Health Promotion International, 2021;36:649–659
doi: 10.1093/heapro/daaa096
Advance Access Publication Date: 18 September 2020
Article

The implementation process of the Confident Birth method in Swedish antenatal education: opportunities, obstacles and recommendations

Sofia Jansson†, Sepideh Farahshoor†, Karolina Linden, and Malin Bogren *

Institute of Health and Care Sciences, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden

*Corresponding author. E-mail: malin.bogren@gu.se
†There authors contributed equally to this work.

Summary

Antenatal clinics in western Sweden have recently invested in a birth method called Confident Birth. In this study, we investigate midwives' and first line managers' perceptions regarding the method, and identify opportunities and obstacles in its implementation. Semi-structured individual interviews were conducted with ten midwives and five first line managers working in 19 antenatal clinics in western Sweden. The Consolidated Framework for Implementation Research was used in a directed content analysis approach. *Intervention Characteristics*—such as perceptions about the Confident Birth method—were found to have equipped the midwives with coping strategies that were useful for expecting parents during birth. *Outer Setting*—the method was implemented to harmonize the antenatal education, and provided a mean for a birth companionship of choice. *Inner setting*—included time-consuming preparations and insufficient information at all levels, which affected the implementation. *Characteristics of individuals*—, such as knowledge and believes in the method, where trust in the method was seen as an opportunity, while long experience of teaching other birth preparatory methods, affected how the Confident Birth method was perceived. *Process*—such as no strategy for ensuring that the core of the method remained intact or plans for guiding its implementation were major obstacles to successful implementation. The findings speak to the importance of adequate planning, time, information and communication throughout the process to have a successful implementation. Based on lessons learned from this study, we have developed recommendations for successful implementation of interventions, such as the Confident Birth, in antenatal care settings.

Key words: antenatal education programmes, Consolidated Framework for Implementation, Confident Birth method

INTRODUCTION

To optimize high-quality maternity care, Sweden has a long tradition of providing antenatal education, including health promotion and birth preparatory courses (Barimani *et al.*, 2018; Pålsson *et al.*, 2019). This education is an essential component in antenatal care (Gagnon and Sandall, 2007; Pålsson *et al.*, 2019), and its provision is in line with international and national

guidelines (International Confederation of Midwives, 2017; The Swedish Association of Midwives, 2018). The goals of antenatal education vary. However, according to a Cochrane review (Gagnon and Sandall, 2007), a common goal of antenatal education is to build women's confidence in their ability to give birth as well as to prepare expecting parents for childbirth and parenting. Because of the varied content and aim of antenatal education classes, it has proven difficult to evaluate and measure their usefulness (Gagnon and Sandall, 2007). Despite these difficulties, some positive emotional effects of antenatal education have been identified, such as decreased anxiety for the mother and increased involvement of the partner during birth (Ferguson *et al.*, 2013). Similar, higher confidence in ability to cope at home during labour and to handle the birth process have been reported on (Brixval *et al.*, 2016). Although the effects of antenatal education are largely unknown (Gagnon and Sandall, 2007), a long-term follow-up of a randomized controlled trial showed that those who had undergone a well-structured antenatal education programme reported a more positive birth experience 5 years after childbirth compared to those who had participated in none, or in a more conventional, less structured antenatal education programme (Maimburg *et al.*, 2016).

The content and structure of antenatal education have shifted over time, depending on trends in society and in maternal healthcare (Bergstrom *et al.*, 2011; Berlin *et al.*, 2016; Forslund Frykedal *et al.*, 2016). One such trend in Sweden has involved psychoprophylaxis, focusing on teaching breathing and relaxation techniques. A randomized controlled trial (Bergstrom *et al.*, 2009) found no associated obstetric outcomes benefits or improvement of the childbirth experience in women using psychoprophylaxis during birth. Yet, there is some evidence suggesting that relaxation techniques may improve pain management during labour and childbirth (Jones *et al.*, 2012).

Although there are similarities between antenatal education programmes and psychoprophylaxis courses, they are developed in different cultural contexts with different content. A birth preparatory method, Confident Birth, has been developed in a Swedish context. According to its developer (Heli, 2013), the Confident Birth method was developed based on coping strategies connected to respiratory and stress physiology and activation of the parasympathetic system. The purpose of the method is to strengthen the mother's inherent physical and emotional capacity through support by a companion of choice, striving to achieve an emotionally safe and confident birth. The support of a companion of choice is a central part of the method (Heli, 2013). The companionship of choice during birth is defined as the continuous presence of a support person during labour and birth (Hodnett *et al.*, 2011). The Confident Birth method consists of four central components: breathing, relaxation, sound and the mind. In recent years, the Confident Birth method has rapidly gained a foothold in public antenatal clinics and maternity departments across Sweden.

Recent research has suggested that future studies on companionship methods, such as the Confident Birth method, should consider factors that may affect the process and context of implementation (Kabakian-Khasholian and Portela, 2017; Bohren *et al.*, 2019). To our knowledge, there are no published scientific studies on the Confident Birth method nor on its implementation. Thus, the aim of this study is to investigate the perceptions of midwives and first line managers regarding the Confident Birth method and to identify opportunities and obstacles in its implementation.

MATERIALS

Study design

A qualitative research design was used, which is useful when little is known about the subject (Elo and Kyngas, 2008), such as the perception of the Confident Birth method and its implementation. Data were collected through semi-structured individual interviews with midwives participating in instructor training in this method, and with first line managers in antenatal healthcare who were involved in the method's implementation. The data were analysed using content analysis with a deductive approach inspired by Elo and Kyngas (Elo and Kyngas, 2008). The Consolidated Framework for Implementation Research (CFIR) (Damschroder *et al.*, 2009) was used as a theoretical framework to guide the data analysis and description of the results.

Theoretical framework

To understand the participants' perceptions about the Confident Birth method and to identify opportunities and obstacles in its implementation, the CFIR framework (Damschroder *et al.*, 2009) was applied during data analysis and the description of the results. The CFIR, a synthesis of concepts described in 19 existing implementation frameworks, models and theories, has previously been applied in research areas such as healthcare science and clinical management research (Damschroder *et al.*, 2009; Lind *et al.*, 2017; Selove *et al.*, 2017). The CFIR describes different aspects to

consider during the implementation process (Lind *et al.*, 2017; Selove *et al.*, 2017), and defines implementation as a constellation of processes intended to bring an intervention into use in an organization. The CFIR consists of five main domains—(i) *intervention characteristics* (features of an intervention that might influence implementation), (ii) *inner settings* (features of the implementing organization that might influence implementation), (iii) *outer settings* (features of the external context or environment that might influence implementation), (iv) *characteristics of individuals* (characteristics of individuals involved in implementation that might influence implementation), and (v) *process* (includes strategies or tactics that might influence implementation)—with 39 sub-domains. These domains interact in a wide and complex manner, to influence implementation in an efficient way, which means that the sub-domains sometimes overlap. Therefore, not all sub-domains need to be used (Damschroder *et al.*, 2009). In this paper, the studied implementation process includes the four steps necessary to become an instructor in the Confident Birth method, and the aspects influencing the delivery of the education to the expecting parents. For an overview of how the CFIR was applied in this study, see Table 1.

Setting

At the time of the study, the participants were working for the largest public primary healthcare provider in western Sweden, consisting of 69 antenatal clinics. Antenatal healthcare in this region is organized in a healthcare choice system with both publicly and privately owned clinics, all governmental financed and free of charge. Midwives are the key care providers during pregnancy, they provide full antenatal care and identify high-risk pregnancies and make referrals to medical specialists when necessary. As an effort to improve antenatal education, 19 of these antenatal clinics have invested in instructor training for midwives in the Confident Birth method in 2018. The instructor training consisted of four parts:

1. A reading part, in which literature related to the method was studied;
2. A structured web-based training part, describing each part of the method in preparation for the upcoming 3-day workshop;
3. A 3-day workshop, consisting of practical exercises and instruction in how to deliver the content of the method's manuscript;
4. A practical training part, in which each midwife had to independently hold two Confident Birth courses for 6–10 expecting parents.

The midwives who underwent the instructor training in the Confident Birth method are expected by their employer to hold one course a month for expecting parents. Confident Birth classes are offered free of charge to all first-time mothers with partners, and to women with secondary fear of childbirth as well as their partners (if capacity allows). The clinics offer 32–33 Confident Birth courses per month, with seven to nine couples per occasion. Approximately 240 couples undergo the Confident Birth course every month.

Participants and data collection

Twenty-eight midwives working at the 19 antenatal clinics underwent instructor training in the method. They, and nine first line managers who held employer responsibility for the midwives, were invited to take part in the study via e-mail. Fifteen agreed to participate in the study and two declined, while the remaining 20 did not reply to the request. Sixteen interviews were conducted with 15 participants, 10 instructor midwives, and 5 first line managers. For details, see Table 2. One of the participants was interviewed twice, this to obtain complementary information, ∼6 months after the first interview. All participants were registered midwives, and represented 13 of the 19 clinics.

The first author (S.J.) conducted the first six interviews in November and December 2018 and the first authors (S.J. and S.F.) conducted the second round of nine interviews in April 2019. Both first line managers and instructor midwives were interviewed to get a deeper understanding of the implementation of the Confident Birth method. The study was approved by the management of the public primary healthcare provider. Before the interview, all participants were given verbal and written information about the study and their right to confidentiality in accordance with the Helsinki Declaration (WMA, 2018). They were informed that the study was voluntary, and that they could refrain from answering questions or discontinue the interview and withdraw their consent at any time without having to give a reason. Written consent was attained from all participants before the interviews commenced (WMA, 2018).

An interview guide with open-ended questions was developed to ensure data were collected to answer the aim of the study. The interview guide prompted respondents to discuss their experiences to undertake the instructor-training course in the Confident Birth method, followed by questions regarding opportunities and obstacles in its implementation. Questions about specific CFIR sub domains (Damschroder *et al.*, 2009)

Table 1: Illustration and description of the CFIR domains and sub domains, and its application in this study

Main domain	Sub-domains	Definitions	Application in this study
Intervention characteristics	Evidence and strength	The participants' perceptions of the quality and validity of the method and the belief that the method will have desired outcome. Sources of evidence may include results from a local pilot, patient experiences and other sources	Participants perceptions' and knowledge about the Confident Birth preparatory method
	Adaptability	The degree to which the method can be adapted to meet local needs. Relies on a definition of the 'core components' (the essential core that cannot be changed) versus the 'adaptable periphery' (parts that can be adapted)	Midwives' perceptions of the strict Confident Birth manuscript
Outer settings	Patient needs and resources	Extent to which patient needs are considered by the organization, as well as facilitators and challenges to meet these needs	Implemented as an opportunity to meet expecting parents' demands regarding birth preparation
	Peer pressure	Extent to which the organization has been affected by competitors in the decision to implement	Method was implemented as an opportunity to become an attractive caregiver
	External policies and incentives	Extent to which an organization has considered polices, regulations, guidelines, research, etc.	Participants' knowledge and perception about research and external policies
Inner settings	Network and communications	The quality of formal and informal communications within an organization	Insufficient information and communication at all levels
	Implementation climate	Extent to which the method will be supported within the organization	
	Tension for change	The degree to which the organization perceives the current situation as intolerable or needing change	An opportunity for improvement and to increase quality and equality
	Readiness for implementation	Tangible and immediate barometers of organizational commitment to its decision to implement the method, consisting of three sub-constructs: leadership engagement, available resources and access to information and knowledge	
	Available recourses	Available resources for the implementation, including money, training, time, facilities, etc.	Insufficient time, access and availability of facilities
Characteristics of individuals	Knowledge and beliefs about intervention	Attitudes toward the method, as well as familiarity with facts, truths and principles	Trust in the method was seen as an opportunity, but difficulties in the implementation
Process	Planning	Extent to which the implementation of the intervention has been planned in advance, with the purpose to make implementation effective	Inadequate planning through the entire process
	Reflecting and evaluating	Feedback about the progress and quality of implementation followed up with regular personal and team debriefing about progress and experience. The focus here is specifically related to implementation efforts	Improvement along the process due to feedback

Table 2: Demographic facts about the participants, both midwives and first line managers ($n = 15$)

Age	36–62 years mean 51 years median 49 years	
Years working as a midwife	>5 years	4 midwives
	>15 years	6 midwives
	>25 years	3 midwives
	>35 years	2 midwives
Years working in antenatal clinics	1–5 years	2 midwives
	5–10 years	4 midwives
	10–15 years	2 midwives
	15–20 years	3 midwives
	20–25 years	2 midwives
	25–30 years	1 midwife
Years working in delivery ward	0 year	2 midwives
	1–5 years	4 midwives
	5–10 years	3 midwives
	10–15 years	4 midwives
	15–20 years	2 midwives
Midwives with experience of other birth preparation methods	10 midwives	

were not asked; rather questions about the participants perceptions of the Confident Birth method; the instructor training and the implementation of the method, followed by probing questions *Do you have any more examples*, *Can you elaborate*. Data collection was continued until the interviewers sensed no new information was discovered. All interviews were held in Swedish, at a location chosen by the participant, were audio-recorded, and lasted around 25–50 min.

Analysis

The interviews were transcribed verbatim and analysed by S.J. and S.F. using qualitative content analysis with a deductive approach inspired by Elo and Kyngas (Elo and Kyngas, 2008). In the first phase, the transcriptions were read multiple times to make sense of the data as a whole. In the second phase, meaning units corresponding to the aim of the study were identified. All content that answered the questions *What are the instructor midwives and first line managers' perceptions of the Confident Birth method?* and *What are the opportunities and* obstacles *in the implementation?* were marked. In the third phase, the meaning units were organized according to the five main domains of the CFIR. In the fourth phase, the sorted meaning units were re-read and organized into 11 sub-domains (of 39 possible) in the CFIR. The authors continually checked that the data used in the analysis was in accordance with the transcriptions, to assure the trustworthiness of the study (Elo and Kyngas, 2008). Finally, after several refinements of the analysis, a final consensus among all authors was reached on the reported results.

RESULTS

The results are presented according to the CFIR's five main domains and 11 of its 39 sub-domains. When organization is mentioned in this study, this refers to the 19 antenatal clinics that have invested in Confident Birth, consisting of instructor midwives and first line managers. In the results we mostly refer to both the instructor midwives and first line managers as simply participants, unless it is relevant to contrast the differences in their perceptions based on their roles.

Intervention characteristics

Evidence strength and quality

The participants' perceptions of the Confident Birth method were similar. They described the method as simple, logical, and built on physiology, and their perceptions were that expecting parents became more confident after completing the programme. The knowledge about the method varied depending on whether the participant was an instructor midwife or a first line manager. The midwives had become more equipped with deeper theoretical knowledge and pedagogical skills after having undergone the training. This included increased understanding of the human body's physiology and its impact on emotions, and of the mediation of coping strategies during childbirth. The midwives stressed that the use of the method made them feel strengthened and proud of their work, as they felt that it enabled them to practice genuine midwifery. The first line managers' knowledge about the method came largely from a previously conducted training day for all staff in the organization:

> A great course that involves women, men, partners, support persons getting knowledge based on physiology. What happens in our bodies due to different emotions.
>
> (Instructor midwife 3)

Adaptability

In accordance with the course manual, being a course instructor required that the midwives strictly follow the Confident Birth manuscript; any editing of the content was prohibited. Some midwives perceived this inflexibility in the method as challenging. Others saw the rigidness as a guiding structure that was easy to follow,

ensuring that everyone was presenting the same content in the same way, with limited risk of losing the core concept:

> It's a fairly strict concept, which I think is good. It's a clear framework guiding the core concept that needs to be presented.
>
> (Instructor midwife 4)

> The trouble with the manuscript was that we were told to memorise it verbatim. That's what was hammered in all the time, and that's what was communicated [by the founder] by e-mail, to memorise it verbatim—which I think was a cardinal mistake, because it would have been much better if we'd mastered it ourselves and used our own words.
>
> (Instructor midwife 10)

Outer settings

Patients' needs and resources

An understanding of the demands and resources concerning the needs of the expecting parents' who would be the beneficiaries of the Confident Birth method was seen as an opportunity. Key needs of the expecting parents included strategies for coping with the upcoming birth, for both the pregnant woman and her companion of choice, which was perceived as having been accomplished through the course's high attendance rate. A consequence, given the high demand, was that the course was not accessible to all expecting parents who wanted to attend. One such group was immigrants, who did not master the Swedish language:

> I understand that it [Confident Birth] is valuable, that patients or women are very satisfied, and we midwives have received a very positive response in their evaluations.
>
> (First line manager 8)

> //We aim at being fair and equal, but it can never be 100%.
>
> (First line manager 13)

Peer pressure

Several of the first line managers mentioned that the Confident Birth method was implemented as an opportunity to become an attractive caregiver. This was seen as essential since the public primary healthcare system was undergoing a restructuring, entailing that it will be easier in the future for expecting parents to choose which clinic to register at:

> We had talked a lot in the management team about our need to profile ourselves. We had started talking about business goals and business acumen; we need to think a little more so that we can make our clinic an attractive choice for parents.
>
> (First line manager 9)

External policies and incentives

No external policies or research had been considered when the method was chosen. In general, the participants described the method as useful and expressed that they did not need scientific proof that it worked:

> Regarding Confident Birth, it's not difficult to assume that this must be good. There's a lot of research that the safer you are when you give birth the better the birth is, so it's not so difficult to understand.
>
> (First line manager 11)

> For me, it does not matter if it's evidence-based or not, because I know it [the confident birth method] works. After all, I have no hesitation even if a research report is not presented . . . I know that this works . . . and I don't think I'm alone having this feeling.
>
> (Instructor midwife 3)

Inner settings

Network and communications

The chain of information and communication had failed at all levels and in all lines during the implementation process. According to the participants, this failure included insufficient information from both the management team and the founder of the Confident Birth method to the midwives delivering the courses. In the end, this had affected the provision of adequate information to the expecting parents. Consequently, the instructor midwives expressed different levels of stress, and some declared that they felt exploited. It was stated that this could have been avoided if adequate information about the different steps involved in the training and its implementation had been communicated to the instructor midwives prior to their decision to participate:

> It was more work than the midwives had expected, and also more work than we had informed them about prior to course start. And here, in retrospect, I can feel that we lost a lot of their trust.

(First line manager 13)

Implementation climate

Before the implementation of the Confident Birth method, the organization was in a situation whereby antenatal education had varied in content from clinic to clinic. Some clinics offered a wide range of birth preparatory courses such as yoga, psychoprophylaxis and conventional birth preparatory courses, while others had cancelled all forms of courses and instead referred expecting parents to open lectures at the university hospital. This was considered unequal and unfair to the expecting parents. It was expressed that the implementation of the Confident Birth method was an important concept for increasing quality and equality among expecting parents:

> It was seen that the antenatal education programmes looked extremely different everywhere in the city, and they were of different durations, and some had psychoprophylaxis and some did not, and some had to pay for psychoprophylaxis and some didn't pay.
>
> (First line manager 14)

Readiness for implementation

The insufficient time provided by the organization for implementing the Confident Birth method made it challenging to achieve a successful implementation. A lack of time was experienced in all parts of the process, from the initial decision-making to the point at which they currently found themselves. The instructor midwives had spent ~40 to 60 h preparing themselves before the training, while the organization only compensated them for 3 h; the majority of the necessary reading had been done in their spare time. Often, this had led to high stress levels and anxiety. Some midwives expressed that becoming an instructor had interfered negatively with their private life, while others expressed trust in the organization and saw the implementation as rewarding for the mothers and themselves:

> It didn't really feel like they [managers] had understood how much time the course preparation required. It was as if they didn't take it seriously, as if they assumed we would do all this in our spare time.
>
> (Instructor midwife 2)

Another obstacle the participants expressed was finding available facilities that were appropriate for the course. It was often difficult to find a suitable venue in the area near the expecting parents' homes. This often resulted in couples not turning up for the course due to the long distance:

> Sometimes the expecting parents have to travel around the whole city, so there's always someone not showing up; that's a big loss.
>
> (Midwife 12)

> //In some places we midwives have to search for facilities ourselves. Sometimes we don't find any suitable facilities, other times they're fully booked, and sometimes we find a venue but with substandard facilities.
>
> (Instructor midwife 3)

Characteristics of individuals

Knowledge and beliefs about the intervention

Most of the participants expressed great trust in the method. Some of the midwives had long experience of teaching other birth preparatory methods, which had affected how they perceived the Confident Birth method. A few midwives stated that the method was nothing new to them, and that the content was just presented in a different form or was an improvement to other birth preparatory methods. This sometimes led to inner conflicts regarding the usefulness of the Confident Birth method, which made it difficult to facilitate the method. The participants who held a more positive view and expressed trust in the method tended to accept the obstacles in the implementation, such as the insufficient information, better than those who held a less positive view. The majority of the instructor midwives had an interest in antenatal education, and had been handpicked or encouraged by their first line managers to attend the instructor training:

> You have to want it; otherwise, it won't work.
>
> (Instructor midwife 7)

Process

Planning

There had not been any plan in place to guide the implementation of the Confident Birth method. With insufficient planning, as well as insufficient time and information throughout the implementation process, both the process of becoming an instructor and what was expected of the midwives had not been clearly described. This was expressed as challenging. When it had become clear what was expected of them, some

midwives had experienced panic and stress. As antenatal education in general was not a priority within the organization, the implementation process was seen as challenging among the first line managers.

There was a desire for a slower implementation process, with the planning anchored in the organization and the instructor midwives being more involved. The insufficient planning resulted in the participants not having a clear picture of what it would require of them. This contributed to some instructor midwives not completing the process, and others mentioning that they were not sure if they wanted to continue holding the course:

> It was panic, so we have to start up already in the fall, so we have something for everyone. After all, the problem was that the staff needed their time and process. Within the management team we'd only been processing for maybe a few months.
>
> (First line manager 13)

> //If I continue to feel that having these courses is anxiety-inducing, then I have to start thinking that maybe I shouldn't expose myself to this forever.
>
> (Instructor midwife 2)

Reflecting and evaluating

Some improvements had been made to the implementation of the method during the implementation process: a contract had been developed for future Confident Birth instructors, including detailed information and expectations; midwives had been compensated for more of their time; discussions had been initiated concerning how to better meet the requirements of women with special needs and courses in English and Arabic had been established. In addition, the management had scheduled regular meetings with the instructor midwives a couple of times per semester for reflection, support and evaluation:

> They (instructor midwives) were very happy with the training, but were upset with the management team for the lack of time.
>
> (First line manager 13)

DISCUSSION

We identified opportunities and obstacles influencing the implementation of the Confident Birth method in western Sweden. The results showed that there was great trust in the method. It had equipped the midwives with tools for mediating coping strategies for women and their companion of choice to use during the upcoming birth. Time-consuming preparations, lack of available venues to conduct the courses, insufficient information at all levels, and no strategy for ensuring that the core of the method remained intact or plans for guiding its implementation were major obstacles to a successful implementation.

A strength was that the instructor midwives and first line managers had trust in the method. Although there were concerns about the strictness and inflexibility in the course manuscript, the midwives had become more equipped with deeper theoretical knowledge and pedagogical skills, and felt proud of their work. This indicates that the instructor midwives' and first line managers' perceptions of the Confident Birth method as useful, for either themselves in their professional work or the expecting parents, affect the implementation. This mirrors another study on organizational readiness to change care routines, which found that the clinical needs for and usefulness of an intervention may be critical factors for successful implementation (Zapka *et al.*, 2013). The fact that the Confident Birth method was regarded as strict and inflexible implies the importance of defining the method's core elements. According to the CFIR, adaptability is described as the extent to which a method can be adapted to meet local needs without jeopardizing the method's core (Damschroder *et al.*, 2009). Thus, it is critical to adapt the Confident Birth method into the local contexts and needs of the antenatal clinics, without losing its essential core elements.

It is promising that the Confident Birth method had been introduced as a step in harmonizing the antenatal education in the region, and that this education would be offered on equal terms to all first-time mothers with partners. The fact that no scientific research or national or international guidelines had been considered before the method was chosen was not found to be an obstacle. Instead, the method was seen as an opportunity, as it provides a means for companionship of choice and promotes women's own capacity to give birth. When comparing our results with international guidelines (World Health Organization, 2014, 2018) and recent research (Renfrew *et al.*, 2014; Miller *et al.*, 2016; Downe *et al.*, 2018; Lunda *et al.*, 2018; Bohren *et al.*, 2019), it can be argued that the organization is in line with these. However, neither research nor international guidelines have any national implications unless they are contextualized into national, regional or local plans, which requires a long-term commitment and a clear national desire from national or local governments (Bogren and Erlandsson, 2018).

It is known that steps contributing to a successful implementation in healthcare include committed care providers who are involved in both the development of the innovation for change and the implementation plan (Grol *et al.*, 2007). In accordance with implementation science, these steps need to be anchored within the organization before any intervention starts. As found in this study, there was an insufficient chain of communication from the management team to the midwives delivering the course and no access to appropriate venues, in combination with insufficient time for planning and preparation for the implementation of the Confident Birth method. In support of Betram *et al.* (Bertram *et al.*, 2015), who suggest that these components are essential for a successful implementation process, it can be argued whether the organization in this study was fully prepared for implementing the Confident Birth method. The provision of good quality antenatal care, including birth preparatory courses, requires sufficient numbers of healthcare providers who are both competent and motivated (Tunçalp *et al.*, 2015). We found that the midwives in this study became stressed and dissatisfied because of the time-consuming preparations and the insufficient information surrounding the process. With no improvements, this could lead to elevated attrition rates and further diminish access and quality care. As long as midwives are left out of the decision-making, planning and preparation that concern them, and until their realities are taken seriously, the provision of high-quality care is at risk (Filby *et al.*, 2016).

It is important to note that the instructor midwives were all skilled professionals, many of them with vast experience of providing antenatal education to expecting parents. Their experiences in facilitating other birth preparatory methods than the Confident Birth method were both an opportunity and an obstacle. Fixsen *et al.* (Fixsen *et al.*, 2009) point out that a method (in this the Confident Birth method introduced in the instructor course) can be introduced during training sessions, but that the real learning occurs when the midwife holds her first class. Furthermore, regular feedback and reflection sessions are needed to ensure fidelity and good outcomes. Reflection groups are a way to ensure that the method's core components are kept intact (Fixsen *et al.*, 2009), but may also provide an outlet for those instructor midwives whose opinions about the method differ from what is taught during the training. The participants' knowledge and beliefs regarding the method play an important role in the success of an implementation process (Damschroder *et al.*, 2009). Personal beliefs are difficult for an organization to influence, but providing ongoing coaching and support as well as listening to the concerns raised by instructor midwives may serve to mediate some of the challenges.

During any implementation, it is important to closely monitor the process and constantly review and make necessary enhancements (Stetler *et al.*, 2006). The lack of time between the decision to invest in the Confident Birth method and its implementation was a major obstacle. A consequence of not having an implementation plan, as found in this study, was that the participants did not know what was expected from them. Clear and abundant information about what the implementation may result in people who were initially interested choosing instead to abstain, which can prevent later dropouts (Fixsen *et al.*, 2005). The organization in focus in this study, has made a number of adaptations to improve the information regarding expectations that is given to midwives prior to their committing to the training, as well as introducing reflection groups for instructors. These are positive developments that will help to resolve the issues that currently plague the midwives, such as time constraints and lack of communication. When implementing a new method, organizational leaders need to map out and prioritize goals, and take into account the likely benefits, costs and resources, as well as potential problems and solutions (Simpson and Dansereau, 2007). Ideally, this should be carried out before implementation, but hindsight can clearly also be useful in evolving the future process.

Strengths and limitations

The key strength of this study is that it is the first of its kind addressing the Confident Birth method. Another strength was its use of the CFIR framework (Damschroder *et al.*, 2009). However, it can be argued that one limitation is that the CFIR was not used to identify determinants distinguishing between high and low implementation success. On the contrary, the CFIR framework made it possible to guide the analysis, thus to set aside the first author's preunderstanding in the subject. To our knowledge, there exists no research on the implementation process of antenatal education; hence, we have no former studies to compare the findings with, rather the discussion concerns implementation in general settings.

Based on the lessons learned from the implementation of the Confident Birth method, we recommend considering the following aspects when planning and implementing interventions in antenatal care settings:

- The intervention fills a clinical need
- The intervention has been adapted to suit the local context

- The care providers are committed and involved in the process
- The implementation plan is anchored on all levels within the organization
- Sufficient time and resources are available
- Goals are identified, stated and prioritized
- The communication between managers and care providers is based on honesty and trust
- The care providers receive regular feedback and reflection opportunities.

CONCLUSION

This study adds insights into the opportunities and obstacles influencing the implementation of the Confident Birth method. The findings in our study show the importance of adequate planning, time, information and communication throughout the process to have a successful implementation. Based on lessons learned from this study, we have developed recommendations for successful implementation of interventions, such as the Confident Birth, in antenatal care settings.

ACKNOWLEDGEMENT

We would like to express our sincere appreciation to all the participants who contributed to this study.
Permission for data collection was obtained from the public primary healthcare management in Western Sweden, and all participants provided oral and written consent before participating in the study.

REFERENCES

Barimani, M., Forslund Frykedal, K., Rosander, M. and Berlin, A. (2018) Childbirth and parenting preparation in antenatal classes. *Midwifery*, **57**, 1–7.

Bergstrom, M., Kieler, H. and Waldenstrom, U. (2009) Effects of natural childbirth preparation versus standard antenatal education on epidural rates, experience of childbirth and parental stress in mothers and fathers: a randomised controlled multicentre trial. *BJOG: An International Journal of Obstetrics & Gynaecology*, **116**, 1167–1176.

Bergstrom, M., Kieler, H. and Waldenstrom, U. (2011) A randomised controlled multicentre trial of women's and men's satisfaction with two models of antenatal education. *Midwifery*, **27**, e195–200.

Berlin, A., Törnkvist, L. and Barimani, M. (2016) Content and presentation of content in parental education groups in Sweden. *The Journal of Perinatal Education*, **25**, 87–96.

Bertram, R. M., Blase, K. A. and Fixsen, D. L. (2015) Improving programs and outcomes: implementation frameworks and organization change. *Research on Social Work Practice*, **25**, 477–487.

Bogren, M. and Erlandsson, K. (2018) Opportunities, challenges and strategies when building a midwifery profession. Findings from a qualitative study in Bangladesh and Nepal. *Sexual & Reproductive Healthcare: Official Journal of the Swedish Association of Midwives*, **16**, 45–49.

Bohren, M. A., Berger, B. O., Munthe-Kaas, H. and Tunçalp, Ö. (2019) Perceptions and experiences of labour companionship: a qualitative evidence synthesis. *The Cochrane Database of Systematic Reviews*, **3**, Cd012449.

Brixval, C. S., Axelsen, S. F., Thygesen, L. C., Due, P. and Koushede, V. (2016) Antenatal education in small classes may increase childbirth self-efficacy: results from a Danish randomised trial. *Sexual & Reproductive Healthcare*, **10**, 32–34.

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A. and Lowery, J. C. (2009) Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science*, **4**, 50.

Downe, S., Finlayson, K., Oladapo, O. T., Bonet, M. and Gülmezoglu, A. M. (2018) What matters to women during childbirth: a systematic qualitative review. *PLoS One*, **13**, e0194906.

Elo, S. and Kyngas, H. (2008) The qualitative content analysis process. *Journal of Advanced Nursing*, **62**, 107–115.

Ferguson, S., Davis, D. and Browne, J. (2013) Does antenatal education affect labour and birth? A structured review of the literature. *Women and Birth*, **26**, e5–8.

Filby, A., McConville, F. and Portela, A. (2016) What prevents quality midwifery care? A systematic mapping of barriers in low and middle income countries from the provider perspective. *PLoS One*, **11**, e0153391.

Fixsen, D. L., Blase, K. A., Naoom, S. F. and Wallace, F. (2009) Core implementation components. *Research on Social Work Practice*, **19**, 531–540.

Fixsen, D. L., Naoom, S. F. and Blase, K. A. (2005) Implementation Research: A Synthesis of the Literature. University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231), Tampa, FL.

Forslund Frykedal, K., Rosander, M., Berlin, A. and Barimani, M. (2016) With or without the group: Swedish midwives' and child healthcare nurses' experiences in leading parent education groups. *Health Promotion International*, **31**, 899–907.

Gagnon AJ, Sandall J. Individual or group antenatal education for childbirth or parenthood, or both. *Cochrane Database of Systematic Reviews*, 2007, CD002869.

Grol, R. P. T. M., Bosch, M. C., Hulscher, M. E. J. L., Eccles, M. P. and Wensing, M. (2007) Planning and studying improvement in patient care: the use of theoretical perspectives. *The Milbank Quarterly*, **85**, 93–138.

Heli, S. (2013) *Confident Birth*. Pinter & Martin Publisher, London.

Hodnett, E. D., Gates, S., Hofmeyr, G. J. *et al.* (2011) Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*, Cd003766.

International Confederation of Midwives. (2017) *Core Document—International Definition of the Midwife*. https://www.internationalmidwives.org/our-work/policy-and-practice/icm-definitions.html (last accessed 15 August 2020).

.Jones, L., Othman, M., Dowswell, T., Alfirevic, Z., Gates, S., Newburn, M., *et al*. Pain management for women in labour: an overview of systematic reviews. *Cochrane Database of Systematic Reviews* 2012, CD009234.

Kabakian-Khasholian, T. and Portela, A. (2017) Companion of choice at birth: factors affecting implementation. *BMC Pregnancy and Childbirth*, **17**, 265.

Lind, S., Wallin, L., Brytting, T., Fürst, C. J. and Sandberg, J. (2017) Implementation of national palliative care guidelines in Swedish acute care hospitals: a qualitative content analysis of stakeholders' perceptions. *Health Policy*, **121**, 1194–1201.

Lunda, P., Minnie, C. S. and Benade, P. (2018) Women's experiences of continuous support during childbirth: a meta-synthesis. *BMC Pregnancy and Childbirth*, **18**, 167.

Maimburg, R. D., Væth, M. and Dahlen, H. (2016) Women's experience of childbirth—a five year follow-up of the randomised controlled trial "Ready for Child Trial". *Women and Birth*, **29**, 450–454.

Miller, S., Abalos, E., Chamillard, M., Ciapponi, A., Colaci, D., Comandé, D. *et al.* (2016) Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide. *The Lancet*, **388**, 2176–2192.

Pålsson, P., Kvist, L. J., Persson, E. K., Kristensson Hallström, I. and Ekelin, M. (2019) A survey of contemporary antenatal parental education in Sweden: what is offered to expectant parents and midwives' experiences. *Sexual & Reproductive Healthcare*, **20**, 13–19.

Renfrew, M. J., McFadden, A., Bastos, M. H., Campbell, J., Channon, A. A., Cheung, N. F. *et al.* (2014) Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *The Lancet*, **384**, 1129–1145.

Selove, R., Foster, M., Mack, R., Sanderson, M. and Hull, P. C. (2017) Using an implementation research framework to identify potential facilitators and barriers of an intervention to increase HPV vaccine uptake. *Journal of Public Health Management and Practice*, **23**, e1–9.

Simpson, D. D. and Dansereau, D. F. (2007) Assessing organizational functioning as a step toward innovation. *Science & Practice Perspectives*, **3**, 20–28.

Stetler, C. B., Legro, M. W., Wallace, C. M., Bowman, C., Guihan, M., Hagedorn, H. *et al.* (2006) The role of formative evaluation in implementation research and the QUERI experience. *Journal of General Internal Medicine*, **21(Suppl. 2)**, S1–8.

The Swedish Association of Midwives. (2018) Description of Required Competences for Registered Midwives. https://storage.googleapis.com/barnmorskeforbundet-se/uploads/2019/11/Description-of-Required-Competences-for-Registered-Midwives_The-Swedish-Association-of-Midwives-2019.pdf (last accessed 15 August 2020).

The World Medical Association. (2018) *Declaration of Helsinki, Ethical Principles for Medical Research Involving Human Subjects*. The World Medical Association

Tunçalp, Ö., Were, W. M., MacLennan, C., Oladapo, O. T., Gülmezoglu, A. M., Bahl, R. *et al.* (2015) Quality of care for pregnant women and newborns—the WHO vision. *BJOG: An International Journal of Obstetrics & Gynaecology*, **122**, 1045–1049.

World Health Organization. (2014) *WHO Recommendation for Augmentation of Labour.* WHO. https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/augmentation-labour/en/ (last accessed 15 August 2020).

World Health Organization. (2018) *WHO Recommendations Intrapartum Care for a Positive Childbirth Experience*. Department of Reproductive Health and Research, Department of Maternal, Newborn, Child and Adolescent Health, Geneva.

Zapka, J., Simpson, K., Hiott, L., Langston, L., Fakhry, S., Ford, D. *et al.* (2013) A mixed methods descriptive investigation of readiness to change in rural hospitals participating in a tele-critical care intervention. *BMC Health Services Research*, **13**, 33.