

Are we still woman-centred? Changing ideologies, a history of antenatal education in Australia

Author

Downer, T, Young, J, McMurray, A

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Australia

Abstract

Background: The medicalisation of childbirth that began in the early 20th century continues to this day. As birth moved from home to the medical environment, antenatal education that prepared families for childbirth and parenting has also changed with little evidence of its effectiveness.

Aim: To help fill a gap in the research knowledge underpinning antenatal education practice.

Findings: Persistent medicalisation and commercialisation of antenatal education raises professional and quality related issues with regards to educational content and delivery. In Australia, as in other countries, there are no requirements for antenatal educators to have any formal training or qualifications, which poses questions about the need for professional regulation.

Discussion: Evaluation of antenatal education has shown variable efficacy to date, but it remains a significant component of antenatal care as it is integral to pregnancy and birth. Changing ideologies have led to the need for professional specialisation for antenatal educators. It is recommended that the Competency Standards for Childbirth and Early Parenting should be implemented to enable evaluation of and compliance with antenatal education programs. Antenatal educators have changed their strategies in providing education within some of the newer models of care; however, without recognition, regulation or a research agenda that could confirm or change these models, evidence-based practices remain elusive.

Conclusion: The history of antenatal education is important to the care of women and their families. Knowing what has preceded the current situation can help health practitioners

develop appropriate classes in the future, ensuring that antenatal education continues to be woman centred.

Keywords

Antenatal education, woman centred, history, regulation, health literacy, midwifery.

Summary of Relevance

Problem

Antenatal education has evolved with little evaluation of contemporary practice or understanding if it meets the needs of class participants.

What is Already Known

The practice of antenatal education proceeds unchecked and there is no formal regulation of the profession.

What this Paper Adds

Knowing what has preceded the current situation of antenatal education can help health practitioners develop appropriate classes in the future, ensuring that antenatal education continues to be woman centred.

Are we still woman centred? Changing ideologies, a history of antenatal education in Australia

Introduction

This paper provides a historical overview of the evolution of antenatal education (ANE) in the Australian context, examining the evolving ideologies that have led to contemporary antenatal education since the 19th century. According to Glenn et al. (1994) an ideology is “the conceptual system by which a group makes sense of and thinks about the world” (p.9). In ANE, educators draw on multiple discourses to construct personal ideologies regarding education about pregnancy, childbirth and parenting; in Australia this is regarded as a ‘woman centred’ approach (Brady et al., 2019).

It is important to trace the history of ANE to explain how certain developments have led to the current structures, methods and sources of this education. Our intention is to inform a gap in the research knowledge underpinning ANE practice with a focus on how women’s ideologies of childbirth have been shaped by historical events.

Historically ANE was woman centred, with women having confidence in their knowledge of childbirth and parenting information. However, over time, pregnant women were influenced by public health initiatives, which saw childbirth become medicalised. Gradually, they put their trust in the medical profession, which led to disempowerment and the vulnerability that arises from having their opinions and decisions dictated by a powerful, seemingly legitimate societal group. Today with improving levels of health literacy among pregnant women who understand their right to knowledge and self-determination, the balance is shifting back to women who are encouraged to make decisions about their care.

Antenatal education can be defined as a single intensive class or interaction or a series of classes/interactions provided for an individual, or groups of pregnant women, and their partners and/or support people (Downer, 2019). While current antenatal curricula vary by program and type of services, the core subjects encompass pregnancy health, labour, birth,

the immediate post-partum period and breastfeeding (Entsieh & Halstrom, 2016). The focus and aims of ANE are described by Gagnon and Sandall (2011) as to:

influence health behaviour; build women's confidence in their ability to give birth; prepare women and their partners for childbirth; prepare for parenthood; develop social support networks; promote confident parents; and contribute to reducing perinatal morbidity and mortality (p. 3).

However, it is unclear from the literature if current ANE programs meet all the outcomes described in this definition.

Historically women would provide information and education regarding childbirth and parenting practices to each other (Smith & Homer, 2017). More formalised ANE is now offered by a variety of providers such as private midwifery practices, public health departments and hospitals, private hospitals, practitioners trained in specific birthing techniques, physiotherapists, obstetric practitioners and doulas (Australian Government and HealthDirect Australia, 2017; Childbirth and Parenting Educators of Australia (CAPEA) 2019).

Antenatal education – major influences and changing ideologies

Formal ANE is a relatively modern phenomenon provided by practitioner groups or individual educators across a range of contexts. Over the last two centuries, several historical developments in both public health and the development of health services have influenced contemporary ANE in Australia. These include public health initiatives, movements to promote natural childbirth and physiological birth, the professionalisation of antenatal education, and commercial provision of antenatal education. These influences will each be discussed in detail and are outlined in Table 1.

Insert Table 1 here

Table 1. Major influences on the evolution of antenatal education

Public health: strategies in the development of maternity care: 18th – 19th century

When Australia was first colonised in 1788, a woman would give birth in her home, attended by her family members, with another woman from her community acting as the midwife if the woman could afford one (Monk et al., 2013). Indigenous Australian women would pass on knowledge about childbirth and parenting through a set of cultural laws referred to as 'Women's Business'; for many women, this information remained secret and sacred (Simmonds et al. 2010). What women in the new colony (Australia) knew about birth and parenting was passed on through family and community (Lindell, 1988) including lay midwives. A lay midwife was someone who practised midwifery in the home but had not received formal training in a midwifery program (Butter & Kay 1988). These lay midwives provided intensive and individualised ANE in what today would be considered a continuity of care model, albeit from a basis of little formal training. Their knowledge about birth and parenting was derived from the oral tradition of 'women's wisdom' (Donnison, 1988), which was passed on from woman to woman and accumulated following personal experiences of attending home births and parenting their own children. Women also shared information with members of the extended family known as the 'women's network' (Jordaan, 2009).

Given the contaminated water supplies and hazardous waste disposal at this time, efforts were made to support and educate expectant mothers on good hygiene practices (Monk et al., 2013). These aimed to reduce high levels of infant and maternal mortality. Poor sanitation was addressed in part by moving antenatal care, education and birth into the public domain, which excluded siblings, relatives and friends from the birth experience and the education it would have provided for them (Nolan, 1997). At this time John Snow was highly regarded as having success in the United Kingdom in improving sanitation through the provision of public health strategies (Brody, 2003). Although sanitation and other public health measures were effective in improving health, there is no published research indicating how women responded to having birth decisions made for them by public health officials.

Natural childbirth: Early 20th century

The key change in the provision of care for women in the early 20th century included public health strategies that professionalised the management of maternity experiences (Schofield, 1995). Competition between doctors and midwives arose regarding the provision of care, with medicine achieving control over women's health (Monk et al., 2013) and maternity policies and practice (Dahlen et al., 2012). In 1912 the baby bonus was introduced, to encourage families to have children with financial support, so that birthing women could afford the services of a doctor or a midwife (Monk et al., 2013). This had several impacts on what women thought about birth, where they birthed and how they prepared for birth. Many went to hospital partly to seek respite from raising a large family of often unwell children due to the prevalence of diseases in the community (Nolan, 1997). By the mid-1930s most women had a doctor in attendance at their birth and with the introduction of antibiotics in 1945, medical management of childbirth was seen as the safer option by many women (Monk et al., 2013). Professional management of pregnancy, birth and parenting led to an emphasis on health promotion, preventive care and what constituted 'good mothering'. The pervasive view of mothering during this time was linked to survival due to high infant mortality rates, rates of infection and the need to produce a labour force to increase productivity. The production of information by experts, and engagement in formal services, resulted in lower reliance on, and ultimately, less availability of women's networks over time. As women's awareness about childbirth and parenting has declined so has their confidence in their ability to give birth (Nolan, 1997).

As birth moved from home to hospital and became more medicalised (Lothian, 2008), ANE became an integral part of antenatal care. In the early 20th century the focus shifted to various techniques to cope with the pain of childbirth (Williams & Booth, 1974). The prevailing view at this time was that childbirth was painful, and to cope with the pain of childbirth women sought to have a 'normal' birth. Women received education about female physiology and were supported during labour, which aimed to promote spontaneous birth (Dick-Read, 1956 cited by Akrich et al., 2014). At this time, women experiencing a problem with their body would seek help from the medical profession, many of whom were males whom they trusted for advice about female physiology.

From the 1930s, other responses to the medicalisation of childbirth were the use of pain-relieving drugs, an increase in operative deliveries, and various approaches to promoting 'natural childbirth' (Beck et al., 1979). Pain was a key focus in the popular texts used at the time (Dick-Read, 1933, 1944). Dick-Read (1933) originally claimed that childbirth is not an inherently painful process: "*Pain of labor must therefore be accepted as a psychic stimulus, reproduced from misconceptions based upon culture*" (p. 52), indicating that pain arises from social expectations. He later modified his description of the origin of pain, stating that fear regarding labour "*gives rise to resistance at the outlet of the womb*" (p. 6) which, in turn, produces pain "*because the uterus is supplied with organs which record pain set up by excessive tension*" (p. 6). Dick-Read (1933) also identified a process which he calls the "*fear-tension-pain-syndrome*" and recommended that contractions should not be referred to as painful (Beck et al. 1979) (p. 46). According to Beck et al. (1979) as Dick-Read's model became more popular he established an antenatal program that provided relaxation training in group settings for couples, provided by midwives and physiotherapists familiar with his theories. He also pioneered husband coaching and participation, actively encouraging husband participation during labour, provided the husband could participate "*without becoming unduly upset*" (Beck et al., 1979, p. 253). Support throughout pregnancy, birth and labour were, and continue to be, considered important aspects of ANE.

The management of pain in labour and birth was a key focus for ANE. Women's pain in labour was meant to be controlled and managed by medical professionals. This focus led to obstetrics becoming over-medicalised through the use of pain-relieving drugs and operative delivery (Beck et al., 1979). In response, the Pavlovian theory or psychoprophylaxis method was developed by Russian scientists (Velvovsky et al., 1960) to manage pain during labour. Like Dick-Read, Velvovsky and colleagues (1960) also argued that labour was not inherently painful, describing psychoprophylaxis as like natural childbirth in that it is based on deep breathing and relaxation exercises, and techniques such as stroking the abdomen. These texts influenced women's thinking about pain prevention techniques that consist of applying pressure to certain "*pain prevention points*" (p. 248) which were found along the back and on parts of the pelvis. According to Velvovsky et al. (1960), the birthing woman should also be instructed to time and record the interval between contractions (Beck et al. 1979), a practice

that is continued and taught in some health care facilities today without a rationale, given the variability of birth experiences.

Following a trip to Russia, Lamaze, a French obstetrician, expanded on the psychoprophylaxis method and adapted it for the European culture (Lamaze, 1958). Again, the approach included relaxation, based on breathing techniques to manage birth pain. Unlike Velovsky et al. (1960), the Lamaze method did not include stroking, timing contractions, or the use of pain prevention points, but did encourage more emotional support from the father of the baby and their involvement with the birth.

A Cochrane review (Gagnon & Sandall, 2011) comparing the benefits of individual and group ANE for childbirth and parenthood concluded that natural childbirth and Lamaze methods were similar in their emphasis on healthy pregnancy, physical fitness, education on the physiology of normal birth, elimination of fear during labour, use of relaxation and breathing techniques, and continuous support by a familiar person. The review concluded that the benefits to pregnant women and their families about preparation for birth and parenting in either model were unclear and that resources should be developed that meet the needs of the family.

Bradley (1965), an American obstetrician, adapted Dick-Read's method, encouraging partners to attend the birth to help coach their wives with breathing and relaxation exercises during labour. Bradley (1965) based his practice on six main beliefs: darkness, solitude and quiet, physical comfort, physical relaxation, controlled breathing, and the need for closed eyes and the appearance of sleep. These are incorporated into 12 weeks of classes throughout the third trimester of pregnancy. One of the key concepts of the Bradley Method® was husband as a coach (Haire, 1999), where husbands provide support to their wives while in labour and ensure a supportive environment to meet the six beliefs outlined above (Walker, Visger & Rossie, 2009). Walker et al. (2009) explain that most instructors for Bradley classes were couples where the woman had experienced a medication-free childbirth and had attended a Bradley childbirth education series themselves. The Bradley Method® stressed the importance of healthy baby, healthy mother and healthy families. Views from many of these approaches still form the foundation of ANE programs today (Lothian, 2008),

although 'natural' and 'normal' are no longer synonymous, since a 'normal birth' in a hospital involves routine interventions guided by hospital policies (Romano & Lothian, 2008).

However, women tended to perceive that what was expected and considered normal was a natural birth.

Promoting physiological birth: late 20th century

Many of the models of ANE in Australia from the 1970s to the 1990s, make use of Dick-Read's and Lamaze's early teachings, emphasising relaxation, support and education on the physiology of normal birth (Jordaan, 2009). Optimal ANE promotes physiological birth which influences the woman's expectations of her birthing experience. The concept of physiological birth recognises that unless there is a medical necessity, interference in the normal birthing process can place the woman and baby at risk of adverse sequelae (Romano & Lothian, 2008). Interfering in a natural physiological birth is not supported by evidence and contradicts the medical imperative to 'first, do no harm' (Jansen et al. 2013). Contemporary antenatal classes have been influenced by a range of prominent antenatal educators such as Sheila Kitzinger, Janet Balaskas and Sharon Schindler-Rising, who are key influencers in the ANE movement (Downer, 2019).

English feminist and social anthropologist, Sheila Kitzinger, had a major influence on how women thought about childbirth. Kitzinger was concerned that women were always told what to do when it came to pregnancy, labour and birth, with their own wishes seldom taken into account. Important components of her classes were relaxation and breathing, which also involved meditation and concentrating on what was happening in the moment, which is similar to the concept of 'mindfulness'. Like Dick-Read and Velovsky, Kitzinger's key influences were the provision of a counter-stimulus by massage, pressure, or stroking the area where pain was being experienced. She also advocated the need for women to be upright and mobile (Kitzinger, 1978), to promote optimal birth outcomes. Kitzinger also developed the Birth Crisis Network; a helpline that women could call if they wanted to talk about a traumatic birth (Watts, 2015).

Janet Balaskas (1983) introduced *Active Birth*, in the early 1980s, based on the work of world-renowned obstetrician Michel Odent (Balaskas, 1983). This method views labour and birth as a normal physiological process and helps women use their instincts to give birth safely by avoiding routine interventions, such as vaginal examinations and to birth successfully through one-on-one continuous support. Like Kitzinger, Balaskas key influences were to encourage women to adopt an upright and mobile position for labour and to become knowledgeable about what was happening to their bodies during the antenatal period, labour and birth. She encouraged participants to participate in yoga exercises for pregnancy to reduce stress and tension, to maintain a good posture, and develop deep breathing techniques throughout pregnancy. This advice has endured as a major influence on women's current approach to childbirth.

Globally, new models of antenatal care and education are emerging in response to evidence of increasing maternal morbidity and poor outcomes following birth, particularly associated with higher rates of instrumental and caesarean births (Dahlen et al., 2012).

CenteringPregnancy™, was developed in the 1990s by Sharon Schindler-Rising as a guide to antenatal care, education and social support in a group setting (Schindler-Rising, 1998).

Individual learning needs are considered as a basis for group participation. This model of antenatal care and education combined with social support is emerging in many countries, with several health care facilities adapting the program to the needs of the local community (Teate, Leap & Homer, 2013). According to Schindler-Rising (1998), this model has the potential to improve health outcomes, increase satisfaction amongst antenatal educators who provide the program and provide an efficient and effective model of care delivery, in this study 96% of participants were satisfied with this model of care. CenteringPregnancy™ classes are run by registered health professionals such as midwives and doctors who have additional training in group facilitation; an important aspect of antenatal education.

Professionalisation of antenatal education

Throughout the latter part of the 20th century, efforts have been made towards the normalisation of physiological birth, optimising birth outcomes and improvement of birth

experiences for women in Australia (Department of Health, 2009); however, ANE and care across Australia remain fragmented. Currently, ANE is embedded throughout a woman's antenatal care, which incurs a cost to both health services and consumers. Additional ANE may also be available through formal and informal antenatal classes, conducted by practitioners with an interest in health and wellbeing in the perinatal period and in parenting. These classes are essential, especially for families with the greatest vulnerabilities and few resources who may only have access to education through their contact with midwives during antenatal care. The structure and format of these education programs vary, as does the background and qualifications of the educators. As ANE has developed there has been a move to professionalise and recognise the practice through formal educational preparation of educators and regulation of the emerging profession (Levett & Dahlen, 2019).

While some commercially available programs are highly structured, most ANE activities conducted within health services or communities vary widely and are led by educators from a variety of backgrounds. In Australia, for most mainstream public and private maternity services, ANE is the responsibility of a midwife, some of whom specialise as antenatal educators. Other providers of ANE come from a wide variety of backgrounds, including physiotherapy, doulas, or individuals with an interest in pregnancy, birth and parenting. A doula is defined by the Oxford Learners Dictionary (Online) as 'a woman whose role is to give support, help and advice to a woman who is having a baby'. In Australia, there are no requirements for antenatal educators to have any formal training or qualifications and, as in other countries such as the UK and some parts of the USA, little is known about their educational preparation (O'Sullivan, O'Connell & Devane, 2014).

While there are no requirements for specific educational preparation for educators in Australia, there have been considerable advocates for improvement. For example, Andrea Robertson, formally a childbirth educator and National President of Parents Centres Australia (1978-1984), organised many campaigns for the improvement of maternity services in Australia (Birth International, 2016). Robertson's key influences were that she was instrumental in establishing the first training course for childbirth educators in Australia. She established Associates in Childbirth Education (ACE) now Birth International, a private educational consultancy to train antenatal educators and to provide in-service and

workshops for midwives and other health professionals interested in birth, including education in the online environment. In 1993 her ANE course was accredited through the Australian Government's Vocational Education and Training Accreditation Board as a Graduate Diploma in Childbirth Education; the world's first such course (Birth International, 2016).

Changing attitudes among antenatal educators demonstrate that there has been a steady increase in educators who favour accreditation to ensure quality and consistency of ANE for women and their families. O'Meara's (1993) Australian study of providers of ANE found that most antenatal educators were in favour of accreditation and recommended that a central register of all antenatal educators should be developed. This view has changed little in the last few decades. Currently, the only national non-profit association - the Childbirth and Parenting Educators of Australia (CAPEA) (formerly NACE) - states that all educators are "*accountable and responsible for their own professional development*" (CAPEA, 2018, p. 6). How this is monitored or regulated is unknown. In their current strategic plan 2016 – 2021, CAPEA propose to work towards professional recognition of childbirth and parenting educators, with a target of 60% of their members being certified by 2021 (CAPEA, 2019a). They also plan to commence a national registration process in the same year, with the intention of ensuring that high quality woman centred ANE is provided through a nationally consistent approach by the educators (CAPEA, 2019a)

In contrast, the United Kingdom (UK) and some states in the USA have a national register of antenatal educators. However, in Australia the health care system is fragmented and multilayered both organisationally and geographically. In Australia, differences exist between the Commonwealth government legislation, state education and health departments, local political goals, and regional priorities, and the mix of public and private hospitals. Unlike the UK with its single health care system and national controls, Australia would require numerous organisational arrangements to agree on and implement national standards. Although there is a national accreditation agency, the Australian Health Practitioner Regulation Agency (AHPRA), employers are often responsible for the development and delivery of educational programs delivered in clinical settings, as is currently the case for ANE.

In the UK it is the role of the regulator to ensure that individuals admitted to a national register are competent to practise and are appropriately trained with a valid qualification, insured, and that they abide by the Code of Ethics and Practice applicable to Federation of Antenatal Educators (FEDANT). This has led to the role of the antenatal educator becoming recognised as a distinct health profession in the UK (FEDANT 2017). Training programs for antenatal educators are mapped against FEDANT Approved National Standards and the competencies used by the Government Sector Skills Council (FEDANT 2020). Levett and Dahlen (2019) pose the question *'is it time to regulate this space?'* in Australia, highlighting that ANE provided by the hospital system is often a form of orientation to the health care facility, rather than a discussion about birth and early parenting. Regulation of all providers of ANE would ensure that classes met the needs of the women and families who attend classes and the requirements outlined in the competency standards (CAPEA, 2018).

International and national guidelines exist, which underpin maternity service provision, encouraging 'normal' physiological birth practices (National Childbirth Trust, 2020; National Institute for Health and Clinical Excellence, 2016) with an underlying aim of reducing costly interventions in birth. Professional midwifery groups are also especially active in this regard throughout the world to protect what has been defined as 'normal' physiological birth (Australian College of Midwives, 2016; New Zealand College of Midwives, 2015; Canadian Association of Midwives, 2008). It could be expected that ANE could be a central component of achieving normal birth.

Commercial provision of antenatal education: late 20th and early 21st century

Since the 1990s a variety of specific types of ANE programs have become popular. In Australia, as independent antenatal educators are not regulated, many types of ANE programs have been developed within a commercial or business model to meet a particular market. Examples include programs that focus on natural birth, HypnoBirth™, Calmbirth™, Active Birth, Yoga, Lactation/Breastfeeding, Homebirth classes and Aqua-natal classes. Many women are exploring alternatives to traditional classes with clear links to the fitness industry evident in these models. The CAPEA assessment tool (CAPEA 2019b) could be used to assess how well these Educators apply the Competency Standards to their practice.

In addition, online courses and mobile apps are influencing antenatal educators delivering education as well as women and their families who attend classes. With the increase in technology women have access to more information than ever before, and they can download an app on their mobile device or go online. In classes, antenatal educators need to be aware of what is available to participants so that they can answer questions raised by families who have accessed online information and help ensure its accuracy. Part of maintaining a woman centred approach is to work in partnership with class participants while monitoring and guiding their knowledge of birth and parenting. This includes being familiar with as many resources as possible; for example, ANE provided in online formats such as Tummy Talks and Born Online™ and a range of mobile applications that have been commercially developed, such as the What Were We Thinking? and The Health-eBabies apps for antenatal education (Dalton et al., 2018). Some of these programs and franchises offer several days of training so that educators can follow the philosophy of the program and become a practitioner of the method. Ongoing annual fees are often charged so that practitioners can register and use their certification or licence on marketing material, once they have established their own business. Many of these programs are held in the private homes of the practitioners, local community centres or sports venues.

Social media, blogs and online forums provide virtual educational experiences with a vast amount of information related to pregnancy, birth and parenting available through web-based resources. It is unclear how women interact in web-based discussion forums; however, Fredriksen, Harris and Moland (2016) found that pregnant women access the internet for support and information with the aim of making better health decisions for themselves. This type of education provides just-in-time learning; however, it often attracts a fee for the service, which is private and unregulated for ANE, and can include online classes and information.

The commercialisation of ANE raises professional and quality related issues with regards to the provision of classes and health related information. While offering choice for participants, costs are involved for those who attend, and annual licencing fees and franchise fees are charged to those who hold the classes. Some of these classes duplicate those

offered by the health care facility, which are often free of charge. These entrepreneurs are currently expanding their practice across Australia which would demonstrate a demand for this service.

Discussion

Is birthing still woman-centred? We began this historical journey by describing a woman-centred ideology, where birthing was women's business and women had the knowledge and confidence to make decisions about birth and parenting. Research and ANE experiences have had an interesting trajectory, with new information, perspectives and models of care developed to guide both families and antenatal educators; yet, little has changed since the 1990s (Downer, 2019). In an attempt to strengthen women's control over birth and parenting, suggestions have been made to reframe ANE in terms of supporting women's knowledge and empowerment. One way of achieving this is through the regulation of antenatal educators; that is, to ensure educators are working from a common ideology. However, many women draw on resources other than the ANE educators for their information; for example, social media, which can lead to inconsistent advice. The last decade has also seen an increase in online websites and commercial services offering virtual and private ANE (Fredriksen et al., 2016). Despite the plethora of information, poor practices go unchecked (Levett & Dahlen, 2019) and little research has been conducted into women's experiences of using the various services.

The medicalisation of childbirth that became prominent in the early 20th century continues to be an issue today. Birth is seen as a medical procedure with women's voices remaining unheard in the health care system; a persistent influence that dictates how ANE strategies as well as birthing and parenting should occur (Downer, 2019; Levett & Dahlen, 2019). This needs to be redressed through the regulation of the antenatal educator profession, which would protect the public interest through consistent, high quality education provided by an appropriately educated and skilled antenatal educator and focused on women's right to make birth choices from a base of appropriate information.

Antenatal educators have changed their strategies in providing education in some of the newer models of care; however, without recognition, regulation or a research agenda that could confirm, challenge or change these ANE models or strategies, evidence-based practices remain elusive. Investigations into the pedagogy of current antenatal classes, processes, and practices of antenatal educators requires evaluation. How the Internet is used by class participants is also recommended as an area of need for future study.

Women's voices and concerns should be integral to the research agenda. There is an imperative to explore further the needs of women and their families who are known to experience poorer birth outcomes, which may be addressed by specific targeted programs, for example, participants who are incarcerated, socio-economically disadvantaged, identify as being First Nations or refugees (Downer 2019). Further, the majority of existing literature focusses on educational strategies and programs most likely to be effective for participants with reasonable literacy and education levels with a similar cultural background to the antenatal educator. Consideration of the goals of antenatal education using health literacy as a conceptual model offers an opportunity to move thinking in ANE away from a simple didactic transfer of knowledge, to an active engagement in learning that builds confidence in class participants.

At their 'Revitalising Childbirth and Parenting Education', conference later this year CAPEA has the opportunity to reach out to childbirth educators to discuss future directions for ANE within Australia. The Clinical Excellence Division paper (Queensland Health, 2018) recommends that ANE *'programs should be regularly evaluated, and consideration should be given to utilising the Childbirth and Parenting Educators of Australia's (CAPEA) Competency Standards and associated assessment tool'* (p.2). Therefore, the foundations and recommendation have been laid for future practice, that could already be implemented to safely support the profession for the benefit of educators, parents and their families to ensure antenatal education is woman centred.

Conclusion

Antenatal education has been normalised in Australian maternity services and is currently delivered within antenatal care services or as formal stand alone educational experience for women and their partner or support person. Recent research indicates that ANE programs can vary widely in length, instructor training, goals, focus and content, with most health professionals agreeing that ANE is informative and is highly recommended for expectant parents (Downer, 2019). While the evaluation of ANE efficacy has been mixed, it remains a significant component of antenatal care. Given that ANE is integral to pregnancy care and that professional specialisation has evolved around its provision, it is important to address issues about professionalisation. It is recommended that the Competency Standards for Childbirth and Early Parenting (CAPEA, 2018) should be implemented to enable evaluation of and compliance with ANE programs. This is particularly important in the Australian context where the development and regulation of ANE as a professional enterprise has not occurred and that while ANE is commonplace, little is known about the way it is designed and delivered by antenatal educators or evaluated by the participants. The history of antenatal education is important to the care of women and their families. Knowing what has preceded the current situation can help health practitioners develop appropriate classes in the future, ensuring that it continues to be woman-centred.

References

- Akrich, M., Leane, M., Roberts, C., & Nunes, J.A. (2014). 'Practising childbirth activism: A politics of evidence'. *Journal of Biosocieties*, 9(2), 129-152. <https://doi.org/10.1057/biosoc.2014.5>
- Australian College of Midwives (ACM), (2016). *Scope of practice for midwives in Australia*, viewed 16 Jan 2020, <https://www.midwives.org.au/resources/scope-practice-midwives-australia>
- Australian Government and HealthDirect Australia, (2017). Pregnancy, Birth and Parenting, HealthDirect, viewed 28 May 2020 <https://www.pregnancybirthbaby.org.au/antenatal-classes>
- Balaskas, J. (1983). *Active birth*, Unwin Paperbacks, London.
- Beck, N., Geden, E., & Brouder, G. (1979). Preparation for labor: a historical perspective. *Psychosomatic Medicine*, 41(3), 243-258, <https://pdfs.semanticscholar.org/6b24/0b62395950095a0e1d40dbb668bc5a9d3806.pdf>
- Berlin, A., Tornkvist, L., & Barimani, M. (2016). Content and Presentation of Content in Parental Education Groups in Sweden. *Journal of Perinatal Education*. 25, 87-96, doi: 10.1891/1058-1243.25.2.87
- Birth International, (2016). *About us*, viewed 7 January 2020, <https://birthinternational.com/about-us/>
- Brady, S., Lee, N., Gibbons, K., & Bogossian, F. (2019). Woman-centred care: An integrative review of the empirical literature. *International Journal of Nursing Studies*. 94, 107-119. <https://doi.org/10.1016/j.ijnurstu.2019.01.001>
- Bradley, R. (1965). *Husband coached birth*, Harper & Row, New York.
- Brody, H. (2003). *Cholera, Chloroform, and the Science of Medicine: A Life of John Snow*. Oxford University Press.
- Butter, I., & Kay, B. (1988) State laws and the practice of Lay Midwifery. *AJPH*. 78(9), 1161- 1169, viewed 2 June 2020, <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.78.9.1161>
- Canadian Association of Midwives (CAM), (2008). *About CAM vision & mission*, CAM, viewed 15 January 2020, <http://www.canadianmidwives.org/vision-and-mission.html>
- Childbirth and Parenting Educators of Australia (CAPEA), (2019a). *Strategic plan*, viewed 16 January 2020, <http://www.capea.org.au/About-Capea/Strategic-Plan>
- Childbirth and Parenting Educators of Australia (CAPEA), (2019b). *Assessment tool*, viewed 2 June 2020, <https://www.capea.org.au/Portals/0/Birth%20and%20Parenting%20Educator's%20Assessment%20Tool%20.pdf?ver=2019-02-25-141001-200>
- Childbirth and Parenting Educators of Australia (CAPEA), (2018). *Competency Standards for Childbirth and Parenting educators*. 2nd edition, viewed 2 June 2020, <https://www.capea.org.au/Portals/0/National%20Competency%20Standards%202019.pdf?ver=2019-02-25-144836-947>
- Dahlen, H.G., Tracy, S., Tracy M, Bisits, A., Brown, C., & Thornton, C. (2012). Rates of obstetric intervention among low-risk women giving birth in private and public hospitals in NSW: a population-based descriptive study. *BMJ Open*, (2)5, doi: 10.1136/bmjopen-2012-001723

- Dalton, J., Rodgers, D., Roberts, C., & Clifton, V. (2018). The Health-e Babies app for antenatal education: Feasibility for socially disadvantaged women. *Journal of Women's Health Care*, 6(4), 54, doi: 10.1371/journal.pone.0194337
- Dick-Read, G. (1933). *Natural childbirth*, Harper and Row, New York.
- Dick-Read, G. (1944). *Childbirth without fear*, Harper and Row, New York.
- Donnison, J. (1988). *Midwives and medical men: a history of the struggle for the control of childbirth*, Historical Publications, London.
- Downer, T. (2019). Exploring Antenatal Education: An Interpretive Description. (Unpublished doctoral dissertation). University of the Sunshine Coast, Australia.
- Entsieh, A., & Hallstrom, I. (2016). First-time parents' prenatal needs for early parenthood preparation-a systematic review and meta-synthesis of qualitative literature. *Midwifery*, 39, 1–11, doi: 10.1016/j.midw.2016.04.006
- Federation of Antenatal Educators (FEDANT), (2020). *Registration*, viewed 12 January 2020, <http://www.fedant.org/>
- Fredriksen, E.H., Harris, J., & Moland, K.M. (2016). Web-based discussion forums on pregnancy complaints and maternal health literacy in Norway: a qualitative study. *J Med Internet Res*, 18(5), e113, doi: 10.2196/jmir.5270
- Gagnon, A.J., & Sandall, J. (2011). Individual or group antenatal education for childbirth or parenthood, or both. *Cochrane Database of Systematic Reviews*, Issue 3. Art. No.: CD002869, doi: 10.1002/14651858.CD002869.pub2.
- Haire, D. (1999). Focal point on childbirth education. A history of childbirth education. *International Journal of Childbirth Education*, 14(4), 26–28, viewed 14 January 2020, <https://search.proquest.com/docview/212858999?pq-origsite=gscholar>
- Jansen, L., Gibson, M., Bowles, B.C., & Leach, J. (2013). First do no harm: interventions during childbirth. *Journal of Perinatal Education*, 22(2), 83–92, doi: 10.1891/1058-1243.22.2.83
- Jordaan, C. (2009). A literature review on childbirth education. *Paediatrics*, 13(2), 34-37, viewed 15 April 2015, <http://www.pntonline.co.za/index.php/PNT/article/view/377>
- Kitzinger, S. (1978). Pain in childbirth. *Journal of Medical Ethics*, 4, 119–21, viewed 15 January 2020, <https://jme.bmj.com/content/medethics/4/3/119.full.pdf>
- Lamaze, F. (1958). *Painless childbirth. Psychoprophylactic method, (translated by Celestin LR)*. Burke, London.
- Levett, K., & Dahlen, H. (2019). Perspectives: Childbirth education in Australia: Have we lost our way? *Woman and Birth*, 32, 291-293. <https://doi.org/10.1016/j.wombi.2018.05.007>
- Lindell, S. (1988). Education for childbirth: a time for Change. *Journal Obstetric, Gynecologic and Neonatal Nursing*, 17(2), 108-112, <https://doi.org/10.1111/j.1552-6909.1988.tb00520.x>
- Lothian, J.A. (2008). Childbirth education at the crossroads). *Journal of Perinatal Education*, 17(2), 45–49, doi: 10.1624/105812408X298381

- Monk, A., Tracy, S., Foureur, M., & Barclay, L. (2013). Australian primary maternity units: past, present and future. *26*(3), 213–218, doi: 10.1016/j.wombi.2013.06.001
- Glenn, E. N., Chang, G., & Forcey, L. R. (1994). *Mothering: Ideology, experience, agency*. New York: Routledge.
- National Childbirth Trust, (2020). *About us*, NCT, viewed 13 January 2020, <https://www.nct.org.uk/about-us>
- National Institute for Health and Clinical Excellence (NICE) 2016, *Antenatal care for uncomplicated pregnancies*, viewed 16 January 2020, <https://www.guidelines.co.uk/womens-health/nice-antenatal-care-guideline/252761.article>
- New Zealand College of Midwives, (2015). *Midwives handbook for practice*, NZCM, Christchurch.
- Nolan, M (1997). Antenatal education: where next? *Journal of Advanced Nursing*. *25*(6), 1198-1204, <https://doi.org/10.1046/j.1365-2648.1997.19970251198.x>
- Nolan, M. (2012). Before we begin. The importance of antenatal education. *The Practising Midwife*, *15*(4), 12–14, <https://www.ncbi.nlm.nih.gov/pubmed/22662533>
- O’Meara, C.M. (1993). An evaluation of consumer perspectives of childbirth and parenting education. *Midwifery*, *9*(4), 210–219, [https://doi.org/10.1016/0266-6138\(93\)90004-C](https://doi.org/10.1016/0266-6138(93)90004-C)
- O’Sullivan, C., O’Connell, R., & Devane, D. (2014). A descriptive survey of the educational preparation and practices of antenatal educators in Ireland. *The Journal of Perinatal Education*, *23*(1), 33-40, doi: 10.1891/1058-1243.23.1.33
- Queensland Health, (2018). Recommendations for antenatal education, content development and delivery. Clinical Excellence division. Queensland Government.
- Romano, AM., & Lothian, JA. (2008). Promoting, protecting, and supporting normal birth: A look at the evidence. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *37*(1), 94-105, doi: 10.1111/j.1552-6909.2007.00210.x
- Schofield, T. (1995). Politics, public policy and childbirth, NSW 1950-1990. PhD Dept of Government and Public Administration, University of Sydney.
- Schindler-Rising, S. (1998). CenteringPregnancy: an interdisciplinary model of empowerment. *Journal of Nurse-Midwifery*, *43*(1), 46-54, [https://doi.org/10.1016/S0091-2182\(97\)00117-1](https://doi.org/10.1016/S0091-2182(97)00117-1)
- Simmonds, D.M., Porter, J., O’Rourke, P.K., West, L., Tangey, A., Holland, C., & Davies, M. (2010). You can tell us your things and we’ll teach you ours: A 'Two Ways' Approach to Improving Antenatal Education for Ngaanyatjarra Women. *Aboriginal & Islander Health Worker Journal*, *34*(2), 10- 14.
- Teate, A., Leap, N., & Homer, C. (2013). Midwives’ experiences of becoming CenteringPregnancy facilitators: a pilot study in Sydney, Australia. *Woman and Birth*, *26*(1), e31–e36, doi: 10.1016/j.wombi.2012.08.002
- The Department of Health, (2009). Improving maternity services in Australia: the report of the maternity services review, Australian Government.

Velvovsky, I., Platnov, K., Ploticher, V., & Shugom, E. (1960). *Painless childbirth through psychoprophylaxis*, Foreign Languages Publishing House, Moscow.

Walker, D.S., Visger, J.M., & Rossie, D. (2009). Contemporary childbirth education models. *The Journal of Midwifery Women's Health*, 54(6), 469–476, doi: 10.1016/j.jmwh.2009.02.013

Watts, G. (2015). Sheila Kitzinger. *The Lancet*, 385, 382.

Williams, M., & Booth, D. (1974). *Antenatal education, guidelines for teachers*, Churchill Livingstone, Edinburgh.