Swedish midwives´ perspectives on group based antenatal care

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ABSTRACT

Antenatal care in Sweden is routinely delivered on an individual level with optional parental education classes. Group based antenatal care (GBAC) is a model of antenatal care that has been implemented in Sweden since the year 2000.

Previous research has focused mainly on parents' experiences and perceptions of GBAC. Midwives have an important role in developing Swedish antenatal care, but studies focusing on midwives' perspectives are rare. Hence, the aim of this study was to investigate and describe antenatal midwives' perceptions and experiences of their current work, with a special focus on their opinions about group-based antenatal care.

Method: An interview study was conducted and analyzed by descriptive statistics and quantitative content analysis.

Participants: 56 midwives from 52 antenatal clinics in Sweden.

Results: The major findings of this study were that midwives were satisfied with their work in antenatal care but have reservations concerning time constraints and parental classes. More than half of the midwives reported an interest in trying the group model but expressed personal and organizational obstacles on the basis of identifiable difficulties in implementing the model. Midwives had strong opinions about the suitability of the model for women.

Conclusions: This is the first study in Sweden to investigate midwives' perspectives on GBAC. Midwives showed an interest in the group model but have concerns about implementing the process. The midwives considered GBAC as inappropriate for immigrants and well-educated parents.

INTRODUCTION

The midwife is the lead caregiver in Swedish antenatal care and works mainly within the primary health care setting, in publicly and privately run antenatal clinics that are free of charge to the women. In Sweden, obstetricians and sometimes family doctors have a consultant role in antenatal care, and midwives refer women with medical complications when necessary. Antenatal midwives usually provide a great opportunity for continuity of care by meeting the same woman throughout her pregnancy and following up with a visit 8–12 weeks after the birth (The Swedish pregnancy register 2012).

Since the introduction of antenatal care in Sweden in 1940s, there have been few changes in the organizational structure. The focus has shifted, however, from being merely medical to also including psychosocial aspects and parental support (The Swedish Association of Obstetrics and Gynecology, SFOG 2008). This work is defined as knowledge and support to prospective parents, mostly in parent education classes, which are offered mainly to first-time parents. The purpose of antenatal education, which was introduced in the late 1970s (SOU 1978:5), was to prepare parents for birth and parenthood and to increase their social contacts through contact with other parents in the same situation. The focus of antenatal education has shifted from teaching breathing and relaxation techniques and preparation for birth to a stronger focus on preparation for parenthood (Petersson, Collberg, Toomingas, 2008).

Most studies on group antenatal care or parent education have focused on the perspectives of pregnant women, with few from the caregivers' perspective (Homer et al. 2012). Nevertheless, a national governmental report showed that midwives were dissatisfied with the parental education and felt that it did not reach vulnerable parents. Midwives also claimed their own lack of educational skills in leading groups (Åhman, Widarsson, Smeds, Fängström, Sarkadi 2008). Another interview study by Ahldén, Göransson, Josefsson, and Alehagen (2008) showed that midwives and obstetricians in leading positions have strong convictions about the importance of parental classes. The authors also stated the need for evaluation of parental classes with the goal of organizing both effective program and to identifying specific educational training for midwives.

Parents' attendance at antenatal education classes has declined in the last decade. In 1994, 95% of first-time Swedish mothers attended childbirth education (SoS Report, 1996:7). In 2012, 72% of women and 67% of their partners attended childbirth preparation (The Swedish pregnancy register 2012). A Cochrane review comprising nine studies involving 2,284 women who were given antenatal education, in group sessions or as individuals, concluded that the effects on their knowledge, sense of control, infant-care capabilities, or labor and birth outcomes remain unknown (Gagnon & Sandall, 2007).

A new approach in antenatal care was developed in the United States in 1990, called Centering Pregnancy© (Icovics, 2003; Grady & Bloom, 2004). This model includes all antenatal care activities such as physical examinations and performed within a group setting. The concept of this model is that the woman herself is in charge of her care; for example, she does her own physical exam. The group model has a non-didactic approach from the caregiver; who could be a midwife, nurse or social worker. The model provides built-in parental education. The model is developing further all over the world (Ickovics et al., 2003). It is built on three components as assessment, education/skills building, and support (Rising 1997). The majority of studies on group model has been conducted on Centering Pregnancy© in USA for vulnerable women (Manant& Dodgson 2011). The findings showed that vulnerable women were more satisfied with the group model compared to vulnerable women in standard care.

In Sweden, two models of antenatal care have existed since the year 2000, individual care with parental classes offered mainly to first-time parents, and group based antenatal care (GBAC). The organization of antenatal care in Sweden has remained almost the same since 1940. GBAC incorporates information and discussion at regular two-hour visits where 6–8 women/couples meet on 8–9 occasions (Wedin, Molin, Crang Svalenius. 2010). Unlike the CenteringPregnancy model the midwife allocates 10 minutes to each woman for a individual health check-up and a time to ask personal questions, rather than women undertaking her own physical examination (Andersson, Christensson, Hildingsson 2013). In a Cochrane review from 2012 on two randomized studies from the United States comprising 1,369 women (Homer, Ryan, Leap, Foureur, Teate 2012), the authors concluded that there were few differences in clinical outcomes between women who received group-based

or standard care. A secondary analysis on a randomized controlled trial from the United States showed not only that the model was suitable for women with difficult lives, but also a time-saving for midwives (Novick et al. 2013a).

The few studies focusing on group care from the midwives' perspective have been conducted in the United States after an implementation period of two years or during the implementation period itself (Klima, Norr, Vonderheid, Handler 2009; Baldwin 2011;Novick et al. 2013b). The results showed that clinicians experienced a challenge in implementing the group model because of organizational constraints and their need to learn new skills. Nevertheless, a positive finding was that the clinicians saw CP as an opportunity to provide educational and support components to parents (Klima et al. 2009). In addition, Baldwin (2011) found that midwives felt empowered and energized in providing a group model like Centering Pregnancy. Another study that evaluated midwives' perspective after the implementation of Centering Pregnancy showed difficulties in offering the model because of organizational issues, but care providers developed modifications such as permitting enrolment in the group over several months (Novick et al 2013b). Additionally, a feasibility study conducted in the United Kingdom (Gaudion et al. 2011) showed that midwives had a positive attitude toward implementing the model. Maier (2013), an Australian midwife, describes her experiences with group care: " I would love to see more midwives exploring this option of antenatal care. It decreases time taken individually, leads to greater learning and understanding as there is more time spent on education".

Only one scientific report in Sweden, a master's thesis on midwives' perceptions and experiences with GBAC in Denmark and Sweden, was identified. It demonstrates that midwives thought GBAC could be developed but demanded awareness of group processes and that more resources were needed. Midwives experienced GBAC as a rewarding and stimulating way to work and felt that the model empowered the parents (Rissanen 2007). Previous research on GBAC has focused mainly on parents' experiences and perceptions of GBAC; but the findings are inconclusive (Wedin et al. 2010; Andersson et al. 2012). Research from other countries has found an increased patient satisfaction with group model but have also found caregivers struggled with organizational difficulties (Novick et. al 2003b).

In addition, there have been studies, which found that midwives emotional well-being affects the quality of care that women received (Halldorsdottir &Karlsdottir 1996). Midwives have an important role in developing Swedish antenatal care, but studies focusing on midwives' perspectives on GBAC are rare. Hence, the aim of the present study was to investigate and describe antenatal midwives' perceptions and experiences of their current work, with a special focus on their attitudes about group-based antenatal care.

MATERIAL AND METHODS

Design

This study is an interview study with closed questions and comments. It was analyzed by descriptive statistics and quantitative content analysis (Berelson 1952).

Recruitment of Participants

All midwifery coordinators in Sweden were sent e-mail with information about the study and were asked to provide names and addresses of midwives working in their area. The midwifery coordinators provided 205 names and e-mail addresses of midwives. Fourteen of these addresses were wrong and nine midwives did not consent to participate. There were 182 midwives who consented to participate, and of these, 90 midwives did not answer the telephone at the booked time and 36 declined to participate. Those who remained were 56 midwives who responded to the invitation and were interviewed.

Data collection

Data collection took place between October 2013 and December 2013 by telephone interviews, which was tape, recorded and lasted for approximately fifteen minutes. A research assistant and the first author conducted the interviews. A structured interview guide was used and included 20 closed questions. The interview guide consisted of closed questions about each midwife's background (age, year of midwifery education, length of work in antenatal care, and residential area) as well as information about organizational issues such as time allocated to booking visits and regular visits, number of antenatal classes each year, professional satisfaction, and knowledge and experiences of group-based antenatal care. In addition to the closed questions, midwives were asked to comment on their experiences and perceptions of group-based care. Before the study began, we conducted five pilot interviews, both face-to-face and by telephone, on midwives in antenatal care.

The response time was measured. This was done to validate the interview guide, and this process motivated small corrections and a redrafting of the guide.

Ethical application was approved by Karolinska Institutet.diare nr: 2013/1597.

Data analysis

Data analyses for the quantitative part were undertaken using software SPSS version 19.0 (IBM Statistical Package for social science). Descriptive statistics and chi square tests were used in the analysis on the closed questions (Machin, Campbell, Walters 2007). Content analysis was conducted on data from the midwives' comments (Elo & Kyngäs 2008).

The comments were transcribed from the verbal telephone interviews into a word document and thereafter only the parts of the text appropriate for description of group-based antenatal care were scrutinized. The analytic process started with all authors reading the text independently to get an impression and sense of the text as a whole and ideas for further analysis. The focus was on midwives' perceptions about group-based antenatal care. In the next step the meaning units within the texts were identified then coded and labeled according to the technique by Elo & Kyngäs (2008). The codes were compared for similarities and differences and sorted into categories. Finally, the categories were gathered into themes. During the process the text was first read independently and then discussed by all authors to control the matching of the categories and the coding. The process continued until consensus was obtained among the researchers. The process continued with counting each category, simply by doing a categories-frequency count, the assumption based on the idea that the categories mentioned most often are the categories that reflect the greatest concerns.

RESULTS

The convenience sample of 56 midwives came from 52 antenatal clinics spread over Sweden. The mean age for the midwives was 53.5 years (range 33–65). The majority had long experience in midwifery (mean 23 years, range 5–41 years) and had worked 13 years on average in antenatal care (range 1–31 years). The majority of clinics were located in small towns (55%), 28% in big cities, and 16% in rural areas. The antenatal clinics worked fairly similarly: they allocated approximately 1 hour for the booking visit and around half an hour for the subsequent visits. The midwives reported having had 0-8 parental classes during the last six months (mean 2.25, SD 1.58) and stated that the parents met 1–5 times (mean 2.95, SD 1.01) in parental classes Table 2).

Three clinics offered only one lecture. The majority of the clinics offered group parent education (95%), and some also offered additional lectures. Half of the clinics offered special presentations with information for parents with previous children.

Table 1 shows that the majority of midwives (60%) perceived themselves as having sufficient skills in teaching parent education classes and 85% felt comfortable in teaching. The vast majority (80%) were satisfied with their general work in antenatal care, but 21% were not satisfied with parental classes. Midwives thought that the parents were satisfied overall with the care they received (80%). Eighty percent had some knowledge of group-based antenatal care (GBAC), but only around 20% had experienced the model, either from their own experience or from a colleague at the clinic. More than half of the midwives (55%) showed an interest in initiating GBAC.

The midwives' perceptions were checked against their background characteristics (age, work experience, and residential area). There were no background differences in the opinions about parental classes, their educational skills, or their knowledge of or experience with GBAC. The residential area was associated with professional satisfaction (p 0.016); 44% of midwives working in large cities were dissatisfied, compared to 10% of those working in small towns and 11% in rural areas. Interest in providing GBAC was highest among midwives working in large cities (81%), followed by rural areas (56%) and small towns (40%) (p 0.028).

Midwives' perceptions about group-based antenatal care (GBAC). Comments from the question regarding a willingness to try GBAC came from 48 midwives. There were eight midwives who did not have any comment on this question. Midwives described their thoughts about starting with GBAC. Positive aspects included time-saving regarding information given by the midwives and enhanced contact between parents. Negative aspects were their own worries about not being able to identify psychosocial problems. Answering midwives valued the individual meetings more highly than meeting parents in group sessions. Hindrances for implementing GBAC were identified in the midwives' personal situations, their organizations, and the midwives' perceptions that group-based care was not suitable for certain women. After coding and categorization, two themes emerged containing nine categories. The themes were expressed as *Benefits and disadvantages of GBAC for parents and midwives from the midwives'*

perspective and *Midwives' attitudes and work-related conditions for carrying out GBAC*. Five categories were found in the theme *Benefits and disadvantages of GBAC for parents and midwives from the midwives' perspective* (Table 3).

Benefits for midwives themselves and the care. The midwives stated that the information given to parents during pregnancy becomes more effective in GBAC, which could lead to saving time. "Time" was a word that was repeated often in the interviews, in different contexts. Midwives reflected upon time-saving for themselves with GBAC, because they expressed concerns about their current workload. They felt that they had not enough time for professional reflection as they needed. The midwives expressed satisfaction in leading groups, because they were able to follow and observe the interactions among group members, and they were able to take part in and to influence the group dynamics. Some midwives thought it would be a positive advantage for them to lead groups in which parents get to know each other better, compared with groups where the parents meet only once. The midwives acknowledged that parents attending group care could support one another and rely on not only the midwife's capacity for support. As one midwife expressed it, *"It is always fun with groups, to see the effect of the group"*.

Benefits for parents compared to standard care. This category was one of the two that had the most frequent meaning units. According to the midwives, GBAC provides the opportunity for parents to meet other couples in groups where they can develop discussions and have the opportunity to create relationships with other parents. They said that it could be an opportunity for parents to get extended social contacts with other parents in the same situation. The model can also increase equality in given care; some of the midwives expressed that GBAC would lead to similarities in the provision of information to all. In this context there were midwives who compared group care with individual care. They considered that the individual meetings could lead to injustice when it comes to information. The information could be reduced for parents who received it at the end of day, when midwives are tired of all the repetitive information. The same information given on the same occasion for parents could in turn affect the need for parents to compare the flow of information that they received. Some midwives stated GBAC could minimize the fact that parents compare information provided, as well as reduce their feeling of receiving different

information and advice. Some midwives compared GBAC with parental classes and identified benefits for parents in group membership, like extended knowledge and understanding. As one midwife expressed it, *"As in parental classes, someone asks something that the other parents had not thought of"*.

Importance of the individual encounter for both midwives and parents. Some midwives considered time allocated to individual encounters very important. The midwives expressed that parents need individual care because they need individual confirmation; this would disappear in groups. The lack of confirmation in a group setting was one of the reasons for the model not being an appropriate alternative for midwives or parents. Individual meetings were also claimed to be more important than group meetings in general in today's society. One midwife expressed the importance of meeting the parents individually: *"Many meetings take place in groups today; we should protect the individual encounter"*.

Parents suitable for GBAC. This category reflects midwives´ consideration of women who would be suitable or not to receive GBAC. They considered that immigrants, well-educated parents, and parents with certain problems would not fit into the GBAC concept.

As one midwife expressed herself about immigrants: *"I understand that mothers who are not born here are not prepared for antenatal groups and ask why they should attend a group session. There is no tradition in their culture with groups"*.
In contrast, midwives suggested that young parents could be suitable for this model of care because midwives thought that they need another kind of care than they are currently offered in standard care. The midwives also stressed other implications; GBAC could be an alternative for contemporary parents, who have much knowledge due to the information society. They do not just need information; they also need help to sort out the body of information. *"The new generations are more informed; they have a flow of information that is Web based. It is a lot of work to pick out the relevant information"*.

Midwives´ worries and concerns about GBAC. The midwives expressed thoughts about missing important information relevant for planning the care for women. Some midwives pointed out that psychosocial problems could be difficult to identify in the group. "*Disadvantages can be that there is a fear, that a midwife misses important information that she may find out later"*.

There were also concerns about bringing up sensitive matters in group

settings—for example, difficulty talking about sexuality in groups. The midwives stressed that colleagues sometimes find it hard to talk about sensitive subjects in front of many people.

The theme *"Midwives' attitudes and work-related conditions needed to carry out GBAC"* consisted of four categories" (Table 4). These categories identified midwives' perception of implementing GBAC.

Resistance to GBAC. This was the second category that had the most frequent meaning units. Some of the midwives clearly expressed a resistance toward starting GBAC, mainly due to bad timing for implementation. They also expressed a lack of interest in starting because the model demands engagement and time. One example of the arguments: "*I do not want to involve myself in something new right now. I do not fancy it just now"*. Some midwives expressed disapproval about implementing GBAC; they were unwilling to become involved in something new or expressed a general resistance with strong feelings against this model. The midwives took the role as representatives of the parents' views and claimed that parents would not like this kind of care.

Showing interest in trying GBAC. This category reflects the midwives' curiosity and interest in trying something new in antenatal care. Some of the midwives also expressed the appeal of trying GBAC because of parents' requests. Those midwives, who were unsatisfied with the parental classes provided today, discussed that changes are needed and GBAC could be worth a try. Some midwives expressed curiosity and had a desire for increased knowledge about GBAC before they would introduce it. One midwife expressed her curiosity: *"The small groups during pregnancy seem to be exciting; it would be fun to try"*.

Circumstances and obstacles for clinics. This category includes expressions about circumstances that could be obstacles to starting GBAC. Some midwives expressed practical hindrances in introducing GBAC, such as premises that were not designed to be used for this model of care. One midwife said," *I had thought that I would be starting it, but then it didn't happen; there was no appropriate room, so the idea disappeared"*. Another organizational hindrance was identified by midwives: small clinics with fewer women can lead to difficulties in carrying out GBAC, because group-based care requires a fairly large number of expectant parents with similar gestational ages. This argument was common among midwives in small units.

Staff obstacles. Some midwives stated that the circumstances in their clinics were unsuitable for the group model. One of the arguments was lack of support from colleagues or managers, which could interfere with the introduction of GBAC. There was a strong opinion that all staff in the clinics needed to be engaged for the purpose of implementing and starting GBAC. As one midwife voiced, "*There was a midwife who wanted to try it out at our clinic, but no other colleague did; therefore, they did not help her book patients to her groups"*. Some clinics were located in areas with many immigrants who often needed support from interpreters. Midwives identified language barriers as obstacles: *"I work in an area with many different languages, and I need extra time when we have an interpreter"*.

DISCUSSION

The major findings of this study were that midwives reported their work at antenatal clinics as satisfying but have reservations concerning lack of time and content and quality of parental classes. Approximately half of the midwives interviewed expressed an interest to try GBAC. They weighed practical pros and cons about implementing the GBAC and had strong opinions about women's suitability for the model.

Most midwives in the present study expressed satisfaction with their work, but 44% of midwives working in large cities reported dissatisfaction; these midwives were the most interested in working with GBAC. When the midwives reported their professional work as satisfactory overall, they also made comments about their working situation. Even if they enjoyed their work, they stated that the work had become too intense in recent years; this led to lack of time for reflection. Midwives commented on their experience with individual care and often mentioned lack of time. Time-saving was seen as an important contribution for implementing the group model. Some of the midwives in the study claimed that the work has become more challenging; parents are more knowledgeable and informed today than they were twenty years ago. Larsson, Aldegarmann, and Aarts (2009) studied midwives' perceptions of their work and explained their role in modern society. The authors found that it could be a challenge to follow contemporary parents' requests and their views on birth as not being a normal process. This could affect the midwives' work situation and it could demand a new approach to the parents. The midwives approach could help parents if they become more facilitative rather than deductive (Gagnon et al 2007).

In the present study, midwives saw an advantage to GBAC in its ability to deliver information in a way that is more discussion-based and adapted to modern parents. Parents may not know about existing alternatives to the care offered. Earlier studies on prospective parents who had experienced GBAC showed that interaction with others contributed to their experiences and those members of the group also helped to normalize symptoms and made women feel more secure (Andersson et al. 2012; Kennedy et al. 2009).

The individual encounter was an important factor in antenatal care with some midwives in the present study proclaiming strong resistance to GBAC. They were concerned that the individual encounter could disappear in the group sessions. There could be several explanations for this argument. One explanation could be that the midwives view the midwife-woman relationship as an important factor in work satisfaction (Sandall 1995; Hunter 2005; Walsh 2007). Another explanation could be related to postmodern society's focus on individualization; individuals are striving for self-identity and self-fulfillment. When people adapt to the modern society in which they live, it contributes to how the individual relates to social activities (Schwalbe 1993, Baumann 2001). In this context is not a surprise that midwives argued that the individual encounter is important. Some midwives thought it GBAC would hamper discovering particular psychosocial problems. In contrast to embracing the individual meetings, there were midwives in our study who reflect upon that group sessions could help parents share concerns in a group and that the group could also contribute to the extension of social contacts. Midwives could visualize the interaction between group members leading to increased satisfaction with their work. In the present study, midwives mentioned organizational struggles in beginning GBAC. They were concerned about implementation and realized that it takes time and also support from colleagues and managers to start a new model of care. These findings are similar to findings from a study from the United States, focusing on perspectives of caregivers' experiences after implementing Centering Pregnancy (Bloomfield & Rising 2013). Studies on midwives' work satisfaction and their motivation for staying in the profession (Sullivan, Lock, Homer 2011; Curtis, Ball, Kirkham 2006) found that support and being valued by managers are important factors. The situation with implementing is reflected in

the Centering Pregnancy instruction: "It takes 2 to 4 years from the initial discussion to sustainable implementation. The site must be ready for change, and for a major change such as this to be sustainable, the top down needs to be involved" (Rising SS personal communication 2011).

Some of the midwives in the present study expressed concerns about problems recruiting parents to groups in small clinics; this corresponded well with the Klima (2009) study, where midwives raised concerns about implementation because of scheduling for groups and lack of adequate recruitment into groups. Another obstacle midwives mentioned in the present study was lack of suitable settings for GBAC, such as adequate rooms or time for planning ahead. These findings are in accordance with studies about midwives' experiences of group care in the United States and Sweden (Tissanen 2008; Novick et al. 2013a). The authors claimed that group care demands different organizational structures and approaches than individual care. Inadequate administrative systems and group space were defined as problems and constrained the opportunity to implement GBAC. In the present study we found that that the midwives were concerned about which women were suitable for this model. They expressed the concern that vulnerable or well-educated women were not suitable or did not like group settings. This assumption can reflect that midwives generalized based on previous experiences or traditions (Green, Kitzinger ,Coupland 1990). This could be compared with parents' opinion in two previous studies in Sweden where both immigrant and well educated parents were included (Wedin et al 2010; Andersson et al. 2012). These studies conclude that these parents appreciate this model and they recommended it for other parents.

To our knowledge, no studies have been performed about midwives' perspectives on women suitable for GBAC. This may reflect the fact that research has been conducted on mainly vulnerable women, such as teenagers and immigrants, in group settings, and therefore there is no general assessment of women suitable for the group model. (Klima et al. 2009; Kennedy et al. 2009; Novick et al. 2013a). Brown, Sutherland, Gunn, and Yelland (2013) studied vulnerable women in antenatal clinics in Australia. Research in Sweden has also identified the complexity of appropriate antenatal care for immigrants (Fabian et al. 2004; Ny ,Dykes, Molin, Dejin-Karlsson 2007).

The authors found that few immigrants attend parental classes in Sweden and had fewer visits than women born in Sweden.

Methodological limitations

Some limits in the study are important to reflect upon. Firstly, we have limited knowledge about the midwives who did not respond to our invitation. The limited sample and the qualitative nature of data make it difficult to generalize the findings to all midwives in Sweden. Another limitation is that more explicit questions could have been helpful in better understanding midwives' thoughts such as questions about their role as midwives. However, the midwives related their discussion to the current care when they were asked to reflect upon willingness to start GBAC. The telephone interviews were performed by two people, one of the authors who had experience working in antenatal care or by an assistant without this experience. This reduces the risk that pre understanding would affect the interviews. Telephone interviews as the method were selected mainly due to long distances. However, telephone interviews are a reliable method of data collection. Compared to face-to-face interviews, equivalent results warranted strong validity (Sturges & Hanrahan 2004; Kempf & Remington 2007). Our study was preceded by a face-to-face pilot study, and no obvious differences were found compared to the telephone interviews. The midwives all were very verbal and interested in expressing their perceptions and experiences of antenatal care. One benefit of the study is that the participants came from different areas in Sweden and that it covers different types of clinics both geographically and socially. This can give an overall picture of how midwives perceive their work and their views regarding GBAC. The selection of informants can affect the transferability; data from 56 interviews representing 50 clinics guaranteed a wide variation of midwives' perceptions and experiences.

CONCLUSION

This is the first study in Sweden to investigate midwives' perspectives on GBAC. More than half of the midwives reported an interest in trying the group model but identified personal and organizational obstacles and difficulties in implementing the model. The group model was considered inappropriate for immigrants and well-educated parents. The majority of the midwives reported high work satisfaction.

Implication for clinical practice

According to our results, midwives required more time and organizational

efforts to be able to develop the current care, especially group models.

Future research

The aim of the present study was to get a broad understanding from midwives working in antenatal care of their feelings about their work in general and GBAC in particular. The key issues identified in this study now warrant a more in depth examination particularly in regard to the underlying assumptions from midwives about the categories of parents suitable for GBAC.

REFERENCES

Ahldén, I, Göransson, A, Josefsson, A & Alehagen, S. (2008). Parenthood education in Swedish antenatal care: perceptions of midwife and obstetricians in charge. Journal of Perinatal Education 17; 21-27.

Andersson, E., Christensson, K., & Hildingsson, I. (2013). Mothers' satisfaction with group antenatal care versus individual antenatal care--a clinical trial. Sex Reprod Healthc. 4; 113-120.

Andersson E, Christensson K, Hildingsson I. (2012). Parents' experiences and perceptions of group-based antenatal care in four clinics in Sweden. Midwifery 28; 502-8

Baldwin K, Phillips G. (2011). Voices Along the Journey: Midwives' Perceptions of Implementing the Centering Pregnancy Model of Prenatal Care. J Perinat Educ. 20; 210–217.

Bauman Z .*The Individualized Society*. Cambridge: Polity. 2001.UK ISBN 0-7456-2506-1.

Berelson B. (1952). Content analysis in communication research. Free press New York, US.

Bloomfield, Rising SS. (2013). Centering Parenting: An Innovative Dyad Model for Group Mother-Infant Care. J Midwifery Women Health. 58; 683-689.

Brown SJ, Sutherland GA, Gunn JM, Yelland JS. (2013). Changing models of public antenatal care in Australia: Is current practice meeting the needs of vulnerable populations? Midwifery. doi: 10.1016/j.midw.2013.10.018.

Curtis P, Ball L, Kirkham M (2006). Why do midwives leave? (Not) being the kind of midwife you want to be. British Journal of Midwifery, 14; 27 - 31

Elo S, Kyngäs H. (2008). The qualitative content analysis process. Journal of Adv Nurs. 62; 107-115.

Fabian, H. M., Rådestad, I. J., & Waldenström, U. (2004). Characteristics of Swedish women who do not attend childbirth and parenthood education classes during pregnancy. *Midwifery, 20*; 226-235.

Gagnon AJ, Sandall J. (2007). Individual or group antenatal education for childbirth or parenthood, or both. Cochrane Database Syst Rev. 18;CD002869.

Gaudion A, Menka Y, Demilew J, Walton C, Yiannouzis K, Robbins J, Rising SS, Bick D. (2011). Findings from a UK feasibility study of the CenteringPregnancy® model. British J Midwifery 19; 796 – 802.

Grady MA, Bloom KC. (2004). Pregnancy outcomes of adolescents enrolled in a Centering Pregnancy program. J Midwifery Women's Health, 49; 412-420.

Green J, Kitzinger JM, Coupland VA. (1990) Stereotypes of childbearing women: a look at some evidence. Midwifery 6;125-132.

Larsson M, Aldegarmann U, Aarts C. (2009). Professional role and identity in a changing society: three paradoxes in Swedish midwives' experiences. Midwifery 25; 373-381.

Halldorsdottir S, Karlsdottir SI.(1996). Empowerment or discouragement: women's experience of caring and uncaring encounters during childbirth. Health Care For Women International 17:361-179.

Homer C, Ryan C, Leap N, Foureur M, Teate A. (2012). Group versus conventional antenatal care for women. Cochrane Database Syst Rev.11: CD007622.

Hunter B. (2005). The importance of reciprocity in relationships between community-based midwives and mothers. Midwifery 22; 308-322-72.

Kempf AM, Remington PL. (2007). New challenges for telephone survey research in the twenty-first century. Annual review of public health 28; 113-26

Kennedy HP, Farrell T, Paden R, Hill S Jolivet R, Willetts J, Rising.SS. (2009)."I Wasn't Alone"—A Study of Group Prenatal Care in the Military. J Midwifery Women's Health, 54; 176-183.

Klima C, Norr K, Vonderheid S, Handler A. (2009). Introduction of Centering Pregnancy in public health clinics. J Midwifery Women´s health 54; 27-34

MacHin D ,Campbell MJ, Walters SJ. Medical Statistics-A Textbook for the Health Sciences. 2007. 4th edition. Wiley. USA.

Maier BJ. (2013). Antenatal group care in a Midwifery Group practice- A midwife' perspective. Women and Birth 26; 87-89.

Manant A, Dodgson, JE. (2011). Centering Pregnancy: An Integrative Literature Review. Journal of Midwifery & Womens Health, 56; 94-102.

Novick G, Reid AE, Lewis J, Kershaw TS, Rising SS, Ickovics JR.(2013a). Group prenatal care: model fidelity and outcomes. Am J Obstet Gynecol. 209:112-116

Novick G, Sadler LS, Knafl K A, Groce, Nora E, Kennedy HP . (2013b.) In a hard spot: Providing group prenatal care in two urban clinics. Midwifery 29; 690-697

Ny P, Dykes AK, Molin J, Dejin-Karlsson E. (2007). Utilisation of antenatal care by country of birth in a multi-ethnic population: a four-year community-based study in Malmö, Sweden. Acta Obstet Gynecol Scand. 86; 805-13.

Petersson K, Collberg P, & Tommingas B. (2008). Föräldrastöd i SFOG (Svensk förening för obstetrik och Gynekologi). Mödrahälsovård, Sexuell och Reproduktiv Hälsa 87-95, ARG-rapport nr. 59).

Rising SS. (1997). CENTERING PREGNANCY: An Interdisciplinary Model of Empowerment. Journal of Nurse-Midwifery 43;46-54.

Rissanen L. (2007). Master thesis. Sahlgrenska akademin. Gothenburg. Sweden.

Sandall J. (1995). Choice, continuity and control: changing midwifery, towards a sociological perspective. Midwifery 11; 201-209

Schwalbe M, L. (1993). Goffman Against Postmodernism: Emotion and the Reality of the Self. Symbolic Interaction, 16; 333-350.

SOU 1978:5. Parent education. National Board of Health and Welfare, Sweden Stockholm, (In Swedish) 1978.

Sturges JE & Hanrahan KJ. (2004). Comparing telephone and face-to-face qualitative interviewing: a research note. Qualitative Research, 4; 107 - 118.

Sullivan K, Lock L, Homer CS. (2011). Factors that contribute to midwives staying in midwifery: a study in one area health service in New South Wales, Australia. Midwifery 27: 133

The Swedish association of obstetrics and gynecology (SFOG) and The Swedish association of midwives (SBF). Antenatal care, sexual and Reproductive health, 2008, report No; 9.

The Swedish pregnancy register 2012: http://www.graviditetsregistret.se

Walsh D, Steen M. (2007). The role of the midwife: time for a review. RCM 10; 320-323.

Wedin K, Molin J, Crang Svalenius E L. (2010). Group antenatal care: new pedagogic method for antenatal care – a pilot study. Midwifery 26:389-93.

Åhman A, Widarsson M, Smeds L, Fängström K, Sarkadi A. Mödrahälsovården dilemma: medicinsk övervakning eller stöd i graviditeten på föräldrars villkor? Föräldrastöd I Sverige idag, när, var , hur?(In Swedish) Report. The National Public Health Institute; Uppsala, 2008.

Table 1. Midwives experiences and perceptions of antenatal care

Variables	Midwife n=56
	m (Sd) / n (%)
Parental classes/6 months	2.25 (1.58)
Enough education in leading groups	
Yes	33 (58.9)
No	23 (41.1)
Comfort with leading groups	
Yes	41 (85.4)
No	7 (14.6)
Satisfied with overall work situation	
Yes	45 (80.4)
No	11 (19.6)
Parents satisfied with overall antenatal care according to midwife	
Yes	45 (80.4)
No	11 (19.6)
Parents satisfied with parental classes according to midwife	
Yes	44 (78.6)
No	12 (21.4)
Knowledge about GBAC	
Yes	45 (80.4)
No	11 (19.6)
Experiences of GBAC	
Yes	11 (19.6)
No	45 (80.4)
Request to run GBAC	
Yes	31 (55.4)
No	25 (44.6)

Table 2. Content of care and clinics characteristics

Variables	Unit n=52 n (%) m(Sd)
Parental classes	
Offer only auditorium	3 (5.4)
Offer parental classes for multipara	22 (45.4)
Number of parental classes occasion	2.95 (1.01)
Time for visits	
Time for booking visit	59.6 (14.2)
Time for visit	29.2 (8.9)
Women born outside Sweden	16.9 (16.9)
Clinic location	
Large city	14 (26.9)
Small town	29 (55.8)
Rural area	9 (17.3)

Table 3. First Theme and categories

Benefits and disadvantages of GBAC for parents and midwives as to midwives perspective				
Benefits for midwives themselves and the care (8)	**Benefits for parents compared to standard care (10)**	**Importance of the individual encounter for both midwives and parents (6)**	**Parents suitable for GBAC (6)**	**Midwives´ concerns and worries about GBAC (7)**

(n) = numbers of midwives included in this category

Table 4. Second theme and categories

Midwives attitudes and work related conditions and to carry out GBAC			
Resistance to GBAC (10)	**Showing interest in trying GBAC (6)**	**Circumstances and obstacles for clinics (4)**	**Staff obstacles (4)**

(n) = numbers of midwives included in the category