Women's Perceptions Using the CenteringPregnancy Model of Group Prenatal Care

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ABSTRACT

A qualitative nonexperimental thematic analysis was conducted at a hospital-based midwifery practice to explore the views of participants in group prenatal care and its impact on pregnancy, birth, and postnatal care. Ten women and three support people, recruited through purposive sampling, shared their feedback on the program. The findings conveyed three broad themes: program experience, midwife relationship, and support. Women enjoyed the opportunity for in-depth learning, and peer-group support led to normalizing of pregnancy concerns. Having support people as participants also helped during pregnancy, birth, and child care. The findings showed the enhanced opportunity for education, learning, and interpersonal support provided by CenteringPregnancy to expectant mothers had a positive impact on their pregnancy experiences.

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INTRODUCTION

Pregnancy is a crucial and life-changing period. It is a time in which a woman is not only challenged physiologically but also becomes psychologically and socially vulnerable (Massey, Rising, & Ickovics, 2006). During this period, her physical, emotional, and informational requirements are enormous and she experiences a multitude of feelings such as excitement, anxiety, confusion, and uncertainty (Rising, 1998). This makes prenatal care a complex and demanding process and an ideal opportunity to address women's needs.

The importance of prenatal care is widely acknowledged in the literature as necessary to foster optimal health for both the mother and her child (Alexander & Kotelchuck, 2001; Nagahawatte & Goldenberg, 2008; Showstack, Budetti, & Minkler, 1984). Health assessments, education, and support are the essential components of prenatal care and have been deemed vital and necessary by many experts in both medical and social sciences. A comprehensive, coordinated, and multidisciplinary model of care that offers risk assessment along with timely advice

on practical issues and complications of pregnancy is instrumental in reducing the incidence of neonatal and maternal morbidity and mortality (Alexander & Kotelchuck, 2001; Showstack et al., 1984).

Traditional, or individual, prenatal care has recently been criticized for having become unfocused in its goals. Individual care often limits the amount of time spent with clients to a typical visit of 10–15 min. Limited time leads to the need for augmenting education through various outside sources including community-based or hospital-based classes focused on birth and breastfeeding. This can lead to a feeling of fragmented care for the pregnant woman (Ickovics et al., 2007; Massey et al., 2006; Robertson, Aycock, & Darnell, 2009).

Group Prenatal Care

Group prenatal care has emerged as an innovative approach to prenatal care in recent years, providing a shift in the individual care paradigm to a group approach. A dominant model of such group care is CenteringPregnancy (Centering). Centering provides prenatal care to groups of 8–12 women of similar gestational age under the guidance of trained practitioners (midwives, nurse practitioners, and obstetricians) who provide informational and emotional support to address physical and physiological needs during pregnancy (Ickovics et al., 2007; Massey et al., 2006; Rising, 1998; Rising, Kennedy, & Klima, 2004). Through facilitated and experiential learning, this model of care equips mothers with life care skills and encourages them to carry out simple progress charting, including blood pressure and weight measurements (Massey et al., 2006). Involvement in these activities can be empowering, allowing the participants to take more control of their health and their lives (Jafari, Eftekhari, Fotouhi, Mohammad, & Hantoushzadeh, 2010; Massey et al., 2006).

Centering and other group prenatal care programs have shown documented benefits including increased knowledge, readiness for labor and birth, and satisfaction with care (Ickovics et al., 2007). One important positive outcome of the group learning process is the climate of social support and the acknowledgement that every individual is a valued and integral part of the group (Jafari et al., 2010; Rising et al., 2004; Wedin, Molin, & Crang Svalenius, 2010).

There are also criticisms of group care models. This approach can be disconcerting for practitioners who believe that an individual relationship is essential to the provision of quality care (Rising,

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1998). There may be concerns that problems at the individual level may be overlooked in the group setting. Another concern is the wish for privacy by the clinician or woman who wants to address certain situations (Novick et al., 2011; Rising, 1998; Shakespear, Waite, & Gast, 2010). Whereas some group care model studies have shown positive birth outcomes such as higher birth weight, longer gestational age, and increased rates of breastfeeding (Grady & Bloom, 2004; Ickovics et al., 2007; Ickovics et al., 2003; Jafari et al., 2010), others have shown that women in group care engaged in fewer health-promoting behaviors related to nutrition, avoiding dangerous substances, and relaxation activities than those in individual care (Shakespear et al., 2010). Other studies found no difference among health behaviors of pregnant women based on type of care (Robertson et al., 2009).

The purpose of this study was to gather information from women regarding their experiences with group prenatal care, specifically CenteringPregnancy. Experiences related to labor and birth, education and care, and working with the program's midwives were explored.

METHODOLOGY

Data for this project were collected as part of a larger program evaluation of a new practice site of CenteringPregnancy, a program from Centering Healthcare Institute (2009–2011). Focus groups—a qualitative data collection method designed to obtain a wide range of ideas, attitudes, experiences, and opinions—were used to gather women's perspectives (Kitzinger, 1995). The sessions were moderated by a trained facilitator (Risisky), with a second team member responsible for note-taking and audio recording (Asghar or Chaffee). One note-taker was also responsible for all transcription (Chaffee).

For more information on CenteringPregnancy visit: <http://centeringhealthcare.org/pages/centering-model/pregnancy-overview.php>

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We conducted three focus groups with adult postpartum women who used the local midwifery practice for their prenatal care. This practice is part of a Catholic hospital located in a small urban city in South Central Connecticut. The first focus group took place in the Centering classroom in the main hospital building in October 2010. The remaining groups took place in the practice's kitchen/break room across the street from the main hospital building (July and September 2011). Women were used to coming to both buildings for their prenatal care and parking was readily available.

The participants were recruited using purposive sampling by the midwife (DeGennaro), who was the program director at this site. To explore women's perspectives on the labor and birth experience, the midwife reached out to women who had birthed at least 3 months prior to the focus group. For each group, the goal was to have a minimum of eight women confirmed for the event, anticipating that some would not show. Women and their support people from various groups were invited to ensure different perspectives about experiences would be shared about the program and the program's midwives. Each focus group was set for early evening time, corresponding with afterwork time, and times when most Centering groups met.

After an initial introduction about the purpose of the study, the moderator used a set of six questions as a guide for the focus group discussion; two had built-in follow-up questions. The opening question asked the women about their decision to select group prenatal care over traditional individual care. The discussion then moved to their experiences related to group meetings, including follow-up questions specific to peer and midwife interactions. Support person attendance and experiences at the meetings were then addressed by the woman and/or her support person, if that individual also attended. The next question focused on the labor and birth process, with a follow-up question specifically regarding perceived impact of the Centering program on labor and birth. The focus group closed by asking participants their opinions about using Centering for future pregnancies and allowing them to share any other issues, comments, and concerns they had about their experiences.

Having women participate in the focus groups from different Centering groups was done with the goal of having various perspectives and for the women to interact. Each Centering group was different, in both size (groups ranged from four to nine

women at this practice) and personality. During the focus groups, women compared their experiences in different groups, which allowed for more in-depth information to be provided. In addition, each had an infant child of a different age, allowing them to reflect on the questions from the perspective of their infant's development. There did not appear to be any problems with women's comfort sharing among new group members; at this point, the women had been used to the group experience and sharing their ideas in the Centering classroom. As women learned about the differences between the group's dynamics, they often asked each other follow-up questions.

Audiotapes of the focus groups were transcribed verbatim (Chaffee) and verified for accuracy (Risisky). Two individuals independently read through the transcripts and created a list of possible codes to be used (Risisky, Asghar). The lists were shared and discussed and then a final code list was developed that included six broad categories (Support, Program Experience, Midwife Experience, Birth Experience, Postnatal Experience, and Support Person Comments). These broad codes were shared with the practice midwives. These key themes were not verified with participants during the analysis phase. This was due to difficulty in gathering women for another session due to their new mothering responsibilities. Each category had between three and five subcodes. Once the list was determined, the two team members independently coded the transcripts and then met to discuss the findings. The team members matched codes 66% of the time; all discrepancies were discussed and codes were agreed upon before moving to the next step.

Once the codes were set in each of the three transcripts, the information was entered into Atlas.ti, a text analysis program (Muhr, 1997–2000). Atlas.ti was used to perform "code and retrieve" analysis to sort transcript excerpts by coded categories and to combine the categories across the three focus groups. Data collection for this project was originally collected to help provide information for annual reports to funding sources, and for quality assurance. Formal secondary data analysis was approved by the Institutional Review Board at Southern Connecticut State University.

RESULTS

Ten women who had recently birthed in the past 3–11 months participated in the focus groups. Three additional individuals, support people who had also

come to most program sessions, took part in the focus groups. Two were male spouses of the women and one was a woman's mother. All mothers were in their 20s and their race/ethnicity matched the demographic profile of the practice: 4 were Caucasian/White, 3 were African American/Black, 2 were Hispanic, and 1 was Asian-Pacific Islander. Eight of the 10 women were first-time mothers.

There were three main themes that arose from the focus group discussions: women's experiences with the program and its impact on their pregnancy; the relationships formed with the midwives because of the in-depth nature of the program and its impact on birth experience; and the role of the support person during pregnancy, labor, and birth, and as a new parent.

Program Experience

Participants spent much time talking about their program experience and the impact it had on them. Main topics included learning/knowledge gained and shared experiences. Embedded within the knowledge discussion was the aspect of the program length.

Learning/Knowledge Gain. Women spent much time talking about how having the 2-hour sessions allowed for in-depth learning about pregnancy, labor, and birth. They felt they were able to attain more advanced knowledge than their peers going through traditional prenatal care. The time frame of 2 hours was also central to knowledge gain. One woman said: "When I finally did come to Centering and when I started learning everything there was to learn . . . it just made sense." Another said, "I would get [an] answer from a friend and still bring it to Centering to, like, make sure this is true."

Sharing information with peers led to further discussions and comfort in asking questions, a key aspect of increased knowledge. Women felt more comfortable asking the midwives questions in the group setting because it often led not only to increased information but also to a realization that others needed the answer to the same question. A participant stated:

. . . A situation where somebody's gonna ask a question that you're thinking but you don't wanna ask. I had so many questions, all different things, and she always took her time and answered it, she didn't make funny faces or ignore, she always . . . she took her time to answer every single question I had and made me understand things.

Shared Experiences. Another major aspect of participating in the program was the shared experience felt by the women. Women start the program with a similar due date (within a month), which allowed them to discuss the body changes and share experiences with each other. This often led to a normalizing of the experience, as well as increased comfort during the program to share stories and ask more questions. One woman noted: "When you have other girls who are going through the same thing, you're more comfortable, you know that it's normal." Another stated, ". . . a couple of other girls in there who were also in the same boat as I was, I wanted to know how they felt and things that they were going through and make sure I wasn't alone." Having support from each other and making new friends was integral to the experience. One woman shared: "It would be nice, too, to have people that you can complain to about it. You know, we're all going through those same pregnancy dramas at the same time . . ."

Midwife Relationships

The experience of working closely with the midwives during the program was vital for women. It helped them to feel supported during labor and birth, and provided the feeling of being more in control of the process. As one woman noted: "I felt more comfortable in my surroundings and just by being with each other for two hours it made it that way." Another said, "[B]ut she was there, I mean the whole time she came in the room, she even took pictures after, when he came out, like she was such a . . . that support that I really needed that wasn't family." This was especially vital when the birth process did not go as planned; having that intimacy with the midwife allowed the women to trust them enough to follow new suggestions and actions. One participant stated:

I think that the classes definitely impacted my labor and delivery because nothin' that I expected happened. I mean, I had a C-section and everything, but . . . I was ready for it because I knew, you know, because of the classes, I mean we were . . . we went over everything [because] you never know.

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The second main aspect of the midwife relationship was how the women felt about their treatment, which was formed by the intensive time spent together. Women felt that they were not just another patient; they felt the clinician was caring, responsive to their clinical and learning needs, and was respectful toward them and their partners. A woman noted:

I think she was really respectful also. . . . Like if you needed something extra she was there, you know, she was just always concerned with how you felt, like would always make sure that you were comfortable and you had everything you wanted.

Support

The most important factor that resulted from the program's experience was the impact that the support person had on the pregnancy and birth experience. Women were encouraged to include a support person during the sessions, and many of them did. Although only three support people took part in the focus groups, other women talked about their support person and the impact that support had, and is continuing to have, on them and their families.

Pregnancy. Women spoke about how the attendance of the program sessions by their support person increased that person's understanding of the physical changes the women were going through. For example, the support people helped women remember their list of questions for the classes, as one woman noted: ". . . tell my husband like, before the class that these are my questions and if I forget, to . . . he used to remember all my questions, so, 'Don't you want to ask this and that?' I said, 'Yea, I forgot.'" Another talked about how her support person felt regarding the importance of participating:

My husband came to most of the meetings, . . . and I didn't know if he like, made other people feel uncomfortable because sometimes he was like one of the few guys that was there, but . . . , he really liked being able to go, and um, learn about everything firsthand.

The support people in attendance also noted how participating in the program helped them. They noted the importance of learning the information,

which helped them feel a greater part of the pregnancy process. One spouse stated:

I think she would have been doing a lot more all by herself if I hadn't . . . I mean as far as the Centering group goes, I think, I don't think I would have had the time or been able to make the time to learn what I learned and be able to be there to support her . . .

Labor and Birth. Having a support person play an active role in the program led to many positive statements regarding the labor and birth process. Women felt they had help from someone who understood and could advocate for their needs and/or desires during the process. They felt the support person was prepared to assist; those whose partners did not attend the full program discussed how their partners could have benefited more from the program during the labor and birth process. One woman stated:

Luckily [he] was my voice in saying you know what, . . . this isn't gonna happen this way. This is gonna happen this way and this is what we want to do, so, you know . . . and amazingly they let it happen that way.

Another said, "He learned some things and he felt pretty comfortable. He was helpful and soothing me while I was in labor and delivery helping me relax and calm down, which was very helpful."

Advocating also came up when the support person spoke of their role in the labor and birth process. Another key element for the support people was feeling prepared and able to support their partners because of the knowledge gained by being a part of the program. One spouse stated: "During all the meetings, they kinda fill you in what you're gonna see and what to expect and how to help and just prepare you so that you were ready." Another spouse said,

Centering also taught us that if . . . we are allowed to ask questions, you know, it's like . . . it's not other people's decisions to make in this process, you know, you can ask questions, you can say no . . . I think, you know, definitely learned that, you know, we were the ones that were . . . it was our experience, not the other people's.

Post-Delivery. Centering also focuses on immediate postpartum issues, including breastfeeding and baby care. Women who had support people participating

in the program noted that their partners also felt more prepared for their role as fathers, because many were also first-time fathers. They were highly supportive in taking care of the baby, including helping with breastfeeding issues, as one woman noted: “No, he was very helpful like, you know, he was like, helping me positioning the baby until I was comfortable. So every time I [breastfeed] . . . he will like, you know, make sure that I’m positioning right.” Another said, “[B]ut he really enjoyed it. He . . . he learned a lot from it, which is helpful now that the baby is here, he’s like 100% in tune with what to do . . .”

The support people also noted how participating helped them in their roles with baby care and how that was an important aspect of their decision to be a part of the program. They felt more in sync with their partner regarding baby care and more prepared. One spouse said: “[W]e had certain ideas but we definitely had our eyes [opened] by that process, you know, I definitely think more men should go through [it].” The grandmother said about participating: “. . . [I] wanted to see what was new and what had changed in that time. So that’s why I came with her, so I could learn too because I knew I was going to be a big part of his life as I am in hers.”

DISCUSSION

This study sought to gather women’s experiences with nontraditional prenatal care, in this case CenteringPregnancy, one form of group prenatal care. Past work has shown positive benefits (Ickovics et al., 2007; Massey et al., 2006; Rising, 1998; Rising et al., 2004), but as a relatively new program, the gathering of feedback to determine consistency is important. The women in these groups noted that they felt direct benefits from the in-depth nature of the program, both in their knowledge gains and experiences during labor and birth.

Sessions that are 2 hours in length allow for greater educational gains regarding all aspects of pregnancy, including labor, birth, and immediate postpartum care. By helping women to develop their skills through this in-depth learning experience, as well as normalizing their concerns through group interactions, the women in this program became actively involved with their pregnancy care. They began to see themselves in a position to influence the process, both maintaining a healthy pregnancy and having a sense of control throughout labor and birth. They also felt they had the ability to influence

positive health outcomes for themselves and their children after going through the program.

CenteringPregnancy group prenatal care is designed to empower women. By allowing the women to take their own blood pressure and weigh themselves, it demonstrates and builds a trusting relationship with the midwife while also assigning value to their ability to participate in their own care. It can empower women to question their labor management and to be more aware of available alternatives based on knowledge gained. Many of the women in this study talked about feelings of empowerment, especially when their labor plans had to change. The women felt they were able to advocate for the option that was best for them; this came from having in-depth knowledge as well as increased comfort with their clinician.

Having education and skills was not enough; the social support gained by being a part of the group care process also influenced women’s perceptions of their outcomes. Similar to other studies, they developed close relationships with peers in their group, which fostered interactive learning through sharing (Rising et al., 2004; Wedin et al., 2010). By sharing their day-to-day pregnancy concerns, women were able to normalize their own concerns and realize that these are common changes that the body and mind goes through during pregnancy. This normalization helped in alleviating anxiety and stress among participants and allowed them to focus more on the big picture of a healthy pregnancy. By spending less time wondering if specific issues were only happening to her, the woman could focus on learning the information needed to ensure healthy outcomes. This may also have played a big role in boosting confidence, which contributed to a feeling of perceived control and empowerment during labor and birth.

Peer support was not the only key factor to having better views on the pregnancy, labor, and birth outcomes. Like other studies, the relationship developed with the midwife through the intensive time spent in program sessions was perceived to have a great value on the pregnancy outcome, especially during labor and birth (Novick et al., 2011; Wedin et al., 2010). Women in this study felt that spending time with and learning from the midwives led to a relationship based on trust. As the mother’s needs changed, she felt that the midwife’s actions changed alongside to match these needs. The midwives went beyond just providing information and skills to

prepare for labor and birth; the added support was comforting during the birth process. The added trust allowed women, and their support people, to advocate for their needs and have those requests be met with respect.

Although over the past few decades it has been increasingly common for the fathers to participate in prenatal care, Centering takes it a step further. Fathers/domestic partners, and other support people such as the mother's parents, siblings, or friends, are also encouraged to be a part of the program (Rising, 1998). For the women, having a support person at the program also helped to foster that sense of control and empowerment because many noted that they had someone who could advocate for them. Because of their new knowledge, support people reported feeling highly engaged during the pregnancy process and able to assist during labor and birth. The comfort with the process was extended not only because of education but also because of a relationship formed between the support person and the midwife. This again speaks to the interrelationship between in-depth knowledge, relationships with support people, and the relationship with the midwife on the woman's perceptions of her pregnancy and pregnancy outcomes.

Limitations

There are a few limitations in our study. Because the participants comprise women who chose to participate, the possibility of selection bias cannot be ignored. It is likely that those who participated may have been the ones who were more satisfied with their program experience. Despite the flexibility of timing and assistance from the midwives in the program, the recruitment process had some issues. The involvement of the providers in the recruitment process may have led to further selection bias.

Several participants did not show up at the time of data collection, so the number of women who participated was small. This is generally not considered significant in qualitative analysis; however, data collected from a larger sample would have allowed us to get more information and would have provided further validation of our findings. Although we know why some women were unable to attend the groups (traffic issues, baby issues), we do not know if they would have provided different information. The data for the study was primarily collected in order to carry out the process evaluation of the program; only a part of the information

collected for this purpose forms the basis of this article. Process evaluation is used throughout the duration of implementation of a program to determine if the program is performing at an optimal level and to identify any gaps in program delivery (Steckler & Linnan, 2002). This was originally done as a method for meeting funding requirements, with the intention of using the findings to strengthen the program at this new implementation site.

The information does not include perceptions of women who may have had negative experiences and chose to either drop out of the program or refused an invitation to participate in the focus groups. If women did not complete Centering, they were not invited to participate in the focus groups as the intent was to talk about labor, birth, and postpartum experiences as related to the program. Those that did come to the focus groups had very few negative comments, even though they were reassured that no practice midwives would hear the tapes or see the transcripts of each meeting. Finally, in methods of data collection such as ours, it is taken for granted that the information collected is honest and accurate and is a true reflection of the participants' program experiences.

Clinical Care Implications

CenteringPregnancy can not only have a positive impact on the women involved but can also have positive benefits for a prenatal care practice. Having group care allows for more women to be seen during a set time frame. In a traditional prenatal care setting, patients are scheduled every 15 min on average. If Centering groups are larger than eight prenatal patients, it becomes more cost-effective to see more patients in 2 hours. In addition, during this time the midwife can spend an hour discussing one topic in-depth, which can address many of the common questions that arise during a prenatal visit, and also allows for sharing among women on these topics. This can limit the need to do a quick overview five to six times during an equivalent time frame. The in-depth nature of the program can also limit individual phone calls between patient and practitioner. More questions being answered at sessions, or just having more time so that women bring their questions to group, can reduce the need for additional phone calls between prenatal care visits.

Getting to understand the patient better prior to birth can also help the process from the clinical side because the clinician is better able to coach and

provide guidance in a way that will be meaningful for the woman. It is also a more rewarding experience for the individual midwife, who is able to disseminate information to several women at one time and not have to repeat the same explanation several times. Continuity of care in seeing one provider can be another benefit for the patient, who is better educated and prepared for the birth experience.

There are practice-based benefits for the participants as well. The women have the additional advantage of knowing their schedule of group meetings for the entire pregnancy, which take place at the same time on the same day of the week. This regularity of scheduling allows women to adjust their childcare and work schedules to accommodate their appointments. It also helps their support person to be able to schedule in the group meetings and be better prepared to assist and advocate during the labor and birth process.

CONCLUSION

For a midwifery practice, we found that the women and those in support roles (spouse/domestic partner, parents) who took part in the program had significant perceived benefits from their participation in the CenteringPregnancy prenatal care program. Women felt more in control during their birth process, more comfortable with their clinician throughout pregnancy and birth, and more knowledgeable of their pregnancy, birth, and postnatal concerns. In addition, the added component of social support from peers helped the women to learn more and also to normalize their concerns. Group prenatal care appears to have created a benefit to the women, not just with their birth experiences, but also with the psychological and social aspects of this life change.

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