Exploring the Experiences of Midwives Facilitating Group Antenatal Care

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COVID-19 Impact Statement

This statement is provided for the aid and benefit of future readers to summarise the impact of the COVID-19 pandemic on the scope, methodology, and research activity associated with this thesis. The academic standards for a research degree awarded by City, University of London and for which this thesis is submitted remain the same regardless of this context.

Title of the research project: ……Exploring the Experiences of Midwives Facilitating Group Antenatal Care……

1. Summary of how the research project, scope or methodology has been revised because of COVID-19 restrictions

It is unfortunately impossible to submit this document without mention of the impact of the Covid-19 pandemic. As the subject of this PhD thesis is group antenatal care and midwives it is important to note that in almost all countries globally gathering in groups was impacted by restrictions, and necessarily paused, and simultaneously, midwives as essential healthcare workers, were obviously personally and professionally affected greatly by the pandemic. Hence, whilst my original plan had been to pursue survey development and ethical approval alongside my systematic review research, which would have had me with a complete survey and ethical approval much earlier, the pandemic made it impossible to think about involving midwives in non-covid related research for some time.

The original plan for this research project following the systematic review of group antenatal care (GANC) was to conduct a survey in the U.K., the United States, the Netherlands and Australia. The lockdowns, widespread health impacts of Covid-19 on the NHS midwifery workforce and national directives to prioritize Covid-19 research and avoid research burden on staff made the possibility of conducting a survey of midwives in the U.K. ethically and practically questionable. Furthermore in-person GANC ceased and whilst there was some limited but important virtual group adaptations, that was not the focus of this research project. Similarly in Australia, all GANC ceased and I was advised by research contacts in Australia that GANC research/survey distribution was unlikely during the height of the pandemic which coincided with my research timeline. Hence a decision was taken to survey only the U.S. and the Netherlands, two countries which had the longest experience of integrating GANC into normal care. Furthermore, in both these countries adaptations were very quickly made to continue GANC in person with modifications or online. Both nations also benefited from strong GANC training institutes (Centering Healthcare Institute and CenteringZorg) which facilitated adapting to Covid-19. The survey was modified to include questions about Covid-19 adaptations to GANC. As a result of limiting the survey to those two countries, the pool of potential interviewees was also limited. I had also planned and received funding for a round of key informant interviews at the ICM conference in Bali in 2020 which were cancelled.

2. Summary of how research activity and/or data collection was impacted because of COVID-19 restrictions, and how any initially planned activity would have fitted within the thesis narrative

A survey pertaining to experiences of GANC at a time when groups were discouraged or forbidden may have garnered a lower response than in non-pandemic times. Travel restrictions meant that nineteen of the twenty-one interviews were conducted virtually. Pandemic video conference fatigue, and the extraordinary personal and professional stress on healthcare workers may have impacted the length or richness of interviews. Furthermore, restrictions on childcare and homeworking or masking restrictions when conducting interviews at work meant dogs and children and masks sometimes impacted audio quality.

3. Summary of actions or decisions taken to mitigate for the impact of data collection or research activity that was prevented by COVID-19

In addition to the decision to limit research to midwives in two countries, decisions around timing of distribution of the survey were taken with input from American College of Nurse Midwives and Centering Zorg. Virtual consent procedures were followed for interviews. All participants who agreed to an interview were contacted and offered maximum flexibility in choice of video platform and interview timing.

4. Summary of how any planned work might have changed the thesis narrative, including new research questions that have arisen from adjusting the scope of the research project

It is interesting to consider whether the inclusion of the U.K or Australia in the survey could have resulted in identifying more midwives that were dissatisfied with GANC. Midwives in the U.S. have something of an outsider status and in the Netherlands they operate very independently in community (discussed in Chapter 4) and this may affect their perception of their midwifery role and their attitude towards engaging with new models of care. Conversely, in Australia and the U.K. midwifery is mainstreamed into health system hierarchies, and so the inclusion of these countries may have shifted some of the findings around midwives' professional identity and perception of GANC as transformative.

Date of statement: 09/12/2022

List of Tables and Figures

Acronyms

CP-Centering Pregnancy

CNM-Certified Nurse Midwife

CM-Certified Midwife

GANC-Group Antenatal Care

ICM-International Confederation of Midwifery

LMIC- Low or Middle income country

MDG-Millennium Development Goals

MPQ-Midwifery Process Questionnaire

NL-The Netherlands

RCT-Randomised control Trial

U.S.-United States of America

WHO-World Health Organization

Acknowledgements

I would like to thank the midwives who made this research possible through their time, their work, their sense of humour, and their unending dedication, advocacy, and so much hard work towards better care and a more humane equitable world. It is my great honour to share in the special bonds midwives have with one another.

I would also like to thank my supervisory team, Christine McCourt, Ellinor Olander, Angela Harden for midwifing me through this process, for reading, and replying and reassuring me as I waded through a PhD in a pandemic. Thank you for your patience with my American English, the technological challenges of virtual supervision, and for making me feel welcome and connected as a foreign student in very challenging time. Thank you to Cindy Farley for being my external mentor extraordinaire, and to Nancy Crowell for patient statistical advice. Thank you Sharon Rising for leading the way.

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I am also grateful to City, University of London for the Covid 19 hardship funding and for the Dora Opoku award.

Declaration

I, Jalana Lazar, confirm that the work in this thesis is my own.

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Thesis Abstract

Background: Group antenatal care (GANC) is a midwife developed model of antenatal care wherein participants receive clinical care, education, and support in a group setting. It offers an opportunity to provide people with midwifery care and a positive pregnancy experience, in line with global health policy directives. This thesis foregrounds previously unexplored perspectives of midwives facilitating GANC, considering the effect of GANC on job satisfaction and changes to midwifery role and identity, with a view towards understanding the sustainability and feasibility of this model for midwives in diverse contexts.

Design and methods: The research used three-phased mixed methods design. The first phase was a systematic review of the existing global qualitative evidence (n=19) around healthcare providers' experiences of facilitating GANC. The results, analysed thematically, highlighted knowledge gaps and informed the next two phases. A cross sectional survey of midwives that facilitate GANC in the U.S. and the Netherlands (the first countries to integrate GANC as part of normal care) was followed by in-depth interviews. The findings were integrated at three points; gaps identified in the review informed survey development, qualitative interviews were used to dive deeper into survey findings and integrated again at analysis.

Findings: The systematic review identified themes relating to provider role, workload and satisfaction. Most surveyed midwives (n=82/125: U.S.) and (n=66/101: Netherlands) found facilitating GANC more satisfying than standard care and stated they could take more time within the visit and deliver more quality care this way. Many also found it to be more work than facilitating standard care. In follow up interviews American (n=12) and Dutch (n=9) midwives described facilitating GANC as meaningful midwifery work, that allowed them to develop relational care by taking time, holding space, and using facilitation skills. Midwives facilitating GANC experienced a network of support with participants, fellow midwives and other professionals that enabled an enjoyable experience of antenatal care as transformative and empowering for the participant women and families. Midwives in both nations identified funding as a primary sustainability barrier, amongst other organisational pressures. Midwives also expressed concerns that the work midwives undertake in GANC is not sufficiently valued as work, by colleagues and the system.

Conclusions: Future policies should consider the positive potential of GANC implementation to offer job satisfaction to midwives as well as the ability to optimize their professional skillset. Furthermore, valuing and funding midwifery work in the antepartum period through support of models like GANC that align with midwifery philosophy could strengthen quality maternity care systems in multiple contexts.

1. Introduction

In recent years we have seen a global shift in the acknowledgement of, and evidence for, the role midwifery care plays in the health outcomes of women[1] and children (Renfrew *et al.*, 2014; Sandall *et al.*, 2015). Furthermore, evidence continues to accrue that, in addition to the obvious need for better birth outcomes, women want a more positive pregnancy experience, leading to the necessity of a re-design and innovation in antenatal care (Downe *et al.*, 2019). Allowing more women to access midwifery care, continuity of care, and care that is more women-centred have all been identified as global priorities (World Health Organization, 2016b).

This has led to a suite of changes, and in some sense, restorations of models of care that had been lost, such as caseloading midwifery, out-of-hospital birth, and freestanding midwifery units, all of which attempt to re-establish a protected space and time in which midwives and women can create the woman-centred partnership that is at the heart of true midwife-led care. In the U.K. the Better Births initiative is an attempt to put the evidence around continuity of carer into practice. Another model of antenatal care that is being trialled in the U.K. and all over the globe is group antenatal care. In GANC, participants of similar gestational ages, receive clinical care, interactive antenatal education, and peer support, together as a cohort. It is a model of care that by design provides antenatal continuity of carer and woman-centred care through its approach to social support, self-empowerment and knowledge transfer.

1.1 Knowledge Gap

GANC was conceptualized by a midwife and is implemented in many countries worldwide predominantly by midwives, offering yet another opportunity to provide more women with midwifery care in a uniquely efficient manner. When asked about the concept of continuity of care models, a majority of midwives state their support for the philosophy that defines these models of care, but voice concerns over how their implementation will affect them (Taylor *et al.*, 2019; Hollins Martin *et al.*, 2020). Too often, the voice of the midwife, on care models that directly affect her, has not been foregrounded. The impact of these important changes in maternity care relies on the midwifery workforce to proceed, and yet, in a fashion that is unfortunately reflective of the lack of power of

[1] Given the feminist orientation of this thesis, I have chosen to use the word women throughout this thesis, and hope that it will be understood as an inclusive term. I stand in full support of inclusivity for all trans, non- binary and gender non-conforming identities.

midwives over their own professional destiny, many of them have not been given an opportunity to speak about their role in these models.

This resonates with my own personal experience. I am an American midwife, with a background in public health, who started a Centering Pregnancy GANC programme in a small Midwestern city with dispiriting infant mortality statistics and limited midwifery autonomy. I had been facilitating GANC for almost a decade before I was invited onto our infant mortality taskforce, where I was the only midwife. Simultaneously, decisions had been made to expand funding for GANC through our state public insurance programme with no input from the midwives who it was anticipated would be responsible to deliver this care. I was repeatedly asked to explain the group model I worked in as well as comment on the practice of midwifery. It was clear to me that midwives were not considered as vehicles of public health messaging, despite the vast amount of time we spent delivering these messages in antenatal care visits, particularly in the group visits, where I had much more time to sit and talk with the women for whom I cared. Additionally, I saw many possibilities for midwife led GANC to address glaring disparities in maternity care.

This PhD research is motivated by my desire to move beyond personal anecdotal experience regarding the benefits and challenges of this care model for midwives and to hopefully contribute some insight and evidence that could empower midwifery participation in future policy decisions that concern them.

In 2017 at the International Confederation of Midwifery (ICM) conference in Toronto, I attended a session presented by Billie Hunter of Cardiff University on opportunities for integration of public health and midwifery in the U.K. With Prof. Hunter's encouragement I started looking for work being done around GANC in the U.K. and happened on the National Institute for Health and Care Research (NIHR) funded REACH Pregnancy Circles trial collaboration through City, University of London and University of East London. This led me to Prof. Christine McCourt and the Centre for Maternal and Child Health Research. Prof. McCourt also introduced me to her work on the European Union funded GC-1000 project which is conducting research on the implementation of group care in seven countries around the world. I have had remarkable opportunities to connect and collaborate with the researchers on both these projects, and in so doing have had repeated confirmation that there is a global need for more research into the ways in which midwives experience and are affected by facilitating GANC.

Work around midwives' experiences in continuity models was a necessary step in supporting the viability of caseloading (McCourt and Stevens, 2005; Jepsen *et al.*, 2016), and similar work needs to be

done among midwives who have actual experience of facilitating GANC and are thus in a unique position to advise policy makers and health systems considering an expansion of this approach.

1.2 Aims

The aim of this PhD is to survey and unpick the experiences of midwives facilitating GANC with a view towards understanding the sustainability and feasibility of these models in diverse contexts. While I theorize that the midwife is the ideal provider for this model of care, based on the International Confederation of Midwives (ICM) definition of midwifery care, I also contend that if midwives do not perceive GANC as a significant improvement over the care they are currently offering, they will be unwilling or unable to make personal and structural professional changes necessary for wider adoption of this model of care. Hence a secondary and reciprocal aim is to understand how midwives may experience changes to their midwifery role or identity in facilitating GANC, and to understand whether these changes shore up the sustainability and feasibility of the recommended expansion of midwifery care.

1.3 Objectives

1. Conduct a global systematic review of experiences of health care providers' facilitating GANC
2. Conduct a cross sectional survey of midwives facilitating GANC in 2 countries with the longest history of GANC using collaborative networks for distribution
3. Conduct in depth interviews with midwives in countries with long established GANC about their lived experiences of facilitating GANC

1.4 Structure of this Thesis

This thesis is comprised of nine chapters counting this introduction. It is a mixed methods study, comprised of qualitative and quantitative methods, and these have been integrated in the design and the analysis of findings at various points.

Chapter One provides the background rationale for research into the experiences of midwives facilitating GANC, including my biographical experience with GANC, as well as setting out the aims and objectives and structure of this thesis.

Chapter Two begins with an overview of the history of traditional antenatal care and the role of maternity care professionals providing that care as a comparative context for the development of GANC. The chapter defines and discusses the development of GANC, reviews the current evidence and theory, and considers the integration of GANC and midwifery led models of care.

Chapter Three presents the research design, considers my positionality as a midwife researcher of midwives, and situates the study's mixed methodology in a feminist pragmatist paradigm. It provides a rationale for the mixed methods approach and discusses the research phases in terms of design, methods, and analysis and ethical considerations.

Chapter Four is a version of the systematic review of provider's experiences of facilitating GANC which was published in *Reproductive Health* in 2021. The qualitative review searched global evidence in April 2020 which identified three themes of providers' experiences of facilitating GANC. The knowledge gaps highlighted in the review were integrated into the survey design and prioritized the sampling of midwives in countries with wider GANC adoption. The thematic findings from the review also contributed to the framework analysis of the midwife interviews.

Chapter Five is an overview of midwifery, maternity care and GANC in the Netherlands and the U.S., as recruitment of midwives facilitating GANC for the cross-sectional survey was targeted to these two nations secondary to their early adoption of GANC as a usual antenatal care option. The chapter gives brief overviews of issues central to midwifery experiences; regulation and professionalization, autonomy and status and special features of each country's maternity care system that have implications for GANC and for understanding the thesis findings in context of midwifery and GANC in these two countries.

Chapters Six and Seven are the survey and interviews findings chapters. The findings of the cross-sectional mixed methods survey are presented in Chapter Six. Descriptive statistics present how the participant midwives work in GANC, and answered questions around satisfaction, workload, professional role and covid. Open ended survey questions were analysed thematically and areas needing deeper consideration are reviewed. The qualitative interview findings which were produced with a framework analysis are presented in Chapter Seven. The chapter begins with an introduction to a conceptual model of the interview findings on midwife satisfaction and then explores each individual theme that contributed to the model and concludes with a summary of the findings.

Chapter Eight considers the strengths and weaknesses of the study and resumes key findings on the meaning of GANC for midwives in an integrative fashion. It then situates the empirical findings on midwives' experiences of GANC in light of literature on midwives' experiences with other care models, the critical nature of support networks and concludes with a discussion of considerations for the professional midwifery role in GANC.

Chapter Nine concludes the thesis by situating the findings in the larger context, considering implications and recommendations for practice, policy and for future research on midwives and GANC.

2. Background

Introduction

This chapter will examine the history of antenatal care and the role of maternity care professionals in the delivery of antenatal care. It will then address the imperatives to deliver antenatal care differently and the ways in which GANC might offer a new paradigm of care that is simultaneously a midwifery model of care, thus fulfilling an identified need to expand midwifery practice and autonomy globally.

2.1 What is antenatal care?

In "Guidelines for a Positive Pregnancy Experience" The World Health Organization (WHO) defines antenatal care (ANC) as "the care provided by skilled health-care professionals to pregnant women and adolescent girls in order to ensure the best health conditions for both mother and baby during pregnancy" (World Health Organization, 2016, p.1).

This definition expands the notion of antenatal care beyond surveillance into the realm of care. As will be discussed later in this chapter, many of the aspects of antenatal care contain surveillance elements. Surveillance itself carries with it problematic associations with notions of power and control, often by the state. Modern antenatal care in the U.K. was arguably endorsed around the time of the first World War as a state solution to the military disadvantages of congenitally malnourished soldiers(Oakley, 1984). Following this line of reasoning, it was in the interest of the state to oversee women's pregnancies in order to produce healthier men.

Although this argument is clearly reductive and disconcerting in the current context of human rights around gender equity, it retains relevance to current conversations around antenatal care's goals. Tensions around surveillance, public health and human rights persist, particularly given the current Covid-19 pandemic (Coxon *et al.*, 2020; Reingold, Barbosa and Mishori, 2020). These tensions bleed into the question of "What is the priority in antenatal care?" The health of the public? The health of the mother? The health of the child?

In the early days of modern antenatal care in the UK, between 1900 and 1936, these same questions informed debates over which professionals should have primacy over the design and delivery of antenatal care. Salaried municipal public health professionals lobbied for mandatory pregnancy notification in order to reach the maximum number of needy women and families with funded social welfare programmes and medical surveillance of pregnancy. Midwives and obstetricians, both struggling to establish or maintain professional autonomy, raised privacy concerns on behalf of women, but their concern was also reflective of their own anxieties around losing autonomous influence and control of

antenatal care(Al-Gailani, 2020). To this day, comprehensive antenatal care presents opportunities for cohesive working between public health practitioners, health visitors, GPs, obstetricians and midwives, and yet barriers to interprofessional cooperation remain.

By centring antenatal care guidelines within the framework of a positive pregnancy experience, and clearly endorsing the health of women and children, the WHO redresses some history of placing pregnant women on the periphery of their own antenatal care experience (World Health Organization, 2016b). There are opportunities for pregnant women to work with the state and networks of maternal and infant welfare professionals to determine their priorities in antenatal care. This collaboration could theoretically reclaim the surveillance element of ANC as an opportunity for both the health of the public as well as women's individual antenatal care narratives.

The problematics of producing a simple definition of antenatal care are summed up well by Oakley (1984) in her feminist text on the history of antenatal care The Captured Womb.

> "Antenatal care is what different people and social groups over the years have said it is; it is what some people have done, what others have had done to them, what some have eulogized and others complained about. Countless official documents and personal and professional exchanges have proclaimed or debated its meaning; and under the apparently consistent heading of antenatal care, a complex and variegated admixture of practices have been located at different times and in different places." (pp 250-251)

Global guidelines attempt to mould the complexity of antenatal care into a more consistent framework of meaning and practice for women and professionals, thus far with varying degrees of success.

2.2 State of Antenatal Care Globally

Regardless of the definition, the practice of regular antenatal care is a relatively recent phenomenon in many countries, which became much more standardized in Western nations around the time of the Second World War, and is bound up with the ways in which societies deliver health care to their citizens(Loudon, 1992). Evidence on antenatal care for improving the health of women and children is inadequate, and WHO guidelines around antenatal care frequently cite a paucity of evidence in their introduction (Dowswell *et al.*, 2015; World Health Organization, 2016b). As women's health care is under-researched and underfunded, perhaps it is unsurprising that antenatal care, along with many other interventions targeted at women, lacks evidence to support it (Committee on Women's Health

Research, 2010). It is also likely that there is a direct relationship between antenatal care and maternal/and infant mortality but it is difficult to establish whether this is causal or secondary to other confounding factors due to the complexity of the intervention of antenatal care and the obvious ethical issues around designing a trial that would exclude women from antenatal care.

Improving reproductive health, decreasing maternal mortality and ensuring maternity care access is part of the United Nations Sustainable Development Goals (SDG) agenda, which aims to ensure healthy lives and promote wellbeing for people of all ages (UN, 2015). Antenatal care attendance can be viewed as a measure of both maternity care access and maternity care quality and as such is a core indicator of public health. Unicef data reports that 87% of women globally attend at least one antenatal care visit with a skilled health professional (doctor, midwife or nurse) but less than 59% receive at least four visits (UNICEF, 2019). In the U.S., a wealthy nation that does not offer its citizens universal health care, economic and racial disparities in antenatal care access and attendance exist. Some disparities in attendance persist in high income nations with universal coverage, such as the U.K. and the Netherlands (National Institute for Health and Clinical Excellence (NICE), 2010; Choté *et al.*, 2011; Pham, 2020).

The impact of antenatal care on outcomes is primarily proved in the negative; in its absence, or where antenatal care visits are reduced, there is evidence of poorer outcomes for women and children in both high and low and middle-income countries (LMICs) (Raatikainen, Heiskanen and Heinonen, 2007; Cantwell *et al.*, 2011; Dowswell *et al.*, 2015). Surveys of antenatal care service attendance in 69 LMICs demonstrated an association between increased attendance and reduced neonatal and infant mortality and improved child nutrition (Kuhnt and Vollmer, 2017). There is also some evidence that for low-risk women in high income countries 'too much' antenatal care (defined as more than ten visits) is associated with a higher risk of induction of labour and caesarean section without any improvement in neonatal outcomes (Carter *et al.*, 2016). These findings track the two extremes of maternity care, too little too late and too much too soon, which have been well described as having global impacts on quality of maternity care and maternal morbidity and mortality (Miller *et al.*, 2016).

A focus on outcomes as the sole rationale for antenatal care reflects the industrialist worldview that saw antenatal care as a necessary step to the creation of a healthy population in order to have a healthy workforce (Al-Gailani and Davis, 2014). This view ignores the psychosocial value of antenatal care to the woman receiving the care and it inherently devalues the process in favour of the outcome (Downe et al., 2019; World Health Organization, 2016b). An "ends justify the means" approach is often a central tenet of obstetric care, and stems from a patriarchal focus on the production of a healthy baby that renders the experience of the mother in producing said baby irrelevant (Davis, 2013). It is worth

noting that even obstetricians have come to accept that a fixation on outcomes over process has not improved the quality of maternity care (Sinni *et al.*, 2016).

Professional and public perspectives on the value of antenatal care have changed significantly over the last century. These changes are likely related to both technological advances and sociological shifts. Early antenatal care focussed on surveillance of maternal and infant nutrition and hygiene and the schedule of visits emphasized late pregnancy as the most important time to seek care. This reflected the fact that identification of life-threatening maternal complications such as pre-eclampsia was most likely to occur in the third trimester (Bell, 2010). Advances in screening and diagnostic technologies during antenatal care (most notably ultrasound and genetic screening) have increased the prioritization of antenatal care in the popular and medical interest, reflecting perhaps cultural preferences for visits in which there is tangible intervention, where for lack of a better term, something is "done." As so many conditions and congenital disorders can now be diagnosed in the first trimester, arguments are now made for a re-ordering the schedule of antenatal visits (which remains the same as it was a century ago) to reflect the importance of early pregnancy care (Nicolaides, 2011). These shifts reflect general patterns in maternity care, particularly childbirth, which witnessed an explosion of medical interventions, followed by a movement to reclaim women's autonomy and humanize or re-humanize childbirth. Expanding these considerations to encompass the practice and process of antenatal care has lagged however.

In some ways, The WHO's Recommendations for a Positive Pregnancy Experience guidelines are the culmination of a clear attempt to redress this concern, firmly grounding antenatal care in a human rights perspective (Tunçalp *et al.*, 2017).

2.3 Human Rights Approach to Antenatal Care

Maternity care is covered under the human rights act of 1988 and the convention against the discrimination against women, as well as being covered in the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) (1979). Antenatal care in its current form has at its roots an imbalance of power between men and women, male obstetricians largely designed and determined, often arbitrarily, the nature and content of antenatal care. Many of the technologies that are cornerstones of antenatal care, such as reliable pregnancy tests and ultrasounds, were lauded by men as allowing them to know what was happening in pregnancy without having to rely on the pregnant woman's own knowledge of herself and her pregnancy (Oakley, 1984). In essence, much of modern antenatal care was developed to alienate the woman herself from the care she was receiving.

There is a growing advocacy and research around respectful maternity care, but often this is focused on the event of childbirth itself, as this event often places women at their most vulnerable to systemic disrespect or abuse (Shakibazadeh *et al.*, 2018). It is also the event in which maternity care professionals feel most vulnerable to the pressures of the systemic dysfunction that is often flagged up by disrespect and abuse (Freedman and Kruk, 2014; Lokugamage and Pathberiya, 2017; Bradley *et al.*, 2019). While disrespect and abuse are particularly egregious in labour, respectful maternity care needs to encompass the entire pregnancy and postnatal period. The fundamental human rights of dignity, autonomy and equality are as relevant to the care provided during a pregnancy as they are to the act of childbirth itself. Even as the language around respectful maternity care has come to reflect this necessity, the concrete acts of improving quality standards to meet the goals of a human rights framework tend to lag behind. This is visible within the WHO report Recommendations for a Positive Pregnancy Experience, which frames itself holistically from its very title. In its introduction it goes on to say,

> "Crucially, ANC also provides the opportunity to communicate with and support women, families and communities at a critical time in the course of a woman's life. The process of developing these recommendations on ANC has highlighted the importance of providing effective communication about physiological, biomedical, behavioural and sociocultural issues, and effective support, including social, cultural, emotional and psychological support, to pregnant women in a respectful way. These communication and support functions of ANC are key, not only to saving lives, but to improving lives, health-care utilization and quality of care" (World Health Organization, 2016b, p. ix).

The hierarchy of recommendations themselves, however, remain heavily focussed on the screening and diagnosis aspects of antenatal care, leaving the recommendations to address the actual experience (the part of care grounded in respect for dignity and autonomy) to the last.
This may be a result of organisations charged with protecting global health prioritizing the potential of antenatal care as a population focussed public health intervention over the primacy of the individual human rights of the pregnant woman.

2.4 Antenatal care as a public heath intervention

The WHO identifies three core aspects of antenatal care, "The components of ANC include: risk identification; prevention and management of pregnancy-related or concurrent diseases; and health education and health promotion" (World Health Organization, 2016b, p. 1). These dovetail with the

three core functions of public health as defined by the Royal College of Nursing "Prevention, Protection and Promotion" (*Public health | Clinical | Royal College of Nursing*, 2020).

Risk identification in antenatal care occurs primarily through screening, indeed, the modern practice of antenatal care occurred after health professionals identified oedema and proteinurea as markers for pre-eclamptic convulsion (Maloni *et al.*, 1996). Over the past century, with medical advances and the establishment of public health programming, pregnancy presented the opportune moment to address screening for both infectious diseases (such as HIV and syphilis) and genetic and congenital disorders (Snow and Coble, 2018). Between additions of serology and ultrasound screening pregnant women in high income countries may be offered up to 20 screening tests as routine (National Institute for Health and Clinical Excellence (NICE), 2008; American College of Obstetrics and Gynecology (ACOG), 2020).

Pregnancy also offers a unique moment for health behaviour and health promotion, essential directives of public health services in improving the health of the public through harm reduction (such as anti-tobacco initiatives) and promotion of healthy lifestyles (e.g., increasing physical activity, healthy eating, good mental health strategies).

From a public health perspective, antenatal care is a perfect time to promote interventions that have repercussions not just for pregnant women, but for their children, partners and families. Both from a societal and individual view, pregnant women are highly motivated to protect and promote their own health and that of their developing child. There are clearly important questions to be asked about the onus placed on the individual women in a patriarchal culture that largely provides insufficient structural support for women and families to effect change. There is much to be examined about female responsibility in antenatal care and in public health. As evidenced by the number of conditions and topics to be covered in a given pregnancy in the interest of public health, it is important to understand that the responsibility to change and protect has fallen largely on the individual woman whereas the responsibility to advocate and promote healthy behaviours has fallen largely on the provider.

2.5 Deficiencies in the Current Delivery of Antenatal Care

> "The current system of care which separates the risk assessment process from the opportunity for substantive discussion, provides little help for true behavioural change."(Rising and Quimby, 2017, p. 16)

As evidenced above, in order to best serve the public health, antenatal care is a vehicle for health promotion of a number of behaviours and disease prevention for a number of illnesses, which in practical terms means the communication of a great deal of information between a woman and her healthcare provider within the constraint of time. This raises the question of how much can be covered in a single visit, or a single pregnancy. Whose job is it to cover the information and how is It being done?

The WHO antenatal care schedule currently recommends eight visits within a pregnancy after determining that an attempt to distil antenatal care down to four focussed visits resulted in higher neonatal mortality (Vogel *et al.*, 2013). The evidence also supports the notion that inadequate quality of antenatal care (specifically inadequate content) has adverse effects on maternal and infant outcomes (Yeoh *et al.*, 2018). However, most antenatal care visits last no more than fifteen minutes, meaning that 8 visits will translate to an average of 2 hours of antenatal care in a pregnancy (von Both *et al.*, 2006; Novick, 2009). This means that providers have a significant amount of material to cover in an overall total of two hours, if we start from the a priori standard model of antenatal care, that assumes that it is the responsibility of the provider to "fill up" women with knowledge. As evidence has accrued countering the pedagogical concept of the brain as an empty vessel, it has been largely abandoned in educational and social theory as paternalistic and ineffective (Freire, 1973). Yet, much of antenatal education is still delivered this way. Evidence suggests that there is room for quality improvement in antenatal care content, as increases in standard antenatal care coverage did not result in corresponding decreases in maternal or infant mortality (Campbell *et al.*, 2016).

Evidence from a global qualitative evidence synthesis of what women and providers want from antenatal care (Downe *et al.*, 2019) highlight a number of barriers to satisfaction with antenatal care. Women and providers both valued continuity of care provider and more time with women. Providers stated that staff shortages were a significant barrier to providing quality antenatal care, particularly in respect to its influence on time. Women and providers also found the focus on risk assessment to be at the detriment of other aspects of antenatal care, such as psychosocial support, which are given less priority. Simultaneously, the review highlights one of the fundamental dichotomies of antenatal care, the desire of women to be assured of their safety and that of their baby, while also recognizing pregnancy as an essentially normal healthy state. In standard antenatal care, this reassurance and risk assessment is primarily the purview of the antenatal care provider.

2.6 Antenatal Care Providers Globally

Antenatal care is provided by a variety of public and private systems and by a range of skilled maternity professionals, doctors (both obstetricians and general practitioners), nurses, and midwives. In LMIC settings skilled and unskilled birth attendants also provide ANC (Powell-Jackson *et al.*, 2015; UNICEF, 2019).

Universal antenatal care provision is dependent on the availability and accessibility of a competent skilled health professional workforce in order to achieve the United Nations SDGs 3.1 and 3.7, which aim to halve maternal mortality and provide universal access to reproductive health information and education, including antenatal care (UN, 2015). There is an anticipated shortage of fifteen million healthcare workers by 2030, the year set out for achievement of the SDGs (Liu *et al.*, 2017). The WHO's global strategy for human resources in health 2030 has prioritized the use of appropriate skill level for primary care provision, and midwives have been identified as the professional group which could cover eighty-seven percent of essential care for women and newborns (*WHO | Global strategy on human resources for health: Workforce 2030*, 2016). Additionally, the midwifery model of care was identified by the Lancet series on midwifery as care that both saved lives and met the quality standards that encompassed the delivery of women-centred care (Renfrew *et al.*, 2014). Midwifery care is relational care with a skilled health professional, ideally a continuous relationship built on mutual trust and safety; it enables the delivery of antenatal care that meets both the public health and the psychosocial functions of antenatal care that women desire.

There are numerous barriers to the provision of universal quality antenatal care by midwives. Midwifery practice is constrained by several factors, some that reflect global trends (e.g., shortages of maternity care workers and midwifery education programmes, discrimination against women in the workforce) and some that reflect local contexts (e.g., competition with obstetricians for market share in privatized health systems, scope of practice constraints) (Renfrew *et al.*, 2014; World Health Organization, 2016b).

In countries where midwives are the primary providers of antenatal care (such as the U.K.), they have identified time constraints and increasing dependence upon technology as interfering in their ability to offer the quality of midwifery care that they would like to deliver (Hunter et al, 2018) Using midwives to deliver a model of care that is antithetical to the relational care that is the speciality of the profession is unlikely to advance the promises of improved outcomes borne out by the research done on more relational models (Hunter, 2006; Sandall *et al.*, 2016).

2.7 The situation of the midwife

Maternity care is a demanding calling. The hours are long and unpredictable, the stakes are high, particularly in the light of the 21st century view of risk and blame in Western nations, where litigation and liability around childbirth have increasingly resulted in defensive practice environments. The vast majority of the midwifery workforce is female, and persistent gender inequities, further highlighted during the covid-19 pandemic, result in women bearing the brunt of home life responsibilities. Numerous studies have identified midwives as suffering from high degrees of professional and personal stress and burnout (Creedy *et al.*, 2017; Hunter *et al.*, 2018). This in turn affects both the quality and sustainability of midwifery care, as many take extended leave from the workforce, or leave the profession entirely. Relational care is the foundation of midwifery care, and this care can involve a high degree of emotional labour. Across practice settings, midwives value offering equitable high- quality care to women in an environment that respects midwifery autonomy and is professionally satisfying. These values unsurprisingly mirror those of women seeking antenatal care, women want high quality satisfying care that respects their autonomy. Kirkham and Stapleton (2000) reported on the paradox whereby midwives, predominantly female, feel undeserving of the same care they demand for women. This paradox potentially contributes to diminished self-advocacy among midwives, which in turn, does a disservice to all women. It may be that, by refusing to recognize themselves as women deserving of care, midwives erect a barrier between themselves and the women they care for, that allows them to cope within an unhealthy industrialized maternity service.

Strategies for improved coping and professional satisfaction among midwives have included "new" models of care, such as caseloading/continuity models. Studies have shown greater satisfaction of midwives working in caseload models and highlight that midwives appreciate the autonomy and deeper relationships they are able to develop with women (Jepsen *et al.*, 2016; Newton *et al.*, 2016). These models access some of the traditional ways of midwifery working that pre-date modern antenatal care. The intervention of the state, modern obstetrics and the publication of standard antenatal advice guides replaced women's and midwives' traditional ways of accessing knowledge, namely through the support and consultation of other pregnant and mothering women (Leavitt, 1986). GANC is one model that reengages this support.

2.8 Group Antenatal Care: A midwife-developed system solution

In the U.S., in the mid-1990s, the recognition that the standard model of antenatal care was not meeting the needs of women or providers began to present itself in the research (Maloni *et al.*, 1996).

This corresponded with an increasing push from payers in the American healthcare system (largely private insurance companies, and to a lesser extent the federal and state governments that subsidize health care for low-income families) for maternity care providers to increase the number of women they saw in an hour. As a practical matter this meant providers were repeating similar public health and maternity guidance 100 times a week. This experience was the norm in the busy antenatal care clinics where the midwife, Sharon Schindler Rising, was working in the Northeastern U.S. in the mid-1990s. Her prior experience with childbirth education and parenting groups led by interprofessional teams of healthcare workers and her frustration with the time pressures and repetition led her to conceive a new model of antenatal care. In this new model pregnant women of similar gestational ages would, after their initial booking in, attend antenatal care together in a group circle (see Fig 1). The new model would have three core components, healthcare, interactive education, and community building. She named this care Centering Pregnancy (CP) (see Fig. 2).

Figure 1:Set up of A Centering Pregnancy Space

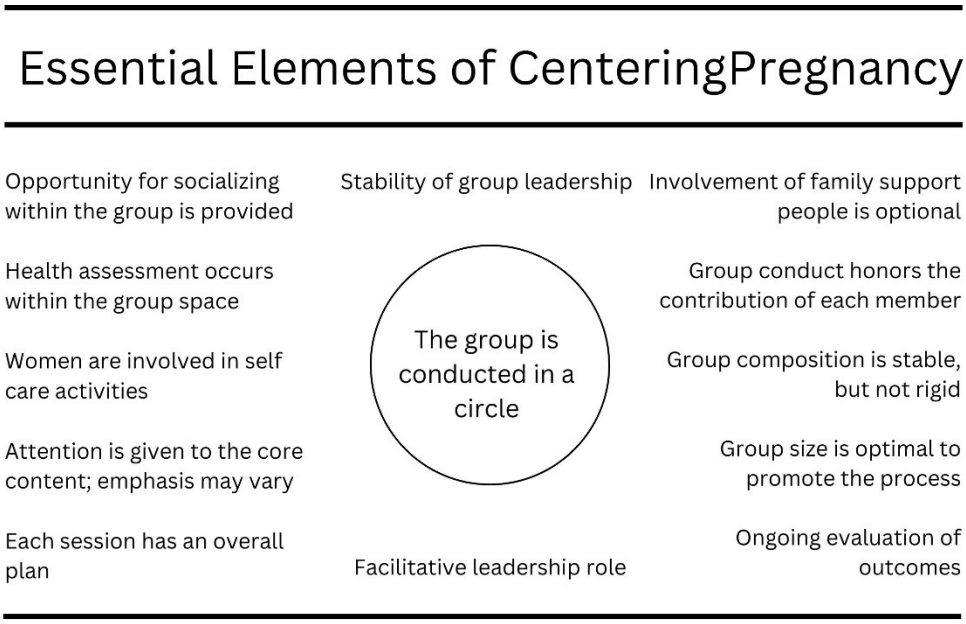


Figure 2: Essential Elements of Centering Pregnancy Programmes (adapted from Rising, Kennedy & Klima in Kennedy et al, 2009)

CP was presented to the American College of Nurse Midwives annual conference and immediately attracted a strong following of interested midwives (and an obstetrician). In order to meet the demand for training and to expand the model, a non-profit organization was developed with the goal of advancing the integration of the Centering model of GANC into maternity care in the U.S. (Rising and Quimby, 2017) Early research on the model showed that the vast majority of women who participated in Centering were satisfied with the model and the response from providers was also enthusiastic (Baldwin and Phillips, 2011).

This enthusiasm was not limited to the U.S.Over the course of the last two decades, GANC has expanded across the globe. In Europe, midwives in the U.K. and the Netherlands ran early pilot programmes, and the Netherlands has gone on to large scale integration of group based antenatal care, forming an analogue to the Centering Healthcare Institute (CHI) founded by Sharon Schindler Rising in the U.S. called Centering Zorg.

In the United Kingdom, early pilot programmes of Centering were conducted at Kings College London and through a collaboration with the Family Nurse Partnership program and in Northern Ireland using an approach based on the Solihull method of parenting support (Gaudion *et al.*, 2011; McNeill and Reiger, 2015; Barnes and Stuart, 2016). A randomised controlled trial of a bespoke model of antenatal

care called Pregnancy Circles was funded by the National Institute for Health Research (NIHR) as part of a wider research program focused on improving equity of access to antenatal care (Wiggins *et al.*, 2018). Australian midwives have also conducted substantial implementation research around Centering Pregnancy care programmes, as well as developing their own bespoke models and are now expanding that research especially in the field of vulnerable or marginalized populations (Craswell, Kearney and Reed, 2016; Riggs *et al.*, 2017; Brookfield, 2019). Swedish midwives have also undertaken work with GANC models and are also looking to them as a model of care that might offer special support for immigrant populations (Andersson, Christensson, and Hildingsson, 2012; Ahrne *et al.*, 2019; Byrskog *et al.*, 2019).

Across the global south, pilot programmes have been implemented with positive process and outcome measures (Patil *et al.*, 2017; Adaji *et al.*, 2019; Grenier *et al.*, 2019; Ibañez-Cuevas *et al.*, 2020). Prior to the Covid-19 pandemic, trials of GANC were in process in Rwanda, India, Nepal and Bangladesh (Sultana *et al.*, 2017; Musabyimana *et al.*, 2019; Harsha Bangura *et al.*, 2020). Furthermore, implementation of group care models as part of local initiatives (some funded with global development funding) is also occurring independent of academic research.

2.9 Group Antenatal Care: What the Research shows

In the U.S., where (Centering Pregnancy (CP)) originated, experimental research has demonstrated some positive maternal child health outcomes (see Table 1). In 2007, a randomised control trial (RCT) (n=1,047) demonstrated a significant reduction in preterm birth and low birthweight infants (Ickovics, 2007). This finding, particularly in the American context, where preterm birth rates remain the highest of any high-income country, and where glaring racial disparities in the preterm birth rates have remained intractable over time, spurred enormous enthusiasm for the expansion of CP care across the country. Numerous cohort studies demonstrated other benefits of GANC; however, other studies have not replicated these findings. A Cochrane systematic review by Catling et al (2015), found that outcomes of women and babies participating in GANC, (which included two RCTs from the U.S.), were equal but no better to those receiving standard antenatal care. Exclusive breastfeeding for instance, which is emphasized in CP sessions, has shown to improve in some studies, especially among adolescents who participate in CP, yet other studies showed no effect, or negative effect (Brumley et al, 2016, Tanner-smith, 2013, Robertson 2009, Ikovics, 2016). Similarly, several studies demonstrated no effect of GANC on perinatal stress, depression behaviour change (Mazzoni and Carter, 2017) A subsequent systematic

review did demonstrate positive outcomes for high risk and vulnerable populations (Byerley and Haas, 2017).

Table 1: Trial Evidence of GANC associated outcomes	
Outcomes associated with GANC	**Supporting RCT Evidence**
Reductions in preterm birth in at risk populations (adolescents, ethnic minorities)	(Ickovics, 2007; Ickovics *et al.*, 2016)
Reduction in low birthweight infants, or increase in average for gestational age infants	(Jafari, 2010a; Tubay *et al.*, 2019)
Increase in women's satisfaction with care and attendance to care *in adolescents, opioid users and low income women	(Jafari, 2010a; Kennedy *et al.*, 2011; Andersson, Christensson and Hildingsson, 2013)
Other Outcomes: • Quality of Care Metrics • Uptake of Family Planning • Better management of gestational diabetes • Improved knowledge in pregnancy	(Grenier *et al.*, 2019)

Table 1: Trial Evidence of GANC associated outcomes

Table 2: Outcomes where review findings demonstrate GANC has no impact
GANC has shown no impact or inconclusive impact with following outcomes:
Preterm birth rates in general populations Low-Birth Weight Infants Caesarean Section rates Breastfeeding Perinatal Depression and Stress Behaviour Change (Catling *et al.*, 2015; Carter *et al.*, 2017; Mazzoni and Carter, 2017)

Table 2: Outcomes where review findings demonstrate GANC has no impact

Whilst this proved a disappointment for advocates of GANC, it did solidify confidence that GANC was a viable alternative form of care for women as clearly the safety and quality was comparable, if not better than what they were already receiving. This allowed the WHO to endorse GANC as an option for a positive pregnancy experience in its 2016 report (World Health Organization, 2016b).

Central to this recommendation is the concept that, in the absence of differentiating outcomes in terms of morbidity and mortality, the research has repeatedly shown that women like GANC, and that the same cannot always be said for standard antenatal care. Improved attendance and satisfaction with care is a finding which seems to resonate across groups of women (Jafari, 2010b; Sword *et al.*, 2012; Andersson, Christensson and Hildingsson, 2013; Adaji *et al.*, 2019). The research on women who disliked GANC is limited, possibly because when women do not enjoy care in groups, they tend to leave them or they choose not to participate in the first place and so can be more challenging to include in studies (Francis *et al.*, 2019). Findings also endorse an increase in confidence and empowerment among women who participate in GANC (Heberlein *et al.*, 2016; Patil *et al.*, 2017). There is insufficient data to conclude significant impact of this type of care on health promoting behaviours among participants, although research among adolescents has been promising (Ickovics *et al.*, 2016; Mazzoni and Carter, 2017).

The vast majority of research around CP and GANC in general has been conducted in the context of trials (see Table 1). Some research in the U.S., where programmes have been in existence long enough to discontinue and fail, has examined implementation challenges (Novick *et al.*, 2015; Pekkala *et al.*, 2020). These challenges have often been somewhat specific to the context of the American health care system (costs, payer mix, tensions between obstetricians and midwives, and also specific to the Centering healthcare model itself, which requires a continued investment to maintain accreditation and materials from the CHI). Other challenges, however, are universally mentioned in the literature, challenges around adequate time and adequate staffing, and space, recruitment of women and adequate training for participating staff (Andrade-Romo *et al.*, 2019; Singh, 2020; Wiseman *et al.*, 2022).

2.10 Group Antenatal Care: The challenge of unpicking the mechanisms of action

The shift in the literature from trial evaluations to implementation science reflects the progressive maturing of the intervention in the global pantheon of health care innovations. It demonstrates that GANC may, after almost three decades, be moving more into mainstream consideration, especially in countries that have been offering GANC models for a long time. That said, there remain some notable gaps in the literature. Sheeder (2012) demonstrated the lack of a theoretical grounding for GANC and while efforts to address that are underway (Haora *et al.*, 2016) it remains true

that just as antenatal care is a complex intervention, and the individual effects of individual components remain difficult to unpick, this may be doubly true of GANC, which is more than a sum of its parts. A complete and systematic consideration of the elements of the mechanism of action of GANC could comprise at a minimum another chapter and possibly an entire dissertation and thus is outside the scope of research questions on midwives experiences' of facilitating GANC. The following paragraphs briefly review some theories around facilitation and trust that are pertinent to the experience of health care providers.

As the mechanism of action for GANC is likely an intersection of several components, it is useful to examine what elements are necessary to reproduce in order to sustain positive process and outcome measures for participants. As discussed previously, although CP remains the most researched model of antenatal care, bespoke models are being created that vary slightly in implementation. A systematic review by Sharma et al, (2018) examined the model components used across multiple low middle income countries LMICs. Similarly, there has been some research in the U.S. around the importance of fidelity to both the content of the CP curriculum and to the process of delivering group care in this model. Key elements include a relatively stable group of pregnant women meeting in a group space, performing self-assessment checks and having extended face to face time with a provider in a facilitative fashion that prioritizes peer to peer learning and sharing (Craswell, Kearney and Reed, 2016; Cunningham, Grilo, *et al.*, 2017a; Wiggins *et al.*, 2018). In response to the covid-19 pandemic virtual and hybrid virtual and in person elements were introduced (Wiseman, personal communication March 2020) and it remains to be seen what this will contribute to the discussions around definers of GANC.

In feasibility studies of group care models, privacy is often raised as an issue of concern, and worries that group care and discussion might inhibit the ability of women to share sensitive information (Gaudion *et al.*, 2011). In actual practice, it appears that the ability of GANC to engender trust allows for women to share intimate disclosures (L. Hunter *et al.*, 2018). A study of trust in the group prenatal care context conducted in the Netherlands advanced the concepts that trust enhanced the social support of the group which in turn facilitated greater feelings of self-confidence and reassurance (Kweekel *et al.*, 2017). This trust was conceived between group members and between group members and the midwife facilitating the group care. Elements essential to building patient provider trust have been identified as having an approachable interpersonal style and taking time (Sword *et al.*, 2012). The dynamics of the group, can, over time, coalesce into an atmosphere that is especially conducive to information sharing, active listening and peer support which may in turn facilitate self-efficacy and self-advocacy throughout the course of pregnancy and beyond. This in turn can benefit the

antenatal health promotion goals, such as those around diet, exercise, and reduction of harmful behaviors, as well as factors that affect pregnancy, such as stress and social isolation, but which are beyond the control of the individual woman. Theories of caring have been proposed as having an impact on group outcomes and there is also documentation of the impact of social support on birth outcomes and mitigating stress (Thielen, 2012; Appleton *et al.*, 2019).

GANC is unique in that it is a group, not a class. Rather than a didactic hierarchical information transfer, the model was conceived as a sharing of experience and knowledge guided by professionals in a facilitative fashion. The findings suggest that the facilitative nature of the group, as opposed to the more didactic structure commonly associated with health education models, may contribute to improved outcomes, and that outcomes are better with model fidelity (Novick *et al.*, 2013; World Health Organization, 2016b). This implies the possibility that skilled facilitation improves the antenatal care environment.

The CP model was originally conceived as being led by two facilitators, 'ideally, group care led by a CNM/CM [Certified Nurse Midwife/Certified Midwife] or nurse practitioner skilled in group process. An additional person, a nurse or aide, will facilitate the flow of the group and help with any follow-up necessary' (Rising, 1998, p. 48). Rising, Kennedy and Klima (2004) also posited the midwifery model of care as a theoretical framework for understanding the success of group care. Shared decision-making, listening to women and a focus on the contribution of women and building partnerships are all characteristics of midwifery care. There has been no examination to date of whether that clinician should be a midwife. Given the growing body of international evidence supporting the midwife as the ideal maternity care provider for women and their families, it follows that midwives are also the ideal providers for GANC. The skills specific to midwifery may predispose them to find facilitative care more intuitive than physicians do (Pekkala *et al.*, 2020), but group facilitation is a learned skill that even midwives may find challenging (Andersson, Christensson and Hildingsson, 2012).

There is a dearth of work examining the impact on providers, often midwives, as a potential mechanism of action, something that this study attempts to consider.

2.11 Midwives and GANC-A symbiotic relationship in matters of quality maternity care

CP was conceived and delivered by American midwives as an innovative solution to gaps in quality of care experienced by both midwives and women in maternity care systems that were not necessarily supportive of midwifery care. The model grew fastest in environments where midwives could act as lead facilitators, but to meet expansion demands the CHI never marketed GANC as a

midwife led model of care. In trainings and in publications, GANC was posited as a system disrupter, an innovation that could completely change antenatal care delivery (Rising and Quimby, 2017). One might argue that the idea was radical enough without introducing the similarly radical concept of midwifery-led care into a maternity care system that is and remains dominated by obstetricians. However, in practice, whilst there are certainly many medical training programmes and family practice physicians who have offered GANC, it has largely been implemented and championed by midwives. As it spread to other countries where midwifery was already embedded in the healthcare system, such as the U.K., Sweden, the Netherlands and Australia, it largely continues to be a midwife-led model. Meanwhile, the global endorsement of evidence supporting midwifery-led care as a means to improve quality maternity care has significantly strengthened the argument for models of care that expand midwifery access.

This convergence of two solutions (midwifery led care and GANC) to improve quality maternity care seems serendipitous. A common pitfall for quality improvement measures is the failure to achieve buy in from the intended participants (Dixon-Woods, McNicol and Martin, 2012). Midwives are the common thread between these two initiatives, yet historically they have been denied a voice in decisions that directly and indirectly affect both them and the women and families for whom they care. The Summary Reflection Guide on a Human Rights Based Approach to Health (OHCHR, 2016) recommends task shifting care to midwives as a key component of their strategy, yet, in spite of recent efforts to strengthen midwifery participation in health policy planning, input of midwives is remains under-solicited (World Health Organization, 2016b; Clark, 2019). Whilst global disenfranchisement of midwives as a professional class continues apace, midwives continue doing the work in the trenches of maternity care. This is particularly true of GANC care. In the U.S. there are midwives who have over fifteen years of experience working in GANC. The Netherlands has been conducting Centering groups for a decade and reached over 6,000 clients. Australia and the UK first piloted midwife led GANC over a decade ago. Research into GANC models has expanded onto all continents, reflecting the support for and interest in new models of meeting women's antenatal care needs.

It is also time to consider the ways in which new models may meet midwives needs. In her study of midwives and burnout Jane Sandall identified three protective elements; "Occupational autonomy, social support, developing meaningful relationships with women" (Sandall, 1997, p. 111). In 2014, Hunter and Warren found that resilience strategies for midwives included self-empowerment and support networks (Hunter and Warren, 2014). Group care happens in a circle and it is designed such that the midwife takes part in that circle. The question of whether the midwife can access the benefits of the circle may hinge on the degree to which she considers herself with the women in the circle or one

of the women in the circle. Research into midwives' experiences of providing GANC may help to answer those questions.

Conclusion

GANC has the ability to fulfil the public health objectives of antenatal care whilst simultaneously applying a woman-centred human rights approach to maternity care. Women offered GANC have found it to be satisfying quality antenatal care. The model's structure remedies some frustrations expressed by women about standard antenatal care, through additional support and additional time with a healthcare provider. This raises questions of who that provider should be, and whether GANC is satisfying for the provider facilitating the model. The evidence supports the concept of midwifery-led care as ideal, so whilst it stands to reason that midwives would be the ideal providers of GANC, this question has not been widely asked. Furthermore, the research has demonstrated that stress and burnout is high among midwives, and that without accommodations, it will be hard to attract and retain midwives in the profession. Is GANC one such accommodation? Do midwives like this way of working? What has their experience been thus far? The upcoming methodology chapter (Chapter Three) explores the ways in which positionality and theory impacted the research design and methods used to ask these questions. The systematic review of qualitative evidence in Chapter Four seeks to begin to address these questions, and in so doing raises further questions about the experience of midwives who have integrated this model into their daily ways of working outside of pilot research contexts. This PhD project sought to elicit the experiences of those midwives in order to better understand the way forward for possible synergies between midwives and GANC.

3. Methodology

Introduction

This chapter sets out the methodology and methods used in my research. In this chapter I will reflect on how my personal background and experience influences my approach to theory and discuss the theory that underpins my approach to conducting this research. I will then present the rationale for the mixed methods research design and conclude with the methods used in collecting and analysing data as well as ethical considerations.

3.1 Standpoint and Reflexivity

Having been a practicing midwife for many years prior to rejoining academic research in pursuit of a PhD, one aspect of undertaking my research that has been both exciting and daunting is the unpicking of the underlying theories that inform my work. My training in biological sciences has provided me with an epistemology that values concepts of evidence and observable "truth", yet I have always been able to concurrently understand, as a woman and feminist and a midwife, working and living in multiple countries and cultures, that reality is constructed and imbued by the artificial power structures in each context. It is precisely an interest in the way that power structures are formed or reformed that has led me to pursue research into midwifery and GANC, as I believe both stand at intersection of different understandings of power and act as conduits for the reorganization of hierarchical structures in ways that can potentially inform positive changes to maternity care systems.

I am a nurse midwife trained in the U.S. where midwifery is very much a profession that suffers from an identity crisis on multiple fronts. Whilst nursing and midwifery are historically aligned in the UK, in the US the relationship between nursing and midwifery is fraught and sometimes contentious. I lived this tension myself. Unlike the other midwives with whom I practised, I never used my qualification to work as a nurse. However, I am a product of my nursing and midwifery education, which emphasized positivist "evidence-based medicine" and in both fields generally approached theory as something that one had to learn to legitimize the professions, but that I was not expected to find of use or particular interest. Most of the theory we read was nursing theory, and because I identify more as a midwife than a nurse, I assumed these theories were less applicable to me, yet I simultaneously resented the short shrift given to these theories, as it felt like a surrender by both nursing and midwifery to the concept that our research is less valuable than medical research. Nursing suffers globally, and in the US, from its continual subordination to medicine, it is highly respected and trusted profession, and yet nursing knowledge and nursing research is always considered "less than" medical research. I continue to live this

paradox in my decision to pursue a PhD in the UK instead of in the US. I wanted to pursue a research degree in a country with a long and rich history of midwifery research, (in the U.S. you can only pursue a doctoral degree in nursing not in midwifery) and yet I am somewhat uncomfortable with the fact that I wanted to do research in a context that felt more independent from nursing, because it feels as though I am somehow complicit in the interprofessional derision that I believe is very much cultivated by the dominant patriarchal nature of health systems.

I was raised a feminist, and an anti-capitalist in 1980s America, which familiarized me with outsider status, and also helped me understand my insider privilege as a member of the white middle-class. I have always functioned well within existing systems of power and surveillance whilst simultaneously distrusting and opposing them. I believe this is why I identify more strongly with midwifery than with nursing, as in the US nurse-midwives have an outsider status, wherein they function within the existing healthcare system, but many are also trying to oppose and change it. I have experienced the benefits and constraints of my association with nursing; it has enabled access and trust, yet in my experience nurses and nurse midwives who have stronger ties to nursing than mine have been less supportive of my feminist framing of the medical system as representative of the patriarchy, and more unsettled by feminist rationales for proposed changes to that system. There are parallels here to my approach to my research around midwives and GANC, I hoped to gain the access to and trust of participants as a midwife who has worked in this model, and yet I used my researcher hat to collect and analyse data with an outsider, or more detached perspective.

In order to achieve this detached perspective, it has been necessary for me to reflect extensively on why I as a midwife am drawn to GANC, and what assumptions I make about group care in relation to midwifery. Midwifery is for me very clearly both about being a competent, trained professional and someone who can guide women in self-actualization. A midwife is there to keep you safe, but also to help you decide what safety means to you and then protect that definition with you. The relationship that “good” midwives establish with women from the beginning is meant to be a partnership and not simply a transfer of knowledge. Hence from my first exposure to GANC as a student midwife I sensed that a model that put many women in a room with one midwife created a partnership not just between one woman and her midwife but many bonds between many women and their midwife. I personally experienced this expanded partnership as dynamic shift of responsibility and power that was both discomforting and freeing. As a feminist and a professional advocate for women, I found the power of a group of women supporting and learning from each other inspiring. I felt most successful as GANC

facilitator when I went almost unnoticed by the women, but I also experienced this as a constant struggle. I have been trained to achieve, to show off my achievement, to feel that if I am not achieving then I am putting something or someone at risk, and I have been trained (by various gendered socio-cultural norms) to be needed. There is something extremely flattering about being told by a woman that she wants you to be there at her birth, as certainly there is no higher job satisfaction. Midwives often say, "I still cry at births" and I do too.

The transfer from knowing what you think women should know to letting them tell you what they think they should know is uncomfortable. It is a maxim of midwifery that we should listen to women, yet women do not exist in a vacuum, but in a culture which inherently devalues their knowledge from birth and simultaneously we are in a time of extreme accessibility of information with relatively little curation. Critical thinking is a skill that has also been undervalued. I saw my job as a facilitator primarily as guiding women to develop skills to access and assess information in relation to their own needs and values. This was hard for me, because I am huge talker, and storyteller, and sitting in silence is a constant struggle. But you cannot safely practice midwifery if you cannot listen and ask questions, and I never found the task of listening to many women in a room speaking more difficult than listening to just one woman alone. The most embarrassing moments for me in midwifery school were always when I could not answer a question from my supervisors because I had forgotten to get that piece of information from a woman, and the beauty of group care is that often, you do not have to be the one asking a woman for the information as one of her peers might.

It is necessary to acknowledge that the decentralization of what I will call knowledge-power that occurred in the group space opened up anxieties about justifying my value. If women can get to knowing without me then what is my utility as a midwife even as I specifically determine my role to be just that, supporting women in self-actualization. However, I do so with the contextual knowledge that this anxiety is a product of my status as midwife working within a health system hierarchy that devalues and denigrates this role. My daily experience of being a midwife in capitalist system that insists on "productivity", and that puts higher monetary and societal value on intervention and professionalization and specialization as a means of controlling women's choices and bodies stands in direct opposition to my understanding of my role as a midwife. In my experience, midwives, myself included, have made significant concessions to the dominant system in order to carve out a space for themselves in which to practice.

Much of my theoretical understanding of power and its relationships with midwifery and GANC is influenced by Foucauldian theories around surveillance and Marxist theories around capitalist commodification of time. Antenatal care can certainly be understood through the Foucauldian lens of women voluntarily putting themselves under the surveillance/medical gaze of the state and thereby enabling the power of the state and its appointed experts whilst shifting much of the responsibility for the outcome of the pregnancy to the behaviour of the woman herself. If we accept the dominant narrative of the primary function of antenatal care as a tool to mitigate risk in pregnancy then,

> "The pregnant woman, therefore, is positioned as a risk assemblage in a web of surveillance, monitoring, measurement and expert advice that requires constant work on her part: seeking out knowledge about risks to her foetus, acting according to that knowledge" (Lupton, 2013, p. 121)

I think there is a theoretical analogy to the position of the midwife in the current medicalized world of childbirth. Much as the pregnant woman is charged with mitigating the risks to the foetus through information gathering and acting on that knowledge for the benefit of the state or society at large, whilst the agency remains significantly with the state, so too the midwife is charged by the state primarily with the responsibility of mitigating the perceived risks of pregnancy and childbirth for the woman and the foetus; however, much of her agency is constrained by her low status in the medical hierarchy.

The reason I became so attached to group care was that I really did find that it changed the balance of power without me having to work so hard to change that balance. Pregnancy can make you feel so vulnerable, physically and emotionally. In a one-to-one encounter, the woman is brought into my space, she waits for me, and I come in and we begin. I know what needs to happen but she does not necessarily. In group care, women assemble in a room and I come to them. They aren't waiting for me, they have each other and I can sit on the periphery. I don't know what needs to happen in a group, any more than they do, the group has to figure it out together. We have goals, but the sessions evolve. Also, in group care, I predominantly cared for women from deprived backgrounds, who were not given space or power in most aspects of their lives. Most of them had not planned to be pregnant and yet pregnancy offered them some status, good or bad, it was a marker that differentiated them, particularly among the adolescents. Group care offered them an opportunity to try out a new identity in some ways, to decide what they were going to share or not, what they were going to learn or not (Friedman, 2016). It offered them a ready-made cohort of individuals in similar stages of pregnancy.

I personally shepherded my practice through the process of establishing this model of care and getting it officially certified by the CHI. I have long believed in this as a transformative care model for midwives and women, particularly from vulnerable backgrounds, but I wanted the opportunity to research this model away from my role as a midwife. I am aware, however, how much my experience with the model biases me, and I have undertaken special efforts to mitigate my biases. In the course of the systematic review, and in coding the interviews, I used disconfirming analysis (analysis which seeks to identify conflicting or contradictory evidence within or among cases) to address bias, but also to identify ambiguity that might lead to a deeper or different interpretation of data (Booth, 2013, Antin, 2015). This was achieved through reflexive memos and notes during interviewing and coding, as well as multiple readings. Furthermore, having a supervisory team comprised of academics who are not midwives diversified my perspective when discussing qualitative analysis. Simultaneously, my research approach is not a positivist one, and thus I understand that I cannot remove myself and my experiences from the research, and I am comfortable with that approach.

3.2 Paradigmatic Approach

The complexity of antenatal care (group and standard), as described in the background (chapter two), is created in part by being a meeting point for two worldviews on health. It can be viewed as a positivist, biomedical surveillance intervention meant to accomplish health for the mother and baby through measurable observable tests and rubrics such as ultrasound findings and bloodwork. It can also be viewed through a constructivist holistic psychosocial lens, as a unique time-period to address emotional and behavioural needs and factors that vary for each woman and family and are reflective of larger societal values around care for women and children. This tension in antenatal care between the empiricist and the holistic is also something that is characteristic of modern midwifery (Power, 2015), and is certainly a tension I experience as a midwife researcher.

My theoretical approach to my research began in flux and evolved throughout the course of the research. My clinical background has made me most comfortable with a pragmatist approach, one in which "rather than being limited to an intellectual activity, theorizing is seen as an embodied, reflexive process of responsive action" (Hartrick Doane and Varcoe, 2005, p. 83). I have also been personally and professionally influenced by feminist thinking and there is a precedent of intertwining these two paradigms, both of which

> "privilege social and political practice over abstract theory, they evaluate theory from the point of view of its concrete effects on marginalized groups, including women, and both share a

common emphasis upon the development of theory from subjects' grounded experience" (Mottier, 2004, p. 323).

I am studying the experiences of midwives with GANC because I agree with Kirkham (1999) that midwives voices are often "muted" (p.738). Kirkham outlined the ways in which midwives are expected to offer power, choice and control to women in a system that denies them the same, and thus their power as advocates for women and themselves is undermined. I find feminist critiques of Foucauldian power theory particularly relevant to my research aims around the experiences of midwives in GANC. Monique Deveaux (1994) argues that:

"addressing women's freedom requires that we reflect upon internal impediments to exercising choice as well as the tangible obstacles to its realization-and this means considering practices and conventions that may have disempowering effects not easily discernible to theorists who focus exclusively on political power. Finally, it involves recognizing certain experiences as ongoing expressions of resistance to power" (p.235).

I think this is particularly relevant to understanding midwives' experiences of the care they deliver, it is not simply enough to understand the external structural impediments that impact midwives practice, we must also consider the internal experiences and feelings that affect midwives, the vast majority of whom are women. Both the midwifery model of care and a model such as GANC entail elements that may be in opposition to the dominant health systems in which they find themselves and enact care ethics a central tenet. The ethics of care also act as a link between feminism and pragmatism (Mottier, 2004).

Pragmatist theorists view theory development as a process rather than a solution, one that has both experience and action at its centre ((Hartrick Doane and Varcoe, 2005). Additionally, pragmatism supports research that transitions between induction and deduction (Doyle, Brady and Byrne, 2009), which is compatible with a mixed methods design. I have chosen a mixed methods research design as I believe it is best suited to the complexity of the external and internal factors that inform midwives' experiences of GANC, and it is also compatible with a pragmatic paradigm.

Pragmatism is a common paradigm endorsed by mixed methods researchers (Creswell, 2011) and often vulnerable to the same critiques as mixed methods designs, primarily that it seeks in some ways to be all things for all researchers (Lipscomb, 2011). I must admit that the criticism that pragmatism attempts to circumvent some contentious theoretical dialectics on ontology and

epistemology, and therefore may appear to waver on the empiricist-interpretivist continuum, appealed to me, as at this stage of my academic career I feel I am still on a journey towards conceptual clarity.

Critical realism also offers a worldview that provides support for mixed methodology. It maintains that cultures, social structures and experience influence our perceptions of an independent objective reality, and has numerous points of overlap with pragmatism, however critical realism may be more ontologically complex (Elder-Vass, 2022). Pragmatism differs from critical realism in that it is focused on experience as reality as its fundamental ontological assumption (DeForge and Shaw, 2012). The assertion that our consciousness is shaped by our experiences seemed more appropriate to a research question that seeks to make meaning out of midwives' experiences with a specific model of care.

3.3 Research Design

3.3.1 The rationale for a mixed methods approach

The aim of this thesis was to elicit the lived experiences of midwives facilitating GANC. Understanding lived experiences is often the rationale given for pursuing pure qualitative research, and often phenomenology (Frechette *et al.*, 2020) and therefore it is important to address the critical thinking that led to the choice of a mixed methods approach to this topic. In many ways this decision is informed by several factors related to the research question.

As antenatal care (group and standard) is a complex intervention that has been relatively under-theorized it lends itself to a qualitative research approach (Bowling, 2014). In undertaking this study, I began by addressing the question of what is already known about the experiences of providers facilitating GANC and that systematic approach and its findings comprise the following chapter. The findings from that qualitative synthesis set the stage for the next steps in this research study by providing a grounding for the population focus (midwives) and highlighted knowledge gaps around that population, namely the fact that very little research has been done with midwives who have facilitated group care outside of pilot research context.

The findings from the systematic review influenced the research design away from a purely qualitative approach towards a mixed methods design, specifically a mixed- methods design that employs an explanatory approach to help focus the sampling for the qualitative interviews of midwives and add meaning to the results from the quantitative component (Creswell, 2015). Adding a quantitative component permitted a greater number of GANC facilitating midwives to contribute measurable input on their experiences of GANC as well as producing a replicable tool for future research.

Key reasons for integrating qualitative and quantitative components in a research study, which I believe are relevant to my research question include:

- Triangulation (the possibility of enhancing the validity of the data through data replication/saturation obtained through both qualitative and quantitative methods)
- Completeness (a more comprehensive approach to the question of midwives' experiences with GANC)
- Explanation (in this case the qualitative component adds depth to the quantitative and the quantitative adds description and breadth to the qualitative sample)
- Sampling (the quantitative component helps focus the qualitative sampling)
- Credibility
- Unexpected results (the quantitative survey provided us some unexpected results that benefited from qualitative explanation, and the interviews illuminated new areas not anticipated in the survey questions

Triangulation, completeness, explanation, sampling, credibility and unexpected results are all supported rationales for mixed methods approaches (Bryman, 2006).

The story of my research has been one of a circular refinement of research design and study population. My initial proposal was for a mixed methods study of the influence of GANC on migrants and midwives in the U.K. Several challenges quickly came to light, namely the impossibly broad scope of the project and the necessity of narrowing the focus. As a midwife with GANC experience, I felt uniquely positioned to address the experiences of midwives with GANC. A scoping review, conducted in preparation for the systematic review, highlighted a gap in research on midwife perspectives on GANC. Key questions raised from the scoping review were: Who are the providers delivering GANC? What are their experiences of GANC? The findings from the systematic review (chapter four) flagged two important points that further influenced the research design: there was a universality to the experiences of providers in numerous countries, and yet the reported findings highlighted a need to hear more from midwives working in GANC about their *own* experiences of this way of working rather than their perspectives of the benefits of GANC for women. This led to a decision to expand the sampling of eligible midwives via a midwife workforce survey in countries that had had the longest history of

implementing GANC (U.S., Australia, the Netherlands and the U.K.). However, the constraints of Covid resulted in a decision to limit the distribution of the survey to the U.S. and the Netherlands.

Although I have conceptualized this mixed methods study under a sequential explanatory framework (see Figure 4), in practice it is more of a qualitative-quantitative-qualitative sandwich. Part I was the work of the systematic review of existing qualitative evidence, which is presented in Chapter 4. Part II is the survey which then informs Part III, the qualitative interviews (see Fig 3). Two types of explanatory typologies have been identified, the explanatory model and the participant selection model, "within the follow-up explanatory model, the researcher identifies specific quantitative findings, such as unexpected results, outliers or differences between groups that need further exploration using qualitative methodology. In contrast, the qualitative phase has priority in the participant selection model, and the purpose of the quantitative phase is to identify and purposefully select participants" (Doyle et al., 2009, p. 181). Both of these variants have relevance for the study, as the follow-up model reflects the relevance of the qualitative interviews to deeper/thicker inquiry into survey responses, and the participant selection model helped identify those participants that are willing to be interviewed in greater depth about their GANC facilitation experiences. It should be noted that an exploratory framework whereby qualitative work is conducted first in order to inform a structured quantitative survey could also have been an option, reflecting an opinion that the quantitative and qualitative work contribute equal weight, however having the survey first enabled a more in-depth approach to key areas of the GANC experience, namely satisfaction and workload that might not have arisen in the inverse.

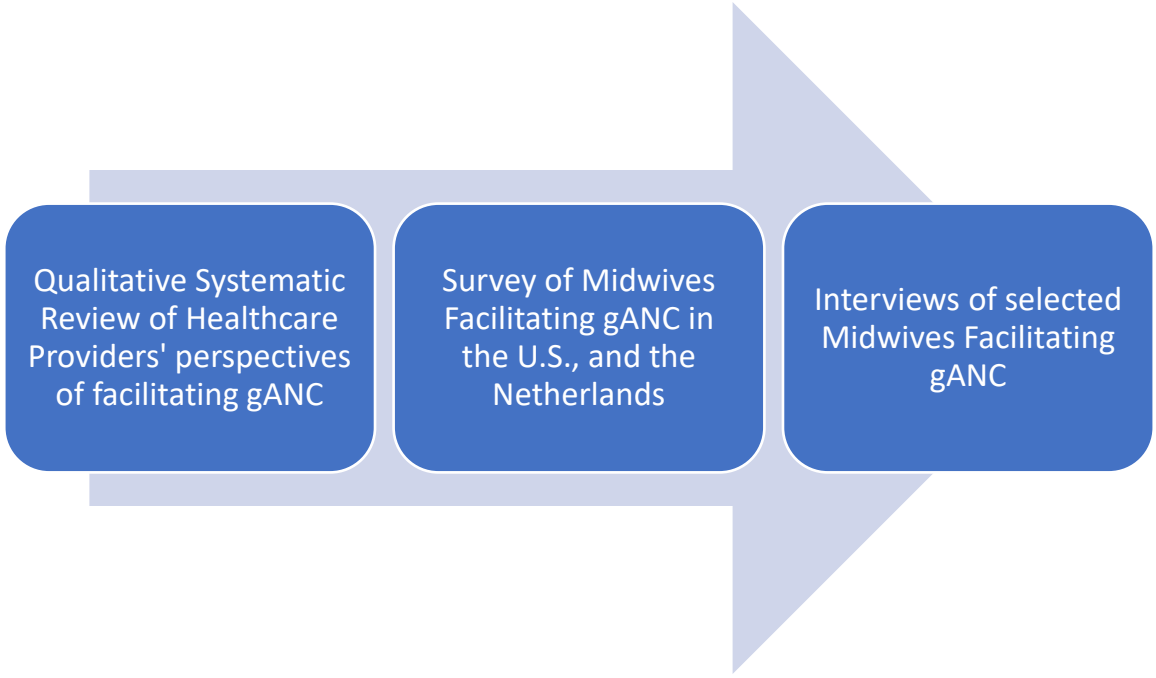


Figure 3: Mixed Methods Research Design

Explanatory Mixed Methods Design

PHASE	PROCEDURE	PRODUCT
Quantitative Data Collection	Cross sectional survey	Numeric Data
Quantitative Data Analysis	Use of descriptive and inferential statistics	Meaningful measures
Connecting Quantitative and Qualitative Phase	Selection of participants purposefully and interview questions development	Interview protocol
Qualitative Data Collection	In-depth interview	Textual data
Qualitative Data Analysis	Coding and thematic analysis Theme development cross thematic analysis	Codes and themes Similar and different themes and categories Cross thematic Matrix
Integration of the Quantitative and Qualitative Results	Interpretation and explanation of the quantitative and qualitative result	Discussion Implication Future research

Figure 4: Explanatory Mixed Methods Design adapted from (Subedi, 2016)

3.3.2 Limitations of Mixed Methods

As mentioned above in the discussion of paradigms, mixed methods research has come under criticism for being paradigmatically muddled (Lipscomb, 2011) or for being used as a catch-all design that implies a lack of intellectual rigour. I contend that using multiple methods, if done well, allows a more thorough examination of the subject. It is also true that mixed methods research requires a researcher who is reasonably comfortable with both qualitative and quantitative methods of analysis (Doyle et al., 2009). This was for me an initial hesitation, because although I have a master's in public health and have completed extensive statistical analysis during that period, there have been significant improvements and changes in statistical analysis software since I last used STATA or SPSS and even Microsoft Excel for statistical testing. To this end I attended several of the School of Health and Psychological Science biostatistics sessions and consulted with two biostatisticians for the analysis of the survey. In preparation for conducting the interviews I attended refresher lecture on effective interview techniques, as well as attending a qualitative research module, to supplement interview skills acquired through previous master's work conducting health care provider interviews.

3.4 Mixed Methods Part One: The Survey

Introduction

The decision to pursue survey methodology, which often sits in a positivist paradigm, can also be construed within a pragmatic feminist approach. The experience of conducting the systematic review identified a need for a tool that had the potential to elevate the largest number of unheard voices and a questionnaire met that criterion. Surveys of midwives' experiences with different care delivery models, such as continuity of care, have produced valuable insights on challenges midwives face working in new ways, such as childcare responsibilities and lack of autonomy (Hollins Martin et al., 2020; Taylor et al., 2019). Viewed through a feminist lens, these surveys highlighted the ways that gender imbalances can affect introduction of a new model of care and inform research around midwives' experiences of GANC.

It is logical that an internet-based survey approach can elicit responses from a larger population of midwives facilitating GANC than could be obtained from interviewing a small sample alone, or from administering a postal paper-based survey, and a larger sample may lend more credibility and generalizability to those experiences. This was also the most affordable option with the widest potential reach and ease of administration. Surveys allow participants to contribute their opinions to research in a manner that respects the time pressures faced by health professionals. Certain questions that are

helpful to the description of the experience of the on-the-ground working midwife are best approached through quantitative survey questions, as the frequency of variables within the given population of facilitating midwives adds weight and essential descriptors. Short open text responses allowed a large sample to provide more detail on their experiences. The survey is attached in Appendix 3.1

3.4.1 Survey Design and Translation

Use of a literature review is a recommended step in rigorous survey design (Gehlbach, Artino and Durning, 2010; Ziniel, McDaniel and Beck, 2019), hence the cross-sectional self-administered survey design was informed by themes that arose from the systematic review presented in Chapter Four (see Table 2 and Appendix 3.1). The review identified knowledge gaps specifically about the population of midwives who have been facilitating GANC as an integrated option of antenatal care at their clinic or service. The review also highlighted that while there is a substantial body of work that reflects providers' views of the benefits of GANC for women, there is much less that addresses directly midwives' views about their own experience of GANC, specifically around questions of workload, job and role satisfaction, long term feasibility and sustainability, and of course the recent impact of a global pandemic. Survey questions were designed to address these specific areas of interest. A validated tool developed to measure midwifery attitudes to professional role, known as the Midwifery Process Questionnaire (MPQ) was also included with the permission of the author (Turnbull et al., 1995). The (MPQ) has been used in studies of midwife satisfaction or attitudes and experiences of midwives in caseloading and continuity settings as well as hospital based setting (Turnbull *et al.*, 1995; Dawson *et al.*, 2018; Hollins Martin *et al.*, 2020; Matthews *et al.*, 2021; Newton *et al.*, 2021). The survey was designed on Qualtrics software as this is an easily accessible web-based platform and which incorporates several tools to reduce bias. Decisions about the length of the survey, and formatting of questions was informed by existing guidance on effective online survey design, and by discussions with supervisors and topic experts (Ball, 2019; Ziniel, McDaniel and Beck, 2019).

The survey was translated into Dutch by Marlies Rijnders, a midwife researcher in the Netherlands who was among the first midwives trained in GANC in the Netherlands and has been instrumental in the training, implementation and research on GANC in the Netherlands over the past decade. The survey was reverse translated from Dutch to English by myself to look for any gross errors of translation, although this technique is controversial, as it is may not pick up nuanced content failures. Of primary importance in translation is the use of translators who are familiar with the subject matter and research goals (Behr and Shisido, 2016). Furthermore the use of topic experts (such as Marlies) is also a hallmark of rigorous survey design, which when integrated as this was with systematic review

findings improves content validity and reliability (Gehlbach, Artino and Durning, 2010; Ziniel, McDaniel and Beck, 2019).

Survey Topics	**Research Questions informed by Systematic Review (SR) Gaps**
1. Characteristics of Midwives Facilitating GANC as part of usual care	• Description of midwives' way of working when facilitating GANC as part of usual care (e.g. # years as a midwife, work setting, work model, trained?)
2. Facilitation and Co-Facilitation	• How do midwives perceive their facilitation and co-facilitation experience? (e.g. how comfortable are they facilitating? With whom do they co-facilitate?)
3. Satisfaction	• Do midwives find GANC more satisfying than normal care? Questions around time and quality of care
4. What midwives feel women get from GANC	• Do midwives feel women can ask questions and disclose sensitive information in this model? Do they feel they give women more autonomy in this model?
5. Workload & Organizational support	• How do midwives perceive amount of work in GANC? Are midwives getting support they need from colleagues and organizations?
6. Professional role	• How do midwives facilitating GANC perceive their professional role?
7. Impact of Covid on GANC	• Did Covid stop GANC? If it continued what modifications were made?

Table 3: Research Questions informed by SR Gaps

3.4.2 Demographic Decisions

After much reflection, I decided not to include some common demographic questions in the questionnaire. The questionnaire does not ask midwives their gender, race/ethnicity, age, marital status or parenting status, all common demographic questions. Demographic data can be useful for comparing survey population to index statistics to see if a sample is representative, while the question of whether the midwives' that facilitate GANC are representative of all midwives in the U.S. or all midwives in the Netherlands could be an interesting one, it is not within the scope of my research questions. Systemic racism faced by Black and Brown midwives is extremely deserving of more research, and there are multiple questions to be asked and answered about the experiences of Black and Brown midwives with

GANC. Important work is being done in Black Centering[2] in the U.S., which will contribute to this topic, and my positionality as a White researcher made me cautious of considering these questions without a research collaboration that would foreground the voices of Black and Brown midwives and researchers[3]. Furthermore, the lived experiences of Black and Brown midwives with GANC deserve to be centered throughout the research design, and not reduced to a comparative variable. Similarly, the experience of male or transgender midwives is not to be discounted, however the number of male and transgender midwives working in the U.S. and the Netherlands is small (Cronie *et al.*, 2019; Bly *et al.*, 2020). The experience of those midwives working in GANC might be more appropriate to a phenomenological methodology outside the scope of my own research questions. It was potentially ethically problematic to collect demographic data that I did not intend to engage with in a meaningful critical fashion, particularly given that collecting demographic data can produce discomfort and thus should be done only when essential to a research question (Petkovic *et al.*, 2019). Furthermore, when developing survey categories for ethnicity and gender in diverse global contexts, a careful anti-racist approach should be applied, one that recognizes that race/racism cannot be reduced to a variable and recognizes that quantitative data has historically been used to reduce concepts to a binary nature that furthers inequities (Gillborn, Warmington and Demack, 2018; Mukharji *et al.*, 2020). These decisions were reviewed with my research supervisors before testing the survey.

The survey did collect demographic information pertinent to the research question, including country where participants worked, questions related to work setting and work model, years of midwifery experience, GANC training experience and number of groups facilitated. This is presented in the survey findings in Chapter 6 Table 6.

3.4.3 Survey Testing

The survey was tested for question logic and clarity, length, ease of access and readability with midwifery students of a Masters' module on GANC as well as colleagues at the Centre for Maternal and Child Health Research. Feedback was incorporated into the questionnaire prior to submission to research ethics. The translated survey was then tested for flow and clarity on another bilingual midwife from the Netherlands who works for CenteringZorg, the Dutch GANC training institute.

[2] Black Centering is GANC facilitated by Black midwives and other professionals for Black families in Alameda County California and in conjunction with work at the University of San Francisco, California

[3] There appears to be minimal reporting in English on Black or Brown midwives in the Netherlands, Cronie et al (2019) doesn't include ethnicity in their survey of midwifery satisfaction. As progress is made in decolonializing research, more work on considering the impact of racism on midwifery satisfaction is clearly needed.

3.4.4 Sample Population & Survey Distribution

The survey was distributed to midwives who had facilitated GANC in the U.S. and the Netherlands where GANC models have been integrated on some level into routine care. November 2022 marked a decade of GANC in the Netherlands and the CHI, which acts as training and resource center for providers working in group care models in the U.S. has been operating since the late 1990s.

Locating a purposive sample population of midwives who had facilitated GANC required a variety of survey distribution techniques. The U.S. and the Netherlands both have organizations (CHI and Centeringzorg) which act as training and resource centers for providers working in group care models. Both organizations train midwives and other non- midwifery professionals, (i.e. GPs, junior doctors, clinic staff, maternity nurses) in the Centering model, however the CHI does not maintain a separate database per professional type, so on recommendation of the organization, the approved recruitment text and a link to the Qualtrics survey was posted to their CenteringConnects message board, which is an online bulletin board accessible by professionals and staff medical practices that are registered with the CHI. As the focus of this research was on midwives, the survey was also distributed via email to all the midwives attending the annual meeting of the American College of Nurse Midwives in May of 2021 (N=1,408); however, we do not know how many of these midwives were trained in GANC and/or have facilitated or are currently facilitating GANC. A snowball sampling technique was also used by sharing the survey link with midwife consultants of Group Care Global, a U.S. based global consulting organization started by Sharon Rising, who were then encouraged to pass it on to any eligible midwives who were facilitating or had facilitated GANC in the U.S. The communities of midwives working in this model of care are often familiar with other midwives working in this way, hence this additional approach to sampling seemed appropriate.

The approved recruitment text and Qualtrics link to the Dutch language survey (which had an option for midwives to complete in Dutch language or the original English) was posted on the Dutch Royal Midwifery Association (KNOV) website as well as distributed by email to the midwife list maintained by the Centeringzorg. Centeringzorg maintains contact with the midwives until they have completed three initial group sessions, and partners with KNOV in an effort to send out questionnaires to determine if the midwives trained did start up their own groups, however the organization states these numbers are not regularly updated (M. Rijnders 2021, personal communication, June 2021).

3.4.5 Survey Administration

The survey link was distributed to midwives as described above in April of 2021 in the United States and September of 2021 in the Netherlands. After receiving the link via email or Centering Counts message board, the participant clicked on the link which brought them to a survey consent page and screening questions (see Appendix 2.2). The survey was open in the U.S. from April 13 (when it was first posted to the CenteringConnects message board) to July 5, 2021 and from September 1-30, 2021 in the Netherlands. The difference in length of time that the survey was open may have affected response rates, although the majority of the recruitment for the U.S. survey happened at the end of May with the ACNM annual meeting email recruitment. In both countries participants received three reminders as described in the recommended practices to improve response rates.

3.4.6 Strategies to increase response rate

Whilst there are some clear advantages to electronic surveys (low cost, ease of distribution,) response rates to electronic surveys can be low, and have been posited to be decreasing, particularly among healthcare providers who have many competing demands on their time (Fan and Yan, 2010). Strategies that have been identified to mitigate low response rates include follow-up and monetary incentives. Those midwives who were contacted via email by ACNM or CenteringZorg were reminded two days after initial survey distribution and again two weeks later, as this has been demonstrated to increase completion rate (Hutchinson and Sutherland, 2019). The survey completers were entered in a prize draw for an electronic gift card worth £75.00, although there is conflicting evidence on incentive amounts , it is clear that incentives, including prize draws, increase response rates (Laguilles, Williams and Saunders, 2011). Qualtrics allowed for embedding of the prize draw anonymously into the survey by directing the participant to a second survey and the winner was then selected at random from those participants who wished to be included. The electronic gift card was purchased and distributed through a system called Tango that is valid in the U.K., the U.S., and the Netherlands. City, University of London approved use of this electronic gift card. Given the varied methods of distributing the survey through both professional organizations' emails, posting on websites and local contacts, the exact number of midwives who facilitate GANC and saw the survey is unknown and therefore a response rate could n be calculated. It is interesting to note research that suggests that non-response bias is less of a concern with surveys of healthcare professionals than among the general population, insofar as studies of response bias have shown the characteristics of responders and non-responders to be more similar with healthcare providers than with general population studies (Flanigan, McFarlane and Cook, 2008; Cooper and Brown, 2017). However, a high response rate remains ideal. Surveys done in Scotland and Australia

of midwives' attitudes around caseloading have had response rates ranging from 70-80% (Turnbull *et al.*, 1995; Hollins Martin *et al.*, 2020). Recommended best practice in the event of the inability to calculate a response rate is to look at completion rates and compare them to the ratio of participants who clicked on the initial consent page to get an overall participation rate (Eysenbach, 2004).

3.4.7 Analysis

The Qualtrics data was downloaded into SPSS. Data cleaning then performed and new variables created or re-coded to allow for descriptive statistics (measures of central tendency, measures of dispersion and variability) to be produced in SPSS to describe the experiences of the study population. The survey analysis plan is attached in Appendix 2. The databases from the Netherlands and the U.S. surveys were then also combined to look for any association between the satisfaction variable and other potentially relevant variables.

The MPQ, which was included as a measure of professional role attitude, is comprised of four subscales (see Table 4). Cronbach's alpha was calculated on the MPQ as it had never been used in a group care context, although it has been used with continuity caseloading models. Although alternative methods of scoring have been published, I scored it according to the original authors' instructions (Turnbull *et al.*, 1995; Hollins Martin *et al.*, 2020). Negatively worded items (marked below with an asterisk) were reverse scored, and all items in each subscale were added together and averaged. 0 was considered a neutral attitude to that domain. Scores below 0 indicated a negative attitude and above 0 a positive attitude.

Table 4: Midwifery Process Questionnaire	
Professional satisfaction subscale	• Generally speaking, I am satisfied with my current role as a midwife. • I feel I am in a rut*. • I feel frustrated with my current role* • I have enough opportunities to make decisions about care. • I have limited opportunities for professional development* • I am confident that I have the skills for my current role.
Professional support subscale	• I have enough time to give women the care they need. • I get professional support from my midwife colleagues. • I get enough support from other clinical colleagues (e.g. GPs and obstetricians). • There is not enough time to do my job properly*. • My current role is very stressful*.
Client interaction subscale	• My current role allows me to provide women with choice about their care. • My current role allows me to plan care with women. • I need greater scope to provide women with information about their care*. • I have limited opportunities to provide women with individualised care* • I have limited opportunities to provide continuity of care*
Professional development subscale	• I have enough professional independence. • I have few opportunities to develop my skills as a midwife*. • I have plenty of opportunities to further my professional education. • I lack professional support from my managers*

Table 4: Midwifery Process Questionnaire used with permission (Turnbull et al.*, 1995)*

Text responses were uploaded into Nvivo. Responses in Dutch were coded in the original Dutch and also translated with Google translate and back translated by me Responses were analysed thematically using Nvivo12 software (Braun & Clarke, 2006).

3.5 Mixed Methods Part Two: The Interviews

Qualitative research is an essential tool to add meaning and deepen our understanding of survey findings and to provide a richer context to the lived experiences of midwives' day to day reality working in GANC models. Strategic sampling of nurses has been used in the U.S. and Canada effectively to produce robust data through experiential interviews (Bourgeault et al., 2010).

3.5.1 The insider/outsider interviewer: positionality and reflexivity revisited

In-depth interviews can take several forms, all of which have value to the research question; however, a unifying factor of the qualitative interview is the interplay between the researcher and the interviewee. Whilst my position as a midwife researcher, and one who has facilitated GANC inevitably coloured and influenced the communication, there was both practical and theoretical value to bringing insider knowledge to the interview. Familiarity with the concept of GANC made establishing rapport easier and facilitated a responsive interview style which in turn hopefully enabled trust and allowed participants to more authentically share thoughts and feelings (Larkin, 2013). It was also in line with my epistemological understanding of knowledge as created contextually and collaboratively between the researcher and the participant (Bourgeault et al., 2010). Being an insider/outsider facilitates access and credibility, however it is essential to carefully consider the ethical implications of that access, which will be further covered in the ethics section of this chapter. Another concern that is ever present in interviews is the dynamic of social desirability bias, which can be further influenced by knowledge that the researcher is also a midwife(Green and Thorogood, 2018). In order to maintain rigour and quality, and to manage the inherent biases and challenges presented by being a midwife researcher it was essential to continue to be transparently reflexive throughout the course of the research (Burns et al., 2012; Larkin, 2013). To maintain that reflexivity, I kept a research journal with my observations and reflections throughout the interview and analysis process, as well as having benefited from the regular input from and discussion with my supervisors.

3.5.2 Development of the Interview Topic Guide

The survey findings discussed in Chapter Six influenced the development of the interview questions and the approach to the interview topic guide, in a somewhat mirrored fashion to the way in which the survey questions were informed by the findings of the systematic review. The survey findings

highlighted a need to probe what exactly midwives found satisfying about GANC, what elements of GANC made it feel like more work, and also to unpick the discrepancies on organizational support findings between the systematic review and the survey (see Table Four and Chapters six and seven for findings).

Interview Topics (Full Topic Guide see Appendix 4.3)	**Survey Topics & Findings that warranted deeper probing in interviews**	**Research Questions informed by Systematic Review (SR) Gaps**
Background in GANC: how you came to be a GANC facilitator? A memorable group?	1. Characteristics of Midwives Facilitating GANC as part of usual care : Survey Findings highlighted satisfaction and workload as areas to be explored; was there something about experience of pathways to facilitating GANC or experience of groups that flagged up certain characteristics of midwives that influenced these areas?	• Description of midwives' way of working when facilitating GANC as part of usual care
Describe collaboration or co-facilitation experience in GANC Describe Facilitation Challenges	2. Facilitation and Co-Facilitation: Survey Findings showed facilitation & co-facilitation mostly viewed positively and happened with many type of professionals; What elements stood out? What did it bring to the experience	• How do midwives perceive their facilitation and co-facilitation experience? (e.g. how comfortable are they facilitating? With whom do they co-facilitate?)
Describe personal and professional benefits and challenges of working in this model?	3. Satisfaction : Survey showed high satisfaction; What elements? Personal? Professional? What is NOT satisfying about GANC	• Do midwives find GANC more satisfying than normal care? Questions around time and quality of care
Describe impressions of the workload associated with GANC?	4. Workload & Organizational support : Survey findings indicated midwives found it more work but had adequate organisational support in contrast with SR-interviews unpick this further	• How do midwives perceive amount of work in GANC? Are midwives getting support they need from colleagues and organizations?

Has working in this way changed the way you approach midwifery care? How does being a midwife affect how you approach this type/model of care Are midwives ideal providers for GANC?	5. Professional role : Survey findings show positive mean midwifery process professional role scores: what influences does midwifery have on GANC and GANC on midwifery	How do midwives facilitating GANC perceive their professional role?

Table 5: Interview Topics Linked with Survey Findings and Systematic Review Gaps

A very loose semi-structured approach was used as it was logical fit for the explanatory mixed methods design of this study. Care was given to a logical organization of the topic guide to maximize the natural flow of the discussion and to appropriate prompts and probes (Bourgeault et al., 2010). The interviews did have something of a narrative flow as some of the first questions asked the interviewee to relate how they came to be a GANC facilitator, followed by asking them to describe a memorable group facilitation experience. The interview topic guide and interview schedule is located in Appendix 4.1. and 4.2.

Interviews produce "language data about beliefs, behaviour, ways of classifying the world or about how knowledge is categorized." (Green and Thorogood, 2018, p. 103). Clearly language is an essential component that must be given careful consideration, particularly in not assuming common understandings, and seeking further clarification. This is another area where the impact of insider/outsider status must be carefully considered and moderated by the researcher.

Interviews aim to produce data about what a participant thinks or feels, and if I am consistent in our application of pragmatist thinking that our experience form our consciousness, then they provide valuable reflections of midwives' experiences.

3.5.3 Recruitment and Sample Population

Forty-Eight of the U.S midwives (38% of n=125) and forty-five of the Dutch midwives (45% of total n=101) who returned the survey entered their details and agreed to be contacted for a follow up interview. All of these midwives were sent a recruitment email, which was sent out in English to the U.S. midwives and in English and Dutch to the midwives in the Netherlands. All the midwives in the

Netherlands were given the option of conducting the interview in Dutch with a translator present (the same midwife who translated the survey) via Zoom at whatever date and time was most convenient to them. Twelve American midwives and nine Dutch midwives agreed to an interview, all the Dutch midwives agreed to be interviewed in English. Any participant that expressed interest in an interview was sent the Participant Information Sheet for review. When interviews were scheduled, they were sent the consent form. Most midwives interviewed preferred to have the consent form read to them and verbally agreed and recorded e-consent following recommended e-consent procedure, some signed and returned a scanned consent document (Skelton *et al.*, 2020).

Sample size determination in qualitative research is often informed by principles of saturation, or principles of information power (Malterud, Siersma and Guassora, 2016). Each midwife who had facilitated GANC, given the aim of the study, provided additional information power. Practically, I intended to conduct ten to fifteen interviews with American midwives and ten to fifteen with Dutch midwives, although after five American interviews, not only similar themes but very similar sentences and words were emerging, which was notable given the different locations and contexts where the midwives worked. Not only was this experience repeated after five Dutch interviews, but the first Dutch interview echoed themes and words from the American interviews. Special efforts were made to recruit midwives who had diverse experiences of GANC or experiences that were not concordant with the dominant themes emerging from the interviews. I obtained amended ethics to reach out to the colleagues of a Dutch midwife who mentioned her colleagues had contrasting experiences to her own outlook on GANC, but received no response to my attempts to reach them. I enquired of every midwife I interviewed if they could refer me to anyone they knew that did had negative experiences of GANC, but received only vague referrals and was unable to locate any of these midwives.

3.5.4 Interview Procedure & Flow

Interviews were conducted via Zoom video conferencing with the exception of two interviews which were conducted in person with midwives who lived in close proximity to my home in the U.S. and who happened to be known to me through local midwifery association work and education and training activities. They were recruited through survey and email in the same process as the other midwives. The in-person interviews were conducted in the midwives' homes following local guidance on Covid-19 protocols and City University of London guidance on in-person field work. The time needed for the interviews varied from twenty-seven to sixty-six minutes. All interviews were audio recorded and contemporaneous notes were also made.

I was very conscious that the Dutch midwives were conducting interviews in a second language, and so extra time was given for responses and frequent check-ins for comprehension and re-phrasing. I speak German which is closely related to Dutch and I can read Dutch (albeit very slowly) so occasionally if there was a word that the participant didn't know in English, or which didn't have a good English equivalent, this word would be said in Dutch or placed in the chat in Dutch and noted for the transcription process later.

3.5.5 Analysis

Framework analysis was chosen for this interview data as the mixed methods approach, that started with a qualitative systematic review had produced a thematic framework (see section 4.3.2) which supported the survey analysis plan. Next the quantitative and qualitative findings from the short answers section of the survey further supported the development of a framework for the interview analysis. The interviews were analysed using a modified framework analysis approach using a combination of deductive coding from the survey findings and interview topic guide and inductive open coding. When the interviews were completed, the steps of framework analysis were covered as follows (Gale *et al.*, 2013);

3.5.5.1 Transcription

Two interviews were independently transcribed and then compared with the audio transcription using Nvivo transcription software to compare each approach for rigour and accuracy. As the transcription software was found to be reasonably accurate, the remaining interviews were transcribed using Nvivo transcription software and then attached to the audio files in Nvivo12; they were then checked for transcription errors and corrected in Nvivo. In certain instances, there was not a good English translation for the Dutch word used by the Dutch midwives, and I chose to leave the Dutch word in place as the meaning was clear.

3.5.5.2 Familiarisation

In order to familiarize myself thoroughly with the interviews, I listened to each interview once through before the transcription process. I then listened to the interview again during the transcription checking/editing. I then read through the completed transcripts as a set before coding.

3.5.5.3 Coding

Coding was an iterative process that began with line-by-line coding of the first four transcripts (two Dutch, two American) and then moved on to grouping into categories and then themes to inform the analytical framework. An "other" code was kept open at all points in the process and regularly

reviewed to identify descriptive or category codes that didn't fit in with the analytical framework. Whilst coding, I paid special attention to use a disconfirming lens, to apply correction where possible to my own inherent biases discussed in the positionality portion of this chapter.

3.5.5.4 Developing an analytical conceptual framework

After the first four transcripts were coded, an analytical framework was developed based on meaning making and interpretation of the findings (see Appendix 4.3). This framework also integrated codes and concepts from the systematic review and survey findings, as the meaning emerging from the first phases of research served to inform the interview phase. Throughout the development of the framework, the context of midwifery was centered, and emotion and intent were considered along with the content of the interview. The framework was then reviewed with my supervision team and further modifications were made. Figure 5 shows an example of points of intersection between the systematic review, the survey and the interviews within the theme of support.

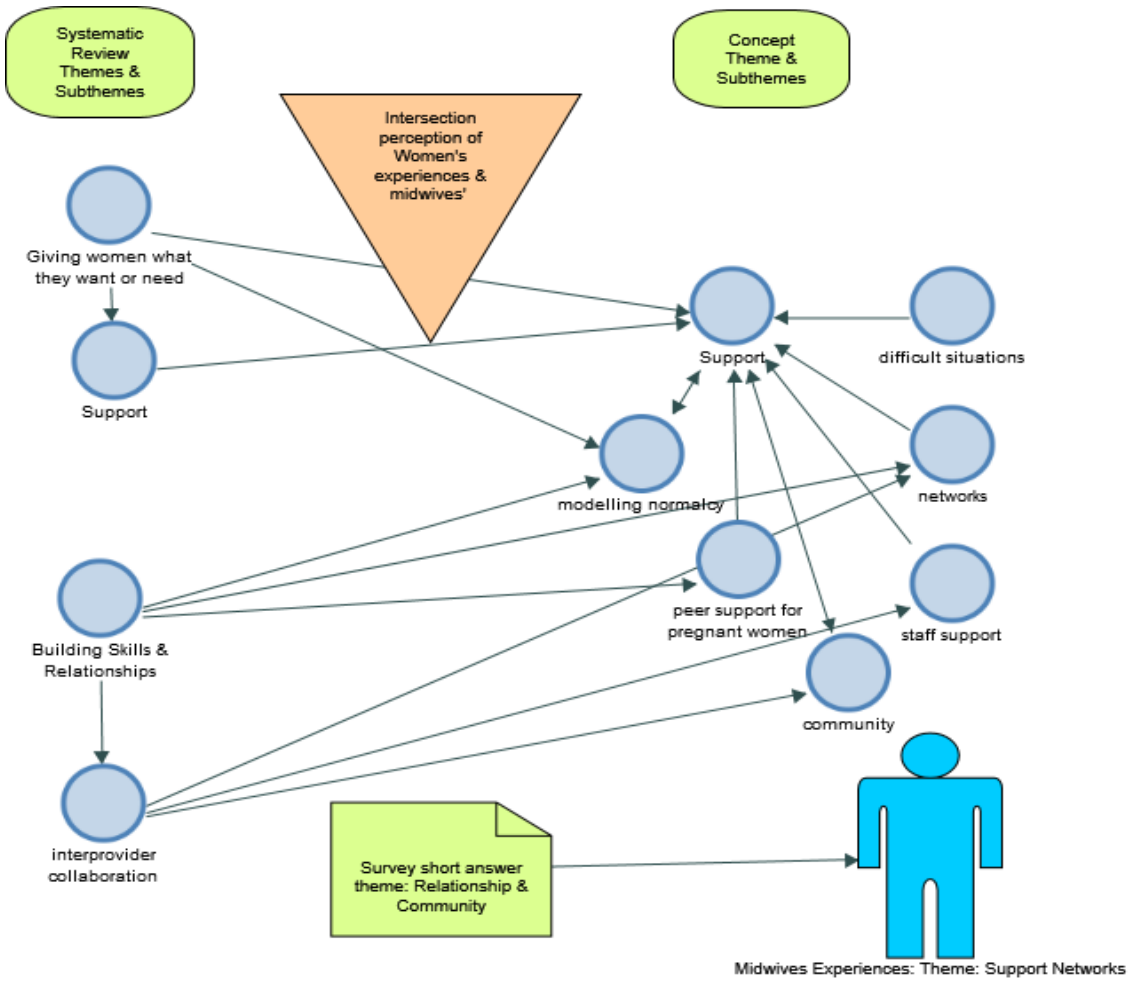


Figure 5: Sample of Integration/Intersections in Framework Codes

Sample Framework Code with subtheme nodes

Support	Codes related to support and community
community	
difficult situations	
modelling normalcy*	*crossover with codes from SR findings
networks	
peer support for* pregnant women	*crossover with codes from SR findings
staff support	

3.5.5.5 Applying the analytical framework, charting and interpretation

The remaining interview transcripts were then read and coded into the framework, leaving open an 'other' category for any content that did not fit.

3.6 Integration in Methods and Analysis

Effective integration of quantitative and qualitative methods is hallmark of effective mixed methodology design and analysis (Plano Clark, 2019). Figure 6 highlights the points of integration throughout the methods design and the analyses.

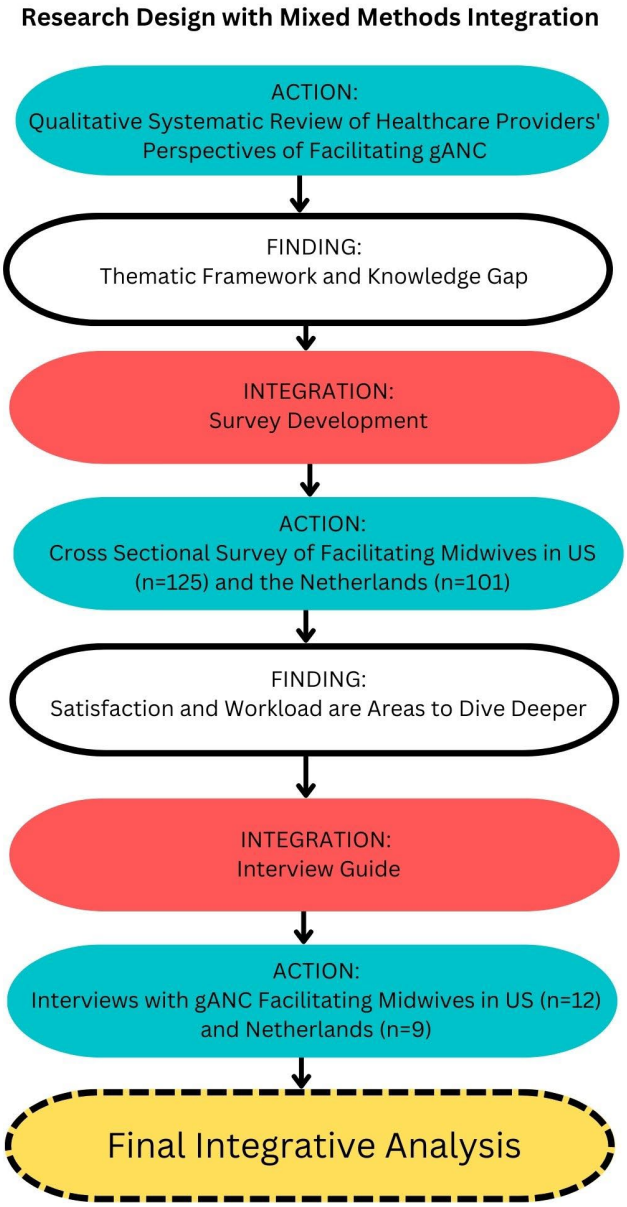


Figure 6: Research Design with Mixed Methods Integration

3.7 Ethics Considerations

3.7.1 Survey

An application for ethics approval from City, University of London School of Health and Psychological Sciences for the survey was submitted and approved and is attached in Appendix 2.1. Amendments were made to the original submission to allow for translation into the Dutch language and this was also approved. This ethics approval was then submitted and approved by the American College of Nurse Midwives prior to the distribution of the survey to their annual meeting participants. It was also reviewed by the manager of the CenteringConnects message board prior to posting to their membership. Survey research is dependent upon public trust and care must be given to maintain that. It is made more difficult in an era in which false information and internet scams are commonplace. This is moderated by some degree through use of trusted professional and personal midwifery networks. Ethical considerations in survey research include consent, data protection, careful consideration of the emotional impact of questions (Joe et al., 2021). The survey was carefully anonymized, so that even those midwives that chose to leave their information to participate in the raffle or be contacted for follow up did so through an embedded link, which allowed them to feel confident in responding honestly on the survey. It can be difficult and emotional for midwives to respond honestly, particularly regarding quality of care or job satisfaction, given the societal and legal pressures of risk and blame and the culture of putting a brave face on difficult situations. Confidentiality can ease some but not all of these concerns. Respectful consideration should also be given, in the era of "attention-economy" media barrage, for the time of overworked midwives.

3.7.2 Interviews

Ethics approval was also obtained and granted for the U.S. interviews through City, University of London School of Health and Psychological Sciences. The U.S. and the Netherlands did not require separate do not require separate ethical approval for research on health professionals and so the interviews in the Netherlands were conducted under the ethical approval of City, University of London.

There are also ethical considerations to asking colleagues to help you recruit participants for your study, as it may place them under an unwelcome sense of obligation. However, for others, familiarity ensures a safer communication space and allows people to say no. I paid special attention to language, phrasing and non-verbal cues (such as not responding to emails) to avoid giving any impression of professional obligation.

When conducting interviews with midwives there are also ethical considerations around time burdens and sensitive questions. At each interview I expressed my deep gratitude for the midwife's time and I genuinely felt it, as a midwife. As discussed earlier, insider/outsider dynamics were also at play. I had intended to rely upon my researcher hat to provide reassurance of neutrality (while also being personally reflexive about the impossibility of true neutrality). However, my anxiety about the ethical dilemma of disclosing my experience as a midwife and with group care proved by and large unnecessary. I did not disclose my midwifery experience in my introduction, but if a question or clarification arose and the interviewee asked, I always answered honestly, and the reaction was always a positive acknowledgement of our mutual common conceptual understanding and appeared to make the participant feel she could keep telling her story without having to clarify terminology or procedure that would have taken her away from her main discourse. It is possible that this assumption of tacit understanding could have deprived me of some explanation that could have contained further useful data, but I am not certain, as some interviews proceeded from start to finish without any questions for me about my background, beyond a deep interest among the American midwives as to what it was like to study for a PhD in the U.K.

3.7.3 Data management, handling and security

In accordance with ethical and legal guidance, all survey and interview data (consents and interviews) are securely stored on a password protected One Drive account. The survey data collected in Qualtrics was anonymized, with the exception of those midwives who followed the embedded link and agreed to be contacted for the follow up. Midwives had the option to leave their contact information if they wanted to receive a copy of the findings, or to participate in the prize draw, or to participate in a follow up interview. Only the minimum necessary identifiers were retained for contacting participants. The data will be archived and destroyed following the City, University of London's data archiving policies. Reports will be fed back to participants that wish to receive them.

Conclusion

This Chapter outlined the design and methods for the study, describing the rationale for the explanatory mixed methods design and relationships between the different parts. It described the methods used and highlighted potential limitations and mitigations and ethical considerations in conducting the research. I reflected on my positionality as a midwife researcher, my feminist pragmatist paradigmatic approach to the mixed methods design, and the considerations needed to ensure the

study would be robust. The next chapter will present the systematic review of providers experiences facilitating GANC which was the first step in the research design and was published in *Reproductive Health* in 2021.

Chapter 4: Systematic Review of Qualitative Evidence: Healthcare Providers' Experiences Facilitating GANC

Introduction

The following is a systematic review of healthcare providers' experiences of facilitating GANC. The GANC model and the existing evidence around GANC was first introduced in section 2.8 and 2.9. It is reintroduced and explored further in the following section 4.1, the background to this review. The purpose of this review was to establish what evidence existed and identify gaps in the research around midwives' experiences of facilitating GANC. A version of this chapter has been published in Reproductive Health (Lazar *et al.*, 2021) and is attached as Appendix; however, I have chosen to include the more detailed version here as part of this thesis for two reasons. Firstly, editorial recommendations for the findings section of the review article renamed the third theme, however the original name, Worth the Work, For Whom? links more clearly to the survey and interview questions. Secondly, the ability to include more textual detail strengthens the argument for the next research phases, the survey and interviews presented in Chapters Six and Seven.

4.1 Background

Prior to undertaking a systematic review of providers' experiences of GANC, it is useful to consider what is known more broadly about the model. As discussed in Section 2.9 (GANC) models have been recognized by the WHO as a health system innovation that may help achieve the global goals of a positive pregnancy experience for every woman and an end to preventable maternal deaths by improving access, attendance and continuity and quality of care (World Health Organization, 2016b).

Typically, GANC models provide clinical risk assessment, education and support (the essential elements of antenatal care) in a group setting of pregnant women with similar gestational ages, and the care is facilitated by the same healthcare provider throughout the pregnancy course. Where resources allow there are two group leaders, one of whom must be a clinical antenatal care provider, and this is most often a midwife. The most widely researched model of GANC, Centering® Pregnancy, was developed by a midwife and outlines 13 essential elements to successful GANC, and has been implemented in the U.S., Canada, Australia and the Netherlands (Centering Healthcare Institute, no date). It has also been adapted to meet the context and needs of low- and middle-income countries (LMICs). Other bespoke models have been developed in both high- and low-income countries. Globally, all models tend to include a relatively stable group of pregnant women meeting in a group space,

performing self-assessment checks and having extended face-to-face time with a provider in a facilitative fashion that prioritizes peer-to-peer learning and support (Cunningham, Lewis, *et al.*, 2017; Sharma, O'Connor and Jolivet, 2018; Wiggins *et al.*, 2018). GANC visits follow the national standard antenatal care schedules, yet allow women 15–20 face-to-face hours with the same antenatal care provider as opposed to the current traditional care average of two and half hours of time with a provider (who may not always be the same) (Tandon *et al.*, 2013; Byerley and Haas, 2017; Cunningham, Grilo, *et al.*, 2017b; Rising and Quimby, 2017; Grenier *et al.*, 2019; Musabyimana *et al.*, 2019).

Since the first pilot GANC programmes began in 1994, research has shown that women like this model of care. High satisfaction is demonstrated across multiple studies in high-, middle- and low-income countries (particularly among vulnerable populations), and attendance rates are higher than with traditional antenatal care (Gaudion *et al.*, 2011; Tandon *et al.*, 2013; Cunningham, Grilo, *et al.*, 2017b; Grenier *et al.*, 2019; Hunter *et al.*, 2019; Musabyimana *et al.*, 2019). In addition to being a satisfying model of care, the outcomes for mothers and babies in GANC are at a minimum comparable in outcomes to traditional care models, and some studies have shown that GANC improved birth outcomes, in particular among African Americans and Latinas in the U.S., as well as in trials in Iran, Nigeria and Kenya (Jafari, 2010b; Heberlein *et al.*, 2016; Mazzoni and Carter, 2017b; Patil *et al.*, 2017; Eluwa *et al.*, 2018; Grenier *et al.*, 2019a; Berge *et al.*, 2020).

Although the original conception of GANC had midwives leading, there has also been interest and research on physician-led groups (Benediktsson *et al.*, 2013; DeCesare and Jackson, 2015; Ghani, 2015; Sharma, O'Connor and Jolivet, 2018). There is no published literature on groups led by other healthcare or social work professionals at this time. The model also provides a unique opportunity for interprofessional collaboration, particularly in the case of women with complicated conditions or in under-resourced areas where community health workers play an important outreach role (Hodgson, Saxell and Christians, 2017; Sutter *et al.*, 2019).

As provider buy-in is essential to successful implementation of GANC (Pekkala *et al.*, 2020), and as it is recommended that two clinical professionals lead group care models, and given the endorsement of midwives as recommended antenatal care providers globally (Sakala and Newburn, 2014), the question arises; who is currently providing GANC and what has been their experience of providing this innovative model of care? A Cochrane review by Catling et al. (Catling *et al.*, 2015) attempted to look at provider satisfaction and found no data with which to examine their question. Several articles have examined provider views on GANC as part of pilot or feasibility studies. Where providers are presented

with information and demonstrations of the model, they seem enthusiastic about the possible benefits of the model but also highlight potential personal and professional obstacles (Andersson, Christensson and Hildingsson, 2014; Ghani, 2015; Jolivet *et al.*, 2018).

GANC has been the subject of research for over two decades now and given the global pivot towards midwifery models of care and continuity of care, as well as the context of global maternity care staffing shortages and evidence of dissatisfaction and burnout among care providers with current ways of working (Hunter *et al.*, 2018), a systematic review foregrounding providers' insights on facilitating GANC is timely. The aim of this review is to explore the experiences of the providers who have themselves facilitated GANC, as their input is a critical component in further successful expansion and integration of GANC.

4.2 Methods

The protocol for this review was registered in PROSPERO, reference CRD42020171848.

4.2.1 Searching

After consultation with a health sciences librarian, searches were performed by JL in seven databases: Cinahl, Medline, Psychinfo, Embase, Ovid Emcare, Global Health and MIDRS. Hand searching and the Scopus database was used to identify further citations from relevant publications, in addition to a complete review of the bibliographies of the Centering® Healthcare Institute and Group Care Global. OpenGrey was also reviewed for any pertinent grey literature. The search was date limited from January 1990 through April 2020 to correspond with the development and implementation of group care models. Search terms chosen related to GANC, healthcare professionals and experiences. Search terms are listed in Appendix 2.1.

4.2.2 Screening

Inclusion and exclusion criteria are listed in Table 4. Papers were included if they contained qualitative data relating to the experiences of healthcare providers facilitating GANC or group antenatal plus postnatal care; this included mixed methods studies as well as qualitative studies. GANC was defined for the purposes of inclusion as any antenatal care with a clinical component that comprises more than four women meeting in a group. As the focus of this review is on the experience of facilitating GANC, reviewers excluded papers in which it was unclear whether the participants had facilitated

	Inclusion	Exclusion
Participants	All healthcare providers who have facilitated GANC where GANC is defined as: defined as any antenatal care with a clinical component that includes more than four women meeting in a group.	Studies of GANC with no health care provider views and perspectives Studies where it cannot if the participants themselves facilitated the GANC will be excluded
Phenomenon of interest	The focus will be on the experiences and perspectives of health care providers (physicians, midwives, nurses, allied health professionals) who have been involved with facilitation of GANC (GANC) models.	Any studies which describe the experience of women with their health care provider in group antenatal settings will not be included unless it is described from the HCP point of view
Outcomes	This review will seek to understand the experiences of health care providers as it pertains to the acceptability, feasibility, and sustainability of group models of care in diverse healthcare systems	Outcomes related to women
Study design	Study must have a qualitative component Mixed method studies that include a relevant qualitative component in the findings	Studies collecting data quantitatively only.
Study focus	Studies should focus on experience of facilitating/participating in GANC	Focus on women
Setting	All countries	None

Table 6: Inclusion and Exclusion Criteria

groups themselves (the reviewer contacted study authors where possible to make this determination); studies in which providers speculated on facilitation of GANC; and studies that did not report experiences from the viewpoint of the healthcare provider.

The search and screening process followed the Prisma guidelines. (See Fig. 7) All retrieved studies were imported into Refworks for deduplication and then into Rayyan software for screening (Ouzzani *et al.*, 2016). One reviewer (JL) screened by title and abstract for relevance to the review topic, and 20% of those were double screened by a second reviewer (LBR) to ensure reliability. The full texts of all relevant studies were screened by both JL and LBR against the inclusion criteria, and conflicts regarding inclusion were resolved in consensus with two other members of the review team (CMC and EO).

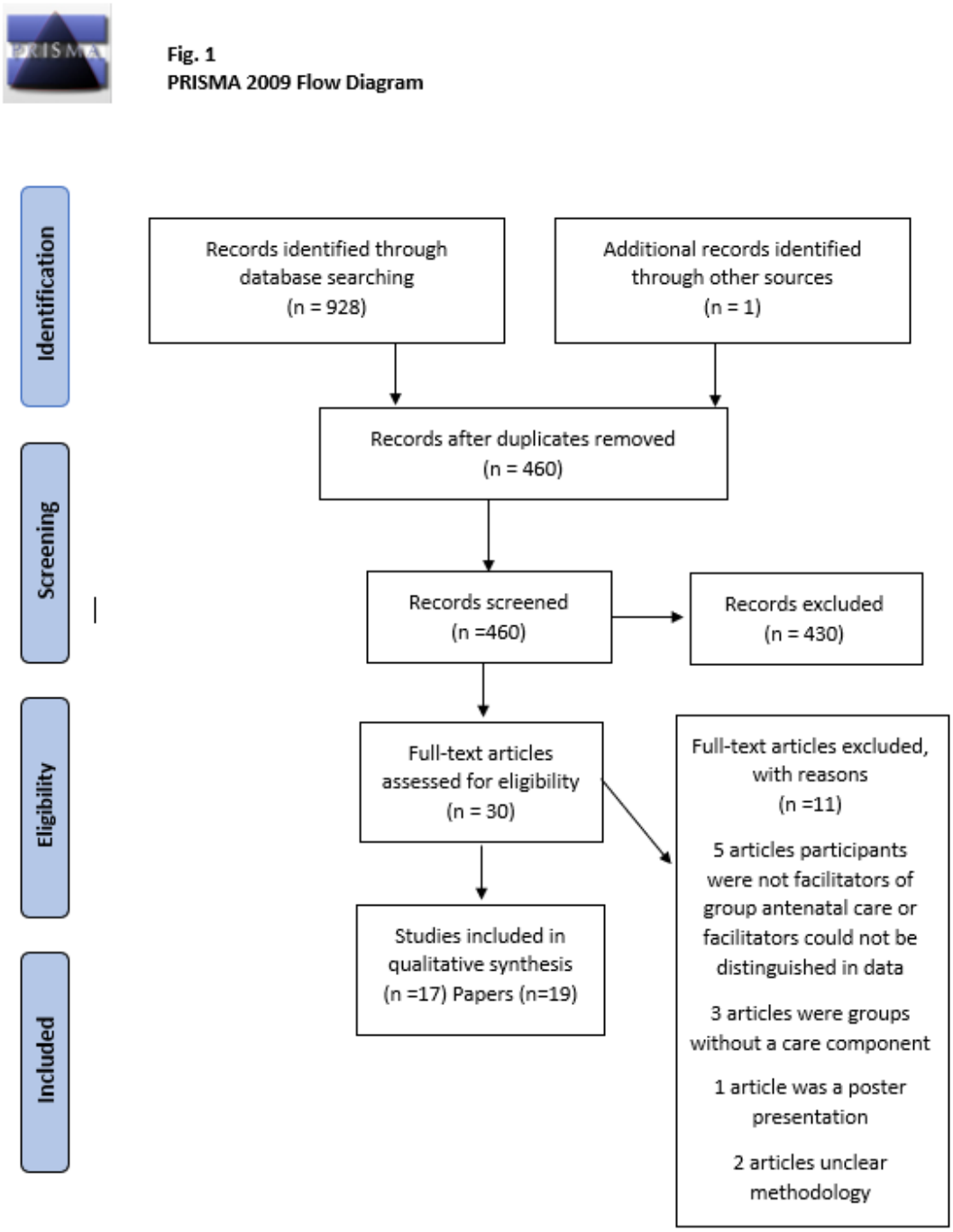


Figure 7: Search Statistics Prisma Flow Diagram

4.2.3 Quality Appraisal

The methodological rigour of all included studies was appraised using the Critical Appraisal Skills Programmeme tool for qualitative research. Reviewers (JL, LBR, CMC) independently rated the papers

high, medium or low quality and discussed and noted discrepancies, but study quality did not exclude papers from the review as there was rich data to be found in some studies of lower quality. CMC was not involved in any evaluations of her own publications.

4.2.4 Data Extraction

See Appendix 2.3 for data extracted from each study. This included study author and date, type of participant health care professional (e.g. physician, midwife), study location, study design and methodology of qualitative data collection, and key findings (with particular reference to experiences of providers).

4.2.5 Data Analysis and Synthesis

The full text of the results section, including participant quotations verbatim, was uploaded into NVivo 11 software. Then following Thomas & Harden's (Thomas and Harden, 2008) approach to thematic analysis, the results section of each study was coded line by line and descriptively by one reviewer (JL), and then organised into subthemes that had reciprocal meaning across studies, whilst attempting to preserve faithfulness to the experiences of participants in the individual studies (Walsh and Downe, 2005) and taking care to include meanings that refuted one another(Noblit and Hare, 1998). The organization of the subthemes into overarching themes then pushed the analysis beyond translation into interpretation in order to add new concepts and meaning whilst remaining aligned with the original findings (Thomas and Harden, 2008). The themes and subthemes were discussed amongst three reviewers (JL, CMC, EO) to ensure accurate reflection of individual study findings and maintain relevance to the aims of this review.

4.3 Results

4.3.1 Included Studies

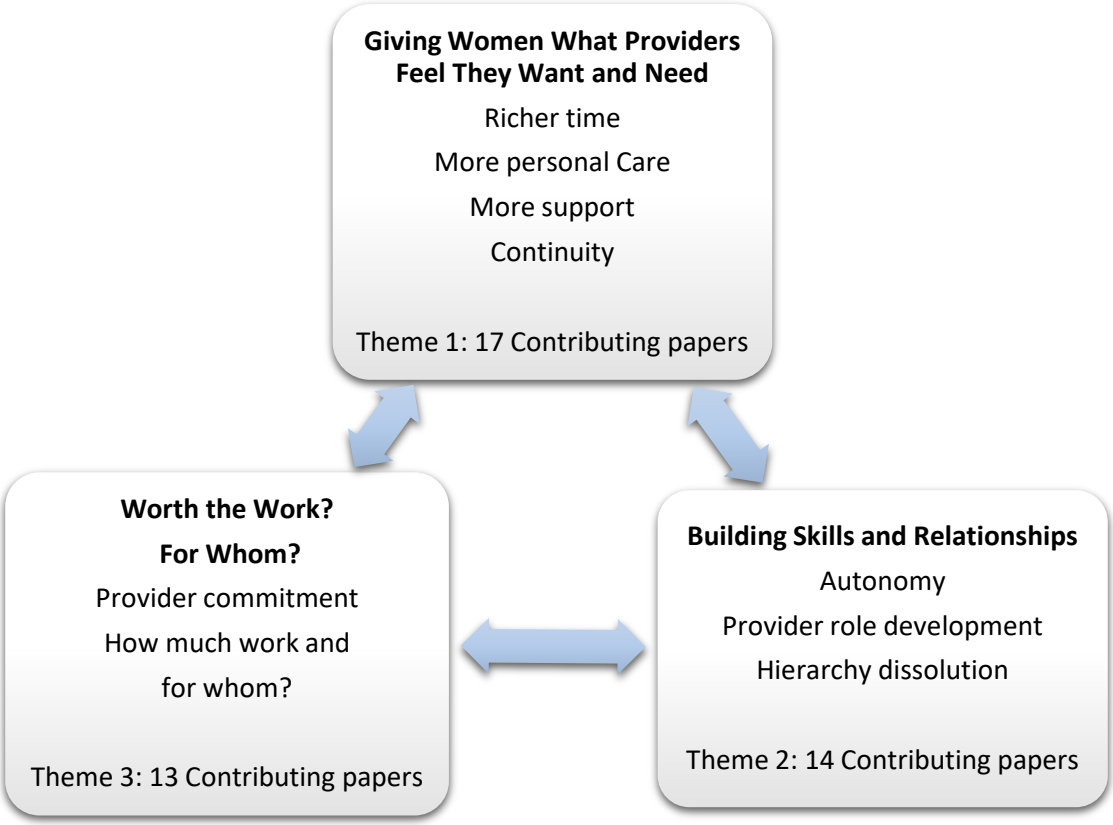
A total of 928 studies were identified through electronic database searching with an additional study identified through hand searching of citations. After duplicates were removed and screening was completed (see Fig. 7), 19 papers from 17 studies were included. Five papers were from LMICs and the remaining studies were from high-income countries. Two papers were personal reflections of midwives conducting group care; 10 papers were pure qualitative research; and the remaining papers were mixed methods analysis that included a qualitative component. In Rwanda, Nepal and one of the U.S. studies, the qualitative analysis was conducted alongside a cluster RCT. Eleven papers were assessed as being

high quality, one as medium-high quality, six as medium quality and one as low quality. The low-quality paper was a personal reflection of an Australian midwife's direct experience of facilitating GANC and thus, although lacking methodological rigour, was clearly relevant to the research question. The vast majority of the facilitating providers were midwives (n=133); in the Rwandan study, both midwives and nurses (n=59) were facilitating and no distinction was made between them in the focus group discussions. The other providers facilitating included three family practice physicians, five perinatal educators and four family support workers. Two papers mentioned ancillary medical staff (qualifications not specified) and obstetricians. In some cases, it is unclear from the papers what facilitative role, if any, the medical staff and obstetricians had (Novick *et al.*, 2013, 2015). In seven studies midwives co-facilitated with other midwives (Baldwin and Phillips, 2011; Teate, Leap and Homer, 2013; McDonald *et al.*, 2014; Allen, Kildea and Stapleton, 2015; Barnes and Stuart, 2016; Craswell A. Kearney L. Reed R., 2016; Lori, Munro and Chuey, 2016), sometimes from academic backgrounds or different disciplines, and in one case with the aid of a support nurse. In one study physicians facilitated with perinatal educators (McNeil *et al.*, 2013; Vekved *et al.*, 2017). In two studies midwives or nurses worked with community health workers (Lundeen *et al.*, 2019; Thapa *et al.*, 2019). In two papers midwifery students were involved in the facilitation process(Maier, 2013; Craswell A. Kearney L. Reed R., 2016). The remaining studies had either no co-facilitator or did not describe a co-facilitator. Some mentioned ancillary medical staff or programmeme staff but didn't specify their training or participation in the facilitation process (Klima *et al.*, 2009; Wisanskoonwong, Fahy and Hastie, 2011; Novick *et al.*, 2013; Patil *et al.*, 2013; Novick *et al.*, 2015). (See Appendix 2.3)

4.3.2 Qualitative Themes

Three overarching themes emerged from the analysis of provider experiences with facilitation of GANC. Firstly, the experience of providing the elements of care they know women want; secondly, the experience of skill building and role change; and thirdly, the theme entitled 'Worth the work? For whom?' addressing provider commitment and workload.

Figure 8: Themes arising from the review



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4.3.3 Giving Women What Providers Feel They Want and Need: the satisfying experience of giving women personalized, supportive, high-quality care

In a GANC model, providers experience the opportunity to offer women many of the attributes of care that influence their uptake and satisfaction with antenatal care.

> "Now due to this programme pregnant women are also enjoying it a lot. Now pregnant women come and ask us, 'When are we coming for our next checkup? When are we going next?' They ask this and then when they get to sit in a group … Now they don't have the 'aa, why do we need to go for checkup?' kind of mentality." –Community Health Worker in Nepal (Thapa *et al.*, 2019, p. 10)

> 'Providers uniformly related that women who participated in group care were happier and seemed to want to come for prenatal care. They stated that women also appreciated not having to wait for their visits, a common issue in this crowded clinic.' –Clinicians in the US (Klima *et al.*, 2009, p. 30)

The following subthemes describe providers' experiences of providing care that women want through the richer use of time, more depth in the time allotted, more personalized care, more supportive care and continuity of care.

4.3.3a Richer use of time

An adequate quantity and quality of time in antenatal care has repeatedly been identified as a key component of what women want, and what providers themselves often feel they lack. In this review, providers repeatedly commented on the ways in which the time was spent in GANC was more productive (Novick *et al.*, 2012). The richer use of time was facilitated by decreased repetition and the ability to achieve more educational and personal depth of care in the time allotted in group care as compared to standard antenatal care (McNeil *et al.*, 2013; Patil *et al.*, 2013; Teate, Leap and Homer, 2013; Lori, Munro and Chuey, 2016). The restructuring of provider hours with group models afforded providers more time to deliver higher quality care.

> "In our regular clinic…sometimes we're kind of rushed and moving pretty quickly and so [I like]

> to just feel like we can sit down and get in depth with people. … I like that. … I'd rather have a thick novel than a one paragraph of a magazine article." –Physician in Canada (McNeil *et al.*, 2013, p. 4)

4.3.3b More personalized care

Providers appreciated that the extra time spent in discussion in GANC models allowed them to assess women's knowledge and better meet their needs, in some ways offering care that is more personalized than in standard care.

> "…facilitating midwives felt that GANC enabled them to be truly 'with woman', building up trust and rapport over multiple encounters and addressing social, emotional, and clinical needs: It's not one-to-one but honestly, I can remember all of the women's names and you can't really say that for when you are in an antenatal clinic and all the women come in and out, you don't remember them." –Midwife in the U.K.(L. Hunter *et al.*, 2018, p. 61)

In addition to getting to know women better, GANC allowed providers more possibility to tailor their care and listen and respond to feedback from numerous women and other providers. The additional opportunities to ask and answer questions invested the time spent with richer education and support around pregnancy and parenting (Klima *et al.*, 2009; McNeil *et al.*, 2013; Lundeen *et al.*, 2019). Midwives also commented that the increased feedback and communication made their jobs faster and easier (Lori, Munro and Chuey, 2016).

4.3.3c More supportive care

> Providers facilitating GANC appreciated the peer component as a vital element that engendered a supportive environment, normalized the pregnancy experience and enabled health behaviour changes.

They witnessed the creation of a community and saw transformative support for young or vulnerable members and bonding between women with the exchange of personal details and valuable information that filled important knowledge and support gaps (McNeil *et al.*, 2013; McDonald *et al.*, 2014; Lori, Munro and Chuey, 2016).

> "…sometimes there's sort of synchrony in the life issues that the women are having in terms of relationships, particularly with their partners. They teach each other and they teach me about

ways in which they are able to cope, and demonstrate some strength in their lives, no matter how chaotic sometimes it appears or how crazy it is." –Midwife in the U.S.(Novick *et al.*, 2012, p. 598)

Additionally, normalization of pregnancy as a healthy state in the presence of peers was identified as an important reassurance for women and a validation of provider beliefs (McDonald *et al.*, 2014; L. Hunter *et al.*, 2018). Maternity care providers identify the group setting as being an advantageous way for women to transition knowledge into healthy behaviours, where sharing experiences among peer experiences in the presence of a clinical facilitator was a motivator for health-seeking behaviour and health-promoting behaviours (Wisanskoonwong, Fahy and Hastie, 2011; McNeil *et al.*, 2013; Patil *et al.*, 2013; Vekved *et al.*, 2017; Lundeen *et al.*, 2019; Thapa *et al.*, 2019) .

"As for me, this group care programme has pleased us very much; you can even learn of this fact through much excitement of the group members. For us who lead group care, we can see it. You can see that mothers are thirsty for knowing all those new things. When you discuss with them and when you are making conclusions together with them, you find the members happy, and most of them wish never to miss out." –Midwife in Rwanda (Lundeen *et al.*, 2019, p. 6)

This final quote highlights the ways in which the benefits of providing more supportive care for women increases job satisfaction for providers.

4.3.3d Continuity of care

Continuity of care has been identified as a driver of improved outcomes for women and as an important element in women's satisfaction with their care. For providers facilitating GANC, the continuity of care delivery was an important benefit for women (Allen, Kildea and Stapleton, 2015), but also for students and the providers themselves.

"It contributes because they [students] won't see it in a hospital setting, they won't see a same group coming at the same time, on set dates…[the women] growing as a group and shifting in their pregnancies' how comfortable they are and sharing, hearing more than one person. So I think it contributes in changing their perception of what a pregnancy journey is…" –Midwife in Australia (Craswell A. Kearney L. Reed R., 2016, p. 419)

In another study, providers identified this continuity as contributing to patient safety and ease of follow-up as well as a sense of autonomy (L. Hunter *et al.*, 2018).

4.3.4 Building Skills and Relationships

The second theme to emerge from the data was that of experiences around skill-building and changes in the roles of providers and participants. Fourteen papers contributed to this theme, which is further explored in three subthemes: independence/autonomy, provider role development and hierarchy shifts.

4.3.4a Independence/Autonomy

Providers repeatedly commented on the increased independence/autonomy of the women in GANC. Notably, in the study of Rwandan nurses' and midwives' experiences facilitating GANC, the focus group participants described ways in which a key element of GANC, the self-checking component, improved care quality by shifting health surveillance tasks to women and allowing them to take more ownership of their care.

> 'Some providers admitted that the structure of group care visits resulted in an increase in routine assessments, especially blood pressure: "We didn't use to test blood pressure, and the effect resulting thereof could take the lives of many women. This test is very important. [In the past] it was very possible [we did not check blood pressure] even until she gives birth. They [group care participants] can test that blood pressure themselves because they already know how to do it. When they have tested one another and found out that there is one who has a problem, they inform the nurse, and the nurse can verify and provide due assistance to the woman having the problem before the situation becomes worse. Things have become very easy."' –Nurse or Midwife in Rwanda (Lundeen *et al.*, 2019, p. 10)

Physicians in Canada also commented on the ways in which women became more confident and knowledgeable through checking their own blood pressure and urine (McNeil *et al.*, 2013). In one study from the U.S., this independence was viewed differently:

> "Some staff complained that group prenatal care was 'spoiling' women for individual care

because they had 'become used to coming in, doing whatever they have to do for themselves and getting everything done instead of just sitting and waiting.'" –Clinician in the U.S. (Novick *et al.*, 2015, p. 469)

In addition to restructuring the task of health surveillance, providers identified the ways in which they found that GANC restructured health education and communication with women and between women.

"Seeing women so comfortable with themselves and me as a health professional was a new experience. … Compared with women experiencing normal midwifery practice in Thailand, the women in my antenatal groups were more independent and talkative. Women in Thailand are usually submissive and they generally do not have the confidence to take responsibility for their own health." –Midwife in Thailand (Wisanskoonwong, Fahy and Hastie, 2011, pp. 633–34)

Other midwives were moved by ways that participating women found coming to the group made them better mothers, and the ways that shifted the focus from the midwife to the group, or the ways GANC rebuilt trust in between providers and women in communities where these relationships were strained (Novick *et al.*, 2012; McDonald *et al.*, 2014).

4.3.4b Provider role development through facilitation and collaboration

The growth in independence and confidence in the women coincided with a shift in the role of the provider. The facilitative role was easier for some providers than others as it required providers to cede some control over what information was given and how. This was experienced by providers in the GANC model as a process of stepping back and experiencing a sense of release from some of the pressures maternity care providers experience in the delivery of antenatal care.

"It was mind-blowing just how much I could just sit back and allow the group to run itself and there was no pressure, it was just easy to facilitate this group…" –Midwife in Australia (Teate, Leap and Homer, 2013, p. e35)

The relational shift that occurred in a facilitative environment was described, as above, as a sensation of relaxation and, for many, it contributed to increased feelings of job satisfaction and provider well-being.

> "Most times you are chatting, you have a laugh, you are doing the work, you are accomplishing what you would do antenatal [sic] but there is a different sort of atmosphere. I find it is very relaxed." –Midwife in the U.K. (L. Hunter *et al.*, 2018, p. 61)

> "It takes a little bit of the pressure off of us as well to be kind of all things to everybody. To be their midwife and their best friend and their mother…it maybe defines our clinical role a little more clearly in some respects and takes away from some of that social role." –Midwife in Canada (McDonald *et al.*, 2014, p. 7)

Stepping back and giving control to the group are core distinctions between didactic and facilitative interaction. This letting go and trusting the group process was not an automatic experience for providers, as demonstrated in studies that examined the experiences of providers over the course of implementing the intervention (Baldwin and Phillips, 2011; Patil *et al.*, 2013; Teate, Leap and Homer, 2013). The fear of failing to deliver all the necessary information or being held solely accountable in a model that shares out responsibility was anxiety producing for some participants (Barnes and Stuart, 2016).

> "It was hard at first because…that lack of control makes you feel like, I don't know if they're getting the right amount of information and then I started to realize…who am I to decide what kind of information they really need?" –Perinatal educator in Canada (Vekved *et al.*, 2017, p. 129)

The following quote illustrates the experience of the challenges of facilitation for maternity care providers who have been trained to deliver prescribed antenatal care content. If that content is up for discussion, providers can feel that they lose control of the narrative.

> "It is impossible in a group to give what we give to people one-to-one because of the constraints of them [the participants] wanting to discuss it." –Family Nurse Partnership Midwife in the U.K. (Barnes and Stuart, 2016, p. 178)

Providers repeatedly acknowledged anxiety about the facilitation component of GANC. They

highlighted fears of being unprepared in the event the women in the group remained silent (Patil *et al.*, 2013; Teate, Leap and Homer, 2013).

As confidence in facilitation skills grew, providers experienced their groups with satisfaction. They learned how to create a comfortable environment, and use silence, encouragement, humour and guidance to create an optimal experience for participants where everyone felt equal and heard and the groups were able to create bonds and feel safe (Baldwin and Phillips, 2011; Vekved *et al.*, 2017; L. Hunter *et al.*, 2018, 2018). The result was that facilitation skills made providers feel more effective.

> "We normally do not have time to listen to such stories. We just give them instructions, do this, do this and do this… But, they don't do what we tell them… In such a discussion, they are learning and are able to see why we are saying [this]." –Midwife in Malawi (Patil *et al.*, 2013, p. 1195)

Another aspect of facilitating GANC that brought about new experiences was collaborating with other professionals. This inter-provider collaboration echoed some of the peer support benefits of group care for women and worked well in instances where providers were able to play off one another's strengths.

> "I learn from her [health service midwife] about the updates in clinical practice …she realises that we're from that evidence based [approach] and so she asks for that input. She says, 'Oh what's the latest thinking on this? And how do you think I could do that better?' It's more of a discussion." –Midwife in Australia (Craswell A. Kearney L. Reed R., 2016, p. 420)

However, inter-provider collaboration could be challenging for some.

> "…but I have to wear the hat of the hospital midwife not the community midwife. … there has been those moments … I haven't necessarily resonated with what the [other] midwife has said." –Midwife in Australia (Craswell A. Kearney L. Reed R., 2016, p. 419)

Inter-provider collaboration also allowed for a shift in professional hierarchies, which was the final subtheme to emerge under provider role changes.

4.3.4c Hierarchy dissolutions

GANC appeared to alter established hierarchies in antenatal care, those between pregnant women and healthcare providers and those between different ranks of healthcare professionals, such as physicians and perinatal educators or junior and senior midwives (Vekved *et al.*, 2017).

> "At the beginning I was 'absolutely petrified'. Now I feel so much more confident as a midwife. I have learnt so much. It didn't matter how junior I was to the rest of my colleagues who were also a part of it. You've created a relationship with them and we had fun you know, we laughed." –Midwife in Australia (Teate, Leap and Homer, 2013, p. e35)

> "I realized that if I wanted women to be empowered in relation to their own health, then I needed to avoid setting myself up as 'the expert' on everything. In order to build equal relationships in group discussion, then it might be best to wear normal clothes."-Midwife in Thailand (Wisanskoonwong, Fahy and Hastie, 2011, p. 633)

This hierarchy flattening was also experienced positively by providers in their relationship with the women in their groups. They found themselves more approachable and sensed the women as more open and more confident in the value they contributed to groups, and more likely to access services they might need (McNeil *et al.*, 2013; Patil *et al.*, 2013; Novick *et al.*, 2015; Lori, Munro and Chuey, 2016).

> "I am very much satisfied [with group ANC/PNC]. I would say that the success results from freedom. When we have come together, we sit and talk freely with those mothers whom we serve." –Nurse or Midwife in Rwanda (Lundeen *et al.*, 2019, p. 8)

The freedom in communication observed among midwives and women in the Rwandan study also occurred between midwives and managers.

> "I have learnt also to play a role in boldly speaking to the manager in favor of group care when elaborating the timetable. We shall inform them about how the group care activities are scheduled throughout the week so that they will provide room for the people trained to handle

group care and do that very job without having much work in other services." –Nurse or Midwife in Rwanda (Lundeen *et al.*, 2019, p. 12)

This quote illustrates both need and desire among providers to advocate for institutional time, space, staffing and support for GANC. It speaks to the third theme that emerged from this review, which can be expressed in the unasked question of whether this model of care is worth the work, and for whom.

4.3.5 Worth the Work? For Whom?

The third theme raised in the included studies related to how providers viewed the experience of implementing GANC, was it worth the work and who is affected by the work.

4.3.5a Provider commitment

Providers expressed their commitment to and enthusiasm for the model in the varied ways that they advocated for the programme, often in the ways they went above and beyond to make GANC succeed.

"They [clinicians] facilitated groups, solved logistical problems, did 'everything' that needed to be done, aggressively recruited women, advocated and 'tapped into every resource.'" – Unidentified Clinician Facilitators in the U.S. (Novick *et al.*, 2015, p. 470)

The majority of included providers expressed that their perception of the value of the programme for themselves rendered questions of workload secondary.

4.3.5b How much work?

Providers differed in their opinions of whether GANC reduced workload or increased it. While, as identified above, they found that the repetition was decreased and they had more time to dedicate to support, relationship building and in-depth education, learning a new model of care increased the work needed in preparation, particularly at the start of programme implementation (Teate, Leap and Homer, 2013; Craswell A. Kearney L. Reed R., 2016; L. Hunter *et al.*, 2018).

"In the beginning, it [GANC] created more work and the atmosphere was chaotic and stressful." –Midwife in the U.S. (Baldwin and Phillips, 2011, p. 214)

The work described fell into two categories, one involving the mental challenge of facilitation and the other being the physical and mental effort put into the structural functioning of GANC within a healthcare organization.

The workload was perceived as much more onerous in the presence of organizational barriers, such as in cases where staffing shortages didn't allow for a co-facilitator or a provider had to cover intrapartum and antepartum services simultaneously, or there was inadequate administrative buy-in.

> "Sometimes I felt, like, helter-skelter trying to do everything by doing this by myself, it's more work than one-on-one care." –Midwife in the U.S. (Novick *et al.*, 2013, p. 695)

In spite of their flexibility, enthusiasm and commitment, some providers experienced real challenges in this model of care. Most of the barriers were organizational: issues around scheduling, staffing, charting and following up labs, lack of support or recognition from colleagues or management, or generalized system dysfunction (Klima *et al.*, 2009; Craswell A. Kearney L. Reed R., 2016; L. Hunter *et al.*, 2018; Thapa *et al.*, 2019). These barriers led some providers to make untenable compromises or to abandon the model altogether (L. Hunter *et al.*, 2018). One clinician stated, "…the joy of doing groups is gone." (Novick *et al.*, 2013, p. 695)

With proper institutional support, most providers found the benefits outweighed the challenges, and several providers felt that GANC reduced their workload or made it easier by increasing confidence in women and reducing unnecessary pages or clinic visits (McDonald *et al.*, 2014; Lori, Munro and Chuey, 2016; L. Hunter *et al.*, 2018; Thapa *et al.*, 2019). Findings from Rwanda and the reflection of an Australian midwife indicate that the workload is more manageable when providers have more autonomy over their scheduling in GANC, as with case-loading models(Maier, 2013; Lundeen *et al.*, 2019). Adequate training in the model and facilitating was routinely appreciated by providers facilitating GANC(Baldwin and Phillips, 2011; Teate, Leap and Homer, 2013; Barnes and Stuart, 2016; Thapa *et al.*, 2019).

> "I'm very satisfied. It's hard work but good work, and I think we're seeing the rewards of doing it." –Midwife in Canada (McDonald *et al.*, 2014, p. 7)

4.3.5c For Whom?

Which women?

This review found that some providers who had facilitated GANC sensed a specific benefit to "my population" (Baldwin and Phillips, 2011, p. 215), whether that population was minority, adolescent, low income, low risk, or low education (Novick *et al.*, 2012, 2015; McDonald *et al.*, 2014; Lori, Munro and Chuey, 2016; Thapa *et al.*, 2019). In the pre-implementation phase of the REACH Pregnancy Circles study, providers felt Muslims might object to components of GANC, and yet after completion of the pilot, all the stakeholders felt that all women and their families would benefit from this care (L. Hunter *et al.*, 2018). Some providers implied that offering this model to vulnerable populations negatively affected attendance or made facilitation more challenging.

> "[Discussing] Weaning has been quite controversial; budgeting too as half the group work and half are on benefits, there was this political overtone." –Midwife in the U.K. (Barnes and Stuart, 2016, p. 178)

However, most facilitating providers did not comment on the appropriateness of GANC for specific populations.

Which providers?

The overall experience of providers with GANC as reported in the literature was a positive one across a wide variety of contexts and countries, from busy urban clinics to rural low-risk practices. Midwives, physicians, nurses and educators all reported enjoying this type of care delivery model. Speaking specifically about the experience of facilitating GANC, the words 'joy, fun, meaningful' were used repeatedly (Baldwin and Phillips, 2011; Novick *et al.*, 2015; L. Hunter *et al.*, 2018).

> "Group care was for me, a rewarding, enjoyable and far more effective way in engaging with women and families and to meet their educational support needs. I miss 'my' women and students greatly." –Midwife in Australia (Maier, 2013, p. 89)

"This Ibaruke Neza [group ANC/PNC] programme which is carried out in the groups made me like my job. Why is that? Clients have lovely and friendly interactions with nurses, they feel at ease when talking

with them." –Nurse or Midwife in Rwanda (Lundeen *et al.*, 2019, p. 10)

4.4 Discussion

The aim of this review was to examine the experiences of health care providers facilitating GANC. The review resulted in three major themes: 1) Giving women the care they want and need; 2) Building skills and relationships; 3) Worth the work? For whom?

While the included studies reflected heterogeneity of origin and methodology, there was notable concordance of experience across country and healthcare organizations. In all three thematic areas, data from high-income and LMICs were represented. The experience of giving women the care that providers feel they want and need was valued by GANC facilitators in every country context. Providers experienced building skills and relationships in Ghana and the U.K. (Lori, Munro and Chuey, 2016; L. Hunter *et al.*, 2018). The thematic question of whether GANC was worth the work and for whom was addressed by advocates in rural Nepal and in the urban U.S. (Novick *et al.*, 2015; Thapa *et al.*, 2019). The concordance reflected in these studies pertained to negative as well as positive experiences, with many providers from numerous countries, with differing health systems and contexts as well as resources for healthcare, experiencing anxiety around the facilitative component of group care and the organizational challenges around implementation of a new model of care (Baldwin and Phillips, 2011; Patil *et al.*, 2013; Novick *et al.*, 2015; L. Hunter *et al.*, 2018; Lundeen *et al.*, 2019). A key finding of this review was that, by and large, GANC offered a satisfying option for maternity care providers to give the kind of quality antenatal care they feel is best for women while simultaneously allowing them to develop their professional role.

Under the theme of providing care that women want, the subthemes the richer use of time, more depth in the time allotted, more personalized care, more supportive care and continuity of care are supported in the Cochrane review of women's views and experiences of antenatal care (Downe *et al.*, 2019). The experiences of time and continuity in GANC models likely engender the ability to offer more personalized, supportive care, as this has been reflected in research around case-loading midwifery models (Dixon, 2017). Case-loading time is described as 'purposeful, flexible, uncertain and personalized' (McCourt, 2009). These same words could easily be used to describe the facilitating providers' plan for each GANC session. While caseloading research demonstrates why close relationships between women and providers are important, the finding from this review that providers also experienced group care as 'individualised' (L. Hunter *et al.*, 2018, p. 61) is surprising and somewhat counterintuitive, given the focus on the group, and warrants further study.

Many echoes from literature around case-loading midwifery can be found in the experiences of the providers in this review, such as the fact that closer relationships with women, professional autonomy and social support appear to enhance providers' satisfaction (Sandall, 1997; Hunter, 2006). While the studies included in this review do not specifically address the question of whether or not providers experienced the groups as personally supportive, the findings of provider comfort and ease, in tandem with increased autonomy for the women and the providers, suggest ways in which GANC models could be protective of provider wellbeing. The facilitative nature of GANC may allow midwives to develop more of the relational reciprocity with women that many midwives are seeking (Hunter, 2006). Burnout among healthcare professionals has been linked to lower quality care, lower patient satisfaction and high staff turnover, which is of particular concern amidst global maternity care provider shortages (West, Dyrbye and Shanafelt, 2018; *Work, Health and Emotional Lives of Midwives in the United Kingdom: The UK WHELM study*, no date). Although there is a burgeoning body of literature around maternity care professionals' experiences of burnout and birth trauma, there is little evidence around the impact of antenatal care delivery on overall professional wellbeing (Elmir *et al.*, 2017).

Similarly, lack of opportunities around skill building and professional development have been highlighted as contributing to dissatisfaction among maternity care providers globally (World Health Organization, 2016a). The findings around the theme of building skills and relationships in this review support the concept of role development as a contributor to professional satisfaction. The subthemes of independence/autonomy, provider role development and hierarchy shifts suggest GANC offers new avenues for meeting WHO recommendations on task shifting in maternity care while also fulfilling expressed provider desires around greater professional self-determination (World Health Organization, 2016a, 2016b). It has been suggested that one contributor to disrespectful care of women in sub-Saharan Africa may be a desire by disempowered midwives to maintain social status through othering (Bradley *et al.*, 2019). In contrast, the findings in this review from LMICs suggest that providers facilitating GANC found the dissolution of hierarchies a positive experience for providers, raising research questions on the possible impacts of GANC on disrespect and abuse in maternity care.

The findings under the third theme, 'Worth the Work? For Whom?', raise important questions about the agency of individual providers (even very committed ones) to effect change in healthcare delivery. It supports recent findings from research that suggest that whilst successful implementation of group care models certainly need providers to be enthusiastic and satisfied, without systemic organizational-level planning and support, sustainability is threatened (Novick, Womack and Sadler,

2020; Pekkala *et al.*, 2020). Although this review has found a surprising number of similarities across country contexts, there is little doubt that, just as the providers in this review benefit from understanding and responding to the needs of the individual women in their groups, organizations implementing GANC would benefit from understanding and responding to the individual needs of their facilitating providers. This review did not have enough data to conduct a sub-analysis of provider experiences by provider type, so it is uncertain whether midwives' experiences were notably similar to or different from those of physicians, nurses or community health workers. Furthermore, some feasibility studies have focused on healthcare provider attitudes towards offering GANC models to specific populations, such as indigenous or immigrant groups(Ahrne *et al.*, 2019; Brookfield, 2019). A survey in Sweden raised interesting points on midwife attitudes regarding which populations they believed are most appropriate for participation in GANC models (Andersson, Christensson and Hildingsson, 2014), but these views have been speculative and did not contain data from providers who had actually facilitated groups. This review only included the views of providers who had facilitated groups, and while they clearly felt GANC benefited women, they did not state from their experience which groups of women they felt might benefit most.

The strengths of this review lie in the robust nature of the systematic search and the quality, quantity and diversity of the nature of the papers that met the inclusion criteria. Limitations include methodologic considerations of the included studies, such as a lack of clarity around defining the roles of study participants, a lack of researcher reflexivity in some included studies, and the possible impact of social desirability bias on the findings from interviews and focus group discussions evaluating GANC interventions. This is of particular concern in low-income country contexts where programmeme implementation may be dependent on external non-governmental organizational funding and participants may be wary that negative feedback could result in economic or political repercussions. The first author has experience as a midwife in GANC; in order to minimize associated biases, the researcher used reflexivity, disconfirming analysis and a diverse research team in analysis and synthesis.

Conclusion

This review of healthcare providers' experiences of facilitating GANC demonstrates benefits for providers of working within GANC models, specifically experiences of delivering responsive high-quality care that they feel is valued by women and is satisfying professionally. Skill building and interprofessional collaboration offer additional areas for provider growth. Whilst the

review demonstrated that there is now a significant body of research that includes experiences of providers facilitating GANC, most of the findings are drawn from research in the context of pilot project or feasibility trials. The experiences of the providers obtained in these pilots reflect the particular needs of new program implementation and evaluation research and may differ significantly from the views of providers who have been delivering GANC in systems where it has become a more routine health care option. The effort and change involved in undertaking a completely new way of working in antenatal care may yield different perspectives than those to be found among professionals who have adapted and integrated this complex intervention into their daily working lives. Further research in this area is therefore warranted to get a more complete picture of the provider experience of integration of GANC into a healthcare system. This finding informed the decision to focus the next phases of the work on countries where GANC was more established. The following chapter will provide an overview of midwifery and GANC in the Netherlands and the U.S. two countries where this integration of GANC has been adopted over a longer term, while chapters 6 and 7 will present the findings of the survey (chapter 6) and interview (chapter 7) studies with midwives in these countries.

5. Setting: An overview of Midwifery & Maternity in the US & Netherlands

Introduction

The U.S. in a relatively young country, and the Netherlands a very old one and in both countries the story of the age-old practice of midwifery has similarities and differences. This chapter provides a brief overview of the history and state of midwifery care in both countries, to contextualize and situate the findings from the experiences of midwives' providing GANC in the U.S. and the Netherlands. It concludes by discussing the implications of each country on GANC.

It can be argued that whilst there are certainly varying spiritual and cultural traditions surrounding midwifery in each individual community, much of history of midwifery in the U.S. and the Netherlands was essentially the same. In both countries, locally skilled women who identified as community midwives helped their neighbours and community members to birth. It should be noted that the indigenous peoples of the U.S. had their own long traditions of midwifery that pre-dated the arrival of the European colonizing settlers. The diary of Martha Ballard, a midwife in the American state of Maine, recorded from 1785-1812 was transformed into a prize-winning history, A Midwife's Tale because it gave such a compelling overview of life in early colonial communities of the new nation of America, as that life was so deeply intertwined with the life of the community midwife (Ulrich, 1991).

All of this changed with the professionalization of medicine and the advent of man-midwives and obstetricians, and their subsequent encroachment on the historically female spaces of childbirth. This change occurred in both the U.S. and Europe at the end of the 18th and beginning of the 19th Century. This time period coincides with the introduction of the use of forceps to expedite deliveries, and a shift from a birth space created and supported by female relations, neighbours, and a known local midwife, to a space dominated by an external expert wielding technology designed to compress the time spent in the birth event (McCourt, 2009). This is not to argue that an expedited delivery was not often a desired event by the labouring woman, but rather to consider the way the birth space and time were redefined by men. This is replicated in the development of standard antenatal care as a compressed time period in which to deploy surveillance technologies. Furthermore, it is to be mentioned that because birth was primarily a female space, male midwives and physicians were generally only invited in when complications had arisen, thus reasonably biasing them to consider pregnancy and birth through a pathological lens.

5.1 Regulation & Professionalization

The Netherlands

National legislation passed in 1818 and 1865 enshrined the profession of midwifery into Dutch law and also restricted midwives to the care of normal low complexity birth (van Lieburg and Marland, 1989). It may be that this relatively early delineation protected the profession from the same near complete professional obliteration experienced by midwives in the U.S.. Although midwives in the Netherlands did suffer through a period of having their reputations denigrated by competitive medical men in the latter half of the 19th Century, they were fortunate to have prominent allies in General Practice and Obstetrics who supported and endorsed midwifery as the standard of care for normal pregnancy and childbirth as well as legislation which protected them from competition (Rooks and Mahan, 1997). Furthermore, whilst the scope of midwifery practice is sharply delineated by a national list of pregnancy risk conditions that warrant referral, it is the purview of midwives and not obstetricians to enforce these boundaries (Goodarzi *et al.*, 2018).

Midwifery in the Netherlands also benefited from the early establishment of professional midwifery education programmes, which allowed lower- and middle-class women to pursue midwifery education. This also protected midwifery from some of the class wars that occurred during midwifery professionalization in the U.K. and the U.S., in which an upper-class cadre of well-educated nurses and midwives sought to distinguish themselves from the low class “ignorance” of the cadre of uneducated working midwives (van Lieburg and Marland, 1989).

The U.S.

The establishment of professionalized medicine took longer in the U.S. than on the European continent, owing in large part to the fact that the U.S. was primarily colonized by labourers and farmers and those seeking a better life than the one they had in Europe, hence there were very few physicians in early America. This allowed community midwifery to proceed unimpeded for a longer period of time, however once American medicine began to organise and form societies and medical schools, all of which were initially only open to men, male physicians, some of whom had travelled to Europe to acquire the latest medical skills, returned home and began to offer their services as an alternative to uneducated female midwives (Varney and Thompson, 2016). Offering chloroform and ether as pain relief, and forceps as a sign of medical progress, they quickly took over the birth sphere for rich women and came to be desired by most women. Simultaneously, under pressure from medical societies and physicians, states began to pass laws that made the practicing of medicine without a license a crime, and as there was only one school licensing midwives and that was only open for thirty years. Physicians

were aided in their crusade to end the practice of midwifery by well-intentioned public health nurses. The years between 1900-1930 were years of abysmal rates of U.S. maternal and infant mortality and, although this was later demonstrated to be related to a number of factors unrelated to the educational level of attending midwives, midwifery conveniently took the blame (Loudon, 1992; Varney and Thompson, 2016). Many of the acts that severely curtailed the ability of midwives to practice, such as the Shepard-Towner act, were in fact intended to put money towards laudable public health efforts to improve the well-being of mothers and children. They did however include provisions that secured the position of medicine and nursing professions at the expense of the profession of midwifery. Over the first half of the 20th century, the pileup of legislation aimed at regulating, registering and licensing midwives, effectively barring Black and immigrant midwives from practice, culminated in the 1959 legislation that stated that the practice of midwifery was the practice of medicine, essentially outlawing all midwives from practice in every state in the U.S. This ensured the demise of a long tradition of "grand" or "granny" midwives in the Southern U.S. Many grand midwives were descended from well-respected enslaved Black midwives and had preserved a long tradition of effective community midwifery, but had been shut out of nurse-midwifery training programmes. Whilst seven states now allow the practice of midwifery without a nursing license, in the other forty-three U.S. midwives practice under the Nurse Practice Acts in their states and require a nursing degree to practice midwifery.

5.2 Special Features of Maternity Care and Place of Birth

The Netherlands

It has been posited that the protection of midwifery, in addition to a national character that considers birth to be a private, physiological event, has allowed home birth (and, to a lesser extent, midwife-run birth centre birth) to remain a not uncommon option in the Netherlands, and fully integrated within the maternity care system. An interesting historical detail that might also have contributed to this is particularly high rates of puerperal fever in one of the largest Dutch lying-in hospitals in the early part of the 20th century, secondary to a medical director who was unconvinced of the value of asepsis (van Lieburg and Marland, 1989). Similar to what we have seen in the Covid-19 pandemic, there were women who declined to go to hospital as it was clearly safer at home. It should be noted however that the percentage of homebirths in the Netherlands has certainly declined over the last fifty years and is cited between 13-24% of women birthing at home, with a slight increase in homebirths noted during the Covid pandemic (Verhoeven *et al.*, 2022). Midwives from the Netherlands recognize that medicalization of birth is an increasingly significant factor in the Netherlands.

Midwives remain the primary providers of antenatal care, provided on a standard schedule of seven to thirteen visits (Seven visits became standard in Covid). Depending on the preference and needs of the pregnant woman, these visits can be in clinics or in the home of the pregnant person. If during the course of antenatal care the pregnant woman develops any condition that requires consultation with or transfer to obstetric care (based on the national list of medical indication) she will be referred by the community midwife to a higher tier of hospital-based care (Goodarzi *et al.*, 2018). She may return to primary midwifery care after appropriate consultation, when the risk-factor is no longer salient, or postpartum after a complex delivery. Thus some community midwives work in individual one-to-one caseloading models, others are small team caseloading practices, although there are larger practices that offer less intrapartum continuity (Offerhaus *et al.*, 2020). Dutch midwives also provide several home-based postpartum visits. Pregnant people also register with a *kraamzorg* agency, which supplies a visiting maternity nurse to help in the home with infant feeding, care and light housework post-delivery.

The U.S.

Although the Netherlands and the U.S. both have insurance-based healthcare systems, in the U.S. there is no universal access to healthcare, and insurance is predominantly privately financed, government funded care is only available to veterans and citizens of the lowest socio-economic status. Until recently, it was not uncommon for private health insurance plans to offer no maternity coverage at all. The vast majority of births in the U.S. occur in hospitals, and the vast majority of midwives working in the U.S. attend birth in hospital settings. Homebirth, having virtually disappeared, is back on the rise, particularly during and after the Covid-19 pandemic made the possibility of nosocomial infection in hospital a real risk for women and babies (Aragão, 2022). Homebirth, however, often occurs in a liminal "extralegal" space, secondary to the aforementioned legislation against midwifery, and the drastic push into hospitals in the first half of the 20th Century, and the fact that there is no straightforward mechanism for billing insurance for homebirth. The American Association of Birth Centers, which licenses birth centers in the U.S., has also reported a rise in birth center births (AABC, 2022). Long overdue attention to the dismal racial disparities in maternity outcomes for African American women has also fueled new support for midwifery care and out of hospital birth in order to improve outcomes.

Almost all antenatal care occurs in a clinic setting, generally over 12 visits and is provided by either an obstetrician or a midwife depending on the preference of the pregnant woman, but not all obstetric practices offer midwifery care, and the majority of antenatal care is provided by obstetrician-

gynecologists, although demand for midwifery care is growing. One six-week postnatal visit for the mother is generally covered by insurance, and newborn care is primarily provided by pediatricians and general practitioners. There are very limited postnatal home visiting services available for some indigent women.

5.3 Autonomy and Status

The Netherlands

Midwives in the Netherlands have maintained an autonomous and independent practice that is protected by law. Midwifery education in the Netherlands is four-year Bachelor's degree which is independent of nursing. The maternity care system in the Netherlands is comprised of three levels, primary care in community, where 72% of midwives work in independent solo or group practices, secondary care in hospital where the remaining 28% of midwives work and the tertiary system in which care for high-risk pregnancies is provided by obstetricians in hospital (Cronie *et al.*, 2019). As mentioned above, midwives have the authority of assessing risk factors and determining obstetric referrals; however, those referrals have been increasing over time, indicating a shift in definitions of normality, a higher proportion of older first-time mothers, and an influx of immigrants from countries with more medicalised views of birth (Amelink-Verburg and Buitendijk, 2010). Concerns about insufficient integration of the primary and secondary care system and the possible impact on perinatal morbidity rates have resulted in a move to rethink aspects of the communication and integration between midwives and obstetricians (van der Lee, Driessen and Scheele, 2016). As midwives are independent practitioners, they contract with the various national insurances to obtain fees for their services. The fee schedule for antepartum, intrapartum and postpartum care is standard and re-evaluated regularly by the national government. There is a supplement for caring for socio-economically disadvantaged women (Zondag, Cadée and Geus, 2017).

The history of midwifery in the Netherlands has not been free from power struggles with obstetricians, and even today midwives acknowledge that power imbalances and a lack of professional respect remain a concern for the quality of maternity care collaboration (van der Lee, Driessen and Scheele, 2016). However, by and large midwives in the Netherlands benefit from a longstanding tradition of autonomous practice and respect as compared to many of their European neighbours. The free choice of birthplace is valued in the culture and the ICM has its headquarters in the Netherlands, in part in recognition of the country's deep support for the value of midwives and midwifery care.

The U.S.

As discussed in the previous section on legislation, midwifery in the U.S. has struggled considerably for legitimacy since the early 1900s. The early enlistment of public health nurses in the campaigns to "sanitize" midwifery created both bonds and tensions between nursing and midwifery that persist to this day. The feminist movements of the 60s and 70s, which fought to reclaim women's control over reproductive freedom, the founding of the professional organization of the American College of Nurse Midwives, and the Midwifery Association of North America and most recently a convincing body of evidence supporting midwifery care as critical to improving America's shameful maternity care outcomes, have all served to strengthen the position of midwifery in the U.S.. However, it is a large country and medical and midwifery practice are largely governed by individual states, setting up a wide diversity in autonomy of practice for American midwives that is very dependent on geography (Rooks and Mahan, 1997; Varney and Thompson, 2016).

Currently there are three pathways to licensed midwifery practice in the U.S.. The first is the Certified Nurse Midwife credential, which requires a nursing degree prior to master's training in midwifery, which is recognized in all fifty U.S. states. The vast majority of CNMs work in hospital settings or in physician owned practices. Their autonomy is very much determined by the Nurse Practice Acts under which they are licensed in their individual states, over half of which require regular supervision of an Ob/Gyn, as well as signed and updated collaborating agreements. Certified Midwives are master's prepared midwives who have entered their midwifery education without a prior nursing degree. CMs and CNMs sit for the same certifying exam, however the CM credential is only recognized in seven states, and the total number of CMs in the U.S. is less than 150, whereas there are almost 13,000 CNMs. CNMs and CMs are trained in reproductive health across the lifespan, primary care, antepartum, intrapartum, postpartum care and newborn care. They also hold prescription authority. The Certified Professional Midwife (CPM) has a different educational path (apprenticeships or certificate programmes) and certifying exam, however these also conform to ICM standards. They may practice in twenty-eight states and are primarily independent practitioners in home birth or birth centre settings (American College of Nurse Midwives, 2017).

Equitable reimbursement for midwifery services is complicated in the U.S. by the fragmented health care system. A large percentage of those the CNMs and CMs tend to care for are women and families on state funded insurance for the poor (Medicaid) and the reimbursement for the global cost of maternity care by Medicaid is often less than the cost of the antenatal care alone. They also contract with a wide variety of private insurance companies and they often work in physician-owned practices

where productivity models of care require them to see a high number of women each day in order to be profitable to their practice. CPMs may not always be covered by insurance as homebirth remains a legal and insurance grey area in certain states in the U.S.

The combination of a capitalist system of healthcare financing and the historical tensions between Ob/gyns and midwives can be deleterious for the expansion of midwifery practice in the U.S. As most midwives cannot practice without the approval of ob/gyns, power imbalances are built into the system. Furthermore, there have been struggles for unity among midwives with a nursing background and those without, which date back to early efforts to align nursing with medicine and alienate midwifery. These internal struggles reinforce the findings of studies globally which illuminate that midwives experience horizontal violence which may spring from internalized oppression (Kirkham, 1999).

In spite of the forces working against midwifery in America, the outsider status has acted to benefit the members of the profession by developing strong midwifery leaders, a tradition of legislative advocacy, entrepreneurial spirit and innovation. Efforts to unite the profession and enact federal legislation to promote and protect midwifery, coupled with burgeoning public support for midwifery care as a safe and smart solution to American's maternity care crisis has encouraged many American midwives to be continue to hope for a more midwifery friendly environment in future.

5.4 Implications for GANC

While midwives in the Netherlands and the U.S. practice in very different maternity contexts, they share some core characteristics that arise from different histories. The marginalized nature of midwifery in America has fostered an independent spirit and a willingness to envision care delivery outside of the mainstream, hence it is not surprising that GANC in its most popular form was conceived by an American midwife. Simultaneously, midwives working in the Netherlands have a long tradition of independence and the autonomy to try new ways of working with relatively little bureaucratic interference as they work mostly in community settings. Furthermore, midwives in both countries have a committed belief in midwifery models of care and offering women choices, this has been a central tenet of midwifery care in the Netherlands and commitment to this philosophy is what has allowed midwifery to survive in an often-hostile environment in the U.S.

This core midwifery dedication to offering and improving quality maternity care options supports GANC implementation and research in both countries. In the three decades since its inception in the U.S., GANC has expanded and evolved within that context. The establishment of the CHI, which

trains and accredits health professionals in GANC has resulted in numerous long-running GANC programmes. Much of the early research on CP was conducted in the U.S., and recently with heightened attention to racial and socio-economic disparities in pregnancy and birth outcomes, there has been renewed interest in and research on GANC as a potential solution to entrenched inequities. Research in the U.S. supports that GANC increases satisfaction among participants, particularly among adolescents, refugees and migrants and others at risk of poor pregnancy outcomes, however challenges remain among recruitment and retention(Tandon *et al.*, 2013; Heberlein *et al.*, 2016; Cunningham, Grilo, *et al.*, 2017b; Francis *et al.*, 2019).

In the Netherlands, which first implemented CP a decade ago, participants were also highly satisfied with the model and quality of care (Rijnders *et al.*, 2019). CP programmes have had success engaging migrant communities through GANC, with a goal of improving outcome disparities for immigrants in the Netherlands (Hesselink and Harting, 2011; Rijnders *et al.*, 2019; Bernard van Leer Foundation, 2022) A study of participant characteristics and attendance showed that CP participation showed low participant attrition in the CP group, however it didn't focus on the north of the Netherlands, where pregnancy outcomes are poorer and women have refused CP because of a variety of psychosocial barriers (Feijen-de Jong *et al.*, 2022).

The U.S. and the Netherlands have arguably made the most progress in integrating GANC as an option alongside standard care outside of a research context. In the U.S. this has happened primarily with support from federal and state dollars allocated for funding clinics or practices that care for low-income populations, and also often employ midwives, whereas in the Netherlands the spread has been a result of entrepreneurship and interest of community-based midwives.

These differences in the systems also have implications for midwives facilitating GANC. In the U.S. midwives are often very dependent on the collaboration and support of physician colleagues, health system administrators and insurance companies to implement new care models. However, as they are frequently salaried employees of physician or hospital own practices, rather than independent business owners like midwives in the Netherlands, they have less personal financial risk if a new antenatal care model does not succeed. Midwives in the Netherlands are already functioning in a system that does not necessarily view birth as a pathology, and thus maybe more open to GANC's physiological focus. However, their strict system of risk stratification may make it impossible for them to offer GANC to a diverse group of participants. Meanwhile, in The U.S. the dominance of midwives with a nursing background may impact their approach to facilitation, given that nursing has a very hierarchical structure and patient education is often accomplished didactically.

Given the primacy of midwifery care in the Netherlands maternity care system, and the success of Centeringzorg in training midwives in GANC, it is interesting to note that there have been no published studies of midwives' experiences working in this model in the Netherlands. Three of the four papers from the U.S. included in the systematic review of providers' experiences facilitating GANC were largely focused on CP feasibility and implementation and the fourth paper interviewed midwives prior, during and just after their training as GANC facilitators. Hence, this thesis will be the first examination of midwives' experiences facilitating GANC in the Netherlands and the first in the U.S. where the focus is on the experiences of the midwife with the GANC model more than the implementation of the model.

Conclusion

Midwifery in the Netherlands and the U.S. have had quite divergent paths, with early regulation and education in the Netherlands cementing an autonomous and respected midwifery environment to this day. The U.S. had a near complete decimation of its midwifery workforce, through restrictive legislation and defamation and competition with obstetrics. However, through a combination of tenacity, alliances with nursing and the continued demand of women and families for midwifery care, it has survived and has opportunities to thrive in a new climate of evidence supporting midwifery's role in improving maternity care outcomes. Midwives in both countries face challenges relating to medicalization of childbirth and continued promotion of safe and satisfying maternity care, and midwives in both countries have led the implementation of GANC as an alternative to standard antenatal care, albeit in different healthcare contexts. The next chapter discusses results of a cross sectional survey of midwives' experiences of facilitating GANC in the U.S. and the Netherlands

6. Survey Findings: More Satisfying and More Work

Introduction

This chapter presents the findings from the self-administered cross-sectional online survey distributed in the U.S. between mid-April and early July of 2021 and the Netherlands in September of 2021 to a purposive convenience sample of midwives with experiences of facilitating GANC, with a view to collecting experiences from a wider population of midwives working in countries with an established GANC model. Completed surveys were submitted from 184 midwives in the U.S. and 113 from the Netherlands. After data cleaning and screening, which involved the removal of participants who stated they had no experience facilitating group care (n=49 US/n=5 NL) or who had less than 80% of responses completed (n=8 US/n=7 NL), and 2 responses were removed for not being based in either the U.S. or the Netherlands,the final survey response number for the US was 125 and 101 for the Netherlands.

The findings are organised by topic area and each topic area addresses research questions raised by knowledge gaps or further original questions raised following the systematic review of providers' experiences facilitating GANC (see section 3.4.1. Table.) The topics covered are: characteristics of midwives facilitating GANC as part of usual care, GANC Facilitation and Co-facilitation, Satisfaction, What midwives feel women get from GANC, Workload, Professional Role and Covid Findings. Thereafter, the qualitative text responses are presented by thematic analysis, and the chapter concludes with a summary of findings. Consistent with the mixed methodology of this thesis, the discussion of survey findings, strengths and limitations is covered in an integrative fashion in Chapter Eight.

6.1 Characteristics of Midwives Facilitating GANC as part of usual care

This section addresses characteristics related to the way midwives work in GANC as part of usual care. Published literature on GANC offered limited description of the working characteristics of midwives facilitating GANC. This section addressed research questions such as how many years of midwifery experience did the midwives facilitating GANC have? Were they trained in GANC and how many groups had they facilitated on average? What was their work model and setting? Did they offer intrapartum continuity?

The range of midwifery experience among respondents was wide (3-42 years with a mean of 17.19 in the Netherlands and 1-41 years in the U.S. with a mean of 19.43 years). 68.8% (61) of U.S. midwives and 45.5% (46) of Dutch midwives in the sample had facilitated more than ten antenatal care groups, reflecting

that the midwives sampled were experienced GANC facilitators (see table 5). There was an interesting divergence in the number of midwives currently facilitating GANC, in the Netherlands 72.8% (75) midwives were currently GANC facilitators compared to 31% (39) of U.S. midwives. This may reflect the impact of the Covid-19 pandemic, but this could not be determined from the data. As demonstrated in the tables, the majority worked in urban settings. 51.2% of U.S. midwives and 94% of Netherlands midwives worked in caseloading models, highlighting systemic difference in the integration of midwifery model of care in the two countries, discussed in Chapter 5.2. It is interesting to note that 89% (US)-99% (NL) provided at least some intrapartum continuity to their GANC participants, although almost none of the participants provided intrapartum care to all their participants. Whilst antepartum continuity is a core element of GANC, intrapartum continuity is not pre-supposed, yet almost all the sampled midwives experienced some intrapartum continuity in this model.

98% (99) of NL and 92% (115) of US facilitating midwives had completed GANC training. Whilst most midwives in both countries chose to be GANC facilitators (Table 5), almost twenty percent of U.S. midwives were assigned to their facilitator role by a supervisor. Those that chose "other" as an option specified that they had initially come to it through a research project, or starting the programme themselves, or as part of maternity or holiday cover for colleagues.

Table 7: Characteristics of midwives facilitating GANC as part of usual care

	US (n=125)	NL (n=101)
Mean Years Midwifery Experience	19.4	17.2
% Trained in GANC Facilitation	92.0	98.0
% working in continuity midwifery model	51.2	94.1
% Chose to be facilitators	67.2	87.1
% Assigned to be facilitators	18.4	4.0
	US (n=119)*	NL (n=100)*
% Working in Urban Setting	55.5	66
% Working in Rural Setting	17.7	40

Table 7: Characteristics of midwives facilitating GANC as part of usual care

* Missing Data (n=6 US, n=1 NL), respondents could choose multiple answers, hence percentage>100

Table 8: Respondent Work Model

	U.S. Percent	NL Percent
Team Continuity/Case loading Model	41.6% (n=52)	90.1% (n=91)
Individual Continuity/Case loading	9.6% (n=12)	4.0% (n=4)
Traditional Community/Shift Model	32.8% (n=41)	1.0% (n=1)
Other (Academia, retired)	9.6% (n=12)	3.0% (n=3)
Total	93.6% (n=117)	98.0% (n=99)
Missing	6.4% (n=8)	2.0% (n=2)

Table 8: Respondent Work Model

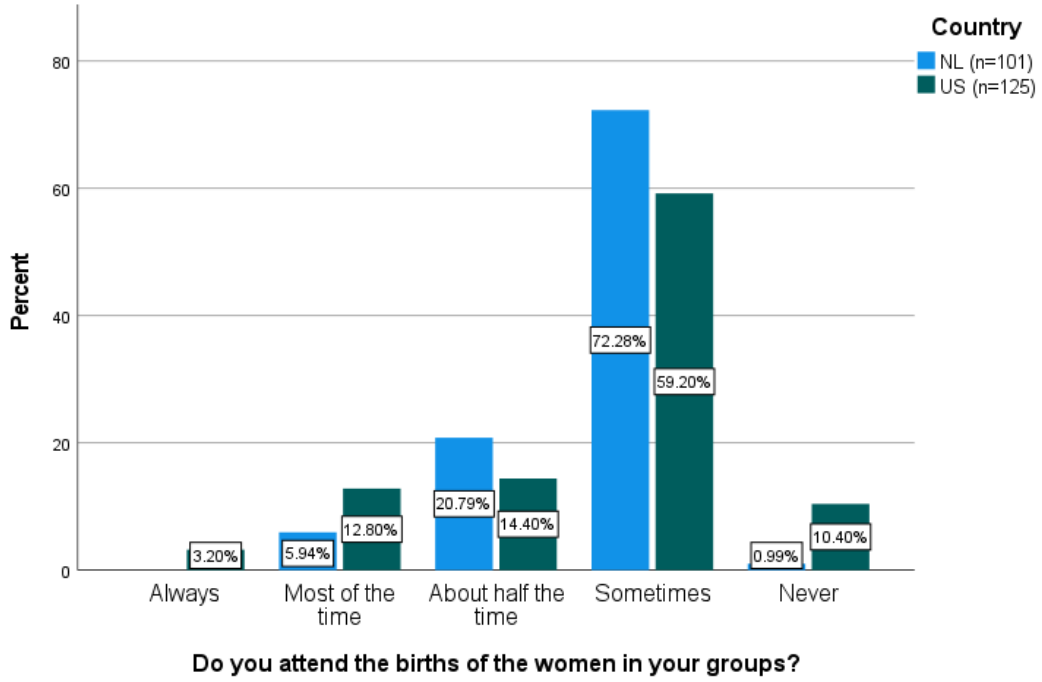


Figure 9: Intrapartum Continuity among GANC facilitating midwives

6.2 Facilitation and Co-Facilitation

GANC models are designed to be co-facilitated with another staff member, whether that is a midwife or other provider, however literature indicates co-facilitation is not always available or mentioned in the existing research (Novick *et al.*, 2015; Lazar *et al.*, 2021). In this survey respondents 73% (N=92) of U.S. midwives and 95% (N=96) of Netherlands midwives reported having a co-facilitator. In the U.S. sample that co-facilitator was most frequently a nursing or medical assistant whereas in the Netherlands the most common co-facilitator was a *kraamverzorgende* (a postpartum home visiting care assistant, see Chapter 5.2), although there was a wide range of other co-facilitators, such as doulas, student midwives and bicultural health workers (see Appendix 2.3). The majority of respondents reported their cofacilitation experience to be “extremely” positive or “somewhat” positive on a five-point Likert scale and only one respondent cited it as a somewhat negative experience. A Mann Whitney testing found no significant differences between the Dutch and U.S. experiences of co-facilitation (z=-1.52, p=.128).

In the systematic review of providers’ experiences of facilitating GANC in chapter four facilitation skills were raised as areas of both anxiety and satisfaction. In both the U.S. and the Netherlands, midwife respondents reported a high degree of comfort with their facilitation skills, with significantly more U.S midwives reporting themselves as “very comfortable” than Dutch midwives (z=-

2.67, p=.007). When asked to identify “areas of facilitation I find challenging” the categories “managing dominant group members”, “drawing out quiet group members” and “managing inaccurate information” were most frequently chosen by respondents in both countries. A third of respondents from the U.S. selected the category, “I do not find facilitation challenging”, whereas just 10% of NL midwives chose this option.

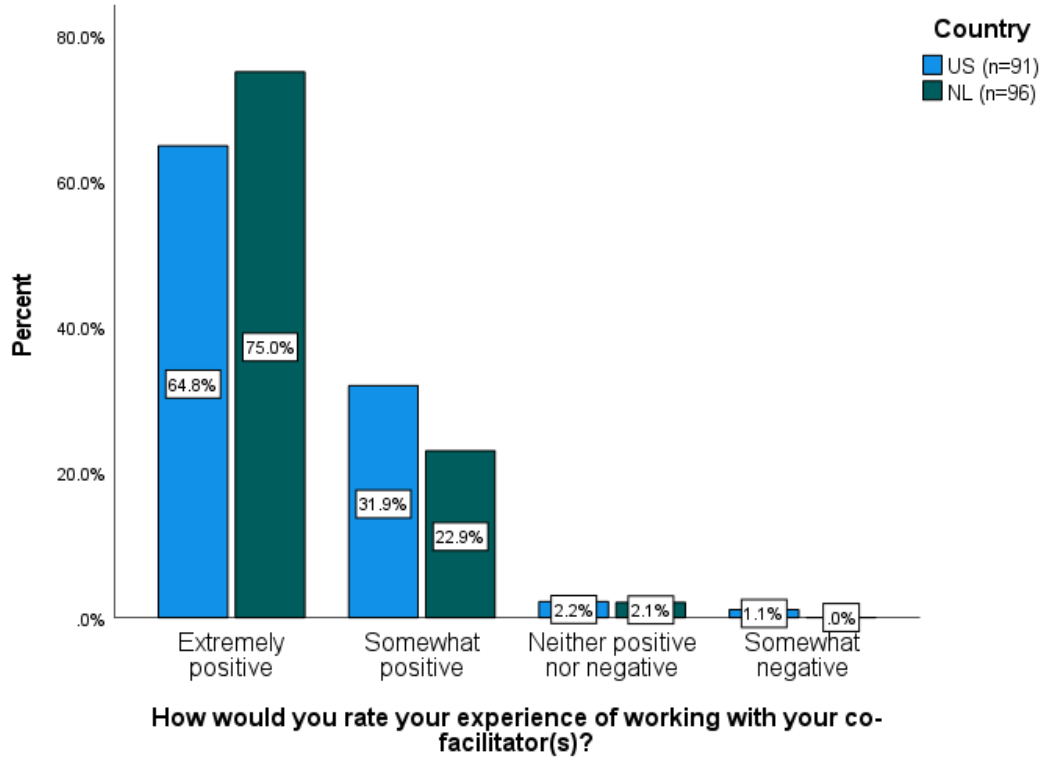


Figure 10: Co-Facilitation Experience

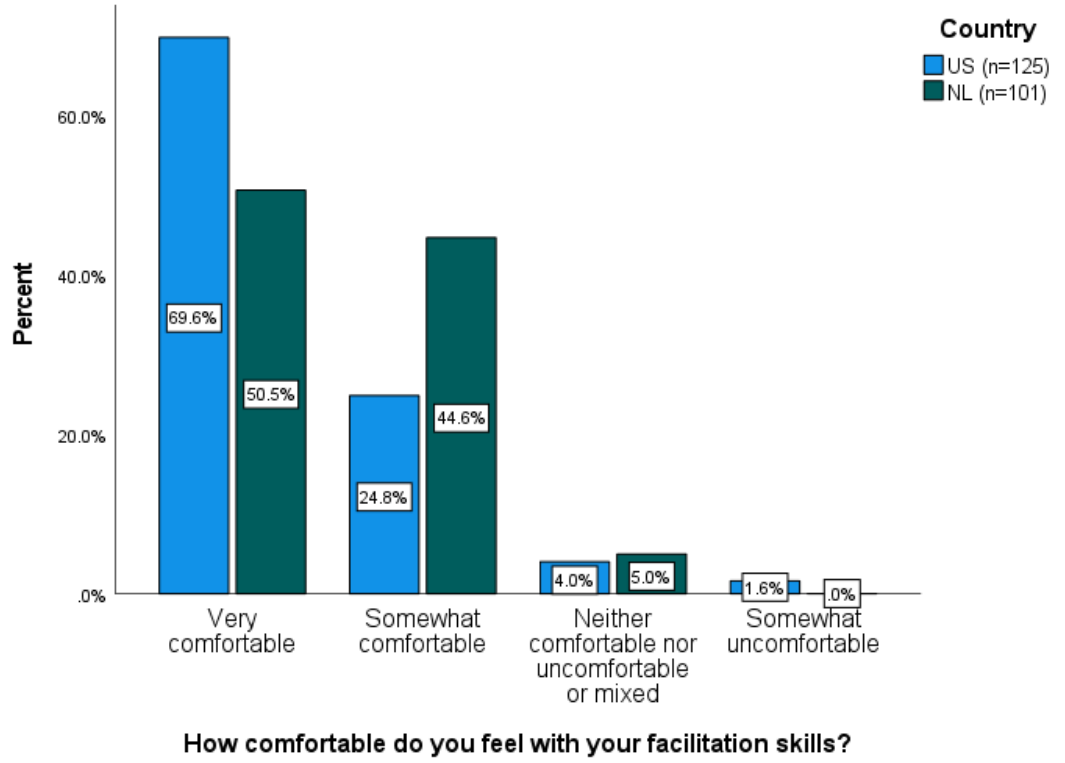


Figure 11: Facilitation Skills Comfort Levels

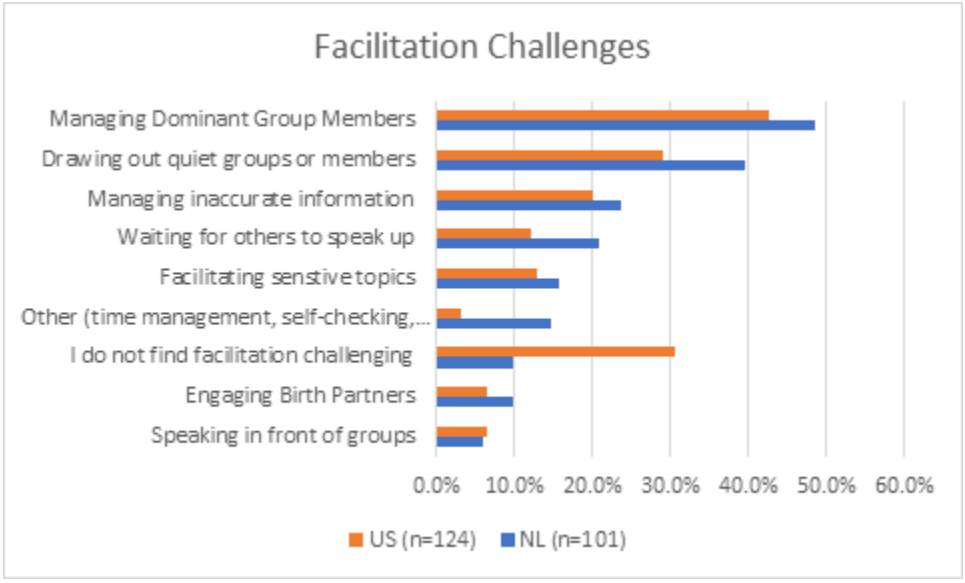


Figure 12: Facilitation Challenges

A quarter 25.6% (32) of the U.S. participants and 14.9% (15) of the Netherlands participants reported facilitating groups in a language other than the language that was predominant in their health service (English or Dutch). Evidence suggests that women from migrant and refugee backgrounds enjoy GANC (Madeira, Rangen & Avery, 2019) and the qualitative responses in this questionnaire supported these findings, with twenty- one midwives using the word positive and another six describing it positively in other words when asked in a short text question to "Please describe your experience of these groups, for example was it positive or negative?"

Table 9: Sample text responses describing experience of facilitating groups in non-native language
• Very Positive. Take[s]people out of isolation and there is also much to learn from them about different cultures and customs"-NL respondent • Humbling. Because my language skills are limited, it forces me to be more of an observer and the group feels more like a peer group and I'm just around for the ride-U.S. respondent

Table 9: Sample Text Response describing experience of facilitating groups in non-native language

6.3 Satisfaction

The question of whether or not midwives find facilitating GANC more satisfying than standard antenatal care is central to the overarching aim of determining how midwives experience GANC. Adequate time and the ability to deliver quality care have been linked to provider recommendations for improving antenatal care, hence it seemed important to understand how midwives experienced their ability to spend time with women and deliver quality care in GANC.

Thirty one percent of midwives surveyed stated they found facilitating GANC as satisfying as facilitating standard antenatal care (see Table 10). This could indicate that they found the model acceptable and also that they are happy with their current standard of antenatal care delivery, or it could also indicate that they are equally unhappy with both options. The majority of responding midwives in both the U.S. and Netherlands sample stated they found facilitating GANC more satisfying than delivering standard antenatal care. Of note, only nine respondents stated GANC was less satisfying for them than standard care. A further sub-analysis of respondents who were removed for survey completion rates of less than 80% (n=15) did not identify any additional respondents who found GANC less satisfying. Facilitating a group is a different skill than standard one-to-one antenatal care and GANC

is a different dynamic from one-to-one care that might not appeal to all midwives. The qualitative text responses to "What did you dislike most about facilitating GANC" are analysed in section 6.9 and may add insight into what aspects of GANC midwives may not like.

When presented with a list of positive and negative words about GANC (drawn from the systematic review findings – see analysis plan in Appendix 3.3) the majority of respondents chose positive words (see figure 13).

As compared to STANDARD antenatal care, I feel facilitating GANC is...

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	More satisfying for me (1)	148	65.5	65.5	65.5
	Equally satisfying for me (2)	69	30.5	30.5	96.0
	Less satisfying for me (3)	9	4.0	4.0	100.0
	Total	226	100.0	100.0	

Table 10: Satisfaction with GANC frequency distribution

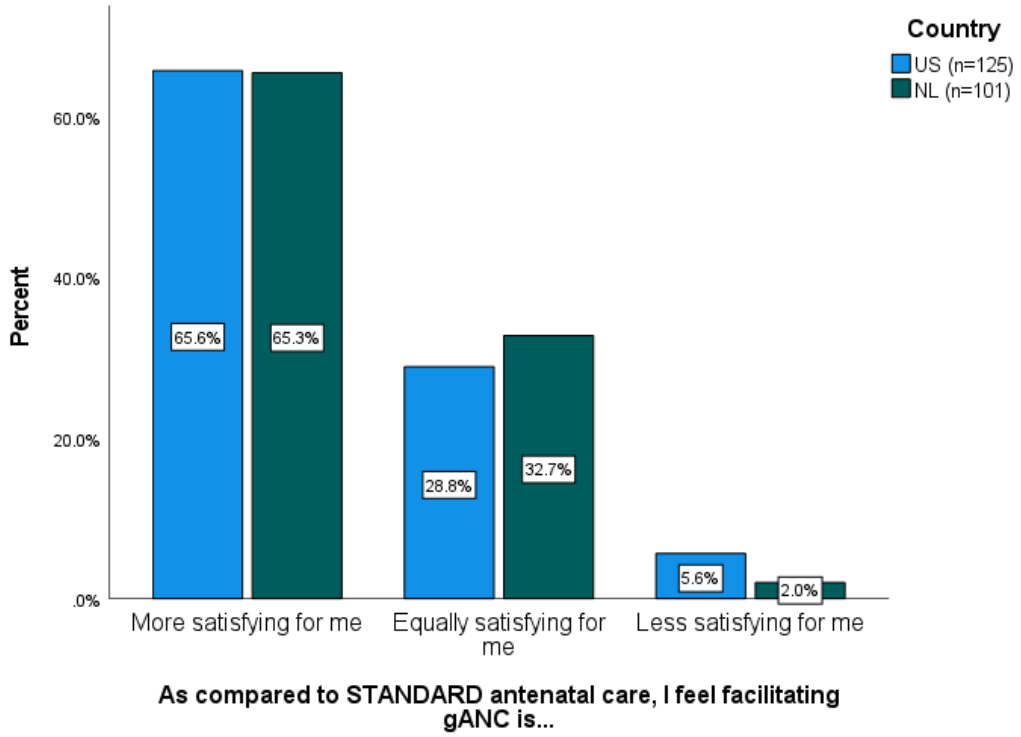


Figure 13: Satisfaction by Country

There were no statistically significant differences between countries on satisfaction findings, X^2 (2, N = 226) = 2.113, p = .348)

When choosing words they would use to describe the experience of GANC, the most frequently chosen words were “meaningful”, “fun”, “challenging” and “joyful” in both the NL and U.S. samples. Free text words in the “other” category included, “energising, fulfilling, rewarding, scary, time consuming and the quintessentially Dutch word “gezellig”, often translated as cosy or warm and pleasant.

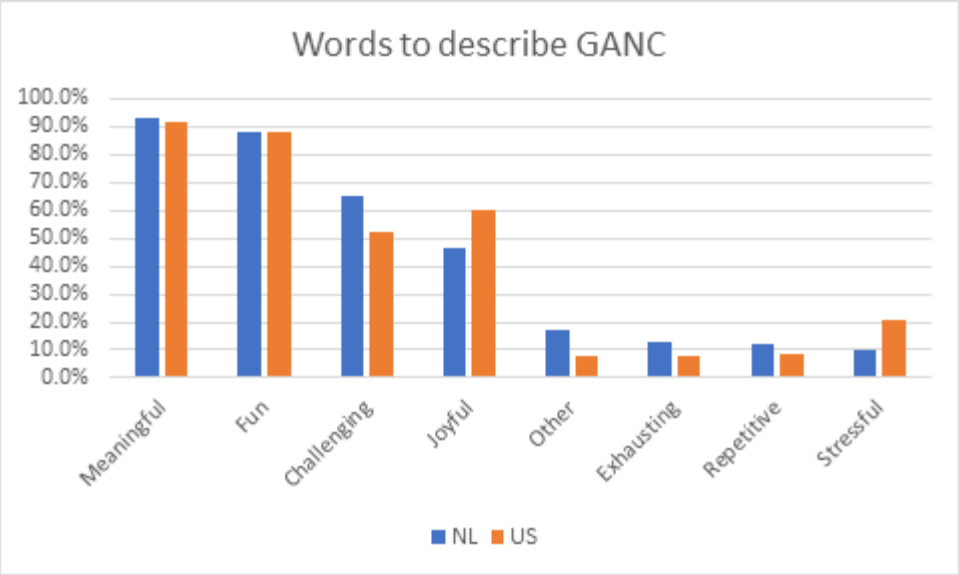


Figure 14: Words chosen to describe GANC

The survey participants were asked if they had enough time to get to know women in standard care and in GANC and whether they could deliver quality antenatal care both in standard care and in GANC (see Fig. 13). Respondents felt they had more time to get to know women in GANC models ($z=-10.124$, $p<.001$) and that they could deliver quality care in this model ($z=-6.846$, $p<.001$). There were no statistically significant differences between midwives in the U.S. and the Netherlands in response to the whether they had enough time in standard care ($z=-.404$, $p=.686$), time in GANC ($z=-1.530$, $p=.126$), or their ability to delivery quality care in standard care ($z=-.231$, $p=.817$) but significantly more American midwives than Dutch midwives strongly agreed with the statement that they could deliver quality care in GANC ($z=-1.972$, $p=.049$).

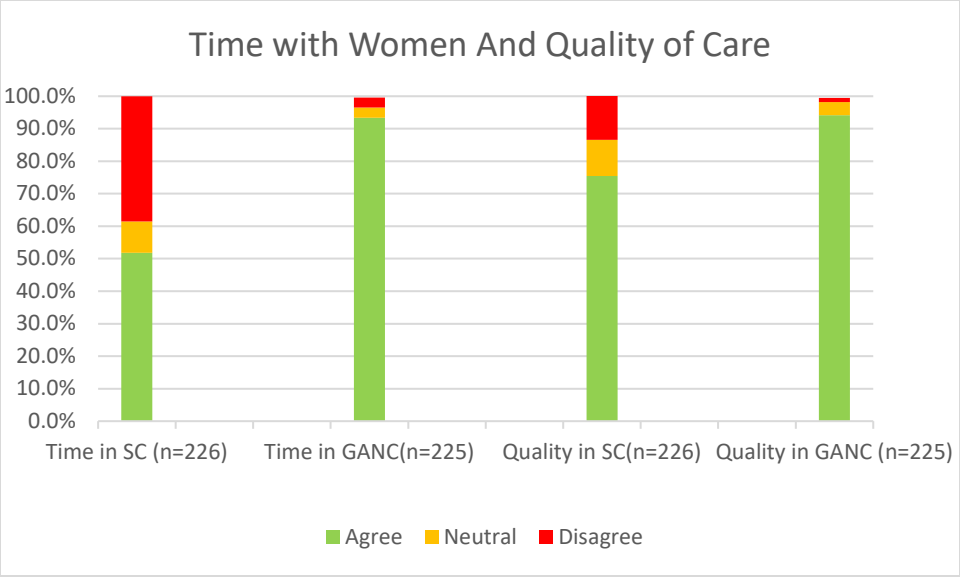


Figure 15: Midwives views of time and quality of care in GANC vs Standard Care (SC)

Another key related finding is that midwives felt women were "more likely to get the care they needed" in GANC as compared to standard antenatal care.

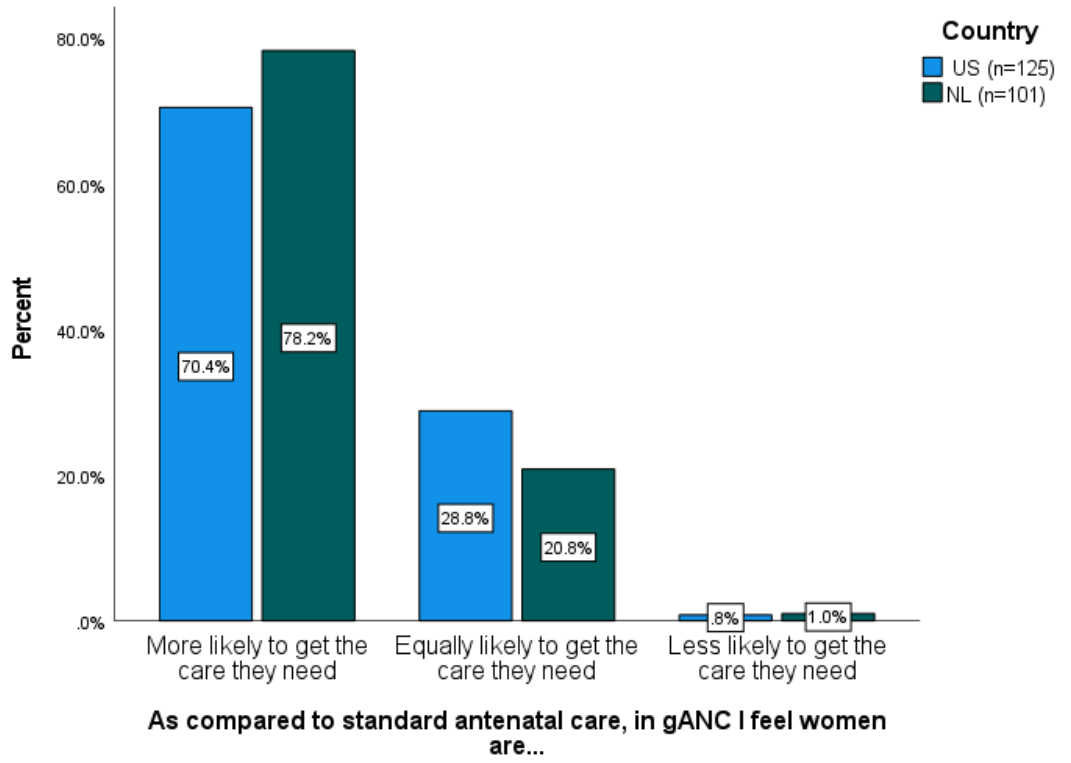


Figure 16: Midwives' views of women's quality of care in GANC

6.4 What midwives feel women get from GANC

When asked to rank aspects of GANC (Antenatal education and Knowledge, Continuity of Carer, Peer Support and Self-Checking) in order of importance from 1-4, half the midwives chose peer support as the most beneficial.

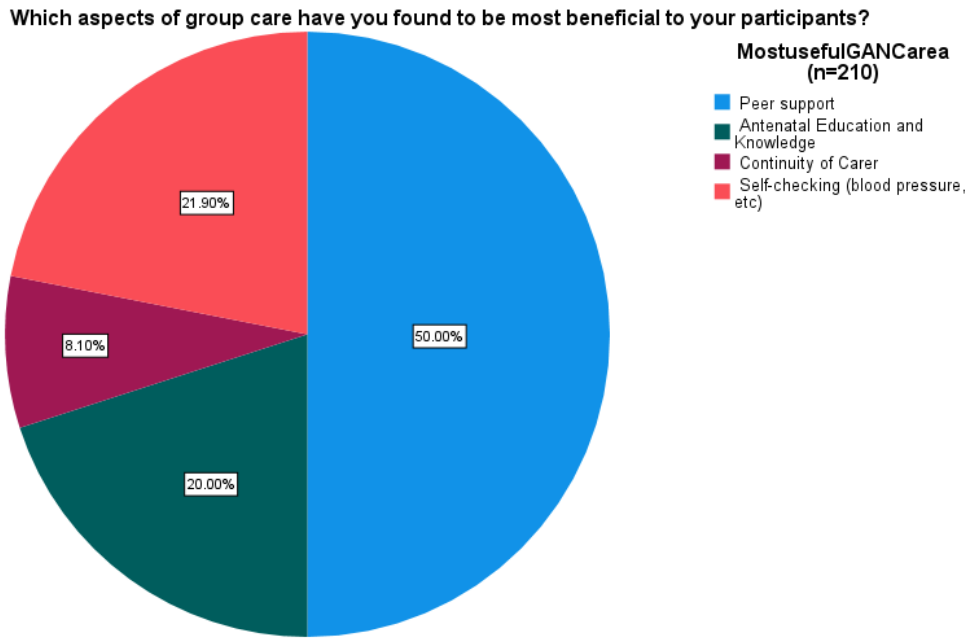


Figure 17: Midwives' view of most beneficial areas of GANC

This survey found that participating midwives in both countries felt that women were more likely to speak up and ask questions and more likely to discuss sensitive topics when compared to standard antenatal care.

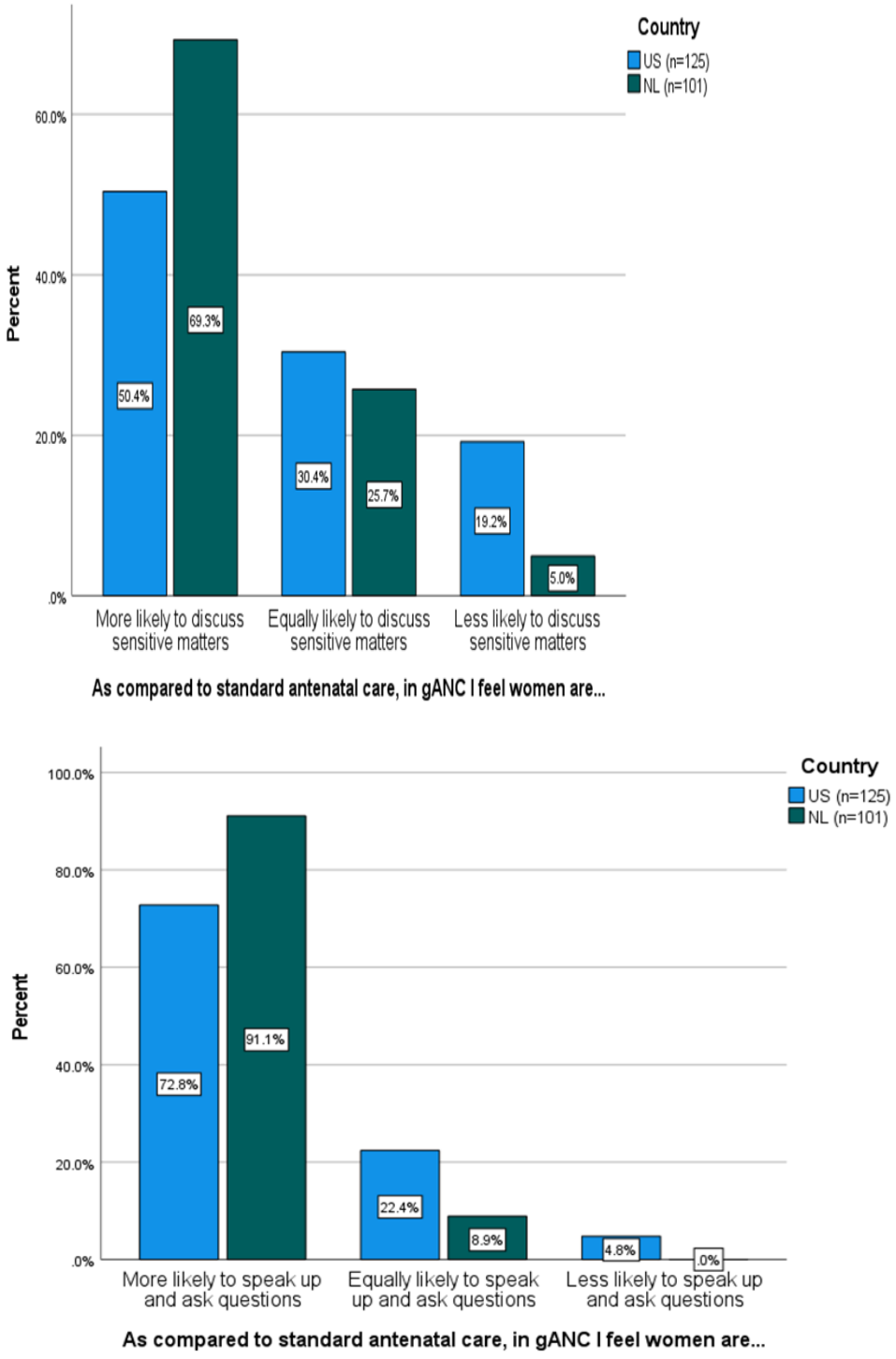
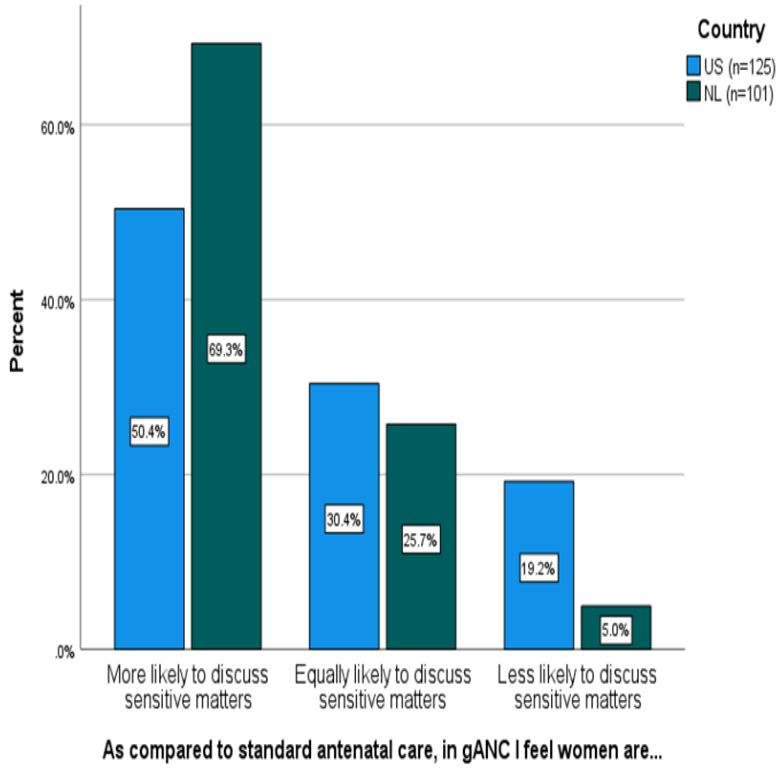


Figure 18: Asking Questions & Raising Sensitive Matters

The systematic review of literature (Chapter 4) highlighted that GANC models are described by providers as increasing the investment of women in their own antenatal care, and providers describe a professional role-change working in this model of care (Lazar *et al.*, 2021). In this survey midwives in both countries corroborated that they felt they gave women more responsibility for education and knowledge sharing, and more responsibility for safety checks (e.g. blood pressure).



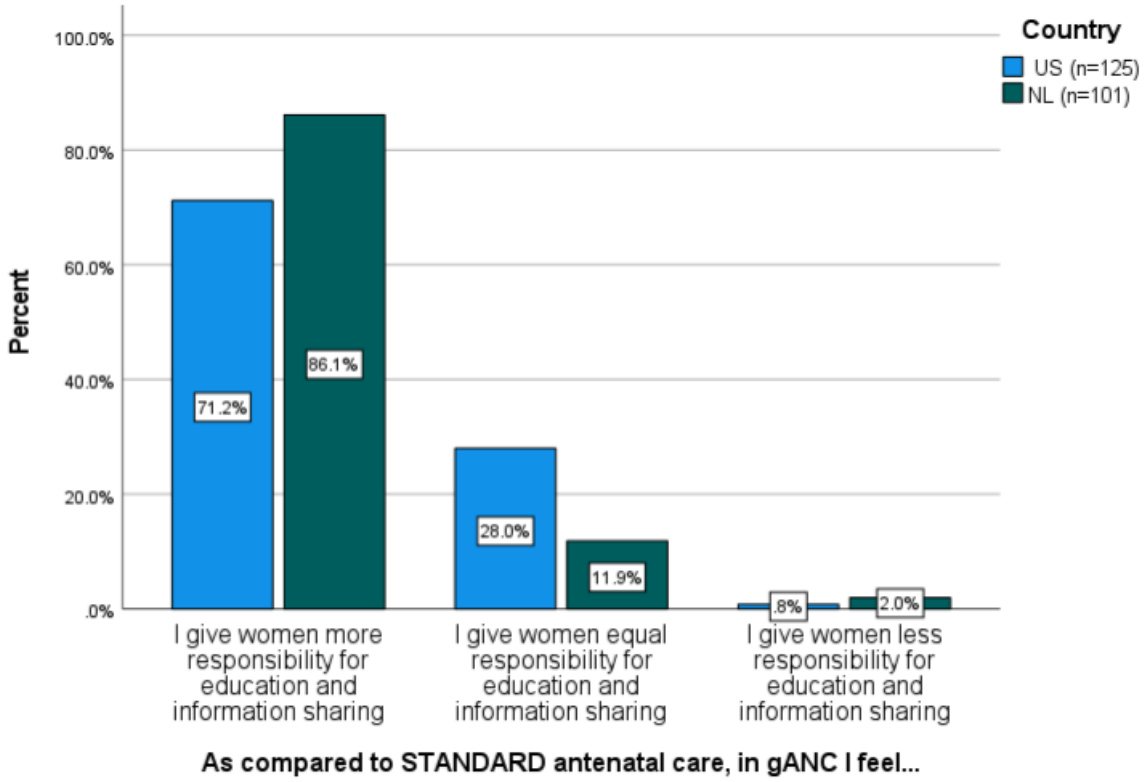


Figure 19: Giving Responsibility for education and information sharing

In the systematic review of providers' experiences facilitating GANC, midwives described GANC facilitation as reducing some of the pressure midwives feel to provide women with social emotional support, possibly because this model has in-built peer support. In the questionnaire, midwives were asked if they felt more, equally or less responsible for providing social support in GANC. 32% of US midwives and 42% of NL midwives felt more responsible for social support, but these differences between countries were not statistically significant (z=-1.1437, p=.151). It is also possible that the facilitating midwives felt responsible for creating a social environment in GANC, as community building is a core feature of the model. It is possible that social support was a difficult term to understand and would have benefited from clarification. It also highlighted an area that needed to be examined in more depth in the interviews.

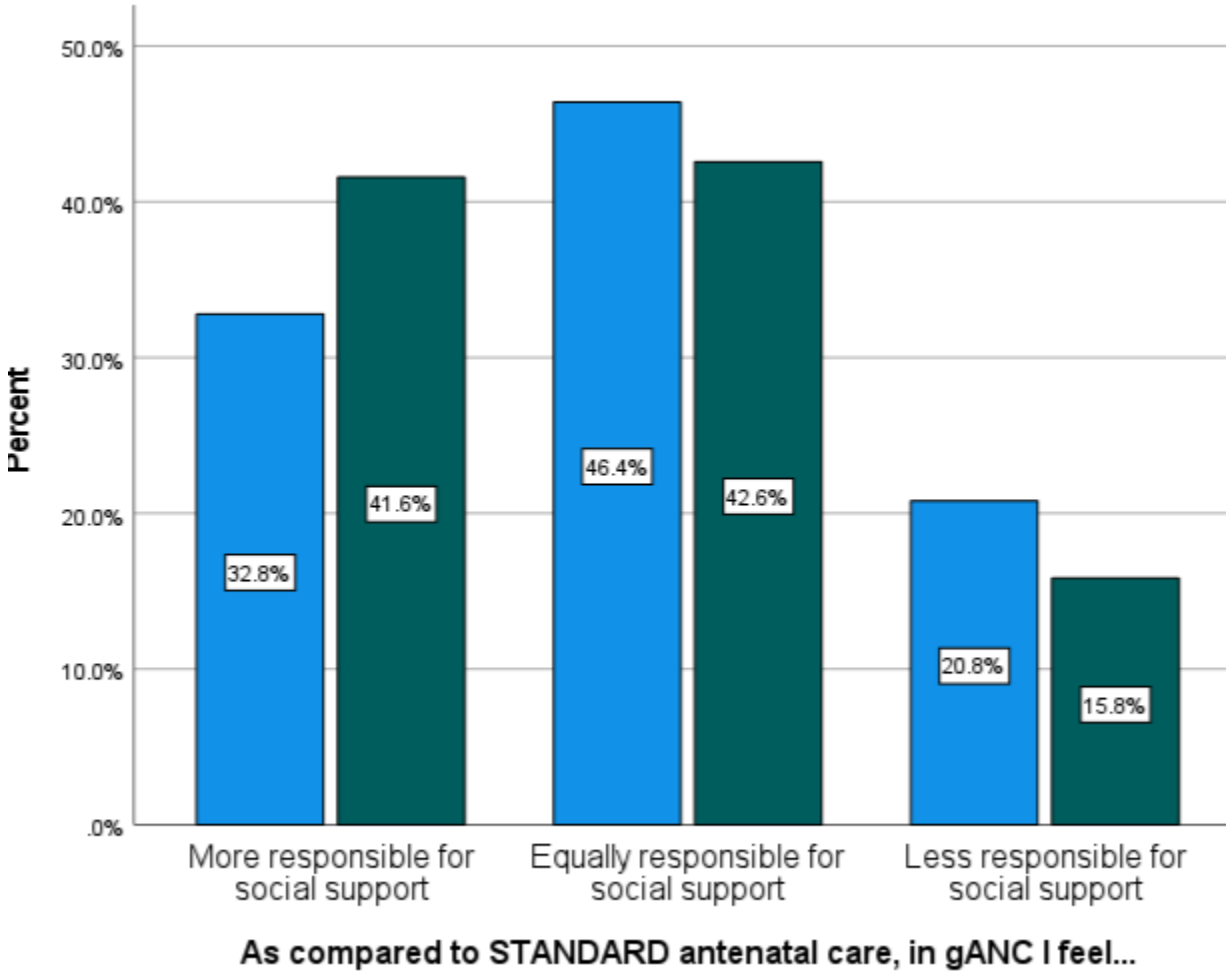


Figure 20: Feeling responsible for social support

Whilst the findings above suggest that midwives share out more of some antenatal care responsibilities to women, the survey also suggests that this model of care does not necessarily reduce midwives' experience of their workload.

6.5 Workload

The findings from our systematic review indicated a need for more study of midwives' perception of the workload associated with GANC. In the U.S. just over half (51.2%) of surveyed facilitating midwives found facilitating GANC "more work" than standard antenatal care, and almost a third (32.8%) of midwives found it "somewhat more difficult" or "much more difficult" than standard antenatal care. In the Netherlands, 83.2% of the midwives stated facilitating GANC was "more work"

and 26.8% felt it was “somewhat more difficult” or “much more difficult” than standard antenatal care. The country differences in workload perception were statistically significant, X^2 (2, N = 225) = 24.623, p < .001 with the Dutch midwives perceiving GANC as more work than the Americans.

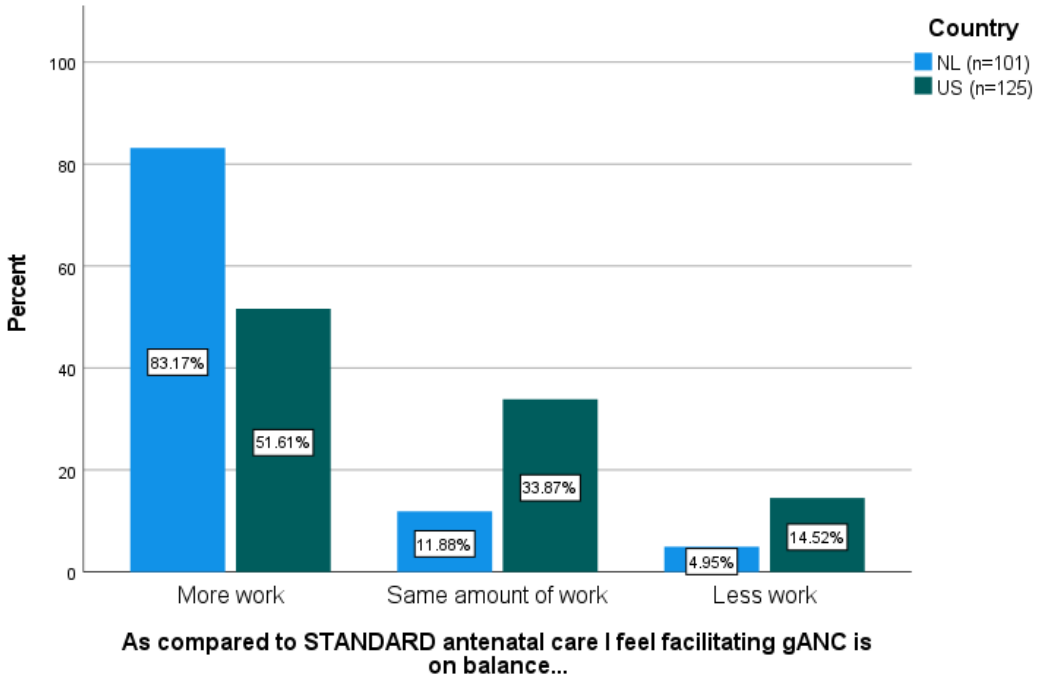


Figure 21: Workload Associated with GANC as compared to Standard Care (SC)

Recruiting women into GANC requires administrative time and effort (Pekkala, 2019). Within the population of midwives surveyed, 97% of NL midwives and 80% of U.S. midwives were personally involved in recruiting participants into their GANC programmes and this may be a contributor to workload, as it was mentioned in the open text responses as area of GANC that midwives disliked (n=10).

Lack of organisational support was described as a barrier to a positive experience of GANC (Novick, 2013, Pekkala, 2019). In order to understand the possible impact of organisational support, a series of Likert scale questions was asked to determine midwives’ perceptions of how they are supported by their organization. 93.1% of NL midwives and 69.6% of U.S. midwives felt supported by their organisation in facilitating GANC. No association was found between workload and organisational support (see Table 14). On each of the other indicators (space, equipment, autonomy and funding) of

organisational support, the majority of participants in both samples somewhat agreed or strongly agreed that they had adequate organisational support (see table 10). This data should be interpreted very carefully given the different healthcare and midwifery contexts of the Netherlands and the U.S. as discussed in the previous chapter. The midwives in the U.S. are generally working for larger hospital systems and the midwives in the Netherlands are self-employed or working for midwifery owned group practices.

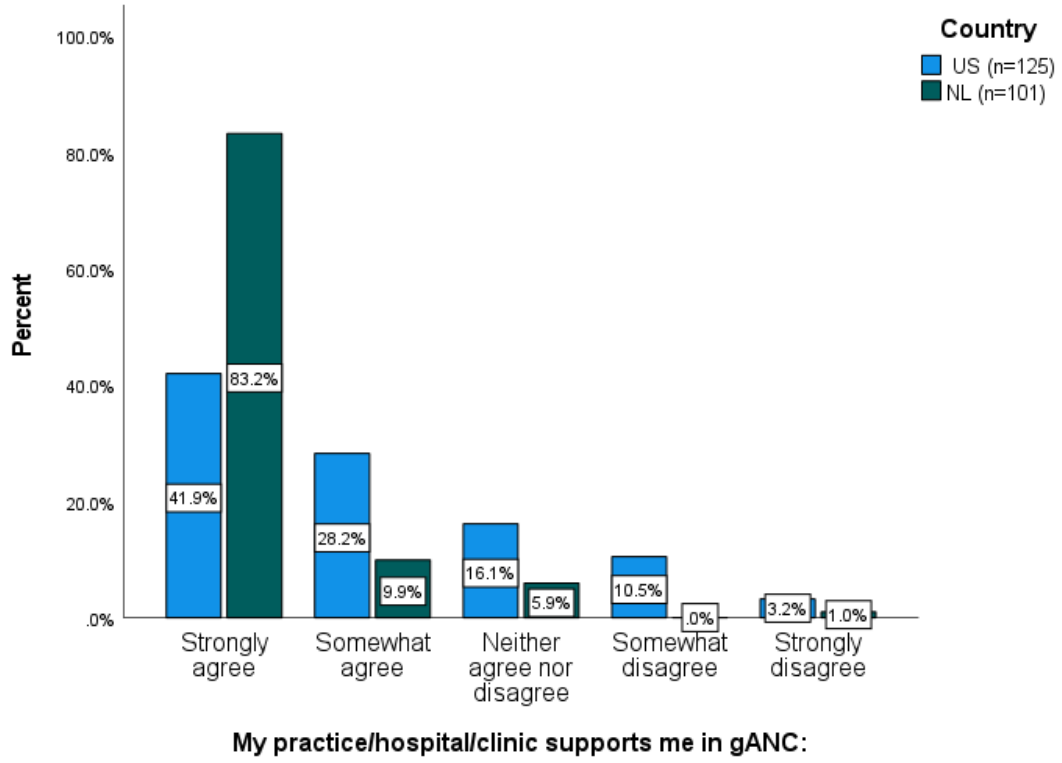


Figure 22: Perception of Organisational Support for GANC

Table 11: My practice/hospital/clinic/trust provides me with the....I need for group care

		Autonomy	Equipment	Funds	Staff
US (n=125) NL (n=101)	**Strongly Agree**				
	US	43.20%	51.20%	31.20%	38.40%
	NL	71.30%	77.20%	33.70%	38.40%
	Somewhat agree				
	US	24.80%	22.40%	22.40%	24.80%
	NL	18.80%	12.90%	17.80%	21.80%
	Neither				
	US	15.20%	10.40%	20.00%	16.80%
	NL	5.90%	5.00%	15.80%	6.90%
	Somewhat Disagree				
	US	14.40%	10.40%	17.60%	16.00%
	NL	3.00%	3.00%	15.80%	3.00%
	Strongly disagree				
	US	2.40%	5.60%	8.80%	4.00%
	NL	1.00%	2.00%	16.80%	1.00%

Table 11: My practice/hospital/clinic/trust provides me with the …I need for group care

6.6 Professional Role

The Midwifery Process Questionnaire (MPQ-described in section 3.4.1) is comprised of four subscales representing sub-domains of the professional midwifery role. Each was analysed descriptively, as well as a total calculated score (as described in section 3.4.6). Internal reliability for the scale was calculated as it was being used in the context of GANC for the first time. The Cronbachs alpha score was .89, which indicates high internal reliability. The mean scores for the participating midwives facilitating GANC in both the NL and the U.S. were positive in all subscale domains (*professional satisfaction,*

professional support, client interaction, and *professional development*), indicating a positive mean attitude towards each of the four subdomains of their professional role (see Figure 23). Tests of association (Spearman's rank) showed no significant association between the response 'satisfaction with GANC as opposed to standard care' (Appendix 3.4) and professional role subscales.

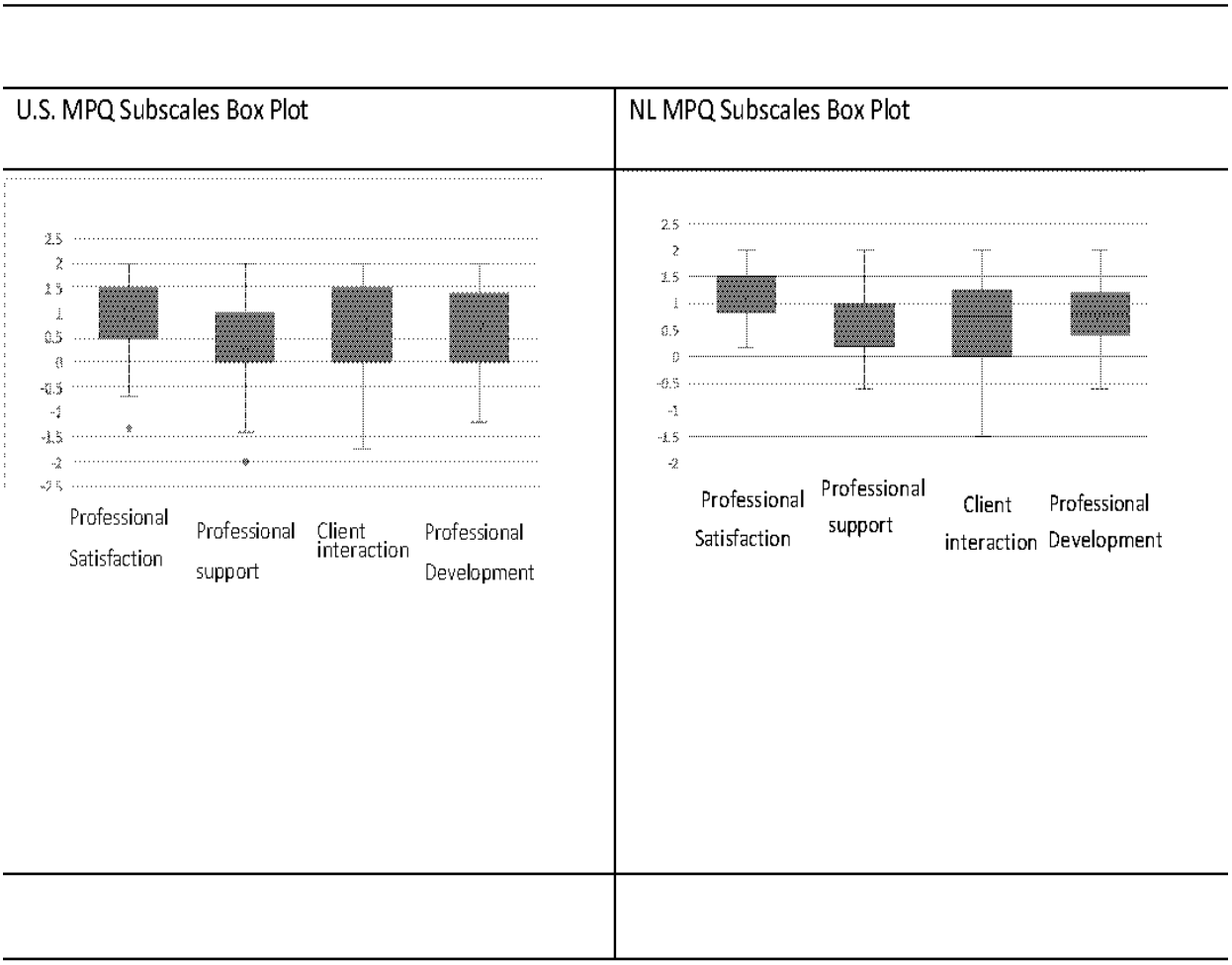


Figure 23: Midwifery Process Questionnaire Subscales Box Plots by Country

6.8 Covid findings

The Covid-19 pandemic has had extensive effects on the delivery of maternity care globally. The requirements for social distancing and restrictions on meeting in groups in order to reduce infection uniquely impacted GANC. The survey asked about covid impacts on GANC and what adaptations were undertaken. Of US respondents just under a third offered GANC at some point in the pandemic, whereas in the Netherlands almost three quarters of respondents had offered GANC at some point (see figure xx below). These differences may reflect the difference in the timing of the data collection, as the U.S. data

were collected from late April 2021 through early July 2021 and the Netherlands data was collected in September of 2021. In both countries respondents reported the most common adaptation reported to the survey question, “what adaptations were made to GANC during the covid-19 pandemic?” was a move to facilitate GANC virtually, other adaptations included limiting group size, partners and activities that involved physical contact. When asked how covid had affected GANC many respondents (n=40) found online groups more difficult or less satisfying than in person groups, but they did not always state why. Some respondents stated groups were less interactive or felt more didactic. Some respondents also noted an increase in loneliness and isolation which they felt demonstrated an increased need for GANC.

> “People are still seeking connection, in my experience even more than before the pandemic. We had more registrations than ever! The digital meetings leave less room for spontaneity and social exchange. It got a little more theoretical. Still of added value, but I found it less fun to do myself” -NL midwife

> “I think the people who switched to virtual from in person did not like it, but the people who started virtual are using it as a chance to reach out and make connections that they haven't been able to make. The people in my group have a group text and text each other questions and let people know what they missed.”-US midwife

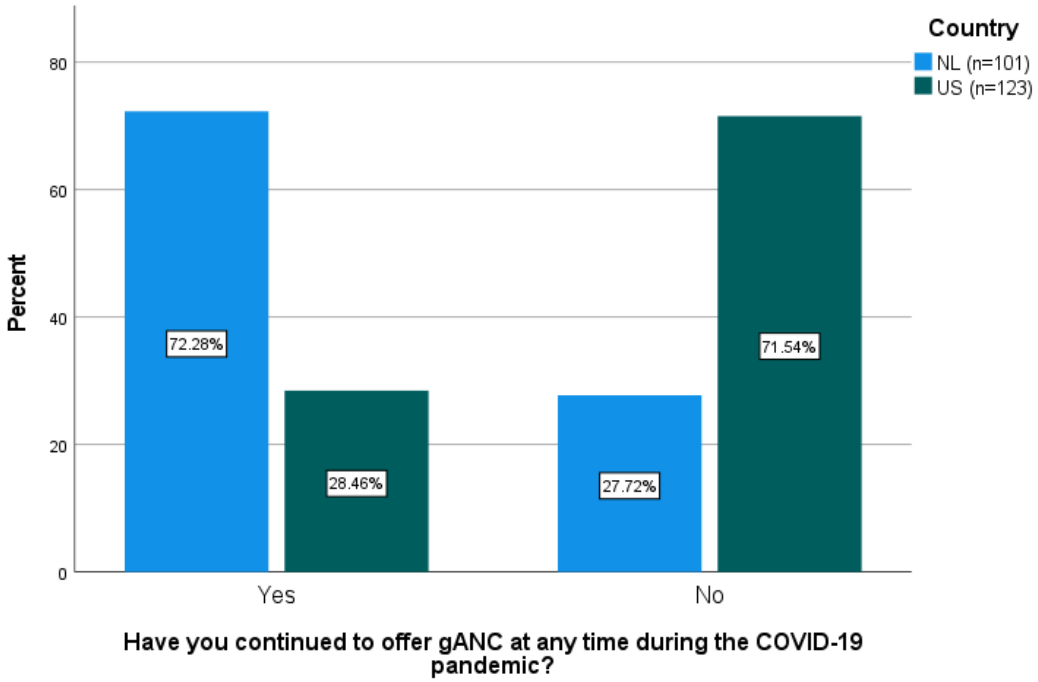


Figure 24: Offering GANC during pandemic

6.9 Qualitative Text Responses: Overall experience

There were 218 text responses to the question “what do you like most about facilitating GANC?” and 213 responses to “What you do you dislike most about facilitating GANC”; these were analysed thematically. Six participants responded that there was “nothing” they disliked. Three major themes identified under “what do you like most” were Relationships and Community, Empowerment & Education and Efficiency.

Table 12: Qualitative Text Responses to What I like Most about GANC Analysed Thematically	
Themes	Survey Respondent Illustrative Quotes
Relationship & Community	• I love seeing the group come together to support one another. There have been lifelong friendships made in group- US#125 • Community of women, sharing their lived experiences, supporting each other and normalizing pregnancy related discomforts-US#114 • De sociale cohesie die in de groep ontstaat. De vragen die gesteld kunnen worden en de discussies die ontstaan.-NL#23 • The contact, the deepening, the pleasure of meeting each other. -NL #26 • The conviviality and that people help and inform each other. -NL #101
Empowerment & Education	• Observing the patients change over time as they feel more empowered and dare I say it "loved" and respected by their peers and the team. They seem to blossom and don’t seem to "need" my support as much. - US#106 • Patient autonomy and growth. Less of me more about the new family. - US#138 • That pregnant women deliver other items than what I thought of and that they go deeper into what concerns them. Postnatal depression, experiences of their partners, the first weeks with a baby are also discussed, while this is often not discussed during regular checkups. They are so open with each other and exchange a lot. Also later via the app when the baby is there.- NL#76
Efficiency	• The fact that women have more time with their provider and the time is more useful to them. Rather than waiting in lobby and exam room for a brief visit with their midwife, their time is better spent (doing self checks, chatting with peers, reviewing any materials we lay out, participating in discussions and activities). Women are able to build community in addition to getting care and health education. - US#174 • I don't feel like I am repeating the same education to multiple clients each day. I can say it once to a group. - US #222 • That you get to know women well and that you can respond better to their needs. That it forms a group that can partly direct itself. That much more can be discussed than in individual checks, etc. - NL#89

Table 12: Qualitative Text Response to What I like Most about GANC Analysed Thematically

The themes identified under what do you dislike most about facilitating GANC were Administration & Charting, Time Lost/Missed and Group Anxieties.

Table 13: What I dislike most about GANC analysed thematically	
Themes	Illustrative Quotes
Admin & Charting	• Pushback from the institution -- lab, medical assistants, clerks -- not seeing group patients as part of the regular workload. US#124 • the administration that comes with it in terms of papers, emails in preparation, you have to plan more NL#80 • the practical hassle (set up, invite everyone, drink name plates, booklets, etc.)-NL#80 • Doing all the charting afterwards -US#161
Time Lost/missed information	• That there wasn't time provided to get the charting done and I had to do it on my own time after the sessions. -US#135 • I wonder if I missed something in a group setting I would have discovered in a private meeting. -US#121 • Feeling of lack of time / haste in external examination. Feeling of too little space for personal attention/privacy. Preparation and completion (still) takes quite a lot of time. Recruiting pregnant women also takes quite a lot of time / energy.-NL#99
Group anxieties	• sometimes frustrating with dominant member or super quiet group -US#212 • That sometimes there is no click within the group or everyone is very quiet. Then the conversation gets off to a very slow start-NL#5 • quiet group-NL#84 • I feel vulnerable before each group even though I know how important it is to trust the group to guide you to what they need. -US#176

Table 13: What I dislike most about GANC analysed thematically

6.10 More satisfying and more work: more questions

This survey was intended to be descriptive, and not designed with a hypothesis in mind, so limited tests of association were planned (see Survey Analysis plan, Appendix 3.2). The descriptive findings pointed to the fact that overwhelmingly midwives in both countries found GANC more satisfying than standard care and yet they also reported it to be more work in both countries. These findings stood out as interesting and potentially contradictory so to interrogate them further, crosstabulation, Pearson's Chi-Squared and other non-parametric tests of association were conducted to see what else the data might reveal about the satisfaction variable and the workload variable. As the data were not normally distributed and the sample size is limited, non-parametric tests were used. Tests

were limited to avoid data dredging, wherein too many analyses are run, and statistically significant associations may appear by chance (Smith and Ebrahim, 2002). The U.S. and NL databases were combined after discussion with the supervisory team, as it was thought this might add power to tests of association, and because the responses to questions had been similar enough that it felt appropriate, tests of difference by country were then conducted and reported when significant. Even with the combined database, the data was skewed as so few survey respondents in either country found GANC less satisfying than standard care (n=9).

Table 14: Spearman Rank Order Correlations between Satisfaction, Workload, Facilitation Skills, and Organisational Support

	Organisational Support	Workload	Comfort with Facilitation Skills	Satisfaction
Organisational Support		.751	.142	.426
Workload	.021		-.104	-.049
Comfort with Facilitation Skills	.142*			.249**

Table 14: Spearman Rank Order Correlations between Satisfaction, Workload, Facilitation Skills, and Organisational Support

Note*: **p<.001 correlation is significant at 0.01 level, *p=.034 significant at the 0.05 level*

A very few statistically significant associations were found, Logically, there was a significant association between being more comfortable with facilitation skills and more satisfaction with GANC.$G^2(6, N=226)=22.65$, p=.001). There was also an association between choosing to facilitate GANC versus being assigned and satisfaction $G^2(4, N=226)=14.991$, p=.005) ; it stands to reason that one might prefer to work in a different way by choice rather than by obligation. No associations were found between the means subscales of the MPQ and satisfaction (see Appendix 3.4), nor were there any associations with organizational support and perception of workload associated with GANC. The non-parametric Spearman's rho and Kruskal Wallis were used to test for these association and variances, given the skewness of the data on satisfaction.

Summary and Conclusions

The systematic review in Chapter Four found that there was little published data on midwives who were currently facilitating GANC as part of normal care, rather than as part of a pilot research programme. The respondents in this survey were largely experienced midwives, however the range of

midwifery experience was broad, ranging from 1-42 years, indicating that perhaps this model may be attractive to midwives at both ends of their careers. The respondents also had a lot of experience facilitating GANC, with close to half of the respondents having facilitated more than 10 groups and two thirds of respondents having facilitated more than six groups. Almost all the respondents in the Netherlands (98%) and the US (92%) had received training in GANC facilitation, and both these nations benefit from organizations that focus on training of GANC facilitators (CHI and CenteringZorg).

The quantitative and qualitative sections of the survey contributed to closing gaps identified in the literature about how midwives facilitating GANC as part of usual are working and what their experience has been. While it was previously identified that providers seemed to enjoy working in GANC in pilot programme contexts, this survey found that a significant majority of midwives in both countries found GANC more satisfying than standard care, and almost all the study participants found working in GANC at least as satisfying as standard care. While the text responses gave insight into what midwives liked about GANC, this area needed to be explored further in interviews, to give depth and triangulate findings.

Second, the finding that a majority of midwives found GANC to be more work than standard care, even outside of a research context, seemed to potentially oppose the finding that it was more satisfying than working in standard care, warranting deeper exploration to understand what contributes to that perception. Given that the surveyed midwives largely felt supported by their organisations in facilitating GANC, their impressions of barriers to expansion and sustainability were also of interest. Furthermore, as midwives in this sample seemed satisfied in their professional role, what could be learned about the interplay of the professional role of midwives and the facilitation of GANC. These considerations were carried into the interview process via the interview guide and a lens for the analysis of the interview findings discussed in the next chapter.

7. The Satisfaction that is Meaningful Midwifery Work

Introduction

This chapter discusses the findings from the analysis of qualitative interviews conducted with a sample of midwives who facilitated or are currently still facilitating GANC in the Netherlands and the U.S.. This section seeks to fulfil the research aim of furthering the understanding of midwives' experiences of facilitating GANC and changes they may experience to their midwifery role in facilitating this model of care by presenting the analysis of in-depth interviews conducted with GANC facilitating midwives.

7.1 Interview Context

On completion of the survey (see Appendix 3.2) participants were given an option to leave their contact details and indicate if they were agreeable to a follow-up interview. Forty-Eight U.S midwives (38% of n=125) and forty-five Dutch midwives (45% of total n=101) agreed to be contacted. All were sent emails requesting an interview. Twenty-one interviews were conducted in total, nine with midwives working in the Netherlands and twelve with midwives working in the U.S.. Nineteen were conducted remotely on Zoom and two were conducted in person (at the request of the interviewee as they were local to the researcher). Interviews lasted between twenty-seven minutes and an hour and five minutes.

As a result of the Covid-19 pandemic and the restrictions on groups, the majority of the midwives interviewed for this research were not currently facilitating GANC. All of the midwives interviewed had worked in group care models that had been integrated into their practice as an offering either alongside or instead of standard one to one antenatal care. Although two midwives in the U.S. had initially come into their facilitation in a research context, the group care models had continued after the research period had ended. The American midwives interviewed had facilitated GANC in a wide variety of health settings, in federally qualified health centers (public health clinics), in private practices, in large academic hospitals, on military bases and on Native American reservations. Three of the American midwives interviewed had facilitated groups in Spanish with primarily Latin-American migrant populations. Of all the American midwives interviewed, only two facilitated group care in the same state (at the same location), and both coasts and the middle of the country were represented.

The Netherlands is a much smaller country, and as it has a completely different health system (discussed in Chapter Five), all of the midwives who were interviewed worked in midwife owned small group practices, although one had experience doing groups in a "second line" facility, namely a hospital setting. However, there was a variety of settings represented, urban, suburban and rural and the

midwives had worked with a wide variety of populations; some facilitated groups in English with immigrants or in Eritrean with refugees, another worked in small rural religious Dutch community, and one was currently working in Belgium. Nonetheless, as observed in the survey, responses were similar across countries, with all themes salient to midwives in both.

7.2 The conceptual model

The development of the conceptual model of midwife satisfaction with GANC is covered in the methodology chapter (section 3.5.5). Using the themes that arose from thorough coding of the first four interviews (two U.S., two NL) and then compared and contrasted the thematic concepts arising from the systematic review of providers' experiences of facilitating GANC, and the findings of the survey of 226 midwives working in GANC models in the U.S. and the Netherlands, I developed an analytical framework (see Appendix 4.3) which was then used to code and interrogate the twenty one participant interviews abductively.

The overarching theme of the systematic review, further validated and focused by the survey was that midwives working in GANC models found it satisfying, but this motivated an interrogation of what led to facilitating midwives' satisfaction (or lack thereof) with GANC. The conceptual model demonstrates a midwife driven by dissatisfaction with standard antenatal care. All the concepts in the circle relate to the ways in which GANC affects midwifery satisfaction. Midwifery work: Taking Time, Holding Space and Facilitation enable relational care which builds support networks that enable hierarchy changes and transformational power. The concepts in the triangle are systemic/organisational factors that put downward pressure on midwifery satisfaction in GANC.

The following are notes from research journal during the creation of the Conceptual Model;

Notes on Conceptual Model: Space, Time and Facilitation Skills allow Relationships to Form. The forming of relationships creates a network of trust and support. This support occurs between the participants, and the participants and the midwife/co-facilitators, and between the midwife and interprofessional collaborators. This expanded support network helps midwives cope with difficult situations but the deeper relationships formed in the group also may result in the midwives becoming more invested in these relationships*. This experience is satisfying for midwives as they get to participate in transformational power/empowerment. It brings the experience of delivering antenatal care closer to the experience of attending birth/watchful attendance concept, namely the midwife is guiding and preparing the family through pregnancy into childbirth and parenthood, by helping people sort out what they already know(intrinsic knowledge) and providing them skills and resources to solve their own problems (analogy to asking a woman to change position in labour when she is frozen in fear or pain) , which encompasses the holistic vision midwives have of care and the transformation power of pregnancy and childbirth.

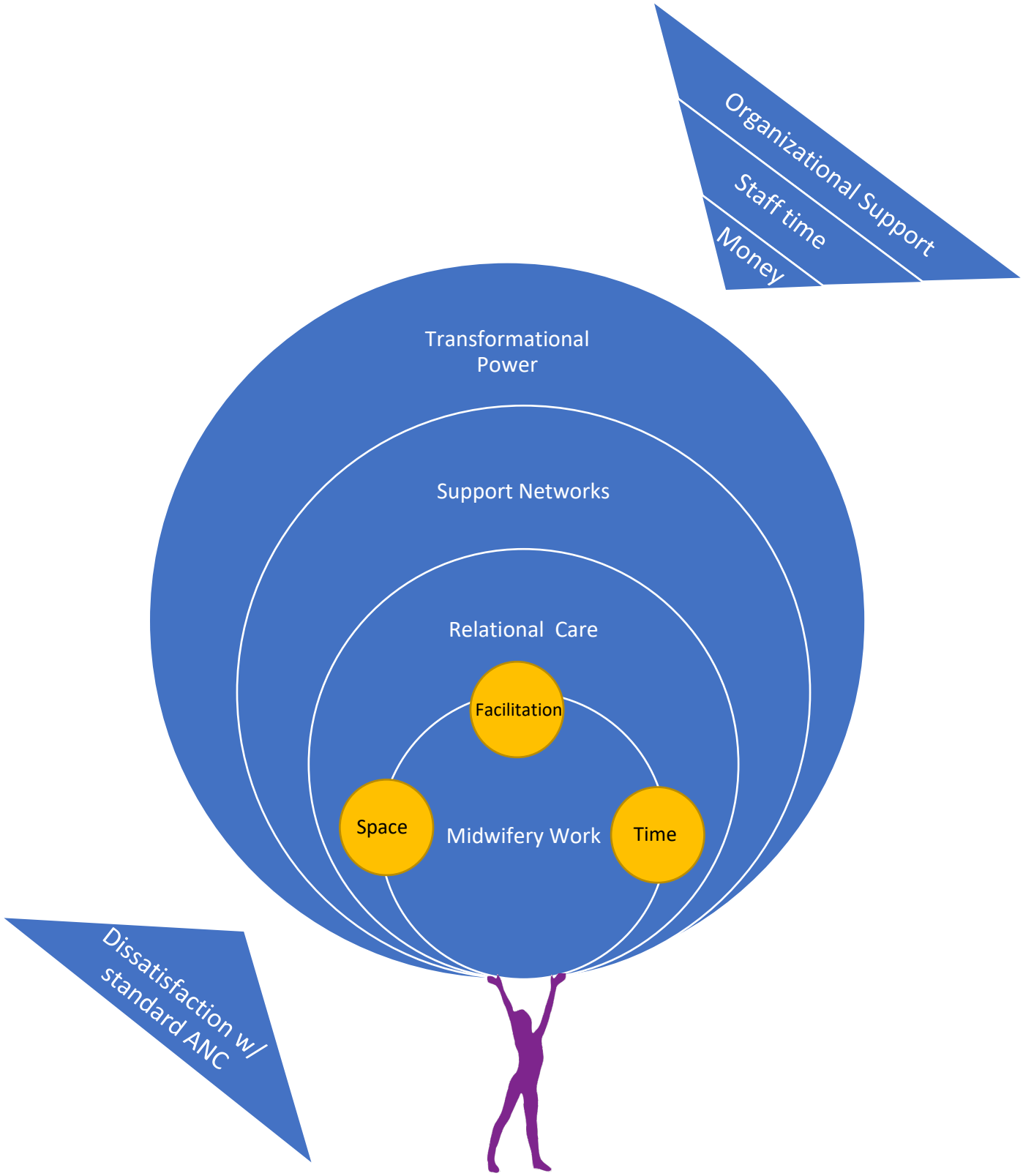


Figure 25: Conceptual Model of Midwife Satisfaction in GANC

The themes are presented in order of the conceptual model, starting with the dissatisfaction with GANC as a contributor to midwifery satisfaction with GANC, and then proceeding through the levels of the conceptual model themes. The findings end with the themes of organisational support, staff time and funding which influence satisfaction.

7.3 Dissatisfaction with standard antenatal care

Many of the midwives interviewed in both countries reported dissatisfaction with the standard method of delivering antenatal care. Time pressures where standard antepartal clinic visits ran from fifteen to twenty minutes in a one-to-one format felt repetitive and unsatisfactory. Those that did not report dissatisfaction directly implied it by emphasizing that they felt that GANC was better, richer, or higher quality care.

> "I really, really hated doing normal prenatal visits. So I was thinking about, OK, how can we do this differently?" -June 10 interview NL

> "our model traditionally is to just vomit this information on them and walk out the door and think that's good because you know we've got fifteen minutes and we need to chart right, and so that didactic divulging of information which I, feels like vomiting"-Oct 26 interview US

> "So I graduated from midwifery school in 2004 and was pretty discouraged by how most prenatal care was done, like in 10 or 15 minute time slots with people and just repeating things and trying to, not really getting to know people" -Nov 18a Interview US

Midwives cited the format of group care as being much less repetitive than clinic visits, and several said this aspect was what initially drew them to GANC. GANC allowed midwives opportunities to use their particular professional skills; taking time, holding space and facilitating information sharing and decision making.

7.4 Midwifery Work in GANC: Taking time, holding space, Facilitating

The findings on the survey suggested an opening to understand how midwives work in GANC. The work the participants described in GANC frequently included Taking Time, Holding Space and Facilitation.

7.4.1 Taking Time

Midwives readily identify the role that time plays in their experience of GANC. For midwives in both the US and the Netherlands, delivering standard antenatal care generally means that antepartum visits may be only allotted 15-20 minutes. In contrast GANC is designed to have participants spend two hours with their midwife. Most midwives interviewed describe the time as allowing them to have richer,

more complex conversations with women, and importantly, to find out what women already know, or what they want to know, thus tailoring their care to the needs of the group.

> "You get more relaxed and you're not it's it's so much stick to the programme and then say, well, what? You want to talk about this some time longer? Okay, we'll do. Then we take the other subjects to the next meeting so that you know, when you when you are relaxed yourself and open and honest well you get it back from the women." -March 8 Interview NL

The extra time also allowed midwives to feel more relaxed and less pressured to deliver didactic antenatal education in the way they would in standard care.

> "And the idea that we don't have to get every, you know, we don't have to do my whole agenda today. We can do the group's agenda today. Sometimes we would spend no half of the time on things that people, a question, you know, things that have come up for people since the last time we had met and they wanted to talk about". -Nov 18a interview US

Some midwives described GANC as a more efficient use of time;

> "A lot of the counselling and care that we give in these little 15 minute blocks is not especially helpful, like, that critique is, I think stands, and it's just there just isn't enough time in that model [standard care] to provide care, reasonably good care, because (pause) and so it's a relief to be in in a group model where people can actually hear each other's questions and answer and and answers and answer each other's questions. And, you know, it's so much more efficient."- Nov 26 Interview US

Midwives also reported in the interviews and on the qualitative portion of the survey that the model required significant time investment on their part, through preparation, the actual conduct of the group and charting and follow up. This contributes to the overall perception of GANC associated workload.

> "The only thing is, yes, you have to be prepared. You have to make a little of some of a healthy snack and something to drink, which is healthy. You have to prepare your room and afterwards you have to clean up that it's a little bit time consuming."-Feb 24 Interview NL

> "I don't want to pretend that, you know, you just go in and it's really easy, like you have to set up and get everything done but after the group is done, you're like, this was SO worth it" -Nov 18b Interview US

> "And so in practice, we see that it takes more time than the standard care occur but it is so much better and with so much more information than we can give normally."-February 24, 2022 Interview NL

Repeatedly the time taken in GANC was reported as valuable. The midwives used this time to address

complex subjects, ask more questions, listen deeply and make participants feel comfortable.

7.4.2 Holding Space

Sitting in a circle around an open space is a key component of GANC models. Negotiating and arranging the physical space in which to hold GANC was frequently mentioned as a task and barrier midwives encountered.

> "We had our first group in November, and then along the way we moved over to the city building. And I had to negotiate space there. And got it, got a conference, got their conference room. But then there were a few times when they just decided they were going to do something in the conference rooms on our, on my Centering day. And so that was a huge problem."-Interview Feb 11, 2022 US

Finding useable space often meant midwives had to be flexible and mobile to go wherever the groups were held, which not always in their regular workplace. In addition to the creating the physical space, midwives also engaged in holding psycho-social space.

> "So I did find it stressful or even like just, you know, running from clinic to get there to feel like I was grounded and prepared to hold space for a group of women. I found it stressful, but it didn't matter. I loved it. I thought it was great."-Interview Nov 18a US

Holding space is a term frequently used in midwifery education and practice. Midwives described the experience of holding space in GANC, using silence and patience judiciously to allow participants to express themselves or ask questions or share intimate details.

> "I always try to do it in an interactive way that people start thinking themselves. And yes, and I also try always try to, to have to create a safe environment for the couples. They feel comfortable and relax and that they dare to ask all the questions they ask." -Interview Feb 24 NL

> "Midwives know how to do this, is to sit and be still. I mean a good facilitator can sit on their hands and a good midwife can sit on their hands right and wait and allow space and to just hold that sacred space and I think that circle like birth has opportunities for that sacred space and midwives are extraordinarily good at doing that." -Interview Oct 26 US

This ability to hold sacred space interacted with the midwives' assessments of their facilitation skills.

7.2.3 Facilitation

Facilitation and demonstration of effective interpersonal communication with women and families are essential midwifery competencies (ICM, 2018). Group facilitation is a learned skill, one that requires the time and space found in GANC. In their facilitative role, midwives' used participants' questions to generate answers and discussions within the group, referred questions back to the group, and managed dominant or quiet group members so that there was time and space for everyone's concerns.

> 'Yeah. And also sometimes there, sometimes you have one, one lady in a group who [is] always, always generous[4], always and you can't stop her, and she has an answer to everything and you want to have the shy one also have space to tell. Yeah, that's that's difficult." -Interview Mar 2, NL midwife

> "Keeping people, sometimes you know they might go way left... And so you have to bring them back or you have some people that will try to dominate the conversation and you want to hear everybody's voice. So those are challenges where you have to bring people back and recenter them or not allow certain people to dominate the conversation." -Interview Nov 18c US

Some midwives expressed being comfortable facilitators prior to working in GANC whilst other described growing better at facilitation with time and experience.

> "When you start, it's always well, when you have to learn to let them talk because the I think the big difference with the normal care we give is they come and sit opposite of me and they ask questions and I answer. And with the group care, we have one subject and we start talking about them. But. Well, in the end, I can lean backwards and they talk, and I just have to make sure that the information is right and just give a summary at the end, but that's it. So I do a lot more themselves and that you have to learn because in the beginning you want to talk and tell and just to learn just to sit back and just wait and see what happens"-Interview May 20, NL

The ability to be facilitative was frequently flagged up by the interviewees as desirable/critical. One midwife described watching a very experienced CP midwife in action this way,

> "You know, kind of watching her facilitate that was like it's just like watching someone ice skating. It's like, you're just like, Oh, it just in such awe of, of how gracefully and how skillful they are at at. At stepping back and putting themselves into the wallpaper, it's just amazing, just

[4] This Dutch midwife used the English word generous, the meaning here implies generous with her words, as in using/offering a lot of words, i.e. talking a lot

> amazing at and how people and how like the listening capacity of like, wait a second, did you just say? You know that thing and then you're like, Oh my God, that is such a, it's SUCH a magnificent skill to be able to to be able to listen, to listen to someone with that amount of umm, To be able to hear someone that profoundly that you can sort of read between the lines and and kind of move, help them move to the next place".-Interview Nov18b US

Some midwives reported that working in GANC and seeing that ANC could be done differently motivated them to try and make their individual one-to-one visits better, either more facilitative or more enriching for the women receiving the care.

> "Even in a one on one visit using some of those facilitative skills I've umm laid a foundation for really getting to collaborative care before there was quite such a push, I mean I've been doing centering for 18 years or whatever, so it feels much more natural to ask back when somebody asks a questions, what have you heard about that, what are you thinking about that, do you have a specific question, or making sure there's some reflection before I just give my answer and just helping again patients to trust their own sense of things, because often when people ask a question it's not so much that they want to answer its they want to know if what they've decided is ok if that makes sense and that facilitative model gets to that, I think if I remember, in the exam room just the same as in the circle it's not about me and so the less of me the more of the patients and the families and that's the right direction." Interview Oct 26, US

> "I feel more needs to give more information in the small 15 minutes I have. So that's that's difficult. And when I have like a break or something, most of the time it's just filled with baby appointments, appointments, then I I don't know the English word for it. But when I have more time than I, when I need more time than I have, I fill more breaks with it and I feel that the regular care is sometimes just not enough because you you want them to tell more to share more. I want them to know them better. I want to know them better because makes the care better. But well, the time isn't there. Unfortunately." -Interview March 2, NL

7.5 Relational Care: the magic of Midwifery:

Relational care is a central tenet of midwifery care. The work that midwives undertake in facilitating GANC; taking time, making space and using facilitation skills, allows them to forge the relationships with women that allow midwives to be "with women." Midwives interviewed consistently reported deeper connections with women, really getting to know women, knowing more about their lives, their families their circumstances. Midwives appeared to really value this ability to create a holistic relationship with women and to better meet their needs.

> “we notice that we get to know these women so well that the the the whole atmosphere, giving care and taking care of women and during the pregnancy, but also during labor and afterwards it was very much. Relaxing because we know the women so well, because in 17 more hours we got to know the women more and more than in the 12th checkups from 15 minutes, it's so much more”-Interview Feb 24, NL

> “And because you see them in the whole evening, you see different things. You see how they sit, you see how they walk, you see how what they eat. And yeah, give me so much more information about who they are and the the evening the the fathers are with us. It's also very interesting to see them and to see them participate. And yeah, it helps in the whole caregiving”.-Interview Mar 2, NL

> “You have like a very bond a lot with this group and you're very invested in their in their lives, you know, outside of pregnancy and centering. It's very rewarding in that it feels that's what midwifery is and that you're really following the family and helping them, you know, outside of their pregnancy and making sure that they're having all of their needs met. You know, do you have enough stuff or how are you? How are you coping? How's your mom? Is she visiting like, you know, that kind of stuff?”-Interview Dec 9, US

Many of the midwives interviewed were still in contact with groups they had facilitated, either via social media, or Whatsapp. One shared a photo album from her groups and many spoke of pictures they received years later, with the group’s babies grown and starting their first days of school or hearing updates from group members about the health and wellbeing of other group members.

Additionally, midwives facilitating GANC expressed that they sometimes shared personal details about their own lives and stories that they rarely or never shared in standard one to one care, emphasizing the multi-directionality of the relationship building in GANC.

> “It's really good. And you tell something about yourself - normally when you have had one on one consult I'm not, I'm not going to tell that I have two children and then I have three home deliveries. But in centering everyone tells about their their children or their home deliveries experience. So that's that's the thing where you come from, what your hobbies are, etc., etc. So they know a little bit about your home situation and also the person after [sic] the midwife. So I think that's important”.-Interview June 8, NL

> “I feel like I've learned a lot about myself as a woman, as a midwife but probably more as a woman. I I've learned a lot about myself. I ended up sharing things with some of my groups, not all, but with some of them that I had never shared with anyone.” Interview Jan 7, US

> “I think that I felt more like a person in a group, you know? I mean, like, I knew what you have to still maintain. You know, you have this special role and that's why I'm getting paid to do, you know, but you I felt like there was just much more of an opportunity to just to be a member of a group if it gets going and people start talking”- Interview Nov 26th, US

GANC enabled midwives not only to build their own deep relationships with women and their families, and also to witness and facilitate relationships between the group participants.

> “And they had their babies together and were like, I'm sure they're lifelong friends. And I thought that that is what it's about for me to facilitate not just discussions, but to facilitate the connections between women. Of course not just women.”-Interview Jan 13, US

7.6 Working Together: Support & Community Building

Creating support networks was a goal and satisfier for midwives working in GANC, it introduced peer support, supported the midwife in difficult situations and built strong professional relationships.

7.6.1. Pregnant and Parenting Peer Support & Community

The support network of peers and the group bonding that occurs in GANC has been previously highlighted as a positive experience for facilitating health care professionals (Lazar, et al. 2021). Both in the qualitative portion of the survey and the interviews, midwives from the U.S. the Netherlands reported watching these relationships form as an essential satisfier of working in GANC. Midwives spoke of these networks as enriching and extending the care they could provide, serving as an antidote to isolation experienced by immigrant groups, substance addicted participants, or anyone who lives in the modern world where families are frequently scattered.

> “prenatal care and postnatal care, specifically in the U.S., is severely lacking. And this is a great way to build a network of of people in support, especially when everybody scattered throughout the U.S. and their families all over in this way. You have literally women in the trenches with you going through the same thing, literally that you're going through at the same time. And it's hugely beneficial. I think antenatally, but definitely postpartum for sure. And they have currently there the text chains because I got to see one of them in the hospital and she's like, Oh my God, you're like so many texts going back and forth and, you know, talking to one another and they're meeting up”-Interview Dec 9, US

> “The ability for them to form a community because they need that in their lives especially well. We all know with people moving around everywhere and they're not close to their families and all of that. So those things really made me happy” (laughs).-Interview Feb 11 US midwife

Midwives in the Netherlands, a much smaller country, also commented on the fact that traditional family support and knowledge networks for pregnant are disrupted and that GANC offers an

opportunity to have a supportive group.

> "The biggest side effect is that they have each other, and on the app group they are going and going and going, and when the babies are crying, they give each other tips. That's I think, the biggest opbrengst[5] of the centering and they learn from us a little bit, but the biggest that's the most wonderful thing because, I think it's in America, maybe the same, but my brother is is living in Maastricht, the one in Harlem, in all different places. And everybody has a lack of network nearby where you learn normally from your mother, your sister, your aunts because they're around you and you can ask them they can help you with breastfeeding or the crying baby. Now everybody is everywhere, everywhere, so the forming of the network, I think that the best things of centering"-Interview March 23, NL

> "The good thing of centering pregnancy and especially for the expats, is that you bring people together and I we have a group, I think, No. 10 or something like that. And there was somebody she was twenty-seven weeks pregnant as she was coming from, I think India or I don't know which country to the Netherlands and because of her husband was working as well and they actually call the midwife and the midwife said, Oh, we have a group tonight if you want to go join us. And she was coming, and at the end of the session, she she says to me, I'm so glad because I don't feel alone anymore. She was so afraid that she has to be pregnant in a in a strange country, without her family, without her mother. And now she joined us with all strange foreign people. And it's yes, it's it really touched me."- Interview June 8, NL

Many midwives described text chains, Whatsapp groups and in person reunions between group members, some of these groups included the midwives. One midwife described how she felt these networks reduced affected the number of phone queries the on-duty midwife received,

> "[I think they call] less because they ask the questions in the in the in the Whatapp group? And normally they, well I read it, but normally I'll wait. And then eight out of 10 problems solved themselves. And otherwise, I give the answer, also although I'm not on duty. I just think, oh, I will give the answer that they don't have to call my colleague who is on duty and it's just, well, it's a matter of two minutes. No problem, but I think they call less. Yes." Interview May 20, NL

Midwives that were part of text chains or Facebook groups often left them after the babies were born but seemed aware and pleased that many continued on independent of their involvement. They also described the ways in which GANC support networks were vital coping mechanisms for the stress middle of the night crying babies and for more women and families in more complex situations.

7.6.2 Difficult Situations: Supporting the Group and the Midwife

By taking time and holding space the midwives facilitated difficult discussions and broached

[5] yield

painful topics, and as a result benefited from the support of other participants in the group in supporting women and families in challenging situations such as foetal anomalies and poor pregnancy outcomes, adolescent pregnancies, domestic violence, substance abuse, depression, family separations, illness and, poverty.

> "I had a group and one of the participants had a baby with a diagnosed anomaly and she had not shared that and we knew that early on, like 20 week US and she had not disclosed and I we got to about 36 weeks and so this was session probably 8 or something and at that point she shared with the group and was saying absolutely nothing, and I'm a participant in it at this point and the group, umm, got up and physically surrounded her and just loved on her and, interesting, asked her, would it be ok if we prayed with you, what do you need, it was just the classic watching of a community come together and love on somebody who was struggling and vulnerable and the group stepped up and they were there for her and it was a beautiful moment and a very sweet group, that, but lots of stories like that honestly but that's what jumped to mind first."-Interview Oct 26, US

> "There was this one patient whose husband had left her, and she was really depressed and discouraged, and I tried with every ability that I had to get her into some kind of counselling…And so I couldn't get her into care, and we just kept meeting with the group. And over time, I saw her mood in her experience, her just her whole... Everything change over time. And then... That group really bonded, and they, they, they never nobody ever missed. And then when they came back to the reunion, everybody came to the reunion, and she was like a different person. She totally had adapted and was moving on with her life and was in a whole different frame, which I attribute to the group that she had the support. So that was one of my most one of my more memorable, memorable groups as well. -Interview Feb 11, US

> "And we've seen a lot of other nice things you. For instance, we have this woman who smoked; two women in the group who said, 'Well, yeah, I also smoked and but I have a good book for you, which helped me shall I lend it to you. Yeah, OK'. And there was another woman in the group. She would say, 'Well, I will pray for you that God to help you stop smoking'. And then there's another lady who would ask. 'Well, I'm curious. Well, my neighbour smoked as well, and I was so curious. Well, what does it do for you and why are you not able to stop it right away? And this woman, she was not planning to stop? No, no, no. That's OK. Well, in the end, she stopped smoking'. No, that's nice. And we end up who who had who had some switch in in winter coats. Oh, I do have a coat from my sister. Maybe I can lend it to you so things like that, that's this. Yeah, yeah. We had this woman who had the mother in Bangladesh and she had to go there, and then they collected more milk to baby who who would stay at home in Holland. Oh, that's so nice. Or this ladies who called me after a few weeks and said, Hey, well, we think in the group that she's not doing well. Are you aware of that? Oh, you know, it's like this. It's so cute. It's so cute."-March 8 Interview NL

In addition to the group participants, in difficult situations the presence of a co-facilitator GANC is an additional support,

> I think it's nice that you're with two because especially with subjects like domestic violence or something, when one of us is doing the act, the activity or the the facilitates the other one can feel around what's happening. And then sometimes she picks up things I can't pick up because I'm busy with the text and the and then, she says afterwards, "N., that woman? I don't know. Maybe you should take a little bit care about her" or something like that. So I think two is not really necessary, but yeah, preferable-Interview March 23, NL

The experience of facilitating GANC created deeper relationships between participants and midwives, expanded peer support networks for women and also expanded interprofessional support for midwives and participants. The co-facilitation experience, largely described positively by midwives on the survey, was described as a rich support resource for facilitating midwives in interviews. Co-facilitators varied, often nurses and medical assistants in the U.S. and generally Kraamzorg in the Netherlands, these Dutch maternity workers provide in home support for the woman, baby and family in the early postpartum period.

7.6.3 Peer Midwife & Interprofessional Collaboration and Support

Co-facilitation with another midwife or another professional was reported as valuable because it helped with logistics, and language support in bilingual groups, and but because it also allowed facilitating midwives to see new ways of working, and to learn from another professional, add different information and resources to the group, even when the midwives had already had a long association with their co-facilitator,

> “In Holland, we call it cosy. Yeah, we have a lot of fun and we learn from each other, although we run the practice for more than twenty-five years together. It was, it was very much a situation [GANC] that we get to know each other. How do you say things to your patients? In what way or how do you do your checkups? And of course, we know in basic how to do it, but to see each other work. It was very interesting, so we learn from each other. Still, after twenty-five years now.”-Interview Feb 24, NL

Opportunities to invite in other professionals, such as lactation consultants, exercise therapists and even dental clinics, were seen as filling care gaps that midwives wanted to see filled.

> “So and just different experiences that people had or like. Like, we always had like a physical therapist, come and talk, and I can't drag a physical therapist into the exam room (laughs) with me on a regular basis. But she could come and talk to 10 women and their partners about things that they should be aware of and exercises and body mechanics and stuff that we couldn't. I couldn't do that, you know, that kind of thing”. -Interview Nov 18a, US

> “I love that because we have guest speakers come for like 10 15 minutes. So we had pediatrics come. We had lactation consultant come. We've had the doulas come and I learn stuff from the from, the lactation, was like, I didn't know that would stick that in my pocket for later. And so it's definitely widening my knowledge base and confidence wise.” -Interview Dec 12, US

Furthermore, midwives experienced deep relationships within their interprofessional support network.

> "The other piece I think that I don't know that we talk about enough is the relationship building with my co-facilitators. I have been very fortunate to have some amazing facilitators that I have worked with we at one point our programme had doula facilitators so they were doulas so learning a great deal from them and sharing with them, I've worked with nurses and with medical assistants as well and we develop that partnership within group and that really sharing that facilitation role so that we're equal there and then when we step out of that setting and back into the clinic and you're working with the same medical assistant and she's rooming your patients and helping with all the things that they do there is such a deeper relationship that we share because of our shared facilitation and shared group I feel like there's just, the communication is better because that hierarchy has been settled a bit umm, and its just more fun, because I'm working much more with a colleague then with that crazy dichotomy of umm, of status goes away when you're able to facilitate with your team members so that's another benefit."- Interview Oct 26, US

Some midwives expressed that the subversion of standard care and knowledge hierarchies enabled development of more extensive support networks that delighted the facilitating midwives and allowed them to create empowering antenatal care that also felt like meaningful midwifery care, where they were able to witness women and families grow, heal and transform into parents.

7.7 Meaningful midwifery: Helping Grow and Letting Go

On the survey, participants in both countries identified that they gave women more responsibility for their own education and knowledge sharing in GANC as compared to standard care. In this theme, the participants elucidated how GANC facilitated hierarchal changes and empowering transformative care, which was experienced as both meaningful and enjoyable midwifery.

7.7.1 Changes in hierarchies

Participants spoke to witnessing friendships forming in GANC across class and culture lines that they had not anticipated.

> "I find it also very interesting to see that people who are from a totally different background can become friends by doing this and can mean a lot to each other. So, yes, and that's that's also nice to see. I'm pretty sure that women's who doesn't taking care in this group care would never have met in their daily lives if we didn't offer this Centering project"-Interview Feb 24, NL

Midwives facilitating GANC spoke of the flattening of hierarchies of expertise by creating a comfortable space,

> "We are midwives, so we are on an equal level with the women. We are not, you know, the

> doctor on the on the standard, you know what I mean? You can just talk to me. I'm not wearing a doctor coat. I'm I'm just this woman, who knows, well probably a little bit more about pregnancy than others. I think the main the main task we have is to to how do you say that in English to. Make them comfortable and and, you know, I think that's the most important thing to let women feel comfortable and feel the room to ask questions, and that when they go home that they have the feeling okay, I can do. Another four weeks without her, I can manage. No, I think that's our our our most important task". -Interview Mar 8, NL

They expressed how much they learned from women in their group that they would not have learned in a standard antenatal visit,

> "I'm constantly learning from my patients, they're constantly reading something new and asking me questions [I'm] like I've never heard of that, I will find out and group allows that so much more than individual visits do."-Interview Oct 26, US

> "I learned a lot. I always learn a lot from my clients, and sometimes if we're having an individual appointment, some things are not going to come out. They're not going to speak to certain things that they would talk about in a group setting where, for example, you know, one of the clients will say, you know, you know, my, I always have this swelling and it happens at this time. And then the next person, you know, that happens to me too. But this is what I do about it. And so you learn different tricks and tools to keep in your toolbox that may help another person. So I learned a lot from them because they then i also found out that they have these Facebook groups and all of these other resources that they tap into".-Interview Nov 18th, US

The rearranging of clinical power dynamics also occurred through another key component of GANC, the conduct of health assessments on the mat on the floor of the group space,

> "we had like mats on the floor and we were helping our clients get up and up and down from the floor. And I just what I remember thinking was, this is so much more. This is sort of more intimate than it would be like in an exam room because you're on the floor with your client. That's how we were doing it. And it really was more, you know, you'd have kind of your client and their partner in this small little space near the, you know, away from everybody else. But it was something very interesting about that probably felt even more weirdly more intimate than it would have been in an exam room where there's a lot of big space around you. And you know, the client is on a on a table when you're doing Leopold's or measuring your tummy. This was a smaller space part of sort of in a corner away from everybody else. But and maybe because we were all kind of on a more because we were on a more like more equal footing, so to speak, we were literally on our hands and knees, on the floor with our clients. It was a power thing I think, and it also felt oddly more intimate"-Interview Oct 27, US

Midwives also reported that facilitation in group setting permitted them to set aside an expectation that they know the answer to every question, and that this in turn allowed them to introduce, develop or

validate the possibility that there are multiple approaches to or possibilities in pregnancy, childbirth and parenting.

> "I like having a cohort because I feel like, you know, even though I give the education or I do the facilitation, that sometimes it's better to do it in a group setting because I don't have all the answers all the time. And other people may have a voice or an opinion or a resource that I just don't have. So I like doing the group."- Interview Nov 18c, US

> "I mean, there's there's such a weird dynamic when you're in an exam room with somebody having a conversation. I mean, you're in this position of being the one of authority. So it tends to be like people ask you questions and you give the answers and what's. And the truth is, often there isn't an answer, (laughs) right? Or there are many answers. And so, yeah, so having that really clear, when you are in a group and you say, So what do people think about this or what's what, you know, what's the answer to this? And having all the answers come out makes it clear that there is no clear answer to this. I mean, there were certainly times where I felt like I wanted to push the conversation a certain way (laughs nervously) or give my own opinion. You know, but but yeah,… that was a really good, good part of it".-Interview Nov 18b, US

The intimate relationships and changes in hierarchies of knowledge experienced by midwives facilitating GANC reinforced one another beyond the antenatal care setting into the birth experience and beyond,

> Sometimes but also it makes me a little bit humble, and because I know them so well, it's when I attend to the birth, it's as well. They are not my friends, but it feels a little bit more like I attend the birth of a friend because you know them better. So you wish them more well. Or something like that. It's not exactly it, but it feels a little bit so, and it makes me more humble because they know much, so much more. -Interview March 2, NL

Many midwives interviewed spoke with great humility about the way in which GANC elevated the relationships and knowledge of the group and de-emphasized the primacy of the midwife in antenatal care,

> I always tell people that Mxxx and I wanted to do it for ourselves. But once we were there, we realized that it was not about us at all. It was all about the relationships with the the women had with each other and with the partners, and it didn't have anything to do with us.-Interview Nov 18a, US

Every single midwife interviewed highlighted the support network as a benefit of GANC, even the one midwife interviewed who felt that GANC model was not right for her caseloading practice in the Netherlands because she did not feel she got to know her women as well in the group as when she

spent one on one time with them, still wanted to find an opportunity to continue offering the accompanying support network that she experienced when she offered GANC to the women and families,

> "What I really, really liked about the centering part, which is a bit contradictory coming from me, is that centering showed that the midwife is not so important. This part I really loved and I do feel that the person who is part of your birth is super important. So I feel for me to be a good midwife during birth. I need to have a good relationship with the woman. She needs to know me. But other than that, I'm not that important. So. Yeah. So does that. I can totally agree with having a group of peers, during your pregnancy and after your birth with a newborn baby is so much more important than have this super cool relationship with your midwife, whereas it's also super important for the birth to have somebody you completely trust." -Interview Feb 2 NL

The deep one-to-one relationships between midwives and women can sometimes blur boundaries, and involve significant emotional labour (Hunter, 2006). Midwives interviewed for this study overwhelmingly cited the importance of GANC in refocusing care on women and families developing their own strength and support.

> "I mean, what one of the big draws for me to midwifery was that emotional connection between two women surrounding the pregnancy and birth process. But I also firmly firmly believe that once that baby is born that should never be the primary focus that relationship between me and the woman. The focus is between that mother and her baby and I, I know midwives that lose that perspective, don't have that perspective. And it becomes a very difficult co-dependency type thing. But I don't know, I think being able to witness a person blooming. You know, they're never going to be, you know, maybe. but they're reaching a part of their potential. They're reaching a part of their potential bloom, which sometimes gives them the taste and the strength to bloom further later on"-Interview Jan 13, US

The changes in hierarchies of knowledge and power in GANC led many of the midwives to comment on the ways in which this model of care allowed them to bear witness to, and guide women through a transformative pregnancy journey that many felt continued on into the postpartum period, and is consistent with a holistic vision of midwifery care.

7.7.2 Transformations and Power

Facilitating GANC sessions was repeatedly described as empowering for women and midwives were very enthusiastic in their descriptions of how happy participating in this process made them,

> "Well, personally, it's a it's a much deeper experience and relationship and and it's more it's just more transformative. You feel much more impactful. And because you're creating something

that's more sustainable, it's richer. It's it it. I think it moves people, it moves the needle in a much larger way than individual prenatal care. As far as transforming people's lives and in better ways and helping people heal from whatever past trauma. And and like just validating learning, communication skills, learning how to trust themselves, *validating* (her emphasis on validating) their experiences and their fears and their frustrations. So you, you end up with a group of people that are that are stronger and that are more excited to take on parenthood and that are more capable of getting through those times and parenthood. So it's just it's more rewarding, you know, you're just like, yes!, instead of like, it's always nice to coach the winning team. Right? (laughs) …[redacted for brevity] It's not because I'm creating the impact. I'm just creating the space for the impact to occur naturally. Right? … Professionally, we just. I think as midwives, the midwifery. What we do, what midwifery is, is... is facilitating people to find their strengths and be their best selves in whatever capacity they choose.-Interview Nov 18b, US

"And I, um, I want the, I think, take the most joy of my work when I see that that the lady has overcome some fears and has worked on some things and can be so proud in the end of what she has done and how she has done this, despite of how everything went. She had a cesarean or not, or if she gave birth in a bath, totally hands off. It doesn't matter if she looks back and say, Well, this was the way. Maybe not the way I hoped it, but but I know I was in charge and that's what I want and I I feel that. In Centering pregnancy, I can encourage encourage them more to to take that path"-Interview March 2, NL

I think I think it's for me, it felt good because you see women in their own strength. They they they decide what's good for them and what they want to talk about and what they want to learn or well, to know about the pregnancy. I just deliver them to the subjects, but they they start talking.-Interview May 20, NL

In both the qualitative responses on the survey and in the in-depth interviews, midwives repeatedly highlighted the process of drawing out participants own knowledge, and validating that knowledge, and guiding women in the process of taking charge of their own learning and growth as pregnant people and future parents.

MW: "So for me, I like it to see how do women get empowered during the sessions. And what I see is that they support each other a lot. So that's what I like for, for the for the women and for me as a midwife, you know, after so much years, it's it's of course, nice to learn something new. I learned a lot from it."

> Interviewer: “How how do you notice it in the women empowerment? How would you say like, Oh, how do you know that it's one of these women has been in the Centering, and she manifests that she's more empowered, maybe?.”
>
> MW: “Well, well, they're telling, and it's not because of me, but it's because of the other women in the group. And you know, we, we discuss a lot of more subjects than individual care. And we we do have a lot more time to talk about subjects. And what I like to to see and what I hear from the from the women that they tell, you know, and that's that's mainly for the for the mothers who are already in the group. So the not the first time moms are the, I must say, the first time moms learn a lot about moms. And I like that. I like to see that because I can tell them a lot as a mom as well, but they see me as a professional when I tell and the moms in the group can confirm what I say and find in my experiences. You know, they believe it more. And that's, I think, the key element of empowering.”-March 8 Interview, NL
>
> “it makes me very proud to think that those centering patients are out there asking questions and demanding answers and letting their voices be heard makes me feel extraordinarily proud of the work I’ve been able to be a part of.”-Oct 26 Interview, US

Many midwives expressed that this is what they felt “real” midwifery was, this getting to know the woman, family and her context, and then helping her build herself and her family and move on empowered and strong. As evidenced above some midwives felt very proud of this process and some felt humbled by it, but by and large this was described as a meaningful way to practice midwifery and one that brought a lot of joy.

7.7.3 Liking My Job: Joy, Laughter, Energy

Midwives in both countries really enjoyed working in group care. The word fun was used repeatedly. Meaningful and joyful and interesting were other words used to describe the experience. In almost every situation where challenges or barriers were raised, midwives expressed that they felt challenges to working this way were outweighed by benefits. Many midwives expressed so much non-verbal enthusiasm during the interviews it was difficult to capture. They spoke of the ways in GANC energized them after a long day, even as they also stated that facilitating GANC required energy as well. Several expressed that GANC was the change they had been hoping for when they were disappointed with standard care, and others said GANC saved them from burnout.

> “I don't know, like I just I enjoyed it, like those were the days that I loved being at work because I knew I had my groups and so I don't know, if it was anything that was going to make me have a feel good moment, it was definitely in my groups.”- Interview Nov 18c, US
>
> “Well, I don't know how long it would have continued in midwifery if centering hadn't come along because it was just was what I thought midwifery should be. And and so it just gave me gave me what I needed in my professional life to to be able to. To continue to work there” -

Interview Feb 11, US

Some midwives expressed concern that they were having so much fun it would not be seen as work, one interviewee expressed concern about recording how much fun she was having facilitating GANC for fear they would stop paying her. Another expressed frustration at her colleagues' attitude that she should not enjoy facilitating GANC,

> " I'm having fun at my job. Is that, is that a problem? I think you should be, as you should be glad that your colleague is having fun at her job and I'm not drinking tea. Yeah, well, you hear a lot of laughing when when we are busy, but that's all part of it. But it doesn't say that it's not good care."-Interview May 20, NL

Midwives expressed anxiety about the vulnerability of GANC, primarily in the context of systemic pressures of funding,

> "I love group and I'm really always scared Group's going to go away and part of it, the university doesn't really seem to want to put that much money into it." -Interview Nov 15, US

7.8 The world would be better if we did everything in Circle

The participants in both countries unanimously identified ways in which GANC offered quality improvements over standard care. Whilst the survey findings suggested many midwives felt they had adequate organizational support, the interview findings suggested systematic and professional complexities to sustainability and expansion of GANC.

7.8.1 Systemic & Organisational Pressures

Every midwife who participated in the interviews was asked what might help or hinder the expansion of GANC and every midwife identified money as a barrier. In the Dutch context, funding was a significant barrier to the ability to staff the model fully with two facilitators. In the U.S. context, the monetary pressures of productivity based models of healthcare on staff time were frequently cited, and midwives expressed having to justify their time or staffing dollars when working in GANC models,

> "I think the main main problem is a lack of money because that, that I hear from my colleagues who doesnt do Centering. When we're calling them is they don't have the time and the persons to do it" -Interview Feb 24, NL

Other midwives highlighted that GANC is a fundamentally different approach to care, one that stands in opposition to traditional care delivery,

> "The one on one model of care really is a patriarchal model of care that was really designed for men and women need groups. You know, we are much more social beings. We sit in circles, that

> we talk. We want other people's opinions that women have always sat in circles from the beginning of time, and we were forced to be into this male model of health care that really actually doesn't fit us as women. But then here we are as midwives being forced into that same model. So that's why I love group. It's not. It's the right model for women and I would love I would love to only do group care if I could".-Interview Nov 15, US

7.8.2 Professional Role Challenges

Whilst a preference for working in group care and viewing group care as better care was a common finding, in keeping with midwifery philosophy around informed choice, many midwives expressed their belief that GANC was an option that should be offered to everyone, but that it might not be right for everyone, even while simultaneously expressing that they felt it was better care. This same dichotomy held when asked if they thought midwives were the ideal facilitators for GANC, midwives were loathe to preclude the possibility that other professionals might not have the same ability to facilitate groups as midwives or to ascribe facilitation skills as a unique trait of the midwifery profession, often stating that facilitation was more dependent on the personality of the midwife, rather than on their professional capacity.

> "It depends on the person, of course, midwives or physicians, we have a physician who has been trained and is in the country, and she is a fabulous human being and like feel like she's a midwife and a doctor suit. So I think she would be totally fine and is very, listens to patients, and has great bedside manner. And like, there are some midwives out there who are just like this what I said, you do this. And so, you know, I can't say that we're better than any other group, but I think that it's perfectly within our wheelhouse to do centering because it kind of goes in line with what we're taught and how we're trained and just our model of care."-Interview Dec 9, US

This stood in some opposition to numerous assertions that facilitation was learned skill, one that improved with time.

The midwives interviewed also flagged up characteristics of midwives that make facilitating GANC a good fit for midwives; the need for flexibility, good listening skills, a commitment to collaborative care and mission driven to provide the best holistic care they can to women and families,

> "I think that midwives are encouraged to umm, see their clients as the experts on themselves. I think that is explicitly part of how we are socialized as as caregivers and how we are trained and that and that that is is very true throughout, it's not just an add on later on like we are trained from jump in every aspect of the care, we learn to see our clients as experts in themselves and that we are Power Sharers, not power overers, if that makes any sense. We don't have a top-down model of how to do this, we definitely have a, you know, we're going to link arms and do this together. But the goal is that you at the end of this are going to have all the skills and confidence that you need not just to give birth, but to be a parent, especially go around with

> parenting that we're trying to. I can't remember who it was. That said, birth is more than about making babies. Birth is about making mothers. And I've always said that's absolutely true. And so that, I think, is a philosophy that we get trained in. Now, I think there's other definitely the possibility of other clinicians adopting that and learning that and having that philosophy. And I think anybody who has that philosophy would be a great fit for this model. But again, it might be a bit more of a stretch for some folks than than others. So and it's certainly I've, you know, probably not every midwife practices, according to that model. So I kinda hate to go 'yes! midwives are the perfect fit for this' but I think, you know, the philosophy of midwifery as we still teach it, I think is a really good fit. And I'm not sure the philosophy that other professionals get is quite as WITH women." -Interview Oct 27, US

Whilst remaining respectful to other professional groups, and circumspect about subscribing homogeneity to midwives as GANC facilitators, the interviewees made clear the ways in which GANC is a satisfying model of midwifery led care for midwives, however challenge to systems integration is well encapsulated by one Dutch midwife,

> "But it's very difficult to change the regular care because there is no there is no space and there is also an insurance company who wants to pay or not pay the extra. If so, it's in free time. And it's no, it's no problem. I don't do the work for the money, but yeah."-Interview March 2, NL e

Until the unseen work of midwives; taking time, holding space, and facilitation, are valued in the larger systems of care, GANC as midwifery model of care remains on the unpaid margins of the uncompensated commitment of midwives to pursue higher quality antenatal care.

Summary and Conclusions

This chapter has reviewed the findings of the twenty-one semi-structured interviews conducted with midwives who facilitated GANC in the U.S. and the Netherlands. As with the survey findings, there was notable thematic congruence between the two settings. The chapter began with a conceptual model of factors that influence the satisfaction of midwives facilitating GANC. The dissatisfaction with standard antenatal care expressed by the midwives interviewed influenced their perceptions of the value of GANC. They expressed the ability to work in a midwifery model of care, taking time, holding space and facilitating relational care. Working together and benefiting from a peer community of women and professionals built them a valuable network of support, notable in difficult situations.

Participants described opportunities to weaken hierarchies and witness women and families empowered in their transition from pregnancy to parenting. These experiences felt particularly meaningful and mission fulfilling to the midwives interviewed. They expressed how working in GANC brought them professional joy. They also noted organizational and systemic barriers to expanding GANC,

particularly around funding. As with the previous chapter, given the mixed methodology, strengths and limitations and the discussion of the integrated findings is completed in the next chapter.

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8. Discussion

Introduction

This overarching aim of this mixed methods study was to explore midwives' experiences of facilitating GANC with a view to understanding the sustainability and feasibility of the model in diverse contexts. The systematic review of existing literature found that most studies had looked at midwives' facilitating GANC in research settings, such as pilot implementation trials. This highlighted the need for a focus on the experience of midwives' who had experience working in the model as part of their normal midwifery practice, which resulted in a subsequent focus on the experiences of midwives in the U.S. and the Netherlands, where, as mentioned in Chapter Four, there is a decade plus of implementation of this model. The survey provided a descriptive overview of the experiences of 226 midwives who have worked in this model as part of their normal midwifery practice, and the follow up interviews of twenty-one of those midwives provided thicker, richer qualitative data that provided deeper insights into the experiences of midwives facilitating GANC. In this chapter I first summarise the principal findings and then discuss and reflect on the strengths and limitations of the work. Following this, the integrated findings and concepts are discussed in the light of wider literature.

8.1 Statement of Principal Findings

The qualitative systematic review identified three themes; 'giving women what providers feel they want and need', 'building skills and relationships', and 'worth the work? For whom?'. The review led me to narrow the research question for the empirical study to the specific experiences of midwives facilitating GANC in contexts where it was being offered as a regular care option. Furthermore, the review identified a need to turn the focus away from midwives' perspectives on women's experiences of GANC, and to give them opportunities or encourage them to share their own experiences of working in this model. It also raised questions about ways in which midwifery roles or skills might support, complicate or intersect with GANC facilitation. Finally, to contemplate the sustainability of midwifery-led GANC, a direct comparison of midwives' experiences in GANC as opposed to standard care was warranted.

Hence, the original research questions informing the next two phases of the study were; Do midwives perceive GANC as an improvement over the care they are currently offering? Do midwives experience changes to their midwifery role or identity in facilitating GANC, and if so how so?

Whilst the development of the survey guide provided opportunities to validate or contradict the findings of the review in relation to midwives' perspectives of the benefits for women, its primary value

was in providing input from 226 midwives about their own experience as GANC facilitators, and how that compared to their experience delivering standard antenatal care. The survey gave insight into how participating midwives were working in GANC. The majority had been trained in GANC facilitation and had chosen to be GANC facilitators. The majority were working with a co-facilitator; some participants were facilitating in other languages and most participants were providing some intrapartum continuity. As compared to standard antenatal care, participants reported that GANC gave them more time with women, more ability to deliver quality care, and that they found the facilitating GANC more satisfying than standard care. Whereas in the review provider perspectives about workload were mixed, the majority of surveyed midwives found GANC more work than standard care. Whilst in the review organisational barriers to GANC were numerous, the majority of survey participants felt supported by their organisations in providing GANC.

These survey findings were integrated in the development of the interview guide in that open ended questions were created to allow participating midwives to expand on their experiences and explain more fully what influenced satisfaction and workload.

An integrative analysis of the data created a conceptual model of midwife satisfaction with GANC. The experience of facilitating GANC was described by the participants as more fulfilling than standard antenatal care. While acknowledging the workload associated with GANC may be greater, the work was described as more valuable in that it aligned with midwifery philosophy of care and fostered reciprocal relationships, while simultaneously expanding support networks for both the GANC participants and the facilitating midwives.

8.2 Strengths and Weakness of the Study

One cannot begin to discuss limitations to any research that took place in the years 2020 to present without mentioning the Covid-19 pandemic. The pandemic made exhausting demands, particularly on the midwifery workforce worldwide. Attempting to research any experience among healthcare professionals during Covid-19 that was not Covid-19-related seemed at times both futile and dangerously inconsiderate. Original plans to also distribute the survey in Australia and the U.K. were halted following national research recommendations to suspend non-Covid related research, and key informant researchers and midwives spoke to the overwhelming stress and sickness in the NHS. It is hard to imagine that pandemic stressors did not affect response rates among the surveyed midwives in the U.S. and the Netherlands as well rates of midwives willing to be interviewed. That said, the great isolation engendered by restrictions on groups certainly caused midwives who had worked in GANC to

consider the benefits and deficits of this model in a whole new light that added richness to this research.

Covid-19 also provides an example of a further limitation of this study. Whilst a strength of working in a mixed methods is the breadth and depth of depth of the findings, it also results in a large rich quantity of data, such as the findings related to the effects of Covid-19 on GANC, that remain unexplored because they fell outside the scope of my research questions and the limitation of time and funding. The analysis of the survey could be pursued beyond the descriptive statistics and some limited tests of association reported in Chapter Six, to deeper sub-analyses of the validated Midwifery Process Questionnaire, however the sample size and the limited variation in the data constrained these.

There has been relatively little survey research conducted with GANC providers. A survey was conducted in Sweden of provider's attitudes towards GANC; however, those providers had yet to facilitate GANC (Andersson, Christensson and Hildingsson, 2014). Lundeen, et al. (2019) conducted a survey of providers facilitating GANC, which asked a job satisfaction question. However, because it was part of a RCT it did not specifically ask questions about GANC experience, so had limited usefulness in design of my survey questionnaire. However, the findings around satisfaction with GANC from Lundeen et al., (2019), as well as the qualitative findings from prior small implementation trials do reinforce the external validity of my survey findings by replicating them in diverse contexts (Ball, 2019; Lundeen *et al.*, 2019; McKinnon *et al.*, 2020; Lazar *et al.*, 2021).

In designing the questionnaire, the recommended steps for rigour in survey research design were followed; performing a literature review, input from topic experts for content validity, synthesizing this information into question design, and pilot testing the survey, in order to improve validity and reliability (Gehlbach, Artino and Durning, 2010; Ball, 2019; Ziniel, McDaniel and Beck, 2019). By using multiple points of contact, and multiple reminders during the questionnaire period, an attempt was made to mitigate non-response bias. If recruitment had only occurred through the CHI and CenteringZorg, it would be reasonable to consider that the sample might be biased towards those who already like GANC as they are engaged with the organization. By including recruitment through the national midwifery organizations, this bias was potentially reduced. Qualtrics software contains built in tools that help with question wording to avoid response bias.

The survey was able to capture the experiences of 226 midwives working in GANC, however the lack of centralized accessible databases of midwives currently working in GANC or who have worked in GANC means that there are few reliable methods to estimate a response rate to my survey. The CHI and

CenteringZorg both track how many people they have trained in this model of GANC, but CHI does not segregate it's data by professional type, and both organizations are limited by staffing and funding in maintaining up to date records of whether those trained ever go on to work in the model or not. The lack of midwife specific data collection at CHI could reflect a continued marginalization of midwifery in American maternity care, and the paucity of GANC data management and maintenance in both group care organizations and midwifery organizations may reflect the still marginal status of this model of care in maternity care systems in both countries.

As a result, this study cannot speak to generalizability of the findings, however as this work may be among the first to survey midwives' experiences of facilitating GANC as normal care integrated into their practice, it can hopefully serve as a point of comparison for future research, particularly if the population of facilitating midwives expands and organises. The survey collected only limited demographic data and although this was a carefully considered choice to not collect data that was not relevant to the scope of the research (as discussed in the methodology section 3.4), it limits the ability to speak to gender or racial diversity of the sample or make comparisons to index data sets. Currently, a several studies, quantitative and qualitative are underway that center the experiences of Black women in GANC, and there is also clearly a need to expand the research into experience of Black and Brown midwives (Liese, 2021, 2022 A Horn, personal communication, 21 Nov). A strength of the research was that in both the U.S. and the Netherlands, the survey and interview participants reflected diversity of geographic and practice settings, and a range of years of midwifery experience, and extensive experience facilitating GANC.

The congruence of the quantitative and qualitative findings between the midwives in the Netherlands and the midwives in the U.S. is a strength of this mixed methods research. It also aligns with the universality noted in the systematic review of healthcare providers' experiences of GANC (Lazar *et al.*, 2021). Considering the differences in the maternity care systems of the U.S. and the Netherlands, the similarity in findings warrants further research on midwives working in GANC in other maternity systems.

A focus group methodology, which has been used effectively in other qualitative studies of midwives' experiences of GANC may have had been a more natural fit for a study on midwives' experiences of GANC (Klima *et al.*, 2009; Teate, Leap and Homer, 2013; McDonald *et al.*, 2014; Lori, Munro and Chuey, 2016; Lundeen *et al.*, 2019). Whilst my decision to use in-depth interviews was pragmatic given the difficulty of convening multiple midwives' at one time, and because I thought it would be an ideal format for sharing honest experiences, the findings of my study around the ways

midwives' who have worked in GANC perceive group spaces to be egalitarian and safe for sharing has caused me to reflect on the possibility that a focus group methodology may have elicited different or richer data. Observations are also valuable tool to see what it is that midwives do in a GANC session. Having observed other midwives facilitating GANC in the past, I am aware there are discrepancies between what facilitators report their experience to have been (for example how didactic they were or were not in a group, or how they handled difficult questions) and what I have observed. In some instances, they are much more critical of their efforts, and in others less aware. However, the goal of this research was to establish what midwives perceive their experiences to have been, and thus observations, while useful in feeding back during a participatory research project, felt a less fitting method for the overarching thesis question of midwives' experiences of GANC.

My decision to sample midwives' who have worked in GANC as part of their normal care was both a strength and limitation. The decision was informed by a pragmatist approach and the systematic review of the literature and added useful insights regarding challenges for midwives' working in existing health systems contexts, rather than the unique and somewhat protected context of research. However, it also limited the inclusion of midwives working in countries that may have pilot research programmes in GANC. It also precluded a longitudinal design that was valuable in considering midwives' experiences training in and implementing GANC and other models of care such as caseloading continuity (Teate, Leap and Homer, 2013; Hollins Martin *et al.*, 2020).

In discussing my positionality in the Methodology chapter, I highlighted the importance of disconfirming analysis in order to counter my own researcher bias toward the experience of working in GANC. Furthermore, adequate discrepant case and disconfirming evidence is useful for showing evidentiary adequacy (Vasileiou *et al.*, 2018). I was eager to talk to midwives who did not like working in GANC, and so when the anonymised survey only presented nine respondents who found providing GANC as a less satisfying than standard antenatal care, and when every interview I conducted was positive about GANC (with the exception of one caseloading midwife, who said she would prefer the model to standard care but not to the care she was currently delivering as a caseloading midwife, which allowed her as much time as she wanted for one to one antenatal care), I made another attempt to reach midwives with a different perspective. During the course of the interviews, two Dutch midwives flagged up that their colleagues had been less than enthusiastic after facilitating one or two groups, so I asked them to please let their colleagues know I would be eager to interview them. Unfortunately, I had no response from either. Similarly, I reached out through some American midwifery contacts in my own professional network, but received no responses. Whenever I asked midwives who worked in GANC for

recommendations of midwives who didn't like working in this way, midwives seemed sceptical I would find someone who had continued working in this model and didn't enjoy it.

In the Systematic Review, organisational barriers were barriers have been well documented, however personal and social barriers less so, I hoped this thesis would uncover some of those, but as detailed above, in spite of reasonably robust efforts to find dissenting voices, there simply aren't a lot of vocal model dissenters. All available information on barriers obtained via the qualitative sections of the survey was included in order to detail any overlooked personal or social challenges experienced with GANC.

8.3 Meaning of the Study

In this section I will detail how the midwives facilitating GANC perceived this model of care, the relevance for a profession in crisis, and why midwives' attitudes towards working in GANC matter. I will also discuss what midwifery work means in the context of GANC.

8.4 Do Midwives Find GANC to be a significant improvement over standard antenatal care delivery?

8.4.1 Midwives Love GANC: Meaning to the Mission

The findings in Chapter Six (More Satisfying & more Work) provided quantitative evidence that midwives find working in GANC more satisfying than standard care. Chapter Seven (The Satisfaction that is Meaningful Midwifery Work) produced a conceptual model of why midwives might find GANC a more satisfying format of ANC based on the qualitative data collected in the interviews. Working in GANC, midwives were able to use the unseen midwifery skills of time taking, holding space and facilitation to foster trusting relational care that engendered support networks. The result was that GANC satisfied midwives' perceptions of 'real' midwifery, which I have interpreted to reflect care that feels meaningful congruent with midwifery philosophies of being holistically 'with women'.

Evaluating job satisfaction in midwifery is complicated by the fact that many midwives do not view it as simply a job but rather more of a calling (Bloxsome *et al.*, 2019; Thumm, Stimpfel and Squires, 2022). One interview participant described midwifery as "mission" driven. The passion of midwives for providing excellent relational empowering care for women in GANC and for being "with" women really resonated throughout the follow-up interviews. This was demonstrated in rapid fire enthusiastic speech, poignant emotional silences, laughter, tears and storytelling. Being a midwife myself, I was also

routinely moved by this passion and by the stories themselves, and several times in early interviews I had to consciously reset my mind into a researcher framework so that I did not launch into enthusiastic sharing stories of my own.

Practising meaningful midwifery was clearly satisfying for the participants in my research. As described in Chapter Six, meaningful was the most frequently chosen word to describe the experience of GANC by surveyed midwives. Meaningfulness has been correlated with job satisfaction for midwives (Hansson *et al.*, 2022). Several studies support that the midwifery philosophy is an intrinsic motivator for midwives and that midwives who work in ways that conflict with their understanding of midwifery philosophy are more likely to leave or consider leaving the profession (Ball, Curtis and Kirkham, 2003; Bloxsome *et al.*, 2019; Bradfield *et al.*, 2019; Peter *et al.*, 2021).

8.4.2 Profession in Crisis

8.4.2a Conflicting Ideologies: Standard ANC is a symptom

As discussed in the first chapter of this thesis, antenatal care in its standard form was imposed on midwives by the state, based on a surveillance model with an outcomes-based focus rather than a process based one. Despite the 2016 WHO policy directive calling for care attuned to a positive pregnancy experience, most modern antenatal clinics currently reflect a transactional capitalist structure comprised of fifteen to twenty minutes of a midwifes' time delivering didactic education and ticking boxes in exchange for overwhelming surveillance testing options and poor preparation for labour, birth, parenthood and healthy lifestyles (McCourt, 2006; Browne *et al.*, 2014; Gottfredsdottir *et al.*, 2016; John *et al.*, 2019). Many midwives have long recognized that this standard system is not fit for purpose, and that stands out in the findings of my research. The three components of GANC (healthcare, interactive education, and community building) reimagine antenatal care as a non-hierarchal system with women, parents and families acting as fully invested and empowered participants, and in this way aligns with midwifery philosophy as well as WHO guidance to provide a positive pregnancy experience (World Health Organization, 2016b).

Additionally, also consistent with midwifery worldview, the findings from the systematic review (Chapter 4), reinforced by the interviews (Chapter 7), support midwives' perspective that GANC supports pregnancy as a physiological process rather than a pathology. Protecting and promoting salutogenesis within a medicalised antenatal care system that is hyper focused on surveillance, and tacks education on as didactic afterthought, does not support midwives to be effective public health practitioners and partners. Many midwives still manage to conduct antenatal and intrapartum care with

a midwifery mindset in medicalised work settings, but it requires great effort and it takes a toll (Browne *et al.*, 2014; Kozhimannil *et al.*, 2015; Petraki and Clark, 2017; Dayyani, Lou and Jepsen, 2022).

Furthermore, many of the midwives expressed in both the survey and interviews, that GANC was an antidote to the repetitious nature of standard antenatal care. In standard ANC, midwives may repeat the same antepartum guidance fifteen to thirty times per day. This brings the experience closer to that of an assembly line worker who is turning out a standardized product, rather than one that is tailored to fit the needs and circumstances of each individual person and family. Whilst there is certainly evidence to support checklists in critical care settings, the evidence in maternity care supports the value of personalized care for the woman and the care provider (Sandall *et al.*, 2016; Downe *et al.*, 2019).

8.4.2b Emotion Work and Midwife Well-Being

Globally, the midwifery profession faces historic staff shortages and moderate to high rates of burnout (Hunter *et al.*, 2019; Albendín-García *et al.*, 2021; Matthews *et al.*, 2022). The reasons for burnout in healthcare, and midwifery in particular, are multifactorial but emotional exhaustion has been cited as a contributor (Albendín-García *et al.*, 2021; Altiparmak and Yilmaz, 2021). Even without the dissonance of providing relational midwifery care in task focused, time pressured, cost and profit driven contexts, midwifery work is emotion work. Systems that are struggling to recruit and retain midwives are asking a workforce under pressure to follow sound maternity policy through the adoption of continuity models. Continuity of carer midwifery models can be protective against burnout, are supported by strong evidence and are satisfying for midwives (Sandall *et al.*, 2016; Pace, Crowther and Lau, 2022). The implementation of these models has been mixed. There are certainly many organizational and personal reasons that continuity of carer models do not work for some midwives. One consideration is that, although the autonomous way of working may be very much appreciated, there remains a great deal of emotional intensity in caseload midwifery. It is strongly predicated on the one-to-one bond between midwives and women, which can be emotionally exhausting for some midwives, particularly in the absence of very good boundaries (Hunter, 2005; Yoshida and Sandall, 2013; Pace, Crowther and Lau, 2022).

Hunter (2006) established the importance of reciprocity in the midwife-woman relationship, and the findings around the support systems experienced by midwives working in GANC models demonstrate the ways in which this model not only accommodates but fosters reciprocity. In creating space for midwives to experience equitable relationships, share their own personal stories, and allow some of the emotion work to be shared among a group of people, GANC offers a unique contribution to

reciprocity. Furthermore, there are opportunities for reciprocal relationships between group members that leave midwives as guardians on the periphery of the relational space, where boundary maintenance may feel safer and easier, while allowing midwives to provide antepartum continuity at a minimum. It also unburdens the midwife of some of the surface acting she may have to do, as demonstrated by a Dutch midwife who in her interview relayed how she often does not know how to respond when a woman tells her birth story, but the other participants in the group always have something beautiful to say. If GANC settings are able to redistribute some of the emotion work of midwifery, it is possible that this type of care could well reduce emotional exhaustion and improve burnout and encourage some midwives to remain in the profession.

8.4.2c Quality of Care

Midwives want to deliver high quality care. The inability to deliver quality care has been cited as another contributor to intention to leave the profession (Kirkham and Stapleton, 2000). The survey and interview findings reinforced the findings from the systematic review, that this is the kind of care midwives think women want and need. The majority felt it was easier to deliver quality care in GANC, and that women were more likely to ask for and receive the care they needed. It is worth noting that in the survey responses two thirds of U.S. midwives and three quarters of Dutch midwives stated they were able to deliver quality care in standard ANC settings; however, in the interviews, all but one of the midwives felt that the care in GANC was of a richer quality. Although social desirability bias may often be a factor in survey research, it is understandably particularly challenging around quality-of-care questions, where responding negatively may imply that you have harmed someone by providing poor care. Whilst midwifery in the Netherlands doesn't suffer from the same profession legitimacy struggles that it does in the U.S., it is nonetheless not immune from professional anxieties (Feijen-de Jong *et al.*, 2022). What the interview findings added to the survey was a sense that many of the services that women are seeking out, such as childbirth education, lactation support, postpartum support, perinatal exercise, could be integrated into GANC and thereby make antenatal care more than just quality care that meets relatively limited surveillance and messaging standards, but rather a holistic vehicle for a wide variety of pregnancy and parenting support. Midwifery is a caring profession and the data supports that midwives do not just care deeply, they care widely, but are constrained by fractured systems that do not always interact in the best interest of the pregnant person or their community. Through the act of increasing the number of people in the room, and the time they have in caring conversation facilitated by a trained midwife, GANC enables an increase in collective sharing of

knowledge and resources and connections that create a wider circle of impact from midwifery led maternity care.

Midwifery care is often defined by a holistic approach to the pregnancy, one that considers social determinants of health, as well as community, culture, context and psycho-social factors. In addition to the proven value of continuity of care, it is likely that this approach contributes to the quality outcomes associated with midwifery care, but more research is needed to determine if one element of midwifery care stands out. I would argue that until now, midwives have not had full opportunity to apply the magic of meaningful midwifery to antenatal care, because, as discussed above, the structural organisation of most standard antenatal care has been antithetical to allowing midwives to work in a meaningful way.

8.4.3 Meaningful Midwifery in GANC

8.4.3a Midwifery Work: Taking Time, Holding Space & Facilitation

As described in the survey chapter, midwives described their experiences of working in GANC as more satisfying and also more work. The follow up interviews of survey participants elicited descriptions of midwifery work in GANC models as taking time, holding space and facilitation.

Whilst taking time has been considerably described in the literature as a core component of intrapartum midwifery care, it's value in antepartum care has been less described (McCourt, 2009). This is unsurprising given that midwives working in standard models of care are constrained by the time pressures of traditional antenatal clinic scheduling. Inadequate time with women was identified by providers in a wide variety of settings as a barriers to quality antenatal care (Downe *et al.*, 2019; Thumm, Stimpfel and Squires, 2022). Survey participants confirmed that they felt they had enough time to get to know women in GANC models as compared to standard care, and the value of that time in deepening relationships and helping facilitating midwives to personalise their care to the needs of the group was repeatedly highlighted in the interviews. My research further corroborated the impression among midwives facilitating GANC that they got to know individual women better in a group setting than they might have done in individual one to one appointments (Lazar *et al.*, 2021; Wiseman *et al.*, 2022). Some text responses on the survey and the interview with one caseload midwife contradicted this overall finding, expressing the reduced one to one time with women as a loss, although it was unclear if it was a loss for the women or for the midwives themselves.

Holding space is a term often used by midwives to describe an essential facet of their work (Bettison, 2019; Bradfield *et al.*, 2019). This term is difficult to characterize within traditional task

oriented medicalised care models but was particularly salient for midwives in GANC settings. This theme underpins the notion of the midwife as a guardian of a sacred space in which women and families can learn, develop and grow (Powell Kennedy, 2000; Leap and Hunter, 2016).

"Facilitation of healthy family and interpersonal relationships" is an ICM Core Midwifery Competency (ICM, 2019), and group facilitation is a learned skill and one that may benefit midwives and midwifery education but certainly requires practice (Rowan *et al.*, 2007; Dawber, 2013; Manley and Titchen, 2017). Many of the midwives surveyed felt confident with their facilitation skills and in interviews midwives flagged facilitative communication as a key component of working in GANC and described the opportunities and challenges that GANC training and facilitation presented them in developing this skill. The fact that there was a significant concordance among identified areas of facilitation difficulties (managing dominant group members, drawing out quiet members and managing inaccurate information) suggests that even in different cultural contexts, facilitating GANC may pose similar challenges. This cross-cultural concordance in provider experiences of GANC was also reflected in the systematic review (Lazar et al, 2021).

A surprising finding was that midwives felt this facilitative approach to be valuable enough to their practice of antenatal care that they often integrated it where possible into their standard care, which inevitably ran up against time pressures, and forced the midwife to make decisions sacrificing quality of care or personal time. This caused palpable frustration, tension and guilt among the midwives who wanted to give the same quality of care to all ANC attendees but felt that those that had more questions should then have opted for a group format, because it was in that model that the midwives could clearly engage with women in a deeper and more personalised way. It is interesting to note that this was true of midwives who were themselves initially sceptical of facilitating GANC. This conversion from anxiety about facilitating groups to utter conviction that facilitated GANC is a preferable option for women has been reflected in the experiences of midwives who joined pilot trials of GANC (Baldwin and Phillips, 2011; Teate, Leap and Homer, 2013; L. Hunter *et al.*, 2018). The fact that midwives were quick to offer that physicians or other professionals could theoretically be good facilitators of GANC, even though very few of them had ever seen that happen, and some had stories of physicians "holding court" in groups, lends some insight into why midwives struggle to define and defend their midwifery role (Thumm, Stimpfel and Squires, 2022). In both the Netherlands and the U.S. the midwives were quick to point out that they knew there were midwives who were more didactically inclined and thus they didn't want to presume that GANC was best led by midwives, even after they had spent considerable time enumerating unseen midwifery skills necessary to be a GANC facilitator.

8.4.3b Unseen Midwifery Work

It is notable that that across the diverse contexts of the U.S. and the Netherlands, where midwives work in very different settings and with divergent levels of professional autonomy, there was a great congruence in the description of the work done by midwives in GANC. This triumvirate of taking time, holding space and facilitation skills comprise core unseen (and perhaps critically, uncounted) elements of midwifery care.

De Jonge, Dahlen & Downe(de Jonge, Dahlen and Downe, 2021) have named the invisible elements of midwifery care work in the intrapartum setting "Watchful Attendance". They argue that, "outwardly skilled midwives …may not seem to be doing much. They sit quietly, speak gentle encouraging words ('midwife muttering'), prepare some drinks or give a massage." (de Jonge, Dahlen and Downe, 2021, p. 13), and yet simultaneously they are discreetly observing the wellbeing of the woman, making gentle recommendations for coping or positioning that facilitate labour progress, and remaining vigilant for signs of complication. Similarly, this builds on the characterization of the unseen but very much *felt* work involved in exemplary midwifery support (Powell Kennedy, 2000; Leap and Hunter, 2016).

This description mirrors several of the descriptions given in the interviews of midwives facilitating GANC. They sit back and let conversations unfurl but remain alert to cues from the participants as to what information they most need, and what support is needed. Several midwives described subtly monitoring participant reactions in discussions of domestic violence or postpartum depression and using that information to respond to those needs. The self-checking component, mat time and discussions with participants about warning signs in pregnancy, allow the group to become active participants in the quiet vigilance of midwifery. The ability for midwives to engage in watchful attendance whilst facilitating antenatal care may explain why they find facilitating GANC satisfying. Watchful attendance in the antenatal care setting enables the relational care that is the heart of midwifery practice. It may also be that the relational care that watchful attendance engenders, may play a part in improving maternity care outcomes, particularly among marginalised populations.

8.4.3c Relational Care

In the qualitative portion of the survey, and in the interviews, getting to know and forming deeper relationships with women they cared for was a central theme. The ability to form meaningful relationships with women and families is a known satisfier of midwives and has been cited as a reason midwives chose to remain in the profession (Versaevel, 2011; Bloxsome *et al.*, 2019; Bloxsome, Bayes

and Ireson, 2020).The trust built in these relationships is described by participating midwives, and in the context of GANC this trust is particularly reciprocal given the self-checking aspect and the facilitative nature of the groups that relies on the development and validation of the collective knowledge of the group.

Whilst the majority of surveyed midwives indicated that they gave participants in their groups more responsibility for health assessment and education and knowledge sharing in GANC, they didn't feel they gave the women more responsibility for social support. This contradicted the findings of the systematic review, where data supported that GANC allowed providers to offload some of the psycho-social labour midwives sometime feel to transcend the health care provider role and become a friend and/or maternal figure. The interviews allowed me to unpick this further, as it is possible that the survey question on social support was poorly worded, or difficult to understand. In the interviews, midwives reported they were often more vested in their relationships with the women in GANC, they stayed in contact for years and appreciated follow up on their families and social situations. Their professional role did appear to change as established hierarchies were softened by the deeper relationships, midwives reported the value they felt in being seen as whole human, rather than just a professional in a group, and felt safe sharing relevant personal experiences that they couldn't/wouldn't in standard care. These findings echo those in caseloading research (McCourt and Stevens, 2008). Deeper, more equitable relationships may guard against depersonalization, which is a contributor to midwifery burnout (Albendín-García *et al.*, 2021). Whilst relational care has been largely associated with caseloading continuity models, the findings in this research indicate that GANC promotes similar opportunities for building fulfilling relationships. GANC may be an opening for reclaiming the relational nature of female interactions, restoring primacy to concepts of collective feminine wisdom guarded/shepherded by an expert midwife (Chamberlain *et al.*, 2016). The collapsing of clinic-room hierarchies, the partnership with women and families and witnessing their powerful transformations in knowledge and power and the joy and fun of practising 'real midwifery' all served to allow midwives who have long been held hostage to a dissatisfying way of working to begin offering meaningful midwifery care from the start of a woman and family's pregnancy journey, rather than only at its conclusion.

8.4.3d Support Networks for Midwives as Participants and Professionals

It became apparent in the interviews that the relationships and trust formed in GANC did in fact serve an important support function for midwives.

Midwives care for women and families in particularly vulnerable moments and also moments of great strength. It is both an empowering and emotional profession. The emotional work of midwives has been well documented, particularly in the intrapartum setting (Hunter, 2005; Geraghty, Speelman and Bayes, 2019). There is also a growing body of research into secondary traumatic stress in midwives, although this also has an intrapartal focus (Beck, LoGiudice and Gable, 2015; Sheen, Spiby and Slade, 2015; Uddin *et al.*, 2022). In the follow-up interviews, when midwives were asked to share a memorable group from their experiences of GANC, many of the midwives shared accounts of groups where a difficult situation, such as fetal anomalies, or intimate partner violence, were disclosed and then supported by the group. It is interesting to consider the ways in which sharing a traumatic experience with a group of women, an obstetric or psycho-social tragedy that midwives encounter not infrequently and one that the midwife would normally carry and support by herself, may be therapeutic for the midwife as well as the other group participants.

The stories of disclosures of sensitive information that were relayed in the interviews supported the survey findings that midwives felt women were more likely to ask questions and disclose sensitive information in GANC. Several of the midwives interviewed stated they were initially surprised by this, but then went on to relate how they had themselves felt moved to disclose information in the group that they wouldn't have in standard visits. This speaks to the ongoing value of safe spaces for women, where they feel trusted and heard, particularly given that rates of violence against women remain persistent and painful. It also attests to the relational reciprocity that exists in these GANC settings. GANC facilitates storytelling, and storytelling engenders deeper relationships and eases worry (Teate *et al.*, 2017).

Through co-facilitation of groups, GANC also provides midwives rare opportunities to collaborate with fellow midwives, and other professionals, such as maternity care assistants (known as medical assistants in the U.S. context) or kraamverzorgter (the postpartum maternity assistants in the Netherlands). The findings of our survey on co-facilitation indicated that most respondents had a co-facilitator, as recommended in Centering-based models of GANC. It is interesting to note that there was a wide diversity of co-facilitators ranging from another midwife to clinic support workers, youth health workers, social workers and interpreters. The need for interprofessional collaboration in midwifery has been documented and this provides an interesting avenue, particularly to look at task shifting and other areas of inter-professional collaboration beyond midwife-obstetrician interfaces (Schölmerich *et al.*, 2014; Taylor *et al.*, 2018; Berge *et al.*, 2020). Co-facilitation was largely viewed very positively in both the survey and interviews, and midwives appreciated sharing expertise, flattening hierarchies and

forming friendships and mutual support. In an integrative review of factors associated with midwives' satisfaction and intention to stay in the profession, the satisfaction benefits of working in a team and having positive intra- and interprofessional relationships have been identified as contributing to midwifery resilience (Bloxsome *et al.*, 2019; Pace, Crowther and Lau, 2022).

Furthermore, the ability of midwives facilitating GANC to invite guest experts from a wide range of specialties ranging from lactation consultants to exercise physiotherapists and nutritionists contributed to their own professional development whilst also offering possibilities for providing more complete whole person-centered care to the participating women and families. While this was cited as a benefit for both Netherlands midwives and the U.S. midwives, it bears remarking that in the U.S. context, by integrating external visitors as part of antenatal care, this allowed midwives to introduce certain benefits (yoga teachers, nutritionists, etc.) to women who could not otherwise afford them. Midwives in both contexts (NL and US) expressed the ways in which GANC could benefit all women by rolling multiple services that many women currently seek externally (doulas, postpartum care, Lamaze classes, etc.) into their antenatal care, opening up possibilities for meaningful transformations in antenatal care that would enhance care quality whilst satisfying midwives.

These support networks that form in GANC also play a valuable role in allowing midwives to share the enormous responsibility they feel for the wellbeing, education and empowerment of the woman and her family. In a review of continuity of care models, the weight of this responsibility, and the feeling of being indispensable were counted as personal costs to the midwife working in CoC (Pace, Crowther and Lau, 2022). In my research, midwives directly addressed the ways GANC allowed them to decentralize their role in the process of pregnancy and parenting, and really facilitate autonomy and knowledge power for the group participants.

8.5 A Change in Midwifery Role or a Rediscovery?

My secondary aim in researching GANC was to discover whether facilitating this care model resulted in midwives perceiving changes to their midwifery role or identity. As discussed above, midwifery identity and optimal role fulfilment is linked to midwifery satisfaction and wellbeing. Hence changes, enhancements or disruptions to midwifery identity need to be taken into account when considering the expansion and sustainability of GANC.

8.5.1 Autonomy, Empowerment & Exclusion

I was impressed that the midwives I interviewed generally appeared comfortable with the notion of NOT being indispensable. Certainly, job security and indispensability seem intertwined, and the transformations in power experienced by midwives in GANC could feel threatening. When GANC flows as it is meant to, a great many of the tasks of the midwife are re-centred in the hands of the participants. Women check their own vital signs, they ask and answer their own questions about pregnancy and parenting, they help one another find emotional and physical resources. The question can be then, what is left for the midwife to do? This is where the unseen work of midwifery and its parallel to midwifery work in the intrapartum setting is relevant. In supporting birth, a midwife can never actually be the one giving birth, she can only equip the birthing person with support and options and suggestions. She can take time, hold space and facilitate choices. This is the sacred work of midwifery and GANC extends that midwifery work to the antepartum period. As de Jonge and colleagues (2021) pointed out, this work is largely uncounted, and because so much of our maternity care system has shifted to task orientation, and time counting, the struggle for the legitimacy of midwifery work in the intrapartum setting will mirror to some degree the struggle for legitimacy of midwifery work in GANC. By creating a system in which this unseen midwifery work can happen, GANC also opens midwifery led antepartum care up to threats to professional legitimacy.

8.5.2 Professional Role Anxieties

As discussed in Chapter two, antenatal care in its standard form came of age in the early part of the 20th Century, which is also when midwifery was undergoing professionalization projects in the U.S., the U.K and Europe that both regulated midwifery and subordinated it to medicine. Much of the history of women working in health care can be examined as a history of the exclusion or delegitimization of women healers in spite of empirical evidence to support their approaches to care and healing (Oakley, 1984; Ehrenreich and English, 2010). Simultaneously, patriarchal intervention and medicalization of the birth space without sound empirical evidence is allowed to proceed and entrench without question, as evidenced by the move to hospital birth following the Peel report or the pervasive adoption of continuous electronic foetal monitoring (Macfarlane and Mugford, 1984; Small *et al.*, 2022). GANC sits squarely in the midwifery tradition of high touch, low tech care, which may explain why it remains on the margins of a maternity system that values technical interventions over time intensive psychosocial support interventions, which rarely receives the same degree of professional respect.

Professional recognition remains one of the main, often elusive satisfiers of midwives, which speaks to their pervasive experience of marginalization (Mharapara *et al.*, 2022). Sadly, particularly since the early part of the 20th century, the history of maternity care is also a history of midwives compromising in pursuit of professional recognition. These compromises involved colluding with patriarchal and racist professionalization projects that led to the exclusion and discrediting of working-class midwives, immigrant midwives, married midwives and, in the American South the systematic destruction of a long tradition of Black Midwives (Sandall, 1996; Suarez, 2020). As oppressed groups theory supports, midwives will often work to prop up the very system that oppresses them, in this case a system that values visible task/technical skill-based work over the unseen work (presence, holding space, attendance), reinforcing industrial era notions that work must be drudgery.

The experience of midwives in GANC could be characterized as an antidote to drudgery, as evidence by the predominance on the survey of the words fun and joyful to describe this experience. In interviews, the midwives reinforced these words, expressing in great verbal and non-verbal detail how much they enjoyed GANC. However, in both the U.S. and the Netherlands, as discussed in the findings section 7.5.3 “Liking my Job”, several midwives expressed concern or indignation that if they were seen to be enjoying themselves too much in GANC, this would be construed as “fun” and not “work.” Midwives spoke of their perception that some of the midwives not involved in GANC viewed GANC disparagingly as too much laughter and drinking of warm beverages. This raises the question of whether midwives working in GANC models may overemphasize the amount of work involved in the model, to deflect speculation about equal burden between midwives who are facilitating GANC and those who are not. It also raises questions about why we expect suffering and sacrifice from our healthcare professionals as a proof of quality of care or professional commitment. It also hearkens back to the era when midwifery and nursing were “sanitized” by making them acceptable pursuits for only single middle class white women, who should certainly not be having “fun” but rather devoting themselves selflessly to societal betterment.

In certain ways this was reflected to me in the process of interviewing the midwives. Midwives struggled to talk about themselves, to credit their own work in GANC, to view building skills and relationships as work. Rather than attribute their successes in facilitating GANC to being a midwife, they attributed it to their personality (“that’s just the way I am, I’ve always been”). The concept of innate facilitative skills ignores both the possibility that midwives with certain personality traits might be drawn to the profession and the overwhelming conviction of the midwives interviewed that facilitation was a learned skill. Hence the reluctance of midwives to claim their own profession as superior at care to

which they are ideally suited seemed linked to an internalisation of status insecurity. This status insecurity is a global phenomenon and may contribute to a lack of collegial and organisational support for midwives undertaking new ways of working in even in countries like the U.K. and the Netherlands where midwifery is a cornerstone of the maternity care system (Kirkham, 1999; Feijen-de Jong *et al.*, 2022).

Sandall (1996) highlighted the ways in which the shift in maternity care towards continuity caseloading models could also constitute problematic exclusionary elements for midwives with families or midwives who wanted or needed part-time work. This anxiety was reflected among rank-and-file working midwives when they were surveyed about implementing continuity of care in Scotland (Hollins Martin *et al.*, 2020). While research has demonstrated that in point of fact midwives experience greater autonomy, flexibility and satisfaction in continuity models, it requires a demanding amount of time and emotional commitment and good professional boundaries and not all midwives can work in caseloading models (Pace, Crowther and Lau, 2022). By significantly re-working the meaning of what it means to be a professional in a group space, and by creating partnerships and community among women, GANC challenges exclusionary concepts of professionalization. Because the status of midwives is regrettably not remarkably less tenuous than it was in either the 1900s or the 1990s, again in spite of copious outcomes evidence to support midwifery care, it is not surprising that some midwives fear facilitating GANC could threaten their status. The U.S. midwives fretted about the impact of time in group on their productivity, and while they lauded the personal efficiency of not delivering the same message over and over, they worried about the groups where there were not enough participants to generate the revenue that is expected from back- to- back clinic visits. In the Netherlands, where midwives are self-employed, funding remained a concern, and the one midwife who had worked very hard to introduce GANC into the secondary, hospital-based system of care, concluded that while the hospital-based midwives had loved providing this type of care, it was untenable for them because of cost demands on their time.

All of this speaks volumes about how little power midwives, even in midwifery friendly countries like the Netherlands, have over the funding and financing of maternity care. The fear of working in a different way, of providing antenatal care in a different way, a way that is “fun” or “joyful” rather than “productive” is real, because the process (the woman in pregnancy) remains devalued in favour of the outcome (healthy baby). In this way, in spite of policy directives that support midwifery care, the antenatal care system appears to retain a myopic focus on birth outcomes without supporting an environment for midwifery care that can enable those outcomes as part of a larger impact on maternal and child wellbeing. The unifying concern of midwives in the Netherlands and the U.S. about the funding

threats to GANC speaks to the continued marginalisation of midwifery led care, particularly when that care challenges existing systems. The sustainability of GANC may well be down to the ability of midwives to continue to operate in a system that devalues unseen/difficult to quantify/caring work. My research indicated that the barriers midwives experienced to GANC sustainability reflected barriers to midwifery practice in all generally medicalised, patriarchal systems of care.

Given that we find ourselves in a time when there has never been more resounding empirical evidence and policy to support midwifery models of care, in addition to dispiriting data on global midwifery shortages, the onus is squarely on health systems to effect change that promotes midwifery and satisfies and attracts midwives. The challenges of space and time and facilitation are analogous to the struggles/challenges of midwives in their professional role in diverse health systems, as space and time are both tied to money. Midwives need the space to operate autonomously, and the autonomy to manage their time in the way that best suits them to develop relationships. Midwives need the ability to facilitate their own interprofessional/collaborative relationships with and within health systems. Midwives are often constrained in this by the hierarchical nature of current maternity care systems, systems that were imposed on a profession whose very heart is relational care. Hierarchies are difficult to maintain as relationships deepen, and so in this way relational midwifery sets itself against the dominant structure. Perhaps capitalist patriarchal structures fear the system transforming possibilities of midwifery care, however rredesigning systems to implement and sustain GANC may be one way to address the global need for satisfied midwives providing quality maternity care.

8.6 Unanswered Questions and Future Research

Whilst this study has provided useful insights into the experience of midwives' facilitating GANC, there remains numerous avenues that merit further research. Evidence has demonstrated that maternity care outcomes are improved with midwife led continuity of carer models, yet there is still a need to unpick to what extent antepartum/postpartum continuity alone might achieve improved outcomes vs intrapartum inclusive continuity models. Furthermore, the exploring the workload burden for midwives working in GANC as compared to traditional one-one caseloading models, or a combination thereof, could be important for service design of continuity models going forward. Midwives who might not consider case-loading a viable option, could potentially achieve similar ideological satisfaction through GANC, whilst maintaining autonomy and continuity options. Delving further into what midwives' and managers feel might reduce barriers to, alternative antenatal care delivery systems, as well as the potential professional stigma associated with alternative ways of

working, would certainly be useful to future implementation research. Additionally, the value of inter-midwifery collaboration warrants further study.

Further surveys of midwives working in GANC in a variety of contexts and health systems, including high- and low-income countries, would add important insight into the role of the health system, and the impact of the role of the midwife within that health system. An examination of the results of changes in midwifery hierarchies noted in this and other research on GANC opens the door to further exploration of the role of GANC in supporting respectful maternity care. Future surveys could include validated job satisfaction and burnout tools as well.

This research has raised questions that are necessary for future research in GANC, but in particular for future research around all midwifery models of care, there is a need for research questions that support midwives in naming and valuing their skills as a component of their professional identity, and endorsing their professional philosophy as integral to midwifery work. Definitions are integral to imagining change (hooks, 2018). In defining our work and our identity, midwives can resist the efforts of dominant groups to define them and fully reclaim the value of their care.

Conclusion

Facilitating GANC is meaningful work for midwives and offer opportunities for midwives to work in alignment with their professional philosophy, but it is also reflective of the constraints on midwifery power, and the need for engagement and advocacy to move maternity systems towards viewing the satisfaction of women, families and midwives as an intrinsic part of quality maternity care.

9. Conclusions

Introduction

This chapter concludes this exploration of midwives' experiences of facilitating by examining the implications of the findings for further research and practice, reviewing limitations, and situating the work in a broader context. This Chapter synthesizes those findings in response to the following research questions, laid out in Chapter One:

1). Do midwives perceive GANC as an improvement over the care they are currently offering?

2.) Do midwives experience changes to their midwifery role or identity in facilitating GANC, and if so how so?

The principal findings of this research in relation to those two questions may be best summarized as follows:

The midwives participating in this research largely found facilitating GANC to be satisfying and fulfilling work, particularly when compared to standard antenatal care delivery. They may experience GANC as more work than standard antenatal care, but also more valuable and enjoyable. The experience of working in GANC provides opportunities to reconfigure or reimagine their professional role in antenatal care settings to better align with a philosophy of meaningful midwifery.

The desire to explore midwives' experiences of facilitating GANC in the U.S. and the Netherlands arose from the findings of the global systematic review of providers' experiences of facilitating GANC. Whilst the review identified that providers appeared to like this model of care, and identified possibilities for associated professional role development, the specific experience of midwives had not been explored. In light of increasing evidence for midwives as the ideal providers of maternity care, and global burdens on the midwifery workforce, the voice of the midwife deserved to be prioritized. Furthermore, in order to interrogate the sustainability of GANC as an alternative model of care, knowledge gaps identified in the review highlighted an opportunity to explore the experiences of midwives who have integrated GANC into practice as part of normal care. As the Netherlands and the U.S. have the longest histories of implementing GANC, the perspectives of these midwives are of particular value, and contribute to a wider knowledge base about the sustainability of GANC as a midwifery model of care.

As discussed in the background chapter of this thesis (Chapter Two), antenatal care should serve the public health functions of health surveillance and health promotion for the mother-baby dyad, and ideally the family and community at large. However, structural time constraints and a consequent

inability to feel they are adequately addressing the psychosocial and educational support needs of women and families has left midwives delivering standard antenatal care frustrated and dissatisfied. By contrast, midwives facilitating GANC expressed, quantitatively and qualitatively, a strong perception that they could provide higher quality antenatal care in group settings, and that this care was more satisfying to the woman and the midwife herself.

9.1 Implications for Practice

The findings from this thesis imply that the midwives facilitating GANC were most satisfied by the ability to foster a supportive empowering antenatal environment that transforms the pregnant person into a confident parent. Furthermore, the evidence supports that midwives found this environment beneficial themselves. It allowed them to develop inter- and intra-professional relationships that contributed to their confidence and competence and that they might not have otherwise been able to access. Midwifery care is designed to be collaborative, but systemic barriers can result in midwives unintentionally siloed from other maternity care professionals, as well as from their own colleagues. GANC created opportunities for midwives to work with each other and with other professionals and they valued that opportunity.

The sustainability of GANC will require institutional support for this collaborative working through continued flexibility and autonomy in scheduling, developing internal training capacity, and evaluation of the benefits for and across services. The Netherlands is currently attempting to resolve the financing of *kraamzorg* to continue as co-facilitators of GANC, as they are financed by local municipalities, rather than the maternity care system. This experience could be valuable for other countries implementing GANC that have fractured funding of the various services pregnant people and families' access, such as health visiting and maternity in the U.K. Organisations should also support the opportunity GANC provides for midwives to collaborate with one another, this research demonstrates that learning and mentorship develops between co-facilitators, and is viewed very positively by the midwives themselves.

Similarly, midwives valued the supportive environment of the group, but it is notable that they struggled to speak about this directly. They often reverted to speaking of how groups were good for women, but gave examples that demonstrated how they were also good for themselves. This tendency among midwives, to dismiss or underestimate their own needs, has implications for the incidence of burnout in the profession and also reflects Kirkham's (1999) assertion that midwives set themselves apart from the women they care for, perhaps in part because they accept treatment for themselves that

they would never accept for those for whom they advocate. The structure of GANC situates the midwife within the circle of participants and allows her easy access to relational reciprocity that supports midwifery wellbeing and allows midwives to be vulnerable enough to access support from the group. Midwives may often feel powerless to address foundational inequities experienced by the women they care for; however midwives in this study repeatedly demonstrated ways in which the group helped participants overcome challenges in transport or clothing or violence, and this fundamentally reduces the burden some midwives feel to address socio-economic or psychosocial needs of women that lie outside the traditional boundaries of midwifery. The emotional labour of midwifery may be made more manageable in group settings.

The potential for the group to serve as a clearinghouse for resource building and development for pregnant people and midwives is another benefit to midwives. Many expressed how much they learned from the groups. It takes significant professional humility to acknowledge that you do not know the answer to a question, and much of midwifery education is focused on acquiring and demonstrating knowledge. Strong facilitation skills, a core component of group care, necessitates returning questions to the group, which fosters validation of various knowledge and a safe space for all participants, including midwives themselves, to acquire and debate new information. While this may require a steep learning curve for midwives, the voices of midwives in the study acknowledged how powerful and rewarding it is.

Incorporating GANC facilitation skills training into pre-registration midwifery programmes would increase the exposure of more midwives to both GANC and the ICM essential competencies around facilitation skills and interpersonal communication with women, families, health teams and groups. Furthermore, it would help build confidence in midwifery students through accessing the support network of professionals and peer support that GANC offers. Moreover, incorporating facilitation in the curriculum validates it, and values it as a clinical midwifery skill. This is an important step in putting midwives on a path to recognizing the unseen skills they use in GANC, taking time, holding space, and facilitation, as essential to midwifery work, and to helping name and value them.

Progress has been made in naming and valuing watchful attendance at birth; now we must find ways to value watchful attendance in antenatal care. Watchful attendance in antenatal care allows the building of deep interpersonal relationships that enable safe care. A group facilitator uses her skills and training to guide the discussion where necessary and sit back and observe where necessary, and this is analogous to midwifery work in the birthing suite. A maxim of midwifery educators is that ninety percent of intrapartum work is completed antenatally, through a combination of education and

relationship building. However, in practice antenatal care is often given short shrift. As women, maternity care professionals and policy makers escalate demands for a respectful birthing environment that facilitates women's choices, so too should they include demands for a respectful empowering antenatal care environment, such as midwives are able to create in GANC.

Participating midwives seemed comfortable with the flattened hierarchies in GANC, with sharing knowledge and power with the group; they highly valued this aspect of GANC and saw it as incredibly satisfying, and viewed it as an essential component of their midwifery role. The implications of flattening hierarchies, which is in fact midwifery work, (if we value midwifery work as a true partnership with the pregnant person and their support network), are problematic given existing definitions and understandings of work in a larger capitalist system, as it defies traditional transactional structures. GANC may enable midwives to move antenatal care beyond didactic information dumping and surveillance tests to creating a reciprocal partnership and empowered parents.

Beyond the task-oriented skills, society struggles to name the work of midwives, and midwives themselves struggle to name their special skills as work. If they sit up all night with a woman in labour, they do not hesitate to name that work, as they know their presence was valuable and supported by the evidence. Conversely, the midwives in this research seemed vulnerable to the criticism by non-GANC facilitating colleagues that sitting with a group of women and facilitating their antenatal care was somehow not work, or not enough work, especially because it seemed fun. We must examine why midwifery work is suspect if it is enjoyable. This speaks to larger questions about what working environments midwives deserve, and how midwives break out of tropes of martyrdom that plague the caring professions. Midwives reclaim and validate their roles as advocates for women and families when they succeed in advocating for themselves. GANC may offer opportunities to facilitate this self-advocacy. Midwives described sharing personal stories with other group participants and experienced the empathy of other group members positively.

A case is made by feminist pragmatist Sean Epstein-Corbin (2014) for sympathy as a guide to moral and political action. In creating deep bonds between women and midwives and other maternity care professionals, as well as disarming existing medical knowledge hierarchies, GANC has the potential to advocate further for quality midwifery models of maternity care. GANC offers potential for midwives to engage in continuity models that align with global policies and midwifery care philosophies, but to be sustainable midwives must believe they are deserving of care as members of the maternity care system and as (mostly) women themselves. Midwives need new ways of working to complete the circle between old ways of working, deep inherited knowledge and evidence-based updates to care.

9.2 Implications for Research

It is a truism that research begets more research, and this has certainly been my experience of exploring midwives' experiences of GANC. Conducting the survey and interviews for this study has raised some new questions about the implementation of GANC and many thoughts and questions about how midwives work and how that work is valued. This raises other questions about how antenatal care, whether conducted one to one or in group settings, by midwives or by other health care providers, is organised and valued. Furthermore, the midwives themselves raised areas they felt warranted more research during the interviews.

WHO's Guidelines for a Positive Pregnancy Experience (2016b) implies that the importance of quality antenatal care in the pregnancy experience, and the review by Downe et al (2019), endorsed continuity, time with the provider and psychosocial support as components of quality ANC, however, much of the literature on quality antenatal care is focused on metrics that do not include support. More research needs to be done around the effect of antenatal psychosocial support on the wellbeing of mothers, babies and families, as well the effect on healthy lifestyles and mental health. Midwives in this study also felt the experiences of fathers in GANC warranted closer examination.

The conceptual framework that arose from my research displayed the experiences of midwives working in GANC as an experience of support that enabled transformative empowering care for women. Midwives described GANC as providing coping mechanisms for women in difficult situations, particularly through the development of a supportive network of peers and professionals. This support and empowerment also touched and encompassed the midwives themselves and contributed to their satisfaction with the model.

What is meant by support, does material and organisational support have greater impact on midwives or is it more important to work in an environment that is philosophically supportive of midwifery care? While the concept of midwifery support in an intrapartum context has been well described, there is room to further define and unpick the support needs of midwives (and women) in the antepartum and postpartum periods (Leap and Hunter, 2016).

The mental health of midwives, and the ways in which satisfying models of working, or enjoying one's work can have impact deserves more attention, as does the question of whether antenatal care quality is influenced by midwives' mood and affect. Longitudinal studies of ways of working in GANC are also needed, particularly looking at adaptation to workload. There is also room to ask hard questions around whether midwifery happiness matters at all. Whilst I strongly support the right of midwives to

work in ways that bring them joy, the health systems in most countries have been largely unmoved to make policy changes in response to evidence around satisfaction alone, even when that is the satisfaction of the women receiving maternity care. Insofar as it is tied to staff turnover, or lost revenue, or poor outcomes, attention is paid to staff wellbeing, so research that investigates the impact of GANC on midwifery retention or recruitment will be necessary for securing more systemic services endorsement of this care model.

A voluntary centralised global database of GANC facilitators would be extremely useful for furthering quantitative and qualitive research on GANC, and particularly on the composition and experience of the facilitators. If there was access to administrative funding, the GANC Collaborative, a research consortium on GANC focused on LMI nations could potentially expand its remit to hosting such a global registry, or ICM or WHO could lead such an effort.

Although this study was not successful in locating or exploring many voices of midwives who may not enjoy working in GANC, more could and should be done to locate midwives who have chosen not to become GANC facilitators, or who have stopped facilitating GANC. The midwives that participated in this project acknowledged that GANC may not be right for every woman, and several had midwife partners who did not want to facilitate groups. As with research into case-loading, there are a multitude of reasons that working differently may not work for all midwives, and understanding those contributes to sensible maternity care service design and improvement.

9.3 Implications for Policy

I had hoped to answer whether midwives were the ideal providers of GANC, and I do believe the findings in this study demonstrated that facilitating GANC aligns ideally with midwifery skills and strengths, and brings midwives joy. The participant midwives themselves, however, reported they felt that other care providers could theoretically be GANC facilitators and refused to insist on the necessity of midwives fulfilling this role. This may demonstrate the welcoming collaborative nature of midwives and their positive experiences co-facilitating with other disciplines such as maternity care assistants or *kraamzorg*, or it may reflect an inability to engage in turf wars, which may inadvertently reduce access to midwifery care. It may also be a practical assessment of realities on the ground. Most midwives participating in this study strongly felt GANC was better care for women, so it is possible that they didn't want women to be excluded from this model in the event there was not a midwife available to lead it. The Netherlands is currently experiencing notable declines in women remaining in primary midwifery-led care. The vast proportion of antenatal care in the U.S. is obstetrician led. It follows then

that a midwife in either of these systems would endorse another provider offering GANC. That said, the findings from this study demonstrate the ways in which an expansion of GANC would dovetail with an expansion of midwifery-led care.

The WHO supports the expansion of GANC within the context of rigorous research. Global evidence also supports the expansion of midwifery care. The findings from this study illuminate that where GANC has been integrated into normal practice, outside of a research context, midwives find the care to be high-quality, satisfying and congruent with midwifery skillsets. Moreover, the findings from the systematic review, the survey and the interviews support maternity care providers' perspectives that women and families benefit from this model of care, and the last Cochrane review (Catling, 2015) endorsed it as a satisfying model for women. These findings could support global policy recommendations to integrate GANC widely as an alternative to standard antenatal care.

Furthermore, the impact of funding concerns on midwives' concerns about GANC implementation and sustainability, speaks to the status insecurity of midwives at a time when global policy supports an expansion of midwifery care. Without real autonomy and decision-making power, including involvement in maternity care funding and financing at all levels, midwifery led models of care, regardless of how satisfying or beneficial they may be, will struggle to succeed. The findings indicate that time taking is a key component of GANC, and if systems continue to prioritize efficiency over process quality, then it will be difficult to integrate GANC into normal care. It is also worth considering whose definitions of efficiency matter. Midwives find GANC efficient because they are not repeating the same message over and over, and because they are able to truly tailor care to the needs of the individual and the group. This conflicts with their concern over how many women they must see in a two-hour period to meet perceived productivity and cost-effectiveness standards.

9.4 Contributions to the Field and Conclusions

This research was the first to conduct a systematic global review of providers' experiences of providing GANC, which answered some questions about the experience of facilitating GANC and identified gaps that the subsequent phases of this project attempted to fill. This work is the first to look at the experiences of midwives in the Netherlands with GANC, which is valuable given the history of both midwifery care and GANC in the Netherlands. This was also the first study of GANC to recruit practising American midwives outside of a GANC implementation research trial. The congruence of the findings between the midwives in the Netherlands and the American midwives experience is noteworthy, given that in much of the literature the U.S. experience of midwifery and the Dutch experience of midwifery

are strongly contrasted. Combined with the similarity of findings across contexts in the systematic review, this may suggest there is some universality to the experience of GANC facilitators.
As GANC expands around the globe, the scope of experiences is widening, and this thesis thus only covered a portion of the experiences of midwives facilitating GANC. The current European Union Horizon GC-1000 study of implementation of group care in seven nations will likely further contribute to this concept as it is also a cross-context mixed methods study.

This research suggests that GANC is a model of care that allows midwives space and time to inhabit and facilitate relationships, supports collective knowledge growth and an empowering transition to parenthood for the women and families for whom they care.

The other significant output of this research has been the opportunity to develop a substantial international network of group care stakeholders, advocates, researchers and midwives. I hope they will persist in pursuit of opportunities to revolutionize systems by creating the possibility that non-hierarchal, safe and satisfying group care could become the new standard against which others are then measured. Much of the work of facilitating group care for me personally was moving through the fear of something new, and the fear of failing at something new towards the possibility of creating a reality of a supportive knowledge sharing community and finding it to be so fulfilling. This PhD research has been a similar process, terrifying, humbling and hopefully the creation of something new with the tremendous aid of a knowledge sharing community. I hope to continue the process of creating a global community of GANC facilitating midwives and others, beginning with the recently created U.K. Maternity Group Care Facilitators community of practice group as a model. This group will allow participants to share stories and struggles of GANC work to move this work and care, in the words of the feminist activist bell hooks (2015), who died this year, “from the margins to the center”, where Centering belongs.

Conclusion

Fulfilling the global recommendations for the implementation of GANC as a viable alternative to standard antenatal care will continue to require the input and voice of experienced providers to successfully reap the benefits for women, families and the providers and systems themselves.

Appendices

Appendix 1: Systematic Review Documents

1.1 Copy of Systematic Review Publication arising from this research

LazarSRGANC.pdf (Command Line)

1.2 Table of Search Terms

This is a table of search terms used in the Systematic Review of Healthcare Providers' Experiences of Facilitating GANC

Search Terms for Healthcare Providers' Experiences of GANC

		MeSH headings	Tiab keyword
GANC Terms	Antenatal Care	(MH "Prenatal Care") OR (MH "Prenatal Diagnosis") OR (MH "Perinatal Care") OR (MH "Maternal Health Services") OR (MH "Obstetric Nursing") OR (MH "Parenting Education")	(prenatal OR "pre natal" OR antenatal OR "ante natal" OR perinatal OR "peri natal") W1 (care OR control OR education OR intervention)
	Group Care	(MH "Group Processes") OR (MH "Peer Group")	Group education OR group class* OR group screening* OR group assessment* OR group checkup* OR group check-up* OR group check up* OR Group Family Nurse Partnership* OR gFNP
	GANC		AB "CenteringPregnancy" or "Centering Pregnancy" OR (group antenatal OR group prenatal OR group ante-natal OR group prenatal) W1 (care OR education OR class* OR assessment* OR checkup* OR check-up* or check up*)
	1 AND 2 OR 3		
lealthcare oviders' periences	Health Professionals	MH "Health Personnel") OR (MH "Allied Health Personnel") OR (MH "Community Health Workers") OR (MH "Medical	AB physician* OR midwi* OR nurse* OR "healthcare provider" OR "healthcare providers

		Staff") OR (MH "Midwives") OR (MH "Nurses") OR (MH "Physicians") OR (MH "Attitude of Health Personnel") OR (MH "Midwife Attitudes") OR (MH "Nurse Attitudes") OR (MH "Physician Assistant Attitudes") OR (MH "Work Experiences")	
	Experiences		AB (physician* OR midwi* OR nurse* OR "healthcare provider" OR "healthcare providers") W3 (view* OR perspective* OR experience*)
	5 OR 6		
Full Search	4 AND 7		

1.3 Table of Extracted Data

This table shows the data extracted from the articles included in the systematic review

Study First Author, year	***Country***	***Study Aims***	***Participant, Setting***	***Study Design, Data Collection, and Analysis***	***Quality***	***Findings***	***Collaborators***
Allen, J., 2015	Australia	Examine younger women's experiences of caseload midwifery incorporating GANC	4 midwives Caseloading practice for women under 21 Purposive sampling	Qualitative critical ethnography FGD and observations thematic analysis starting with women's data and applied to midwives	H	Women had some benefits, and midwives observed some benefits for participants. The conclusion was that the model interfered with relationship building	Midwives co-facilitate with each other

Study First Author, year	*Country*	*Study Aims*	*Participant, Setting*	*Study Design, Data Collection, and Analysis*	*Quality*	*Findings*	*Collaborators*
Baldwin, K., 2011	USA	Midwives' thoughts, feelings, perceptions from pre-implementation through facilitation of five sessions of CP, also focus on sustainability	6 midwives 5 clinics in different regions of the U.S. (Northeast, Midwest, South) recruited at CP training Convenience sampling	Qualitative Design SSI face to face and over telephone at 5 different time periods transtheoretical health education model Colazzis method and thematic analysis	H	Emergence of five themes progression from current practice is just fine through anxiety about the model to empowerment and looking to the future	Midwives co-facilitate with each other

Study First Author, year	*Country*	*Study Aims*	*Participant, Setting*	*Study Design, Data Collection, and Analysis*	*Quality*	*Findings*	*Collaborators*
Barnes, J., 2016	UK	Evaluation of the feasibility of the group family nurse partnership (FNP) programme	8 family nurse partnership nurse midwives 4 community midwives 4 supervisors 4 family support workers Purposive sampling	Mixed Methods FGD and SSI Content Analysis	M	Content and format was positive for participants and FNP facilitators but women struggled to attend regularly and most vulnerable were not recruited and FNP found working with community staff challenging	FNP midwives cofacilitated with community midwives or family support workers

Study First Author, year	*Country*	*Study Aims*	*Participant, Setting*	*Study Design, Data Collection, and Analysis*	*Quality*	*Findings*	*Collaborators*
Craswell, 2016	Australia	Evaluate a group care model collaboration between an academics, students, and public health service midwives	5 midwives 5 midwifery students clinic held on university grounds Purposive sampling	Qualitative design SSI and FGD thematic analysis following donobedians structure process outcome framework	H	Positive opportunity for continuity of care for midwifery students and positive collaboration between university and clinic midwives and positive views from participants	Academic midwives co-facilitate with students and clinic midwives

Hunter, L., 2018	UK	Feasibility of implementing GANC in high diversity area by exploring midwife and other maternity care provider views	16 stakeholders 9 facilitating midwives 1 student midwife large diverse London NHS trust Purposive sampling	Inductive qualitative approach SSI informal group discussions and workshop post implementation thematic analysis	H	Intervention was supported as a solution to dissatisfaction with standard care, worries about privacy, self-checking and partners were overcome with adequate support and training and experience with the model and midwives enjoyed delivering care this way and felt satisfied with that care	Midwives co-facilitate with each other
Klima, C., 2009	USA	Feasibility of implementin	4 midwives	Mixed methods	M	Midwives and staff felt	Midwives co

Study First Author, year	*Country*	*Study Aims*	*Participant, Setting*	*Study Design, Data Collection, and Analysis*	*Quality*	*Findings*	*Collaborators*
		g CP in a large urban clinic and associated outcomes	5 health centre staff Large urban public health clinic Purposive sampling	feasibility FGD thematic analysis		women enjoyed their care and improved their attendance and satisfaction midwives and staff experienced challenges with implementation aspects such as scheduling and midwives found facilitation challenging and losing one to one interaction	facilitate with project assistant or medical staff (training undefined)

Study First Author, year	*Country*	*Study Aims*	*Participant, Setting*	*Study Design, Data Collection, and Analysis*	*Quality*	*Findings*	*Collaborators*
Lori, J., 2016	Ghana	Does GANC improve providers perceptions of communication and engagement -does facilitative GANC improve health information delivery -is a health literacy skills framework suitable for maternal health literacy development	6 midwives (4 participated in FGD) 1 nurse who co-facilitated groups busy clinic Ashanti region Convenience sampling	Mixed methods survey and FGD constant comparative analysis	H	No significant difference in survey of communication and engagement focus group identified themes of improved understanding of patient concerns, enhanced information and sharing with facilitated discussion, and improved communication with picture cards	Midwives co-facilitated with each other and a support nurse

Lundeen, T., 2019	Rwanda	Understand the experience and job satisfaction and perceived stress of GANC providers as compared to standard ANC providers	59 nurses and midwives completed questionnaire 29 participated in FGD 18 health centres in Rwanda Cluster randomized sampling	Mixed methods nested study survey 3 FGD thematic analysis	H	Survey showed no change in job satisfaction or perceived stress however 86% midwives said they preferred GANC and FGD showed benefits for women and midwives and opportunities for problem solving implementation challenges with peer nurses and midwives	Midwives and nurses co-facilitate with CHWs whose experiences were not reported in this article
Maier, B., 2013	Australia	Reflection piece	1 midwife caseloading	Personal reflection	L	Author found this a very	Doesn't mention a co-

Study First Author, year	*Country*	*Study Aims*	*Participant, Setting*	*Study Design, Data Collection, and Analysis*	*Quality*	*Findings*	*Collaborators*
			Large urban hospital			satisfying way to deliver antenatal care and thus extended it to postnatal groups and included students	facilitator but did have midwifery students in group

Study First Author, year	*Country*	*Study Aims*	*Participant, Setting*	*Study Design, Data Collection, and Analysis*	*Quality*	*Findings*	*Collaborators*
McDonald, S., 2014	Canada	Experiences of low-risk women and their care providers with GANC	5 midwives Midwifery clinic in Ontario Purposive sampling	Qualitative descriptive study FGD thematic analysis	H	Women felt they received more information and support but less one on one time with midwife midwives saw systems level challenges but saw professional benefits such as reduced workload and more autonomy for women	Midwives co-facilitate with each other

McNeil, 2013 *Vekved, 2017*	Canada	Understand the central meaning of centering pregnancy to family physician facilitators and perinatal educator facilitators	3 family physicians providing CP care in Calgary 5 perinatal educators providing CP care Low-risk group practice in Calgary Purposive sampling	Phenomenological approach IDI meaning units/thematic analysis confirmation fgd and interviews and re-analysis	M/H	Core meaning for physicians of "providing richer care" examined across six themes around more time and more satisfaction and seeing women create relationships with each other and physician perinatal educators found a core meaning of "invested in success" covered by six themes including bridging the gap and getting to	Physicians co-facilitate with perinatal educators

Study First Author, year	*Country*	*Study Aims*	*Participant, Setting*	*Study Design, Data Collection, and Analysis*	*Quality*	*Findings*	*Collaborators*
						knowing and stepping back	

Novick, 2013 *Novick, 2012*	USA	What are perceived as the challenges to implementing centering and how is centering model adapted to meet these challenges?	2 nurse midwife group leaders 3 support staff included in participant observations 2 urban clinics in north-eastern US Purposive sampling	Longitudinal qualitative study interpretive description (Thorne, 2008) SSI with group leaders participant observation of centering sessions thematic analysis and situational mapping	M/M	Leaders were committed to GANC but hampered by resource constraints which resulted in modifications to the model that further impacted success group leaders felt strongly benefits to vulnerable women of participating in this model of care and women participating in this group found some respite from their stressors	One midwife had a staff member co-facilitator (not identified) the other had no co-facilitator

Study First Author, year	*Country*	*Study Aims*	*Participant, Setting*	*Study Design, Data Collection, and Analysis*	*Quality*	*Findings*	*Collaborators*
Novick, G., 2015	USA	Identify barriers and facilitators to implementing CP in 6 urban sites	14 clinical site staff (2 administrators, 4 obstetricians, 3 nurse midwives, 1 registered nurse, 3 social workers, and 1 dietician) of whom 6 facilitated care Urban women's health care clinics in 6 large hospitals Purposive sampling	Qualitative research conducted alongside a cluster RCT IDI and SSI A priori coding and implementation frameworks ATLAS software	H	Thriving sites had organizational cultures that supported innovation and committed staff and provider champions	Some had co-facilitators but they are not specified

Study First Author, year	*Country*	*Study Aims*	*Participant, Setting*	*Study Design, Data Collection, and Analysis*	*Quality*	*Findings*	*Collaborators*
Patil, C., 2013	Malawi/ Tanzania	Determine if CP is an acceptable model in African antenatal care context develop CP curriculum that maintains national guidelines and essential CP elements small pilot trial in Malawi	1 administrator or 6 midwives 4 HSAs (community health workers)	Feasibility study with small pilot in advance of RCT ethnographic rapid assessment (action research model) observations and field notes by researchers of groups FGD with semi structured guide	H	Centering Pregnancy Africa was feasible and acceptable in the Malawian context and midwives adapted to and enjoyed the facilitation and greater information sharing	Co-facilitation format not specified

Study First Author, year	*Country*	*Study Aims*	*Participant, Setting*	*Study Design, Data Collection, and Analysis*	*Quality*	*Findings*	*Collaborators*
Teate, 2013	Australia	Explore midwives' experiences as they moved from one-to-one care to Centering Pregnancy care	8 midwives 2 public maternity services in Sydney (3 antenatal clinics, 2 community health centres) Purposive sampling	Qualitative descriptive and iterative action research design pre- and post-surveys, checklists, FGD, observations of facilitation meetings thematic content analysis	H	Midwives progressed throughout the action research from initial anxiety through to appreciating the benefits of CP for women and for their own relationship with women and for the support and training they received	Midwives co-facilitated with each other

Thapa, P., 2019	Nepal	# of ANC visit institutional birth rate experience of the model and mechanism of impact from a variety of perspectives	2 CHW and 2 government care providers Rural Nepal Purposive sampling (one interview with gov't care provider excluded)	Mixed methods cluster-controlled trial FGD with participants KII with providers directed content analysis approach theory of change codes and moving on to open coding [p. 4 Qualitative data were only gathered from those with direct experience of the intervention supervisory and Nyaya programme staff had insights-where to include]	M/H	Women appreciated groups for learning and support providers appreciated relationship with community health workers and birth planning was a challenge for women and facilitators	Governme nt midwife co-facilitated with Nyaya health chw

Study First Author, year	*Country*	*Study Aims*	*Participant, Setting*	*Study Design, Data Collection, and Analysis*	*Quality*	*Findings*	*Collaborators*
Wisanskoonwong, P., 2011	Thailand	Develop a culturally appropriate model of GANC for Thai women	1 midwife Meeting room near antenatal clinic of large hospital in Bangkok	Feminist Action research personal reflection and evaluation	M	Reflection on decision to not wear her uniform for group care resulted in her perception of more equalized relationships in group care and giving up role of expert allowing more open discussion	Doesn't mention co-facilitator in reflection

Legend:

FGD-focus group discussion
SSI-semi-structured interview
KII-key informant interview
CP-Centering Pregnancy

Appendix 2: Survey Documents

2.1 City, University of London Ethics Approval

Ethics-ETH2021-0519-Ms-Jalana-Noreen-Lazar-Low-risk- (2).pdf

2.2 Survey with Analysis Plan Attached

The following is a Word copy of the Qualtrics survey of midwives' experiences of facilitating GANC. The questions derived from gaps in the themes that arose from the systematic review Chapter 2). The

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Start of Block: INTRO AND CONSENT

Q1 The following research survey is intended to understand more about the experiences of midwives who are working or have worked as GANC facilitators. For more information about this survey, the Participant Information Sheet is attached here. PisGANCsurvey. To complete the survey please read through each question and tick your answer. The survey should take approximately 12-15 minutes to complete. Thank you for your time!

Q2

GANC facilitator survey

By completing and submitting the survey you are indicating your consent and eligibility to participate in this study.

You are confirming that you have had an opportunity to read the participant information sheet and you understand the information provided in the link above.

You understand that your participation is voluntary and you may discontinue the survey at any time.

You understand once the survey is completed and your responses are made anonymous and you will not you be able to retrieve your data.

You understand that direct quotes from text responses may be used in reports or publications but they will not be linked to your name as all data is unlinked and anonymous.

If at the end of the survey you decide to enter your name and email address for the prize draw for a £75.00 electronic gift card or to request a copy of the final report or to be contacted for follow up, that information will not be linked to your data and will be kept confidential and be stored separately and securely on a password protected drive according to City University's data protection guidelines and deleted once the prize draw is complete or you have received your requested copy of the study findings.

○ I understand what is involved in this study and agree to take part in this survey (1)

Skip To: End of Survey If GANC facilitator survey By completing and submitting the survey you are indicat... != I understand what is involved in this study and agree to take part in this survey

End of Block: INTRO AND CONSENT

Start of Block: GANC FACILITATION

Q3

GANC Facilitation

The following questions will refer to GANC. GANC is defined as antenatal care delivered to a group of 4 or more women with a clinical assessment component included (blood pressure checks, fundal heights,

etc). Examples of group care include, but are not limited to, Centering Pregnancy or Pregnancy Circles. GANC will be abbreviated for the remainder of the survey as GANC.

Q4 Do you work at a facility that offers GANC?

- Yes (1)
- No (2)
- Don't know (3)

Q5 Have you ever been a GANC (as defined above) facilitator?

- Yes (1)
- No (2)

Skip To: End of Survey If Have you ever been a GANC (as defined above) facilitator? = No

Display This Question:

If Have you ever been a GANC (as defined above) facilitator? = Yes

Q6 Are you currently a GANC facilitator?

- ○ Yes (1)
- ○ No (2)

Q7 How many groups have you facilitated?

- ○ 1-5 groups (1)
- ○ 6-10 groups (2)
- ○ More than 10 groups (3)

Q8 Do you attend the births of the women in your groups?

- ○ Always (1)
- ○ Most of the time (2)
- ○ About half the time (3)
- ○ Sometimes (4)
- ○ Never (5)

Q9 How did you come to facilitate GANC?

- ○ I chose to be a GANC facilitator (1)
- ○ I was assigned to be a GANC facilitator by my supervisor (2)
- ○ Prefer not to say (3)
- ○ Other, please specify: (4) _____

Page Break

Q10 Did you receive training in GANC facilitation?

- ○ Yes (1)
- ○ No (2)
- ○ Don't know/can't remember (3)

Display This Question:

If Did you receive training in GANC facilitation? = No

And Did you receive training in GANC facilitation? = Don't know/can't remember

Q11 Would you like any training on GANC facilitation?

- ○ I would like training on GANC (1)
- ○ I would like training on other aspects of GANC (e.g. scheduling groups, organizational support (2)
- ○ I don't feel I need any GANC training (3)
- ○ Prefer not to say (4)
- ○ Other, please specify: (5) _____

Page Break

Q12 How comfortable do you feel with your facilitation skills?

- ○ Very comfortable (1)
- ○ Somewhat comfortable (2)
- ○ Neither comfortable nor uncomfortable or mixed (3)
- ○ Somewhat uncomfortable (4)
- ○ Very uncomfortable (5)

Q13 Please add any explanation you would like regarding your comfort/discomfort with your facilitation skills

_____

_____

_____

_____

_____

Q14 Areas of facilitation I find challenging include: (tick all that apply)

- ☐ Waiting for others to speak up (1)
- ☐ Managing dominant group members (2)
- ☐ Drawing out quiet groups or members (3)
- ☐ Managing inaccurate information (4)
- ☐ Facilitating sensitive topics (5)
- ☐ Engaging birth partners (6)
- ☐ Speaking in front of groups (7)
- ☐ I do not find facilitation challenging (8)
- ☐ Other, please specify: (9) _____

Page Break

Q15 Do you have a co-facilitator (a co-facilitator is a co-leader of your GANC sessions who attends each session with you and is generally the same person)?

- ○ Yes (1)
- ○ No (2)
- ○ Don't know (3)

Skip To: Q20 If Do you have a co-facilitator (a co-facilitator is a co-leader of your GANC sessions who attends e... = No

Skip To: Q20 If Do you have a co-facilitator (a co-facilitator is a co-leader of your GANC sessions who attends e... = Don't know

Display This Question:

If Do you have a co-facilitator (a co-facilitator is a co-leader of your GANC sessions who attends e... = Yes

Q16 Is your co-facilitator (tick all that apply)

- ☐ Another midwife (1)
- ☐ Nurse (2)
- ☐ Social worker (3)
- ☐ Physician/GP (4)
- ☐ Community health worker/Health Visitor (5)
- ☐ Other medical staff, i.e nursing assistant (6)
- ☐ Interpreter or Bi-cultural health worker (7)
- ☐ Student midwife (8)
- ☐ Other, please specify: (9) _____

Q17 How would you rate your experience of working with your co-facilitator(s)?

- ○ Extremely positive (1)
- ○ Somewhat positive (2)
- ○ Neither positive nor negative (3)
- ○ Somewhat negative (4)
- ○ Extremely negative (5)

Q18 Please describe why this experience was positive or negative

_____

_____

_____

_____

_____

Page Break

Q19 **Women in GANC**

Q20 How do women in your groups come to be in GANC?

- ○ They are offered this option of care by me (1)
- ○ They are offered this option of care by another midwife or staff member (2)
- ○ They are offered this care by me and other midwives/staff members (5)
- ○ This is the only type of care offered at my workplace (3)
- ○ Other, please specify: (4) _____

End of Block: GANC FACILITATION

Start of Block: WOMEN IN GANC

Q21 In your experience which women/populations are most appropriate for GANC?

- [ ] Everyone (1)
- [ ] Women with complex social factors (for example age under 20, domestic violence, drug or alcohol misuse) (2)
- [ ] Women who are recent migrant or asylum seekers, or have difficulty reading or speaking English (3)
- [ ] Other, please specify: (4) _____

Q22 Do you facilitate groups in any languages besides the predominant language of your health service? (Tick all that apply)

- ○ Yes, I facilitate in another language I speak (1)
- ○ Yes, using interpreters (4)
- ○ Yes, using another method (Ex. co-facilitator speaks another language, etc) (5)
- ○ No (2)
- ○ Don't know (3)

Display This Question:

If Do you facilitate groups in any languages besides the predominant language of your health service... = Yes, I facilitate in another language I speak

And Do you facilitate groups in any languages besides the predominant language of your health service... = Yes, using interpreters

Q23 Please describe your experience of facilitating these groups, for example was the experience negative or positive

_____

_____

_____

_____

_____

Q24 As compared to standard antenatal care, in GANC I feel women are...

- ○ More likely to get the care they need (1)
- ○ Equally likely to get the care they need (2)
- ○ Less likely to get the care they need (3)

Q25 As compared to standard antenatal care, in GANC I feel women are...

- ○ More likely to speak up and ask questions (1)
- ○ Equally likely to speak up and ask questions (2)
- ○ Less likely to speak up and ask questions (3)

Q26 As compared to standard antenatal care, in GANC I feel women are...

- ○ More likely to discuss sensitive matters (1)
- ○ Equally likely to discuss sensitive matters (2)
- ○ Less likely to discuss sensitive matters (3)

Q27 Which aspects of group care have you found to be most beneficial for your group participants? Please rank in order of importance, 1 being most important and 4 being least important.

_____ Peer support (1)
_____ Antenatal Education and Knowledge (2)
_____ Continuity of Carer (3)
_____ Self-checking (blood pressure, etc) (4)

End of Block: WOMEN IN GANC

Start of Block: YOUR FEELINGS AROUND GANC

Q28 **Your Feelings around GANC**

Q29 As compared to STANDARD antenatal care, I feel facilitating GANC is....

- ○ Much easier (8)
- ○ Somewhat easier (9)
- ○ Neither easy nor difficult (10)
- ○ Somewhat more difficult (11)
- ○ Much more difficult (12)

Q30 As compared to STANDARD antenatal care I feel facilitating GANC is on balance...

- ○ More work (1)
- ○ Same amount of work (2)
- ○ Less work (3)

Q31 As compared to STANDARD antenatal care, I feel facilitating GANC is...

- ○ More satisfying for me (1)
- ○ Equally satisfying for me (2)
- ○ Less satisfying for me (3)

Q32 As compared to STANDARD antenatal care, in GANC I feel...

- ○ I give women more responsibility for education and information sharing (1)
- ○ I give women equal responsibility for education and information sharing (2)
- ○ I give women less responsibility for education and information sharing (3)

Q33 As compared to STANDARD antenatal care, in GANC I feel...

- ○ I give women more responsibility for safety checks (Blood pressure, etc) (1)
- ○ I give women equal responsibility for safety checks (2)
- ○ I give women less responsibility for safety checks (3)

Q34 As compared to STANDARD antenatal care, in GANC I feel...

- ○ More responsible for social support (1)
- ○ Equally responsible for social support (2)
- ○ Less responsible for social support (3)

Page Break

Q35 Please select one option for each statement below:

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
I feel I have enough time to get to know women in STANDARD antenatal care. (1)	○	○	○	○	○
I feel I have enough time to get to know women in GANC. (2)	○	○	○	○	○
I feel I can routinely deliver quality midwifery care in STANDARD antenatal care. (3)	○	○	○	○	○
I feel I can routinely deliver quality midwifery care in GANC. (4)	○	○	○	○	○

Page Break

Q36 What do you like most about facilitating GANC?

_____

_____

_____

_____

_____

Q37 What do you dislike most about facilitating GANC?

_____

_____

_____

_____

_____

Q38 Words I might use to describe my experience of GANC are: Please select all that apply.

- ☐ Challenging (1)
- ☐ Fun (2)
- ☐ Exhausting (3)
- ☐ Meaningful (4)
- ☐ Repetitive (5)
- ☐ Joyful (6)
- ☐ Stressful (7)
- ☐ Other, please specify: (8) _____

End of Block: YOUR FEELINGS AROUND GANC

Start of Block: YOUR PRACTICE

Q39 **Your practice**

Q40 My practice/hospital/clinic supports me in GANC:

- ○ Strongly agree (1)
- ○ Somewhat agree (2)
- ○ Neither agree nor disagree (3)
- ○ Somewhat disagree (4)
- ○ Strongly disagree (5)

Q41 My practice/hospital/clinic/trust provides me with:

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
The equipment and space I need for group care (1)	○	○	○	○	○
The time and autonomy I need for group care (2)	○	○	○	○	○
The staff I need for group care (3)	○	○	○	○	○
Adequate funding for group care (4)	○	○	○	○	○

Q42

Considering support for GANC, please select one response for each of the statements below:

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
My colleagues support me (8)	○	○	○	○	○
My managers support me (9)	○	○	○	○	○
My obstetric/medical colleagues support me (10)	○	○	○	○	○

Q43 Have you continued to offer GANC at any time during the COVID-19 pandemic?

○ Yes (1)

○ No (2)

Display This Question:

If Have you continued to offer GANC at any time during the COVID-19 pandemic? = Yes

Q44 What accommodations did you make to your GANC for COVID-19?

_____

Q45 How do you feel COVID-19 affected GANC in your practice?

_____

End of Block: YOUR PRACTICE

Start of Block: YOUR PROFESSIONAL ROLE

Q46

Your professional role

The following questions relates to your attitude towards your professional role (This Midwife Profession Role Scale is adapted from Turnbull, et al, 1995 and used with author permission).

Q47 Please select one response for each statement below:

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
Generally speaking, I am satisfied with my current role as a midwife (1)	○	○	○	○	○
I feel I am in a rut (stuck in a work routine) (2)	○	○	○	○	○
I feel frustrated with my current role (3)	○	○	○	○	○
I have enough opportunities to make decisions about care (4)	○	○	○	○	○
I have limited opportunities for professional development (5)	○	○	○	○	○

I am confident that I have the skills for my current role (6)	○	○	○	○	○

Q48 Please select one response for each statement below:

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
I have enough time to give women the care they need (1)	○	○	○	○	○
I get professional support from my midwife colleagues (2)	○	○	○	○	○
I get enough support from other clinical colleagues (e.g. GPs, and obstetricians) (3)	○	○	○	○	○
There is not enough time for me to do my job properly (4)	○	○	○	○	○
My current role is very stressful (5)	○	○	○	○	○

Q49 Please select one response for each statement below:

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
My current role allows me to provide women with choice about their care (1)	○	○	○	○	○
My current role allows me to plan care with women (2)	○	○	○	○	○
I need greater scope to provide women with information about their care (3)	○	○	○	○	○
I have limited opportunities to provide women with individualised care (4)	○	○	○	○	○

Q50 Please select one response for each statement below:

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
I have limited opportunities to provide continuity of care (1)	○	○	○	○	○
I have enough professional independence (2)	○	○	○	○	○
I have few opportunities to develop my skills as a midwife (3)	○	○	○	○	○
I have plenty of opportunities to further my professional education (4)	○	○	○	○	○
I lack professional support from my managers (5)	○	○	○	○	○

End of Block: YOUR PROFESSIONAL ROLE

Start of Block: ABOUT YOU

Q51 **About you**

Q52 How many years have you been a qualified midwife?

_____

Q53 Describe your current work setting (Tick all that apply)

- ☐ Hospital (1)
- ☐ Urban Community (2)
- ☐ Rural Community (3)
- ☐ Urban Health Facility (4)
- ☐ Rural Health Facility (5)
- ☐ Other (6) _____

Q54 Describe your work model:
(Individual Continuity/Caseloading means the same midwife, sometimes with a buddy, cares for the woman antenatally, during birth and postnatally, Team Continuity/Caseloading means the same team of midwives provides antenatal, intrapartum and postpartum care, Traditional Community/Shift models mean the midwives work a set number of shifts per week in clinic or hospital and care for the women who present during those shifts)

- ○ Team Continuity/Caseloading Model (1)
- ○ Individual Continuity/Caseloading Model (2)
- ○ Traditional Community/Shift Model (3)
- ○ Other (4) _____

End of Block: ABOUT YOU

Start of Block: Block 7

Q55 Please leave your contact details if

you would like to be included in the prize drawing for £75.00 e-gift card prize draw OR you would like to receive a copy of the findings OR you would agree to be contacted for follow up

-

- ○ Yes, I would like to leave my contact details for one of the above (1)
- ○ No thank you, I do not want to leave my contact email (2)

End of Block: Block 7

2.3 Survey Analysis Plan

Below is a provisional analysis plan for the survey findings. The colored bands identify which systematic review theme corresponds with those survey questions. ***Giving Women the Care Providers Feel they Want and Need*** *is grey,* ***Building Skills and Relationships*** *is blue and* ***Worth the Work? For Whom?*** *Is pink. The analysis will be done in SPSS and in consultation with the School of Health Sciences biostatistician.*

Research Question	Theme from SR	Survey Questions	Using Survey Questions to Answer Research questions

How many midwives surveyed are facilitating GANC now or have in the past and how much experience do they they have	Identified gap in SR-as most research was pilot description of history or experience with GANC was lacking	Q4-7	Frequency tables of # midwives surveyed currently facilitating # facilitating in past # of groups facilitated Central tendency of # groups facilitated (mode, mean)
Are surveyed GANC midwives offering Intrapartum continuity, how often?	Identified gap in SR theme-this was never described	Q8	Frequency Distribution % attending births -possible independent association with satisfaction and role development scale (chi square vs mann whitney or appropriate non-parametric test)
Are midwives volunteering for GANC facilitation or assigned? Subtext: does it impact experience	SR Theme-WORTH THE WORK-Subtheme provider commitment Only addressed in one article in SR	Q9	# assigned vs. #chose -possible independent association with satisfaction and role development scale

Are the sample midwives trained in GANC, do they feel they need more training	Training Identified in SR as valued, does this differ in research vs. practice?	Q10-11	Frequency Distribution tables -possible independent association with satisfaction and role development scale
How do midwives perceive their facilitation skills	Facilitation skills identified as an area of potential area of stress and satisfaction	Q12-14	Likert scale of comfort-median, mode Frequency distribution of areas of challenge Text responses analysed thematically
Do most midwives have co-facilitators, who are they? How do midwives experience co-facilitation	Collaboration identified as a key theme, co-facilitation varied greatly in description, sometimes not mentioned at all	Q15-18	% of midwives who have cofacilitators Frequency table co-faciltator types Text responses analysed thematically
Are midwives carrying recruitment burden-view to sustainability	recruitment issues are often raised as barriers to sustainability, in the review the “motivated”	Q19	Distribution table of how women are brought into care (i.e. % of responses

	midwives put in extra effort in this area…unclear if that is sustainable		midwife involved in recruitment)
Unpicking midwives perception of appropriate women for GANC and experience of non-native speaker	Gap identified by SR	Q21-23	FD of categories of appropriate women % of surveyed respondents offering alternate language facilitation Text responses thematic
Do midwives feel GANC meets needs of women? How do they perceive it meet those needs?	SR didn't explicity compare midwives views of women's satisfaction with GANC to standard care nor did it answer questions raised about sharing sensitive info by midwives in background literature or suggest which aspects of GANC were best	Q24-27	Ordinal rank data # of respondents that feel GANC meets identified needs better than standard care

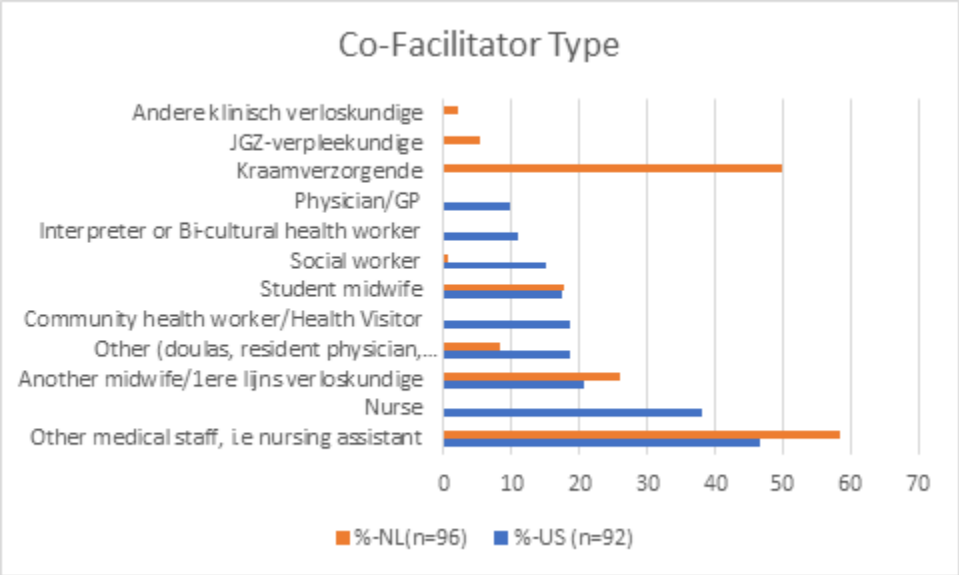
Is GANC perceived as more work (view to sustainability)	Conflicting findings in SR on this theme of workload	Q29-30	Ordinal rank data explicit comparison to standard care FD tables
Does GANC contribute to midwife satisfaction	Underreported in SR, especially when framed as explicit comparison to SC	Q31	Ordinal rank data explicit comparison to standard care FD tables
Does GANC change how midwives share responsibility with women	Identified as a theme in SR but not explicitly delineated or compared to SC	Q32-34	% of midwives who report give women more responsibility vs. less Associations with professional role scale or satisfaction?
Do midwives experience GANC as giving them adequate time and enable quality care delivery If they don't feel GANC is improvement will they continue to do it?	Identified as a theme in SR but not explicitly delineated or compared to SC	Q35	% who respond that they have adequate time in GANC % who respond they have adequate time in SC

			% who respond they give adequate quality care in GANC % who respond they give adequate quality in SC Possible associations
Best and worst aspects of GANC for midwives	Knowledge gap identified from SR	Q36-37	Text responses thematic analyses
How midwives describe GANC experience	Words drawn from SR	Q38	Frequency table Could be made binary (negative v positive words)
Are midwives getting support they need (resources, staffing, funding, collegial) for GANC	SR identified these items as organizational barriers to GANC	Q40-42	Likert ordinal data FD tables detailing support # reporting support associations with satisfaction

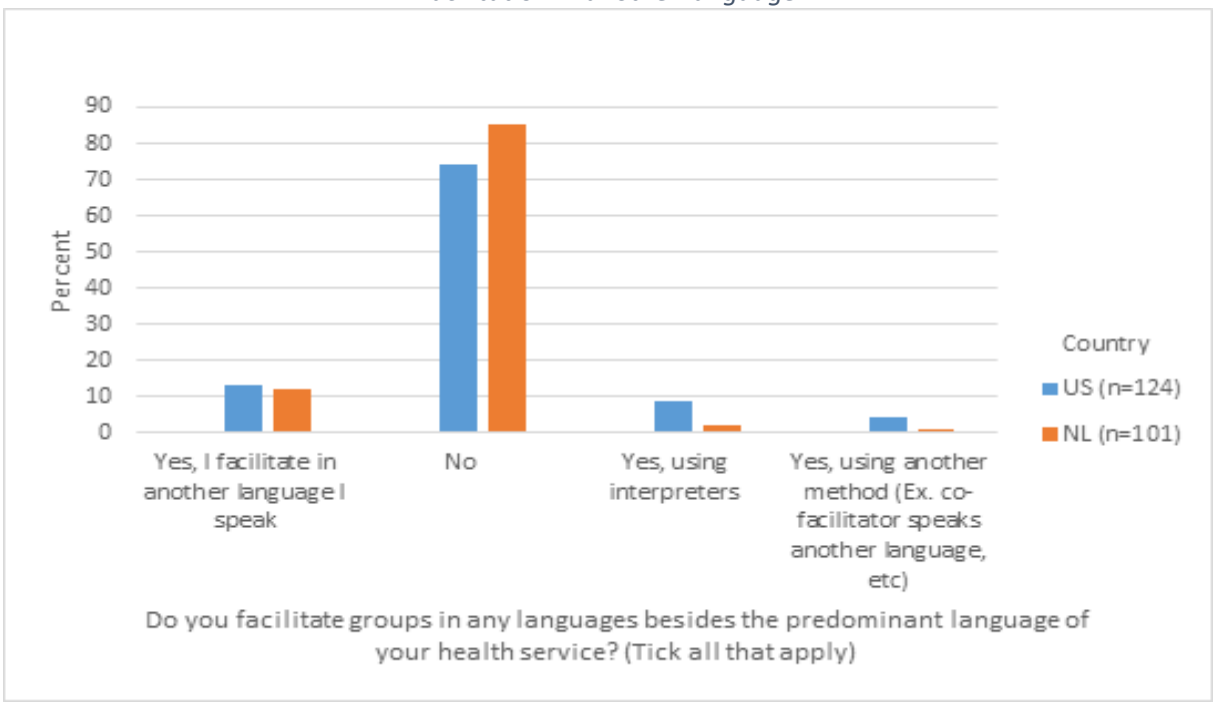
Effect of covid on GANC-accomodations and interruptions	n/a	Q43-45	% of midwives facilitating who continued during pandemic Thematic analysis of accommodations in text response
How do the midwives in the survey view their professional role	SR identified GANC as affecting professional role development	Q46-50	Scales and subscales will be calculated using turnbulls scoring system (-2 through 2) and then mean scores and chi square test can be considered applied to this sample-need to consult with statistician for refresher on calculating cronbach's alpha for this scale
Description of Participant Sample	SR had gaps in sample description of midwives in terms of years experience	Q52	Mean # of years as a qualified midwives Potential independent variable for examining associations with professional role,

			comfort with facilitation, or other dependent variables
Description of Participant Sample	Urban vs rural was described in SR but generally setting was not described	Q53	Frequency table
Are midwives working in GANC continuity teams	Knowledge gap from SR-no description of continuity among facilitating providers	Q54	Frequency table ? association with professional role satisfaction or satisfaction with GANC

2.4 Supplementary survey findings



Facilitation in another language



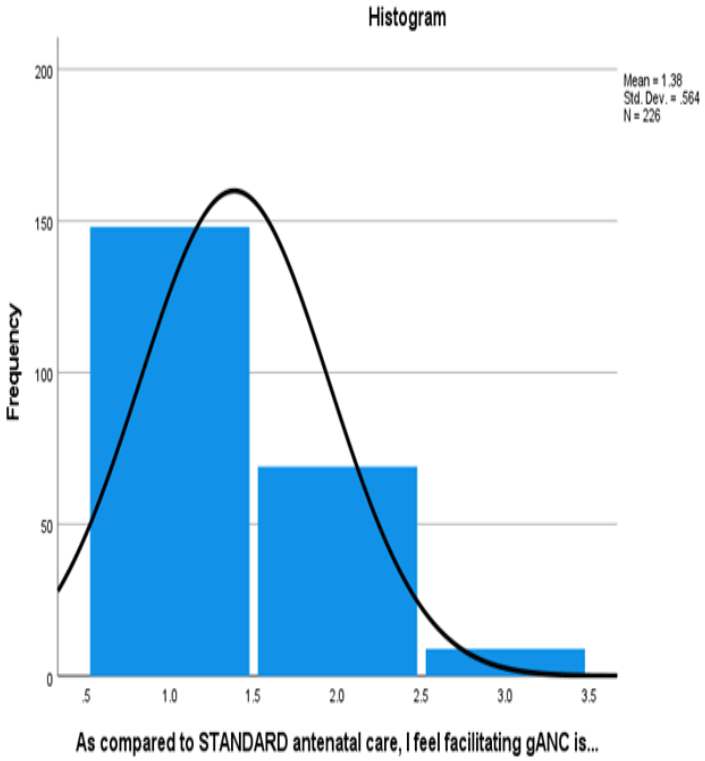


Figure 26: Skewness of satisfaction with gANC

Correlations

			As compared to STANDARD antenatal care I feel facilitating gANC is on balance...	As compared to STANDARD antenatal care, I feel facilitating gANC is...	Professional support subscale mean	Client interatction subscale mean	Professional development subscale mean
Spearman's rho	As compared to STANDARD antenatal care I feel facilitating gANC is on balance...	Correlation Coefficient	1.000	-.049	-.019	.047	-.04
		Sig. (2-tailed)	.	.466	.777	.495	.48
		N	225	225	216	215	21
	As compared to STANDARD antenatal care, I feel facilitating gANC is...	Correlation Coefficient	-.049	1.000	.086	-.063	.00
		Sig. (2-tailed)	.466	.	.205	.358	.99
		N	225	226	217	216	21
	Professional support subscale mean	Correlation Coefficient	-.019	.086	1.000	.505**	.522**
		Sig. (2-tailed)	.777	.205	.	<.001	<.00
		N	216	217	217	215	21
	Client interatction subscale mean	Correlation Coefficient	.047	-.063	.505**	1.000	.533**
		Sig. (2-tailed)	.495	.358	<.001	.	<.00
		N	215	216	215	216	21
	Professional development subscale mean	Correlation Coefficient	-.048	.000	.522**	.533**	1.00
		Sig. (2-tailed)	.484	.996	<.001	<.001	
		N	215	216	215	215	21
	Professional satisfactions subscale mean	Correlation Coefficient	.041	-.004	.553**	.621**	.648**
		Sig. (2-tailed)	.657	.967	<.001	<.001	<.00
		N	118	119	118	117	11

**. Correlation is significant at the 0.01 level (2-tailed).

Table 15: Correlations with MPQ and satisfaction and workload

2.5 American College of Nurse Midwives Survey Approval Letter

ACNMAMSurvey Approval Letter_Lazar_Signed.pdf

Appendix 3: Interview Documents

3.1 City, University of London Ethics approval for interviews from

Ethics-ETH2021-2299-Ms-Jalana-Noreen-Lazar-Low-risk- (2).pdf

3.2 Interview Consent

Name of principal investigator/researcher: Jalana Lazar

REC reference number: **ETH2021-2299**

Title of study : Exploring the Experiences of Midwives Facilitating Group Antenatal Care

		Please tick or initial box
	I confirm that I have read and understood the participant information sheet or had it explained to me verbally. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	
	I understand that my participation is voluntary and that I am free to withdraw without giving a reason without being penalised or disadvantaged.	
	I understand that I will be able to withdraw my data up to the time of publication.	
	I agree to interview being audio OR video recorded.	
	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) explained in the participant information and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
	I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose.	
	I understand that direct quotes may be used in publication of this research but my name and personal identifiers will not be attached to them. This anonymous data may be made open access to support journal publication.	
	I agree to take part in this interview.	

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of Researcher	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher file.

3.3 Interview Guide

Interview guide for midwives who have facilitated GANC

Background in GANC

1/ Tell me how you came to be a GANC facilitator?

PROMPT (if needed only for midwives that volunteered to facilitate): – What appealed to you about GANC?

PROMPT: Tell me about any GANC training your received

2/ Tell me about a memorable group you facilitated

Opportunities and Challenges

3/ Can you relate any personal or professional benefits of working in this model?

PROMPT: How did this experience impact on your knowledge and confidence levels?

PROMPT: How did this experience impact on your sense of wellbeing/stress levels?

4/ Can you relate any personal or professional challenges?

PROMPT: What specific aspects of facilitation have you found most challenging?

5/ Describe your impressions of the workload associated with GANC?

Interprofessional collaboration

6/ Tell me about any collaboration or co-facilitation experience you had with other professionals as part of your GANC experience?

Midwifery sustainability/expansion

7/ Has working in this way changed the way you approach midwifery care?

8/ How does being a midwife affect how you approach this type/model of care?

8/Do you feel midwives are the ideal provider for GANC?

PROMPT: Why our why not?

9/What do you feel would enable the expansion of this care model?

10/ What could hinder the expansion of this care model?

.

3.4 Interview Schedule

Interview Schedule				
Interview Date	Initials	Midwife Nationality	Interview Length (minutes)	Pertinent geographical notes
26 October 2021		U.S.	40:05	CO-urban
27 October 2021		U.S.	44:31	KY- Rural-Substance Misuser specialist groups
15 Nov 2021		U.S.	42:51	All over since 2008
18 November 2021		U.S.	38:22	VA-urban
18 November 2021		U.S.	26:52	Military
18 November 2021		U.S.	37:32	MA Spanish speaking groups
24 November 2021		U.S.	33:00	Native American Reservations
26 November 2021		U.S.	27:00	Urban, NYC, adolescents
09 December 2021		U.S.	27:41	California, Military
7 Jan 2022		U.S.	44:15	FQHC (low income) Spanish speaking groups Ohio (in person interview)
13 Jan 2022		U.S.	33:26	FQHC (low income) (in person) Ohio
02 February 2022		NL	47:33	Caseloading near Amsterdam MW-1st midwife to say CP didn't work well
11 February 2022		U.S.	66:48	Texas, Spanish speaking co-facilitator
24 February 2022		NL	35:45	Southern border and Belgium
24 February 2022		NL	33:20	Rural southern NL

02 March 2022		NL	32:38	Small city surrounded by rural areas, and high population of low SES
08 March 2022		NL	53:58	Small city practice, LOTS of CP experience/lots of groups
23 March 2022		NL	51:07	Small city surrounded by villages
20 May 2022		NL	37:58	Big city
08 June 2022		NL	47:27	Large city, immigrant population, different language groups, hospital too
10 June 2022		NL	58:44	Northern NL

3.5 Analytical Framework

MidwifeInterviews

Nodes\\Framework Coding

Name	Description
hierarchy	codes relating to shifts in relationships, hierarchies or position
Knowledge Skill	References to increased knowledge about women or themselves or increased skills in facilitation
cultural learning	
using stories	
Midwifery Work	References to midwifery work, specifically work that is unseen or watchful attendance type of work, relational work, time and quality related
holding space	
mission	
Relationships	
taking time	
Trust	
Organisation Impacts	Impacts of Organisation on GANC from viewpoint of provider
children in groups	
money	
organizational	
Practicalities	Pertaining to practicalities of running groups (charting schedules, logistics, etc)
Professional Role	References that speak to view of midwifery professional role
autonomy	
Characteristics of Midwives	
Satisfaction	References to satisfaction, personal or professional, references to joy, happiness, pleasure,fulfilment, etc
dissatisfaction with standard care	
energy	
laughter	
meaningful	words related to fulfilling or meaningful-(see also link?)
Strength or Power	Codes relating to strengths of facilitating midwives or power or empowerment
doing something hard	
Empower	
Support	Codes related to support and community
community	

difficult situations	
modelling normalcy	
networks	
peer support for pregnant women	
staff support	
Other	

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