



Maternal Health Task Force



HARVARD SCHOOL OF PUBLIC HEALTH

Department of Global Health
and Population



2014

INNOVATIVE METHODS

Group Care

**Alternative models of care delivery to increase
women's access, engagement, and satisfaction**

INTRODUCTION

Many cultures have a long tradition of discussing important issues of common concern in groups, circles or meetings. Shared problems often lead to shared solutions, creating bonds and common histories between individuals and ultimately communities. However, personal health-related issues are traditionally not discussed in larger groups but are kept within a smaller circle of relatives and close friends.

Experience from various corners of the world has shown that providing health information and basic care in a group format is very effective^{2,3} and becoming increasingly popular. Though it can be more time-consuming from the perspective of the care provider, the advantages seem to far outweigh the limitations.

This case study will discuss group care models that are used during and after pregnancy, showing the innovative elements of these approaches and how they can be implemented widely to improve maternal and newborn health.

1. PARTICIPATORY WOMEN'S GROUPS

Participatory women's groups are a basic yet effective means of discussing many health and non-health related topics. Health information can be successfully discussed with only the occasional presence of a health care provider.

In India, participatory women's groups were organized in three states⁴ to deliver education and information and assess their ability to improve pregnancy outcomes. The groups, which met monthly, were organised and facilitated by women from the community who received training in participatory processes during a seven-day residential training course. These women received continual support through biweekly meetings with district coordinators. Groups discussed clean delivery practices and health seeking behaviours. The group members identified and prioritised maternal and newborn health problems in the community, collectively selected relevant strategies to address these problems, implemented the strategies, and assessed the results. Various methods were used, such as role playing, storytelling, and picture-card games.

2. GROUP ANTENATAL CARE

Group antenatal care is specifically targeted to pregnancy and birth and mainly provided by one or more health care professionals. It is based on the same premise as participatory groups, but is more structured and focused in nature. The specific number and order of the group discussions differs per setting.

Group-based antenatal care in Sweden,⁵ for example, consists of six to nine two-hour sessions in which six to eight pregnant

women meet over the course of their pregnancies. During these sessions, information is shared and discussed during the first hour and individual examinations are conducted during the second hour. Studies conducted in four clinics showed that the method appeared to meet parents' needs for physical assessment and screening. The group model created a forum for sharing experiences and helped participants to normalize their pregnancy symptoms. Parents acknowledged that the groups helped them prepare for birth, but not for parenthood. However, the review showed that the midwife's role in facilitating group-based antenatal care requires her to learn more about pedagogical strategies and approaches, such as greater encouragement for group participation, increased tailoring of the programme to the group's needs, and greater focus on couples rather than only the pregnant woman.

Group ANC started by a midwife in Adelaide, Australia⁶ was attended by a broad variety of women as well as by student midwives. While the program has not yet been rigorously evaluated, initial reviews have been positive. In her reflection on this approach to providing care, the midwife concludes that group care engages women and their partners, encourages meaningful discussions, and helps participants to learn about aspects of their pregnancies which they may not have asked about in an individual setting.

3. CENTERINGPREGNANCY

A formalised and structured way of providing group ANC is found in *CenteringPregnancy*. The order of the sessions, the specific role and capacity of the facilitator and the hands-on involvement of women in their care each play a specific role.

The *CenteringPregnancy* model was developed in the 1990s by nurse-midwife Sharon Rising, President and CEO of the Centering Healthcare Institute (CHI), who had started bringing groups of pregnant women together for support 20 years earlier. CHI developed two areas of Centering care: *CenteringPregnancy* (CP), which starts at the beginning of the second trimester and continues through delivery, and *Centering Parenting*, which combines well-woman and well-baby care through the child's first birthday.⁷ The CP model of care puts the pregnancy at the centre of service provision and gives pregnant women the chance to meet others in similar stages of pregnancy, normalizing the pregnancy process and giving women a sense of community. In this group setting, women are also able to meet with their care providers for longer than they would in an individual antenatal care visit.⁶

The CP model includes ten group antenatal sessions that take place over the last two trimesters of pregnancy. The model incorporates 13 'Essential Elements'⁸ (see sidebar) which combine health care with interactive learning and community

Centering Pregnancy's 13 Essential Elements

1. Health assessment occurs within the group space.
2. Participants are involved in self-care activities.
3. A facilitative leadership style is used.
4. The group is conducted in a circle.
5. Each session has an overall plan.
6. Attention is given to the core content, although emphasis may vary.
7. There is stability of group leadership.
8. Group conduct honors the contribution of each member.
9. The composition of the group is stable, not rigid.
10. Group size is optimal to promote the process.
11. Involvement of support people is optional.
12. Opportunity for socializing with the group is provided.
13. There is ongoing evaluation of outcomes.

building. Groups are managed through facilitative leadership and have a standardised structure.⁶ Each group is comprised of eight to twelve women of similar gestational age, and sessions last approximately 90 to 120 minutes. Each session has two main parts: during the first part, women have brief individual assessments with the care provider, conduct self-assessment (weight and blood pressure), and are able to hold informal discussions amongst themselves. In the second part, the care provider facilitates group discussion based on the group's needs, experiences, and interests.⁶ There are several advantages to working in groups, including improved understanding; community-building; positive peer influence; increased motivation to learn; cost-effective use of provider time; support for participants and families; and skill development.⁹

CP was first rolled out at a hospital clinic in Waterbury, Connecticut in the early 1990s. The pilot program included 13 groups totalling 111 women. The women in the pilot groups had comparable pregnancy outcomes to women in the general clinic population, including caesarean section rates (12.6% and 13.5%, respectively) and Apgar scores below seven (1% and 2%, respectively). Evaluations were also conducted regarding the educational content and group activities. The vast majority (94%) of women in the pilot program felt that they were learning a lot about prenatal care, and 98% enjoyed being in a group with other pregnant women.¹⁰

Since then, CP has been implemented in a variety of settings across the United States. In military health facilities, women receiving CP have been found to be six times more likely to receive adequate antenatal care, defined as at least nine visits.¹¹ They were also significantly more likely to be satisfied with their care ($p < 0.001$), and postpartum women were significantly less likely to report feelings of guilt or shame associated with their labour and delivery ($p < 0.05$).¹⁰ Another study conducted in a civilian hospital found that adolescents in CP groups had a significantly lower incidence of preterm births ($p < 0.05$) and significantly fewer infants with low birth weight ($p < 0.05$) than similar adolescents receiving traditional care.¹²

In the Netherlands, CP is being implemented in three midwifery practices to replace individual prenatal care visits with a group model that includes substantially more health promotion content than the traditional one-on-one model.¹³ The model is also being expanded to include one post-natal meeting and several additional meetings during the early years of life when infants have to come to early childhood clinics for vaccinations. Midwives and their clients expressed great enthusiasm for this model of group care. A pilot project aimed to assess the feasibility of CP in the Dutch health system, and determining the enabling and prohibiting factors is underway, with substantial monitoring and evaluation included

in the programme design. New research projects will look at the effects of CP on perinatal and maternal psychosocial outcomes, cost-effectiveness of the programme, and factors that enhance implementation.

A pilot project in Malawi and Tanzania showed that CP is feasible in resource-constrained, low-literacy, high-HIV settings in sub-Saharan Africa.¹⁴ During the project the model was tested with a group of women and midwives and lessons were learned on all sides. The women and the facilitators were surprised at how easy it was to learn the self-assessments, which include various measures such as height, weight, and blood pressure. The facilitators observed that the women effectively helped one another, and the women themselves described how the self-assessments made them feel confident and proud. They pointed out that they could now see for themselves how the equipment worked and where the information was recorded. While initially concerned about the women's ability to conduct health self-assessments, by the end of the pilot a midwife said, 'I was surprised by their ability. Today I found out that women were capable and eager.'¹⁴

USER AND PROVIDER PERSPECTIVES

Several studies report the positive reactions that women have to CP. Though there are differences between individuals, one of the overall themes emerging from these studies is that women 'received more than they realised they needed'.¹⁵ Women enjoyed learning from others' questions and appreciated the supportive environment of the groups as well as the connection with other pregnant women.¹² The adolescent groups discussed previously also reported high satisfaction with group care, emphasising the added learning opportunities and chances to connect with other pregnant teens.⁹

Group ANC and CP have the potential to reduce job-related stress and enhance job satisfaction for care providers. When trying out CP, a Canadian group of physicians¹⁶ perceived that they provided better care and a better professional experience through CP compared to their experience of individual prenatal care. In interviews with the care providers, six themes emerged: (1) having a greater exchange of information, (2) getting to know the women better, (3) seeing women get to know and support each other, (4) sharing ownership of care, (5) having more time, and (6) experiencing enjoyment and satisfaction in providing care. These themes contributed to the physicians' core experience of "providing richer care", and conclusions that CP could improve work place satisfaction, increase retention of providers in maternity care, and improve health care for women.¹⁶

A pilot study to assess the potential of training midwives to be CP facilitators in Australia¹⁷ described CP as 'a rewarding

way to work and decreased the repetition of individualised antenatal care'. Facilitating a group allayed midwives' initial concerns, particularly about undertaking the antenatal assessment in the group setting, managing the group processes and facilitating the group discussions. The midwives felt they developed confidence in skills related to group facilitation, for example, their ability to 'throw things back to the group – not talk too much myself'. The midwives valued 'getting to know the women' and the relationships they were able to develop with the women by providing continuity of care through pregnancy. They observed the women developing self-confidence and supportive relationships, and enjoyed 'watching the women get to know each other and support each other'. They felt this led to 'long-term support after the birth and a decrease in the need for postnatal care and less loneliness'.¹⁷

MONITORING, EVALUATION AND RESULTS

Evaluations of participatory women's groups have shown positive results. Even though no health interventions were included in the curriculum, the results of a 3-year project in India showed a 32% reduction in the neonatal mortality rate and a 57% decrease of moderate depression in the third year.¹⁸ Secondary positive outcomes included a reduction in the number of stillbirths and maternal and perinatal deaths, a better uptake of antenatal and delivery services, positive home-care practices during and after delivery, and health-care-seeking behaviours, such as seeking care from qualified providers in the antenatal, delivery, and postnatal period, for check-ups and problems.⁴

Research in Tennessee showed that CP recipients had slightly longer gestational ages, lower odds of having very low birth weight babies, were more likely to attend postpartum follow-up visits, and were more likely to breastfeed their babies.¹⁹

A 2007 randomised controlled trial²⁰ compared CP, CP+ (which included HIV prevention), and an individual care control group among low-income, predominately African American women in the US. Both CP groups had a 33% risk reduction for preterm childbirth with a 41% reduction among African Americans. Both CP groups also had more health-related knowledge, higher breastfeeding initiation rates and satisfaction with care, and the CP+ group had more condom use and fewer repeat pregnancies at six months postpartum.²⁰

CenteringPregnancy has also shown positive results for women's health outcomes after pregnancy. A recent study²¹ compared family planning uptake among women who had received CP with those having received individual ANC. Attendance at postpartum family planning visits was higher in women having received CP, demonstrating that CP also has the potential to improve the utilisation rate of preventive services. In this study, the uptake was highest among non-Hispanic black women, which provides

evidence of the possibility for group care to reduce health disparities.²¹

A recent Cochrane review of group care found that it was positively viewed by women with no adverse health outcomes for themselves or their babies.¹⁷ At the same time, no statistically significant improvements in health outcomes were found to be associated with group antenatal care.

SUSTAINABILITY, SCALABILITY, AND FUTURE DIRECTIONS

Group ANC and CP are being developed to incorporate postnatal care and care in the early weeks and years of life. As groups of women and their infants form networks and communities, the support they provide each other can grow and extend into other areas of life. From the enthusiastic and broad uptake that group ANC has received, it is clear that it is already being scaled up and integrated into existing antenatal care provision. Further exploration will be needed on whether, in the light of ever-increasing health care costs, it is financially sustainable. However, the impact the model can have on prevention or early detection of complications and both physical and mental health problems could indicate that it has staying power in the inevitable reform of health systems over the coming years. Furthermore, the successful pilot of CP in two African countries suggests great potential to benefit pregnant women and their infants in low-resource settings, and could make a positive contribution to MGDs 4 and 5.¹³

While group care models seem promising, more rigorous evaluation is needed, particularly regarding CP and other structured group antenatal care programmes. Anecdotal evidence and studies of small-scale programmes have shown improvements in health outcomes and satisfaction with care, but stronger quantitative data will be necessary to demonstrate the effectiveness of this model.

INSIGHTS FROM GROUP ANTENATAL CARE PROGRAMMES

- **Greater involvement leads to greater client satisfaction.** Women who received group care appreciated being more involved with their own health and learning from each other. Similarly, providers are more satisfied with the deeper relationships they develop with women through group care.
- **Group care has good results.** Group antenatal care results in good health outcomes for mothers and newborns and greater satisfaction with care for mothers and fathers.
- **Strong community networks are vital for childbearing women.** These can be developed and strengthened through group antenatal care programmes.

- **Group care is a gateway to the health system.** Group ANC models can improve the utilisation rate of preventive services and reduce health disparities.

CONCLUSION

CP and other forms of group antenatal care, including participatory women's groups, show great potential in improving user and provider satisfaction with care, as well as in leading to better health outcomes. CP has been tested in a wide variety of care settings and has shown to be adaptable to local health systems, cultures, and needs. It positively influences how pregnancy, childbirth, and the postpartum period are experienced, and has also shown to improve health outcomes of pregnancy, birth, and early parenting.

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ACKNOWLEDGEMENTS

This working paper was written as part of the Adding Content to Contact project, which aims to systematically assess the obstacles that prevent and the factors that enable the adoption and implementation of cost-effective interventions for antenatal and post-natal care along the care continuum. As part of this process, the project is working to identify existing and potentially innovative approaches to improve delivery of antenatal and postnatal health services through interviews with key informants.

We extend sincere gratitude to Sharon Rising of Centering Healthcare Institute for her time and assistance with this case. The Adding Content to Contact project was made possible by Grant Number OPP1084319 from the Bill & Melinda Gates Foundation.

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May 2014 (Revised August 2014)