FACT SHEET

GROUP ANTENATAL CARE AND INDIGENOUS WOMEN

UNIVERSITY OF TORONTO

POLICY BENCH

Fraser Mustard Institute for Human Development

January 2022

Recommended Citation:

Sistovaris, M., Fallon, B., Sansone, G. (2022). *Group Antenatal Care and Indigenous Women: Fact Sheet.* Toronto, Ontario: Policy Bench, Fraser Mustard Institute for Human Development, University of Toronto.

Companion document:

Sistovaris, M. & Fallon, B. (2019). *Group Antenatal Care and Indigenous Women: Policy Brief.* Toronto, Ontario: Policy Bench, Fraser Mustard Institute of Human Development, University of Toronto.

Overview

Group antenatal care (GAC) is becoming more commonly accepted by policymakers and health practitioners as an alternative to traditional antenatal care approaches. This fact sheet reviews and assesses the efficacy of GAC as a possible model for the delivery of more effective and equitable antenatal care to Indigenous women in Canada.

Why is the issue important?

The issue is of importance for two central reasons:

1) There are considerable disparities in access to, use of, and quality of antenatal care provided to Indigenous and non-Indigenous women in Canada. Indigenous women are more likely to face barriers and experience poor care, resulting in a higher probability of pregnancy complications and adverse birth outcomes.
2) Rising healthcare costs and demands on healthcare systems have led policymakers and healthcare professionals to seek alternative models for delivering adequate antenatal care to all Canadians who need it.

What is Antenatal Care?

Antenatal care (also referred to as prenatal care) is designed to improve health outcomes for the pregnant woman, her fetus/infant and family. It is considered a key preventive health service and an integral part of maternal health care for women before birth. [1]

Three components lie at the heart of prenatal or antenatal care: [2]

1) risk assessment;
2) treatment for medical conditions or risk reduction; and
3) education.

Who provides antenatal care?

Antenatal care can be delivered by a variety of health care providers, whose roles are described in Table 1.

Table 1: Antenatal care providers [3, 4]

Provider	Role
Family Physicians	Traditionally provide antenatal care for low-risk patients in an office or hospital setting; but have increasingly transferred many of their responsibilities to other medical professionals (i.e., obstetricians and/or midwives).
Obstetricians and Gynecologists	Offer specialized knowledge and experience in pregnancy, childbirth and female sexual and reproductive health care and provide antenatal care to low and at-risk patients in an office or hospital setting; also serve as consultants for high-risk pregnancies.
Midwives	Commonly provide antenatal care to lowrisk patients in the community, medical clinics, birthing centres or at home. In addition to providing basic services such as requisitioning and receiving tests, assisting women at home or in birthing centres, and admitting women for traditional hospital births; midwives also work in partnership with other healthcare professionals when appropriate.
Nurses	Nurses account for the largest group of perinatal care providers in Canada, particularly in rural and remote northern locations, and typically provide antenatal care for low-risk clients in an office or hospital setting. Their roles include monitoring the health status of mother and fetus; providing emotional support and education; and sometimes provide additional care to manage common antenatal symptoms.
Nurse practitioners	Typically provide antenatal care for low-risk clients in an office and hospital settings and perform a variety of tasks such as physical examinations, screening and diagnostic tests. They often work alongside other healthcare professionals such as physicians and midwives; and play a central role in the provision of care in rural and remote communities.
Doulas	Provide emotional, practical & informational support and care to mothers before, during and after birth, including educating women and their families about support services and providing assistance with daily tasks and needs. Doulas do not provide medical or surgical, direct health care or deliver babies.

Who Receives Antenatal Care?

⇒ The availability of antenatal care varies across Canada and is largely dependent on where an expectant mother lives and the health status of both the mother and baby.[5]

⇒ Data suggests that overall, Canadian women have relatively good access to antenatal care, with approximately 95% of women initiating care in the first trimester of their pregnancy.[2]

⇒ The need for antenatal care is even more important for high-risk women—women with pre-existing health conditions, pregnancy complications and/or who have experienced issues with previous pregnancies—who require additional medical attention or guidance from their healthcare provider.[3,6]

Image Credit: Joey Nash, 2019

How is antenatal care typically provided?

Traditional antenatal care involves regularly scheduled one-on-one visits with a healthcare provider, usually in a hospital or clinic. These visits allow expectant mothers to address any concerns about their pregnancy and access valuable information, resources and support services during each stage of their pregnancy.

Using a combination of medical screening and diagnostic tests, antenatal care monitors fetal and maternal health to identify, prevent and/or treat complications that may compromise the health and well-being of the developing fetus prior to birth and the mother's health at a critical period during pregnancy.[4,5]

In order for antenatal care to be effective, it is necessary that expectant mothers begin receiving care early in their pregnancy, typically in the first trimester, and continue care at regular intervals throughout the course of their pregnancy.[2]

Why is Antenatal Care Important?

Research suggests **that antenatal care is effective for detecting, treating and preventing conditions** that can result in poor maternal or infant health outcomes by helping to identify and mitigate potential risks and address behavioural factors that contribute to poor outcomes.[2]

Studies have also shown **positive associations between inadequate antenatal care and several adverse pregnancy outcomes**, such as preterm birth, low birth weight, and fetal, neonatal and post-neonatal deaths.[7-10]

A critical component of antenatal care involves measurements of a baby's growth. Routine antenatal visits are effective in charting growth patterns and identifying possible undetected issues that may hinder the health of the fetus and mother.[11]

Growing importance of midwives for Indigenous communities[4,12-14]

The role of midwives in perinatal care has grown over the years, and Indigenous midwives in particular have secured an even more prominent role in the care of pregnant women in Indigenous communities. Their unique cultural knowledge, practices, and competencies enable Indigenous midwives to be much more attune to the needs of diverse communities such as Indigenous communities. This is reflected by their competency in the management of antenatal care involving: communicating and facilitating a women's pregnancy options; managing early pregnancy loss; assessing the need for genetic testing and communicating results; conducting and interpreting routine antenatal diagnostic testing; supporting the healthy nutritional status of pregnant women; and educating pregnant women about techniques that contribute to a positive birthing experience during labour and delivery.

Antenatal Care for Indigenous Women

Disparities in antenatal care access and use for Indigenous women:

Compared to non-Indigenous women, Indigenous women in Canada are more likely to:[15]

⇒ Have fewer visits for antenatal care
⇒ Begin antenatal care later in their pregnancy
⇒ Receive inadequate antenatal care

Antenatal care needs and challenges for Indigenous women:

Image Credit: Tamara Phillips, 2019

Past historical events and **government policies** continue to **negatively affect all aspects of the health of Indigenous peoples in Canada**, including an above-average risk for pregnancy complications.[3]

Indigenous women tend to have rates of risk factors that not only necessitate regular antenatal care but also additional care that non-Indigenous women may not require.[16]

The consequences of disparities in access to, use of, and the quality of antenatal care between Indigenous and non-Indigenous women are reflected by consistently unfavourable birth outcomes among Indigenous women.[17]

⇒ For example: In Canada, **Indigenous women experience higher rates of infant mortality,** including post-neonatal death, neonatal death, infant death and stillbirth; as well as large-for-gestational-age (LGA) birth and preterm birth compared to non-Indigenous women.

Barriers to antenatal care for Indigenous women:

Social determinants of health (SDH)	Indigenous people experience inequalities in SDH, which refers to the social and economic environment; the physical environment; and individual characteristics and behaviours that influence health behaviours and outcomes; in addition to restricted access to resources and services that could improve their health.[18]

Racism and/or discrimination	The widespread reach of racism and other forms of discrimination act as barriers to health care for many Indigenous peoples. For example, racism within the healthcare system fuels distrust with healthcare providers and increases stress, which negatively impacts health outcomes.[19]
Cultural barriers	The emphasis or bias towards Westernized medicine and practices can be considered insensitive or inappropriate for Indigenous practitioners of traditional medicine, leading to poor communication between healthcare providers and clients and inadequate care.[20] Insensitivity to Aboriginal cultural values in the provision of health care is also a contributing factor to Indigenous women's reluctance to seek medical attention and diagnoses for antenatal complications.[21]
Legacy of colonialism and associated government policies and practices	Has resulted in intergenerational trauma that has and continues to affect the physical and mental health of Indigenous peoples.**Error! Bookmark not defined.** Research indicates that populations that experience greater marginalization typically have worse perinatal health outcomes than the general population.[22]

Alternatives to traditional antenatal care

Although individual antenatal care continues to be the predominant model of care in many countries, the emergence of new models of care are challenging traditional models of delivering care to pregnant women.

Midwife-led continuity of care is considered to be one of the most successful care models in recent years and has grown in popularity among the general population and in Indigenous communities. However, the adoption and implementation of midwifery has been limited and challenging in Canada and throughout the world.[1]

GAC is quickly gaining popularity as an innovative and effective method of delivering antenatal care to pregnant women, and an alternative to traditional individual and midwifery models.

Image Credit: Simone McLeod, 2018

Group Antenatal Care (GAC)

What is group antenatal care?

GAC models are based on the **CenteringPregnancy© foundation** developed by Sharon Schindler Rising,[23] who recognized the need for greater antenatal education and comprehensive culturally appropriate care for pregnant women.

Group vs. individual centred antenatal care models can be differentiated according to the following key components: delivery of antenatal care; content of care; patient access or involvement in care; time spent by providers and patients; administration and scheduling; and provider, resident and student education.[24]

Central components of GAC include:[25]

⇒ **Health assessment** – the one-on-one time between patient and provider; engages patient in their own self-care
⇒ **Interactive Learning** – activities and facilitated discussions to help inform and empower patients
⇒ **Community Building** – reduces feelings of isolation and stress while building friendships, communities and support systems

Table 2: Core features of Centering Pregnancy© [1]
✓ Health assessment occurs within the group space
✓ Women are involved in self-care activities
✓ Stability of group leadership is required
✓ A facilitative leadership style is used
✓ Each session has an overall plan
✓ Attention is given to core content but emphasis may vary
✓ Group conduct honours the contribution of each member
✓ The group is conducted in a circle and group size is optimal to promote the process
✓ The composition of the group is stable but not rigid
✓ Involvement of family support people is optional
✓ Group members are offered time to socialize
✓ Evaluation of outcomes is ongoing

Evidence for GAC

⇒ Much of the evidence on GAC is limited to evaluations of CenteringPregnancy© models in the US.[5]
⇒ Some research suggests that **GAC leads to positive maternal health outcomes** (i.e., decrease in preterm births and admissions to neonatal intensive care; and increased rates of breastfeeding); however, this evidence is inconsistent and inconclusive.[5]
⇒ There is growing evidence that group-based antenatal care such as CenteringPregnancy© can be of considerable **benefit to high-risk populations**, including those with a higher risk of preterm birth, infant mortality and other adverse health outcomes; however, more research is needed.[27]
⇒ There is no empirical evidence that GAC approaches are harmful to women.[28]

Table 3 summarizes some of the benefits and limitations of GAC based on the available literature.

Table 3: Benefits and limitations of GAC models[Error! Bookmark not defined.,29]

Benefits	Limitations
Improved health outcomes for both mother and infant	GAC models can be complex and often difficult to implement in healthcare systems
Elimination of racial inequities in preterm birth	Barriers to implementation include program costs and increased labour demands
Enabling women to become actively engaged in their own self-care	GAC requires adequate infrastructure
Empowering women with the confidence to better prepare them for a positive labour and delivery experience	Challenges with scheduling group sessions and recruiting participants
Developing and/or strengthening the relationship between client and provider through increased interaction and time spent together	Family members are excluded from group sessions
Fostering a sense of community by encouraging support and friendships with other women	Challenges with sustainability must be addressed if GAC is going to thrive
Equipping mothers with the necessary knowledge and skills to make well-informed decisions affecting their pregnancy and the care of their infant.	

Conclusions

With no clear evidence that GAC causes harm to a pregnant women and significant evidence of the potential benefits of GAC—particularly for high-risk mothers, **GAC models should be embraced by both policymakers and healthcare practitioners as viable alternatives to traditional antenatal care.**

If carefully designed, implemented and monitored, **GAC models can be utilized to address the needs of both the mother and fetus during pregnancy** as well as the unique needs of particular groups in society such as Indigenous women who continue to face considerable barriers to adequate antenatal care.

However, **more research assessing GAC models is still needed** to help determine its feasibility and acceptability among diverse populations; to identify barriers and facilitators to implementation; and to grow the evidence base for its effectiveness.[5]

Policy Implications

Implications for Policymakers:

Policymakers can help address longstanding inequities in the delivery of antenatal care to Indigenous women in Canada by legislating and promoting policies that support innovative methods of delivering healthcare services that speak to the unique needs of Indigenous peoples.

Implications for Healthcare Providers:

Healthcare providers also share the responsibility to reduce or eliminate disparities in healthcare through the design, adoption, delivery and monitoring of programs that acknowledge and address barriers to the provision of adequate healthcare to Canada's Indigenous peoples.

Group-based care models offer healthcare professionals an opportunity to empower Indigenous women to reclaim their traditional roles in maternal and infant health and ensure the best possible health outcomes for maternal and infant well-being.

This requires incorporating cultural considerations throughout all aspects of GAC including: the adoption of appropriate language for purposes of communication; providing a safe and culturally appropriate environment during group sessions free of fear and distrust often attributed to racism and other forms of discrimination that discourage Indigenous women from seeking healthcare; and accommodating the special needs of those who have suffered intergenerational trauma.

References

[1] Catling, C.J., Medley, N., Foureur, M. et al. (2015). Group versus conventional antenatal care for women. *Cochrane Database of Systematic Reviews*, Issue 2. Art. No.: CD007622. doi:10.1002/14651858.CD007622.pub3.

[2] Public Health Agency of Canada. (2009). *What Mothers Say: The Canadian Maternity Experiences Survey*. Ottawa, Ontario: Government of Canada. Available at: https://www.canada.ca/content/dam/phac-aspc/migration/phac-aspc/rhs-ssg/pdf/survey-eng.pdf

[3] Ontario Best Start Resource Centre. (2016a). *Routine Prenatal Care: Supporting Evidence.* Toronto, Ontario: Health Nexus. Available at: https://www.ontarioprenataleducation.ca/routine-prenatal-care/

[4] The Vanier Institute of the Family. (2017). "In Context: Understanding Maternity Care in Canada," *In Context* series. Ottawa, Ontario: The Vanier Institute of the Family. Available at : https://vanierinstitute.ca/context-understanding-maternity-care-in-canada/

[5] Ontario Best Start Resource Centre. (2016b). *Routine Prenatal Care: Key Messages*. Toronto, Ontario: Health Nexus. Available at: https://www.ontarioprenataleducation.ca/wp-content/uploads/2016/02/Routine-Prenatal-Care.pdf

[6] British Columbia Perinatal Health Program. (2010). *BCPHP Obstetric Guideline19: Maternity Care Pathway*. Vancouver, British Columbia: British Columbia Perinatal Health Program. Available at: http://www.perinatalservicesbc.ca/Documents/Guidelines-Standards/Maternal/MaternityCarePathway.pdf

[7] Barros, H., Tavares, M. and Rodrigues, T. (1996). Role of prenatal care in preterm birth and low birthweight in Portugal. *Journal of Public Health*, 18 (3):321-328.

[8] Krueger, P.M. and Scholl, T.O. (2000). Adequacy of prenatal care and pregnancy outcome. *Journal of American Osteopath Association*, 100 (8): 485-492.
[9] Petrou, S., Kupek, E., Vause, S. et al. (2003). Antenatal visits and adverse perinatal outcomes: results from a British population-based study. *European Journal of Obstetrics and Gynecology and Reproductive Biology*, 106 (1): 40-49.
[10] Vintzileos, A.M., Ananth, C.V., Smulian, J.C. et al. (2002). The Impact of prenatal care on neonatal deaths in the presence and absence of antenatal high-risk conditions. *American Journal of Obstetrics and Gynecology*, 186 (5): 1011-1016.
[11] Stanford Children's Health. (2019). Large for Gestational Age. Retrieved from: https://www.stanfordchildrens.org/en/topic/default?id=large-for-gestational-age-lga-90-P02383
[12] National Aboriginal Council of Midwives. (2019). *Indigenous Midwifery Knowledge and Skills: A Framework of Competencies.* Montreal, Quebec: National Aboriginal Council of Midwives. Available at : https://indigenousmidwifery.ca/wp-content/uploads/2019/07/NACM_CompetencyFramework_2019.pdf
[13] National Aboriginal Council of Midwives. (2020a). *What is an Indigenous Midwife?* Montreal, Quebec: National Aboriginal Council of Midwives. Available at: https://indigenousmidwifery.ca/indigenous-midwifery-in-canada/
[14] National Aboriginal Council of Midwives. (2020b). *Why Indigenous Midwifery Matters.* Montreal, Quebec: National Aboriginal Council of Midwives. Available at: https://indigenousmidwifery.ca/core-competencies/
[15] Heaman, M.I., Gupton, A.L., and Moffatt, M.E. (2005). Prevalence and predictors of inadequate prenatal care: A comparison of Aboriginal and non-Aboriginal women in Manitoba. *Journal of Obstetrics and Gynecology Canada*, 27 (3): 237–46.
[16] Gracie, M. and King, M. (2009). Indigenous health part 1: determinants and disease patterns. *The Lancet*, 374: 9683: 65-75.
[17] Sheppard, A.J., Shapiro, Gabriel D., Bushnik, Tracey, et al. (2017). Birth outcomes among First Nations, Inuit and Métis Populations. Research Article. *Health Reports*, (November) 28 (11): 11-16. Catalogue no. 82-003-X.
[18] Appiah-Kubi, T. (2015). Social determinants of Aboriginal peoples' health in Canada. Fact Sheet Number 5. Available at: http://www.healthyweightsconnection.ca/ModuleFile/resource?id=3368
[19] Abma, S. (2018). Racism a barrier to prenatal healthcare, midwives say. CBC News. (18 October). Available at : https://www.cbc.ca/news/canada/ottawa/midwife-racism-antenatal-health-care-conference-1.4867236
[20] United Nations Inter-Agency Support Group (IASG) on Indigenous Issues. (2014). *The Health of Indigenous Peoples*. New York, New York: United Nations. Available at: https://www.un.org/en/ga/69/meetings/indigenous/pdf/IASG%20Thematic%20Paper%20-%20Health%20-%20rev1.pdf
[21] Heaman, M. I., Blanchard, J. F., Gupton, A. L. et al. (2005). Risk factors for spontaneous preterm birth among Aboriginal and non-Aboriginal women In Manitoba. *Pediatric and Perinatal Epidemiology*, 19 (3): 181-193. doi:10.1111/j.1365-3016.2005.00644.x
[22] Verstraeten, B., Mijovic-Kondejewski, J., Takeda, J. et al. (2015). Canada's pregnancy-related mortality rates: doing well but room for improvement. *Clinical and Investigative Medicine*, 38 (1): E15-E36.
[23] Rising, S.S. (1998). Centering Pregnancy: an interdisciplinary model Of empowerment. *Journal of Nurse-Midwifery,* 43(1): 46–54.
[24] Ickovics, J. R., Kershaw, T. S., Westdahl, C., et al. (2007). Group prenatal care and perinatal outcomes: A randomized controlled trial," *Obstetrics and Gynecology*, 110 (2 Pt 1): 330–339. doi:10.1097/01.AOG.0000275284.24298.23
[25] Centering Healthcare Institute (2021). Centering Pregnancy. Boston, Massachusetts: Centering Healthcare Institute. Available at : https://www.centeringhealthcare.org/what-we-do/centering-pregnancy
[26] Hodin, S. (2017). Strength in numbers: Is group antenatal care the way forward? Boston, Massachusetts: Harvard T.H. Chan School of Public Health. Available at : https://www.mhtf.org/2017/06/27/strength-in-numbers-is-group-antenatal-care-the-way-forward/
[27] Byerley, B. M. and Haas, D. M. (2017). A Systematic overview of the literature regarding group prenatal care for high-risk pregnant women. *BMC Pregnancy and Childbirth*, 17(1): 329. doi:10.1186/s12884-017-1522-2
[28] American College of Obstetricians and Gynecologists. (2018). *Group Prenatal Care. ACOG Committee Opinion No. 731*. Obstetrics and Gynecology, 131:e104–8. Available at: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Group-Prenatal-Care
[29] Mazzoni, S.E. and Carter, E.B. (2017). Group prenatal care. *American Journal of Obstetrics and Gynecology,* 216 (6): 552 – 556