Focus Groups to Reveal Parents' Needs for Prenatal Education

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Abstract

Focus group interviews are a useful qualitative research technique to obtain data from small groups about their opinions, attitudes, and/or feelings on a given subject. This particular technique has been used in Western Quebec in order to reveal the opinions, needs, and feelings of health professionals and future parents concerning prenatal education. As part of the region's priorities for 2002, all future parents in this part of the province were to be offered prenatal, government-paid, community health education. Consequently, the Ministry of Health at the regional level sought a customized program for all community centers, based on identified regional needs and recent research. This program had to prove to be innovative, user-friendly, effective, and efficient. After reviewing the literature and conducting discussions with representatives from all regional health agencies throughout the province, the author of this article designed and conducted focus groups with perinatal health professionals from all community centers and hospitals of the Outaouais region. Later, focus groups were also conducted with parents. Following the analysis of the data and comparisons with existing resources, the author of this paper designed and proposed a specific program aimed at the empowerment of future parents. This paper reports the original problem and its context, the research methodology, and the proposed program (underlying philosophy, objectives, content, and educational techniques).

Journal of Perinatal Education, 11(3), 1-9; empowerment, prenatal education, future parents' needs.

Introduction

The health care literature not only supports the need for prenatal education for future parents as a means to re-

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duce risks, but also enhances a couple's positive experience during the pregnancy and parenting cycle (Boyd & Richardson, 1991; Canadian Institute of Child Health [CICH], 1992, 1994; Health Canada, 2000; Nichols & Humenick, 2000). Health care professionals, especially perinatal nurses, are in a privileged position to inform couples and reinforce their knowledge about bearing a child and becoming a parent. Interventions aimed at preventing risks and promoting healthy lifestyles during pregnancy is a well-known determinant of children's positive health and growth during their first years (CICH, 1992, 1994; Martin & Boyer, 1995; Quebec Ministry of Health and Social Services, 1991). These interventions allow the development and the actual maturation of health improvements in the parents' lives, which in turn promote better health habits.

Figure Western Quebec, or Outaouais

In Quebec, Canada, prenatal education is generally offered at no cost to high-risk couples as part of the government-paid services provided in most of the province's local community health centers (CLSCs). Prenatal education is considered a *specific* or *selective* preventive measure. However, some centers also provide classes for low-risk populations on a fee-for-service basis. As a third pattern, a few parents prefer meetings offered by private practice nurses in certain areas of the province. These couples generally come from a higher socioeconomic environment (de Montigny & Dumas, 1993). Historically—for the last several years, at least—prenatal education was essentially aimed at both reducing the number of low birth weight and premature babies and informing high-risk couples about pregnancy, labor and birth, and postpartum events. In 1997, following major transformations in the province's health care system, all regions of Quebec were required to develop and offer free prena-

tal classes for all pregnant couples (Regional Boards of Health and Social Services' Conference, 1997). Recent researchers concluded that offering such an opportunity to all couples was strategic in the early prevention of a variety of difficulties within young families (Martin & Boyer, 1995; Quebec Ministry of Health and Social Services, 1991, 1993). The Quebec government has called this undertaking a *universal* promotion/prevention measure.

In Western Quebec, or Outaouais (see Figure), the Regional Board of Health and Social Services decided to plan universal measures to reach all parents-to-be who lived in its territory. Following massive changes in the system, including early discharge from hospital after birth, health administrators recognized the need for increased preventive prenatal and postnatal interventions that focused more broadly on the health and well-being of all young families. Offering prenatal classes as a universal measure was part of this plan with an aim to reduce the physical and psychosocial difficulties of young children as soon as possible. The Regional Board of Health and Social Services wished to develop this measure across the territory as uniformly as possible: nine CLSCs were to offer this type of prenatal class to more than 3,500 mothers-to-be and their partners per year, over the 33,000-square-kilometers territory of Outaouais.

Many details were unspecified. What would be the desirable content of such a prenatal program? How could perinatal educators attract the low-risk population to such a program? Would there be measurable benefits of such a costly initiative? What is optimal and still affordable? A perinatal clinical nurse specialist was commissioned to conduct a research project specifically focused on these issues. This article describes the research project, its goals and methodology, and the program (philosophy, objectives, content, and approaches) that resulted in the findings and conclusions addressed here (Dumas, 1999).

Purpose of the Research

The purpose of the research reviewed here are:

1. to describe the actual prenatal education opportunities presently offered to low-risk pregnant couples in each CLSC of the region; and

2. to design a customized, uniform program for all the CLSCs of the region—a program that is evidence-based, innovative, user-friendly, attractive to health educators, effective, and efficient.

Research Methodology

Methodology was aimed at uncovering what existed elsewhere (review of the literature), what was currently offered in the rest of the province (survey), and especially what was desired by parents and professionals in all the health institutions of the Outaouais (focus groups).

Review of the Literature

Little research has been conducted or reported in the literature concerning perinatal education of low-risk populations. A few research reports were from Quebec (de Montigny, 1991; de Montigny & Dumas, 1993; Séguin, Ferland, Lambert, & Ouellet, 1986) and isolated articles were from elsewhere (Boyd & Richardson, 1991; Hallgren, Kihlgren, Norberg, & Forslin, 1995; Hetherington, 1990; Hillier & Slade, 1989). However, most of the publications described programs or interventions that can be categorized as the following:

- proposed for high-risk populations (CICH, 1992, 1994; Freston et al., 1997; Martin & Boyer, 1995);
- targeted to a specific health-promotion subject, such as breastfeeding (Dumas & Lepage, 1999), transition to parenthood (Léonard & Paul, 1996; Nichols, 1995), and smoking cessation (O'Connor, Davies, & Dulberg, 1992); and
- suggested but not evaluated (Bonapace, 1992; Enkin, Keirse, Renfrew, & Nielson, 1995; Nichols & Humenick, 2000).

Broad interventions such as prenatal classes are hard to evaluate as a whole, given their potential impact in many areas such as pregnancy or obstetrical outcomes, parenting or self-care abilities, and the self-confidence of mothers and fathers as parents. O'Meara (1993) proposed a framework to evaluate such health education programs, but—to our knowledge—no one has published reports on its utilization. When education interventions bring about positive changes in high-risk populations, they can

also be useful as health-promotion elements in a program aimed at low-risk parents.

Although no documentation exists on the outcomes of a comprehensive perinatal program, elements in the literature offer a set of essential categories that together would constitute a comprehensive approach. These categories are described as part of most programs or classes, including being suggested by the Regional Boards of Health and Social Services' Conference (1997) as a basis for all regions in the province of Quebec. The essential categories are as follows:

- lifestyle and environment during pregnancy;
- preparation for labor and birth;
- baby's care and nutritional requirements;
- parents' roles when returning home;
- socioeconomic aspects of pregnancy; and
- rights, work compensation, environmental resources, and recommendations related to parenting.

Strategic Planning

Proposing these categories raises questions that are fundamental to planning universal prenatal classes:

- What are the goals of such classes?
- Is the objective to inform or to educate?
- Should parents be comprehensively prepared for the pregnancy, birth, immediate postpartum period, and return home?
- Should the communication and the relationships within the couple be influenced in order to enhance their decision-making process during and after the perinatal cycle?
- How far into parenting should women and men be initiated?
- How many preventive measures concerning baby's care should be introduced to parents?
- Should parents be taught how to access information when needed?
- How much content is too much?

To plan strategically, clear, specific goals and activities must be established. We could not find any evidence-

based indications of what or how much should be covered in prenatal education to low-risk couples. Nichols and Humenick (2000) have asked similar questions. One approach is to focus on transferable abilities that couples could develop.

In the recent literature on health education, the concept of empowerment is increasingly present (Fetterman, Kaftarian, & Wandersman, 1996; Gibson, 1991; Jones & Meleis, 1993; Lord, 1990; Malin & Teasdale, 1991; Rafael, 1995; Skelton, 1994). This concept refers to abilities that could be developed with assistance, so that one feels ready either to assume a specific role or to seek timely, needed information. The concept of empowerment is appealing in prenatal education for low-risk populations because couples need to learn how to help themselves in the transition to parenthood during a time when they are vulnerable both as persons and as couples (Simkin, 1992). In fact, the perinatal period is recognized as an excellent time for teaching because parents-to-be are especially open to suggestions for health promotion (Boyd & Richardson, 1991; de Montigny & Dumas, 1993; Dumas & Lepage, 1999; Séguin et al., 1986).

The concept of empowerment is appealing in prenatal education for low-risk populations.

Empowerment refers to acquiring self-help abilities and attitudes during a difficult period. These skills can be transferred to different situations later in life. Offering empowerment to pregnant couples means giving power to parents and allowing them control over situations that affect them, rather than leaving them dependent on professionals. Empowering expectant parents involves more than allowing simple parent participation in classes or in care; it involves showing parents how to acquire the tools (or how to develop them) to solve their own problems. Thus, they become more autonomous in their own lives. Parents and professionals also alluded to the concept of empowerment while participating in the sub-regional focus groups held by this author. Fostering empowerment in childbirth classes and creating a climate of confidence is one avenue of promoting satisfaction for women and their partners during pregnancy and

birth. Over the years, this approach to educating expectant parents seems to have been lost in many settings. As O'Meara (1993) writes, "[T]he transformation of childbirth into a medical ritual from a normal physiological process has deprived women not only of satisfaction of their affective needs, but also of their status, power, and fulfillment in childbirth" (p. 28).

A perinatal education intervention based on an empowerment philosophy is consistent with the Lamaze Philosophy of Birth (see Table 1). This focus to educating can help reduce the overload of specific content covered during the classes. The educator would focus more on the development of abilities, such as communicating and verbalizing feelings and needs, becoming self-assertive within the couple and with others, expanding one's network, and improving one's self-confidence and self-efficacy (Bonapace, 1992; de Montigny, 1991; de Montigny & Dumas, 1993).

Using an empowerment model within a health care system such as the one in Quebec, an integrated program that is jointly planned and offered in coordination by providers across the community and health institutions could result in a system that responds effectively to parents' needs (Shearer, 1995). This model could be promoted in a coordinated educational program together with systematic patient-care management or nursing case management. A concept of systemic coordination has been introduced in an effort to individualize care in an efficient manner (Cohen & Cesta, 1993; Goulet & Dallaire, 1999; Order of Nurses of Quebec, 1993). Most of

Table 1 Lamaze Philosophy of Birth*

- Birth is normal, natural, and healthy.
- The experience of birth profoundly affects women and their families.
- Women's inner wisdom guides them through birth.
- Women's confidence and ability to give birth is either enhanced or diminished by the care provider and place of the birth.
- Women have the right to give birth free from routine medical interventions.
- Birth can safely take place in birth centers and homes.
- Childbirth education empowers women to make informed choices in health care, to assume responsibility of their health, and to trust their inner wisdom.

* Lamaze International, Inc. (2000). Lamaze philosophy of birth. *Lamaze International, Inc.* [On-line]. Available: www.lamaze.org.

the experiments in this type of coordination have been with adult patients suffering from chronic or acute medical-surgical conditions and requiring complex care from many providers either from different institutions or within the same institution. A perinatal education intervention could also be planned as an integrated systematic case management involving continuous communication within the health care team: parents and professionals from both the institutions and the community. It appears even more feasible to plan because it covers only a 12- to 18-month period for each family, contrary to chronic medical patients. However, in order to organize such an integrated system around an empowerment model of care, all administrations involved would have to preclarify values, beliefs, goals, language, etc. (Shearer, 1995) and keep in mind that the parents' empowerment should be a high priority. Universal understanding would need to acknowledge that the process of delivering perinatal care is important to achieving its highest potential: an empowered parent able to effectively problem solve.

Survey of Regional Boards of Health and Social Services in Quebec

The investigator surveyed representatives from all Regional Boards of Health and Social Services across the province of Quebec, except three, whose populations and services were not comparable with her region, the Outaouais. Fourteen brief questionnaires were electronically transmitted to the regions. The questions were as follows: Did you initiate universal measures in prenatal education in your region? If yes, do you have a uniform canvas (survey of needs and/or teaching program) for your region? Did you develop (or are you in the process of developing) material that could be shared with other regions? Did you (or do you) intend to develop evaluation measures for the perinatal education program? Initially, only five responses were received, even after a second direct mailing to the appropriate administrators. The investigator then pursued discussions by phone with those who responded and found they were eager to share their thoughts, realizations, and dreams about this subject.

Respondents exchanged interesting information and expressed raised hopes for the possibility of a common survey of needs and teaching program for the province. Considerable commonality of thoughts existed among

the respondents on basic concepts, philosophy, and contents that should be part of the ideal program. However, no respondent was developing or had developed or intended to develop in the near future a program based on either a conceptual framework such as an empowerment model or evidence-based interventions with the intent of evaluating its impact. One region shared a plan for common content in a program using common material and approaches over the previous year. The information was useful to the investigator, but no conceptual framework or evaluation process was specified. More detail about each region's experiences is available (Dumas, 1999).

Focus Groups with Professionals and Parents

In order to determine the services offered and those needed or envisioned by the providers or the parents, the investigator conducted focus groups in every health institution of the Outaouais region of the Quebec province, including both hospitals and CLSCs. In total, 15 groups of 2–13 participants provided semistructured interviews that were subsequently content analyzed. Focus groups are a qualitative research method to unveil opinions, attitudes, and/or feelings during group interactions (Krueger, 1994; Morrisson, 1999; Webb & Kevern, 2001)—in this case, among parents and professionals on prenatal education for low-risk populations. “The principal advantage claimed for focus groups . . . [is] the ability to use participant interaction to gain in-depth and rich data that would not be obtained through individual interviews . . .” (Webb & Kevern, 2001, p. 804).

Responses to the invitations to focus groups were rapid, positive, and informative. Parents and professionals were genuinely interested in the discussions and eager to share their energy, time, and creativity in order to bring about a customized program. No attempt was made to control the number of participants or their backgrounds. An invitation was presented through the nurse in charge of perinatal care in each institution of the Outaouais region. Most participants were health professionals. However, parents and future parents, women and men, were present in most of the groups.

The investigator used an interview guide developed for the focus groups. The guide contained 10 questions, as well as sociodemographic data of the institution and the persons present. The interview guide is outlined in

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Table 2. Similarities in content and especially in envisioned approaches were striking. Most parents and professionals expressed a desire for interventions based on a philosophy that fosters autonomy of parents-to-be in order to help them remain confident in their decisions both during and after the perinatal period. After the discussions, when the investigator introduced the concept of an empowerment model of care, the majority of the participants agreed that the model described their desires.

Recommended content for prenatal classes was traditional in nature and included the following elements:

- reality of the pregnancy (physiology, difficulties and solutions, healthy lifestyle, etc.);
- preparation for labor and birth (symptoms of premature labor, physiology, what helps and what hinders, role of the support person, etc.);
- obstetrical procedures (episiotomy, cesarean section, forceps, etc.) and the parents' level of choice regarding these procedures;
- pain control (more alternative means and fewer medications or regional anesthesia);
- breastfeeding (physiology, success conditions, confidence, etc.);

Table 2 Interview Guide for the Focus Groups

1. Programs or interventions actually offered for all parents-to-be.
2. Programs or interventions actually offered for low-risk parents-to-be.
3. Needs of future parents in terms of knowledge, abilities, and attitudes.
4. Specificities of the subregion covered by their institution and those of the parents-to-be.
5. Wishes and dreams related to prenatal education of a low-risk population.
6. Mandatory themes and/or approaches to be included into universal prenatal education classes.
7. Pitfalls to be aware of in prenatal education to a low-risk population.
8. Recommended approaches and their foundations.
9. Tools needed to offer good quality prenatal education to a low-risk population.
10. Special message to leave with the investigator related to prenatal education.

- home return (baby's and parents' care); and
- transition to parenthood (positive and negative aspects, practical solutions, resources, etc.).

Participants had strong opinions about the importance of the practical and transferable nature of the offered education. This was in order for parents to learn how to choose, according to their own values and beliefs. Participants suggested that the content was more a passport for acquiring abilities and attitudes favorable to autonomy and subsequent good parenting than a dictated procedure to follow or paternalistic counseling. Participants frequently repeated that the education should focus on the parents' needs and, as such, should evolve with groups according to changing needs. Respondents from rural areas were more organized in their approach to specific needs in their subregion. For example, because low-involvement of men in family life was identified as a major problem in one community, the local CLSC program included a father who planned and taught parts of classes with health professionals in order to involve more fathers-to-be from one of the villages.

In summary, data collected from focus groups, a survey of other regions, and a review of the literature were analyzed for similarities and differences; use of an empowerment model was determined to be desirable. It is recognized that the data were interpreted through the lens and, thus, potential bias of the investigator's many years of professional practice as a perinatal nurse, clinical specialist, professor, and researcher.

Proposed Program

The goal was to propose a program that is innovative, creative, responsive to identified needs, user-friendly for health educators, effective and efficient in design, and based upon evidence as much as possible, especially given the lack of research data on this matter. It was designed as a foundation upon which providers can employ their own creativity in response to the parents' needs specific to the locale. In this respect, the curriculum is transferable to any other center and would benefit from periodic evaluations, especially when used in other cultural settings. The empowerment philosophy is the most important element of the program and dictates the content, activities, and approaches.

Philosophy

Given acceptance of a philosophy of birth (as outlined in Table 1), it is useful to enhance it with a philosophy of perinatal care. The main elements of the philosophy underlying the proposed program of care are presented in Table 3. Such a philosophy is essential to understanding the approaches and contents included in a program; the focus is on delivering care, including education, by a process that fosters health and empowerment, not merely on information-giving. Within each of the seven meetings of the proposed program, the following content areas are covered through diverse activities: the mother's health during the perinatal cycle; the preparation to pregnancy, birth, and postnatal periods for parents-to-be; the empowerment of couples through gradual control over decisions; communication within the couple; and the abilities to access community resources, if needed.

Goals

Based on the philosophies of birth in Table 1 and the philosophy of perinatal care in Table 3, the main goals of the program of perinatal care are as follows:

1. actively promote the normalcy of the birth process and breastfeeding;

Table 3 Dumas Philosophy of Empowerment in Perinatal Care

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- The normalcy of the process of pregnancy and birth can be fostered in the provision of perinatal care.
 - Pregnancy/Birth is recognized as a vulnerable period for couples, especially those with less family support.
 - Couples are the experts of their own life and should be regarded as such.
 - Professionals are counsellors and supporters in the pregnancy/birth process, but nondeciders.
 - Complete and objective information is the basis for informed decision for self.
 - Health education is more than information-giving; it encompasses the development of abilities, competencies, and attitudes.
 - Couples facing difficulties should receive increased specific support.
 - Continuity of care from one resource/care provider to another is vital.
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2. equip parents in order for the perinatal period to become a growth experience for the parents, both individually and as a couple;
3. encourage couples to take control of the whole experience of becoming a parent;
4. increase abilities and competencies of the couples in order to decrease their insecurity, lack of comfort, suffering, and feelings of incompetence during the whole perinatal period;
5. detect high-risk situations in the regular prenatal population;
6. give rise to the exchange of ideas, feelings, interests, solidarity, and, possibly, durable relationships between couples.

These goals can be promoted across all areas of perinatal care; however, they have particular relevance in child-birth classes because of the opportunity this setting provides. The curriculum to meet these goals can be divided into small, specific learner objectives that can be evaluated with the parents after each program. This approach offers the potential satisfaction of all participants, as per the congruence of the needs of both the parents and the institutions. Evaluation of the impact of the prenatal education on pregnancy and obstetrical outcomes should include the influence on mothers' and fathers' empowerment as care recipients, their parental abilities, and family functioning.

Recommended Content and Approaches

In this proposal, the first two early meetings take place as soon as possible; the remaining five later meetings occur after 20 weeks of pregnancy for all couples. The early meetings occur during the first weeks of pregnancy, as soon as possible after the referral by any health professional of the territory or initiation by the woman, herself. The focus of the first two meetings is clearly on the pregnancy itself and includes:

- the parents' needs, expectations, and beliefs;
- first trimester's physiological changes;
- discomforts and natural solutions to them;
- life habits and their impact on the fetus (smoking, food, exercise, work, medications, etc.);

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- signs of alarm during first trimester; and
- psychological changes in each expectant parent.

The subsequent late pregnancy five meetings occur preferably during the last weeks of pregnancy and involve:

- second and third trimesters' physiological changes;
- discomforts and natural solutions to them;
- premature labor (risk factors/premonitory signs);
- normal labor and birth processes;
- pain of labor and how to reduce it;
- role of the support person during labor and birth;
- possible obstetrical interventions during labor and birth;
- role of partners in the decision process;
- sharing of needs, expectations, beliefs by parents;
- breastfeeding;
- returning home (mother, baby, father, the couple, the family); and
- transition to a parental role.

Each subject is introduced not as a content to be taught but as a subject to be discussed, reflected upon, and taken home for further discussion and decision-making by the couples. The teaching process involves exercises such as visualization, relaxation, assertiveness, decision-making, problem-solving in small groups, resource-seeking, practising with one another or with dolls, etc. Ultimate goals are the empowerment of couples during the education about the perinatal cycle through a process of consciousness-raising, group discussions, respectful and open communication, up-to-date evidence-based information, and support of the couples in their decision-making processes. An advisory group of professionals and parents may be important to the planning of classes that use experiential techniques and modelling as the educational focus, rather than the traditional teaching approach of a heavy focus on content. An interdisciplinary collaboration of educators with all the other care providers through the entire perinatal cycle is critical to the success of this empowerment approach. The childbirth educator is thus challenged to educate parents in what may be a new model of education for her. She is simultaneously challenged to advocate for this model as

she collaborates with other health care providers. This is a "tall order," but one whose time has come for those who wish to maximize the potential of perinatal education.

Conclusion

The proposed program is innovative, creative, responsive to identified needs, user-friendly for health educators, effective and efficient in design, and based upon the evidence available, given the lack of research data on this matter. Interested providers are encouraged to use this approach and evaluate the impact of such a program on parents, their children, and all participants.

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