade, Escott, & Fraser (1999)	Exploratory research; questionnaires and interviews; convenience sample	121 primiparous women	United Kingdom	A significant proportion of women were dissatisfied with the amount of practice of coping strategies during antenatal classes.
10	The participants' views of childbirth education: Is there congruency with an enablement framework for patient education?	Stamler (1998)	Qualitative study; convenience sample; interviews	7 primiparous Caucasian women	Canada	Women welcomed an atmosphere in classes where they could ask questions and receive answers; participants learned more when there was more socialization.
11	Nobody actually tells you: A study of infant feeding	Hoddinott & Pill (1999)	Grounded theory; purposive sample; interviews	21 White, low-income, primiparous women	United Kingdom	The current approach to preparing pregnant women is heavily weighted toward theoretical knowledge rather than apprenticeship-style learning and support.
12	The influence of antenatal information on breastfeeding experiences	Britton (1998)	Qualitative study; convenience sample; focus groups	30 women	United Kingdom	Peer learning and self-help groups support breastfeeding.
13	Antenatal 'booking' interviews at midwifery clinics in Sweden: A qualitative analysis of five video-recorded interviews	Olsson, Sandman, & Jansson (1996)	Phenomenological research; purposive sample at 5 health centers; video-recorded antenatal booking interviews	5 midwives; 5 pregnant women; 2 fathers	Sweden	The expectant parents shadowed the midwives' content themes and ways of relating.

and some investigated traditional antenatal group sessions.

Identified studies included those in which women were asked what kind of educational approaches they found most effective in helping them acquire information and skills during pregnancy (1, 3, 4, 5, 7, 8, 9, 10, 11, 12, and 13). Studies also included those in which providers were asked for their views and experiences of delivering antenatal education (2, 5, 6, and 13).

Two studies (2 and 13) took place in Sweden; one study (1) took place in the United States; seven studies (3, 4, 5, 6, 9, 11, and 12) were located in the United Kingdom; and one each of the studies took place in Canada (10), Australia (7), and Hong Kong (8). Studies involving questionnaires had larger numbers of women participating (139 participants in Study Number 1, and 121 in Study Number 9). Investigations involving focus groups and in-depth interviews with women tended, as is the nature of qualitative and phenomenological research, to be smaller (from 7 participants in Study Number 10, to 21 participants in Study Number 11). One Swedish study (13) interviewed two fathers. Two U.K. studies involved large numbers of women and health professionals (163 childbearing women, 177 midwives, 28 obstetricians, 12 obstetric ultrasonographers, and 3 obstetric anesthetists in Study Number 5; and 70 perinatal care practitioners in Study Number 6). The women who took part in many of the studies appear to have been White, middle-income women; some studies, however, clearly stated that they involved women from different ethnic and socioeconomic backgrounds. Participants who responded to the U.S. study (1) were of White or Hispanic background and attending an urban clinic in a poor area. The Hong Kong study (8) included native-born Chinese women. In one of the U.K. studies (11), participants were described as ''low-income.'' Overall, the review represented the views and feelings of a fairly broad cross-section of pregnant women living in developed countries.

Research methods employed to gather information relevant to this review included questionnaires (1, 3, and 9), interviews (2, 3, 4, 5, 6, 7, 9, 10, and 11), and focus or discussion groups (6, 8, and 12). Study Number 13 involved video-recorded antenatal booking interviews, which were subsequently transcribed. Some studies involved mixed methods.

Studies were analyzed, using methods characteristic of qualitative research (except in Study Number 1, which employed descriptive statistics), with transcriptions of interviews and focus groups and subsequent identification of content categories.

RESULTS

Antenatal Education: The Language of Women and the Context of Women's Lives

Abrahamsson, Springett, Karlsson, Hakansson, and Ottosson (2005, Study Number 2) interviewed 24 midwives involved in helping women address their smoking behavior during pregnancy. The midwives found it difficult to abandon the role of expert and to engage the women as *participants* in their care, allowing the women to set their own learning agendas and design their own approaches to tackling their problems. Yet, the midwives also recognized that women's response to smoking cessation advice is varied and unpredictable, unless advice takes into account the nature of the investment the woman has in smoking and reflects a realistic rather than a prescribed range of strategies to enable her to quit. The study conducted by Ho and Holroyd (2002, Study Number 8) makes a similar point. Women attending antenatal classes in Hong Kong described how their anxiety increased because midwife educators neither dealt with their individual worries nor organized learning experiences around their life situations rather than according to subject matter. As a result, the women found it difficult to remember what they had been told.

In defining the tenets of adult education, Knowles (1990) noted that adult learners are pragmatic, have limited resources of time, and operate a ruthless sifting system to determine which items of information and which skills to commit to long-term memory. This determination is made on the basis of the perceived relationship between the new learning and previous significant events in the learner's life. If such a relationship can be established, leading to ''emotional tagging'' of the new information and skills, learning is likely to be retained (Richter-Levin & Akirav, 2003, p. 247).

Pilnick, Fraser, and James (2004, Study Number 4) describe how midwives must undertake ''interactional work'' (p. 82) with women both before and after the nuchal translucency test in order to ensure women fully understand the kind of information this investigation provides. As the extent and complexity of prenatal screening and diagnosis become ever more challenging to lay people, the need for interactional work—talking to women about procedures in language that they understand and helping

them to make decisions in the context of their culture and lifestyle—will likely become increasingly vital. The recently published report of the U.K. National Perinatal Epidemiology Unit, *Recorded Delivery*, notes that a significant minority of women who participated in the national survey felt that midwives and doctors did not talk to them in a way they could understand during their pregnancies (Redshaw et al., 2007). This professional responsibility to communicate effectively likely cannot be shifted to other media (see this article's section titled "Women's Preferences for Antenatal Education: Medium of Delivery").

Olsson, Sandman, and Jansson (1996, Study Number 13) video-recorded five antenatal "booking" visits involving five midwives, five pregnant women, and two fathers. As highlighted again later in findings from Stapleton, Kirkham, and Thomas (2002, Study Number 5), parents try to manage the interviews and please the midwives by responding to questions in terms of a midwifery-based discourse rather than the midwife engaging with them by using a layperson's discourse. In 2003, Jacqui Smith, U.K. Minister of State for Health, invited midwives to create a service that responds to ever-changing individual needs and expectations. Yet, findings from McCourt's (2006) study identify a continuum of communication styles at the booking visit, with hierarchical and formal styles being most evident in conventional care despite the midwife's vocation to be, as McCourt noted, "with woman" (p. 1307) and despite recent policy emphasis on placing patients at the center of their care (Department of Health, 2006). Olsson et al.'s (1996, Study Number 13) analysis of the conversation and video footage of participants in their study showed how expectant fathers seem like "strange visitors in the women's world" (p. 62). This failure to include fathers in antenatal care, to help them relate to their partners' pregnancy and give them the opportunity to discuss its impact, has been frequently commented upon (McElligott, 2001; Pollock, 2001; Smith, 1999). Within the context of the present review, it is another instance of information being transmitted in a vacuum, rather than tailored to the particular needs—in this case, gender-based needs—of the recipients. The marginalization of fathers during pregnancy, birth, and the postnatal period has been commented on extensively by the Fatherhood Institute (2008; formerly known as Fathers Direct) whose overview of research on fatherhood concludes that high paternal involvement at all stages of the childbearing year and in the early years of parenting may be correlated with greater family stability.

Abrahamsson et al. (2005, Study Number 2) urge midwives to discover and adopt "the lay perspective of a woman" so that her "thoughts. . .are given the space to grow while she talks" (p. 344). However, the difficulty for midwives of being in the same emotional space as the pregnant woman becomes apparent from findings reported by Williams, Alderson, and Farsides (2002, Study Number 6). Their study of the information needs of pregnant women in relation to Down's syndrome found that, although information giving about the process of screening for Down's was satisfactory, little or no information was given to women about the lives of people with Down's syndrome or of the families who cared for them. Women were therefore asked to make choices about screening based on information that did not enhance their understanding of how parenting a baby with Down's might affect their lives or of what the life of the child might be like. The authors speculate as to the midwives' own feelings about screening and disability and whether these, knowingly or not, prevented them from entering into discussion with the women in their care about screening choices.

Women's Preferences for Antenatal Education: Medium of Delivery

There has been considerable interest in recent years in the potential for transmitting information to clients using resources that are less expensive than health practitioners' time. These resources include DVDs, CD ROMs, evidence-based leaflets, and posters. In their U.S. investigation of women's educational preferences, Risica and Phipps (2006, Study Number 1) concluded that women prefer receiving information from a health-care professional involved in their care over and above any other source. This finding is entirely in keeping with the seminal study of Stapleton et al. (2002, Study Number 5), which rigorously explored the effectiveness of evidence-based, accessibly written, high quality leaflets in promoting women's choice around key areas of pregnancy, labor, and postnatal care. The study involved nonparticipant observation of 886 antenatal consultations and 383 in-depth interviews with women and a variety of health professionals. The courage of the researchers in reporting that, despite the immense effort that had been put into producing the leaflets, they were

unsuccessful in promoting informed choice in childbearing women should not be overlooked. Women wanted to discuss the content of the leaflets with midwives, but midwives had insufficient time to do so on an individual basis. Despite the accessibility of the language used in the leaflets, this method of giving information to promote choice was unsuccessful in the face of what the authors described as "existing normative patterns of care" (p. 639). Within the clinical context, women were far more influenced by the perceived views and preferences of health professionals, especially obstetricians, who conveyed that, despite the leaflets' "message" assuring women they were entirely free to choose, there were choices that their providers preferred them to make. While U.K. government ministers state that the challenge throughout the National Health Service is to make health information accessible in order to facilitate choice for users (Smith, 2003), it appears that the way forward for childbearing women, at least, is to use leaflets to support information given first-hand and explained by midwives, rather than in place of individual contact.

Another dimension to the subject of teaching aids was highlighted by Ho and Holroyd (2002, Study Number 8), who reported findings from two focus groups in which Hong Kong women who had attended antenatal classes participated. Although the midwives leading the classes were Chinese, their teaching aids depicted Western women and Western contexts of childbirth and early parenting. The women objected to materials that had been developed for another culture and articulated the need to approach childbirth from a culturally specific perspective. In the United Kingdom, there has long been awareness of the need to ensure a multicultural approach to antenatal classes; however, in my experience, this awareness does not preclude a continuing tendency to use White dolls to represent the baby, as well as pictures of White women in labor and of White parents in homes clearly decorated in a Western manner. The lack of multicultural representation is partly due to the difficulty of obtaining ethnically and culturally sensitive teaching aids and, in part, to the failure of childbirth professionals to recognize and challenge their own stereotypes.

Women's Preferences for Antenatal Education: Teaching Style and Group Size

Findings reported by Stamler (1998, Study Number 10) and by Ho and Holroyd (2002, Study Number 8) provide invaluable insights into how to organize antenatal classes to meet women's needs. Stamler's study is interesting reading for those who want to develop a curriculum for classes. Although a discussion on curriculum development is not within the scope of this article, it is pertinent to mention here that women in Stamler's study wanted to know what to expect of hospital staff and what hospital staff would expect of them. This finding ties in with the studies that illustrated women's eagerness to please staff by entering into the world of midwifery on the midwives' terms (Olsson et al., 1996, Study Number 13; Stapleton et al., 2002, Study Number 5). Stamler implies that women's agenda for antenatal classes includes learning how to behave appropriately during labor so they can operate successfully within the medical and midwifery system. This finding is contrary to the thrust of current legislation and professional rhetoric that envisions a health service designed around the patient (Department of Health, 2000).

Stamler (1998, Study Number 10) notes that women attending antenatal classes like to feel welcome to ask questions and want to receive answers. Ho and Holroyd (2002, Study Number 8) develop this theme in their lengthy, comprehensive, and extremely interesting study of classes in Hong Kong. The key problem with these classes, from which all other difficulties stemmed, was their size. The five classes that the researchers observed were attended by between 48 and 95 women, a situation familiar to midwives in the United Kingdom. Under these circumstances, the women identified that it was impossible to engage in questioning and discussion, to have their personal problems addressed, to make friends, and for the educators to seek appropriate feedback from their clients. The authors conclude that "small informal classes using role-play, problem-solving activities and experience-sharing sessions would promote interaction" (p. 83). Their conclusion supports the literature on adult education. In J. Daines, C. Daines, and Graham's (1993) seminal work, *Adult Learning, Adult Teaching,* the authors note that most sessional classes in adult, community, or further education comprise between 12 and 20 adults in order to allow tutors to "create a climate where interaction can flourish, where people can participate in safety and learn both with and from others" (p. 61). If this outcome is true for all subjects, how much more likely is its success when applied to a class where pregnant women learn about one of

the most intimate and powerful experiences of their lives?

Amount of Information

Several of the studies highlighted problems with information overload during antenatal classes and women's concern that, in labor, they could not remember all that they had been told and practiced. The women who participated in Ho and Holroyd's (2002, Study Number 8) study said that too much information was given in relation to the limited time available for the classes. They found it additionally hard to retain information because they had received no opportunity for discussion with their peers and, therefore, no chance to contextualize what they were learning in relation to their own lives and circumstances. Women who took part in the study by Spiby et al. (1999, Study Number 9) voiced dissatisfaction because too little time was given to practicing coping strategies for labor during antenatal classes, advancing the lack of practice time as one reason for not utilizing such strategies while they were in labor.

Stamler (1998, Study Number 10) found that the women in her study felt less anxious when they had more information, but she noted that the women who most appreciated their antenatal education were the ones whose caregivers (both lay and professional) during labor reminded them of what had been said and practiced in classes. Stamler's finding implies that women need assistance in recalling information and the skills they learn in classes in order to be able to use them in the strange environment of the hospital and under the stress of labor when adrenalin levels compromise memory.

Socialization

Women do not attend antenatal classes solely to receive information and develop skills (Nolan, 1999a). The social agenda—namely, the opportunity to meet other women going through pregnancy at the same time—is also a high priority. Stamler (1998, Study Number 10) notes that the desire of the seven women she interviewed was "always for more socialization" (p. 943) and that classes that did not encourage socialization by facilitating discussion among the women were perceived as unsatisfactory. Ironically, the women in Ho and Holroyd's (2002, Study Number 8) investigation enjoyed participating in the focus groups that were part of the research because, unlike their classes, the focus groups consisted of a small number of women with whom they had the chance to talk and exchange views. Some women later told the researchers that they had made friends in the study's focus groups and intended to keep in touch with each other.

Peer/Apprentice Style of Learning and Teaching

The importance of providing pregnant women with the chance to learn from each other and from experienced mothers is highlighted in two reviewed studies that considered the merits of an apprenticeship style of learning. Hoddinott and Pill (1999, Study Number 11) interviewed 21 White, low-income women expecting their first baby and found that the women in their study who had a lot of experience with newborn babies and constant support from someone with recent mothering experience felt more confident about their abilities to cope as new parents than the women without such exposure. Britton (1998, Study Number 12) investigated antenatal information on breastfeeding and found that experienced mothers are as effective as midwives in preparing women to breastfeed their babies and have the added advantage of helping to build social support networks that sustain women through the early weeks of feeding.

DISCUSSION

The implications for practice of this review are very clear. The fact that they are so does not, of course, mean that they are easy to implement, especially in a health-care economy where little midwife time is available for one-to-one discussion with women, and midwives receive limited training in leading groups for adult learners. The review makes it clear that pregnant women like to receive emotionally demanding or intellectually complex information from a health-care professional in person. They want to be able to ask questions, seek clarification, and relate information to their own circumstances. They like to learn about labor, birth, and motherhood in peer groups made up of a small number of pregnant women, with a facilitator who is able to identify how much information to give, has skills to present it in a way that is easy to remember, promotes discussion, gives plenty of opportunities for practicing skills, and encourages them to get to know and support each other. Large groups, in which it is difficult to ask questions, and facilitators who present themselves as "experts" and who do not interact with women render education in the antenatal period ineffective. The implications for

midwifery practice of the studies discussed above are succinctly summarized by Abrahamsson et al. (2005, Study Number 2) when they speak of building antenatal education on *cooperation* and *dialogue*. Pregnant women enjoy learning from each other and respect and value the input of other women who have recently been through the experiences they are about to face themselves. None of this is the least surprising and has been well known within the literature on adult education and antenatal education for many years (Henderson, 2005; Mezirow, 1983; Robertson, 1994; Schott & Priest, 2002).

CONCLUSION

Antenatal classes present an ideal opportunity to help women learn how to communicate effectively with hospital staff. By so doing, women can make their own choices rather than merely conforming to hospital policies, protocols, and professional preferences. Giving information in a way that allows women to choose for themselves requires educators and midwives to have reflective skills to understand where women's needs are different from those the maternity care system believes it is catering for, and to show courage in educating women to challenge a system of which they themselves are part.

Schneider (2002; Study Number 7) found midwife educators can be hampered in delivering effective antenatal education by their belief "that pregnant women cannot learn" (p. 238). If educators truly feel this to be the case, then antenatal education is certainly doomed to failure. Schneider retains a positive outlook, however, and suggests that a comprehensive review of childbirth preparation programs needs to be undertaken, focusing on philosophy, content and evaluation, and the qualifications and skills of the people leading the programs. Antenatal education continues to be highly valued by the many women who would otherwise receive little preparation for birth beyond that delivered by the Discovery Channel and television soap operas. Therefore, antenatal education deserves to be evaluated when delivered in optimum circumstances and by well trained educators rather than in highly unfavorable circumstances, as is so often the case. Until this kind of research is carried out, it is not possible to know whether and how classes impact women's ability to access services and mold them to their particular needs, and their childbirth and parenting experiences.

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