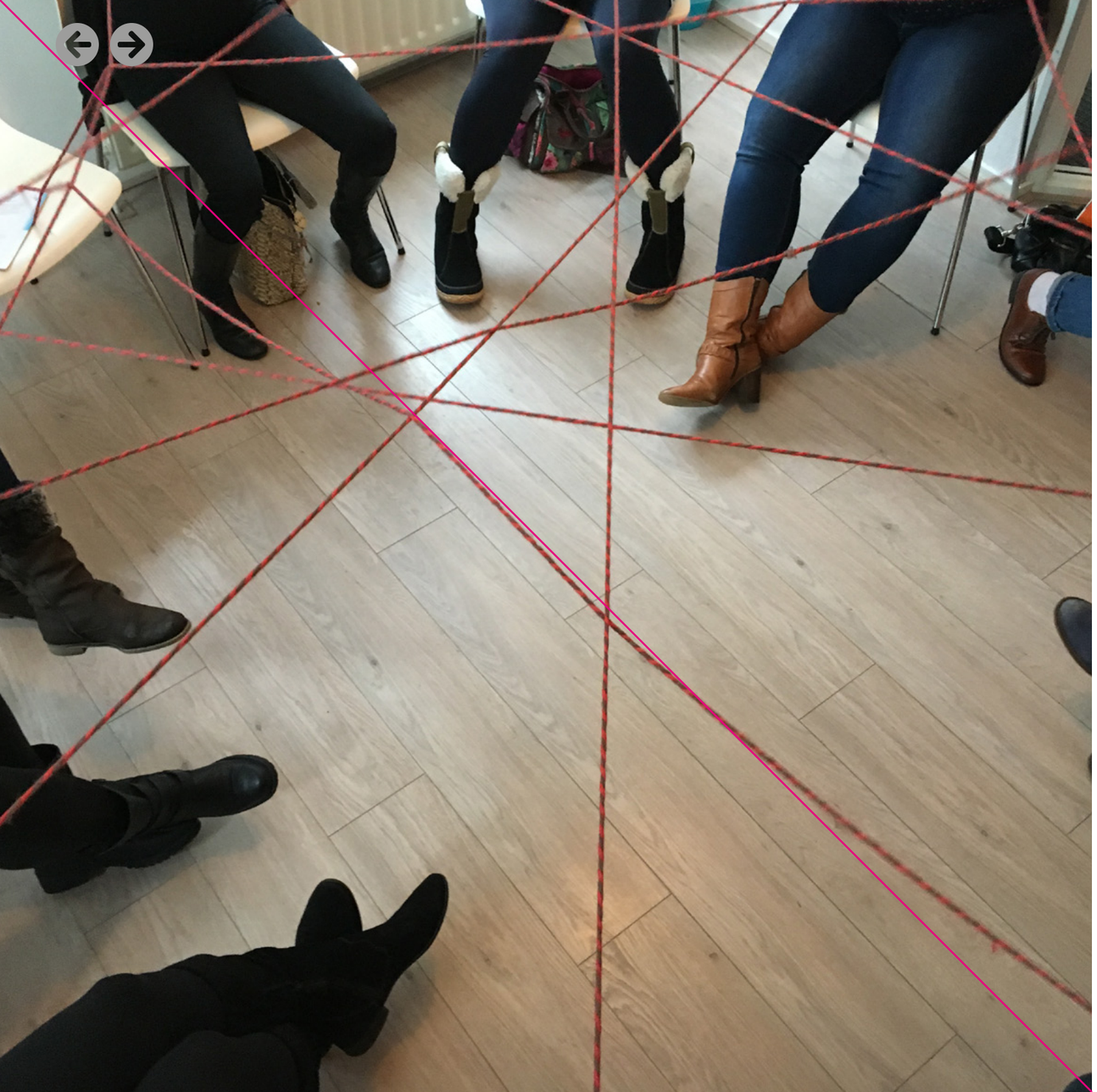
Little pearls

Short group care stories with a LARGE impact.



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Short group care stories with a LARGE impact.

Colophon

The stories in this book originate from every day maternity care practice based on the centering method. With the exception of the portraits, names and places have been changed to ensure anonymity. For the same reason the names of health professionals are omitted.
The book is also available in PDF.
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Text + project management
Suze Jans

Portraits
Denise Hilhorst

In collaboration with
Dharma Raj Kadayat, Jinguo Helen Zhai, Sheele Maru, Sharon Rising and Marlies Rijnders

Artwork + layout
Grafisch Ontwerp Pi&Q

Photography
Caro Bonink
Sannaz Photography (Portret Marlies Rijnders)
Nyaya Health Nepal (Photo 'Group Antenatal Care program in Achham, Nepal'

Contact
TNO
PO Box 3005
2301 DA Leiden
childhealthsecretary@tno.nl

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Letter from a midwife

Dear Centering trainers,

Today I completed the third Centering group in our practice.

I followed the 2 day training course and I attended 3 Centering intervision meetings. All together with the attached process evaluation, I should be ready to receive my Centering certificate. Personally, I also feel that I am ready! I am no longer nervous, can allow the process to run its own course and am growing more and more into my role as a facilitator. Each new group teaches me something new. I will definitely carry on, starting with my fourth group next Wednesday. The group is completely filled again!

After initially being somewhat reserved and skeptical, I am now very enthusiastic about Centering and find that providing group care is rewarding, also for myself. After so many years of conducting 'traditional' consultations and having individually supported and cared for pregnant women with a lot of pleasure and much love, Centering has turned out to be a welcome change in my daily practice. Moreover: I see that it works!

It is wonderful to see that seemingly completely different women find each other and support each other. A truly special bond and connection develops between them. A more powerful model of care does not exist.

In addition, your role as a midwife within the group is a special one. You get to know the pregnant women in the group much better and you build a different kind of relationship with them, compared to traditional one-to-one care. This makes Centering a more effective model of care: you really get to know the women; you need fewer words or less care to truly understand one another.

Best wishes,

Nathalie Manders
Midwife
The Netherlands

'A more powerful model of care does not exist'

Preface

There is a growing body of evidence which demonstrates the positive effects of antenatal care based on the Centering method. The model fosters better outcomes for mothers and babies, improves lifestyles and leads to more care satisfaction. More recently, the model was extended to include young babies and families in parenting groups. I believe the group care model based on Centering is an opportunity for care professionals to truly engage in partnership with women and their families. It helps to build the supporting community that many women lack in current societies.

However this group care model has more far-reaching consequences but which do not show up in the evidence. The stories in this book, that emerge from daily practice with group care, the so-called 'little pearls', illustrate what it means for women to receive this type of antenatal care. To truly understand the impact of the Centering model I recommend everyone that influences health care for women and their families, to read this book. It will show you the world behind statistics.

Franka Cadee, RM
ICM President

International Confederation *of* Midwives

'I believe the group care model based on Centering is an opportunity for care professionals to truly engage in partnership with women and their families'

Foreword

Imagine having a pregnant woman come into the community health center saying, 'I'm worried about my headache.' She has received her antenatal care according to the centering-group care model. 'We talked about headaches in our group and I now know that this headache is different from the malaria headaches that I often get.' The clinical staff quickly check her blood pressure, which was very high, and immediately refer her to the nearest hospital. Or imagine that during the postnatal session of the group, the women share with the midwife their concerns about another group member possibly suffering from depression.

Group health care is a manner of Maternal Newborn and Child Health (MNCH) provision that goes beyond the traditional one-to-one care. With a group of 8 to 12 women, the saying applies 'when you get to know everyone, you get to care about everyone'. As the group meets together, 8–10 times during pregnancy, continuing during the postnatal period for baby and women's health care, the sharing and caring amongst the members becomes quite profound. Women share concerns and life experiences that they never disclosed before; not with a care provider and not even with their family or friends. The privacy and security of the group creates a safe environment for talking, leading to creative solutions generated by the group itself. As each person's confidence grows the resultant empowerment is expressed through improvement in health behaviors for herself and her family.

For me, there was a clear reason to develop and implement a group model of care: a model resulting in better care-and-health outcomes and higher satisfaction with the care provision. I had been a practicing nurse-midwife for over 20 years and knew there was a better way to provide care than the traditional one where throughout the day I was answering the same questions at each individual antenatal care checkup. I envisioned a care model that would empower women to make their own decisions about their health care needs; a care model that would unite women in support of each other, a care model that would encourage women to share the knowledge I knew they had with others. The model I developed, CenteringPregnancy®, is relationship-centered,

Sharon Schindler Rising
Verloskundige en secretaris & penningmeester
Group care Global

building on the knowledge and wisdom present in the group, and where cultural values and norms that influence health behavior are respected. Although the midwifery care provider remains accountable, her role has changed. She[1] becomes a group member and takes on a facilitation role instead of the traditional didactic and health promotion role. Because of the growing connection and the strong trust in the group, it can meet needs that a health care provider is not always able to provide. This calls for a re-evaluation and adaptation of the traditional care provider's identity. But at the same time, this innovative role brings more far-reaching satisfaction to her work because the care provider is an eyewitness to sustainable relationships being forged in the community, promoting healthy behavior.

Perhaps the real question is: why wouldn't we want to provide the best possible care for the women and families that we serve? Group care brings joy to all the participants and supports a sense of community whereby long-lasting relationships start and may carry on for years.

The stories in this book reinforce for all of us what we all already knew. Group care is a powerful and innovative way of providing and receiving (maternity) care.

Sharon Schindler Rising
Nurse-midwife, secretary & treasurer of Group Care Global
Silver Spring, MD, USA

1. 'She' is used here realizing that there are many men who are providing midwifery care and also acknowledging many physicans who also provide human-centered 'midwifery' care.

'Centering-Pregnancy is relationship-centered, building on the knowledge and wisdom present in the group'

Care according to the Centering model: what does that mean?

Care according to Centering model is group-based antenatal and child health care that takes women, expecting around the same time or who have newborns of the same age, out of examination rooms and into a comfortable group setting for their check-up appointments.

Facilitated by a health professional, (midwife, doctor, or a child health nurse) with a co-facilitator (practice assistant, maternity aid nurse, health care receptionist or medical/midwifery student), 8 to 12 women meet for their check-ups and are able to take on a more significant role in their care process. Participants measure their own blood pressure, register their weight and maintain their own files. The traditional individual check-ups are replaced by group sessions. These sessions are not didactical by nature but have the character of a facilitated discussion that uses group knowledge and experience for collective learning. The unfolding group dynamic supports feelings of autonomy and competence. In addition, it creates special and long-lasting bonds.

Each group meets 10 times. Nine of the meetings take place during pregnancy and the tenth and last meeting takes place after all the women have given birth, approximately 6 weeks postpartum. Group sessions last 2 hours, much longer than the 10 to 15 minute check-ups during standard antenatal care provision. Care providers have a facilitating role instead of the traditional care provider's role. This requires adaptation and training.

This model has now been extended to community based child health services replacing traditional one-to one-well-baby check-ups with parenting group sessions based on the Centering model. During these meetings, the parents carry out standard health and developmental assessments for their child according to local guidelines. Facilitated by a professional provider (child health nurse or a child health doctor), the group then engages in discussions and interactive activities about parenting and specific topics as attachment, safe sleeping, breastfeeding, nutrition, development, and safety etc.

The 9 essential centering elements

1. The medical check-ups take place in and during the group sessions
2. Participants are actively involved in the medical assessments
3. Every group session has a set themed program, variation is possible
4. The facilitators stimulate the interactive involvement of all participants
5. There is time for informal contact during each session
6. Participants are seated in a circle during the group sessions
7. Group composition, including facilitators, is consistent
8. In order to stimulate the group process, an optimal group size is needed (<12)
9. There is continuous evaluation.

In maternity care the model is known as CenteringPregnancy or group antenatal care. In child health the model is known as CenteringParenting. In the Netherlands both are known as Centering or 'Samenweetjemeer (Knowingmoretogether)'. More information: https://samenweetjemeer.nl or Group Care Global, http://groupcare.global

Introduction

Safe, respectful health care that is consistent with the norms and values of (expecting) parents, is essential. Every maternal health professional endeavors to achieve this. But how? How do you generate and transfer knowledge in an equitable, respectful and comprehensive manner? How do you make use of the knowledge and experience of (expecting) parents, giving them an opportunity to share this with others? Above all, how does a health system enable people to shape themselves in one of the most important periods in their lives, where they find themselves on the eve of guiding a new life into adulthood?

In the current maternity care model of one-to-one care, it is not always possible to address all the aspects of safe and respectful health care, which is far more than just medical-obstetric check-ups. Think about making healthy choices during pregnancy, preparation for parenthood, the impact pregnancy has on a relationship, the social environment and living conditions. The Centering model allows for space and time to discuss all these aspects with women and their partners while building supportive mutual relationships and communities. It also strengthens the connection between client and health professional making the relationship more equitable.

Maternity care improvement

Dutch perinatal and child health care provision is changing constantly. Since 2009 efforts have been made by all health professionals involved to improve the quality of these services[2]. Recently a new impulse was introduced with the new government action program 'A promising start'[3]. The program aims to give more children a healthy and promising start in life by improving preparation for pregnancy and parenthood and by ensuring that (vulnerable) parents receive timely appropriate help for their needs.

2. *Steering party Pregnancy & Birth. (2009) A good beginning. (Stuurgroep Zwangerschap en Geboorte. (2009). Een goed begin.)*

3. *VWS. (2018). Actieprogram A promising start (Kansrijke Start).*

One of these health care improvements is care according to the Centering model. Pregnant women who receive antenatal care according to this model, attend more antenatal check-ups, smoke less, use less pain medication during labor, initiate breastfeeding more often and have better psycho-social pregnancy outcomes[4]. Moreover, group participants experience more social support and are more satisfied with the care they receive[5].

Medical care in a group model

The Centering care model originated in the United States (US). In 2011 it was further developed by TNO and introduced in the Netherlands in collaboration with the Dutch Organization for Midwives (KNOV). In this model, medical check-ups are integrated into a group format, using interactive learning and peer support (see box). Parents play an active role in the care they receive; their needs determine the agenda and the health care professionals involved have a much more facilitating role than before.

The implementation of the care model started with the training of midwives and practice assistants from 3 innovating midwifery practices, a midwifery teacher from the Midwifery Academy in Amsterdam, a KNOV policy advisor and a TNO researcher. Currently more than 100 midwifery practices in the Netherlands (out of just over 400) have successfully implemented this model. The introduction of CenteringParenting into Community Child Health Services is gaining more and more attention. The evidence-base for this model is constantly growing because of studies being carried out by TNO and Leiden University Medical Centre (LUMC).

With the establishment of the Foundation Centering Healthcare Netherlands in 2017, the corresponding trainings, intervision, recommendations and guidance have been tailored for use in Dutch

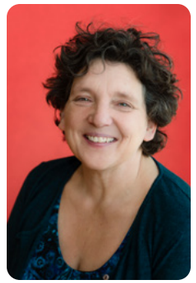
4. *Rijnders M, Jans S, Aalhuizen I. etal. Women-centered care: Implemenation of CenteringPregnancy in the Netherlands. Birth. 2019 Sep;46(3):450–460.*

5. *McNeil DA, Vekved M, Dolan SM etal. Getting more than they realized they needed: a qualitative study of women's experience of group prenatal care. BMC Pregnancy Childbirth. 2012 Mar 21;12:17.*

health care. Through the development of materials and modules for specific groups as fathers, Eritrean women and low-literate women, multiple target groups are being reached.

Currently TNO, partnering with midwives and child health care professionals, is developing a comprehensive form of the Centering model by taking the (expectant) parents as the starting point around which care is organized during the first 1000 days in the life of a child[6]. The recently published indicator set, belonging to the 'Action Program A Promising Start', underlines the importance given by the Dutch Ministry of Health[7] to the Centering model: both the percentage of midwifery practices and the number of municipalities offering the Centering model of care are considered as indicators for good quality of care.
In summary: a lot has happened since the introduction of the Centering model in the Netherlands in 2011! CenteringPregnancy or group antenatal care, also known as TogetherYouKnowMore (SamenWeetJeMeer, the Netherlands) has been firmly established in the Netherlands, allowing many women and their families to receive high quality care with this appealing care model.

Marlies Rijnders, PhD, RM.
Researcher, TNO



6. *The first 1000 life days of a child includes the preconception period, pregnancy and until the child is 2 years of age.*

7. *VWS. (2019). Indicatoren Kansrijke Start. Een Delphi-studie.*

Why this book?
Currently a considerable body of evidence exists supporting the benefits of group antenatal care. We know it improves outcomes and empowers women to look after their own health as well as providing the support that young families need. But what does that really mean? What does empowerment look like in daily life? This reality does not fully emerge from the research. However as researchers we do hear plenty of stories: wonderful and impressive stories that typify group care according to the Centering model. These stories, the so-called 'little pearls', illustrate what happens during the care women receive through the Centering model. This is what the stories in the book will show you: the world behind statistics.

Little pearls

Short group care stories with a **LARGE** impact.

Together is more!
It is the first meeting of the new group. Frederique enters the room somewhat uneasy. She hides her belly in a dress that is far too big for her and her eyes are cast downwards. She is not sure what to do and shuffles discreetly to the nearest chair she can find. The midwife is busy examining one of the other women, but can't help noticing the timid figure in the room.

Frederique is the last one to join the midwife for her abdominal examination. The large dress reveals a beautiful little belly. The midwife tries to make contact with her but Frederique does not open up. In silence they quietly listen to the baby's heartbeat together.

The midwife wonders if Frederique's extreme shyness might prevent her from being able to join in. But the power of the group proves to be strong enough. The women in the group begin to talk. They tell each other who they are and how they feel about being pregnant. This encourages Frederique to talk. Shy at first, but with the group's encouragement, she tells her story. She talks about the town where she grew up and how she unexpectedly became pregnant, how her family abandoned her and that she is all alone.

The group is noticeably touched. Frederique looks relieved. 'It is the first time that I don't feel alone having people around me who are interested enough to ask me things and who want to help me.'

Frederique becomes more and more self-assured to the following group sessions. The group app is in full swing and coffee dates are made. The group sends each other tips about common pregnancy ailments and support each other to achieve personal goals. Frederique is able to stop smoking, to stop drinking Red Bull, and to eat a healthy meal at least twice-a-week.

The midwife: 'I really wondered how Frederique would experience being in the group. Would she be able to find her place? Would we be able to make her feel comfortable enough? But it was really special to see what happened in the group. At a certain point during the first meeting, I realized I hadn't said anything for 15 minutes. The group didn't need me, they did it themselves. I realized that this care model improves the health of the mother and child so much more compared to the 'old fashioned' care model. Frederique's positive experience was the result of the power of Centering. Together really is more!'

Twins
The Centering group holds a postnatal meeting for the women to get together one last time. It is a large group of 15 women. Birth stories are shared and new topics are discussed, such as feeding, coping with a new baby and family planning. One of the participants is Maartje. It was her second pregnancy and this time with twins. Her first child is 2-years-old and her partner has a demanding full-time job. The twins, 2 boys, are healthy and Maartje is very pleased about how the birth went. Still, the tears well up in her eyes. Maartje is having a hard time and confesses that she cries a lot. Two small babies and a toddler who is constantly demanding attention. She can't seem to get anything done, not even prepare daily meals. She often reverts to simple meals as store bought pizza. Her partner does his best in the evenings. But it is not enough. Sadly she asks the group, 'How will I ever manage?'.

'What makes it so difficult for you? What are the most difficult moments? Is there anything you can delegate?' The group takes the lead asking analytical questions. They finally decide that together they can lend Maartje a helping hand. For example, taking care of one hot healthy meal-a-day, so that she doesn't have to shop and cook herself. This is not a lot of extra work for the other mothers in the group. In this case it is advantageous that the group is larger than average. With 14 women, everyone only needs to cook a little extra once every 14 days. The group sets up a schedule and for the next month, a prepared meal is brought to Maartje and her family each evening.

The midwife: 'I can't offer this type of care unless I open up a soup kitchen. It is 'only' about a plate of food, but in the meantime Maartje feels enormous support.'

Teenager
Group care is sometimes used to see if people are receptive or self-reliant. However, this is not a goal in itself but a simple way to assess to what extent something is understood, without having to ask explicitly. For example: Can someone read and write? Are they able to achieve a set goal?

This is the case with Sofie, a 14-year-old girl who is unintentionally pregnant by her 17-year-old boyfriend Daan. She joins the group with her mother. Sofie will continue to live at home where she will care for and raise the baby with the help of her mother. Sofie's mother does not have much confidence in her daughter's mothering skills. The group consists of 11 other women between the ages of 22–40-years-old.

During the first group session, every women receives a workbook. It contains a lot of health information and has space where the results of the pregnancy check-ups can be recorded. There are also assignments as preparation for the group sessions and Sofie takes these very seriously. After all, she is used to doing her homework tasks for school. She always comes to the sessions prepared. She is able to answer many of the questions asked by the other group members. After a few sessions, it is clear that the other

women have developed respect for Sofie, trusting her knowledge and information, treating her as an equal and not as just a pregnant kid. This strengthens her self-confidence and sense of responsibility. Sofie's mother's attitude also changes. She sees her daughter maturing, gaining the respect of the others in the group. It makes her more confident about Sofie becoming a mother, making it easier to have an adult conversation with her daughter about the division of responsibilities and tasks after the baby is born.

The midwife: 'It is impossible to generate a dynamic like this during one-to-one care. During traditional antenatal care, there is just not enough time to foster this kind of relationship. It happened here, right in front of my eyes without any extra effort on my part. The group gave Sofie the self-confidence she needed to care for her baby. This group still meets regularly.

Domestic violence
In each group, domestic violence is a topic for discussion using a number of statements. Now it is this group's time to discuss the subject. The women in the group work well together and really enjoy each other's company. They say themselves, 'we have a good click'. They see each other outside of the group and communicate using WhatsApp. The subject domestic violence is discussed calmly without any issues emerging.

A few weeks later Aaf, one of the women in the group, invites the midwife for coffee. Aaf lives in one of the apartment complexes in the city that has a bad reputation. She tells the midwife that she is trapped in a violent relationship. Her partner beats her and they fight often. On some occasions, the police has come to investigate. Aaf feels unsafe. 'Do I want my child to grow up in this kind of circumstance?' She has discussed her situation with the group. 'I don't want this anymore, but how do I get out of this. How do I do that?' She tells the midwife that with support from the group she decided that her partner can move in with his brother. Her partner has accepted this solution. The group helped her to move his things to his brother's house. When this was done, the group advised her to inform the midwife about what had happened. They thought it was the right thing to do.

The midwife: 'This woman created her own support network and together they found a solution for her problem. The group discussion made her think further. She was able to end the situation in the safest possible way for herself, her child and her partner.'

Itchy hands
The group counts 10 participants. Today is the last session when all the women are still pregnant. At the end of it, one of the women has something to say 'I can't go home like this. I will sit and worry if everything is going to be alright because you talked about itchy hand palms and foot soles. You have to be careful when you feel this, right? And get yourself checked?' she asks worriedly. She nudges Anja, the woman next to her. 'If you don't tell them, I will!'

Anja has joined the group even though she receives her care in the hospital due to her history of having a still birth. Anja has been experiencing itchy hand palms and foot soles for a while. Not a nice feeling, but she forgot that it could be a sign of serious problems. She has not said anything about this during the sessions or to the midwife. But she has complained about the discomfort to her fellow group members. Stammering, she now talks about her complaints.

The midwife refers Anja directly to the hospital for examination. Her serum bile acids[8] are seriously raised. Because of this and her history, her labor is induced.

8. Cholestasis of pregnancy is a condition marked by (severe) itchiness without skin changes (apart from scratch marks), combined with raised serum bile acids. A relation exists between cholestasis of pregnancy and serious fetal complications. (Guideline Cholestasis of Pregnancy, NVOG 2018).

The midwife: 'Social control within the group brought this woman's complaints to light. The topic of itching hand palms and foot soles is not a standard subject during one-to-one care. It doesn't happen that frequently and we simply don't have the time. This is not the case for group care where there is more time and opportunity to bring up this issue.'

Failure to progress
Ayla is pregnant with her first child and has enjoyed participating in the group care sessions held by her local midwifery practice. Her labor is induced due to high blood pressure. Her blood pressure is stable and the CTG [heart trace] shows that her baby is in good condition. She has reached a dilation of 6 cm but this has taken a long time. The obstetrician on-call thinks that progress is too slow and proposes to carry out a cesarean section. It scares Ayla. She contacts the midwife on call in her practice. 'Why do I need a cesarean? What does it mean that my labor is too slow?' Ayla asks the midwife despairingly. 'Everything seems to be fine, my baby is doing well, and my blood pressure is good. I don't want a cesarean section, at least not yet. I can cope with my contractions. The amniotic fluid is good too.' The midwife explains to her that from a distance she cannot make an accurate judgement about the situation. But she does explain to her, that if the situation is the way Ayla describes it, she could probably wait a little longer, especially if she and the baby are doing well. 'Talk to them', she advices Ayla. 'Make a deal with the obstetrician about how much longer you can try.' Ayla talks to the doctor, who agrees to postpone the operation. Ayla waits, keeps moving, showers, and walks around. Eventually she has a cesarean section but at the moment when Ayla is ready for it.

The midwife: 'The medical outcome is the same: A healthy mother, a healthy baby and a cesarean section. But her birth experience was probably much better than when the cesarean section had been carried out earlier. Ayla learned a lot during the group sessions in which we discussed the birth and what you may or may not want. Ayla looks back on the birth with pride and satisfaction. She knows she did everything she could to have the best birth experience. She kept the control over this event.'

Pesto troubles
It is not uncommon to have women in the group who have an unhealthy diet. Therefore healthy eating is an important theme during group sessions. The current group has a participant who has very unhealthy eating habits. Maaike doesn't like much. Pasta with ready-made pesto from the local supermarket is one of the few things she manages, as well as white bread with chocolate cream, sweets and potato chips.

It was wonderful to see how quickly you can get to know each other. The first group meeting was somewhat awkward. You don't know each other at all. The only thing that you have in common is that you are pregnant. But because of the Centering model, we soon started talking about discomfort, things we came up against or what worried us during pregnancy.

Easier to talk
Every meeting had a specific theme, for example minor complaints during pregnancy. The midwife started the conversation, but before we knew it, our stories flew back and forth across the room. Because we recognized so much in each other, it was easy to say what we wanted to share. Nothing was thought of as strange. That made me feel more secure and free to ask questions.

Good exchange
During my first pregnancy, I only experienced the one-to-one visits with the midwife. When I was able to join a Centering group during my second pregnancy, the exchange between women specifically appealed to me. And it really worked. For me it meant that I retained information much better and I thought deeper about certain topics.

Impact
One of the women who already had a baby, told us that she only heard about the birthing stool *after* giving birth. It seemed better for her to use the birthing stool for her second birth because the first time she found it hard having to lie on her back all the time. That really had an impact on me. If the midwife had encouraged me to use the birthing stool, I don't think I would have accepted her advice as easily. I wasn't really keen on a birthing stool, but this story made me look at it differently.

My story
The 20-week ultrasound scan was discussed during one of the sessions. With my first child, spina bifida was discovered with that scan. We decided to terminate the pregnancy. My story made the other women more aware of the fact that the 20-week scan is more than just having a fun look at the baby. One woman who had decided not to have the 20 week scan, changed her mind. She didn't realize how much could be

seen during the scan. And when a small abnormality was seen in another woman's scan, she was able to talk to me about it. It is easier to talk to someone who has had a similar experience.

Encouragement
I also received support from one of the women in the group. I am a nurse and when I started experiencing pelvic instability, I found it really difficult to talk about it at work and indicate that I needed to work less or change my duties. One of the women in the group had the same problem but she approached it differently. This encouragement was what I needed to talk to people at work.

Michelle (27):

'It is easier to talk to someone who has had a similar experience'

During the group discussion, it is Maaike who asks, 'What can I do to eat healthier?' 'You can make your own pesto', one of the women in the group remarks. 'Fresh basil is a step in the right direction.' 'Try rocket in your pesto', suggests another participant. 'You'll find lots of recipes on the internet', says another woman.

One of the assignments during group care is that every week each participant places a photo of a meal she is most proud of in the group app. This encourages the other participants to think about what they eat. It is how they learn from each other.

Four weeks later the group comes together again. Maaike says that she tried out a salad: the recipe also contained pesto! She proudly adds the photo to group app.

The midwife: 'Maaike realized she needed to change. Especially for the benefit of her child. During pregnancy, people are more open to change. We use that to our advantage. Moreover the assignment doesn't cost me any time at all. Inspired by the group Maaike started to experiment. She is still not the best example of a healthy eater, but her trying out other things is a huge step forward!'

Partner meeting

One of the participants in the new group is Nienke. A healthy lifestyle is very important to her. She is a professional coach and works in a clinic for substance abusers. She feels connected to the group and is excited but also a little stressed. Especially the feeling that she has no control over what is to come.

Nienke is in a good stable relationship with a man who is very involved with the pregnancy. The group invites their partners twice to participate in the group: one session when they discuss the birth and another session when a father coach joins in as co-facilitator. During the session with the father coach, the group splits up. The women in one group and their partners in the other. They discuss separately what their expectations are about having a baby. How will a baby affect their relationship? How did your parents raise you? How will you and your partner organize things? Important themes are discussed. Nienke's partner Fons attends the sessions.

During the last group session approximately 6 weeks after all the women have given birth, Nienke talks about the impact of the partner sessions and how important they were to her and her husband. Together they often spoke about the issues that were raised during these sessions: their expectations, how to raise the baby. They also talked about scary and difficult issues. She remarks enthusiastically that they were very happy with all the tips and the presence of the father coach.

The midwife: 'I was really surprised. This well-educated couple with a stable and honest relationship. I caught myself thinking that for them it would be a normal thing to discuss these kind of things with each other. But apparently not. This meeting had an enormously positive effect, even on them.'

Smoking cessation

Bianca, a women with a lower educational level is part of a group with mostly higher educated women. Bianca smokes, even during her pregnancy. It is always up to the women to decide for themselves what information they share with the group. Bianca wants to share that she still smokes and that she finds it hard to stop. The group response is judgmental but also supportive. They see her dilemma but also ask how they can be of help. Having the group's support, Bianca decides to quit smoking.

The midwife makes an extra effort in this group when smoking during pregnancy is discussed. She brings a CO-meter* to the session. When someone breaths out into the meter, it shows if that person has smoked. With every positive beep the group cheers loudly!

** Carbon monoxide (CO) is an odorless gas. When cigarette smoke is inhaled, CO is absorbed into the blood stream via the lungs. Too much CO in the blood is unhealthy because it binds easier to the red blood cells than oxygen, taking away essential oxygen for the body.*

By comparing CO results, the theme 'smoking during pregnancy' is easier to discuss during the group care sessions. The test can also be an encouragement for those who have just stopped smoking. Especially because 48 hours after the last cigarette, CO levels are the same as those of a non-smoker!

During each session, Bianca proudly informs the group how she is doing. She is still not smoking. And every time, the women in the group applaud for her. She shines with pride.

The Midwife: 'This support has been fantastic. Group feedback made it possible for her to permanently quit smoking!'

Together

Rachel is a quiet sensitive woman. She was raised by her mother, a single parent. Her father left soon after she was born. Rachel is now pregnant for the first time. She is in a relationship where she feels there is not enough support and commitment. She wonders how healthy her relationship really is and if she should stay in it.

To orientate herself, she asks the midwife if, in addition to the group sessions, it would be possible to get in touch with other single mothers. Meeting these other single mothers gives her a lot of strength and self-confidence.

Rachel is somewhat surprised when her partner Alvaro agrees to come to the group partner session. A father coach is present during this meeting.

This session has considerable impact on this couple's relationship. Alvaro is able to show his interest in her pregnancy and feels more engaged because of this session. In an email to the midwife Rachel describes how happy she is and that she no longer feels so alone:

'Happily, Alvaro and I are now doing much better. This gives me more confidence that we can work things out together. It was good to realize that it is no longer just about ourselves but about us. The recent partner session contributed greatly to this. Great idea to add a father coach to the Centering sessions.'

The midwife: 'Rachel and Alvaro now talk to each other about their future and how things will be once the baby is born. It surprises me every time that only one session for the partners with the father coach can have such an enormous impact. It really has added value.'

Difficult childhood

The group is made up of strong women, all who appear to be in good relationships. Nil feels a bit like an outsider. She had a difficult youth. She bursts out in tears during the fourth meeting when domestic violence is discussed. She shares with the group what she went through as a child. She talks about the foster families in which she grew up because her own parents were unable to raise her. She talks about the mental health problems she has because of this. And now she finds herself in a difficult relationship. She is struggling with this. Because what will this do to her child?

The group listens. They think she is very brave. A couple of the women invite her for coffee after the session. She attends pregnancy swimming classes with another woman from the group.

The midwife: 'It was beautiful to see how the group took care of Nil. The invitations for coffee and visits with each other. That is the added value of group care and something I can't offer. It was special how she opened up to the group and had the courage to ask for help. Clearly a bond of trust was created in the group. Nil even shared that she was in counseling for attachment problems. It was heartwarming to see how she landed in the warm embrace of the group.'

Powerful collaboration

Tara is an insecure young 18-year-old woman. She lives at home with her mother. Tara is unintentionally pregnant by her boyfriend who disappeared when he heard the news. She seems vulnerable.

Tara is eager to join antenatal group care. She finds herself in a group of strong women who happen to live in her neighborhood. They are not the type of women she usually hangs out with in her social life.

This group is special because for the first time, a primary care midwife facilitates the sessions together with a hospital-based midwife; a powerful collaboration.

Towards the end of her pregnancy, Tara's baby is in breech position. Tara is nervous. She is very happy that the hospital midwife is part of her group. She explains to her how things work in the hospital. Tara goes into labor. Progress is slow. Together with Tara and her mum, the doctor decides it is better to perform a cesarean section.

The tension is visible on Tara's face. When she is being wheeled to the operating theater, she happens to see the hospital midwife from the Centering group. 'My midwife!' shouts Tara excitedly. 'You have to be with me' she begs her. The midwife is able to arrange it and goes with her to the operating theater. Tara feels calmer and more supported.

The midwife: 'This story shows the power of collaboration between primary and secondary care in Centering. The hospital became more familiar to Tara making the referral less stressful for her. In the past 4 years, I have run into her regularly. Every time I see her, it strikes me how well she looks and what a strong woman she has become. She says time after time how relieved she was when she saw her midwife in the hospital corridor. It was a very important event for my hospital colleague as well. How special it was for her to experience how her presence could make someone so happy. What a difference that makes in your work. Unlike what she is used to, she now sometimes already knows some of the women who are referred to the hospital, like during birth. Tara is still in touch with the women from the group. They are still supporting each other and they celebrate their children's birthdays together. One of the participants has even become Tara's best friend.'

Too early
Dunya is pregnant with twins. The group is very excited and sympathizes with her. But Dunya doesn't get enough time to enjoy her pregnancy. She goes into labor at 25 weeks gestation. Despite hospital treatment to stop or delay her labor, she gives birth to 2 daughters. The babies are admitted to the neonatal intensive care unit (NICU) of a university hospital. Dunya visits them every day. She keeps the group updated in the WhatsApp group. She shares pictures and the group is empathetic. One baby develops a bowel infection and the other suffers from serious lung problems. Both babies are too weak to survive.

Dunya shares the news in the group app. She receives poems, cards and lots of tender love and attention. The group does not forget her. At every session, they light 2 candles in remembrance, one for each of Dunya's babies.

The midwife: 'It is very common that when parents experience this type of loss, they are afraid to leave the house. They shut themselves off and even the family finds it hard to make a visit. The group was very open giving Dunya a lot of support. Not a single woman left the group because of this sad event. Nobody was afraid to step down from her pink cloud.'

Eritrean stories in the Netherlands

Connection
A special project brings pregnant Eritrean women together for group care sessions. During these sessions, a key person in the Eritrean community co-facilitates and interprets. It is not easy to find a suitable location for the first session of the new group. Eventually a location was found but the midwife was unable to check it out beforehand. On arrival, it turns out to be some kind of clubhouse with a pungent smell of sweat. A group of men hangs around in one of the corners. The room cannot be closed off and completely against the Centering tradition, a large, heavy table is blocking the middle of the room. The men help move the table. Because of this, the women keep bumping into the low hanging light fixtures in the middle of the room. Still, this doesn't stop them from making the best of it.

The midwife has picked up Ayana, otherwise she wouldn't have been able to attend. She is very quiet in the car, with a shy demeanor and her face taut with anxiety. Ayana is not yet able to speak the Dutch language.

The midwife sees that Ayana slowly relaxes during the first session. By the end of the session, a smile appears on her face. After the group session, when they are clearing up together, the co-facilitator shares with the midwife what Ayana told her: that for the first time in 6 months since she came to the Netherlands, she has had a lovely evening.

The midwife: 'How deeply unhappy and how lonely this woman must have been. She felt connected for the first time since arriving in the Netherlands. For me this is one of the most beautiful effects of Centering: the contribution to forming networks.'

Beer?
Suwa is home-brewed Eritrean beer. Most Eritreans have no idea that it is an alcoholic drink. 'The reasoning being that if it isn't added, it's not in it', the Eritrean co-facilitator translates for the midwife. The belief is that suwa washes everything clean, like the kidneys but also the baby in your belly. That makes it a very popular drink. 'It is served at parties and it gets you really drunk!' she adds with a laugh. Everyone sings its praises and especially pregnant women are advised by their family to drink suwa.

The midwife and her co-facilitator decide to put this topic on the agenda during one of the group sessions. The reason being that they have noticed that when asked about the consumption of alcohol, the women do not associate that with drinking suwa. And what do you know? Almost everyone in the group drinks suwa on a regular basis. The women are interested in the subject. What is alcohol? Why is it in suwa? How does it affect the baby? How do you deal with it during pregnancy? The women have many questions.

By chance, this time the midwife gives Ayana another lift home. 'Does she want to stay for dinner?', Ayana asks. During dinner the midwife listens to the conversation in Tegrinya between Ayana and her husband. The only word she understands is 'suwa'. She is curious and asks the husband to translate the conversation for her. 'My wife tells me suwa contains alcohol and that it is not good to drink it during pregnancy. I am so happy that she now knows this.'

The Midwife: 'I saw it on his face that he understood. He understood the fact that suwa is not good for you when you are pregnant. This confirmed to me that the message had been understood. We had a hard time finding the right 'Centering way' to address this in the group. You really do not want to revert to giving health information in the traditional manner. This story shows the power of discussing this kind of topic in a group format. Apparently everyone felt safe enough to honestly admit that they regularly drank suwa and could talk about it together. Without the group and my co-facilitator, the subject would never have surfaced. Suwa is not associated with alcohol and in a one-to-one consultation there would never be a reason to bring it up. Above all, there is time during group sessions for these kind of topics'.

Ultrasound scan

There is often no interpreter present during the routine ultrasound appointment. During one of the group sessions it becomes apparent that this can cause a lot of confusion.

The midwife has the results of the scans and discovers that the scans of 2 women show serious abnormalities. Together with the co-facilitator she discusses the results with both women. She does this during the private moment all women have before the start of the group meeting. She spends a bit more time with the women than usual. One of the women's babies shows signs of trisomy 19, also known as Edward's syndrome[9]. The woman had understood that the baby had an extra toe. She wasn't worried since this was common in her family.

9. Children with Edward's syndrome have a serious mental disability. Most children die during pregnancy or shortly after birth. Because of serious physical problems, children with Edward's syndrome rarely survive after one year.

The contact with people in the same life phase and environment seemed to me and my husband the biggest advantage of Centering. Our friends live far away. We followed the entire program together for both my pregnancies. The midwifery practice also encouraged this. The men's input was totally different compared to that of the women. This was really good for the group balance.

Standing up for yourself
In my first group, there were women who were pregnant for the second or the third time. We found the mix very pleasant. So with my second pregnancy, we chose to join Centering again. This time we wanted to contribute to the group. And it worked. It happened that a woman from our group took action when she felt that her maternity aid nurse didn't really fit in with her family. Because of our experience, she knew that she had a say in this and stood up for herself.

Confidence
There was a woman in our second group who had not been able to breastfeed her first baby. Now expecting twins, she had no confidence about breastfeeding. We had some huge success stories in the group about breastfeeding. This gave her so much confidence, that with the right support she was able to breastfeed both her babies. She was really happy. Of course the midwife could have encouraged her or referred her to a breastfeeding consultant, but she indicated that the group really made the difference.

Less abstract
I gave birth at home with my second pregnancy even though I had concerns. But the positive stories from the group combined with the theoretical discussions with the midwife reassured me to go for it. The experiences of others make these type of choices less abstract. The group members stimulate each other to think deeper about certain things. When one of the babies in the group was born too early, we talked about it and if it is possible to prevent this and what are the warning signs.

Reassurance
While everyone is still on maternity leave, the women from the second group have a weekly coffee date. Sometimes we talk about the physical discomforts we experience after birth. You can't always talk to your friends about these things and you don't call the midwife or family doctor for every single complaint. Having all gone through the same experience, there is a great understanding for each other in the group. This gives us more confidence. And when a story is so different from the others, we know it might be a good idea to seek professional advice.

Merel (35):

'I wanted to contribute during my second pregnancy'

The other woman's baby had been diagnosed with a gastroschisis [abdominal wall defect]. She thought however that her baby had no belly and no organs and was extremely upset. Supported by the co-facilitator and the use of drawings, the midwife is able to explain what is going on with her baby. Now that she understands that her baby does have all its organs, the woman is very relieved.

The group then discusses the subject of ultrasound scans in general. What is visible on a scan? What does it mean? They also discuss which options you have when an abnormality is found. The fact that you have a choice about the next steps and how you go about making this decision. This is new for the women. Contrary to the situation in Eritrea, in the Netherlands you can ask the doctor or the midwife questions.

The Midwife: 'Information doesn't come across because of the language barrier. Moreover, they think: you don't ask the doctor any questions.'

After some time goes by, one of the women calls the co-facilitator:

'I went back to the hospital and I asked the doctor lots of questions. Now I understand the pros and cons of having more tests done. I have decided not to continue with more tests. I am so happy with the choice that I was able to make myself!'

The group meeting enabled her to make her own decision; one she stood behind. She was much calmer now that she understood the situation better.

The midwife: 'Being part of the decision making and making your own decisions is so normal for us. If we are not careful, these women undergo their care and they miss out on the process of self-determination. During the group sessions, I have enough time to discuss everything thoroughly and I have the added luxury of a co-facilitator who is able to interpret.'

Birthing stool

As in the 'regular' group care sessions, the Eritrean women also discuss pain relief and labor positions. They talk about the fact that they have a choice in these matters, and how to communicate your choices clearly to the midwife or doctor.

The women practice the use of the birthing stool and the hands and knees and side-lying positions. The women seem not to have a lot of basic knowledge. It is difficult to explain the importance of calling the midwife when you have contractions every 5 minutes when you don't even know what a contraction is and that it can be painful. It is not surprising that the message doesn't always come across.

Because she is 42 weeks pregnant and the ultrasound scan has shown a reduction in amniotic fluid, Halewat's labor is induced. She enters the labor ward at the agreed time. 'You do know that I don't want an epidural?' she asks the midwife. 'And I want to use the birthing stool', she announces with determination. The midwife is a surprised, 'I have never met an Eritrean woman who speaks her mind like you. How did you come to these decisions?' Halewat proudly tells her about group care sessions and how much she has learned there.

Halewat cannot attend the postnatal group care session where birth stories are exchanged and babies are proudly shown to each other. Halewat did however tell the co-facilitator that she really wants to let them know what she has gotten out of the group. How strong she felt giving birth and how proud she is of how the birth went.

The midwife: 'We caregivers are not used to Eritrean women speaking out for themselves. The hospital midwife expressed the reality of everyday life. Many (Eritrean) women do not know they have choices. They just do what the midwife or doctor tells them to do. They don't have enough knowledge to make their own decisions. Centering is so much more than just antenatal care. It connects the women at a very special moment in their lives when they need all their strength. I realize this even more with the Eritrean women. It is wonderful to see how involved the co-facilitator is with the group. Antenatal group care is what you call true integration!'

Uvula

The co-facilitator tells the midwife about the Eritrean custom of removing the uvula when the baby is only a few weeks old. This is sometimes done surgically by a doctor but more often it is carried out at home with a pair of scissors or a kitchen knife. When this goes wrong, there is risk of heavy bleeding and further complications as a result of this. It is believed that the babies with uvula are thirsty, vomit more and are more often sick.

The midwife can hardly believe that this still happens and certainly not in the Netherlands. One of the regular topics during group care is female genital mutilation (FGM). During this session the midwife decides to address the subject of uvula removal.

As usual, she draws an imaginary line across the floor. The women then choose where to stand, somewhere in between the two ends of the line: 'I want this' or 'I don't want this.' She is amazed when 90% of the group says they want their baby's uvula removed. She uses this to start a discussion. 'Why would you do this? What is the effect on the baby?' The women explain to her that children with uvula are often more thirsty. 'Just look at all those Dutch people with their water bottles' declares one of the women triumphantly.

'Can you imagine a reason why this is forbidden in the Netherlands?' the midwife asks the group. At the end of the discussion she draws another imaginary line across the floor. The distribution of the women along the line is different this time. There are more women standing towards the end that indicates 'I don't want this'.

The midwife: 'It is important to me that the discussion leads the women to realize themselves that, in the Netherlands, you can't just cut off a body part. The power of group care is having time to address these kinds of topics. Using different methods and games during the sessions, you listen to each other and the women come up with their own answers. It shows again how important it is having the Eritrean co-facilitator present: without her I would never have brought this up.'

Breastfeeding
Lieneke is pregnant for the second time. Her first baby was breastfed. But it didn't go the way she wanted it to. 'It was always a hassle. I never had enough breastmilk and had to give supplementary feeding', she explains. Lieneke does not have fond memories of the supplementary feeding, especially the thought of giving her baby formula makes her unhappy.

Lieneke gives birth at home to healthy son. The boy is put to the breast straight after birth and he seems to be drinking well. However in the following days, the breastfeeding does not go well again. The baby loses too much weight. The midwife, knowing that it won't be easy for Lieneke, still advises her to start with breast pumping and supplementary feeding. She recommends formula until Lienke is able to produce enough breast milk. There is no local breast milk bank.

But Lieneke explains that she has already sorted it out with the women in her group. She has posted a message in the actively used postnatal group app with a request if anyone has enough breast milk to give to her or would pump extra for her. One mother offered her help. For a few days, this mother pumps just enough extra for Lieneke and her son. It is enough for supplemental feeding for the next few days until he is back up to his birthweight. After a few days Lieneke has enough breastmilk of her own and the problem is solved!

The midwife: 'It is wonderful seeing how Centering lowers thresholds and enables women to support each other. I did advise her to ask the donor mother about infectious diseases explaining that screening for infectious diseases is standard protocol by the mother milk donor banks.'

Sharing loss
All the participants in the group have given birth and proudly share their photographs in the group app. Only Dorien has yet to give birth. Her labor starts a week after her due date. At home she puffs away the contractions, in the shower, on the stairs. Initially all goes well. When she is fully dilated, her waters break. The amniotic fluid is meconium stained, quite heavily. The midwife supervising the birth, is worried about the baby's heartbeat. She calls an ambulance and they rush to the local hospital.

Once in the labor room, the CTG [fetal heart trace] shows that the baby is in distress. The obstetrician performs an emergency Ventouse extraction. Joost is born without any signs of life and the pediatrician is unable to resuscitate the boy.

When the couple are back home, the midwife visits them. They talk about the birth and their incredible loss. Dorien says softly that she wants to inform the group. Together with her husband she composes a text for the group app. The group is in shock and deeply saddened. Many virtual hugs and comforting words follow in the app group.

The customary postpartum group session takes place soon after Joost is born. All the new mothers with their babies will be there. Dorien wants to go as well, despite her intense loss. She has a little photobook of her son that she brings to the session. The group is pleased to see Dorien. They cry together when she talks about the birth of Joost, the loss and the terrible sorrow. The group admires the photographs. They embrace her, comfort and support each other.

The midwife: 'It is often difficult for mothers who have lost a child, to meet pregnant women or new mothers. But it just happened naturally in this group. The first step is already taken in a comfortable safe environment.'

Don't complain
Sometimes the women in the group complain. Pregnancy can be so difficult. One woman complains about backache, and the other about constipation, sore legs, Braxton Hicks [practice] contractions. 'I hope I will have the baby early' is an often heard remark. 'When you give birth early, the baby is smaller and birth will be easier' is what a lot of the women think.

Marije goes into labor at 30 weeks gestation and is the first in the group to give birth. Much too early. Initially mother and baby remain in a university hospital, far away from their home. After a while, Marije can go home and the baby is moved to the local hospital. Four weeks after giving birth, Marije visits her group to talk about her birth and to proudly show them the photos of her daughter. All the other women in the group have not yet given birth and are eagerly awaiting the moment. Marije tells them that it wasn't easy at all, despite the fact that her labor came early and her daughter was small. She talks about her concerns and how she worries about her fragile little girl. The feeds are also not easy. Marije explains to them what it means to have a premature baby. So many things did not come easily for her or the baby. She missed out on a lot, she wasn't able to hold her baby after the birth. 'You have to make an extraordinary effort to nurture and hold your baby. Things that come naturally when the birth is normal. It is not easy at all when the baby comes early. You shouldn't complain so much', she says to the group.

After a long time, the baby comes home to Marije. The little baby girl has been in the hospital for 6 weeks. The other women in the group have already all given birth. When they meet again for the postnatal session, it is a celebration and everyone has their baby with them. Marije is there on her own.

The midwife: 'Marije showed the group what it means to have your baby prematurely. Her experience gave everyone more insight and convinced them that it is much better to let nature take its course. They realized that giving birth early is not easy at all. While everyone had already given birth, Marije was still traveling back and forth to the hospital every day. Moreover, I have never seen so much effort go into successful breastfeeding as in this group!

Together not alone
It is the second time Maroushka takes part in group antenatal care. At that time, she had chosen for planned single motherhood (PSM). She got pregnant using artificial insemination with donor sperm.

Being pregnant again, she really wants to join group care again. Maroushka has a complicated history with mental health problems. She has put her past behind her and is employed locally as an 'experience expert'. On the surface she seems to be a bit of an outsider in the group.

During the session when domestic violence is discussed, she talks frankly about her mental health problems and what she has gone through. This encourages the other participants to share stories about their unhappy or happy childhoods.
Mandy is also in the group. She listens carefully to Maroushka's story. Based on the remarks she makes, it is obvious that she too has had a difficult past and did not have it easy in her young years. She has very little contact with her family.

Maroushka is very sensitive to this and she takes Mandy under her wings. They meet regularly for a coffee in the local shopping center and support each other.

After a difficult birth, Mandy is struggling. She seems on the brink of a postnatal depression. An arrangement is made to give her extra support. Maroushka also drops by regularly to see how she is. She talks with her, helps her. Mandy is experiencing support from the group through the group app. Thanks to all the support given, she manages and gets better. At the postnatal reunion session, she tells the group how difficult it had been but thanks to them, she felt she was not alone.

The midwife: 'I was concerned about how the sessions would go with 2 participants with complicated histories. But the group handled it very well and created a great support network. Moreover, I got to know the women much better than I would have in standard one-to-one care. The women in the group really supported each other. I just stood on the sideline and watched it unfold.'

The idea of sharing experiences with other women really appealed to me. But to be honest, after the first couple of sessions I was in doubt whether to continue or not. For me pregnancy is an intimate thing. I really had to get used to being in a group with 9 strangers.

Kind word

The aim of centering is that you really do it together and share things in the group. I had some difficulty with that at the beginning because there were some things I preferred to discuss one-to-one. I felt very insecure because of a previous miscarriage. It wasn't easy for me to discuss this in the group. But after we got to know each other this feeling went away. When I did have the confidence to share my story, I was supported. Everybody had a kind word for me.

Light hearted

I noticed that every woman experiences pregnancy differently. Sometimes you hear 'fine, you have that too' and another time it is more like 'oh can it be that way too'. I learned a lot from this. I found pregnancy to be very uncomfortable with this big belly and all the discomforts that go along with that. Others experienced the same but were more light-hearted about it. This helped me to look at things differently.

Better prepared

When we talked about a certain subject, the midwife would start by asking a question to the group. Only after everyone had their say, would she join in adding her knowledge to the conservation. I found the different perspectives that came up in the conversations, very helpful. Sometimes someone would ask a question that would really make me think. Of course this doesn't happen during an individual consultation. Because of this, I was better prepared for the birth: for example knowing that the midwife is not always immediately present at the start of labor. The practical tips we exchanged in the post-birth app group were also very helpful, about sleeping, baby phones, or swaddling.

Jacomijn (36):

'Sometimes someone asked me a question that made me think'

Group help

We discussed very personal things with each other, bringing us closer together. Some things touched me. One woman had a very hard time after giving birth. Together as a group we looked at how we could help her. What she needed the most was babysitting so she could have time for herself and rest. I ended up babysitting for her once a week for six months.

Smoking & domestic violence

The topic of ‘smoking’ is discussed during the first group session. It is a mixed group of women from various backgrounds. Two of them smoke. One of them is a health scientist. She is very aware of this bad habit but finds it really hard to quit smoking. The midwife knows Lydia, other woman who smokes, from a previous pregnancy. At that time, she had the feeling that something just wasn’t quite right with Lydia, but couldn’t put her finger on it.

During the intake, Lydia is a bit reluctant to accept the offer to join group care. ‘As long as you don’t talk about smoking again’, she agrees angrily, ‘...and don’t start up again about me quitting smoking. I know it is not good for me. I just can’t do it, so stop it.’

The midwife reassures her. The subject is on the agenda, but participants are not directly confronted about their behavior. ‘It remains your choice’, she reassures Lydia.

During the first session, the group opens ‘the forbidden box’. It is a box with objects associated with things that are or are not ‘forbidden’ in pregnancy. It contains objects like a bottle of cola, a cigarette, hair dye, a paint brush and a sauna voucher. One by one, each participant picks something from the box. The subject that it symbolizes is addressed in the group discussion. When the cigarette is chosen, they talk about what exactly happens to the baby when you smoke? Why is it so hard to stop? The health scientist talks openly about her situation and really understands what the problem entails. The group acknowledges that for some people, it is very difficult to quit smoking. Lydia doesn’t say much and keeps a low profile. The group leaves to go back home.

At the start of the next meeting, Lydia stands up in the circle ‘I have quit smoking’, she declares. Her face is beaming with pride: she had to tell them! Spontaneously the group follows her example and everyone stands up and applauds her. They enthusiastically clap their hands acknowledging Lydia’s personal strength.

Lydia sticks to her resolution not to smoke during the entire pregnancy. But the midwife cannot shake the nagging feeling about her.

During the fourth session, when the group is really beginning to bond, domestic violence is discussed. Again Lydia is very quiet. When they discuss the subject of ‘mental health problems’ during the eighth session, Lydia starts to cry softly. She explains that she and her partner fight a lot at home. They hit each other, but actually he hits her more often. The group is visibly upset. At this point, the midwife intervenes. Together they figure out how they all can best support Lydia.

The midwife makes a home visit. With Lydia’s consent, the family doctor is informed and she is referred to a psychologist.

The midwife: 'The open atmosphere in the group gave Lydia courage to ask for help and enough confidence to know that she was going to really get the help she needed. Lydia and her husband got on track for counselling, receiving more attention and support. I have seen this woman grow. It is not about who is at fault, but about how to solve the situation together.'

Centering tree
The last session before birth has taken place. They all use the group app to let each other know how they are doing. They are all looking forward to the postnatal reunion session where they get to admire each other's baby. Only Yara has not yet given birth.

One of the midwives from the practice is present when Yara gives birth in the hospital. It is a difficult birth and the baby dies during the last part of the birth process.

Without telling the midwives, Yara sends a message to the group: 'The worst thing you can imagine, has just happened to me. My baby is dead.' The women are in shock and call the midwife one after the other, in tears.

What to do with the postnatal session? The midwife decides to organize 2 sessions: one where all the new babies will be there and another one where only the mothers, including Yara, will be present. She also become a mother.

It is an emotional session and they close it with a ceremony. 'Centering is like a tree, it is the trunk of life: a family tree', the midwife explains. Everybody receives a slice of the tree trunk. On one side of the slice, the name of the child is written and on the other side, all the names of the babies in the group, including 'Jesse', Yara's son. Yara also receives a drawing of her slice of the trunk to take home.

The midwife: 'It was such a beautiful session. We called the names of all the children out loud. For Yara, it was part of her grief process but above all, it was a confirmation of her son's birth and an affirmation of her motherhood.'

Illustration: Centering tree trunk

Social safety net
The midwife is aware of Leontien's mental health history. The group also knows about it as she told them about it herself during the second session. Fortunately her pregnancy goes very well and her son Finn is born at home. Only her response to Finn is distant. Leontien is tired and she leaves her son's care to her husband. Leontien remains tired, even in the following days. Despite her tiredness, she finds it hard to fall asleep. She struggles with the breastfeeding, making her feel insecure. The midwife is worried. The family doctor is informed and he prescribes sleep medication. But Leontien is afraid to take it. However, she does use the group app to tell that she is not doing very well.

The midwife plans extra postnatal visits and arranging a longer period of help from the home maternity aid. The family doctor has also arranged a visit from a primary health care psychologist. There is periodic contact between all the care providers.

Seven weeks later, Leontien doesn't show up for the postnatal meeting. This worries the midwife because Leontien gave no notice. Does the group know how she is doing?

I doubted whether or not to join Centering. I thought that I would like the individual contact with the midwife much more than the group participation. On the other hand, I intentionally became a single mother and my network was not so big. It could be a good way to get in touch with other mothers. So I decided to give it a go. The midwife told me I could always decide to stop, if I didn't like it.

Opening up
Because I have a history of depression, I felt very insecure at first; would I be able to handle motherhood? I was able to open up in the group and talk about my doubts. Now I am used to this and I work as an 'experience expert' at a community mental health organization. If you are an open person, others usually open up as well. What really helped me was our app group where I could say what I needed to say anytime, night or day. Otherwise I might have fallen into another depression.

Suddenly alone
The contact we had with each other after we all had our babies was very helpful. Suddenly I found myself at home on my own, with a baby, without a partner. I had no one to turn to when I felt insecure about something. I was the first one with a baby in my family and in my group of friends. I could always turn to the group with all my questions: they were my 'surrogate partner'. Maybe I overdid it a bit with my questions, but they really didn't mind. There was always someone available. That was really nice.

Not ashamed
One of the topics we addressed in the group, was postnatal depression. Someone in the group told us that she had gone through this after her first pregnancy. It was very emotional, but is was also very good that it was talked about. This created awareness about the fact that pregnancy is not always that pink cloud that you imagine it to be. You don't have to feel ashamed when it gets tough. Nobody experiences a perfect pregnancy. For some women this was a real eye opener.

Beacons of light
With my second pregnancy, I joined the Centering group again. I did it for fun but I also learned new things even the second time around. Just like during my first pregnancy, I experienced extreme nausea. The evenings with the group were my beacons of light. Regardless of how I felt, I went. Because I enjoyed it so much and the atmosphere was so very positive. It really helped me.

Zinzi (32):
'All my questions were answered by the group'

The stories start to flow. They are in regular contact with Leontien. Even the grandmother of one of the new babies helps out. She babysits her granddaughter, so one more doesn't make a difference! One of the new mothers often picks Leontien up to go for a walk together with their baby carriages. They all have their own busy lives. But they take turns and it works out well!

The midwife: 'Leontien would have never had this social safety net if she had attended traditional one-to-one antenatal care!'

Winter coats

It is a cold winter month when the new groups starts. Not everybody is warmly dressed when they enter the room. 'Handling your finances' is a standard topic during group care sessions. The things you need for the baby are expensive. How do you spend your money wisely? Margie says she finds it hard to make do with the small income she has. She could use a new winter coat, 'but with a new baby on the way... I just can't afford it', she sighs sadly.
'I have one over from my sister,' offers one of the participants, 'you can have it if you want.' Other women have clothing to offer. Margie is not the only one in the group that could use some new clothes. Before you know it, the group is busy swapping winter coats and other articles of clothing. Margie is not out in the cold anymore.

The midwife: 'This doesn't happen with traditional antenatal care! And Margie did not have to feel ashamed because the other women were also interested in the clothes.'

Language barrier

One of the women in the new group has a Tunisian background. Her name is Aisha. Even though she can hardly speak Dutch, she is eager to join the group. Her neighbor at home speaks both Dutch and Arabic and can help her translate the activity workbook.

It is not easy for Aisha to follow what goes on in the group. She worries that she might be a burden, but she really wants to stay in the group. The group does not see her as a burden at all. On the contrary, 'It is very important that you stay in the group', says one of the participants. 'It is great for your social contacts. Do you want to come and have tea with us?' asks Annemarie, who lives around the corner from Aisha. Aisha beams with pleasure. 'Yes, I would love that'.

The group encourages her to call if she needs them. They are here to help. The Arabic speaking neighbor helps her with the group app.

The midwife spends more time with her outside of the sessions. That way she can slowly explain some things better.

The midwife: 'I saw her blossom. She learned so much despite the language barrier. The group really supported her tremendously, pulling her out of her isolation.'

Worried

Shanti is pregnant with her third child. In her past she has dealt with mental health issues. She speaks to the midwife about this during the intake visit before the start of the group care sessions. Shanti really wants to join the group because she has recently moved and does not know many people in the area.
Half way through her pregnancy Shanti struggles with her mental health problems. After consultation with the family doctor, the midwife arranges extra support.

It turns out that group is also worried about Shanti. They decide that, on behalf of the whole group, one of them should call the midwife: 'We are very worried about Shanti. Do you realize that she is in a bad state? We think you should give her extra attention and plan a visit with her'. Besides this, the group makes a schedule together arranging regular visits to keep Shanti company. They also help her with looking after her other children.

The midwife: 'Very special to see that the group felt responsible and took it upon themselves to convey their concern and offer support. With the group support and the extra care provided, Shanti got better. She is doing very well.'

Story from Nepal

Better health!
Durga, who is 28-year-old, is pregnant for the first time. She has a loving and supportive family who works in the fields. Together with her husband she runs a general shop. She has been careful with her health during pregnancy and does not carry any heavy loads.

She attends the group care meeting for the third time. The group discusses how little they knew about health issues during pregnancy before the clinic started offering group antenatal care. Before these meetings her only source of knowledge was her family, especially her mother-in-law. Durga explains to the group that she only ate what her mother-in-law advised. 'She said I shouldn't eat curd, meat or spinach because it might harm me and my baby. But in the group I learned that nutritious food is very essential for both of us.' Other women also explain how little they knew before they joined the group. They all make sure they attend at least 4 group sessions and they talk about how they learned that it is safer to give birth in the hospital.

Durga says 'when I feel tense I just think about the group and I remember the topics that we shared in the sessions and that helps me a lot!'

The midwife: 'It was lovely to see how Durga changed her habits and became more positive in her thinking. The group really supported her to improve her health.'

Stories from The States

Adoption
Sherry, is 14 years old and her-15-year-old boyfriend, Dean discussed parenting options with the social worker from the hospital. They decided to give their baby up for adoption.

Sherry accepts the midwife's offer to join the antenatal group care sessions and she attends every single one. She is very open with the group about her plans to have her baby adopted after it is born. Dean is very supportive of his girlfriend: riding his bike he meets her every time to accompany her to the clinic where the group sessions are held. The group grows attached to the teenage couple and becomes a real support to them, listening carefully to how they are planning to manage their feelings about placing the baby for adoption.

In preparing for the reunion session the midwife is plagued with worries: Should she invite Sherry and Dean even though they won't have their baby to bring to the group? The midwife knows they have followed through with their plans for adoption but she decides to invite them anyway. Much to the group's surprise the adoptive father also comes to the group meeting and brings the baby. The adoptive mom has taken all her time off already and now it was the dad's turn to do something for his new baby. He offers the biological parents the baby to hold during the meeting. It is the first time Dean actually holds the baby. Both Sherry and Dean ask the adoptive father for advice: 'How do I hold the baby? Am I doing this right?' They get to spend some time with the baby before they hand the baby back. The rest of the group is moved to tears. There is a lot of respect for these teen parents who have grace and courage.

The midwife: 'We didn't know if we should offer Centering to Sherry because she was placing her baby for adoption. We thought she would feel uncomfortable. But then we thought, why not? She will say no if she feels uncomfortable with the idea. To my surprise she said yes! Again I had my doubts for the postpartum session, but I thought, of course she is part of the group.

And when the adoptive parents indicated they wanted to come to the meeting, again I had this feeling of *Oh, gosh, what is going to happen, now?* What I love most about this story is how the group helped to normalize this experience for the couple. Instead of being a shameful chapter in these teens lives, it was respectful and supportive.'

Undocumented

Maria is an undocumented 27-year-old woman from Mexico. Together with her husband, she has been in the United States for a couple of years now and has been working as a cleaning lady. When Maria finds out she is pregnant, she isn't sure what to do. She is not very happy about her life in the States. She feels depressed. Maria feels her life is compartmentalized, with her going to work, going to school, and being home with her husband. None of these parts of her life are integrated. Maybe she should return to Mexico now that she is pregnant.

When she turns up at the antenatal clinic, the midwife encourages her to join a Centering group. Maria says that to sit and talk to a group of women is the last thing she wants to do, she is too depressed for this. But the midwife is persistent and eventually convinces her to give it a try. During the first meeting Maria holds back and doesn't say much. But over the course of the next couple of sessions, she comes out of her shell, starts to participate and actually finds the meetings enjoyable. So much so that she is looked to as a leader in the group.

The midwife: 'We kept in touch with Maria. She told me that looking back, Centering was a bridge for her between her culture and the United States' culture. It is what got her feet on the ground in the country.'

'She had her baby and then returned to the health center to give something back to Centering as a member of a group we call 'graduadas', or 'graduates': Spanish-speaking women who have experienced Centering and who have shown leadership potential. They work together doing community outreach and education, and become helpers in our Centering groups. Currently Maria is moving forward in her education and is on her way to college with the goal of becoming a midwife!'

Smoking men

It is the seventh session, so the group is quite comfortable by now with the check-in and the discussion process. The sessions for this group are held with the partners present who are usually dressed in jeans and cut-off shirts. Most of them have lots of tattoos. During the check-in time they gather around the food table, casually teasing each other. The co-facilitator, a young male physician, sits on the floor with dolls and blankets around him, ready for a discussion about breastfeeding and baby care. All of the group members start talking about what they know or don't know about babies. For some it turns out to be very little. Then one of the men says, 'Doc, I heard that if I'm sitting near

my old lady on the couch toking up[10], my kid gets a hit inside her. Is that true?'
The men look at each other startled. The women are suddenly at full attention. The physician facilitator talks a bit about brain development and the possible impact of drugs and alcohol. Several men comment: 'no way', 'you gotta be kidding', indicating their amazement.

Suddenly, one of the men gets up, walks to the corner, retrieves a trash basket and comes back to the circle where he goes from one man to another. 'Throw it in here,' he says, 'all of it.' 'We aren't doing this anymore.' Man after man empties his pockets of glassine envelopes, pipes, and other smoking related paraphernalia. When he puts the basket down, he proceeds to give the men his cell phone number. 'Call me and I'll call you. We can do this for our kids' brains.'

10. Rolling a joint.

The midwife: 'I didn't anticipate this and never could have made it happen myself. The group took over and I just watched as the men responded to the power of the discussion and their ability to do something positive for their growing baby. It was an amazing moment!'

Grandmother

Araati is 26 years old and is pregnant for the first time. She comes from East India and has absolutely no family near her. Her husband has been denied an immigration card and is still in India. The midwife encourages her to join a Centering group. Araaiti agrees. Clearly it provides her with the community she needs. One of the women, whose grandmother always comes with her, asks Araati about her labor support. Araati admits she has no one to accompany her. Hearing this, the grandmother offers to be with her. Then one day before her due date, Araaiti's baby dies. The grandmother sticks to her promise and accompanies her during her labor. What's more, the family invites her to stay with them so that they can look after and support her. Postpartum Araati stays for a week with the family. At the reunion session 6 weeks postpartum, Araati joins the group and shares her experience.

The midwife: 'A very special community developed around this woman.'

Stories from China

Shy

Su, a nervous 29-year-old, is pregnant for the first time. It is a planned pregnancy. Like many Chinese women, against the background of traditional culture, she feels shy about being pregnant. She is also very worried about giving birth. As a first time mother, Su has very little knowledge about pregnancy and childbirth and doesn't know how to deal with some of the typical pregnancy symptoms. The books she has bought give her information but haven't reassured her. The women in the group understand her and encourage her to ask questions. Su embraces this opportunity despite her shyness and eagerly communicates with the group, gaining more knowledge. She finds a friend in Hong, a second time mother. They often meet outside the group meetings so that Hong can share her experience with Su.

During the second trimester, Su gets a serious cold. She is very worried that the cold will affect her and her baby's health. She discusses her worries and doubts with the group. The other women reassure her and give her advice such as drinking lemon tea.

With support of the group Su has become a confident pregnant woman by the end of the pregnancy. She is no longer worried about the birth. With the help of the stories the women have shared in the group, she knows what to expect.

The midwife: 'The group gave Su all the reassurance and knowledge she needed to feel confident about her pregnancy and the birth. In one-to-one care she would have never have found this important friend. The group method allowed the midwife to introduce more targeted discussions and spend more time on the subjects that were needed by the group.'

Own decision

After a difficult procedure Tao Tao is pregnant through IVF. It is her first pregnancy and she feels very anxious. At the beginning of the pregnancy Tao Tao suffers from severe hyperemesis. Fortunately for her, she is not the only woman pregnant through IVF. Some of the other women also experience nausea. The women eagerly share experiences and give each other advice on how to deal with this. Tao Tao realizes she is not the only one experiencing problems and this allows her to relax. The women have agreed to let their husbands participate in the group sessions. Both the women and the men all join in the group activities. In the third trimester the group discusses the birth. Tao Tao's husband says he has encouraged his wife to choose a caesarean section. Tao Tao says that he is afraid of the pain. Some of the other participants agree with her husband. The midwife asks questions about the benefits of normal birth and together they conclude that normal birth may be less traumatic, may cause less bleeding, less risk of infection and take less recovery time. A second time mother, who previously had a caesarean section, tells the group about her experience.

Together with her husband, Tao Tao decides to have a vaginal birth. She is visibly happy and very proud when she announces this to the group.

The Midwife: 'Each group meeting is an emotional event, not just a meeting about theory and practice. The group supported Tao Tao to make her own decision regarding the birth of her baby. The participants were able to reassure and teach the couple. The group discussion about what to expect during the birth made her see that she was not the only one who was worried. The group members helped each other to cope with the stress around birth so that they felt better prepared and experienced more peace of mind, especially the husbands.'

Story from Surinam

Mother and grandmother
Esmerelda is a 42-year-old woman who is unintentionally pregnant by her husband. She already has a 25-year-old son. Coincidentally his girlfriend is also pregnant. Esmerelda finds it hard to accept that she is pregnant at the same time as her 'daughter-in-law'. The midwife advices her to join the antenatal care group. Reluctantly Esmeralda agrees. During the intake prior to the start of the group sessions, Esmerelda tells the midwife she feels depressed. She didn't want to be pregnant at this age. Terminating the pregnancy is no option, it is against her faith.

During the first session the women introduce themselves one-by-one. They tell their name, who they are, if they have any other children and also how old they are. It turns out that Esmerelda is not the only one who is a bit older. One woman in the group is 40 years old and another is 42 years old, just like Esmerelda! 'Hey, I belong in this group!' she says visibly relieved. Esmerelda no longer feels alone. The women admire the fact that she will also become a grandmother. Esmerelda feels proud.

The midwife: 'From the moment Esmerelda discovered that she was not the only older pregnant woman, she felt at home in the group and she could accept her son's pregnancy. With the support of the group, she was able to be both a grandmother and raise her own child. She is very proud of her own child ánd her grandchild who are about the same age, thanks to the group. And the best thing is that her baby is the only girl. The rest of the children in the family are sons.'

Centering-Parenting

Sleeping
Today the group discusses how you solve your child's sleeping problems. It gives rise to a lot of discussion. Thamar, a 15-year-old girl, is the only one who comes up with a solution: 'Sometimes I let my baby cry a little longer. I don't go to him straight away. In the beginning, I swaddled him, but you can only do that with very small babies', she explains to the group. She also shows them the *White Noise app* on her mobile phone. The peaceful sounds help her baby to fall asleep. She says triumphantly, 'It really works!'

The community child health physician: 'Thamar was very shy at first. She had to get used to being seen as an adult. The group really respects her and gives her plenty of support. I saw her blossom. She would have never stood in her own power if she had received traditional community child health care services.'

Thamar: 'I am not taken seriously in my own environment, but in the group I feel like a real mother.'

On your own
'What makes you feel proud and what makes you feel less proud?' asks the community child health physician.
The parents write down their answers anonymously on paper. Crumbled up, these paper balls lie in a small heap in the middle of the group circle. One after another, the parents read each out loud. Almost all the partners take part in this session, except for Mila's husband. When her paper is read out, they learn that she is proud of her birth and how well she is able to look after the baby. She is not so proud of her husband. He doesn't support her and leaves her alone to raise their child.

The group is visibly touched by Mila's story. Her husband was not very happy when she got pregnant. Now the baby has been born, he doesn't want to have anything to do with his daughter. Mila feels very alone. The other mothers in the group decide it is easy to help her out. They visit her regularly and help her with practicalities like giving her a lift to go shopping (Mila can't drive). Every now and then they babysit for her or just drop in for a cup of tea.
The discussion also touches the men in the group. One of them is much occupied with setting up his own business and wonders if he is giving his wife enough support. Fortunately she reassures him. One of the other men is on his own because his girlfriend is on holiday. He is very worried about her. Her past mental health issues are slowly resurfacing. He promised his girlfriend that he wouldn't tell anyone about it, he tells them in tears. Using the baby's sleeping issues as an excuse, the community child health nurse pays a home visit. His girlfriend finally gets the help she needs.

The community child health physician: 'Even personal subjects are discussed in the group. In one-to-one care, these

stories would have surfaced too late or not at all. This man was very burdened by the responsibility he was carrying alone. Fortunately, in the group he found a safe place to share his concerns'

Miscarriage
During the last parenting session when the children are all about 15 months old, one of the mothers, Zoë is looking pale. She is not herself. The group is concerned, asking how she is doing. Zoë starts to cry. She has just had a miscarriage. Another mother in the group says that she recently went through the same thing. 'Normally I wouldn't have said anything, but seeing how sad Zoë is...'

New stories burst open in the group. They start to talk about who is planning another baby and when.

The community child health physician:
'It was heartwarming to see there was space for Zoë's sorrow and how well they supported each other. Moreover, the subject of preconception care was introduced quite organically. The sessions are very dynamic. With the children crawling around on the floor, it gives us (the facilitating care providers) insight into child-parent interactions and how the children explore the environment. During a short traditional one-to-one consultation, most children sit on their parent's lap, giving us less opportunity to observe.'

Dealing with stress
Stress occurs in many families. Dealing with stress is therefore an important topic during the group sessions. This theme is usually introduced by playing 'the stress-game': with the help of cards with written subjects on them and a coin. Participants use the coin to indicate what things are stressful for them.
A coin is placed on the card that reads 'family'. The facilitator asks, 'Who wants to talk about this?' Hesitantly Angela starts talking. The coin is hers. Her baby cries a lot. 'Your baby cries because you couldn't push the baby out yourself', her grandmother has told her. This hurts Angela. It wasn't her fault that her labor took so long, and that the baby's heartrate went down...'

The group thinks it is ridiculous that her grandmother makes her feel guilty like that. It is a nice reaction, but the facilitator feels that it doesn't help Angela. She asks everyone in the group to give Angela good tip. What can you do in this situation?

Angela goes to work with one of the tips. But secretly what helped her the most was that everyone in the group thought that her grandmother was being ridiculous. She is certainly not a bad mother!

The community child health nurse: 'Angela went home with a big smile on her face.'

Vaccinations
The periodic child vaccinations are given during the group sessions. It is always a tense afternoon. None of the parents find it a pleasant session. For that reason, parents often come together. However,

Chazia is there alone because her husband is at work. She is scared of the vaccinations and her baby always cries loudly.

One of the other women calls out, 'You can borrow my husband if you want!'

The community child health physician:
'Because that husband actually went with Chazia while her baby was being vaccinated, she was less stressed. This made the baby relax more and he stopped crying.'

Relationships
A new baby can put pressure on the parents' relationship. This is also a standard topic during the parenting sessions. In the opening game in today's session, the participants are asked to explain how they named their children. 'All my kids have names I don't really like', Eliza blurts out. The other parents are surprised and outraged. 'I prefer short and strong names, but my husband likes exactly the opposite', she explains. 'It was easier to just give in to him.' In daily life Eliza is a strong well-educated professional, but privately and at home, she often feels insecure. The group works it through with her. 'During which other moments do you feel insecure and how do you handle them?'

It is not easy for Eliza to share this with the group. It is scary to put yourself in such a vulnerable position. She is not used to that. 'But I am not afraid to talk about it with you', she says to the group.

The facilitator: This is a classic short story with a big impact.'

Smoking Joints
There is one mother in the group who regularly smokes a joint. The community child health physician and the group members know about Sandra's habit. She also smoked joints during pregnancy.

Sandra's baby is weighed during the baby check-up. The children have to be undressed beforehand. Sandra is absent minded and leaves her baby unattended on the dressing table and her daughter almost falls off. One of the other mother's jumps up just in time to prevent this.

The group is shocked. Sandra admits that she had smoked a joint before she came to the group session. 'Do you realize what can happen?' one of the mothers asks her. Sandra cries softly.

Together with the group, Sandra decides not to smoke joints when her daughter is awake. She can't quite stop yet altogether.

The community child health physician:
'It was beautiful to see the way the group dealt with this incident and how they supported each other. By the end of the group care sessions, her smoking was reduced to a minimum.'

Word of thanks
We would like to thank all mothers and health professionals for their contributions and Kathy Herschderfer for the final language editing.

Medical care in a group model

The Centering care model originated in the United States. In 2011 it was further developed by TNO and introduced in the Netherlands in collaboration with the Dutch Organization for Midwives (KNOV). In this model, medical check-ups are integrated into a group format, using interactive learning and peer support. Parents play an active role in the care they receive; their needs determine the agenda and the health care professionals involved have a much more facilitating role than before.

Contact
TNO, Child health
Postbus 3005
2301 DA Leiden
childhealthsecretary@tno.nl

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