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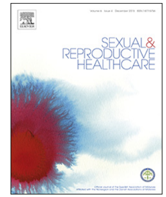

Challenges and benefits of conducting parental classes in Sweden: Midwives' perspectives

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Objective: There is lack of knowledge regarding antenatal care midwives' perspectives concerning parental classes provided during pregnancy, and this study aimed to explore midwives' experiences and thoughts about these parental class activities.

Methods: Twenty-six semi-structured, individual, telephone interviews were carried out with midwives at antenatal clinics across Sweden, and the data were analysed using systematic text condensation (STC).

Results: The midwives noted that parental classes were a demanding task, and they appeared to lack the confidence and skills required to manage the classes. They expressed a "need for collaborators to achieve the objectives" (theme 1). The midwives felt that "creating new networks is most valuable for parents" (theme 2), and they were also "striving to give the 'whole picture' to both parents" (theme 3), i.e. looking beyond just the delivery. Although they had the ambition, midwives realised it was "not possible to reach all" (theme 4).

Conclusions: Organisational resources as well as developing skills to lead groups are imperative for midwives to fulfil the goals of the parental classes. The midwives are aware that they cannot reach all parents with the group format; thus, it is important to acknowledge the needs of minority populations and develop multidisciplinary collaborations to be able to better address their needs.

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Introduction

Parental classes were introduced in Sweden in 1980 as an integrated part of the antenatal and child healthcare programme [1], and are – at least in theory – offered to all expectant parents [2]. In Sweden, such classes are free of charge, and there are several broad topics that are covered during these sessions, such as pregnancy and delivery, breastfeeding, the perinatal period and the newborn baby, lifestyle, the couple relationship and parenthood. Antenatal programmes for pregnant women and their partners providing information related to pregnancy, birth or parenthood exist in many developed countries throughout the world [3]. The primary objective of these classes is to promote child health and development by enhancing parenting skills and parents' ability to meet the needs of the newborn child [4]. An additional aim is to create contact and fellowship between participants; moreover, the number of meetings shall be adapted to make this possible. Midwives should be offered continuing training to lead these groups, and a psychologist is to be available for consultation regarding the content, design and implementation of the parental classes. Furthermore, antenatal care should promote equality in parenthood [4]. The number of times when the group meets varies between antenatal centres, from one to six; additionally, some centres have lectures for larger groups only or as a complement to other group sessions [5].

Most of first time expectant parents attend parental classes. National register data show that of first time parents, 72% of women and 67% of men attend classes [5]. However, young women, those with low educational level and foreign-born parents attend to a lesser extent [6]. The effect of such parenting classes is uncertain [3,7], and Swedish studies have not shown any clear advantages regarding the childbirth experience, breastfeeding rates or parental stress in expectant parents [8,9]. Although women and men seem satisfied overall with the classes regarding the childbirth preparation, only a few are satisfied with the parenthood preparation component [8,10].

Unlike in many other high-income countries, in Sweden, midwives are the primary caregivers during pregnancy, and in the absence of known pregnancy-related risk factors, there is no planned visit with a physician. Although there has been a shift in Sweden towards increasing medical monitoring and information concerning health risks, Swedish midwives are still the main caregivers

Abbreviation: STC, Systematic Text Condensation.

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during pregnancy and childbirth, focusing on normal reproductive health and prenatal care [4]. As such, midwives often work alone, both at individual visits as well as when they perform group sessions.

Even though parental classes have been implemented for 30 years in routine antenatal care by midwives and offered to all expectant parents [2], Swedish studies have mostly focused on the parents' expectations and experiences [11–14]. Some work has been done on the perceptions of midwives and obstetricians in charge of the services [15], but there is still a lack of knowledge regarding front-line antenatal care midwives' experiences and views on parental classes.

Aim

The purpose of this study was to explore antenatal care midwives' experiences and thoughts about the parental class activities provided during pregnancy.

Methods

Data were drawn from individual telephone interviews with midwives (n = 26) at different antenatal clinics across Sweden. A purposive sample of 27 clinics was selected from different regions of the country, with catchment areas that varied with regard to: socio economic status of the population, size of clinic and organisation (Table 1). Inclusion criteria were registered midwives who had worked at the selected antenatal clinics during the past 12 months. The chosen clinics were contacted by telephone, and the midwife who answered the call was given a short verbal description of the study and then asked if she would consider participating in a telephone interview. Of the 27 midwives who were invited to participate, one declined participation because of lack of time, and another did not meet the inclusion criteria of having worked long enough at the facility and therefore referred the question to a co-worker. The 26 midwives who agreed to participate were sent written information about the study and a consent form via e-mail.

Table 1
Characteristics of the participants and their clinics.

Midwives/clinics	N = 26
Professional experience years	Range (median)
As midwife	2–41 (20)
Antenatal healthcare	1–40 (8)
Employment	N (percent)
Family centre[a]	12 (46)
Antenatal clinic	14 (54)
Clinic size	Range (median)
Number of midwives	1–20 (3)
Parental group activities	Range (median)
Number of sessions	1–8 (4)
Length of session (hours)	1–6 (2)
Parent education classes offered	N (percent)
Only first time parents	13 (54)
All expectant parents	11 (46)
Main type of session	N (percent)
Traditional parental groups	20 (77)
Theme sessions	5 (19)
Group antenatal care[b]	1 (4)
Catchment area	N (percent)
Large city	2 (8)
Suburb of large city	3 (11)
Middle-sized city	9 (35)
Small city	9 (35)
Rural area	3 (11)
Socio economic status	N (percent)
Mixed	10 (38)
High/medium	9 (35)
Low/large proportion immigrants	7 (27)

[a] Antenatal clinic co-located with the child health clinic, open pre-school, and social services.
[b] Regular antenatal check-ups at the midwife, combined with group activities.

Characteristics of participants

Participants' professional experience and characteristics of the clinic where they were employed are described in Table 1. Forty-six percent of these antenatal clinics were so-called family centres. This is a concept of co-located services where the idea is that co-location will promote multidisciplinary collaboration and early prevention across service borders. Services include the antenatal clinic, the child health clinic, a drop-in pre-school where parents attend social or educational activities (such as singing or massage) together with their babies or young children, and the voluntary branch of social services with personnel available to give support and advice. The number of parental class sessions varied from one to eight, and the length of each session was about two hours (median). Almost half of the clinics (46%) invited all parents, regardless of parity, whereas the others only offered parental class sessions to first time parents. The majority offered traditional parental class sessions, and a few organised recurring thematic lectures at the antenatal clinic.

Data collection

Semi-structured, in-depth telephone interviews were carried out using an interview guide developed for this study, including probing questions and follow-up questions. The interview guide was based on earlier research and personal knowledge about antenatal health-care by one of the authors who is a registered midwife (A.Å.). None of the authors, however, had organised parental groups themselves, and thus lacked specific preconceptions about being a professional in that situation. Between interviews, the authors continuously reflected on the material (peer debriefing); specifically, the feasibility of telephone interviews and the appropriateness of the interview guide were discussed between the first couple of interviews.

All 26 interviews were scheduled at a time when the midwives had access to a telephone in a separate room at their clinic, to which the interviewer called at an agreed upon time. The interviewer sat in a separate room where it was possible to ensure that there would not be any disturbances. The interviews, which lasted between 25 and 45 minutes, were recorded and thereafter transcribed verbatim.

Data analysis

Data were analysed using systematic text condensation (STC), as described in detail by Malterud [16]. First, all interviews were read and re-read to obtain a comprehensive image for each case. During the process of decontextualisation, recurrent themes reflecting the midwives' experiences and thoughts about parent group activities at their clinic were identified. Meaning units were thereafter identified and grouped on the basis of identified themes, after which the units in each theme were sorted into categories describing different aspects of the theme. Once a category was assigned, the condensation process followed, where the content of each category was summarised using 2–3 sentences as if it were expressed by a single participant, hence, integrating all statements in that category into a single statement. After condensation, the analytical text was formulated and quotes were selected from the units assigned to that category to exemplify the contents. The selected quotes were labelled with the respective interview number, the number of professional years as a midwife, if the midwife was working at an antenatal clinic or family centre, and the location of the clinic. All quotes are verbatim transcriptions of the interviewee's words; parentheses (…) indicate that some of the text has been omitted due

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