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Parents' experiences and perceptions of group-based antenatal care in four clinics in Sweden

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ABSTRACT

Background: group-based antenatal care consists of six to nine two-hour sessions in which information is shared and discussed during the first hour and individual examinations are conducted during the second hour. Groups generally consist of six to eight pregnant women. Parent education is built into the programme, which originated in the United States and was introduced in Sweden at the beginning of the year of 2000.
Objective: to investigate parents' experiences of group antenatal care in four different clinics in Sweden.
Method: a qualitative study was conducted using content analysis five group interviews and eleven individual interviews with parents who experienced group-based antenatal care. An interview guide was used.
Settings: the study was set in four antenatal clinics that had offered group-based antenatal care for at least one year. The clinics were located in three different areas of Sweden.
Participants: the participants were women and their partners who had experienced group-based antenatal care during pregnancy. Other criteria for participation were mastery of the Swedish language and having followed the care programme.
Findings: three themes emerged, 'The care—combining individual physical needs with preparation for parenthood, refers to the context, organisation, and content of care'. Group antenatal care with inbuilt parent education was appreciated, but respondents reported that they felt unprepared for the first few weeks after birth. Their medical needs (for physical assessment and screening) were, however, fulfilled. The theme, 'The group—a composed recipient of care', showed the participants role and experience. The role could be passive or active in groups or described as sharers. Groups helped parents normalise their symptoms. The theme, 'The midwife—a controlling professional', showed midwives are ignorant of gender issues but, for their medical knowledge, viewed as respectable professionals.
Key conclusions: in the four clinics studied, group-based antenatal care appeared to meet parents' needs for physical assessment and screening. Parents identified that the groups helped them prepare for birth but not for parenthood. The group model created a forum for sharing experiences and helped participants to normalise their pregnancy symptoms.
Implications for practise: the midwife's role in facilitating group-based antenatal care demands new pedagogical strategies and approaches.

Introduction

Since the introduction of antenatal care in Sweden, changes have been made in the number of visits, as well as the content of care, although the organisation of care remains the same.

The Swedish antenatal care system is based on a UK model and was introduced in Sweden in the 1930s. It has always been free of charge for the parents. In the 1970s, antenatal care expanded to include both physical assessments, such as screening for infectious diseases and preparation for parenting, with antenatal education classes. In the late 1980s, the antenatal care programme continued to expand, e.g. with the introduction of ultrasound screening. Fathers were usually invited to participate in care. Based on WHO's randomized controlled trial of the optimal number of antenatal care visits and a Swedish population study, which suggested that reducing the number of antenatal visits did not increase the risk of negative maternal and perinatal outcomes, the Swedish National program for antenatal care

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reduced the recommended number of visits for normal pregnancies (Berglund and Lindmark, 1998) and the number of antenatal education classes was also reduced (Villar et al., 1998). Studies on the relationship between maternal and child mortality, morbidity and antenatal care are available (Villar et al., 1998), but still, little is known about expecting parents' satisfaction with the content and quality of antenatal care. Quite recently, various psychosocial issues, such as smoking (McLeod et al., 2003), drug abuse (Göransson et al., 2003), domestic violence (Stenson et al., 2005), and weight problems (Claesson et al., 2009) have been identified as factors that may adversely affect maternal health and, therefore, should be addressed in antenatal care programs.

During the first half of the 1990s, a new model of care known as CenteringPregnancy (CP) was introduced in the United States of America (USA). This was a new approach in promoting the health of pregnant women, fetuses, infants, and families (Rising, 1998), by including self-care activities such as monitoring their B/P, urine and weight and filling in their records antenatal education and networking with other parents, all in the same session (www.centeringhealthcare.org/pages/centering-model/pregnancy-overview.php).

The sessions do not focus on education and is not a case of antenatal care with parent education in a group, rather a period for discussion that occurs in an individual consultation expanded with other parents.

The essential elements of the CenteringPregnancy model are aimed at increasing empowerment and encouraging self-efficacy for participants (Rising et al., 2004).

Group-based antenatal care has been introduced in Sweden in a rather ad-hoc, rather than systematic, way.

The Swedish programmes took inspiration from CenteringPregnancy in the USA, but are mainly based on a Danish model (Wedin et al., 2008). The main difference compared to the CenteringPregnancy model is that the physical assessments and check-ups are provided individually. Physical examinations in group-based antenatal care follow the national guidelines for antenatal care (SFOG/SBF, 2008) and take place individually after the first hour in the group, where each woman has around 10 mins alone with the midwife. No special education preceded the introduction of group-based antenatal care in Sweden; midwives were free to develop their own models that suited their practices.

Most studies on group antenatal care are performed in the USA and recently also some studies in UK and Australia (Teate et al., 2009; Gaudion et al., 2011). Evaluations of group-based antenatal care have mainly focused on infant outcomes, such as preterm birth and birth weight (Ickovics et al., 2003; Grady and Bloom, 2004; Ickovics et al., 2007). Satisfactions with care (Ickovics et al., 2007; Teate et al., 2009; Gaudion and Menka, 2010) and breast-feeding outcomes (Ickovics et al., 2007; Klima et al., 2009) have also been of concern to researchers. Although most studies favour group antenatal care, one study has compared group antenatal care unfavourably with individual care, noting that group antenatal care does not result in healthier behaviour during pregnancy (Shakespear et al., 2010). There also has been studies focused on mothers' experiences of group antenatal care, but research on fathers/partners experiences are lacking The aim of this study was to investigate parents' experiences and perceptions of group antenatal care in different antenatal clinics in Sweden.

Methods

Design

This qualitative study is based on interviews with parents who participated in group-based antenatal care during 2007.

Setting

The four clinics were chosen from a total of seven clinics that offered group-based antenatal care at the time and were located in three different geographical areas, both urban and suburban. Two of the clinics catered to a large number of immigrants.

The clinics offered this model of care in different time periods during the years 2004 and 2007. Group interviews took place at the clinics where the participants had received their care and lasted one hour on average, the settings of the clinics and the participants are explained in the table (Table 1).

Group-based antenatal care was designed differently in each clinic. In three of the antenatal clinics, parents could choose a model of care, but in one clinic, group-based antenatal care was the only option available. There were variations in how men were invited to participate in group sessions and in clinics' visiting schedules. The gestational week in which group-based care started also differed amongst clinics. In one clinic, antenatal group-based care started with the booking visit (week 12). The majority of group sessions were held in a separate group room, but at one clinic, group meetings were held in the waiting room. Table 1 describes the settings for the care.

Participants

The midwives at the four clinics recruited women and their partners who had had received group-based antenatal care during the most recent year. The invited couples were approached after receiving written and verbal information about the group interviews. If parents agreed to participate, the research group contacted them. Thus, all participants had experiences of group antenatal care in the most recent year, and some also had experience with individual care during earlier pregnancies.

Twenty-two couples were asked to participate in the study. All women and ten partners (all male) consented to participate. Five women did not turn up for the planned group interview. Three of these later agreed to be interviewed by telephone. Initially, ten partners agreed to be interviewed. Two changed their minds and did not want to be interviewed at all, but the remaining eight

Table 1
Overview of respondents.

Clinic number	I	II	III	IV	All interviews
Number of women interviewed in group	2	9	2	4	17
Number of individual interviews, women			3		3
Number of individual interviews, men		4	2	2	8
All interviews	2	13	7	6	28
Background characteristics (women)					
Parity (0 para)	1 (G)	8 (G)	2 (G)	2 (G)	
Parity (1 para)	1 (G)	1 (G)	3 (I)	2 (G)	
Country of origin	Non-Swedish	All Swedish	2 Non-Swedish	All Swedish	

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agreed to telephone interviews. The main reason for refusing the group interview was lack of time. When conducting individual interviews participants could choose the time for the interview that suited their individual schedules. An overview if the participant is shown in Table 1.

Data collection

Five group interviews and eleven individual interviews were undertaken (Table 1). An interview guide was used. This included questions about participants' experiences and perceptions of group-based antenatal care. The guide included questions such as knowledge about the existence of the model, opinion about the organisation of the care, the midwife's role and the impact of the group. The guide also included questions about experience of content related to different components of group antenatal care such as physical examinations and group discussions. All interviews were tape-recorded and transcribed verbatim (Table 1).

The research ethics committee at Karolinska Institutet, Sweden no. 2007/553-31 approved the study.

Analysis

Content analysis was used as described by Elo and Kyngäs (2008). This type of analysis is a stepwise process of categorisation that is based on the expressions of feelings, thoughts, and actions described. Our intention was to stay close to the words of the texts transcribed and preserve contextual meaning. All three researchers were involved during the analysis process. They went through constantly backwards and forwards between the whole and the parts of the text.

The first step of the analysis involved reading through transcripts and field notes several times, making additional notes whilst reading, in order to gain a sense of the whole. In the second step, meaning units were extracted and shortened to condense the meaning, while preserving its core, and labelled with a code. Thereafter, the codes were compared and sorted into subcategories and categories based on similarities and differences. Each category included several codes that formed the content of the described experiences and exemplified quotations from the interviews. The last step involved identifying themes using the categories.

Findings

The following three themes emerged from the analysis and described participants' experiences and perceptions of the group antenatal care: '*The care—combining individual physical needs with preparation for parenthood*'; '*The group—a composed recipient of care*'; and '*The midwife—a controlling professional*'. These themes contain specific characteristics but are also related to each other, in the context of care.

The care—combining individual physical needs with preparation for parenthood

The care—combining individual physical needs with preparation for parenthood in groups, includes three categories and eight subcategories (Table 2).

Choice of care

Sources of information

Usually, it was the midwife who had suggested the group-based antenatal care programme. In most cases, parents had never heard about group-based care before being introduced to it at the antenatal clinic. Some participants – especially those in urban areas – had received information from friends with experience with group-based care or from clinics' websites. Men often received second-hand information about care from women. Almost every woman stated that she had decided to participate in group-based care before discussing it with her partner.

Reasons for participation

In their interviews, parents reported that joining group programmes brought access to care that was faster than what they would have received under the individual model of care. A common reflection was that the way group-based care was presented made parents curious about getting to know other parents. One example:

> It would be fun to compare experiences of being pregnant and to meet other parents
> (woman, Swedish, first pregnancy, group interview).

In contrast another woman expressed:

> It wasn't a good idea in the beginning of the pregnancy, I would not want the pregnancy be open to the public
> (woman, non-Swedish, second pregnancy, group interview).

Structure of care

Organisation of care

Mostly, group-based antenatal care took place during the morning or afternoon and lasted for two hours. None of the participants thought that the two-hour sessions were too long. Usually the same midwife, or two midwives, led the sessions. In their interviews, parents confirmed that it was good that all group members had the same midwife. Receiving the same kind of care made them feel safe and comfortable.

Parents also reported that they appreciated the continuity that resulted from their groups' remaining the same, as well as from the continuity in content of group session subjects and schedules. The first appointment (the booking visit) was mostly provided on an individual basis, but some clinics also offered booking visits to groups. In the latter case, group care sessions started with an hour of group activity, followed by individual appointments with the midwife.

If groups were formed early in their participants' pregnancies, they were not really established until the middle of pregnancy. This was because some women miscarried or because parents moved in or out of the area. Another reason was that the expected

Table 2
The care—theme and categories.

Theme:	The care—combining individual physical needs with preparation for parenthood							
Category:	Choice of care		Structure of care		Content of care			
Subcategory:	Sources of information	Reason for participation	Organisation of care	Gender issues	Information and discussion	Medical exam	Preparation	Comparison

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date of birth changed after ultrasound examination, prompting couples to move to groups with more similar gestational ages. Some parents requested that the expected dates of birth in their group not be more than one month apart; otherwise they might miss the last sessions and important information.

As one woman said:

> I was expecting my baby one month before the others and I missed the last two sessions and important information about labour and birth
>
> (woman, Swedish, first pregnancy ,group interview).

Another woman talked about beginning group-based care early in her pregnancy:

> In the beginning, there was a very long time between the first and second meeting, we were a completely different group at the second meeting, and I did not remember who of the others who had been present at the first meeting
>
> (woman, Swedish, first pregnancy, group interview).

Gender issues

Nearly all parents suggested that one or two group sessions consist of separate meetings for women and men. Only in one clinic did the midwife suggest these alternatives. Most men voiced disappointment that the focus of group sessions was the same as the focus of individual visits. They expected that the midwife would take a different approach in group sessions, focusing less on medical issues and more on parents' and partners' perspectives on childbirth. As a woman expressed herself:

> discussion related often to the mothers, as a bonus the midwife asked, '-do you fathers think the same way'
>
> (woman, Swedish, first pregnancy, group interview).

Content of care

Information and discussion

Group sessions consisted of information-sharing and discussions. Midwives provided information about issues related to pregnancy, birth and pain relief, partner relationships, and breast feeding. Sometimes, parents felt that too much discussion distracted attention from the informative part of the session. Some parents thought that they might have asked too many questions, and some women were unsure of how much time they were allowed to talk. They also realised that they shared many experiences and that issues arose within the group.

Most participants reported that there was usually a balance between discussions and information-sharing. Imbalances occurred when parents perceived that the midwife did not listen to the needs of the group and only shared information she wanted to give, or when discussions took so long that the midwife's information-sharing was curtailed.

Partners' main priority was obtaining information.

As one man said:

> If the husband is not present at the group sessions he only gets knowledge through his woman…
>
> (man, Swedish, first pregnancy, individual interview).

When interviewed, participants felt, in retrospect, that they had received enough information about childbirth. However, almost everyone desired more information about the first few weeks after birth, mainly regarding how to adjust to taking care of a new-born infant and being a parent. As one woman explained:

> What an enormous change it is for the mother the first time. It never came up, despite the fact that many of us asked for it. You should be informed about what will happen
> (woman, Swedish, first pregnancy, group interview).

Physical examination

Individual check-ups always took place after group sessions and lasted for 10–15 mins. Participants thought that enough time was allocated for these examinations. They also clearly stated in their interviews that when there was a need for extra visits, such a need was accommodated. Only one participant needed an extra visit, due to medical complications. There were seldom questions remaining after group sessions. Hence, individual visits took less time than expected.

Preparation

Participants reported that sufficient time was allocated for learning about how to prepare for birth. This included taking time to reflect, which led to increased insight and knowledge. Some fathers revealed that they learned to focus and coach practical exercises, such as relaxation and breathing techniques or testing breast-feeding positions using an artificial breast and a doll. Preparation exercises were said to be appreciated and helpful. Most men, however, said they lacked preparation for the postnatal period. They wished that their sessions had included practical exercises about baby care. The majority of women wanted to learn about postpartum complications, such as breast-feeding problems. One partner felt that he was unprepared to meet the ambient prejudices and other paternal norms that fathers face. He said:

> You need to be prepared for the ambient expectations of what a father should be able to do—to share parent leave, the courage to go against the stream
>
> (man, Swedish, first pregnancy, individual interview).

Comparison

Participants often compared group-based antenatal care with their own or others' previous experiences of individual antenatal care. Nearly every parent who had received individual care before participating in group sessions said that they were given more information during group sessions than during the lecture classes that were offered as part of their individual care programmes. One multiparous woman reflected:

> In the early stages of my pregnancy, I went to another clinic and it was rather like, 'Ok, everything is good (…) We need only to measure the blood pressure and measure your weight and hemoglobin (…) Have you any questions?
> (woman, Swedish, second pregnancy, group interview)

The group—a composed recipient of care

The group—a composed recipient of care, comprised three categories and related subcategories (Table 3).

Constitution

Participants

The number of group members ranged from three to nine women and their partners.

Parents asserted that three participants was not enough and explained that forming a sense of group was difficult when there were too few members—that, in such scenarios, efforts to socialise were weaker because there was less communication. In some groups, only a few men were present, making such groups

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Table 3
The group—theme and categories.

Theme:	The group—a composed recipient of care					
Category:	Constitution	Parents' roles			Group effect	
Subcategory:	Participants	Passive	Active	Sharer	Sense of group	Social network

imbalanced and also resulting in the men dropping out over the course of their partners' pregnancies. Nearly every group consisted of first-time parents, as well as parents with previous children. One woman expecting her first baby described the benefit of having an experienced mother in her group:

> It became more realistic when the woman told us about her experiences compared to when the midwife explained it
> (woman, Swedish, first pregnancy, group interview).

Partners were invited by midwives to be present at group sessions either three times or every time. Those who were invited to attend three times expressed a desire to be present more often. Some participants, however, said that it was occasionally difficult to be absent from work. Women reported that their partners' presence and involvement was entirely positive. However, some identified pros and cons to men's participation. On the one hand, it was important to women to have their own partners present; on the other hand, they felt more inhibited in the presence of other women's partners. One woman said:

> I think it's good if they can come, but when they were present, there were things you did not want to ask in front of others. I did not want to raise questions in front of them
> (woman, first pregnancy, non-Swedish, group interview).

Some partners expressed a need for women to meet alone to discuss certain topics that would be considered sensitive if men were around.

Parents' roles

Passive

Parents typically played three roles in groups. Some thought themselves passive recipients who felt comfortable listening to others, especially when other parents raised questions that were similar to their own but that they felt they could not express themselves. In general, fathers felt that they had passive roles. As one man explained:

> Dads are shy, are novices, and are not socially trained to speak on traditionally female topics therefore it difficult to speak in groups like this
> (man, Swedish, first pregnancy, Individual interview).

Active

Parents who perceived themselves in active roles were those who initiated discussions and brought up important questions. Some felt that discussions were more enlivened during the last hour, when the midwife was absent. Some women felt that they were supposed to speak. One woman expressed herself like this:

> Sometimes I felt a demand to be the clever girl and be active. I didn't know when I should speak
> (woman, Swedish, first pregnancy, group interview).

Sharer

Still other parents perceived themselves as sharers. Participants clearly stated in their interviews that being a sharer meant openly discussing expectations, concerns, and experiences, although fathers mentioned this less often than mothers. One woman reflected:

> If you have chosen group-based antenatal care, you are there to share your experiences otherwise you never choice this model of care
> (woman, Swedish, first pregnancy, group interview).

Group effect

Sense of group

There was a positive attitude to group-based care, and almost every parent thought it should be offered to all prospective parents. Women felt that the most important impact of group sessions was normalising pregnancy and helping women not to feel alone during pregnancy. Women with previous children also said that antenatal group care was a means of compensating for what was lacking during their previous pregnancies; they had either missed out on opportunities to socialise with other pregnant couples or to prepare for parenthood. Men observed that when they shared their situations with other group members, they felt less anxiety. Both men and women said that being part of a group gave them strength and self-confidence by making them feel normal.

Social network

After birth, few women took the initiative to meet with other group members. All men stated that they had not met outside of group-based antenatal care; some also commented on their disappointment that group sessions did not provide increased networking opportunities.

The midwife—a controlling professional

The midwife—a controlling professional, the theme is comprised of two categories and related subcategories (Table 4).

Midwife's role

Midwives were described as initiators of discussion, though they did not promote discussion of such matters as relationships and changes in life after birth. The midwife was expected to lead the group discussions and to share information. She was also perceived as a professional medical expert. Sometimes, she suggested discussion topics, and sometimes she allowed the group to choose topics. The midwife also set the ground rules by giving instructions about the programme and the content of group sessions. She also stipulated the timetable and encouraged or ignored participation. Parents were sometimes critical that the midwife adopting a didactic pedagogic style in the groups. They were especially disapproving of midwives who did not encourage group members to take initiative. One example was:

> I was disappointed that the midwife did not ask about the wishes of the group
> (man, Swedish, first pregnancy, individual interview).

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Table 4
The midwife—theme and categories.

Theme:	The midwife—a controlling professional				
Category:	Midwife's role			Characteristics and skills	
Subcategory:	Initiator	Leader	Rule setter	Ideal qualities	Perceived reality

A contrary expression about the midwifes approach: 'Our midwife gave suggestions for subjects to discuss in the group' (woman, Swedish, 1st pregnancy, group interview).

Characteristics and skills

Most parents thought that every midwife should have the skills necessary to lead group-based antenatal care. One woman described good midwife leadership by saying:

Our midwife is very good, knowledgeable, warm, and a little unstructured in a positive way and therefore is fit to lead group-based antenatal care
(woman, Swedish, second pregnancy, group interview).

Other participants, however, felt that their midwives required more skills and/or training to lead groups. Many men expressed a wish that midwives be better prepared for group sessions. Most parents thought that their midwives too seldom focused on fathers, both in group meetings and in individual visits. Nearly all participants requested more focus on couples, rather than pregnant woman. In spite of participants' reservations about the group facilitation styles of midwives, they still recommended group antenatal care for all pregnant women.

Discussion

Group-based antenatal care seems, from the perspectives of the parents interviewed for this study, to meet participants' physical and medical needs and desire to prepare for childbirth.

It did not, however, prepare them for parenthood. The group model was perceived as a forum for sharing experiences with others and thus helped participants normalise their pregnancy experiences. Midwives were viewed as controlling professionals but interchangeable and ignorant of gender issues.

Meeting physical needs and preparing for parenthood

Parents did not request more physical check-ups and were viewed with satisfaction, previous studies on women's perceptions of individual antenatal care visiting schedules (Hildingsson et al., 2002; Hildingsson and Thomas, 2007) have reported that women have a lot of uncertainty and 23% of pregnant women preferred to have more visits than what is recommended.

Group sessions satisfied parents' need to obtain information and ask questions. Respondents said that questions raised were fully discussed, and being active during sessions helped them to remember most of what was covered. These results correspond to the results of studies that have shown that knowledge about pregnancy and childbirth increases amongst parents who attend group-based care, compared to those who only receive individual care (Baldwin, 2006; Ickovics et al., 2007; Jafari et al., 2010).

With regards to parenthood preparation, parents thought there was a need for more—including greater discussion regarding changes of relationships and sexuality this finding could be discussed in relation to similar findings from a pilot study of antenatal group-based care, which reported that women wanted more information about the postnatal period (Wedin et al., 2008).

Parents relied on midwives' knowledge about the most important matters after childbirth, but if a midwife did not mention certain subjects, such as postpartum complications, parents did not know how to address these topics.

Comparable findings are identified in another study (Kline et al. (1998)), where mothers complained that education about the postpartum period was inadequate in content and timing.

According to studies on parenthood education, there might be a need for a new pedagogical approach, a change from traditional lecturing approach to focusing on parent's skills (Nolan, 1997; Ahlden et al., 2008).

The group is a forum for sharing experiences

One of the most commonly expressed reasons for choosing group-based antenatal care was a need to share pregnancy-related issues, benefit from peer support, and share experiences with others.

Similar results, published by Teate et al. (2009), support this notion; women's satisfaction with group-based antenatal care was associated with the ability of groups to promote supportive relationships and opportunities to develop social networks. The importance of peer support from a group is echoed by Jafari et al. (2010).

Regarding the normalisation of pregnancy symptoms, it seems like group participants were more important to this process than midwives. This observation is confirmed by other studies about group-based care, which have shown that the normalisation of symptoms is an important factor of the satisfaction with care (Powell et al., 2009; Novick et al., 2010). Group discussions covered a wide range of topics, particularly when mothers who had previously been pregnant were present.

The midwife—a controlling professional, interchangeable and ignorant of gender issues

In this study, most participants felt that the individual midwife's qualities as a person were less important than her role in the group and that continuity with the same group and midwife was important to get a safe atmosphere in the group. This result could be compared with the results of a previous study on antenatal care, in which 97% of pregnant women reported the importance of meeting with the same midwife when receiving antenatal care (Hildingsson et al., 2002). That study reported, however, on experiences with individual care. The results in the present study could also be discussed in light of the results of another previously published Swedish study that focused on mothers' perceptions of postpartum care; participants identified that one of the most important people in postpartum care was the father of the baby, rather than the midwife (Lindberg et al., 2008).

Compared to individual care, group-based antenatal care offers three times more time with midwives. In this study, it appeared that having more time with midwives was related to building trusting relationships between parents and between midwives and parents.

This study also indicates that parents wanted midwives to act like a facilitator with expertise in antenatal care, rather than a

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dominant group leader who takes command. To act as facilitators, midwives would have to exhibit more non-didactic approaches and an understanding of group processes, skills they have traditionally not been expected to display. Lindberg et al. (2005) have shown that midwives sometimes struggle to support parents' abilities, instead of asserting their traditional role as controlling expert.

Participants raised issues about midwives appearing to be ignorant of gender issues. Men thought that the focus they observed in physical examinations 'spilled over' to group sessions. Previous studies have reported that fathers are made to feel invisible in individual antenatal care (Hildingsson and Häggström, 1999) or treated like 'strange visitors in the woman's world,' as reported by Olsson (2000). In addition, a study on group-based care reported that women expressed disappointment when their partners were not able to attend group sessions (Teate et al., 2009).

Strengths and limitations

The major strength of this study was that we included both women and men in interviews and parents from different geographical areas and social contexts. The researchers themselves had no clinical experience with group antenatal care, which made them exceptionally curious and created an open climate for discussion. One limitation was that men and women were interviewed differently; men just participated in individual interviews. Despite this, we found that parents' willingness to talk about their experiences was unrelated to interview format. Group interviews took place at the antenatal clinics, which may have affected the results, depending on how women felt about their experiences there.

Implications for clinical practice

Compared to the role in providing individual care, the midwife's role in providing group-based care is more similar to that of a professional facilitator. It is important to meet today's parents with a non-didactic attitude. Meeting both women's and their partners' demands is of new importance for midwives. More studies are needed about expecting parents' experiences with different models of antenatal care and about caregivers' roles.

Conclusion

The present study adds to existing knowledge of parents' perceptions and experiences of group antenatal care. Most parents felt secure in groups and said that their pregnancy symptoms were normalised with peer support. Physical needs were also perceived fulfilled and needed information about pregnancy and delivery issues was shared, although parents requested more discussion and information about the period immediately after birth.

Parents made suggestions for improving the group model of care, for example, they thought that midwives should encourage more communication in group settings and be more observant of men's needs in the group.

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