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The importance of face to face, group antenatal education classes for first time mothers: A qualitative study

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ABSTRACT

Objectives: To explore and understand perspectives of women expecting their first child and why they wanted to attend NHS antenatal education. This included what worries and concerns they wanted to be addressed and why this would be beneficial. It also included what they wanted their partners to be able to gain from attending classes.
Design: A longitudinal qualitative study using Template Analysis was undertaken with data collection during pregnancy and postpartum. A semi-structured topic guide was used to guide data collection, either via focus groups or one to one interviews which were audio recorded and transcribed.
Setting: National Health Service Trusts providing maternity services to women for labour and birth, purposively selected to allow the perspectives of specific groups of women to be included.
Participants: Women expecting their first child from one of three groups: Women from the general population aged 20 years or more, women from ethnic minority groups and young women aged 16 to 19 years.
Findings: Eighty-two pregnant women participated. Three substantive themes are reported: the search for information, the functions of antenatal classes, and the specific information desired. Women wanted to attend NHS antenatal education to access trustworthy information that would reassure, increase confidence, and help them feel prepared. Women wanted to meet others in the same situation to help normalise concerns and offer the potential for ongoing relationships. Classes were seen as a way to help partners engage more fully with the transition to parenthood. Specific information required and shared by all groups was around understanding the stages of labour, managing labour, and common interventions.
Conclusions: Access to a wide range of information increases women's anxieties about labour that women want addressed through antenatal education. However, antenatal classes serve broader functions beyond information- giving and women anticipate that attending antenatal classes will address both their own and their partners' needs.
Implications: Service providers should ensure their antenatal education provision provides the information required and is structured in a way that enables women to develop relationships and supports partners' engagement in the transition to parenthood.

Background

A significant number of women experience anxiety during pregnancy; with rates of 36.3%, 32.3% and 35.8% for the first, second and third trimesters respectively (Lee et al 2007). Antenatal anxiety predisposes women to postnatal depression (Heron et al., 2004, Austin et al., 2008) and impacts on children's emotional and behavioural wellbeing. Fear of childbirth is an important component of anxiety. Ten elements have been identified which contribute to the construct of fear of childbirth. These include fear of not knowing and inability to plan for an unpredictable event; fear of inability to cope with pain and fear of harm to self (Slade et al., 2019). Prevalence of fear of childbirth has been reported at 14% (O'Connell et al., 2017).

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Table 1
Participants by site, by group and method of data collection.

Total N=82	'General' Women N= 36	Women from Minority ethnic backgrounds N= 27	Young women (16 to 19 years) N= 19
Trust	Method of data collection and number of participants for each method		
1	1st Focus group = 5 2nd Focus group = 3 Interviews = 2 TOTAL 10	1st Focus group = 4 2nd Focus group = 7 3rd Focus Group = 3 Interviews = 0 TOTAL 14	1st Focus group = 3 2nd Focus group = 4 Interviews = 0 TOTAL 7
2	Focus group =9 Interviews = 0 TOTAL 9	1st Focus group = 2 2nd Focus group = 2 Interviews = 0 TOTAL 4	Focus Group = 0 Interviews = 3 TOTAL 3
3	1st Focus group = 4 2nd Focus group = 6 Interviews = 0 TOTAL 10	1st Focus group = 5 2nd Focus group = 3 Interviews = 2 TOTAL 9	Focus group = 0 Interviews = 7 TOTAL 7
4	Focus group = 5 Interviews = 2 TOTAL 7	Unable to recruit 0	Focus group = 0 Interviews = 2 TOTAL 2

One means of addressing concerns about labour and birth is through preparation for labour, traditionally provided during short courses of antenatal education classes (Nolan, 2009). These are available in many settings internationally, provided by healthcare professionals and childbirth educators. Classes have traditionally included information about labour, infant feeding and caring for a new baby and strategies to cope with physical and emotional aspects of labour. Although preparation for labour is a well-established component of maternity care, its evidence base is limited (Gagnon and Sandall, 2007) and it has rarely drawn on psychological theory (Escott et al., 2009). Further, provision varies across healthcare providers (blinded for peer review) and not all women receive or accept an invitation to sessions (Henderson and Redshaw, 2017). Antenatal education has the potential to profoundly influence both expectations (Downer et al, 2020) and evaluations of labour (Sanders & Crozier, 2018), which in turn can influence maternal emotional wellbeing postnatally.

Informed by systematic reviews, empirical evidence and an expert panel, a resource pack *Preparation for Birth and Beyond* (PBB) (Department of Health, 2011) was designed to inform group antenatal education, especially to support groups identified as underserved: young women, women from ethnic minority groups, and fathers. Further details about the PBB and background to that initiative are located in (Spiby et al., 2021).

This research reports findings from the first phase of a longitudinal study which focuses on pregnant women expecting their first child and why they were interested in attending NHS antenatal education, including any worries or concerns they wanted addressed, the reasons for that and what women wanted their partners to gain from attending classes. A subsequent paper reports how adequately their needs were met.

Methods

Study design

A longitudinal qualitative study sought information firstly, about why women attended antenatal education and secondly, their perceptions in the light of their childbirth experience (reported separately).

Setting

Four Trusts (organisations providing NHS care) were purposively selected that served ethnically diverse populations in the Northwest, East Midlands and North of England.

Participants, setting and recruitment

Eligible participants were pregnant women, expecting their first baby, planning attendance at NHS antenatal education; able to provide informed consent and from one of the following groups:

- General population of childbearing women aged 20 years and above (abbreviated subsequently to general women) (GW), or
- Women aged 16 to19 years (abbreviated to young women) (YW), or
- Women from an ethnic minority group aged 16 and above (abbreviated to MeW)

Recruitment was supported by Clinical Research Network (CRN) midwives and a specialist team providing care for young parents in one Trust, Participant Information Sheets offered by either CRN midwives or members of women's usual care team, either at scanning appointments between 18 to 20 weeks of pregnancy or during the second or third trimester. Written consent was obtained by CRN midwives or members of the research team (where preliminary information had been provided by the usual care team). Translator support (Arabic, Gujerati, Polish, Punjabi and Urdu) was utilised for the provision of information, obtaining consent and data collection.

The aim was to include a planned sample size of 108 participants, i.e., twelve women from each of the three groups and four Trusts as above. Eighty-two women participated: general women (36), women from minority ethnic communities (27), and young women (19), Table 1

Data collection

Focus groups allow group dynamics to be utilised (Freeman, 2006). Data created through participant interactions provides insights into views, and how and why these are held (Kitzinger, 1994). In some cases, participants could not attend or only one person attended a planned group. The research team made a pragmatic decision to offer individual interviews to enable participation, conducted where possible face to face but if this was not feasible, by telephone.

Separate focus groups were held for women from each group; those with women from minority ethnic communities comprised participants who shared a common language to enable language support. Focus groups were held in locations where participants usually accessed their maternity care. Data collection took place between 21st November 2013 and 31st January 2015, during

women's third trimester of pregnancy. Focus groups were between 37 and 77 minutes; interviews between 15 and 51 minutes.

A semi structured topic guide, was piloted in a focus group in one Trust and minor changes to question sequence made. The topic guide explored:

1. Why women were interested in attending NHS antenatal education, including worries or concerns they hoped would be addressed and why
2. What women wanted their partners to gain from attending classes
3. Anything women would prefer *not* to be included?

The topic guide included prompting for topics covered in the 'PBB' resource pack (Department of Health, 2011) 'Giving Birth and Meeting our baby', if not mentioned spontaneously. Focus groups and interviews were digitally audio recorded and professionally transcribed verbatim. When translators were involved in data collection, the paraphrased interpreted data were transcribed. Transcripts were imported into, and data managed using QSR NVivo 10 (QSR International Pty Ltd, 2014)

Data analysis

Template Analysis

Template analysis is positioned in the middle ground between inductive and deductive analytic approaches (King, 2012). Template analysis can be utilized from a variety of epistemological positions but was used in this context from a realist perspective with a focus on reliability of coding and reflexivity (Brooks et al, 2015). The research team included midwifery, psychology and health visiting and consciously worked to critically challenge any existing preconceptions and recheck evidence for emergent themes. A subset of data was read and re-read, an initial coding template developed by one researcher and confirmed by a second. Three major themes were named and derived from the topic guide, whilst the analytic process of noting and agreeing patterns within the data allowed the generation of, and coding in subthemes by three members of the research team (JS, HS, PS).

This initial version of the template incorporating the *a priori* themes was agreed by the research team, and subsequent transcripts were coded using the agreed template. The template was reviewed by the team as coding progressed to assess the fit of subsequent transcripts as they were coded. Revisions were agreed, generally this involved merging two sub themes. The final template was applied to the full dataset. The same template was replicated three times to allow data from all three groups of participants (i.e., GW, YW and MeW) to be coded separately and then combined. Transcripts were not returned to participants for pragmatic reasons.

The process of template development is illustrated in Fig. 1.

Quotes are presented for each theme. Examples demonstrate the Trust, study group, method and contributor

1GW G2 P3 – Trust 1 – the general women's group (GW); a focus group (G) and the second focus group carried out at that Trust (2); speaker from the group was participant 3 (P3)

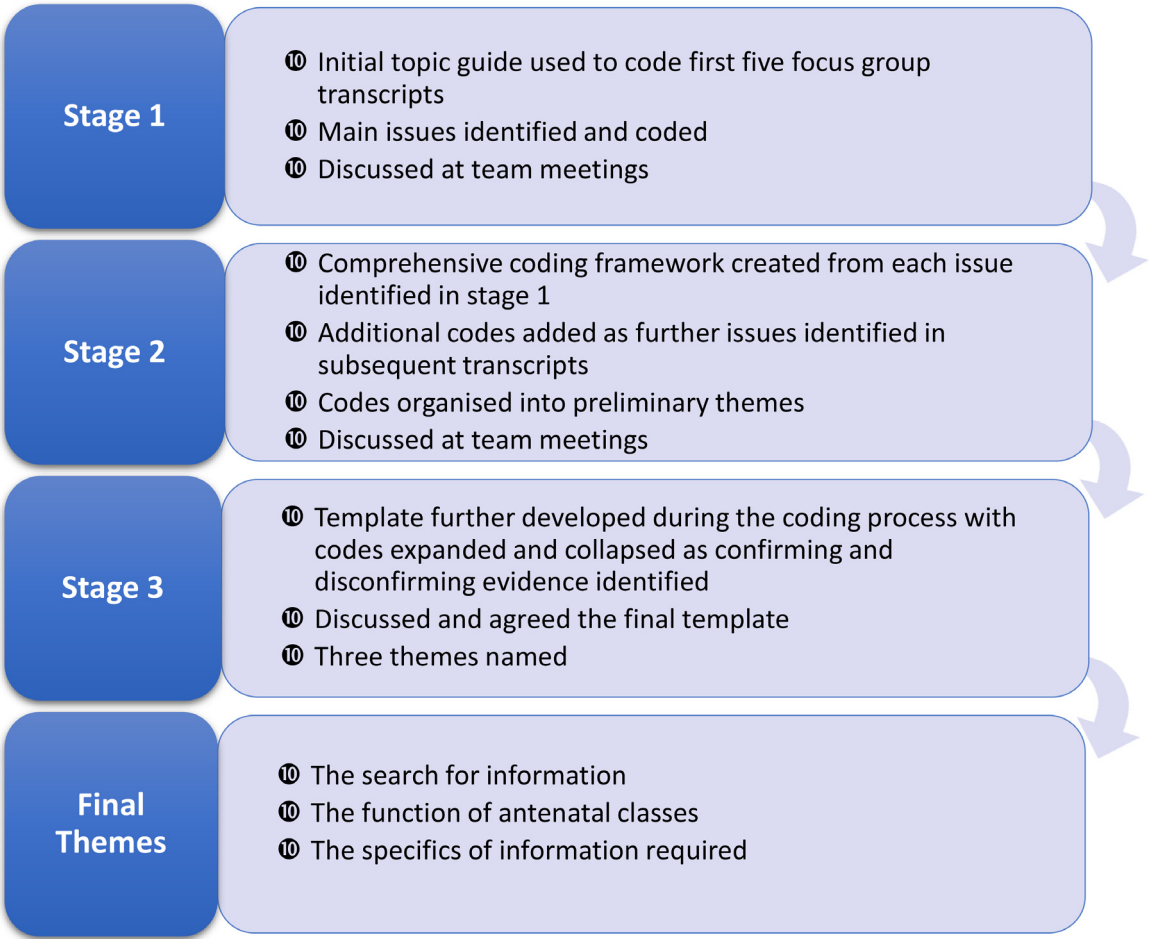

Fig. 1. The process of template development.

4YW I1 – Trust 4 – the Young Women's group (YW); an individual interview (I); the first participant interviewed (1)

1MeW G2 P7 – Trust 1 - a group of minority ethnic women. When the contributor of the quote was a woman talking via the translator indicated by the suffix 'T' e.g., 3MeW 11 T

Ethical Considerations

Ethical approval was gained for the protocol and amendment from NHS research ethics committee NRES Committee 13/WM/0188. Organisational approval was received from each Trust. Informed consent was provided by all participants.

Results

Three major themes and subthemes are shown in Fig. 2. A clear story emerged about women's search for information, why it was necessary, and the specifics required to meet their needs. Similar findings were identified across all groups.

Theme 1 The search for information

General information about pregnancy and childbirth

Women expressed disappointment that routine antenatal appointments did not support the acquisition of information. Against this backdrop, women sought and obtained information from other sources: the internet, television or social media apps, family, friends and work colleagues.

I did my own research on Google like there are a lot of images and a lot of jargon words, uterus and things, so things like cervix, I didn't know what the cervix was or anything, so I was really ignorant but looking at those images, it was really intimidating for me, and nothing made sense (1MeW G2 P1)

Searching for information and the limitations of the information found/given

The different sources resulted in conflicting information. Trustworthy information was needed and typically NHS was cited, however even this had limitations.

You don't know where to trust the sources from. And yes, as much as you can say just go on the NHS website, it doesn't always give you what you need to know (1GW G1 P1)

Overall, women felt the best way to access trustworthy information that met their information needs was face to face, with access to expertise.

There is stuff now available online….. There's so much available but obviously having that face-to-face human contact is much more helpful for me (1MeW G2 P3)

I mean you do hear stories and you hear things from certain friends, but I just think it would be nice to hear it from a professional (4GW I1)

Theme 2 The function of antenatal education classes

We asked women about any concerns they would like antenatal education to help with. Women wanted to fill their perceived

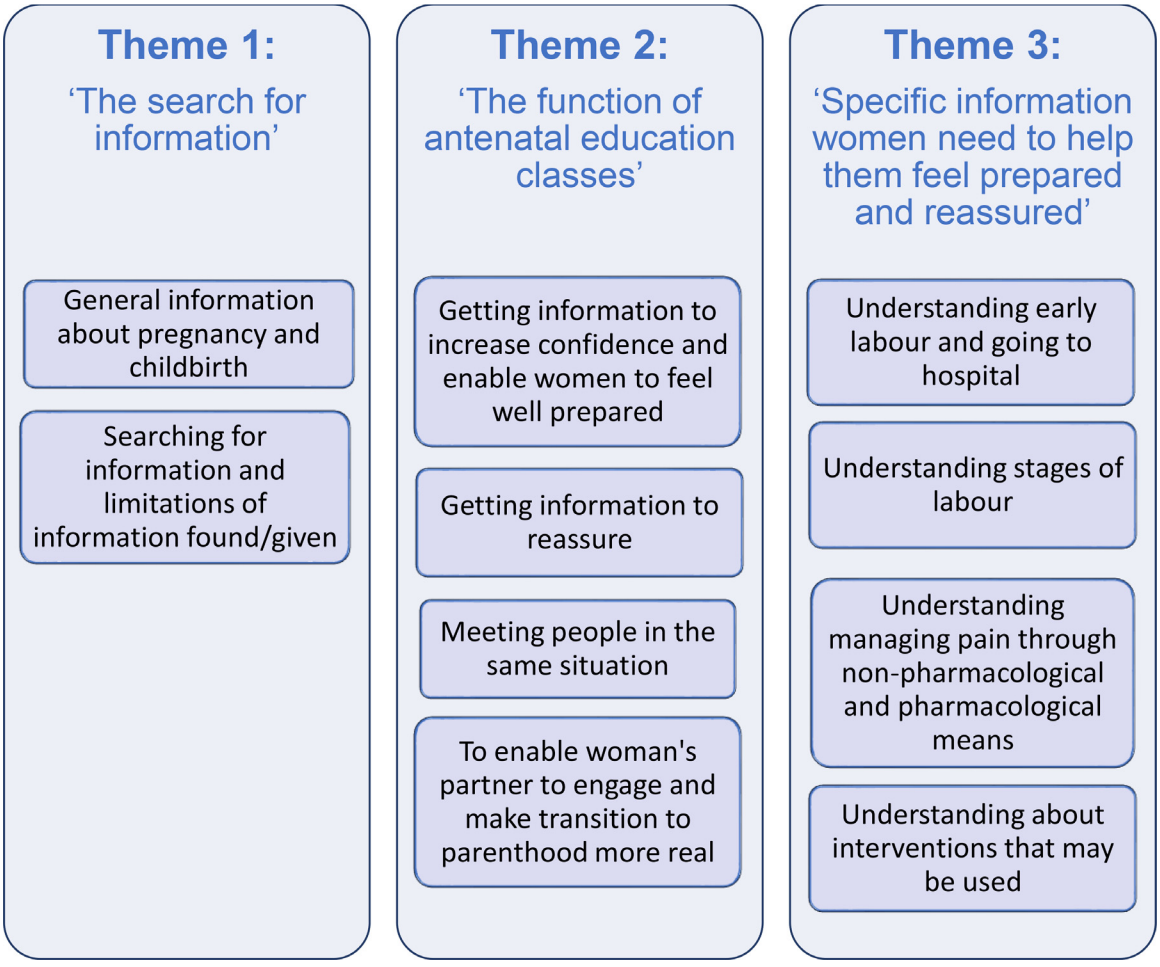

Fig. 2. Final themes and subthemes.

knowledge deficits although they were not always sure *what* they needed to know.

Getting information to increase confidence and enable women to feel well prepared

Women did not feel secure in their existing knowledge so sought to understand the unknowns.

Because I don't know what to do. I think if I went to them (classes) they'd make me more aware of what's going to happen and how it's going to go (labour and birth) (1GW G1 P3)

Getting information to reassure

Women viewed classes as a way of obtaining information that would address their fears and anxieties; fear of dying during childbirth was voiced only by women from minority groups. For some women whose first language was not English, lack of a shared language contributed to anxiety. Most women wanted as much information as possible, but others wanted to avoid thinking about labour in advance.

When I think of antenatal (classes), I kind of think of, you do like loads of breathing techniques, but I'd like to know about like birth plans and complications that could happen. Just lots of reassurance, I guess. (4GW G1 P5)

I'm going through this phase where I'm scared if I die in labour; and I don't know if that's normal or not. I think I've passed two days crying, oh, I'm going to die, I'm going to die…I'm not saying, dying in that sense, but I think I'm scared of giving birth. (1MeW G3 P2)

So [woman's name] is just saying that obviously the cooperation with the midwife is very important, and obviously you need to listen. What if the midwife says something to me and I can't understand? (3MeW G1T)

Well, giving birth it's just...that's something I try and block out…. I don't want to think of that…… I don't really know anything else like what positions are more comfortable and easier to get the baby out...stuff like that and it just scares me. (3YW I1)

Meeting people in the same situation

Although gaining information was important, there was value in being with other women at the same stage of pregnancy to help judge whether their own experience was 'normal'. Meeting other women at the same stage of pregnancy could offer the potential for ongoing friendship and social support.

Yes, because you meet people who are going through the same thing at the same time, so even if you have some concerns or maybe you can say I'm going through this, they can say they're going through this… You can make friends as well (1MeW G2 P7)

I think one thing I'm looking forward to, apart from the information, is hoping to meet other mums to be really and making some mum friends in a way really, … I'm hoping that I'll meet some people that I can stay in contact with. (4GW I2)

Antenatal classes to enable the woman's partner to engage and make the transition to parenthood more real

Women perceived that an important purpose was to support partners' needs. This included redressing perceived exclusion from antenatal care, making the transition to parenthood 'more real' and if both of the couple received the same information, this would facilitate joint discussion about preferences for childbirth. This provided another source of reassurance for the women, who anticipated sometimes not being in a position to make a decision, when their partner could step in to make preferences clear to staff. Women often recognised that their partners were worried about impending childbirth, so another function was to reassure them. Women from all groups felt it was important for their partners to attend classes to understand what they should and should not do to support them during labour.

I'd like his support but he feels like the way the hospitals are run now that it's pushing him out a bit like... he's a bit like, oh, well, they'll only talk to you. (3YW I1)

It's not real to him at the minute, till it's actually happening. So I think classes would benefit him …it would prepare him for what's going to happen, the things that are going to take place while I'm having the baby. And what kind of support he can give me as well. (2YW I3)

I think once you'd been to an antenatal class it gives you more an idea of what you both want. And then when the time comes [partner's name] will actually know what I want as much as I know what I want and hopefully between the two of us it'll happen. (1GW G1 P1)

I think he's more scared than I am, to be honest.…He's petrified…about the labour. I think the classes will help him, if he knows what to expect if I'm screaming or doing something, he might understand why it's happening and not panic. (1GW G2 P1)

Theme 3 Specific information women need to help them feel prepared and reassured

Women wanted to better understand labour, its stages, managing labour pain and common interventions.

Understanding early labour and going to hospital

Women expected antenatal classes would help them to recognise the right time to travel to avoid causing problems or complications. Women used phrases that reflected embarrassment at their lack of knowledge and were keen for information to help them do the right thing

She would feel mentally prepared if she knew exactly the signs of things that are happening. And she worries that she would like to know when she should go, she doesn't want to go back and forth to the hospital like a silly person, but then she wouldn't want to stay at home too long in case something happens (3MeW 11 T)

Understanding stages of labour

Despite access to many forms of information, women were uncertain about the stages of labour and what this meant for them

Just the general stages of labour as well. I read somewhere the other day there're like three or four different stages of labour. I had no idea you had to actually give birth to the placenta afterwards. Like that really scares. (3GW G2 P2)

Understanding managing labour pain through nonpharmacological and pharmacological means

Women were keen for information about both approaches to manage labour pain. They had heard about different forms of pain relief from a variety of sources but saw antenatal classes as a route to definitive information to support their decision making.

And also breathing, so it keeps me calm, and like the baby is as healthy as he can be, and as calm as he can be…… Like labour, like the best position to help with like the pain, to give birth, that you can find. (1GW I1)

Yes, because a lot of your friends that you talk to, they're all quite biased as to what they chose, so I'll have one friend say have an epidural, another will say don't do it, you want to make your own opinions based on actual facts. (3GW G1 P2)

Understanding about interventions that may be used

Women accessed varied information and were aware that not all births are straightforward. The PBB resource pack states that women and partners need to understand the interventions that might be suggested. Several participants mentioned concerns about the possibility of induction. Generally, women were keen to receive factual information about what might happen, if problems arose

and that there were systems to deal safely with these; this knowledge, even if not detailed, would reduce the potential for panic. However, a minority felt information about complications might lead to more worry and therefore did not consider it useful content for antenatal classes; others were unsure whether it might make them more anxious.

Yeah, like what to expect if the baby is late, you have to be induced, what kind of things happen. (2YW I3)

*what happens if things go wrong and how people intervene and things like that, not to a ridiculous point where it's, you know, making you more worried but I think I'd just like to know. The more I know the less I'll over think it, I think. (*3GW G2 P1)

my other worry is that you're going to get too much information, I know it's important to know what are all the possible options that happen, but sometimes knowing too much might actually make me panic more. Like if this goes wrong this happens, and in the end, I'll be going, which way is it going wrong is actually going to happen to me? Rather than actually focusing on this is what normally happens. (2GW G1)

Discussion

Our qualitative study explored women's needs and expectations of antenatal education classes in England amongst first time mothers.

The search for information

Women's considerable information needs were not being addressed during their antenatal appointments. It could be assumed that, as information is so widely available, the need to provide antenatal education classes has diminished. Our research suggests the opposite: women used a variety of resources, including reality television and social media, but often found contradictory and frightening information that caused concern around accuracy. Their accounts reflect the 'information heaven and hell' (Sanders and Crozier, 2018) (p12) where the information amassed can increase a sense of control but also anxiety, as it does not fully meet needs and therefore triggers further searching. A systematic review identified that quality of online health information is a problem (Daraz et al, 2019).

Women were aware of and sometimes embarrassed by their lack of knowledge. They planned to attend antenatal classes to access reliable, first- hand information from facilitators with expertise. Knowledgeable facilitation of group antenatal education was important as a means of accessing trustworthy information, to check the accuracy of that sourced elsewhere, and as a route to increasing confidence about knowledge of childbirth.

The function of antenatal classes

Our findings demonstrate women's profound concerns, including fear of dying, and their need for information about what happens to their body during childbirth. Women wanted to reduce the unknowns and there were commonalities across the groups. Most seemed to accept the technological representation of birth as risky (Roberts et al., 2017) and unpredictable (Sheen and Slade, 2018) as they wanted to learn about what might happen if interventions were needed. However, a minority were concerned such information may make them more, not less anxious. Anxiety is typically construed as perception of threat divided by perception of personal coping and availability of help. Reliable antenatal preparation information about how common complications are routinely, supportively, and competently managed can mitigate potential negative responses to what could be viewed as threat information and thereby reduce anxiety. Our findings resonate with a recent UK study (Slade et al., 2019) and a qualitative enquiry in Australia (Fenwick et al., 2015) where sources of fear included the unknown, hearing about other women's negative experiences, fear of labour pain, and loss of control. Fear and anxiety about birth is moderated by the quality of information and support; when good it has the potential to reduce anxiety, but lack of or inappropriate information exacerbates concerns (Fenwick et al., 2015).

Women had expectations beyond the provision of information. They hoped to meet other women, at a similar stage, to normalise feelings and worries, and for ongoing friendship and support. Recent changes to antenatal education in the UK include increased use of digital approaches, and latterly suspension of face-to-face group provision and transfer online during the Covid 19 pandemic (Early Intervention Foundation, 2020); however, future services should retain group provision. Group approaches to antenatal care which include an education component, such as Pregnancy Circles (Wiggins et al, 2018) may offer this but this model is not available for all women.

A further key function was for classes to help redress partners' feelings of exclusion from antenatal care and assist them to better engage with the transition to parenthood, prepare to be an effective support during labour, and if necessary, make decisions on the woman's behalf. These perceptions were shared across groups. Fathers feel excluded from some aspects of maternity care (Burgess and Goldman, 2018), their role is unclear (Johansson et al., 2015) and thus their contribution, experience and the woman's experience are impacted detrimentally (Etheridge and Slade, 2017). Our research demonstrates these issues from women's perspectives and illustrates the potential benefits for women from the active involvement of fathers in this aspect of maternity care.

Specific information needs

Women identified specific aspects of labour for which they needed information; understanding early labour, and the timing of travel to their maternity unit reflect concerns identified previously (Green et al., 2012). Women are exposed to professionally framed information about the stages of labour; the appropriateness of this has been questioned (Dixon et al., 2013) so it is unsurprising that information to understand these stages is required. Similarly, women required trustworthy information about pharmacological and non-pharmacological pain management to support their decision making and, as reported previously, information about induction (Coates et al., 2019). Women also wanted information about childbirth which was not straightforward, factual information about interventions and most women, common complications, and reassurance that these could be managed.

Strengths and Limitations

We used robust and transparent processes to maximise trustworthiness and achieved a large and rich dataset. We made pragmatic decisions, (Hammersley and Atkinson, 1995) about recruitment and data collection; firstly, recruiting some participants through pre-existing groups, secondly through collecting data via both focus group and individual interviews. This enabled inclusion of women who would otherwise have been unable to participate.

This research was carried out prior to the Covid 19 pandemic; the latter has heightened stress and social isolation, (Matvienko Sikar et al., 2020) and concerns about false information online (Mortazavi and Ghardashi, 2021). Women have been emotionally distressed by changes in maternity service provision and uncertainties during the pandemic (Sanders and Blaylock 2021). An information needs and research priority setting exercise amongst service users and providers responding to the Covid-19 pandemic,

identified high-quality antenatal education as a priority, reinforcing the utility of our findings (Evans et al 2021).

Conclusion

Antenatal education continues to be available to women internationally and our findings resonate with research in other settings (Fenwick et al., 2015) thus providing utility beyond the UK. This research emphasizes its importance to women who want it to fulfil a range of functions including providing information, reassurance and a means of helping partners, which will also support them. Service providers should develop their approaches to meeting women's needs for trustworthy information, ideally face to face from a knowledgeable person. Group antenatal education is a potential opportunity to alleviate fears, also for normalisation of experience and social support. Antenatal education should be acknowledged as an essential preventative perinatal mental health service and a means of addressing policy directives for improved perinatal mental health (NHS England, 2019). Antenatal education should be accessible for the father or co-parent, to mitigate feelings of exclusion, and to increase the childbearing woman's confidence of being fully supported during childbirth. Given its potential role, antenatal education merits higher prioritisation in contemporary maternity services.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

CRediT authorship contribution statement

Helen Spiby: Conceptualization, Methodology, Validation, Formal analysis, Investigation, Resources, Data curation, Writing – original draft, Writing – review & editing, Visualization, Supervision, Project administration, Funding acquisition. **Jane Stewart:** Methodology, Software, Validation, Formal analysis, Investigation, Data curation, Writing – original draft, Writing – review & editing, Visualization, Project administration. **Kim Watts:** Conceptualization, Methodology, Investigation, Writing – review & editing, Supervision, Project administration, Funding acquisition. **Anita J Hughes:** Formal analysis, Writing – review & editing. **Pauline Slade:** Conceptualization, Methodology, Formal analysis, Resources, Data curation, Writing – review & editing, Visualization, Project administration, Funding acquisition.

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