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ANTENATAL EDUCATION: A pedagogy of the oppressed

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By Mary Nolan

My brief for this article outlined by AIMS Editor, Alex Smith (an innovative, radical and hugely skilled antenatal educator if ever there was one) was to reflect on what sort of antenatal education might work to protect women from the 'conveyer belt care' that is harming so many.

It would be hard to formulate a more complex question because there are two distinct contexts operating within it:

- Firstly, the context within which antenatal education takes place – during pregnancy, a period of heightened hopes and fears, in a small, hopefully supportive, group, with one (ideally) skilled facilitator;
- Secondly, the context of labour and birth – generally an institutional setting where staff shortages are common, where women may be left alone for long stretches, may see many different maternity professionals and are subject to invisible (to them) hospital policies and protocols.

Therefore, transferring intentions formulated during antenatal classes and the confidence that well-conducted classes instil, into the labour environment, is going to be challenging.

I first realised this discrepancy – perhaps better described as a gulf - between the antenatal education context and the context of labour and birth in the mid 1990s when I was compiling the findings of my doctoral dissertation (unpublished).[1] One arm of my study had been to compare two groups of pregnant women's stated preferences for pain relief in labour with what actually happened when they gave birth. One group had attended antenatal classes at a large hospital in the Midlands and the other with various NCT teachers in the area. In pregnancy, the NCT women expressed a strong preference to have an epidural rather than pethidine if the need for medical pain relief arose and the hospital-educated women wanted pethidine rather than an epidural. In the event, the NCT women chose pethidine almost en masse and the hospital women, epidural.

This was a small study, conducted by one person over a short period of time and with no financial resources. Nonetheless, it was methodologically sound (as it had to be if I was to be awarded my PhD!) given its acknowledged limitations. I was shaken that the education NCT teachers had provided (whose approach was philosophically akin to my own at that time) had apparently not resulted in women being able to achieve the birth they had said they wanted. And likewise for the hospital women. You might reasonably comment that perhaps the fact that the women changed their minds in labour about what they wanted indicated not the failure of their antenatal education but rather its success in empowering them. Nonetheless, as far as I was concerned, it was a revelatory moment when I started to question what the purpose and outcomes of antenatal education were.

The research

As readers of this article may know, research into the effectiveness of antenatal education in terms of birth outcomes – mother's health and wellbeing, baby's health and wellbeing, mode of birth, number of interventions - is above all, inconclusive. To give you a taste of some of the more recent papers…

> *There is contradictory evidence on the effect of antenatal education on mode of birth. More research is required to explore the impact of antenatal education on women's birthing outcomes.* (Ferguson et al., 2013)[2]

> *Due to the heterogeneity of CBPE [ChildBirth and Parenting Education], research examining its impact on birth outcomes has conflicting and sometimes inconclusive findings, with limited evidence for its effectiveness in improving maternal and fetal birth outcomes such as Apgar scores and birth weight.* (Ferri et al., 2024)[3]

> *Maternal mental health outcomes of stress and self-efficacy significantly improved in the antenatal education group, although there was no difference in anxiety and depression. The foetal outcomes of birth weight or gestational age at birth were also not different between the groups.*

(Hong et al., 2021)[4]

If you go to Google Scholar and input 'antenatal education', you will find a plethora of papers published this decade from all over the world. It's interesting that academics and practitioners continue to feel the need to research the impact of antenatal education despite the – to my mind – huge, possibly insuperable difficulties of conducting such research. It's like an itch that must be scratched: surely*education* must be 'a good thing'; it *must* enable women to be more in control of their care, more able to communicate their wishes to the staff caring for them, more confident in their ability to birth their babies…… Why on earth doesn't the evidence bear this out? Women say that they want information. Why, then, when they are given information do they not find their birthing experiences more satisfying?

Research difficulties

I pause here to outline the 'huge difficulties' to which I referred in the last paragraph. They are and have been and will continue to be:

- Ensuring that all educators involved in a particular study have the same level of training and have sufficiently debriefed their own experiences of labour and birth, whether first-hand or vicarious, so as not to be at risk of foisting their own ideas and prejudices on the women in their groups;
- That all educators in the study are delivering the same curriculum,
- Over the same number of weeks/sessions,
- And that women in the study attend the same number of sessions;
- That outcome measures are clearly defined: maternal satisfaction with antenatal education? mode of birth? number of interventions during labour? breastfeeding or formula feeding? maternal postnatal mental health?……..
- And, most importantly (and most difficult, if not impossible, to achieve) controlling 'for*incidental teaching* of the participants in the control group' (Hatamleh et al., 2019)[5] (i.e. given that many women will access multiple sources of antenatal education, how can you be sure that the control group has not accessed opportunities for antenatal education other than the classes included in the study?)

So what do women want from antenatal education?

Let's have a look at a very recent study (Larkai et al., 2025)[6] which aimed to answer this key question. Academics from the University of Bristol 'aimed to explore the antenatal education needs and preferences of women who are currently pregnant or planning a pregnancy'. Slightly oddly, their paper

begins with a statement about the purpose of antenatal education (isn't the study supposed to be about this?):

> *Antenatal education (ANE) equips pregnant women with knowledge and skills for pregnancy, birth, and the postnatal period. It should facilitate preparation for the whole spectrum of the maternal journey and empower women to make informed decisions.*

And what were the findings?

> *Participants valued practical skills, particularly for labour and the postpartum period, and actively sought perinatal social networks.*
>
> *NHS antenatal classes are a trusted source of ANE, forming a core element of many women's antenatal journey. However, inconsistent provision highlights the need for a standardised, comprehensive curriculum. Flexible delivery models and tailored content are crucial to address diverse needs.*

Absolutely none of the content of the first sentence is new – not that this means the study was a waste of time. It's helpful when new research confirms what has gone before, adding to the weight of the evidence. The second paragraph is confusing. The authors advocate a 'standardised comprehensive curriculum' alongside 'flexible delivery'. What exactly does a *standardised flexible* curriculum look like? Where does *comprehensive* begin and end?

In my opinion, and experience (see author bio), it is the flexibility of antenatal education that is key. The curriculum, as far as women are concerned, is predictable – women come to classes to learn about what to expect in labour and birth, how to manage pain, how to look after their new baby and take care of their own mental health and their relationships. The skill of the antenatal teacher is to cover these topics while referencing the individual needs and aspirations of every woman in the group. Any health professional can give information, but at the heart of antenatal education is supporting women to contextualise that information in their own lives. If my name is Molly and I am absolutely petrified about giving birth, I need to talk about why I am so frightened, think about who is going to support me during labour, what is involved in the various pain relief options that the hospital can offer and how I can help myself. I need to talk to other women and discover that I am not the only one who is frightened. I certainly need to be reassured that choosing an epidural does not make me less of a woman or mother, but I also have a right and need to understand all the evidence around epidurals. If my name is Isla and I am determined to have a home birth, I need to know whether there are the resources available locally to accommodate my wish, what to have at home ready for the birth, and what my postnatal follow-up will be like. If my name is Ziva and I am profoundly deaf, I need to know how to engage with the hospital antenatally, during labour and after so as to have my wishes respected and my physical and emotional safety assured.

What does effective antenatal education comprise?

To return to the conundrum I outlined at the start of this article: Will antenatal education ever be 'effective' while it is operating within a different context from that of labour and birth? And what, in any case, does 'effective' mean? For me, it means that women who have attended classes feel that they now have sufficient information and confidence to be able to communicate clearly, confidently and respectfully with their professional carers; that they have been able to formulate the choices that are right for them in their circumstances, and acquire the practical skills and emotional resilience to cope with the expected and the unexpected in labour, birth and early motherhood. And finally, but very much not least, that they are now part of a support group developed through their antenatal classes, a community of peers, who will help them through the confusion and exhaustion of the first months of having a baby, as well as being there to share the immense joys.

So what does an antenatal course look like that will achieve all of the above? First of all, it must respond to what women say (and have said for many decades) that they want from their maternity care (of which, antenatal education is a vital part); namely, they want their feelings and values to be understood and respected by professionals, and they want professionals to demonstrate empathy and commitment to them as individuals rather than merely being sources of information (important though information is) (Goberna-Tricas et al., 2011).[7]

Antenatal education should therefore demonstrate continuity of*carer*,[8] not continuity of *care* which is so often talked about and which, because its definition is nebulous, enables the status quo to argue that it*is* woman-centred while still providing fragmented rather than relationship-based care. Feeling understood and respected by the antenatal teacher, sets the bar against which emotional safety in maternity care can be measured (O'Reilly et al., 2025).[9] Antenatal education can model continuity of carer when it is provided over a period of time (preferably weeks if not months) by the same skilled facilitator so that women can build up a relationship wherein they are free to ask questions, to reflect, to try out, to disagree with and to laugh.

This will also enable women to acquire the skills they are asking for: you don't learn to ride a bike by sitting on the saddle once. It takes many failed attempts to be able to cycle with confidence. So it is with skills for labour, birth and motherhood. It is practice that breeds confidence and success. Virginia Campbell's excellent work on yoga for pregnancy (2019)[10] comes finally to a very simple conclusion, namely that it is the week in, week out practice of relaxation skills that enables women to use them effectively in labour.

And what about the friendships and the networks that women, especially those having their first baby, leaving work perhaps and all the securities that its routines offer, know they will need? Ask women why they have come to antenatal classes and they will more than likely say that they want to get information *and to make friends.* Friendships are formed over a period of time within a relaxed environment where people gradually get to know a little about each other and their backgrounds and aspirations. My own work (Nolan et al., 2012)[11] on the special nature of friendships formed during antenatal classes suggests

that, certainly in the long run, it is these friendships that are for many women a key outcome of antenatal education.

Should antenatal educators soldier on?

Antenatal education conducted along these lines is more likely to play a part in contributing to a radical overhaul of care than providing a series of single online sessions with different untrained facilitators reading from a standardised script.

When antenatal educators model the kind of care that women have repeatedly said they want, women are more likely to demand such care from all maternity professionals in whatever context they meet them. Perhaps, one confident, well-prepared woman at a time, a system that is currently hostile to *listening* and to providing care tailored to the individual, will start to change. The system is already under attack as a result of numerous enquiries – Morecambe Bay (2015), the Ockenden Reports (2022-2024), East Kent Maternity Services (2022), National Maternity and Neonatal Investigation (ongoing) - and antenatal education has its part to play in bringing change about.

It will be evident from what I have written that I still firmly believe that there is a key place for antenatal education in maternity care. It is a 'pedagogy of the oppressed' (1968)[12] to use the words of Paulo Freire, the great Brazilian philosopher. Freire conceptualised education as a collaborative act of liberation, a means of educating those who are bullied by 'the system' to challenge the system through providing education based on love and empathy. Antenatal education can and should aspire to just this.

Author Bio: Mary Nolan worked as a birth and early parenting educator for 28 years before spending 13 years as Professor of Perinatal Education at the University of Worcester. She has published extensively in academic journals on birth-related issues and is the author of eight books. The most recent, 'Birth and Parent Education for the Critical 1000 Days', was published in 2020.

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