Description

The Power of Relationships in Group Care

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Summary

In this interview, group care researchers Jalana Lazar and Anna Horn discuss the lived experiences of group care, from the perspectives of those providing and receiving group care. Informed by their fieldwork, they unpick the web of relationships amongst women, midwives and other health care professionals. Together, they consider a key group care feature – relationship building – exploring the model's potential to bridge interdisciplinary relationships and apply relational maternity care.



Jalana

I'm a midwife. I completed my mixed methods doctoral research on midwives' experiences of facilitating group care in diverse contexts. To disclose my own positionality, I facilitated group care for over a decade in the United States.

Anna

I'm a PhD candidate at City, University of London. My research on women's experiences of group care is a part of the Group Care 1000 project. As a doula and maternal health scholar-activist, I use a Black feminist and abolitionist perspective to better understand how the model addresses health and social inequalities.

Anna: Why is group care described as a relational model?

Jalana: I would say it is a relational model of care from three standpoints. Firstly, it's a group model, allowing participants to build relationships with each other as a part of their antenatal course, and in some cases including the postnatal period, with babies and their families. Secondly, the structure of the model allows for facilitators (e.g. midwives or other maternity care providers) to spend more time with women and pregnant people, which facilitates building deeper relationships. This is a surprising finding. We often assume that one-to-one care would allow you to build up a deeper relationship with a person rather than in a group setting. However, findings from my research and systematic review indicated midwives felt they got to know women better in a group model than in one-to-one care. Finally, this model encourages midwives to work together and with other professionals because groups are led by two facilitators. There are many possible combinations of professionals, but they all promote possibilities for developing inter-professional and intra-professional relationships.

Jalana: With whom, and how, do relationships develop for women in the model?

Anna: In England, women describe developing a deeper relationship with their facilitating midwives. Having two- hour sessions maximises time with their facilitator, creating opportunities to get to know each other more deeply. Having a care provider who they can trust and who knows their circumstances is truly valued by women. The other layer is the relationship that participants have with each other. Group care participants do not always become best friends, but they at least meet someone experiencing a similar situation. They share resources and information, or there is someone to simply say, 'I had that happen to me'. That is reassuring for some women. The most surprising finding from my research is the relationship which develops between partners, most often male partners but not always, who come to the group. Of the few male partners I interviewed, they said that group care helped them to understand the experience of pregnancy from the woman's perspective. It helped them to offer better emotional and practical support.

Anna: How do relationships with colleagues and participants develop, and how is this different from one-to-one care?

Jalana: Many facilitators, even very experienced facilitators, described being anxious before they meet a group for the first time because they feel invested in the group bonding. I am not stressed before I meet a woman for the first time in a one-to- one clinic visit, because I'm slightly less invested, personally. This sentiment was reflected in my research with facilitating midwives. However, they also said that facilitating groups changed the way they delivered one-to-one care, because they became invested in the relationships they had with women in group care and wanted that for women who weren't in the group. Group care is structured to be interactive and facilitative. There's more room for relationships to develop because the midwife is not saying, 'I'm the expert,' she's saying, 'what do we know about this topic?'.

> "The structure of the model allows for facilitators (e.g. midwives or other maternity care providers) to spend more time with women and pregnant people, which facilitates building deeper relationships. This is a surprising finding."

This is also where inter-professional relationships are valuable. Midwives often work in a vacuum and need opportunities to learn from each other, and to share the burden that we carry in trying to be all things for the women in your care.

Anna: It seems like facilitating group care is developing some muscles in how to be emotionally vulnerable by being able to ask questions and share information?

Jalana: Absolutely. In midwifery there's a disconnect between the hierarchies within our education systems and our mission as midwives to meet birthing people where they are and empower them.

Jalana: Do you feel that hierarchies change?

> "Trust the group, because the right answer will arrive."

Anna: There are opportunities for challenging power dynamics. Paulo Freire's work in the Pedagogy of the Oppressed sheds light on dialogic practice. In the group care context this is when the facilitator takes a step back and allows others to speak. In observations where this happens, women take the notion from the artfully curious facilitator, and drive the conversation, sharing information and answering other women's questions, for example, about the signs of gestational diabetes. The midwife doesn't jump in, she just waits… and another woman begins to speak. Women value others' experiences to affirm their own or help guide them when making decisions about their own care.

For example, one woman shared with the group that she did not want to take this medication that the doctor prescribed. Another woman tells her story of a similar experience where she was glad that she did take the medication, and suddenly she said, 'okay, well, maybe now I'll do it'. The conversations built from relationships within group care challenge sources of knowledge. They affirm women's experiences alongside clinical knowledge. Examples like these demonstrate how power dynamics are challenged.

Jalana: That's such a great example. It speaks to the fear that midwives sometimes have of losing control of the narrative in a group setting. However, seasoned facilitators say, 'trust the group, because the right answer will arrive'. And if it doesn't, you can help guide them to where the right answer might be. That is how to use your expertise, but in many cases that job is done for you as the women usually arrive at the answer. One midwife I interviewed said that the most beautiful moment of the group is when you just you see those women fly. It was a beautiful statement. In other words, she was satisfied that their needs were met, their wings are lifted, and then they fly.

Anna: Yes. That is an example of letting go and not trying to control.

Jalana: Yes, midwives said they feel, 'that's why I went into midwifery to help empower people'. Several midwives in my interviews described powerful experiences so comfortably as part of the group that it allowed them to share personal stories and be closer to the participants, to be more humanised.

Anna: I think that's a wonderful way to summarise the power of these relationship webs within group care; how and why it works in this way: it humanises people, builds bridges and breaks down barriers. It empowers and values knowledge diversity. **TPM**

NB. We support inclusivity for all gender expressions; where the term women is used please understand it as expansive to all women identifying and gender diverse people.

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