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Childbirth Education: Comparative Analysis

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Abstract

Prenatal education programs are a powerful tool to increase maternal and child health. Today, no one knows the most effective educational approach. The objective of the study is to identify differences in approaching and methodology of major schools of childbirth education. Methodology includes the review of the databases such as PubMed, Embase, Lilacs, Scielo and Cochrane since 2000; review the websites of the schools; study the documentation using the comparative method; and analysis using a database with Excel. Results analyzed and compared the five old one schools and 12 of emerging new one schools. The chapter concludes the conceptual approach and methodology of the schools, which can facilitate the choice for professionals and research design to increase the quality of programs.

Keywords: antenatal education, childbirth education, parenthood education, centering pregnancy/group care, pregnancy, prenatal care/methods

1. Introduction

The paths that can lead women to become pregnant are multiple and not always happy [1]. Depending on the circumstances of life, the decision to accept a pregnancy may not be easy. The knowledge of being pregnant produces a feeling of ambivalence of whether I want it or not, in all women and their partners [2]. This feeling raises doubts about whether it is the right time, if you have the resources necessary to raise a child and if you are going to be able to play the role of mother or father [3]. Once the decision is made to continue with a pregnancy that the woman, or the woman and her partner accepts, it is necessary to advise the future parents about the care of the gestation, delivery and the puerperium. A personal work of bonding with the child must also be initiated, which lays the foundations for the development of the affective warp that every human being needs in order to fully develop. This element is so important that it is the axis of much international research on attachment and attachment in early childhood [4].

Science has shown that child health begins in the prenatal stage, in pregnancy, and this makes prenatal education very important. Everything from the mother's diet to her emotions influences the future health of her child [5, 6]. So from the World Health Organization and from all related scientific societies education is promoted at this stage [7]. Prenatal education has ceased to be a concern of midwives and obstetricians to become a field of study that is approached from multiple disciplines, such as pediatrics, psychology and pedagogy. This makes it necessary for professionals to know the history of prenatal education and the main paradigms from which their study has been developed [8]. In this chapter, we are

going to approach the evolution of health education for women and their partners in pregnancy.

The objective of this work is to identify differences in approaching and methodology of the major schools of childbirth education.

2. Methodology

In the first quarter of 2019, a review was made of publications in the health sector in both Spanish and English, going back a maximum of 19 years. MeSH terms were selected that best reflect the objective of this work, these being: antenatal education, childbirth education, parenthood education, centering pregnancy/group care, pregnancy, prenatal care/methods and their equivalents in Spanish. The PubMed, Embase, Lilacs, Scielo, Cuiden, Cinhal and Cochrane databases were consulted. The websites of the main current antenatal education schools were reviewed and the relevant studies of the main European schools pre-2000 were located. Once the documents had been located, they were studied and analyzed using the comparative method. To conduct the analysis, a database was set up using Excel.

3. Developing

The results have been structured in four sections:

1. Prenatal education before the twentieth century.
2. The beginning of prenatal health education.
3. The first large prenatal education schools, prenatal education schools.
4. The new prenatal education schools.

3.1 Prenatal education before the twentieth century

Until the twentieth century, women gave birth in their homes attended by midwives and accompanied by the women of the family and the environment [9]. According to anthropological studies, there are few cultures in which women separated from the group and were to give birth by themselves. There are references that cite some Eskimo and Indian tribes of North America. In general, childbirth was a common phenomenon in people's lives. Women and girls, of all ages, had seen their mothers, sisters, daughters and/or neighbors give birth [10]. In this situation, birth should not have been as feared a moment as it is now. In her home, the woman in childbirth had greater prominence and control, but the mortality and morbidity rates were very high. In fact, today, in those parts of the world where women give birth without health care assistance, childbirth continues to be the first cause of death [11]. To remedy this situation, each culture has developed special care for pregnancy, childbirth and puerperium. This great variability of care is related to the eminently social nature of every human birth and the need for group survival [12]. These first cares constitute an informal prenatal education that occurred within social groups in a natural way.

3.2 The beginning of prenatal health education

At the end of the twentieth century, great changes took place in the health sector, which gave another profile to hospitals. These had arisen from the hand of religious orders dedicated to charity. Over time they were developed, technified and became the great centers of training and development of medicine. At this time, the first maternities arose to serve the most disadvantaged women. Progressively, delivery assistance moves from homes to hospitals [13]. Women no longer had the opportunity to see their relatives give birth and lost ancestral control over their physiology and their natural knowledge of childbirth. In hospitals, seeking to improve perinatal outcomes, deliveries are intervened and instrumentalized. These interventions led to pain and anxiety for women in childbirth, so the need arose to look for ways to reduce pain [14]. As early as in 1870 James Young Simpson tries to apply chloromorphic anesthesia to childbirth. At the beginning of the century, studies were developed throughout Europe to achieve analgesia in childbirth with psychological means [13, 15, 16]. Obstetricians start prenatal education programs for childbirth. These early programs are the forerunners of the current Maternity/Paternity education programs.

3.3 The first large prenatal education schools, prenatal education schools

In Europe, the first models of prenatal education emerge in the first half of the century. Their sole object is to reduce the pain of women in childbirth and consist of only a few sessions. Gradually the programs expand their objectives and their sessions, and deal with pregnancy, the couple, bonding and the newborn.

3.3.1 The school of hypnosis and autosuggestion

The schools of Charcot (Paris) and Berheim (Nancy) investigated clinical hypnosis [17–19]. In 1922 the obstetricians Schultze and Rhonhof proved that the introduction of educational sessions before childbirth reduced the time needed to achieve a hypnotic state. In 1923, Kogerer used post-hypnotic self-suggestion [20, 21]. These two techniques posed some difficulties so new methods were sought to relieve pain during labor [22].

3.3.2 The English school

In 1932, the obstetrician Grantly Dick Read published “Natural Childbirth.” He viewed childbirth as a physiological phenomenon in which pain is created by fear which unleashes the defense mechanisms in the form of muscular tension. He formulated the *Fear-Tension-Pain* concept and developed a method featuring explanatory conversations, relaxation, breathing techniques and strategies that enhance trust in the healthcare team. He did not rate gymnastic exercises and warned against any muscle training. This concept has been disseminated worldwide and has undergone many changes [23, 24].

3.3.3 The Russian school

At the same time, Drs. Velvoski, Platinov and Nikolaiev, who were working with hypnotic suggestion, were looking for new approaches (Obstetric Psychoprophylaxis) [25]. In accordance with Pavlov’s Classical Conditioning Theory, they concluded that pain in labor is a reaction conditioned by sociological and religious-cultural stimuli. They suggested de-conditioning the fear through aseptic language, relaxation (Schultze), positive thinking, the celebration of maternity and

obstetric information [26]. To get the woman actively involved, they introduced breathing and muscle exercises [17, 27]. They came up with a simple and accessible method which encouraged its spread throughout Russia, Eastern Europe and China.

3.3.4 *The French school*

Dr. Lamaze (1940) learned from the Russian school and was familiar with the English school. He created a more technical method that insisted on the need for a loving environment with the presence of a partner. His partner, Dr. Vellay, insisted on the therapeutic power of speech and the active role of the woman [28]. Later, in his book “*Birth Without Violence*” (1975), Leboyer popularized the creation of an environment of tranquility in the labor room and the submersion of newborns in a small bath of warm water; he is thus regarded as the precursor of water births [29].

3.3.5 *The Spanish school*

In 1955, the midwife Consuelo Ruiz presented her book “*Labour Without Pain*” featuring the new tendencies [30]. In 1956, Aguirre de Cárcer founded the school of “*Obstetric Sophropedagogy or Maternal Education*” and gave a substantial change from the focus of pain during labor for that of achieving a new sociocultural standard whereby both the woman and her partner would acquire the necessary knowledge to face labor with serenity, having diminished their fears, and experience this transcendental moment in their lives with full consciousness and satisfaction, as this experience will impact on the child by encouraging the development of the “*Emotional Network*” [31]. In 1959, the Compulsory Health Insurance entrusted her with a program and in 1986 Maternal Education was included in the service portfolio of the National Health System. This helped with its dissemination and facilitated significant further development [32].

3.4 **The new prenatal education schools**

In the middle of the twentieth century, these first methods obtained good perinatal results, with which they developed and spread throughout the world [33]. Subsequently, multiple methods have emerged and, in every country, there are professionals concerned about improving care for women in childbirth and that disseminate this concept. Next, the emerging models that have a greater presence in the review are presented.

3.4.1 *International childbirth educators’ association*

In 1960 the International Childbirth Educators’ Association (ICEA) was founded, which further evolved the Lamaze method. It is a non-profit organization that promotes freedom of choice for women and their partners based on the informed knowledge of childbirth options. Its orientation is centered on maternity care and the care of the newborn by the family. It respects the individuality of the woman and her sense of autonomy [28, 34, 35].

3.4.2 *Husband-coached childbirth*

In 1965, Robert Bradley, in his book “*Husband-Coached Childbirth*,” claimed that the partner is the person who should ensure that the woman is in a safe, quiet environment and who should know her well enough to be able to help her in this process. He empowers fathers to ‘coach’ their partners with instructions, relaxation techniques and massages [36]. He was the pioneer of ‘father training’ (American Academy of Husband-Coached Childbirth).

3.4.3 Mindfulness-based childbirth and parenting

In 1970, Kabat-Zinn developed the *Mindfulness-Based Childbirth and Parenting* (MBCP) method at the University of Massachusetts Medical School, based on Mindfulness-Based Stress Reduction. This method emphasises the development of the conscience at a precise moment through meditation. The results indicate that this helps to reduce pregnancy-related depression and anxiety [37, 38]. It is also giving rise to new models such as “*Centering Pregnancy*®.”

3.4.4 Birth your way

In the 1970s, Sheila Kitzinger reinstated the wisdom of a woman’s body in giving birth. The author of “*Birth Your Way: Choosing Birth at Home or in a Birth Centre*” proposes that women tune in to their contractions in the way they feel they achieve harmony and rhythm and acquire the knowledge to make their own decisions. The presence of the husband, the instructor and the midwife create a favorable environment for childbirth. Her partner, Janet Balaskas, created the Active Birth Movement and proposed the practice of yoga adapted to pregnancy [39].

3.4.5 Haptonomy

In the Netherlands, in the 70’s, a new approach to preparation for birth appeared: “Haptonomy,” which passed to France in 1978 by Frans Velman and later extended to Switzerland and Spain. Dr. Etienne Herbinet explains that haptonomic work is exercised on touch, on palpation in its affective aspect, on tactile contact as a means of communication. During preparation at birth the haptonomic approach can help future parents to have a more emotional perception of the baby to be born. Through touch they develop an active affective relationship between the mother, the father and the baby. The method helps to establish and develop a sense of paternity/maternity through affective contact with the baby [40].

In 1975, in the United States, the percentage of pregnant women who used this type of practice was higher than 6–7% according to the program carried out under the name of “Prepared Childbirth” assumed by the “American Society for Psychoprophylaxis in Obstetrics” (2010) [41].

3.4.6 Primal health research center

The French obstetrician, Michel Odent (1977) popularizes birth in water and founds the “Primal Health Research Center.” He guides his work to help each woman choose the way she will give birth following her own instincts and respecting at all times the physiological process of childbirth. Author of numerous books, he postulates that the emotional situation of the pregnant mother is determinant in the psychological and physical future of the individual, and also points out the temporal importance of childbirth and the subsequent moments on the development of the person. He highlights the role of birth hormones (oxytocins and endorphins) and provides numerous investigations [42].

3.4.7 Respiratory autogenic training and psychoprophylaxis in obstetrics

In Rome, in 1984, Umberto Piscicelli, professor at the Catholic University of Rome, publishes his book “*Respiratory Autogenic Training and Psychoprophylaxis in Obstetrics*.” His method is known as “Respiratory Autogenic Training” or R.A.T. It is inspired by Schultz’s autogenous breathing, the laws of conditioning,

group psychotherapy, relaxation therapy and his deep knowledge of psychosomatic medicine. Its objective is the psychological therapy of pain through its connections with uterine contractions, but also the correction of negative psychic aspects and non-adaptive behaviors. For this, the woman is given maximum autonomy to be the protagonist of her birth and is prepared to act in an environment full of stimuli [43].

3.4.8 Waterbirth

In the US, Barbara Harper, is one of the great scholars and disseminators of childbirth in water around the world. She founded Waterbirth International in 1987 after visiting Russia for the first time and sitting with Igor Charkovsky, where she was “influenced by her faith in the parturients and their babies” [44]. She has also worked extensively with Binnie Dansby in the early 1980s on cognitive learning and repressed experiences and memories of birth. She is a nurse, midwife, doula and perinatal educator. She has been Founder and Director of the World Association for Maternal and Child Health, and Founder and Director of Waterbirth International. She is recognized worldwide as an expert researcher and author of protocols for delivery in water since 1983 and responsible for the opening of and instituting policies for delivery in water in 140 hospitals in the United States.

3.4.9 HypnoBirthing

In 1990 Marie Mickey developed the Mongan Method, known as HypnoBirthing. Based on the premise that all women have within them the power to call on their natural instincts to achieve the best birth for their baby and for themselves, it works with mothers and families on birth expectations and taking a positive approach to the experience. It puts a lot of emphasis on language, breathing, relaxation, visualization and self-hypnosis and it highlights the fact that childbirth does not have to be painful [45].

3.4.10 Intrauterine harmonization

In 1992 a new method or program appears based on the affective bond with the baby: “intrauterine harmonization.” Dr. Thomas Verny and Pamele Weintraub prepare parents with music, deep relaxation, visualization and massage. They strengthen the bond between parents and children through dream induction, guided work with images, drawings, lullabies and words addressed to the child. The conflicts that future motherhood can arouse in parents are solved by examining their own childhood and positive thinking techniques [46].

3.4.11 Birthing from within

In 1998, Pam England and Rob Horowitz devised a holistic approach to the preparation for childbirth and the postpartum period, known as *Birthing from Within*. As well as information on childbirth and children’s upbringing, they also addressed introspection and self-discovery from the perspective of the woman’s own internal experience [47].

3.4.12 Awareness of welcome

In 2004, Dr. Wendy Anne McCarty, co-founder of the Masters and Doctorate programs of “Santa Barbara Graduate Institute” in Prenatal and Perinatal Psychology, reviewed 30 years of clinical research in this field. Her book, “Awareness of Welcome,” presents an integrated model of early development

that was a reflection of the clinical results found in her research of prenatal and perinatal psychology. The transcendental aspects of consciousness and human rights from the beginning of life become the central thread of this holistic model. It is an integrating model of early human experience, learning, development and care (from before conception to early childhood) that includes our sensitive nature and integrates several fields such as theories of infant development, new clinical investigations of babies that incorporate a conscious state, prenatal psychology and perinatal, paternity practices and some ideas that make up the new physics sciences. The author affirms that the most important thing is to reconstruct our sensitive spiritual nature as well as our fundamental nature of Sensitive Human Beings [48].

4. Comparison between the main models of prenatal education

Maternal and child health and the emotional attachment around birth are so important that they are the axis of multiple health guidelines worldwide [49], and the body of numerous international research [50]. However, despite the importance of prenatal education, according to the latest reviews, neither the results nor the best educational approaches are known [51–56]. This situation makes it necessary to consider studying and analyzing the most representative prenatal education schools. For this, we must look for the paradigm that lies behind each school and know the methodology they use. This work is arduous because of the difficulty of finding detailed information about some schools. In order to make the comparison work more explicit, **Tables 1–4** have been made. Schools that have not found a paradigm have not been included in them.

Education models	Main elements of teaching	Characteristics of the sessions	Paradigm
Hypnosis (1922)	<ul style="list-style-type: none"> • Hypnosis explanation • Relaxation, somnolence • Precise suggestions • Hypnosis practice 	<ul style="list-style-type: none"> • Individuals • Before childbirth • 3 or 4 sessions • Coach at childbirth 	“Childbirth under hypnosis = painless childbirth”
Read (1932) English school	<ul style="list-style-type: none"> • Natural childbirth explanation • Relaxation (Jacobson) • Steady, deep and natural breathing • Passive childbirth collaboration • Trust in the trust in the team 	<ul style="list-style-type: none"> • Individuals or small groups • Before childbirth • 4 or 5 sessions • Childbirth team • Natural childbirth course 	“Fear of childbirth = pain.”
Velvoski (1939) Russian School	<ul style="list-style-type: none"> • Natural childbirth explanation • Pain de-conditioning • Relaxation (Schultze) • Fast thoracic breaths during contractions • Directed push • Pregnancy exercises • Active collaboration in childbirth • Simple language • Trust in the trust in the team 	<ul style="list-style-type: none"> • Individuals or small groups • Before childbirth • 4 or 5 sessions • Childbirth team • Obstetric Psychoprophylaxis course 	“Childbirth = De-conditioning pain”

Education models	Main elements of teaching	Characteristics of the sessions	Paradigm
Lamaze (1940) French school	<ul style="list-style-type: none"> Natural childbirth explanation Relaxation (Jacobson) Fast thoracic breaths during contractions Directed push Pregnancy massage Pregnancy exercises Communication skills Positive ideas Health measures Active collaboration in childbirth Trust in the team 	<ul style="list-style-type: none"> Small groups With partner Before childbirth 4 or 5 sessions Childbirth team Care of the birthing atmosphere Obstetric Psychoprophylaxis course/painless childbirth 	“Childbirth = Preparedness”
Aguirre de Cárcer (1956) Spanish School	<ul style="list-style-type: none"> Explanation Natural birth Educate Maternidad Relaxation (sophrological) Thoracic breathing Directed push Gymnastics in sophrology Communication skills Welfare measures Baby care Breastfeeding 	<ul style="list-style-type: none"> Small group With couples Prior to delivery 6 or 8 sessions Environmental care After childbirth 2–4 sessions Maternal Education Program 	“Childbirth = emotional encounter”

The first large prenatal education schools.

Table 1.
Comparison between the main models of prenatal education.

Education models	Main elements of teaching	Characteristics of the sessions	Paradigm
International Childbirth Educators Association (ICEA) (1960)	<ul style="list-style-type: none"> Centred on family care in maternity Freedom of choice of childbirth options Educational programs Choice of programmes at instructors’ discretion (exercises, relaxation, breathing exercises) 	<ul style="list-style-type: none"> Individuals or small groups Before childbirth From 1 to 4 or more sessions Postpartum Sessions (educator’s choice) Education program for childbirth 	“Childbirth = Family experience/informed choice”
Robert Bradley (1965)	<ul style="list-style-type: none"> Natural childbirth explanation Coaching of fathers for childbirth Avoidance of medication and medical procedures Nutrition and wellbeing Abdominal breathing Aerobic exercises with partner Relaxation tailored to the partner Pregnancy massage given by the father 	<ul style="list-style-type: none"> Small groups of 2–6 couples Before childbirth 12 sessions Partner at childbirth Bradley Method or “Husband-Coached Childbirth” 	“Childbirth = Coaching fathers for childbirth”

Education models	Main elements of teaching	Characteristics of the sessions	Paradigm
Kabat-Zinn (1970) <i>Mindfulness-Based Childbirth and Parenting</i>	<ul style="list-style-type: none"> • Natural childbirth explanation • Stress reduction • Full attention • Relaxation (meditation) • Exercises (yoga) • Abdominal breathing • Discussion group • Positive emotions 	<ul style="list-style-type: none"> • Small groups of 2–6 couples • Before childbirth • 9 × 3-h sessions + 1 day rest • Postpartum 1 session • Commitment to 30 min per day of meditation and yoga • “Centering Pregnancy®” 	“Childbirth = awareness of birth and upbringing”
Kitzinger (1970) <i>Active Birth Mouvement</i>	<ul style="list-style-type: none"> • Natural childbirth explanation • Women’s freedom during labor • Free breathing • Free relaxation • Exercises (yoga) • The woman as the protagonist of childbirth 	<ul style="list-style-type: none"> • Individuals or small groups • With partner • Before childbirth • Variable number of sessions • Childbirth team • Active childbirth movement 	“Childbirth = No pain, Active childbirth movement”
Velman (1970) Haptonomy	<ul style="list-style-type: none"> • Tactile contact as a means of communication • Emotional perception of the baby that will be born 	<ul style="list-style-type: none"> • Individuals or small groups • With partner • Before childbirth • Variable number of sessions • Touch work in pregnancy 	“Childbirth = develop a feeling of parenthood through touch”

The new prenatal education schools [1].

Table 2.
Comparison between the main models of prenatal education.

Education models	Main elements of teaching	Characteristics of the sessions	Paradigm
Leboyer (1975) French school	<ul style="list-style-type: none"> • Natural childbirth explanation • Relaxation (Jacobson) • Thoracic breaths • Pregnancy exercises • Communication skills • Wellbeing measures • Active collaboration • Trust in the team 	<ul style="list-style-type: none"> • Small groups • With partner • Before childbirth • 4 or 5 sessions • Childbirth team • Labor room atmosphere • Baby bath • Non-violent birthing course 	“Childbirth = Baby fear” (non-violent birth)
Michel Odent (1975)	<ul style="list-style-type: none"> • Non-interventional labor, following instincts. • Free relaxation • Music-therapy • Exercises or dance • Women’s freedom during labor • Activation of endorphins and endogenous oxytocin 	<ul style="list-style-type: none"> • Small groups • With partner • Before childbirth • 6 or 8 sessions • Childbirth team • Rooms for natural childbirth • Training in “Primal Health” 	“Childbirth = Recovering natural instincts. Personal and intimate experience”

Education models	Main elements of teaching	Characteristics of the sessions	Paradigm
Piscicelli (1984) Respiratory autogenous training	<ul style="list-style-type: none"> • Autogenous Schultz breathing • Conditioning • Group psychotherapy 	<ul style="list-style-type: none"> • Small groups • With couples • Prior to delivery • Before childbirth 	“Childbirth = woman protagonist of her birth in an environment full of stimuli”
“National Health System, Spain (1986) Maternal Education Program Spanish School	<ul style="list-style-type: none"> • Explanation pregnancy/delivery/puerperium care • Educate Motherhood/Paternity • Emotional education • Free relaxation • Abdominal and free breathing • Directed and expiratory push • Labor positions • Aerobic gymnastics or yoga • Communication skills • Wellbeing measures • Baby care (up-bringing) • Breastfeeding • Family reorganization 	<ul style="list-style-type: none"> • Small groups • With couples • Prior to delivery • Before childbirth—three levels • Level 1: second trimester—from 1 to 4 sessions • Level 2: third trimester—from 6 to 10 sessions—Care of the birthing atmosphere • Level 3: postpartum—2 to 4 sessions • Educational program for parents 	“Childbirth = emotional encounter”
Harper (1987) Waterbirth	<ul style="list-style-type: none"> • Cognitive learning • Repressed experiences and memories of birth • Cognitive learning • Repressed experiences and memories of birth • Waterbirth 	<ul style="list-style-type: none"> • Small groups • With couples • Prior to delivery • Before childbirth • Cognitive learning • Repressed experiences and memories of birth—Waterbirth 	“Childbirth = Waterbirth

The new prenatal education schools [2].

Table 3.
Comparison between the main models of prenatal education.

Education models	Main elements of teaching	Characteristics of the sessions	Paradigm
Mongan (1990) Hypnobirth	<ul style="list-style-type: none"> • Natural childbirth explanation • Working in peace and quiet • Deep breathing • Abdominal breathing • Exercises (yoga) • Denial of the fear-tension-pain cycle • Positive focus • Emotional education • Family unity • Hypnobirth 	<ul style="list-style-type: none"> • Individuals or small groups of 2–6 couples • Before childbirth • 5 sessions • Childbirth team • Hypnobirth 	“Childbirth = Hypnobirth No pain”

Education models	Main elements of teaching	Characteristics of the sessions	Paradigm
Verny (1992) “Intrauterine Harmonization”	<ul style="list-style-type: none"> • Work with the music • Deep relaxation • Visualization • Massage • positive thinking 	<ul style="list-style-type: none"> • Small groups • With couples • Prior to delivery • Before childbirth • Music 	“Childbirth = Intrauterine Harm-onization”
Horowitz (1998) “Birthing From Within”	<ul style="list-style-type: none"> • Natural childbirth explanation • Holistic and spiritual focus • Creative expression (diary writing/ painting) • Relaxation (meditation) • Joint creation of classes between coach and couples • Facing challenges • Education on child upbringing 	<ul style="list-style-type: none"> • Small groups • With partner • Before childbirth • No. of sessions at the coach’s discretion • Postpartum sessions at the coach’s discretion • “Birthing From Within” 	“Childbirth = Self-discovery (birthing from within)”
McCarty (2004) Welcome awareness	<ul style="list-style-type: none"> • Holistic model • Awareness • Human rights since the beginning of life • Rebuild our sensitive spiritual nature 	<ul style="list-style-type: none"> • Small groups • With partner • Before childbirth • Rebuild our sensitive spiritual nature 	“Childbirth = Welcome awareness”

The new prenatal education schools [3].

Table 4.
 Comparison between the main models of prenatal education.

5. Conclusions

Given this multiplicity of methods, Walker affirms that we are at a crossroads [14]. Women and their partners have, in the developed world, more information opportunities on pregnancy and labor than ever before, but does this information really reach them in a way that they are capable of applying to their personal experience? Do we know which is the best educational method? Do we know which elements should be included in educational programs to obtain the best results? The professionals who work in antenatal education need to understand the current situation of women and be able to guide them in making informed decisions based on scientific evidence. It is also necessary to eradicate the current belief that technology and medical interventions guarantee the well-being and safety of women during childbirth. Therefore, education for women and their partners on care during pregnancy, labor and the postpartum period is still, in the twenty-first century, an issue of great concern in order to recover the experience of childbirth for women and to reinstate the birth of a human being as an integral part of the family experience from the beginning of the pregnancy [57].

6. Implications for practice

This work allows us to see how the first courses on “childbirth education,” “natural birth” and “painless labor,” in which the main approach was to reduce the pain for women in hospital childbirth, have evolved toward educational health programs in which. The main approach is maternal-infant health during pregnancy, labor and the postpartum period and the emotional bond with the newborn.

The work describes the characteristics of the five main schools and of the main new models of antenatal education. The comparative analysis is the basis for identifying the similarities and differences of each of them. This will help professionals to choose the educational approach that best meets the characteristics of their environment. It can also lay the foundations for the design of research questions that remain unresolved, such as finding the best educational approaches and the best learning strategies in this environment [14, 49–56]. The biggest limitation was restricting the search for works published in English and Spanish, as there may be schools in other languages that identify with different cultures. In the review, only three articles were found that analyzed the different models [8, 14, 33], so there is not a great deal of scientific literature with this approach for investigation. This means that the results offer the opportunity of thinking about the importance given to this subject, as health professionals, and the strategies we use to address and develop them. It also allows us to re-think the approach of antenatal education that underlies the care of women and their families at such a crucial point in life and health that is labor and the birth of a child. This can only be of benefit to health professionals, who will be able to provide more appropriate and efficient care, as well as to all future mothers and fathers who could receive a higher quality of medical attention.

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