PUTTING GROUP CARE INTO ACTION

A Toolkit to Implement, Sustain, and Scale-Up Group Antenatal and Postnatal Care

GC_1000

GROUP CARE FOR THE FIRST 1000 DAYS (GC_1000)

Acknowledgements

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We also thank our implementation partners in the GC_1000 project, namely Group Care Global and Simavi.

While this Toolkit was developed as part of an implementation research project conducted in the period January 2020 – June 2024, the knowledge embedded in this Toolkit includes years of experience of the contributors and editorial team. Sharon Rising, a nurse-midwife who contributed to this Toolkit, developed the Centering-Based Group Care model in 1992-93, which serves as the foundation for Group Care. Other contributors have been supporting the implementation of Pregnancy Circles in the United Kingdom for eight years and, in the Netherlands, contributors from CenteringZorg have been supporting implementation of Group Care for eleven years.

Editorial Team:

Marsha Orgill (University of Cape Town)
Wiedaad Slemming (University of Cape Town)
Sharon Rising (Group Care Global)
Marlies Rijnders (TNO Innovation for Life)
Christine McCourt (City, University of London)
Margie Rickell (Group Care Global)
Eline Vlasblom (TNO Innovation for Life)
Katrien Beeckman (Vrije Universiteit Brussel)
Matty Crone (Leiden University)
Deborah Billings (Group Care Global)

Contributors

Okarina Gorani (Action for Mothers and Children)
Ilir Hoxha (Action for Mothers and Children)
Vlorian Molliqaj (Action for Mothers and Children)
Nathalie Leister (City, University of London)
Christine McCourt (City, University of London)
Deborah Billings (Group Care Global)
Margie Rickell (Group Care Global)
Sharon Rising (Group Care Global)
Katja van Groesen (Group Care / CenteringZorg)
Matty Crone (Leiden University)
Nele Martens (Leiden University)
Elske Van Den Akker-Van Marle (Leiden University)
Ashna Hindori-Mohangoo (Perisur)
Manodj Hindori (Perisur)
Jedidia Abanga (Presbyterian Church of Ghana)
Rudolf Abugnaba-Abanga (Presbyterian Church of Ghana)
Loan Liem (Simavi)
Seng Bu (Simavi)

Eline Vlasblom (TNO Innovation for Life)
Marlies Rijnders (TNO Innovation for Life)
Yvonne Schönbeck (TNO Innovation for Life)
Marsha Orgill (University of Cape Town)
Wiedaad Slemming (University of Cape Town)
Malibongwe Gwele (University of Cape Town)
Astrid Van Damme (Vrije Universiteit Brussel)
Florence Talrich (Vrije Universiteit Brussel)
Katrien Beeckman (Vrije Universiteit Brussel)

Communication consultant: Thania Gopal

Language editing and formatting: Emma Arogundade

Design: Mandy Lake

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Foreword

Changing the way healthcare is provided requires vision of what might be possible as well as guidance through the implementation process. Such change is both exciting and challenging.

Group Care provides an opportunity for participants to learn from each other and to share their joys and concerns in a supportive environment. Healthcare provider-facilitators, support staff and pregnant women and parenting people all benefit from Group Care. Results documented from around the world support that pregnant women and parenting Group Care participants experience excellent care and that both participants and Group Care facilitators, who are healthcare professionals, feel positive about their experiences.

This Toolkit is a concrete guide based on the experience of sites in seven countries that profoundly changed the way antenatal and postnatal care is delivered and experienced through implementing Group Care.

The GC_1000 implementation research project sought to contribute to a growing global body of knowledge on the implementation of Group Care in different country contexts. Throughout the world, Group Care has different names, including CenteringPregnancy and CenteringParenting as well as Pregnancy Circles.

We encourage you to utilise the resources provided in the Toolkit to support planning, implementation, and scale-up. By using these resources, you become part of a global community working to implement Group Care.

Contents Page

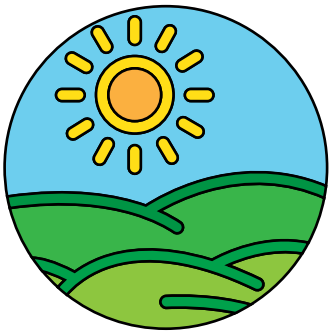
List of Tables

List of Figures

Abbreviations

CBCR	Centering-Based Group Care
CoP	Community of Practice
FRAME	Framework for Adaptations and Modifications to Evidence Based Interventions Expanded
GC	Group Care
GC CoP	Group Care Community of Practice
WHO	World Health Organization


It is easier to talk to someone with the same experience.



SECTION 1: What is this Toolkit about and who is it for?

This Toolkit provides guidance and practice-based lessons learned on how to prepare for and implement a Centering-Based Group model of antenatal and postnatal care. In this Toolkit, we refer to this model of care as "Group Care" as it is person-centered, relationship-based care offered in groups. Throughout the world, it has different names, including CenteringPregnancy and CenteringParenting as well as Pregnancy Circles.

1.1 The purpose of the Toolkit:

- To provide a description of the three core components of Group Care
- To provide a summary of the evidence-based benefits of Group Care
- To describe and provide guidance on key elements that need to be considered when preparing for implementing, sustaining, and scaling-up Group Care.

- To provide resources and tools that can assist you in preparing for implementing, sustaining, and scaling-up Group Care
- To provide practical lessons learned from implementing Group Care in seven countries around the world (GC_1000 implementation research project).

1.2 Who is this Toolkit for?

Healthcare providers, hospital and clinic managers, policy makers, and directors of community organizations that provide antenatal and postnatal services, among others, who want guidance on preparing for, implementing, sustaining, and scaling-up Group Care.

1.3 Why did we develop this Toolkit?

In 2016, the World Health Organization (WHO) published comprehensive recommendations for antenatal care that moved beyond survival and reduction of pregnancy complications to emphasise the importance of a positive pregnancy experience. The rationale is based on evidence that shows a positive pregnancy experience influences the likelihood that a pregnant woman will return for antenatal care and that the same experience will facilitate positive health outcomes and an effective transition into parenthood (WHO 2016). The WHO recommendation related to Group Care was as follows *"Group antenatal care provided by qualified health-care professionals may be offered as an alternative to individual antenatal care for pregnant women in the context of rigorous research, depending on a woman's preferences and provided that the infrastructure and resources for delivery of group antenatal care are available"* (WHO, 2016. p. 91). While global evidence for the impact of Group Care is growing, a gap between evidence and practice remains.

In this Toolkit, we aim to go beyond the prenatal period up to the first thousand days of a child's life. As such, the postnatal Group Care discussed in the sections that follow refer to care offered up to two years after birth. These first two years bracket a critical phase of development the outcome of which will have long lasting impacts for the child well beyond this period. This period also is important to ensure the health and well-being of parents.

1.4 Where does the Toolkit come from?

An implementation research project called Group Care in the First 1000 Days (GC_1000) was carried out from January 2020 – June 2024 by a consortium of 10 partners who worked together to prepare for and implement Group Care in different contexts. The project received funding from the European Union's Horizon 2020 research and innovation programme (Grant Agreement No 848147). Together the consortium partners implemented a mixture of antenatal and postnatal Group Care in their health systems. As part of this process, they spoke to a range of staff and participants in their respective implementation sites to document lessons for implementing, sustaining, and scaling-up Group Care. While Group Care has proven to be effective, more knowledge of how to practically implement, scale-up and sustain Group Care in different contexts was needed. The GC_1000 project sought to fill this knowledge gap.

The primary aim of GC_1000 was to deliver antenatal and postnatal care in a way that improved care experiences for pregnant women and parenting people, and to improve the experience of providing care for healthcare providers. This required a transformation in the way antenatal and postnatal services were provided – moving from the traditional individual based care to care within a group. To do this, country teams partnered with relevant healthcare providers and other stakeholders to implement Group Care in their settings and to document its implementation. Partners engaged in five key activities:

1. We spoke to local health system decision makers and implementers to understand the health services in each country context in which Group Care would be implemented and tested. We also used this time to introduce the project to the relevant decision makers and implementers in the health service.
2. Based on these discussions we identified context specific needs and barriers and facilitators to Group Care in the specific context. This led to discussions about what needed to be adapted (e.g. space, appointment bookings etc.) in the health service to enable Group Care to be implemented taking account of health service capacity and resources available.
3. We then conducted training in facilitation skills with healthcare providers and other cadre of staff who can co-facilitate groups. Training included experiential learning and skill-build-

ing using the same group facilitation process that is used in Group Care.

4. During this initial process and during implementation we documented, in each site, the experiences of and satisfaction with Group Care of all participants, including the providers. We also documented key features of the system that were adapted to enable the implementation and sustainment of Group Care.

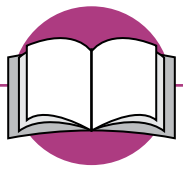
5. We disseminated the lessons learned from the project to a range of decision makers and implementers in each country in a series of workshops to co-create a way forward. We have also developed a series of tools that can help policy makers, researchers, healthcare providers and others to implement Group Care in their setting, this Toolkit is one of those tools.

FURTHER READING

For more information on the GC_1000 project please see the following video:

https://www.youtube.com/watch?v=7AaIGloJ3yM&t=27s

Or go to the project website: https://groupcare1000.com/



FURTHER READING

Billings D., Vlasblom E., Hindori- Mohangoo A., Abanga J. Group Care: First 1000 days. The Pract. Midwife. July 2024 08-11.

1.5 Where was Group Care implemented through GC_1000?

While the world went through a COVID-19 pandemic, the consortium successfully managed to implement Group Care in a range of sites in seven countries, focusing on pregnant women and parenting people with babies, many of whom were living in vulnerable situations. Some of the participating countries had experience with implementing Group Care before the GC_1000 research project started (Belgium, Suriname, the Netherlands and the United Kingdom) while Group Care was new in other settings (Ghana, Kosovo and South Africa). During the project, 141 antenatal groups, 16 postnatal groups and 12 antenatal plus postnatal groups were carried out in 32 facilities in seven countries.

GC_1000 was thus implemented in a diverse range of country contexts with different health systems and different implementation starting points. The lessons we share in this Toolkit are thus taken from a wide range of contexts, recognising that implementation, sustainability, and scale-up of any new healthcare service must take account of the health system context. We provide guidance on key features of context you should consider in **Section 3**.

Figure 1: The GC_1000 partner countries

SECTION 2: What is Group Care?

2.1 Description of Group Care

Group Care offers standard health care to pregnant women and parenting people and newborns and, equally important, provides for interactive learning and community building. Group Care includes all the usual assessments and occasional interventions needed to help ensure the best possible outcomes for pregnant women, parenting people, and babies. Individual visits are replaced by group sessions that are facilitated by a trained health care provider who is trained to provide group antenatal and postnatal care- and a co-facilitator. Depending on context, the co-facilitator may be another health-care provider or another person – e.g. community health advocate, healthcare assistant or family support worker.

Group Care includes all the usual assessments and occasional interventions needed to help ensure the best possible outcomes for pregnant women and parenting people, and babies. Group Care is health care, recognized as such by the World Health Organization

and many health systems throughout the world. A basic check-up of the pregnant woman, for antenatal care, and of the baby and parent, for postnatal care, is provided preferably in the same space or adjacent to the space where group sessions are held.

During the group session itself, participants sit in a circle and exchange information and converse among themselves in a format that is fun and encourages open dialogue among all the members. Discussions are facilitated by the trained healthcare facilitator and co-facilitator and value the knowledge and experience of group participants. They are not didactic classes. The interactive format fosters collective learning among participants about issues that are important to them, to strategise possible solutions to a variety of challenges, to learn about resources in their communities, and to support one another in the pregnancy and early parenting journeys. Group activities allow participants to learn in dynamic ways that are fun and engaging, making it unlike the usual antenatal or postpartum visit to the health service. To further support this effort, there is time within the group for participants to get to know each other. This structure contributes to the building of community that may continue long after pregnancy and birth and to enhanced health knowledge.

Centering-Based Group Care is built on the CenteringPregnancy/CenteringParenting care models developed in 1992-93 by a nurse-midwife in the United States (US), and sometimes changed into a country specific model, for example the Pregnancy Circles model widely promoted in the United Kingdom. The model has flexibility that allows it to respond to cultural beliefs and values as well as the demands and available resources of health systems (Rising 1998, Wiseman et al. 2017).

2.2 The three core components of Group Care

Figure 2: The three core components of Group Care

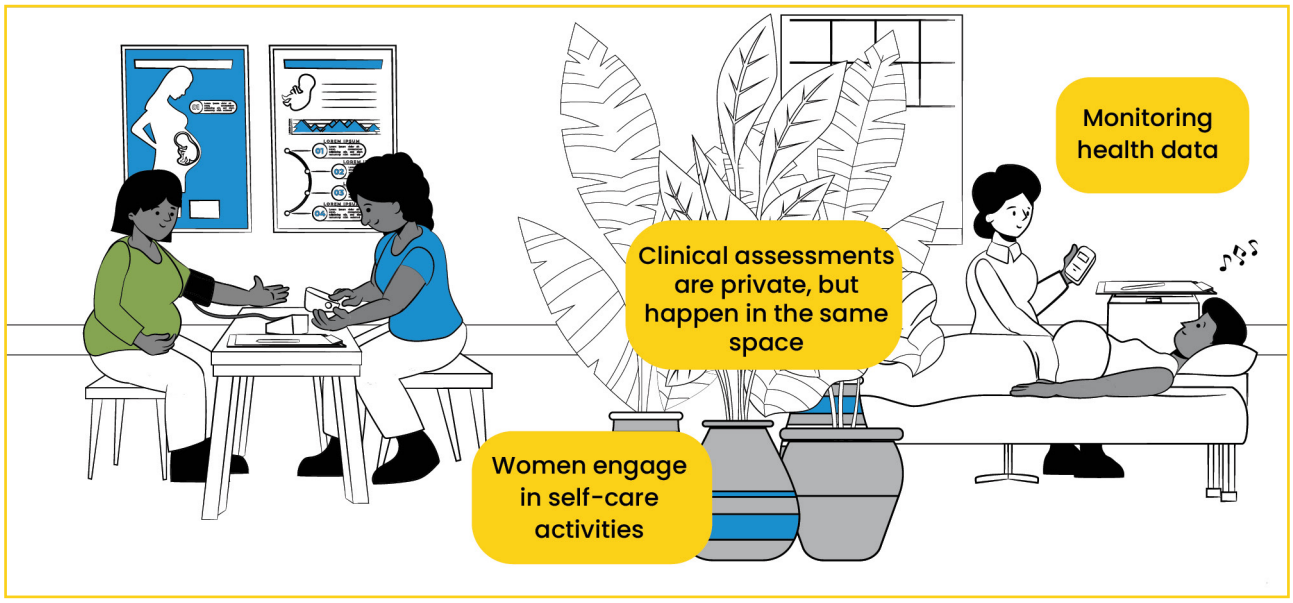

Clinical Health Assessment
Community building

The three core components of Group Care

Group Care is comprised of three components: health care, interactive learning, and community building - happening within a group setting with a stable cohort of pregnant women and parenting people who stay together through the sessions of antenatal care, and ideally, through the first two years of the baby's life. This model fundamentally changes the way that care is delivered and experienced.

Health Care

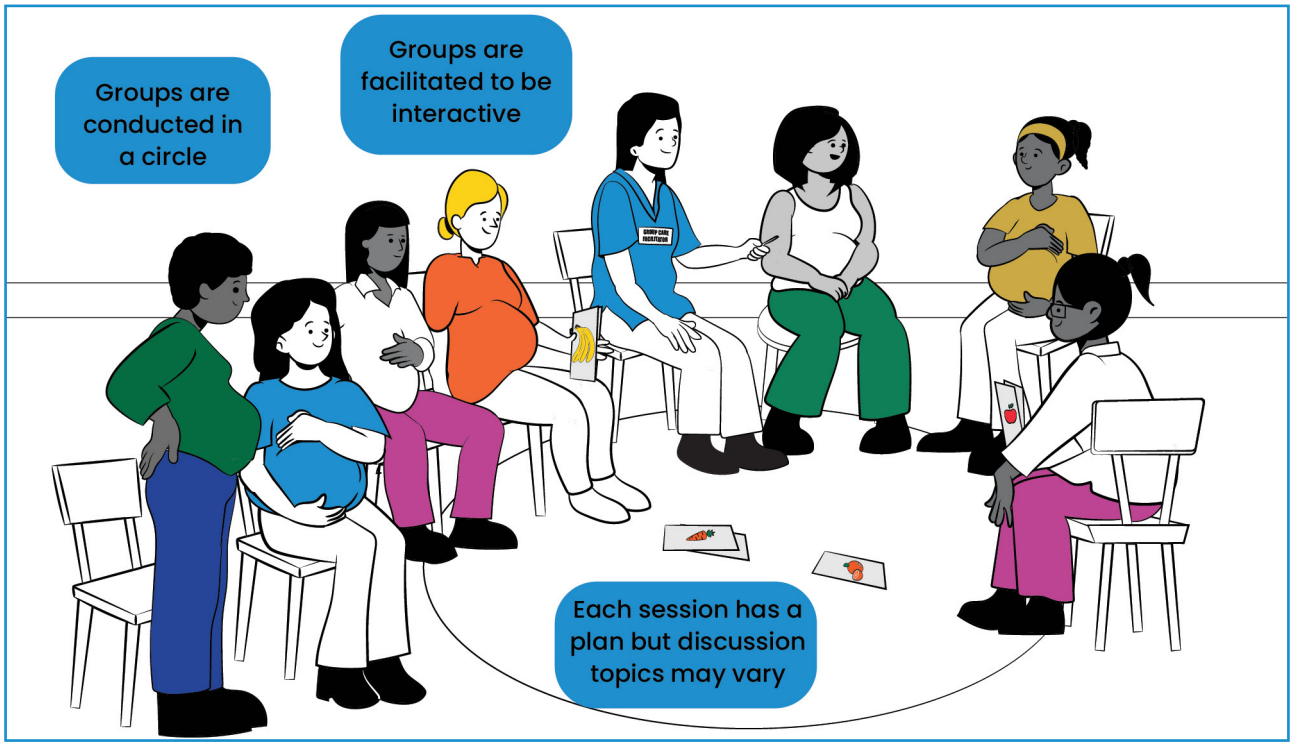
The holistic health of pregnant women and parenting people and babies is at the center of Group Care. Health assessment, education and health promotion, and on-going evaluation are not removed, but rather enhanced and improved through the group environment. Health assessment is *not taken from* the participant or *delivered to* the participant as in traditional individual care, rather the health assessment happens *with* the participant and within the group space.



Health assessment happens in the group space	• Clinical assessment with the healthcare provider takes place in a space that ensures some level of privacy without isolating the group participant from the rest of the group • Clinical assessments are kept brief, e.g. take approximately three to five minutes per person. The assessment is otherwise comparable to routine health assessments, including referral pathways for any specialised care need • The private clinical health assessment is briefer because most questions are referred to the group discussion
Pregnant women and parenting people engage in self-care activities	• Pregnant women and parenting people assess their own and their baby's health data as much as possible, for example their own weight and blood pressure; and in postnatal care, their baby's weight and length
There is on-going evaluation in the health service	• There is a plan for recording data and regular assessment of outcomes (e.g. birth weight, preeclampsia etc.) that will help health services to understand how well Group Care is going and where improvements need to be made • Responsibility for data collection is assigned to different staff in ways that are meaningful and appropriate

Interactive Learning

The interactive experience of the group is foundational to how and why group care works. Women and families are engaged in a whole new way with their antenatal and postnatal care. While there is a topic guide to enable discussion, participants themselves bring information and experience to the group, and facilitators are on hand to counter any commonly held disbeliefs that can be harmful. What is special about Group Care is that participants interact with the information and this interaction gives meaning and life to the topics covered in the groups. Interactive learning is described in the group care model as follows:



Groups are facilitated to be interactive

- Facilitators are trained in facilitation and listening skills
- Activities are planned to encourage interaction
- Activities are culturally sensitive and engaging to take part in
- Sharing among the group members is encouraged
- Formal didactic presentations are not used (e.g. no use of PowerPoint slides)

Groups are conducted in a circle so that participants can see and interact with one another

- All people in the room should be part of the circle, not stand outside of it, so as to create a sense of equity among all participants

Each session has a plan, but emphasis may vary

- Session topics can be structured in line with the phase of pregnancy or baby's age, but topics are also designed around the needs of the group participants
- The number of sessions is flexible, but the goal is to have at least eight sessions to meet the WHO (2016) recommendations for antenatal care and provide an opportunity to build trust. For antenatal care, the number of group sessions should align with the country standards for the number of antenatal care visits

Group size is optimal for interaction

- Optimal group size is 8-12 participants
- The space where groups are held is easily accessible, private and conducive to group sharing

Community Building

Community building refers to the connections made among Group Care participants, often resulting in mutual support during and even after the group sessions end. For example, participants may create social groups (e.g. WhatsApp, Viber, Facebook) to connect, problem solve, and celebrate in between sessions as well as after sessions end. The consistent meeting of a cohort of women or families is also the catalyst to community building. To enhance community building, it is important that group members are consistent and that time for socialising is built into each meeting. Key factors that make this community building successful include:

Group members, including facilitators and support people, are consistent

- A cohort of women/ families is stable throughout the Group Care sessions
- The facilitators are consistent throughout the group sessions
- Confidentiality reminders are used if any new members or support people join the group
- Attendance of children needs to be considered carefully in antenatal sessions: it may make participants less focused on one another and/or jeopardise confidentiality

There is time for socializing during the group

- Allowing participants free time within the Group Care session encourages informal interaction
- Free time can take place as participants are arriving for the session or when the private clinical assessments are taking place. The co-facilitator should be present to encourage informal interaction amongst the group
- Water should always be available to all participants to consume throughout the Group Care time
- Having healthy snacks available will be appreciated and will encourage conversation

2.3 What do we know about the effects of Group Care? A summary of global evidence

Any service delivery model implemented in a health service should benefit clients. In this section, we summarise research findings on the benefits of Group Care. Throughout the world, an increasingly common scenario is of healthcare providers serving many clients with very limited time for each person. As a result, antenatal and postnatal visits need to be brief and are often didactic in style. Short visits are often not satisfying for the client or the clinician and provide limited time for discussion. With Group Care, healthcare providers reframe healthcare from risk assessment and information provision to mutual learning and understanding of health, including engagement with and discussion of social, economic, and political determinants that affect people's wellbeing. Healthcare providers get to know the people they are serving, resulting in more effective care that is often also professionally satisfying. Many providers report an improvement in the quality of their work lives when they participate in Group Care (Lazar et al. 2021).

The effects of Group Care

Research conducted worldwide has examined the impact of Group Care models compared to traditional antenatal care, revealing important insights into their impact on care experiences and maternal and newborn health outcomes (Abshire et al. 2019; Adams et al. 2016; Ahrne t al. 2023; Benatar et al. 2021; Brumley et al, 2016; Byerley and Haas, 2017.; Carter et al. 2022, 2017, 2016; Catling t al. 2015; Crockett t al. 2019; Cunningham et al. 2019; Fredrickson et al. 2019; Sigmon et al. 2017; Grady 2004; Gullett et al. 2019; Harris et al. 2012; Heberlein et al. 2020, 2022; Hodgson et al. 2017; Ickovics et al. 2003, 2007, 2016; Jafari et al. 2010; Jones et al. 2023; Kennedy et al. 2011; Klima et al. 2009; Kominiarek et al. 2017; Kominiarek et al. 2018; Lazar et al. 2021; Lori et al. 2017; Mazzoni et al. 2016; Momodu et al. 2023; Patberg et al. 2021; Picklesimer et al. 2012; Potter et al. 2019; Risisky et al. 2018; Sadiku et al. 2024; Sayinzoga et al. 2021; Schellinger et al. 2017; Smith et al. 2020; Tanner-Smith et al, 2014).

Group care improves key outcomes

Group Care has demonstrated significant benefits. Randomised studies involving over 14,000 women overall showed a trend towards a decrease in **preterm births** for those receiving Group Care compared to traditional care (Carter et al. 2022; Ickovics et al. 2016, 2017; Jafari et al. 2010). Some studies conducted in the United States also found a reduced disparity in preterm birth for Black women, relative to white and Hispanic women (Picklesimer et al. 2012). Similarly, Ickovics et al. (2007) and colleagues showed that the effects on preterm birth seemed to be stronger for low income Black women in the United States, which suggests that marginalized or under-served populations can benefit from Group Care.

There is some evidence from randomised trials suggesting a reduced occurrence of **low birthweight** in babies born to women who experienced antenatal Group Care (Ickovics et

al. 2016, 2017; Jafari et al. 2010; Kennedy et al. 2011) and these results have been reiterated in observational studies or matched control studies (Carter et al. 2017; Crockett et al. 2019; Cunningham et al. 2019; Sigmon et al. 2017; Ickovics et al. 2003; Jones et al. 2023; Tanner-Smith et al. 2014). This is in agreement with Carter and colleagues' review of 14 studies, which reports a positive association between Group Care and birth weight (Carter et al. 2016).

The evidence is still not sufficient to unconditionally claim that Group Care leads to improved birth outcomes (Caitling et al. 2015; Byerley et al. 2017; Liu et al. 2021). The review by Liu et al. (2021), which includes only randomized controlled trials, does show significantly lower rates of depression at six months postpartum for people receiving antenatal Group Care. A 2017 systematic review focused on higher-risk women (Byerley and Haas 2017) found significantly lower rates of preterm birth among low-income and African American women, as well as improved rates of breastfeeding among adolescents and African American women. Improved attendance and public health benefits such as reduced smoking and improved weight management were also identified for some groups in vulnerable situations.

Group Care participants tend to have a reduced likelihood of **caesarean section births** (Carter et al. 2017; Harris et al. 2012; Jafari et al. 2010; Risisky et al. 2018). The likelihood of new-borns being admitted to the **neonatal intensive care unit (NICU)** was also shown to be lower in randomised trials (Ickovics et al. 2016) and cohort studies, which revealed an even stronger reduction in neonatal unit admissions (Carter et al. 2017; Crockett et al. 2019; Harris et al. 2012). Some studies have also identified improved diabetes symptom control (Byerley and Haas 2017).

Beyond clinical outcomes, pregnant persons report **higher satisfaction** with Group Care than with traditional care. This preference remains consistent across various studies, underscoring the value of the Group Care approach (Sadiku et al. 2024). Additionally, healthcare providers experience greater satisfaction offering Group Care as compared to individual care as they can provide the care that women want and need and they can build skills and relationships (Lazar et al. 2021).

Limited or inconclusive evidence

While Group Care shows promising results in several areas, the evidence remains inconclusive for other outcomes as study effects can go both ways. The impact of Group Care on **excessive gestational weight** gain remains unclear, as studies have shown inconsistent results (Brumley et al. 2016; Kominiarek et al. 2017; 2018; Tanner-Smith et al. 2014; Trudnak et al. 2013). Data on **hypertensive disorders** and **gestational hypertension** did not consistently show differences between care models (Carter et al. 2022; Jafari et al. 2010; Momodu et al. 2023; Wagijo et al. 2024). Although cohort studies showed a reduced incidence of **gestational diabetes** in Group Care, the quality of evidence varied across studies (Kominiarek et al. 2017; Tanner-Smith et al. 2014). Findings on pre-eclampsia also presented mixed results, with some cohort studies indicating higher odds among Group Care participants (Kominiarek et al. 2017, 2018; Momodu et al. 2023).

There has been limited research on the effects of postnatal Group Care, but the studies that have been conducted showed higher frequency of **well-child visits** in the first year of the child's life and a trend of increased **immunization or vaccination** rates (Gullet et al. 2019; Dimovitz et al. 2023). Studies also show an increased clinician and/or parent satisfaction for postnatal groups (Gullet et al. 2019; Dimovitz et al. 2023).

Overall, despite benefits in some areas, and for some groups of people, the evidence for certain maternal and newborn outcomes remains limited or inconclusive. Small sample sizes, varying study designs and methodological differences as well as different social and health system contexts and participant groups across studies hinder definitive conclusions, emphasising the need for more comprehensive research to fully understand the potential of Group Care models. Nonetheless, Group Care demonstrates significant benefits in improving maternal and new-born health outcomes, particularly for those in more vulnerable situations, such as reducing the likelihood of preterm births, low birth weight, and caesarean sections, along with enhancing client satisfaction. Health care providers who offer Group Care consistently report satisfaction with the benefits it offers to them, including the opportunity to spend more time with the people they serve and the enhanced ability to meet clients' specific needs.

These results highlight the potential of Group Care to redefine the standard of maternal care and provide a solid basis for its broader adoption and for further research into its impact.

2.4 Further reading on what we know about the implementation of Group Care

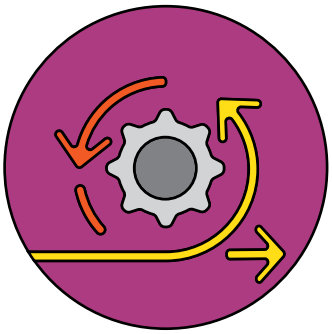
Aside from presenting this Toolkit, one of our goals from the GC_1000 research project is also to contribute to a growing body of knowledge in this field. If you would like to read additional research on Group Care, please use these websites which host an ongoing collection of peer-reviewed articles, systematic reviews, and an updated list of resources.

FURTHER READING ON GROUP CARE RESEARCH

https://groupcare.global/resources/

https://centeringhealthcare.org/why-centering/research-and-resources


In Group Care the participants raise their questions and our discussion revolves around their interests and concerns.
MIDWIFE
MIDWIFE
PREGNANT
MOTHERHOOD



SECTION 3: Preparing for the implementation of Group Care

Introducing a new way of doing things, such as antenatal and post-natal Group Care, can be both an exciting and challenging process, especially when there are so many activities taking place in the health provision site at the same time. Introducing a new service and asking healthcare providers and staff to change their normal way of working requires meeting and careful planning with the managers and staff who will implement Group Care. This section provides guidelines and resources on a range of key activities that should be done as part of implementing Group Care in order to enable its smooth roll-out in your facility.

> "Implementation science embraces the reality that contextual factors are active and dynamic forces working for and against implementation efforts in the real world"
>
> *(Damschroder et al., 2022. p. 2)*

3.1 Understanding your implementation context

If you are a local policy maker or a healthcare provider wanting to implement something new, it is important to think about the implementation context you are working in before going ahead. This helps to ensure that you understand the environment in which you are going to implement the new intervention, helps you to plan for implementation barriers, and identify opportunities that you can leverage to make the intervention a success. Understanding the implementation context also helps you to make sure your intervention is well aligned with the maternal health goals and policies in your country. Importantly, this information can help you develop implementation strategies to facilitate buy-in and support from decision makers during the implementation and scale-up process.

In this section we will discuss the different levels of context you need to consider, and we will provide guidance on what information you will need to gather. In the GC_1000 project we applied concepts from scientific literature to understand what was important in the context (Damschroder et al. 2022). The model we used includes taking into account the outer context, the individual domain and key processes and implementation strategies that need to be considered. This section shows you what these are, and how to use them to build the full picture of your context that will help you in implementing your new project.

Whilst this section provides guidance to help you think through the different features of context that may influence implementation, it is impossible to study and anticipate all possible contextual factors that may influence delivery of a health service before implementation. However, it is important to explore some, if not all these factors before you start implementation. Having a solid grasp of the context ahead of time will help if you need to make changes quickly during your strategising and implementation of Group Care to improve your chances of success.

TOOL

If you would like to conduct a formal contextual analysis, together with a research partner, as we did in the GC_1000 project, please follow this link for a guide on how to conduct a contextual analysis.

https://zenodo.org/records/12578537

The outer context

DEFINITIONS

What is the outer context?

The outer setting is everything surrounding the setting/facility where you will offer Group Care, including the geographic, cultural, economic, epidemiological and political factors that influence healthcare. There may be multiple outer settings and/or multiple levels within the outer setting, e.g., community, system, state.

Determinants in the outer context include critical incidents, local attitudes, local conditions, policies & laws, funding mechanisms, partnership & connections, and external pressures.

Figure 3: The key features of the outer context that one should consider

Source: Damschroder et al, 2022

Key questions you should ask about the outer context:

- What are the key policies and policy goals in my country or my region that govern maternal healthcare?
- How is Group Care aligned with these policies?

COUNTRY LESSON: SOUTH AFRICA

In South Africa, there are a set of national guidelines for antenatal care in the public health system. When planning for implementation and service delivery, the South African team had to ensure that the clinical assessments in Group Care were aligned to routine norms and standards, and that all the necessary staff and equipment were available for Group Care sessions to comply with these standards.

COUNTRY LESSON: UNITED KINGDOM

In the UK, managers had targets in relation to national policies, so the implementation leads had to illustrate how introducing Group Care could help them meet these targets.

Are there any critical incidents that are potentially going to happen in my region that may affect implementation?

- Do we perhaps have any seasonal critical incidents that may affect health system actors ability to implement and run Group Care?

COUNTRY LESSON: SURINAME

Suriname faces an economic crisis, which was worsened by the COVID-19 pandemic. Resources are scarce at the governmental level as well as in the population. While many families live in crowded houses and for most families affording healthy food is a challenge, health policies focus primarily on curative care and cost-effectiveness and less attention is given to health improvement and preventative approaches. You thus need to be aware of what is prioritised in your country and may have to actively advocate for support of Group Care.

- Are there any environmental, economic, political or sociocultural conditions or processes that potentially may affect implementation?
- What are the characteristics of the population in the context that you would like to implement Group Care?

COUNTRY LESSON: GHANA

In Ghana a cultural belief is that women do not want others to know that they are pregnant because they are afraid that people will wish their baby harm, or even use juju to negatively affect the baby before it is strong enough to survive. As one person said: "Her reason was that she lost a pregnancy before and she thinks it was because she went for antenatal too early [at one month] and people got to know of her pregnancy too early." This asks for even more attention in Group Care sessions to respect privacy.

- Who is it important to partner with and/or who are important people in the health service delivery network that you should approach for the implementation of Group Care?

COUNTRY LESSON: BELGIUM

In Belgium, antenatal care is mainly provided by obstetricians, in hospital care and not by midwives in primary care. Due to the payment system and the prevailing culture where pregnancy check-ups are viewed as a task for specialised care, primary care midwives have more difficulties with recruiting women for Group Care. There needs to be an attitudinal shift from professionals and clients. It took time to make those working in specialised care to understand the benefits of Group Care and the willingness to refer women to Group Care in primary care.

- Are there external pressures that can stimulate or hamper the implementation process? Are there, for example, advocacy groups that might help in setting the stage for Group Care?

COUNTRY LESSON: KOSOVO

In Kosovo, an independent NGO (AMC) promoted Group Care in their country by advocating for midwifery leadership of Group Care. Using evidence from the GC_1000 project, engaging with high level officials, and through the media they stimulated awareness of and support for Group Care.

COUNTRY LESSON: THE NETHERLANDS

In the Netherlands, the relatively higher antenatal mortality rate forced the Dutch government to improve perinatal care. Looking for interventions, Group Care with its improved outcomes, higher satisfaction of clients and fitting in the Dutch midwifery system (=midwives liked it!) may have been a factor why it was defined as an indicator of good healthcare in their national policy to improve perinatal care.

Individual domain

DEFINITIONS

What do we mean by individual domain? And who are the relevant individuals in your context? Within the individual domain we focus on the roles and characteristics of individuals involved with implementing, delivering, and/or receiving the innovation.

You need to determine who the individuals are who are relevant to the implementation of Group Care, and what their roles are. Think of midwives, doctors, health visitor, managers, opinion leaders (village heads, religious leaders, grandmothers etc.), and the recipients of care (i.e. pregnant women and parenting people).

Important characteristics that need to be considered are their needs, capabilities, opportunities, and motivation to implement Group Care. They can have different roles in the implementation: some are more directly involved in providing Group Care, while others are more important in organizing what is needed for the implementation.

Figure 4: The key characteristics of individuals that you should consider

Source: Damschroder et al, 2022

Key questions you should ask about individuals:

What are characteristics of the population in your setting?

- What is their educational level, language/s and cultural characteristics?
- What drives their need to attend Group Care and how big is the need?

COUNTRY LESSON: KOSOVO

In Kosovo many women are afraid of giving birth. They also struggle with their body image (impression of excessive weight gain), and breastfeeding is frequently a challenge. Mothers also said they felt not ready to be mothers and that they doubted their parenting skills. As Group Care is known to enhance social support and quality of information, these features may motivate them to attend, even though this model of care is not familiar.

What are the characteristics of the facilitators?

- Have they already completed Group Care training?
- How motivated are they and what drives their motivation (financial gains, role identification, job satisfaction, workload)?
- What are their skills in providing Group Care?

COUNTRY LESSON: THE NETHERLANDS

In the Netherlands, some midwives reported that with Group Care they had to reshape their relationship with pregnant women and parenting people. This was linked to their role identity. Midwives are used to having a close bond with their clients, being their clients' only and first point of reference. However, in Group Care, this relationship is distributed between themselves and the other participants in the group. Some midwives might need some time to get used to their new facilitative role in Group Care. However, midwives also highlighted that the longer interaction time in groups made them get to know their clients a lot better.

ADDITIONAL READING

Lazar, J., 2023. *Exploring the Experiences of Midwives Facilitating Group Antenatal Care* (Doctoral dissertation, City, University of London).

TOOL

Readiness assessment templates can be found in **Appendix 1**: Site Readiness Assessment for implementation of Group Care (antenatal), and **Appendix 2**: Site Readiness Assessment for implementation of Group Care (postnatal).

Process/Implementation strategy:

Once there is a clear picture about what can affect implementation of Group Care on the outer, inner (organisational) and individual domain, the Steering Committee (see **section 3.2**) can plan processes and implementation strategies to support the implementation. Readiness at this level is critical – while one cannot predict every eventuality there are a few areas one can identify before implementation. Conducting a **Readiness Assessment** can assist in preparation at the organisational/facility level.

DEFINITIONS

The implementation process is defined as the activities and strategies used to implement Group Care

Figure 5: What are strategies and activities that are crucial for stimulating the implementation process? How will you implement Group Care?

Source: Damschroeder et al, 2022

Key questions you should ask about the implementation process/strategies:

- How will clients be recruited? [for more information on this go to **section 3.3**]
- How diverse will your groups be (different socio-economic status, languages, cultures, ages) and how will we cope with diversity, and tailor your content and tools appropriately?

COUNTRY LESSON: THE NETHERLANDS

Initially, in the Netherlands, cohesion was challenged by language barriers and small group size. Some women could not fully participate because materials were not translated, and midwives did not have sufficient language skills. These were challenges that were addressed over time.

3.2 Setting up a Steering Committee

A Steering Committee or implementation team is also vital for planning and implementation, and for longer-term sustainability, it continues to meet regularly to provide support to Group Care facilitators, and to monitor processes and outcomes.

It is important to invite members through one-on-one conversations, especially if the concept is new. This will help to encourage participation and understanding of Group Care. The size of the facility will help to identify the number of members to include in your Steering Committee. Depending on the size and complexity of the context, it will be made up of about three to eight members who meet frequently prior to the start of Group Care. However, a small site with very few staff may only have two members involved, and a large multi-clinic system may have eight to ten members that drive implementation at several sites. In this instance, it helps to have a champion or representative from each site on the Steering Committee to ensure cross site learning. Small standalone sites may not need a Steering Committee as their planning and troubleshooting will be fluid and ongoing.

KEY MESSAGES AND TOOL

- The Steering Committee must have a lead or chairperson
- The Steering Committee should have a routine meeting scheduled in diaries
- A contact list of members should be developed
- Alternatively, Group Care should be an agenda item in existing scheduled meetings that members of the Steering Committee sit on.

Templates for setting up a Steering Committee are available in the Planning Guide on the Group Care Global website under the resources tab https://groupcare.global/.

Who are important members of a Steering Committee?

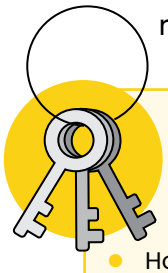
Based on your context, you might start with:

- A manager or administrator (*this title varies across contexts and countries)*
- A champion who is enthusiastic about providing Group Care in your setting
- A healthcare provider who is trained to provide antenatal and/or postnatal care (usually a midwife or physician)
- A representative from the midwifery or nursing department (if the clinic is large, the lead or head midwife or nurse)
- A patient registration/appointment/billing administrator, or all three in a large system
- A pediatric provider to facilitate the continuity of antenatal to postnatal Group Care
- A representative from an advocacy or service user group or interested community organisation

What are the basic responsibilities of the Steering Committee?

- To ensure representation across the facility to provide continuity of service provision
- To engage and inform managers and staff about ongoing activities related to Group Care in the different areas represented in the Steering Committee

- To ensure that training is prioritised and that staff can attend
- To reach agreement on quality benchmarks and outcomes that should be monitored, regularly review the data, and provide strategic direction based on the data
- To provide feedback to funders and other stakeholders as required



KEY QUESTIONS FOR THE STEERING COMMITTEE TO DISCUSS

- How can Group Care improve experiences of care for women and health outcomes in your organisation?
- Who are the stakeholders you need to engage with in the health service and the community?
- How can you engage meaningfully with internal and external stakeholders and support staff?
- What strengths and barriers have been identified in our readiness assessment? How will these be managed?
- What infrastructure is required to be available to support implementation now and in the long term?

3.3 Understanding and identifying who your participants will be in Group Care

While Group Care is for everyone, depending on your specific context, one may need to opt for a selection of participants first. It is then important that you define the characteristics of the participants that will be part of antenatal and postnatal Group Care sessions.

The Steering Committee will need to decide if you are targeting a specific population group or if you will be providing Group Care to all the pregnant women and parenting people who arrive for care at your facility. This is important as you need to plan appropriately to ensure that Group Care is provided in a way that is culturally appropriate and sensitive to participants' particular needs, for example literacy levels, and enables make up of groups of around 8-12 participants within a suitable catchment and range of gestational age that can meet consistently. The choice of who participates in each group can, for example, be influenced by clinical decisions (high risk versus low risk) or it could be influenced by, the availability of pregnant women and/or parenting people who can only attend on certain days and/or particular times during the day. A choice might be made to be inclusive of partners or other support people in all or specific sessions.

COUNTRY LESSONS: THE NETHERLANDS

In the Netherlands, in the asylum-seeking center, groups were created of all those that spoke Arabic to ensure easy communication amongst participants. And if that was not possible, groups were made up of not more than two different languages spoken.

KEY QUESTIONS THAT CAN HELP YOU UNDERSTAND YOUR POPULATION

- What is the availability of the population being served to attend Group Care? Do prospective participants work, will participants need childcare?
- Will groups only be for pregnant women and parenting people?
- Does the population being served have the means to travel to the place where Group Care is being held?
- Will other support people be included?
- What is/are the language(s) of the population being served?
- What are the age ranges of the population being served?
- What is the literacy level of the population being served?
- What are the priority health issues of the population being served?
- Are there any cultural issues that may influence the way in which Group Care is facilitated?

Once the decision has been made who the participants will be, the Steering Committee should also then decide on a communication strategy to inform pregnant women and parenting people about the availability of Group Care at your facility. Part of a communication strategy includes informing pregnant women and/or parenting people about Group Care in your facility, in figure 6 we provide an example of a pamphlet produced by Perisur in Suriname as part of the GC_1000 project.

COUNTRY LESSON: BELGIUM

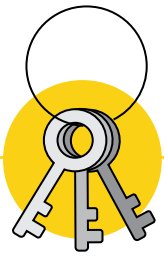
IIn Belgium, the participating sites reflected on their inclusion criteria for Group Care. At the start, they focused on participants with psycho-social vulnerabilities. They experienced that mixed background characteristics of the population is beneficial, rather than focusing on one specific target population. Mixed groups enforce mutual learning experiences and augment chances for support.

Figure 6: Example of a communication pamphlet used in the implementation of the GC_1000 project in Suriname

3.4 Scheduling Group Care

Planning your Group Care session schedule is an important part of implementation. It includes determining the frequency of Group Care sessions, the duration of the session, and must ensure that the same participants stay together in the same group. Scheduling must also consider **context-specific health service capacity and protocols.**

First, settings should think about what care is done regularly in one-on-one care and how to transform this into Group Care, acknowledging that it is empowering for clients to do as much themselves as they are able to while still ensuring quality of care and following the professional guidelines in your country. The health care provider should also consider how to align the clients' needs to professional guidelines when considering frequency of visits, content to be covered in groups and clinical assessments.



KEY QUESTIONS FOR SCHEDULING

- How many groups will start each month?
- What days and times will be best for women to come to groups?
- How many and when are healthcare providers and staff needed for groups?

KEY MESSAGE

Before or after the first Group Care session an intake visit is needed with physical and lab assessments. After this initial visit, groups are formed based on gestational age. Group Care for pregnancy follows antenatal care recommendations as outlined by the WHO (2016) or by national guidelines. Groups usually organise between 16-20 weeks of pregnancy and meet every month for about four months, and then more often. The last antenatal session for the group should occur in the first half of the month most participants are due. Many groups also have at least one session when everyone has given birth.

Group care for parenting after babies have been born can be spaced from an initial two weeks, with a gap of a month between sessions as the babies get older and parents are more adjusted to their parenting role.

When scheduling, it is also important to keep in mind that the **cohort needs to be stable**, meaning the same participant, healthcare provider and co-facilitator ideally attend each session. This enables the development of relationships and assists the facilitators in providing effective Group Care. Time before and after sessions should also be considered for such things as set-up and break down of the space, preparation of medical records and session content, as well as time for reflection after the session. The person who schedules/books appointments for pregnant women of similar gestational age or for parenting people should ensure that the same participants are scheduled in the consecutive sessions of their cohort. If a participant has a referral consultation with another healthcare provider in the case of complications or additional care then the person has to make sure to reschedule the person back to Group Care when appropriate.

When scheduling, settings must consider **space** availability. Depending on whether they have a dedicated space for Group Care or if they are using a space that serves other purposes, other practical arrangements will need to be made.

Finally, group scheduling and participant **enrolment** are inextricably linked. To target successful enrolment, we recommend organisations to develop a multidisciplinary plan consisting of specific strategies, such as informing, motivating and training staff who will enrol participants; investing in communication and concretising the collaboration with referrals; increasing visibility of Group Care and ensuring Group Care is held at times that are suitable to the pregnant woman or parent.

CROSS -COUNTRY LESSONS FROM THE GC_1000 PROJECT ON SCHEDULING

- Scheduling Group Care must align with the space availability in your setting, or plans must be made in advance to access alternative settings (e.g. a children's centre or community facility with suitable rooms).
- Scheduling must take account of the fact that groups last between 60-120 minutes
- You must decide on the amount and frequency of Group Care sessions you will schedule and consider how it aligns with your countries' national policies on antenatal and postnatal care
- When scheduling Group Care sessions, you must consider how it will interact with other existing services for antenatal and postnatal care that is provided in the same facility (including referrals and any individual appointments)
- You must consider the working hours and shift availability of healthcare providers and co-facilitators when scheduling sessions. This includes the amount of time before the session to set up the chairs and other equipment and time afterwards to write up referrals
- What days and times will be best for women to come to groups?
- When scheduling it is important to remember that Group Care will replace routine individual consultations, as the clinical assessments are part of the Group Care core components. Therefore creating free time elsewhere.

TOOL

There is a space checklist from the Group Care Global planning guide available as Appendix 3: Group Care **space**.

3.5 Preparing the space to host Group Care sessions

Providing care in groups requires different space than that required for individual care. While individual care requires small private rooms, the group requires a space that will hold an open circle of about 20 chairs comfortably, with two to three stations outside the circle estimated at 900-1000 square feet (280-300 square meters). The room will work best if it is basically square. Finding space where patients can feel safe to share their thoughts and often leads to unexpected opportunities. Some clinics have used waiting rooms (outside of clinic hours); meeting rooms (after moving the central tables) or arranged circles of chairs outside the clinic under a tree.

Practices that use dual-purpose rooms find that set up and break down of the room for group use can be time-consuming, stressful, and exhausting. A trick to help with this is to host Group Care for example on a Thursday evening and then again on a Friday morning, to limit the need for preparation of the room. Ideally space will be designated for the sole purpose of conducting Group Care. Having dedicated space will also allow more groups to be conducted throughout the day.

The Steering Committee needs to explore space options as the size of the space will impact the number of participants that can be accommodated in each session.

KEY QUESTIONS WHEN THINKING ABOUT SPACE

- How many people can we get in an open circle of chairs in the center?
- Is there room for four stations outside the circle – Check in; self-check; medical check-up with some privacy and water/snacks (if planned)?
- Is there a bathroom nearby?
- Where will Group Care supplies/equipment be stored?
- Is the space easy for patients to access, if not how will access be managed?

TOOL

You can find equipment checklists for antenatal and postnatal Group Care in **Appendix 4** and **Appendix 5**.

3.6 Equipment needed to host antenatal and postnatal Group Care

You will need to ensure that all the available equipment for being able to host antenatal and postnatal Group Care sessions is planned for. Items including educational materials, required medical equipment, medical charts, water, specific training materials and the facilitators guide are just some of the things you need to consider.

3.7 Building staff support

Once you have successfully formed a Steering Committee to provide strategic direction for Group Care and have a better understanding of the context of your specific health system, the next step is to ensure that the relevant administrative, clinical and support staff are ready and motivated to embark on the Group Care journey. It is also critical to share the values that underlie the Group Care model to show your staff that Group Care is well aligned to the values and goals for maternal and child health globally.

This includes:

- Administrative support:
    - Ensuring that you have the support of key stakeholders such as the relevant health authorities in your setting and managers within facilities
    - Ensuring that you have the support of staff who administer the scheduling and enrolment of patients, as well as staff who administer routine data, as these are critical stakeholders
- Clinical staff support:
    - These team members may be healthcare providers, birth attendants and others involved in providing health services
    - Ensuring that they understand and support the objectives of Group Care
    - Managing expectations and the adjustment from individual care to Group Care
    - Enabling the necessary training and ongoing learning
    - Ensuring that proper channels of communication are set-up and maintained
- Support staff:
    - These are team members who may be responsible for recruiting participants, scheduling, billing, and may also be Group Care facilitators
    - Their involvement not only enhances the operational aspects of Group Care but also helps in establishing a stronger connection with the community

TOOL

To assist you in building staff support, please see the Worksheet on Building Staff Support drawn from the GC_1000 Planning Guide in **Appendix 6**

When thinking about building support for Group Care, think about who the key decision-makers in your organisation are and identify whether a range of important role-players have been included in the Steering Committee leadership team. Regular feedback sessions can help staff express concerns and contribute ideas, fostering a sense of ownership and collaboration. Establishing clear communication channels will ensure that everyone is informed and engaged in the process. Also, acknowledge to staff that implementation of Group Care takes time to get it right, and that they should not simply stop, but rather persevere.

3.8 Financial and costing recommendations and tools for Group Care

You will need to think about the cost of Group Care and how to finance this. Both aspects are elaborated below.

Costs of Group Care

In implementing Group Care we can distinguish three phases with specific cost components:

1. Design
2. Initiation
3. Maintenance

Design Phase

Costs include the adaptation of the Group Care model to the specific situation, adapting the IT system (e.g. to enable Group Care bookings), and establishing the necessary (e.g. financial) infrastructure.

Initiation Phase

Activities that must be costed should include Group Care training of professionals; building/adapting a space where the individual clinical assessment component can be offered, as well as space for group work; purchasing items needed for Group Care which might include posters, educational materials, chairs, and other things that create an inviting environment; and purchasing equipment, such as blood pressure cuffs and weighing scales that allow pregnant women and parenting people to monitor their own basic health data.

Maintenance Phase

Costs include elements needed to conduct Group Care sessions, ongoing Group Care training, monitoring of the groups, advocacy with decisionmakers, and outreach to patients and general community members to raise awareness about the service.

Costs that cut across all phases

Within each phase, implementation costs can be incurred at the site of delivery ('site-specific' costs) or more centrally ('central costs'). Furthermore, there are one-off costs (especially in the design and initiation phases) and annual recurring cost (maintenance phase). In **Table 1** a more detailed overview of the cost components in the different phases of implementing Group Care is provided.

TOOL

Through the GC_1000 project we have prepared excel costing tools that can be used to calculate the cost of implementing Group Care, these tools are available for download at:

Calculating the costs of implementing Group Care: Excel tool 1
https://zenodo.org/records/11638812

Calculating site implementation costs of Group Care: Excel tool 2
https://zenodo.org/records/12586674

Table 1: Cost components of Group Care in different phases of implementation

	Design phase (one off costs)	Initiation phase (one off costs)	Maintenance phase (recurring costs)
Central costs	Adaptation to specific setting • Facilitator guide & associated materials • IT systems Arranging funding and reimbursement in specific setting	Initial training • (co-)facilitators (time including preparation and travel) • Training participants (time, including preparation and homework and travel) • rental training location • training materials • refreshments/snacks • Cost of expert trainers as needed • Cost of materials for communication about the new service	Ongoing training/peer to peer feedback sessions/ supervision Monitoring and evaluation to generate relevant data Ongoing communication and advocacy
Site- specific costs		Building/adapting venue* for Group Care sessions that includes clinical care where privacy and confidentiality is still maintained. Additional equipment: • Blood pressure devices that women can use themselves • Weighing scales • Equipment that allows pregnant women and parenting people to monitor their own basic health data.	Renting venue for Group Care sessions** Administrative time for reorganising Group Care sessions Group Care sessions • healthcare provider (time including preparation and travel) • participants (time and travel, if applicable also partners time and travel, and child care) • education materials • refreshments/snacks

**Not applicable if a separate venue is rented*

***Not applicable if Group Care takes place on own premises*

Financing Group Care

The way the financing is organised depends on your specific context. It is important to note that for financial sustainability, resources have to be found for the yearly recurring cost in the maintenance phase.

Ideally, it is good to think about long term sustained funding for Group Care from the beginning of your implementation journey. However, if you are starting out and require initial funding to start the implementation process and/or there is no current budget available in your organisation, the Steering Committee could write proposals and apply for grants for short term funding through:

1. The private sector in your country: some companies may have funds for corporate social responsibility
2. Global funders such as bi- and multi-lateral funding agencies

However, for long term sustainability of Group Care, it is important to understand how healthcare financing works in your country. This includes understanding how revenue is raised for healthcare services (e.g. budgets from governments, insurance schemes, direct payments from patients). This then influences how money is allocated to your healthcare facility and how healthcare providers are paid. This will influence which services are paid for (the purchasing function). In some countries, antenatal and postnatal care might be provided for free at the point of service to patients because the government pays the healthcare facility on their behalf, but in other countries these services might be purchased by insurance schemes on behalf of the patient. You would need to identify whether insurers are willing to purchase and pay for Group Care. Summed up, the relevant decision makers need to be identified, and discussions held to establish whether Group Care can become part of the routine package of services that are offered as part of antenatal and postnatal care.

Once Group Care has been shown to be feasible and effective in your context, the goal is to integrate Group Care into routine systems of payment. Both for healthcare services and healthcare providers, and into routine building and design guidance and healthcare professional training.

COUNTRY LESSON: UNITED KINGDOM

One should also aim to discuss with the relevant decision makers whether Group Care can become part of the benefit package of services that are offered as part of antenatal and postnatal care. You will need to understand how the health financing system in your country works to do this, for example in the United Kingdom, the National Institute for Health and Care Excellence (NICE) follows an evidence-based committee process for a health care intervention to become part of the recommended routine package of services.

KEY QUESTIONS TO ASK IN RELATION TO HEALTH FINANCING

- Are the budgets for antenatal and postnatal care allocated from national, regional, and/or local health authorities? Which levels pay for what and how does funding flow from one budget to the other?
- Will Group Care be free for pregnant women and parenting people at the point of service? Or will there be out-of-pocket expenses related to Group Care?
- Will the payment for Group Care, if relevant, in any way negatively affect the access that different population groups have to healthcare? Or does Group Care improve the affordability of healthcare?
- How will healthcare providers be paid for providing Group Care? Will they be reimbursed by healthcare insurers or as part of the normal budget from the government? Will it be incorporated within their normal workload?
- Will there be costs linked to needing to use different care venues or are existing locations suitable (e.g. community-based location with large enough rooms for a group).

COUNTRY LESSON: BELGIUM

Group Care should not cost participants more than routine care. In Belgium, Group Care did not add extra costs for the participants, and this benefited enrolment. A financing system where costs remain equal or less for participants, enables freedom of choice, regardless of the antenatal care model they choose.

3.9 Monitoring and evaluation during and after Group Care

Why evaluate?

When a new approach to care is introduced, it is important to monitor the impact on the organisation, the health care providers and the people the care is intended to benefit. We know from international evidence that antenatal Group Care has benefits for the people providing and receiving care and is associated with high engagement and satisfaction. But you will want to know how Group Care works in your own setting, including any implications such as costs, for facility or organisational arrangements, and how it works for pregnant women and parenting people in practice.

What kinds of monitoring and evaluation should be considered?

There are various levels to consider. At the most vital level is service monitoring or audit – services will want to know about **impact on staff workload** and on **patient attendance rates**. Most services will also want to **monitor referrals and outcomes** through routine record keeping and auditing. Beyond this, and especially with a new healthcare service, it is a good idea to plan more detailed evaluation to understand the impact on costs of care, on professional and patient satisfaction, and if possible on psychosocial wellbeing as well as clinical outcomes.

Planning for routine monitoring and audit

Most services will have existing record systems, so a crucial step is to review what data are already collected routinely. With a new model like Group Care, especially if not provided to all, a code or other identifier to be able to distinguish Group Care from standard antenatal and/or postnatal care is vital – this makes audit using routinely collected data possible. The second step, depending on local system factors is to check whether and how records are integrated.

COUNTRY LESSON: UNITED KIGNDOM

In the UK, child health records are on a separate system from maternity records so if you are implementing a model including antenatal and postnatal Group Care, or if you want to monitor longer-term impact on indicators like infant immunisations, you will need to look at ways to link the different records for auditing purposes.

Who should lead the routine monitoring and auditing

The Steering Committee you have set up to provide leadership for Group Care should plan for a small group to take a lead in monitoring, or to add the topic to existing audit team roles. The group will need to work with the Steering Committee and other relevant implementers to identify what the aims are – what kind of process indicators (like attendance, tests or referrals) or outcomes (like birthweight or mode of birth) are most relevant to focus on, relating to your aims in introducing Group Care. You can use **section 2.3** on the Global evidence base for Group Care to assist with this exercise.

Monitoring fidelity

If you are implementing Group Care for the first time it is important to ensure you are staying true to the three core components of Group Care. You will need to adapt Group Care to your context and/or adapt features within the context (see **section 3.1** for more on this), and ensure that this is done in a way that keeps the important components of Group Care (for example health assessment including self-assessment; groups facilitated to be interactive; and through consistency and social support groups contributes to community building).

TOOL

A Model Fidelity Checklist is available in **Appendix 7**. You can use it to ensure you are staying close to the three core components of Group Care. It includes a set of questions to think through before assessing fidelity to the three core components of Group Care and a checklist for monitoring fidelity. You may also find the facilitator self-evaluation tool provided in **Appendix 8** useful for this. See also **Section 3**, which describes how to conduct a situational analysis and **section 3.10** which explains how to identify adaptations and modifications needed in your context, while still maintaining the three core components of Group Care.

Planning for a research-based evaluation

If Group Care is a new health service in your setting, you may consider doing a research-based evaluation, we provide some key tips here and a link to resources that could support the process.

KEY MESSAGE

Your core implementation group or Steering Committee should meet with service managers and relevant stakeholders, including service-users or advocacy and community organisation representatives to discuss the priorities for evaluation and plan the approach. Research-based evaluation is time consuming and needs research skills and experience so consider applying to relevant agencies for funding, or ideally include evaluation costs in any transitional funds you are seeking for implementation. Working with a local or regional university or research institute may be valuable to provide research expertise, and these may also have graduate students keen to collaborate to underpin their dissertations.

FURTHER READING

If you would like more information on how others have conducted research-based evaluations, please contact the Group Care Community of Practise: https://groupcare.global/cop/. The GC_1000 project has also published their evaluation protocol at the following link: https://link.springer.com/article/10.1186/s43058-022-00370-7. In addition. You can contact Professor Christine McCourt at City, University of London, who led the implementation research evaluation in the GC_1000 study who can provide you with the data collection tools that were used in the study: Christine.mccourt@city.ac.uk

3.10 How to identify adaptations and modifications needed in your context

After considering all the factors above (including understanding your unique context) you may have to make adaptations in your organisation to ensure the feasibility of Group Care. It is important to know how to think about and identify adaptations that are needed in your context and then to identify implementation strategies that can help you implement and sustain Group Care while still maintaining fidelity to the three core components of Group Care.

In this section we explain what an adaptation is, we provide guidance on how to identify what adaptations are needed and guidance on how to track adaptations and modifications. We also provide practical examples from the GC_1000 project on implementation strategies that facilitated the implementation of Group Care in the seven different country contexts.

First step: Identifying adaptations needed in your context

As a first step, the required adaptations for your context need to be identified. To begin with, we provide some more insight into what we mean by 'adaptations'. In implementation science, 'adaptations' is described as *"the process of thoughtful and deliberate alteration to the design or delivery of an intervention, with the goal of improving its fit or effectiveness in a given context*" (Stirman et al., 2013). Thus, 'adaptations' encompasses more than merely making some changes in the Group Care model. In practice, it focuses equally on

changes in the implementation site or the planned implementation strategies, to enable contextually suitable organisation of Group Care in a specific site.

As described in **section 3.1**, it is essential at the start to understand the context in which you will organise Group Care. By having a clear overview of this, the necessary adaptations can be identified. As a supporting tool, we developed the Anticipated Challenges Framework to support the implementation of Group Care (See **Appendix 8**). This framework was developed based on context analyses conducted in the GC_1000 project in 26 different sites across seven diverse countries (Van Damme at al., n.d). The research in various GC_1000 project sites gave us clear insight into eleven anticipated challenges for which adaptations and modifications were needed, these are listed in Figure 6. The Anticipated Challenges Framework (**Appendix 8**) brings together these eleven anticipated challenges – the framework will help you to reflect on the possible adaptations needed in your context.

TOOL

The Anticipated Challenges Framework (in worksheet format) can be found in **Appendix 8**.

Figure 6. Anticipated challenges/adaptations that were identified in the GC_1000 project

Surface Structure Anticipated Challenges
- Content
- Materials
- Facilitators
- Timing
- Location
- Group composition

Deep Structure Anticipated Challenges
- Health Assessment
- Scheduling Group Care into regular care
- Enrolment
- (Possible) partner organisations
- Financials

Source: Van Damme et al., (n.d)

A distinction is made between anticipated challenges that can usually be addressed quite easily within the organization, such as place and timing of the sessions, and group composition. These are described as 'surface structure anticipated challenges'. For other challenges, cooperation with other partner organisations or alignment with the local policies might be needed. These are listed as 'deep structure anticipated challenges'. For each challenge you will need to describe the anticipated challenges, think about what actions the implementation team or Steering Committee can take to tackle the anticipated challenges, and make specific actionable plans including what/who/where/when actions will be taken if required.

Step 2: Develop an adaptation plan and track the process

We recommend using the Worksheet for applying the Anticipated Challenges Framework in discussion with the Steering Committee, and applying them to your specific context to enable Group Care implementation. In order to define a concrete action plan you can use the adaptation actions recorded in the last column of the framework (**Appendix 8**) which includes identifying actions, identifying who will be responsible, and identifying when the action will take place. This action plan can be the basis for tracking progress.

In addition to using the 'Anticipated Challenges Framework', we have also adapted the Framework for Adaptations and Modifications to Evidence Based Interventions Expanded (FRAME) (Stirman et al. 2013; 2019) – See **Figure 7** below. It demonstrates that the adaptation process involves deliberately thinking about the reason for the adaptation, for whom the adaptation is being designed, who should be involved in the design of the adaptation, when and where in the system the adaptation should take place and clearly identifying what the goal of the adaptation is.

The application of the adapted FRAME (Figure 7) can also help to track these adaptations over time. This can give more insight into whether adaptations are effective or not and may highlight elements that contributed to not achieving the desired outcome. Our adapted FRAME for Group Care is suitable for planning adaptations as well as monitoring the process of adaptation.

Figure 7: Adaptation process tracking tool for Group Care based on FRAME

<table>
<tr><td colspan="4">WHAT was adapted?

Description of the most impactful adaptation</td></tr>
<tr><td>Was the adaptation PLANNED?

• Planned (proactive)
• Unplanned (reactive)</td><td rowspan="2">For WHOM/WHAT was the adaptation made?

• Individual – pregnant person
• Individual – (co-) facailitator
• Target population
• Site/organisation
• Community
• Group Care 1000 research team
• Country research team
• Health care system
• Other (specify)</td><td colspan="2">What were the REASONS to adapt?</td></tr>
<tr><td>WHEN did the adaptation occur?

• Before the first Group Care session
• Within the first year after the start of the first Group Care session
• After the first year of the first Group Care session</td><td>SOCIO-POLITICAL

• Existing laws
• Existing mandates
• Existing policies
• Existing regulations
• Political climate
• Funding policies
• Historical context
• Societal or cultural norms
• Funding or resources availability</td><td>(CO-)FACILITATOR

• Race/ethnicity
• Sexual/gender identiy
• First/spoken language
• Previous training and skills
• Preferences
• Clinical judgement
• Cultural norms</td></tr>
<tr><td>What was the most important GOAL of the adaptation?

• Increase engagement
• Increase retention
• Improve feasibility
• Improve fit with recipients
• Reduce costs
• Increase satisfaction
• Improve effectiveness/ outcomes</td><td>WHO participated in the decision to adapt?

• Group Care_1000 research team
• Country research team
• Management at the site
• Staff at the site
• Pregnant people/ their families
• Group Care steering committee
• Group Care Global consultant
• Other (specify)</td><td>ORGANISATION/SITE

• Available resources
• Competing demands or mandates
• Time constraints
• Service structure
• Location/ accessibility
• Regulation/ compliance
• Billing constraints
• Social context
• Mission
• Cultural or religious norms</td><td>PARTICIPANT

• Race/ethnicity
• Sexual/gender identity
• Access to resources
• Cognitive capacity
• Physical capacity
• Literacy and educational level
• First/spoken language
• Legal status
• Cultural or religious norms
• Comorbidity/ multimorbidity
• Immigration status
• Crisis of emergent circumstances
• Motivation and readiness</td></tr>
<tr><td colspan="4">What was the impact on model fidelity?
(1) Health assessment in group space – (2) Self-care activities – (3) On-going evalutation – (4) Interactive – (5) Open circle – (6) Session plan, emphasis may vary – (7) 8-12 participants – (8) Stable group composition – (9) Time for socializing</td></tr>
</table>

Source: Van Damme et al. (n.d) adapted from Stirman et al. (2013; 2019)

For example, we saw in practice that adaptations were often joint decisions, and were therefore more supported by the implementation team. Many of the adaptations in the GC_1000 project were related to the current organisation of the healthcare system, rather than needing to adapt the three core components of Group Care.

COUNTRY LESSONS

Research in various GC_1000 project sites gave us clear insight into adaptation requirements. Here are two examples of how the application of FRAME thinking assisted in the effective implementation of Group Care.

Finding a suitable location

In different countries, finding a suitable location that is large enough to fit for a group and to include the private clinical assessment medical check-up in a private corner was challenging. Creative solutions were put in practice to make Group Care possible at the site. For example, in South Africa the Group Care sessions are organised in a waiting room while it was not being used, and the private clinical assessment medical check-up was conducted in an adjoining room. To achieve this, agreements with the management and the staff at the site were made. The Steering Committee was actively involved in how to make Group Care possible with minimal disruption of the routine care in the site.

Shift in working hours of the facilitators

In two countries, it was reported that the timing of the Group Care sessions was not feasible for the participants, and therefore this was adapted. This very much depended on the local context. For example, in the Netherlands, they shifted to evening sessions because this was easier to attend for the participants. In Suriname, they shifted from morning to afternoon hours. This required agreements with the management, as it was outside the regular working hours of the facilitators, but thanks to open discussions and clear agreements between management and staff at the site, it was possible to organise the Group Care sessions in the afternoon.

3.11 Training and training materials to support the implementation of Group Care

Training facilitators who will host Group Care is critical to successful implementation, sustainability and scale-up of the model.

In this section we will provide an overview of the training required for facilitators of Group Care. Group Care Global has designed a 16-hour (ideally over two days) curriculum for the training of facilitators. A facilitator guide is a key resource that will need to be developed to support training and implementation. The training embraces a learning-by-doing approach.

Why do we need training?

Group Care is different from individual care in several ways, making training vital for healthcare providers and co-facilitators as they move from individual care to providing care in the group setting. After initial training, continued consultation will also be helpful to sustain the model, plan for additional facilitator training, and identify/train facilitators who are ready and interested to become In-Country Trainers.

An overview of training for group facilitators

The training is an interactive one or two-day course designed for healthcare providers and key staff to introduce participants to the skills essential in facilitating Group Care.

The course is structured to ensure that trainees actively engage with the three core components of Group Care: **Healthcare** (self-care activities and individual clinical assessments in the group space); **Interactive Learning** (facilitated discussion led by a facilitator); and **Community Building** (in ways that are participatory and encourage participants to speak freely about their experiences).

Each participant will have the opportunity to practice building skills in facilitation, and the opportunity to participate in exercises designed to increase understanding of the model and to build self-confidence.

Who should be trained?

- Healthcare providers who are trained to provide antenatal and postnatal care, including those with expertise in social and behavioral health.
- Individuals who will be co-facilitators for example: medical assistants, nursing staff, community health workers and other support people.
- People in administration and management who need to understand the model to support the system changes.

The Group Care training course curriculum

As far as possible, the participants will, through experiential learning, have an experience of an actual clinical Group Care session so they can feel what their clients experience. The course provides an opportunity for each participant to practice facilitation skills and to participate in exercises designed to increase understanding of Group Care and to build self-confidence in facilitation.

The core components of the curriculum for training include:

- Discussion and practise of the three core components of Group Care.
- Teaching Group Care participants the skills to perform their own self-assessments.
- Demonstrating and practising a 3–5-minute short concise clinical assessment in a private area within the Group Care space, addressing the appropriate protocols for gestational age.
- Familiarising the facilitators with a Facilitator Guide which provides facilitators with ideas for key topics to discuss in each session.
- Discussion of the difference between didactic lectures and facilitated discussion that lead to interactive learning.
- Discussion and practising of group facilitation skills that are grounded in the belief that participants have life experiences that enrich conversation. For example: curiosity; listening; asking open-ended questions; being creative; time management and improvisation.
- Demonstration of and role-playing techniques and activities that support empowerment and community development within the group.
- Providing access to the free online training modules available to support continued growth as a facilitator and access to the Community of Practice.
- Enrolment of participants
- Handling difficult group dynamics and/or situations

Individual competencies that facilitators should have learned at the end of this learning experience:

- Understand the three components of the Group Care model.
- Demonstrate how to do a 3–5-minute individual assessment.
- Translate individual questions into general topics for group discussion.
- Describe ways in which Group Care is different from usual care.
- Discuss the difference between a didactic class and a facilitated discussion.
- Demonstrate facilitation using the listen, acknowledge, clarify, refer, return and summarise technique.
- Become familiar with at least three activities to use to begin discussion.
- Describe the importance of facilitated guidance to encourage deep discussion. Demonstrate a willingness and ability to step away from didactic teaching methods.
- Recognise the purpose of the facilitation tools is to promote discussion among group members.
- Describe an understanding of group dynamics and process.
- Demonstrate the ability to improvise and apply interactive facilitation techniques.
- Recognise that facilitating group discussion is a learned skill that can be improved overtime using a lifelong learning approach.
- Describe ways in which the activities and discussions empower the people in their groups.

Facilitation: the need for two facilitators

Facilitative leadership requires the facilitator to be interested in and curious about each member of a group. This means not only sharing your own thoughts but also being open to what others have to say. A facilitative leader needs strong listening skills to understand group members better and to guide the discussion effectively. A facilitative leader aims to include different voices in the conversation, ensuring everyone has a chance to contribute. IPaying attention to body language cues of the participants is also important to guide the facilitation.

Having two facilitators is important, especially in complex situations. Sometimes, cultural issues or personal matters shared in the group require careful handling. If a participant has a clinical need, one facilitator can attend to them while the other keeps the discussion flowing. An additional facilitator can also assist with managing late arrivals or early departures and giving individual attention when needed.

The second facilitator should be someone familiar with the group's background, trained in facilitation, and knowledgeable about community resources. This person may be a community health worker, a medical assistant, a social worker, a nutritionist, or a play therapist, etc. If in your setting it is required for the co-facilitator to also be a health professional, you will need to factor the higher cost into your plans. The second facilitator can share responsibilities including managing the session's logistics such as overseeing check-in, attendance, and room setup, addressing any issues that arise, keeping time, debriefing after the session, and following up with participants who missed the session or need extra support.

Being a facilitator and listening to the group is a unique privilege. Pairing the clinician with a co-facilitator will help to assure stability of the group and support for all members of the Group Care session..

The Facilitator Guide

The material covered in Group Care is flexible as it is responsive to issues raised by group participants. However, it is good to be prepared with a set of topics and a **facilitator guide** should be developed and adapted to meet the needs of care in your country. Many countries have clear guidelines on what discussion topics should be covered in antenatal care (at the appropriate gestational age) and in postnatal sessions and you should use your country guidelines to develop your facilitator guide of topics to discuss. These topics would be linked to health outcome goals for pregnant women and/or parenting people in your country. The facilitator guide should also provide practical examples for facilitators on activities that promote interaction in the group (e.g. ice breakers).

A sample of topics that have been covered previously in antenatal Group Care sessions includes (1) nutrition using culturally appropriate foods, (2) common discomforts of pregnancy and warning signs, (3) who and how to contact care, (4) infant feeding, (5) preventing infections, (6) family planning, (7) relationships and (8) depression

and domestic abuse and (9) preparation for parenthood.

A sample of topics that have been covered previously in postnatal Group Care and Well Childcare includes (1) infant feeding, (2) family planning, (3) emotional well-being (4) infant crying patterns, (5) developmental stages, (6) infant safety, (7) discipline, (8) preventing abuse, (9) relationships and (10) stress.

TOOLS FOR FACILITATOR GUIDE

A list of examples of topics and intended outcomes of the sessions that could be included in a facilitator guide is included in **Appendix 9**.

For further guidance on the development of a facilitator guide to support training and implementation, please contact Group Care Global and/or CenteringZorg and/or the Group Care Community of Practice.

Who will deliver the training?

The training course is designed to be offered in-person over two full days or a total of 16 hours by skilled trainers – you can contact **Group Care Global** directly, Group Care Global designed the curriculum and the training materials and they have experienced consultant trainers available. **CenteringZorg** in the Netherlands and City, University of London in the UK, also have skilled trainers available. Or you could be trained by in-Country trainers who are conducting training in your country. To find out if there are any trainers available in your country you can contact the **Group Care Community of Practice**.

TOOLS AND LINKS FOR GROUP CARE IMPLEMENTATION

While not replacing in-person training, Group Care Global has designed a set of free modules on how to implement Group Care to supplement and reinforce this. These are available in multiple languages, including English, French, Dutch, Flemish, and Albanian on the Group Care Global Website under Resources. Additional languages will be added over time.

The Planning Guide for Implementation of Group Care that is discussed in the modules is also available in multiple languages, including English, French, Dutch and Albanian on the Group Care Global website under Resources. Additional languages will be added over time.

Website and contact details to find out more about in-person training and the development of a facilitator guide:

- Group Care Global: https://groupcare.global/ or email info@group-care.global
- CenteringZorg: https://centeringzorg.nl/contact/ or email info@centeringzorg.nl

Join the Group Care Community of Practice by emailing groupcare+subscribe@groups.ibpnetwork.org.

You can find out more about the Group Care Community of Practice at this site: https://groupcare.global/cop/

These organisations can provide your site with the training as well as connect you with information on experienced trainers in your country or region.

COUNTRY LESSON: BELGIUM

Group Care Belgium was established as a national training centre. Its establishment is recognised as an added value. Group Care Belgium and its experts are consulted in regional and national projects, both with regard to practice and policy making around Group Care.

Setting up for training:

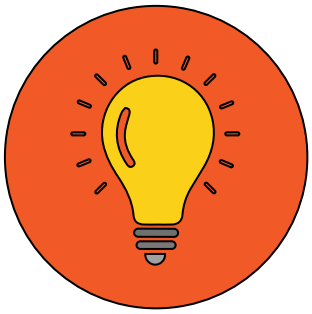
As the training is designed to model care in a group setting, supplies for training include anything that is or will be used in clinical practice and staff should also be available for the training. There are some key resources you will need to have available when training.

TOOLS

You can find a checklist in **Appendix 10** of a list of key items you will need for training staff to be Group Care facilitators.

COUNTRY LESSON: SOUTH AFRICA

Training facilitators and co-facilitators together with their managers was key to building capacity in the service delivery area where Group Care was being implemented (in this case, the outpatient department antenatal clinic in the hospital). It meant that their manager/supervisor also fully understood the components of Group Care and could provide the support needed from her staff and it facilitated buy-in. It also meant that the facilitator and co-facilitator had experience practicing facilitation together as a team.



SECTION 4: Lessons for implementation

Bottom up implementation theory reminds us that front-line providers are critical in shaping the experiences of clients

(Orgill and Gilson, 2018)

We have provided you with a range of tools and guidance on how to prepare for the consistent implementation of Group Care as part of health service delivery. Training is a critical part of preparation, and you would have experienced much more learning while participating in the training. Ideally you should start your first group within a month of training so that facilitators can start using and consolidating their new skills immediately.

A quick checklist before starting your first Group Care session:

- You have assessed how Group Care will fit into your organisational context
- You have identified who your participants will be, and you have communicated widely about the availability of Group Care
- You have a Steering Committee who is providing leadership and oversight
- You have space for Group Care
- You have trained facilitators who are motivated to deliver Group Care

- You have an enrolment and scheduling system in place that ensures consistency in the participants in the groups and ensures alignment with the facilitators work schedule
- You have all the equipment and materials you need to host Group Care sessions
- You have set up a monitoring system to capture relevant data regularly

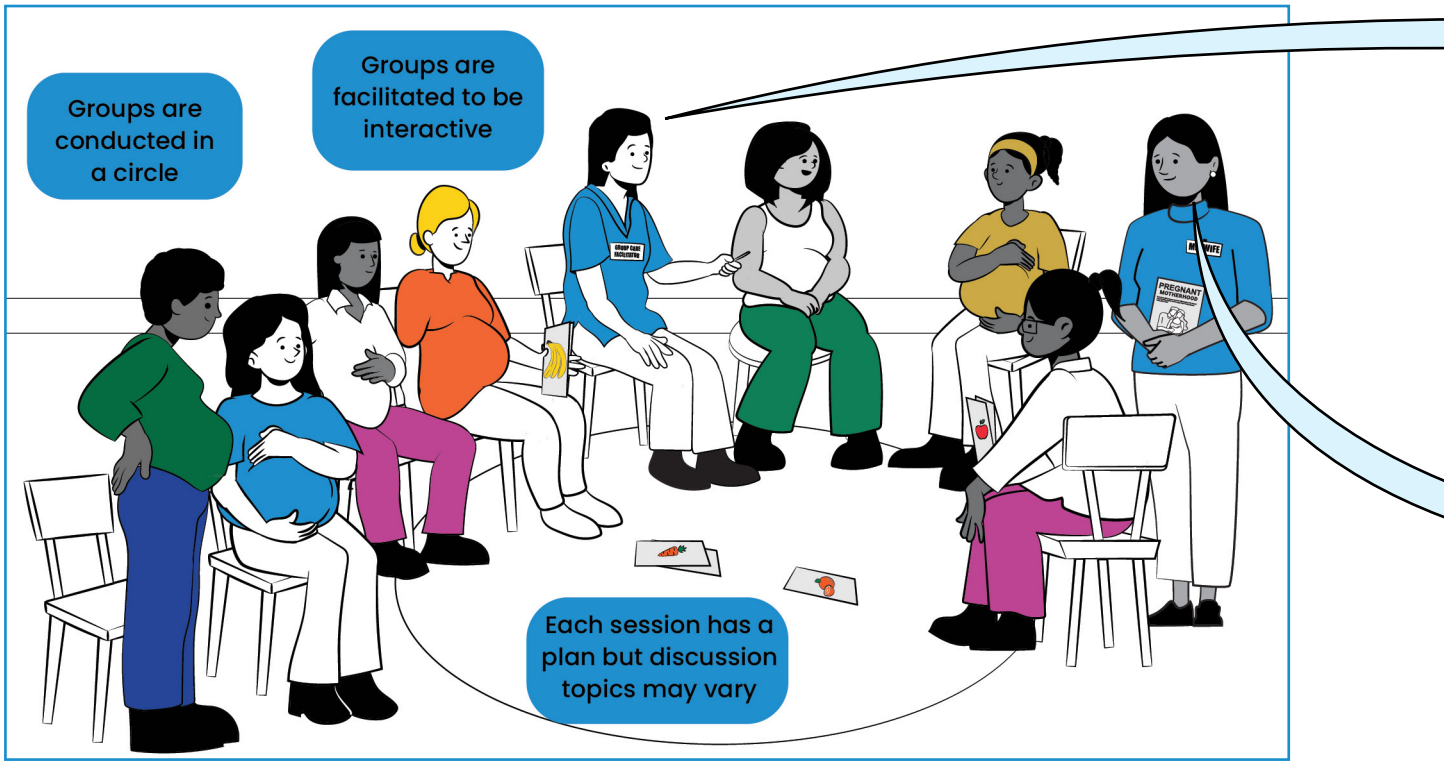
4.1: Lessons learned in the GC_1000 project

One of the reasons implementation research was conducted in the GC_1000 project was to understand how Group Care could be implemented in different countries, and how to successfully implement Group Care while dealing with normal everyday realities of delivering healthcare. While you will have to prepare and engage in continuous learning to understand how Group Care will work in your context, we learned several lessons in the GC_1000 project about what makes Group Care function well. In this section lessons are shared on what supported the implementation of the **health assessments (private clinical assessments and self-care activities)** in facilities, how to support and ensure **interactive learning** in groups, and lessons on how **community building** was supported over time. Please see the three diagrams that follow which show some of the examples from practice, when implementing **the three core components of Group Care**, that were learned in the GC_1000 implementation research project.

TOOLS

More detailed implementation findings from the GC_1000 project can be found on the GC_1000 project website in the resource section, including the cross-country evaluation report and the cross-country lessons learned report.

Real world examples on how to enable interactive learning

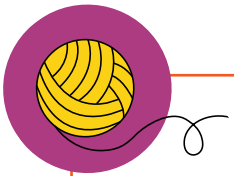


OBSERVATIONS FROM THE HEALTH SERVICE

"One of the facilitators tells me about how the team prepare the content, making sure they cover the information women need at their gestation age, but also being flexible and adapting to what women want to talk about on the day. Next week, partners are invited so [they are] moving topics around and adapting the programme, so they get the best for everyone. They put an initial list on the whiteboard to which the women's ideas/needs will be added in the Group Care session" (United Kingdom)

CROSS -COUNTRY LESSON

Where participants speak different languages the use of an interpreter was important. The facilitator also played a role by using positive body language such as maintaining eye contact and staying present while the interpreter was talking.



TOOL: ICEBREAKERS

Getting participants to speak for the first time as part of the group is an important part of the process, using an icebreaker at the beginning of each session has worked well to get all voices to be heard from the start. Example: stand in a circle and allow participants to throw a ball to each other and introduce themselves or reflect on a question.

"The facilitators engaged the women through an interactive game and asked for their preferences on topics for future discussions. This approach enables women to take an active role in shaping the content of their sessions"

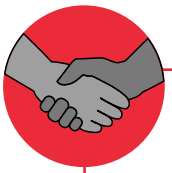
CROSS-COUNTRY LESSON

A facilitator's cultural sensitivity and attitude toward vulnerable communities was pivotal in ensuring women felt included and felt free to speak their mind without judgement in the group space.

"In Group Care the topics revolve around the interests of the participants with time spent to assure a helpful, culturally appropriate discussion." (Ghana)

COUNTRY LEARNING FROM GHANA

Topics for sessions were put into more pictorial and physical items to stimulate discussions amongst participants, as literacy levels were low among participants and reading proved a challenge for most women.



CROSS-COUNTRY LESSON

Healthcare providers observed that collaborative work can be challenging due to the differences in their professional backgrounds and work styles. However, they found that dividing tasks and ideas amongst the team members, ensuring active participation from everyone, and working together can significantly improve the team's efficiency and effectiveness.

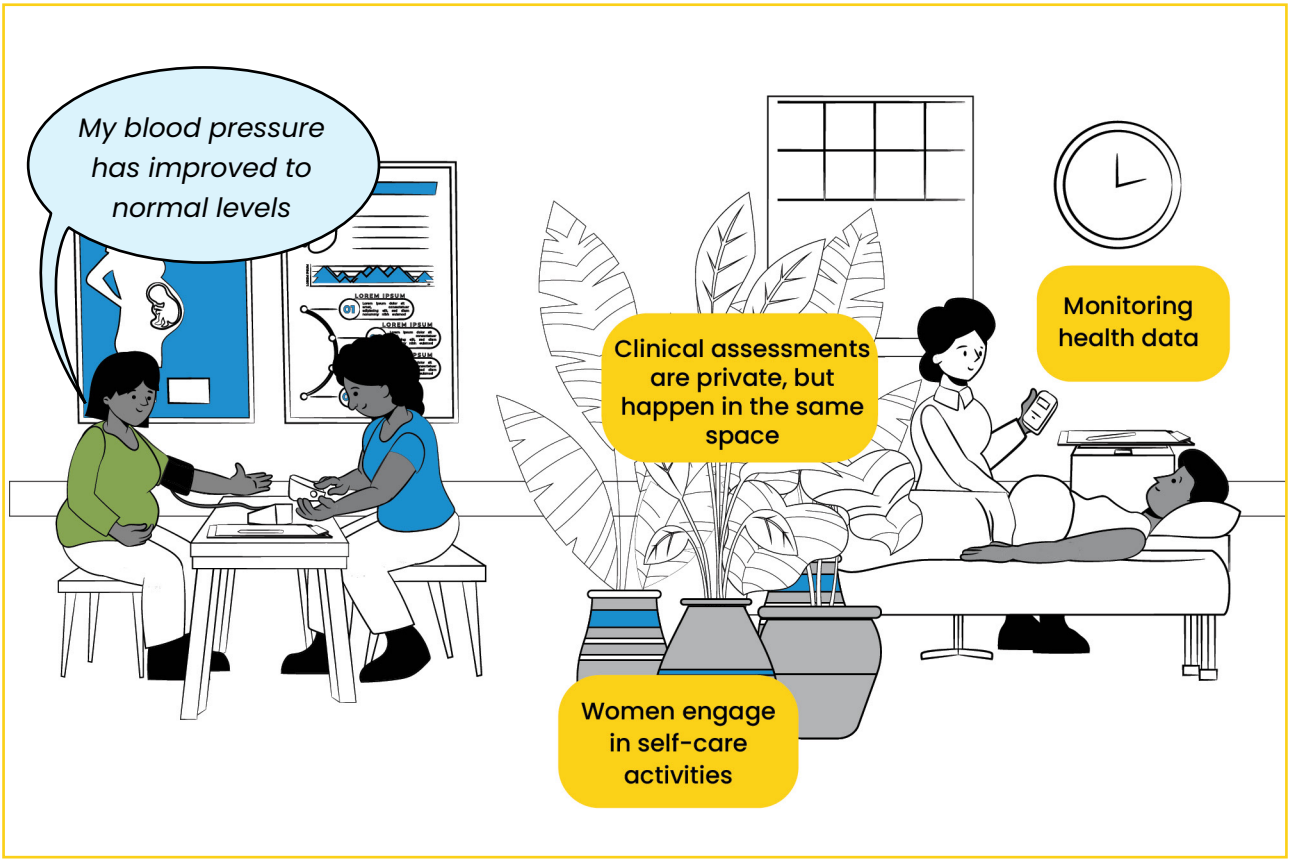
COUNTRY LEARNING FROM SOUTH AFRICA

The facilitators led the group through a variety of activities, including sharing information about pregnancy and childbirth, discussing common concerns and experiences, and providing emotional support. Activities were planned with adaptable content and utilised various visual aids and props for discussions.

COUNTRY LEARNING FROM GHANA

When discussing healthy nutrition, it is important to include locally available foods as health education on diet/nutrition must reflect the local foods available to participants.

Examples from practice on enabling a good clinical experience



CROSS-COUNTRY LESSON

Women's active participation was emphasised. They learned to conduct certain health checks such as taking their blood pressure together and discussing their weight, which not only increased their knowledge but also their confidence in understanding health indicators. For example, a woman from the UK noted that she could recognise her normal blood pressure readings before being informed by the midwife.

COUNTRY LESSON: KOSOVO

Think creatively about what women love to do during their pregnancy and add to Group Care sessions as much as possible. In Kosovo, the integration of a doppler in antenatal sessions was shown to be highly motivating for women. The possibility for expectant mothers to audibly experience their unborn child's heartbeat fostered a deep commitment to the overall care program, humanising the pregnancy experience.

CROSS-COUNTRY LESSON

Many countries in the GC_1000 project found it difficult to find a space suitable to do theprivate clinical assessment, with privacy, in the same space as the group. This was largely due to limited availability of space infrastructure. Sites found creative solutions, such as doing clinical assessment in an adjoining room to the group or doing the clinical assessment behind a curtain. You will need to figure out how to adapt your context to stay true to the three core components of Group Care within the resources available. In GC_1000 we found it critical to include implementers in this decision process during the planning stage.

COUNTRY LESSON: KOSOVO

An impactful adaptation in scheduling Group Care into regular care in Kosovo involved collaborative efforts between midwives and obstetricians. Pregnant women were recruited for groups, and their appointments with the obstetricians were scheduled on the same day as the group sessions. This convenient arrangement facilitates attendance, seamlessly integrating Group Care into regular care. And addresses the challenges faced by pregnant women residing in rural areas, eliminating the need for separate days for doctor appointments and group sessions. This not only reduces travel costs but also saves valuable time for participants.

KEY MESSAGE

It is important that the clinical assessment within Group Care is understood as part of routine care, it is not in addition to normal individual clinical assessments. Hence Group Care should align with your normal clinical guidelines and practises for antenatal and postnatal care, including the frequency of visits and referrals to specialised care as needed.

Examples from practice on how to foster Community Building

"The thing that excites me is that we used to not know each other, and soon after weighing, we would just go, but due to Group Care, we now know each other's names and houses as well. We also made new friends." (Ghana)

COUNTRY LEARNING FROM UNITED KINGDOM

A participant in the UK reflected that she was having her second baby and that she loved Group Care. It was totally different to her first pregnancy which was during lockdown. She liked the way there was time to relax and chat, and to find out more about the issues she was facing.

COUNTRY LEARNING FROM SOUTH AFRICA

In South Africa, women used WhatsApp groups as their own group community space. Cohorts that had completed Group Care, remained in contact via WhatsApp after birth, some connected together in parks and/or other meeting places as friends. They chose to continue the journey together after birth, to continue sharing experiences and to introduce their babies to each other.

"We are like friends, for everything we need, when we have problems or we are happy, we always talk with each other. We also sent pictures to one another, pictures of the babies or pictures of us with the babies, or some memes related to parenthood" (Ghana).

CROSS COUNTY LESSON

To enhance community building, it is important that group members are consistent and that time for socialising is built into each meeting. Implementing reminder systems can also enhance attendance rates and consistency in the group.

4.2 Ongoing reflection and learning for the facilitators while implementation is happening

We found in the GC_1000 project that reflection by the facilitators after each session is especially important for ongoing learning while implementation is happening. This ensures that the facilitators reflect on what is working well and timeously identify what needs course correction. This is also a moment for facilitators to plan for the next session.

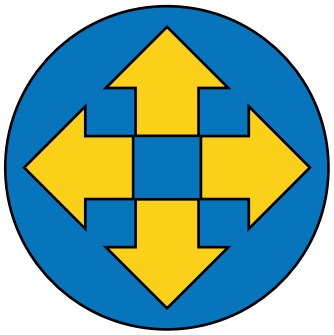
Similar reflection sessions in the whole team would also be valuable and, if available, follow-up reflection and mentoring from a trainer, as developing group facilitation skills can take time.

The Steering Committee must also reflect regularly on the experiences of participants and providers in Group Care and should be routinely monitoring the health outcomes of Group Care as explained in the section on **monitoring and evaluation**.

TOOLS

Facilitators can use a **self-evaluation checklist** shown in **Appendix 11**: Group Facilitator self-evaluation checklist as a tool for ongoing reflection and learning after each session.


Our clients love Group Care, let's think together about how we can continue implementation to make sure more people benefit.
MIDWIFE
PREGNANT
MOTHERHOOD



SECTION 5: Scaling-up and sustaining Group Care

5.1 Scaling-up Group Care

Scaling-up Group Care is imperative for true health system and health service transformation; it is also necessary so that more pregnant women and parenting people, as well as healthcare providers, can experience the benefits presented throughout this Toolkit.

What is "Scaling-Up"?

According to ExpandNet, scaling-up refers to "deliberate efforts to increase the impact of innovations successfully tested in pilot or experimental projects so as to **benefit more people** and to **foster policy and program development on a lasting basis**."

ExpandNet is an information network of global health and development professionals who seek to advance the science and practice of scale-up. It was founded in 2003. The website is the source of many tools, publications, and a scaling-up bibliography that is constantly updated.

Table 2: Key aspects of the WHO Expand.net Scaling-Up model (2010), and how they apply to Group Care implementation

Deliberate efforts Scaling-up typically requires systematic guided efforts to achieve success *The worksheets (**Appendix 12**) in this section of the Toolkit supports the creation of a plan for such guided efforts. Country teams in the GC_1000 project used them to foster discussions among stakeholders*
Innovations If the package of interventions is new in the local context, it is an innovation, even if it has been implemented elsewhere *Group Care is an innovation in contexts throughout the world. Even when implemented in selected sites, it remains a system-wide innovation. Innovations also take place when implemented with specific populations, such as people who are displaced, refugees, and asylum-seeking.*
Successfully tested The intervention package requires local evidence of feasibility, acceptability and effectiveness to ensure appropriate fit to the context *Prior sections of this Toolkit support users in experiencing and documenting Group Care's feasibility, acceptability, and effectiveness in specific contexts, which may include adaptations to how the Group Care model is implemented.*
Benefit more people Reaching new populations and/or geographic areas with interventions is a primary rationale for scale-up *By scaling-up Group Care, we reach more pregnant women and parenting people with services that make a positive impact; and more healthcare providers who can deliver care in ways that support them in connecting with the people they serve. A goal is to be able to refer to Group Care as a standard of care.*
Foster policy and program development Embedding the innovation in the policies, organisational structures, and operational guidelines is critical for sustainability *Scale-up and Sustainability are intimately linked; throughout the GC_1000 project, partners worked with health systems and health services to adapt policies, structures, and guidelines so that Group Care could be both scaled-up and sustainable (Please see section on **Sustainability**).*
On a lasting basis Expansion of new interventions without ensuring continued implementation wastes valuable resources *Group Care often is implemented first (but not exclusively) to serve populations living in vulnerable contexts, such as low resource settings, and can support the efficient and effective use of resources.*

Source: (WHO, 2010)

In sum, developing a strategy from these worksheets includes a visioning exercise for defining expectations for scaling-up, before initiating the steps. These steps, which we have summarized to seven, include:

- Step 1: Planning actions to increase the scalability of the innovation
- Step 2: Increasing the capacity of those putting Group Care into practice to scaling-up
- Step 3: Assessing the environment and planning actions to increase the potential for scaling-up success
- Step 4: Increasing the capacity of the implementation team to support scaling-up
- Step 5: Making strategic choices to support vertical scaling-up (institutionalisation) (See Figure 8)
- Step 6: Making strategic choice to support horizontal scaling up (expansion/replication) (See Figure 8)
- Step 7: Finalising the scaling-up strategy and identifying next steps[1]

Figure 8 brings all these steps together. Tools that help enact the graphic are included in the **two worksheets** that can be used to plan for both ***vertical*** and ***horizontal scale-up***.

Vertical scaling-up engages with the question: What is the policy, political, legal, regulatory, budgetary, programmatic, operational or other health systems changes needed to institutionalize Group Care at the national or sub-national level?

Horizontal scaling-up engages with the question: What's needed to implement Group Care in different sites or extended to serve larger and/or different population groups?

TOOLS

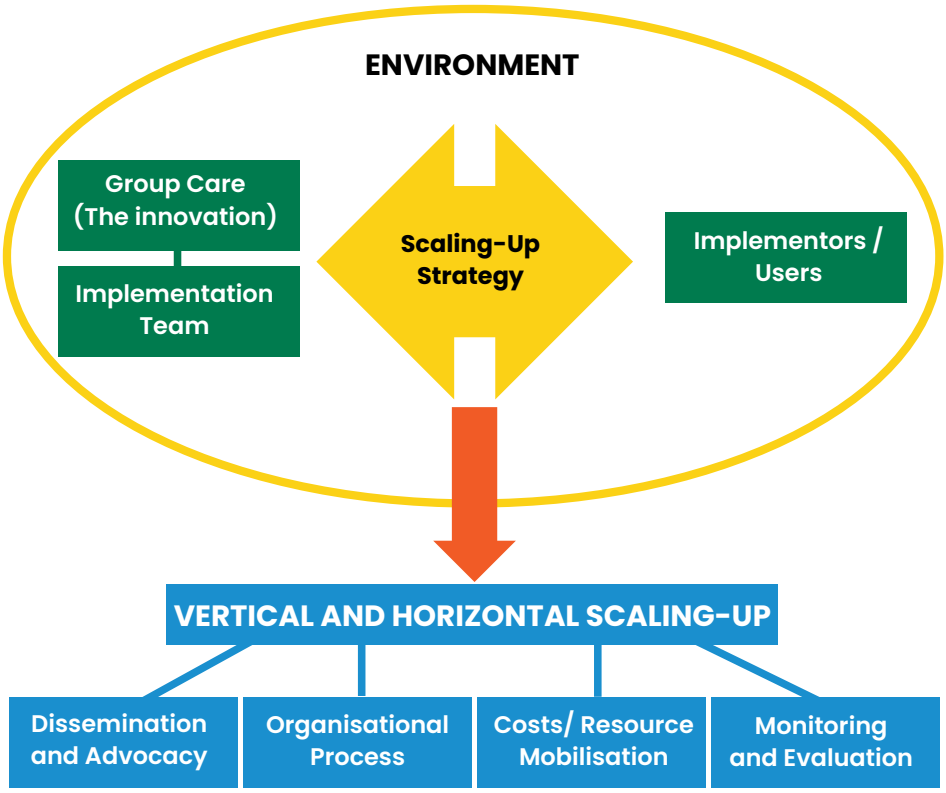
Please consult Expand.Net for worksheets, they are freely available.

TOOLS

To work through what the vertical (institutionalisation) and horizontal (expansion) scale-up implications are for you when implementing Group Care, you can find Worksheets in **Appendix 12**.

1 This is step 9 in the WHO ExpandNet process

Figure 8: Vertical and horizontal scaling up



Source: WHO (2010, p. 5)

5.2 Sustainment and sustainability

Sustainment, sustainability, and scale-up processes are intertwined. This section of the Toolkit focuses on sustainment and sustainability, while a discussion of scale-up can be found in **section 5**. Ultimately, they are linked to planning as discussed in **section 3.1**, implementation processes, and adaptation processes as discussed in **section 3.10**.

Sustainment and sustainability must be considered and discussed throughout implementation, in coordination with strategic stakeholders who can foster Group Care continuing well beyond a pilot phase. Despite many successes, Group Care has not yet succeeded in penetrating the healthcare system to become the standard of care. Change is hard and sustainable change is even harder.

The GC_1000 project focused on generating in-depth understanding and systematically developing acceptable, feasible and sustainable strategies to integrate Group Care into health systems for antenatal and postnatal care during the first 1000 days.

This Toolkit provides an array of tools and approaches that support planning and implementation that take sustainment and sustainability into account **from the very beginning** of any Group Care work in new settings. These same tools and approaches can be used to examine sustainment and sustainability in ongoing services, especially in preparation for **scale-up**.

DEFINITIONS

In this section we define sustainment and sustainability, as they relate to Group Care. We also provide a set of key questions to think through.

Sustainment

Sustainment is the sustained implementation and use of Group Care during implementation. Defined as "...the continued enactment of processes, practices, or work routines that are conveyed and learned through an intervention" (Wagg et al., 2019).

KEY QUESTION

What are the elements that make current Group Care implementation possible?

KEY MESSAGE

What does it take for an intervention to be sustained?

There is no one answer to this question.

"High implementation fidelity during an intervention may contribute to sustained use and benefits. Conversely, the adaptive perspective suggests that sustainability and sustainment is achieved in organizations that are adept at striking a balance between fidelity and responsiveness to the implementation context." (Berta et al., 2019: 3)

DEFINITIONS

SUSTAINABILITY

"...the extent to which 'an evidence-based intervention can deliver its intended benefits over an extended period of time after external support from the donor agency is terminated" (Rabin et al., 2019:13).

Sustainability

Sustainability - sustained benefits of Group Care anticipated into the future

KEY QUESTIONS

- What are the elements that will sustain Group Care into the future (1, 5, 10 years and beyond)?
- One year from now (date of inquiry), will ***your organisation*** continue to support implementation of Group Care? What about 5 years from now (date of inquiry), what about beyond 5 years?
- One year from now (date of inquiry), will Group Care continue ***in your country***? What about 5 years from now (date of inquiry), what about beyond 5 years?

KEY MESSAGE: HEALTH SYSTEM SUSTAINABILITY

Aside from 'affordability' issues, another aspect of sustainability is the question of how the health system can maintain sufficient levels of infrastructure, technologies and human resources to deliver good quality services (system sustainability).

Source: European Observatory on Health Systems and Policies (2024)

If you would like to discuss more about sustainment and sustainability:

The **Group Care Community of Practice** offers space to discuss sustainment and sustainability issues and to create action plans at local, regional, national, and global levels in **section 6**.

Worksheets to foster and support discussions about sustainment and sustainability

Sustainment and sustainability were key issues in the GC_1000 project. To foster discussions of these issues and ensure that the GC_1000 work was not another project that ends when the funding ends, we continuously asked: *How do we sustain and scale up Group Care beyond the funding period?*

To this end country teams met and completed Sustainment and Sustainability **worksheets** with as much detail as possible at any given period in the project. Periodically, teams revisited and revised the worksheets. They then used this information to guide discussions with stakeholders in strategic meetings held during the last year of the project. Worksheets were revised according to the discussions generated with stakeholders and to document any commitments made during those discussions regarding sustainability of Group Care beyond the project period (2020-2024). The information was used to guide ongoing work and to inform any advocacy that was needed.

You can use these worksheets to:

- Guide discussions among **Steering Committee members**
- Guide discussions with (potential) funders, policymakers, and other stakeholders
- Update on a regular basis to document how well Group Care is being implemented and if it will continue; identify elements that need to be strengthened and what's needed to support that process; identify elements that are working well and what's contributing to that success

TOOLS

You can find and use the Worksheet for tracking sustainment of Group Care implementation and the Worksheet for tracking sustainability for the same in **Appendix 13**.


We can all learn together from people all over the world who are implementing and scaling-up Group Care

SECTION 6: Community of Practice

6.1 What is a Community of Practice (CoP)?

A Community of Practice is a group of people who share a common concern, a set of problems, or an interest in a topic and who come together to fulfil both individual and group goals. (Barbour et al., 2018: 327) In the CoP, we share best practices and generate new knowledge by connecting, listening, discussing, and valuing all participants' knowledge and experience.

6.2 What is the Group Care Community of Practice (GC CoP)?

The Group Care CoP connects people who want to implement, sustain, and scale-up Group Care in their healthcare settings. These connections support all CoP members to share resources, strategies, and innovations so that collectively we can make Group Care a reality throughout the world.

"A community of practice (CoP) is a knowledge translation (KT) strategy that brings together people who have a common concern, set of problems or passion for a topic which aims to deepen knowledge and expertise around the common issue by facilitating ongoing interaction."

(Barbour et al. 2018: p. 327)

6.3 Where is it housed?

The Group Care Community of Practice is housed on the IBP Network platform, which is hosted by the Department of Sexual and Reproductive Health and Research (SRH) at the World Health Organization. The Network brings together over 23,000 global health professionals from more than 1999 member organisations to share knowledge, best practices, experiences, and tools.

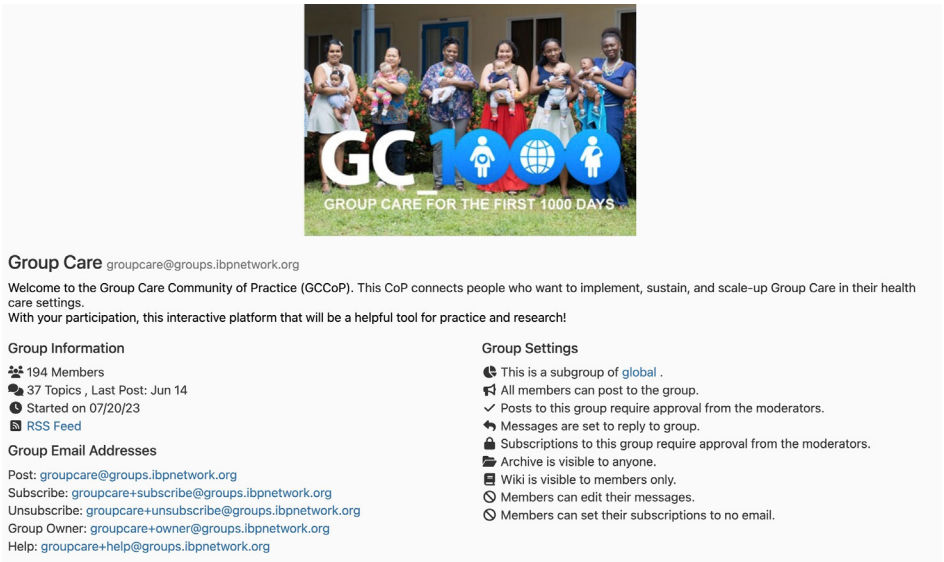
6.4 How do I join and participate?

If you are interested in being a member of the Group Care Community of Practice, please email: groupcare+subscribe@groups.ibpnetwork.org

A CoP facilitator will send you a link to join, which you need to approve. Once you're a member, you can log in, review past messages and discussions, access files and photos, and receive notifications about upcoming events. You can also propose new topics and lead a roundtable discussion.

This is what the home page looks like:

Figure 9: Group Care Community of Practise website home page



The Group Care Community of Practice thrives when members actively engage to create a dynamic space. You can share resources as well as connect with colleagues around the world to collaborate, learn, and improve your own practices. You can do this by posting messages, asking questions, attending roundtables via zoom-

which are announced through email and posted on the CoP calendar- and by accessing those resources if you're not able to join during the discussion.

6.5 How the Group Care CoP is being used

- Sharing experiences and discussing approaches to challenges, in real-time, with participants who log in, via zoom, from all over the world
- Serving as a repository of resources and conversations that serve as source of information and inspiration to others implementing or planning to implement Group Care
- Supporting new implementers and experienced implementers through the virtual platform or in real time

Examples of Live Roundtable Group Care CoP Discussions Conducted via Zoom (Recorded and posted for ongoing access)

- Facing our Fears: A Roundtable Discussion about Managing the Challenges of Facilitating and Implementing Group Care in Diverse Contexts
- Identifying Influential Group Care Stakeholders
- Mlinde Mama Project: Implementation of Group ANC Model in Geita-Tanzania
- How to Start Group Care in My Area with Special Guest Katja van Groesen of CenteringZorg
- Group Care Roundtable Discussion: Building Capacity for Group Care Training in my area
- Building Confidence in Group Care Facilitators
- Financing Group Care

Thank you

Thank you for engaging with this GC_1000 Toolkit. We hope this toolkit supports you in implementing and scaling up Group Care. Please use this Toolkit and its appendices for further guidance or contact us via the Community of Practice or view more on the GC_1000 website.

References

Abshire. C., McDowell, M., Crockett, A.H., and Flesicher, N.L. 2019. The impact of CenteringPregnancy group prenatal care on birth outcomes in Medicaid eligible women. *Journal of Womens Health*, 28(7), pp. 919-28.

Adams, J., Kenny, T., Frantz, K., Craig, M. and Eden, R. 2016. Comparison of outcomes in maternal opioid medical support using Centering Pregnancy versus maternity care home. *Journal of Pregnancy and Child Health, 3* p. 271.

Ahrne, M., Byrskog, U., Essén, B., Andersson, E., Small, R. and Schytt, E. 2023. Group antenatal care compared with standard antenatal care for Somali-Swedish women: a historically controlled evaluation of the Hooyo Project. *BMJ Open, 13*(1), p.e066000.

Barbour, L., Armstrong, R., Condron, P., and Palermo, C. 2018. Communities of practice to improve public health outcomes: a systematic review. *Journal of Knowledge Management, 22*(2), pp. 326-343.

Baumann, A.A.C., Leopoldo, J., and Stirman, S.W. 2018. Adaptation in dissemination and implementation science, in *Dissemination and implementation research in health: Translating science to practice 2.* R.C.C. Brownson, A. Graham, and E.K. Proctor (Eds.), pp. 286-300. Oxford University Press.

Benatar, S., Paez, K., Johnston, E.M., Lucado, J., Castillo, G., Cross-Barnet, C., and Hill, I. 2021. Intensive approaches to prenatal care may reduce risk of gestational diabetes. J*ournal of Womens Health, 30*(5), pp.713-21.

Berta, W.B., Wagg, A., Cranley, L., Doupe, M.B., Ginsburg, L., Hoben, M., MacEachern, L., Chamberlain, S., Clement, F., Easterbrook, A., Keefe, J. M., Knopp-Sihota, J., Rappon, T., Reid, C., Song, Y., and Estabrooks, C.A. 2019 Sustainment, Sustainability, and Spread Study (SSaSSy): protocol for a study of factors that contribute to the sustainment, sustainability, and spread of practice changes introduced through an evidence-based quality-improvement intervention in Canadian nursing homes. *Implementation Science, 14*(1), pp. 109. doi: 10.1186/s13012-019-0959-2.

Brumley, J., Cain, M.A., Stern, M., & Louis, J. M. 2016. Gestational weight gain and breastfeeding outcomes in group prenatal care. J*ournal of Midwifery and Women's Health, 61*(5), pp. 557-62.

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, pp.1-9.

Carter, E.B., Temming, L.A., Akin, J., Fowler, S., Macones, G.A., Colditz, G.A., and Tuuli, M.G. 2016. Group prenatal care compared with traditional prenatal care: A systematic review and meta-analysis. *Obstetrics and Gynecology, 128*(3), pp.551-61.

Carter, E.B., Barbier, K., Sarabia, R., Macones, G.A., Cahill, A.G. and Tuuli, M.G. 2017. Group versus traditional prenatal care in low-risk women delivering at term: a retrospective cohort study. *Journal of Perinatology, 37*(7), pp.769-771.

Carter, E.B., Barbier, K., Hill, P.K., Cahill, A.G., Colditz, G.A., Macones, G.A., Tuuli, M.G. and Mazzoni, S.E. 2020. Pilot randomized controlled trial of diabetes group prenatal care. *American journal of perinatology*, pp.045-053.

Catling, C.J., Medley, N., Foureur, M., Ryan, C., Leap, N., Teate, A. and Homer, C.S., 2015. Group versus conventional antenatal care for women. *Cochrane database of systematic reviews*, (2).

Crockett, A.H., Heberlein, E.C., Smith, J.C., Ozluk, P., Covington-Kolb, S. and Willis, C., 2019. Effects of a multi-site expansion of group prenatal care on birth outcomes. *Maternal and Child Health Journal, 23,* pp.1424-1433.

Cunningham, S.D., Lewis, J.B., Shebl, F.M., Boyd, L.M., Robinson, M.A., Grilo, S.A., Lewis, S.M., Pruett, A.L. and Ickovics, J.R., 2019. Group prenatal care reduces risk of preterm birth and low birth weight: a matched cohort study. *Journal of women's health, 28*(1), pp.17-22.

Damschroder, L. J., Reardon, C. M., Widerquist, M. A. O., and Lowery, J. 2022. The updated Consolidated Framework for Implementation Research based on user feedback. *Implementation science,* 17(1), p.75.

European Observatory on Health Systems and Policies. 2024 Health System Sustainability. Available at https://eurohealthobservatory.who.int/themes/health-system-functions/financing-and-payment/sustainability (Accessed April 15 2024)

Fredrickson, J.D., Kirkland, L. and McCarty, K., 2019. Improving prenatal health behaviors: implementing a blended model of prenatal care. *Women's Healthc, 7*(2), pp.44-49.

Grady, M.A. and Bloom, K.C., 2004. Pregnancy outcomes of adolescents enrolled in a CenteringPregnancy program. *Journal of midwifery & women's health, 49*(5), pp.412-420.

Gullett, H., Salib, M., Rose, J. and Stange, K.C., 2019. An evaluation of CenteringParenting: a group well-child care model in an urban federally qualified community health center. *The Journal of Alternative and Complementary Medicine, 25*(7), pp.727-732.

Harris, S.J., Janssen, P.A., Saxell, L., Carty, E.A., MacRae, G.S. and Petersen, K.L., 2012. Effect of a collaborative interdisciplinary maternity care program on perinatal outcomes. *CMAJ, 184*(17), pp.1885-1892.

Harris, S.J., Janssen, P.A., Saxell, L., Carty, E.A., MacRae, G.S. and Petersen, K.L., 2012. Effect of a collaborative interdisciplinary maternity care program on perinatal outcomes. *CMAJ, 184*(17), pp.1885-1892.

Heberlein, E.C., Smith, J.C., Marton, J., Otekunrin, A., LaBoy, A., Britt, J.L. and Crockett, A.H., 2023. Well child visit attendance for group prenatal care participants. *Academic Pediatrics, 23*(2), pp.296-303.

Hodgson, Z.G., Saxell, L. and Christians, J.K., 2017. An evaluation of Interprofessional group antenatal care: a prospective comparative study. BMC Pregnancy and childbirth, 17, pp.1-9.

Ickovics, J.R., Earnshaw, V., Lewis, J.B., Kershaw, T.S., Magriples, U., Stasko, E., Rising, S.S., Cassells, A., Cunningham, S., Bernstein, P. and Tobin, J.N., 2016. Cluster randomized controlled trial of group prenatal care: perinatal outcomes among adolescents in New York City health centers. *American journal of public health, 106*(2), pp.359-365.

Ickovics, J.R., Kershaw, T.S., Westdahl, C., Magriples, U., Massey, Z., Reynolds, H. and Rising, S.S. 2007. Group prenatal care and perinatal outcomes: a randomized controlled trial. *Obstetrics & Gynecology, 110*(2 Part 1), pp.330-339.

Ickovics, J.R., Kershaw, T.S., Westdahl, C., Rising, S.S., Klima, C., Reynolds, H. and Magriples, U. 2003. Group prenatal care and preterm birth weight: results from a matched cohort study at public clinics. *Obstetrics & Gynecology, 102*(5 Part 1), pp.1051-1057.

Jafari, F., Eftekhar, H., Fotouhi, A., Mohammad, K. and Hantoushzadeh, S. 2010. Comparison of maternal and neonatal outcomes of group versus individual prenatal care: a new experience in Iran. *Health Care for Women International, 31*(7), pp.571-584.

Jones, T.H., Crump, W.J., Foster, S.M., Mullins, S.J. and Farris, A.N., 2023. Group prenatal care vs. traditional prenatal care: a parity-matched comparison of perinatal outcomes in a rural community. *Maternal and Child Health Journal, 27*(4), pp.575-581.

Kennedy, H.P., Farrell, T., Paden, R., Hill, S., Jolivet, R.R., Cooper, B.A. and Schindler Rising, S., 2011. A randomized clinical trial of group prenatal care in two military settings. *Military medicine, 176*(10), pp.1169-1177.

Klima, C., Norr, K., Vonderheid, S. and Handler, A., 2009. Introduction of CenteringPregnancy in a public health clinic. *Journal of midwifery & women's health, 5*4(1), pp.27-34.

Kominiarek, M.A., Crockett, A., Covington-Kolb, S., Simon, M. and Grobman, W.A., 2017. Association of group prenatal care with gestational weight gain. *Obstetrics & Gynecology, 129*(4), pp.663-670.

Kominiarek, M.A., Gray, E.L., Vyhmeister, H., Grobman, W. and Simon, M., 2018. Association of gestational weight gain with prenatal care model. *Journal of midwifery & women's health, 63*(3), pp.283-288.

Lazar, J., Boned-Rico, L., Olander, E.K. and McCourt, C., 2021. A systematic review of providers' experiences of facilitating group antenatal care. *Reproductive Health, 18*, 180.

Liu, Y., Wang. Y., Wu, Y., 2021. Effectiveness of the CenteringPregnancy program on maternal and birth outcomes: a systematic review and meta-analysis. *Int J Nurs Stud*, 120.

Lori, J.R., Ofosu-Darkwah, H., Boyd, C.J., Banerjee, T. and Adanu, R.M., 2017. Improving health literacy through group antenatal care: a prospective cohort study. *BMC Pregnancy and Childbirth, 17*, pp.1-9.

Mazzoni, S.E., Hill, P.K., Webster, K.W., Heinrichs, G.A. and Hoffman, M.C., 2016. Group prenatal care for women with gestational diabetes. T*he journal of maternal-fetal & neonatal medicine, 29*(17), pp.2852-2856.

Momodu, O.A., Horner, R.D., Liu, J., Crouch, E.L. and Chen, B.K., 2023. Participation in the CenteringPregnancy Program and Pregnancy-Induced Hypertension. *American Journal of Preventive Medicine, 65*(3), pp.476-484.

Orgill, M. & Gilson, L. (2018). 'Policy Implementation' in Gilson, L. Orgill, M. & Shroff, Z. (eds.) A Health Policy Analysis Reader: The politics of policy change in low- and middle-income countries. Geneva: World Health Organisation, pp. 81 – 90.

Patberg, E., Young, M., Archer, S., Duininck, G., Li, J., Blackwell, C., Lathrop, E. and Haddad, L., 2021. Postpartum contraceptive use and other reproductive health outcomes among CenteringPregnancy group prenatal care participants. *Journal of Women's Health, 30(*7), pp.990-996.

Picklesimer, A.H., Billings, D., Hale, N., Blackhurst, D. and Covington-Kolb, S., 2012. The effect of CenteringPregnancy group prenatal care on preterm birth in a low-income population. *American Journal of Obstetrics and Gynecology, 206*(5), pp.415-e1.

Potter, J.E., Duthely, L.M., Diaz-Mendez, N., Smith, L., Messick, B.J., Echenique, M., Galli, J., Yasin, S. and Villar-Loubet, O., 2019. Implementing CenteringPregnancy group prenatal care for minority women living with HIV at an urban university hospital. *Journal of midwifery & women's health, 64*(4), pp.451-461.

Rabin, B.A., Brownson, R.C., Haire-Joshu, D., Kreuter, M.W. and Weaver, N.L., 2008. A glossary for dissemination and implementation research in health. *Journal of Public Health Management and Practice, 14*(2), pp.117-123.

Rising, S.S., 1998. Centering pregnancy: an interdisciplinary model of empowerment. *Journal of Nurse-Midwifery, 43*(1), pp.46-54.

Risisky, D., Chan, R.L., Zigmont, V.A., Asghar, S.M. and DeGennaro, N., 2018. Examining delivery method and infant feeding intentions between women in traditional and non-traditional prenatal care. *Maternal and Child Health Journal, 22*, pp.274-282.

Sadiku, F., Bucinca, H., Talrich, F., Molliqaj, V., Selmani, E., McCourt, C., Rijnders, M., Little, G., Goodman, D.C., Rising, S.S. and Hoxha, I., 2024. Maternal satisfaction with group care: a systematic review. *AJOG Global Reports, 4*(1), p.100301.

Sigmon, K., Parlier, A.B., Descieux, M.A., Scott, K.R., and Galvin, S.L., 2017. Care utilization and birth outcomes among women obtaining CenteringPregnancy group prenatal care. *MAHEC Online Journal of Research, 3*(2), pp1-12.

Stirman, S.W., Miller, C.J., Toder, K. and Calloway, A., 2013. Development of a framework and coding system for modifications and adaptations of evidence-based interventions. *Implementation Science, 8,* pp.1-12.

Sayinzoga, F., Lundeen, T., Musange, S.F., Butrick, E., Nzeyimana, D., Murindahabi, N., Azman-Firdaus, H., Sloan, N.L., Benitez, A., Phillips, B. and Ghosh, R., 2021. Assessing the impact of group antenatal care on gestational length in Rwanda: A cluster-randomized trial. *Plos One, 16*(2), p.e0246442.

Schellinger, M.M., Abernathy, M.P., Amerman, B., May, C., Foxlow, L.A., Carter, A.L., Barbour, K., Luebbehusen, E., Ayo, K., Bastawros, D. and Rose, R.S., 2017. Improved outcomes for Hispanic women with gestational diabetes using the Centering Pregnancy© group prenatal care model. *Maternal and child health journal, 21*, pp.297-305.

Smith, A.M., Zainab, M. and Lian, B., 2020. Effects of CenteringPregnancy on Pregnancy Outcomes and Health Disparities in Racial Groups versus Traditional Prenatal Care. *Journal of the Georgia Public Health Association, 8*(1), pp.52-57.

Tandon, S.D., Colon, L., Vega, P., Murphy, J. and Alonso, A., 2012. Birth outcomes associated with receipt of group prenatal care among low-income Hispanic women. *Journal of midwifery & women's health, 57*(5), pp.476-481.

Tanner-Smith, E.E., Steinka-Fry, K.T. and Gesell, S.B., 2014. Comparative effectiveness of group and individual prenatal care on gestational weight gain. *Maternal and child health journal, 18*, pp.1711-1720.

Tanner-Smith, E.E., Steinka-Fry, K.T. and Lipsey, M.W., 2014. The effects of CenteringPregnancy group prenatal care on gestational age, birth weight, and fetal demise. *Maternal and child health journal, 18*, pp.801-809.

Tilden, E.L., Emeis, C.L., Caughey, A.B., Weinstein, S.R., Futernick, S.B. and Lee, C.S., 2016. The influence of group versus individual prenatal care on phase of labor at hospital admission. *Journal of Midwifery & Women's Health, 61*(4), pp.427-434.

Trotman, G., Chhatre, G., Darolia, R., Tefera, E., Damle, L. and Gomez-Lobo, V., 2015. The effect of centering pregnancy versus traditional prenatal care models on improved adolescent health behaviors in the perinatal period. *Journal of pediatric and adolescent gynecology, 28*(5), pp.395-401.

Trudnak, T.E., Arboleda, E., Kirby, R.S. and Perrin, K., 2013. Outcomes of Latina women in CenteringPregnancy group prenatal care compared with individual prenatal care. *Journal of midwifery & women's health, 58*(4), pp.396-403.

Tubay, A.T., Mansalis, K.A., Simpson, M.J., Armitage, N.H., Briscoe, G. and Potts, V., 2019. The effects of group prenatal care on infant birthweight and maternal well-being: a randomized controlled trial. *Military Medicine, 184*(5-6), pp.e440-e446.

Van Damme, A., Talrich, F. Crone, M., Rijnders, M., Patil, C.L., Rising, S.S., Abanga, J., Billings, D.L., Hindori-Mohangoo, A., Hindori, M., Martens, N., Matthews, S., Molliqaj, V., Orgill, M., Slemming, W., Beeckman, K., [n.d]. Identifying anticipated challenges when implementing Centering-Based Group Care in the first thousand days: extensive context-analyses across seven countries to develop an Anticipated Challenges Framework. *Submitted for review*.

Walton, R.B., Shaffer, S. and Heaton, J., 2015. Group prenatal care outcomes in a military population: a retrospective cohort study. *Military medicine, 180*(7), pp.825-829.

Walton, S., Roberson, K., Onsomu, E.O., Hall, S. and Dearman, C., 2021. Evaluating Centering group prenatal care in rural women with low socioeconomic status to promote access to care and improve pregnancy outcomes. *Journal of Public Health, 29*, pp.285-291.

Wagijo, M.A., Crone, M., Bruinsma-van Zwicht, B., van Lith, J., Billings, D. and Rijnders, M., 2024. The Effect of CenteringPregnancy Group Antenatal Care on Maternal, Birth, and Neonatal Outcomes Among Low-Risk Women in the Netherlands: A Stepped-Wedge Cluster Randomized Trial. *Journal of Midwifery & Women's Health, 69*(2), pp.191-201.

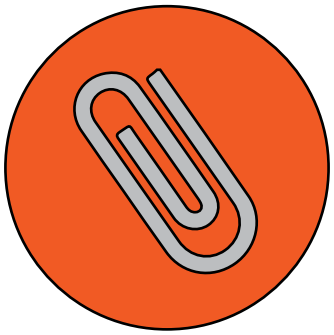
Wiggins, M., Sawtell, M., Wiseman, O., McCourt, C., Eldridge, S., Hunter, R., Bordea, E., Mustard, C., Hanafiah, A., Hatherall, B. and Holmes, V., 2020. Group antenatal care (Pregnancy Circles) for diverse and disadvantaged women: study protocol for a randomised controlled trial with integral process and economic evaluations. *BMC Health Services Research, 20*, pp.1-14.

Wiltsey Stirman, S., Baumann, A.A. and Miller, C.J., 2019. The FRAME: an expanded framework for reporting adaptations and modifications to evidence-based interventions. *Implementation Science, 14*, pp.1-10.

Wiseman, O., Hunter, L., Robinson, H., Leap, N. and Mackeith, N. on behalf of the REACH Pregnancy Programme team. (2017) Advancing Practice: Facilitating group antenatal care: a new way of working. *The Practising Midwife,* 20(9), pp. 18-20.

World Health Organization. 2010. *Nine steps for developing a scaling up strategy*. World Health Organization and Expand.net. Switzerland.

World Health Organisation. 2016. *WHO recommendations on antenatal care for a positive pregnancy experience.* WHO, Switzerland.



APPENDICES

Appendix 1: Group Care global site readiness assessment (SRA) for implementation of Group Care (antenatal)

Completing this form will help you to determine the readiness of your clinical site to implement group *antenatal* care.

Please complete a separate form for each site.

Date completed (Day/Month/Year)
Completed by
Title

COUNTRY:

SITE NAME:

Please mark the number that best indicates the readiness of the site, according to each category

Administrative Support	
	None or unknown
	Beginning support Key administrator(s) have been contacted about plans to begin work on possible model implementation and indicated initial support/interest
	Fully supportive; part of planning Key administrator(s) supportive of moving forward with implementation work and are part of the planning team

Clinical Staff Involvement	
	None or unknown
	Early involvement in planning Key clinicians interested in participating in the model project. Beginning information reviewed on the model
	Champion involved Familiarity with Group Care models. There are key providers, including midwives and physicians, actively involved in the planning

Population Served	
	Not identified or fewer than 15 pregnant women of similar gestational age available per month to make a cohort
	Between 15-30 women available per month to make a cohort Some data regarding general risk factors, suitability for Group Care
	30+ women available per month to make a cohort Numbers available on antenatal registrants/month, assurance that there are enough women to easily make monthly cohorts of 8-12 women with similar gestation

Space for Groups	
	No identified appropriate space
	Access to appropriate space The space available is private and will hold at least 20 chairs/pillows in an open circle. Recommended: at least 20 ft x20 ft / 6m x 6m; square is better than rectangular
	Dedicated appropriate space available All of the above (#1) but space is dedicated to the group implementation so doesn't need to be set up/rearranged for every group. In general, it is better to have a space that is too big rather than one that is on the small side

Funding for Group Care	
	None identified
	In-kind funding available to support group needs
	Internal or ongoing grant funding available for sustaining the model after the grant ends

Evaluation of Group Care	
	No data available or accessible for evaluation
	Data collection taking place at the site Site has a process for collecting basic data on patients including baselines, such as registration for care and attendance
	Site committed to data collection and evaluation Besides basic data collection there is evaluation of health outcomes based on site benchmarking

Language: Group Participant cohort formation	
	Forming group cohorts difficult due to multiple language challenges
	Separate groups based on language needed for communication Education materials available in a variety of languages
	Language not an issue for placement in groups Education materials available

1. **Other assessment items for comment:**

2. **Site Self-Assessment:**

3. **Notes from discussion with GCG:**

Appendix 2: Group Care global site readiness assessment (SRA) for implementation of Group Care (postnatal)

Completing this form will help you to determine the readiness of your clinical site to implement group *postnatal* care.

Please complete a separate form for each site.

Date completed (Day/Month/Year)
Completed by
Title

COUNTRY:

SITE NAME:

Please mark the number that best indicates the readiness of the site, according to each category

Administrative Support	
	None or unknown
	Beginning support Key administrator(s) have been contacted about plans to begin work on possible model implementation and indicated initial support/interest
	Fully supportive; part of planning Key administrator(s) supportive of moving forward with implementation work and are part of the planning team

Clinical Staff Involvement	
	None or unknown
	Early involvement in planning Key clinicians interested in participating in the model project. Beginning information reviewed on the model and/or have experience with antenatal groups
	Champion involved Familiarity with Group Care models. There are key providers, including midwives and physicians, actively involved in the planning

Population Served	
	Fewer than 6 mothers/babies of similar gestation to form a cohort
	More than 6 mothers/babies of similar gestation to form a cohort
	Antenatal groups active, with ability to transition into postnatal groups

Space for Groups	
	No identified appropriate space
	Access to appropriate space The space available is private and safe for babies to crawl. Room for at least 15 pillows on the floor in a circle. Recommended: at least 20 ft x20 ft / 6m x 6m; square is better than rectangular.
	Dedicated appropriate space available All of the above (#1) but space is dedicated to the group implementation so doesn't need to be set up/rearranged for every group. In general, it is better to have a space that is too big rather than one that is on the small side

Funding for Group Care	
	None identified
	In-kind funding available to support group needs
	Internal or ongoing grant funding available for sustaining the model after the grant ends

Evaluation of Group Care	
	No data available or accessible for evaluation
	Data collection taking place at the site Site has a process for collecting basic data on patients including baselines, such as registration for care and attendance
	Site committed to data collection and evaluation Besides basic data collection there is evaluation of health outcomes based on site benchmarking

Language: Group Participant cohort formation	
	Forming group cohorts difficult due to multiple language challenges
	Separate groups based on language needed for communication Education materials available in a variety of languages
	Language not an issue for placement in groups Education materials available

1. **Other assessment items for comment:**

2. **Site Self-Assessment:**

3. **Notes from discussion with GCG:**

Appendix 3: Identifying a Group Care appropriate space

Providing care in groups requires very different space than that required for individual care. While individual care requires small private rooms, the group requires a room that is estimated at 900-1000 square feet (depending on the amount of participants). The room will work best if it is basically square or at least not long and narrow. With two to three tables along the wall, that would leave remaining space for the group circle which should accommodate 20-24 people comfortably (is for example support people are included). You may reorganise an existing space or use existing meeting or waiting rooms. Practices that use dual-purpose rooms find that set up and break down of the room for group use can be time-consuming. Ideally space will be designated for the sole purpose of conducting Group Care.

Having dedicated space will also allow more groups to be conducted throughout the day.

1. Do we have a group space that:	Yes/No	Describe
Is private?		
Is quiet?		
Has comfortable seating and is welcoming?		
Has nearby bathroom access?		
Has a storage cabinet or moveable cart for education Items?		
Has adequate lighting, windows are best?		
Has the ability to control room's temperature?		
Room can be arranged so participants can sit in a circle without a table in the middle.		
Has a table that can hold check-in materials?		
Has an assessment corner that provides some privacy?		
Is easily accessible?		

2. **Explore the availability of the group space.**

   a. Does the group space need to be found away from the health center such as in a community building?

   b. Is the space multi-purpose? How will this impact scheduling of the room? Will the space be available when you need it?

3. **Describe any cultural considerations or challenges that may impact your space or Group Care facilitation.**

   a. Will partners be included or excluded?

Appendix 4: Checklist for equipment and materials needed for antenatal Group Care

Equipment and materials	Yes/No
Flip chart or other writing board (if available and if appropriate)	
An appropriate place for pregnant women and/or parenting people to lay on when the clinical assessment is conducted.	
Blood pressure device	
Adult weighing scale	
Name tags	
Chart or other forms for recording of personal health data	
Drinking water, small healthy snack if available	
Materials to support interactive activities	
Facilitator's Guide for each facilitator	

Appendix 5: Checklist for equipment and materials required for postnatal Group Care

Equipment and materials	Yes/No
Safe space for babies once they reach 6 months and are able to crawl	
Flip chart or other writing board	
An appropriate place to lay the baby for assessment	
Adult scale	
Baby scale	
Baby length board or other measuring device	
Tape measure	
Name tags	
Chart or other forms for recording of health data	
Drinking water, small healthy snack if available	
Materials to support interactive activities	
Facilitator's Guide for each facilitator	

Appendix 6: Worksheet – Building staff support

When thinking about building staff support it is important to consider who and how decisions are made within your health facility so that you identify the relevant people to support the implementation of Group Care. Provide an organisational chart, if possible.

In the following tables, note who is already on board with implementing Group Care and who needs to be brought in to join the team.

Key Personnel involved in decision making		**On Steering Committee?** Yes/No/Should Be	**Describe potential involvement with Group Care** (facilitator, data manager, scheduler, etc.)
Name	**Title/Position**		

Healthcare Providers (Midwives, physicians, nurses, etc.)		**On Steering Committee?** Yes/No/Should Be	**Describe potential involvement with Group Care**
Name	**Title/Position**		

Support Staff (Social Workers, Nutritionists, Receptionists, Community Health Workers, Patients, etc.)		**On Steering Committee?** Yes/No/Should Be	**Describe potential involvement with Group Care**
Name	**Title/Position**		

1. **Describe how familiar your administration is with Group Care.**

2. **Outline any experience your health care providers have with the Group Care model and/or group facilitation.**

Appendix 7: Model fidelity checklist for antenatal and postnatal Group Care

Questions about Training and Planning and Running Groups	Answers and Descriptions:
Have facilitators been to workshop where they were trained in facilitation and listening skills?	List when and where they attended.
What health measures will each patient collect?	
Where do patients record and keep their own health measures? (This could be on a maternity card, pages from the patient-facing materials, or other forms)	
What is the pre-determined number of sessions?	
Are educational content/activities planned that are flexible/adaptable to women's needs?	
Are group members, including the clinician facilitator, the staff facilitator and support people, consistent throughout the group cohort sessions?	

Is there a dedicated space for the group in which Group Care is given scheduling priority?	
Are children present? Or is there a plan for child care?	
Questions about Evaluation and Reflection	**Answers and Descriptions:**
What is the site's plan to record/ evaluate selected data (outcomes or processes)?	
Who will be responsible for the data collection?	
Do group facilitators reflect/plan/adapt after each session?	
Do group participants have opportunities to provide feedback on group process and functioning?	

Monitoring Group Care fidelity[2]

Component: Health Care		
FACE-TO-FACE	**Yes/No/NA**	**Comments**
Health assessments happen in the group space.		
IF FACE-TO-FACE		
Antenatal assessment with clinician occurs with privacy on floor mat or low bench/table.		
Assessment time is limited to approximately 3-5 minutes per person.		
IF VIRTUAL		
Patients engage in self-care activities		
Women assess own health data such as: weight, blood pressure and urine or other testing as indicated by protocol		
Data is recorded and kept by each patient.		

2 A facilitator can use this as a reflective tool to ensure you are staying close to the threecore components of Group Care.

Component: Interactive Learning		
Groups are facilitated to be interactive.		
Facilitators appear to use listening skills.		
Activities encourage interaction.		
Sharing among the group members is encouraged.		
Formal didactive (lecture) presentations are not used.		
Groups are conducted in a circle		
IF FACE-TO-FACE		
An open circle without a central table is used		
All facilitators, patients and support people are in the circle when the formal circle-up begins		

IF VIRTUAL		
All participants can be seen on the screen		
Each session has a plan, but emphasis may vary.		
Facilitators appear to have planned for the session.		
Facilitators are responsive to the needs of the women during the group session.		
Group size is optimal for interaction.		
Group size is 8-12 patient members.		
_____Number of facilitators _____Number of support people _____Number of patients _____Number of others		
Space is private.		

Space is conducive to group sharing.**There are no disruptions (phone calls, people coming in and out of the space, overhead speakers, etc.)*			
Component: Community Building			
Group members, including facilitators and support people, are consistent.			
If there is a new member, that person is welcomed and introduced to the group.			
Confidentiality reminders are used if any new members or support people join the group.			
Both clinician facilitator and co-facilitator are present for the entire session.			
There is time for socialising.			
There is unstructured time for informal interaction.			
There is access to drinking water.			

There are snacks available			
There is an interactive opening.			
There is an interactive closing.			

Overall Assessment:

1. **To what extent was the group didactic (lecture) v. facilitative today? (circle one number)**

Didactic 0 1 2 3 4 5 6 7 8 9 10

2. **How much were group members involved and connected? (circle one number)**

Didactic 0 1 2 3 4 5 6 7 8 9 10

Appendix 8: Worksheet for applying the Anticipated Challenges Framework for Group Care

Anticipated challenges category	Description of the anticipated challenges	Expected barriers/ facilitators to tack-le the anticipated challenges	Action plan: What/who/ when?
SURFACE STRUCTURE ANTICIPATED CHALLENGE			
1. Content			
2. Materials			
3. Facilitators			
4. Timing			
5. Location			

6.	Group composition			
DEEP STRUCTURE ANTICIPATED CHALLENGE				
7.	Health assessment			
8.	Scheduling Group Care into regular care			
9.	Enrolment			
10.	(Possible) partner organisations			
11.	Financials			

Source: Van Damme et al. (nd)

Appendix 9: Examples of antenatal and postnatal topics in a Facilitator Guide

Antenatal topic examples

Session #	Topics	Timing: # weeks gestation and postpartum	Outcomes of interest
2	Changes in Body in Pregnancy Self Esteem Exercise & Relaxation Common Discomforts	16-20 weeks	Live birth Healthy pregnancy Self-esteem/Self-worth
3	Stress Management Infant Nutrition & Breastfeeding Alcohol & Substance Use Healthy Family Relationship	20-24 weeks	Live birth Healthy pregnancy Self-esteem/Self-worth Partner involvement Return to school/work Family and other social support Feeding methods over time
4	Goals for my family Intimate Partner Violence Family Planning	24-28 weeks	Live birth Healthy pregnancy Self-esteem/Self-worth Partner involvement Family and other social support Contraceptive initiation
5	Safer Sex Preparing for birth	26-30 weeks	Live birth Healthy pregnancy Self-esteem/Self-worth Partner involvement Family and other social support
6	Goals for myself before another baby Labour & Birth	28-32 weeks	Live birth Healthy pregnancy Contraceptive initiation Return to school/work

7	New Baby Care Bonding with Baby Postpartum Mental Health	30-34 weeks	Live birth Healthy pregnancy Partner involvement Family and other social support Contraceptive initiation Pre-/ Postpartum depressive symptoms
8	Bringing baby home Changing Relationships Stress and Postpartum Resource Circle Building	36-40 weeks	Live birth Healthy pregnancy Partner involvement Family and other social support Contraceptive initiation Pre-/Postpartum depressive symptoms

Postnatal topic examples

Session #	Topics	Timing: # weeks gestation and postpartum	Outcomes of interest
Postnatal Sessions: *Flexibility regarding scheduling to accommodate varied delivery dates. Group Care suggests frequent sessions during the early postpartum period to address RRP.*			
9	Maternal Physical Wellbeing Changes in my postpartum body Infant Nutrition & Safe Sleep	2-3 weeks postpartum	Healthy (live) mother Live birth Partner involvement Family and other social support Contraceptive initiation Postpartum depressive symptoms
10	Family Planning Choices Sleep for me and baby Postpartum Mental Health Immunizations	6 weeks postpartum	Healthy (live) mother Healthy baby Partner involvement Family and other social support Contraceptive initiation/ continuation Postpartum depressive symptoms Immunisations

11	Support Network Baby Development Playing with Baby	10-14 weeks pp (2 months) *	Healthy (live) mother Healthy baby Partner involvement Family and other social support Contraceptive initiation/ continuation Postpartum depressive symptoms Immunisations
12	Baby feeding and sleeping behaviors. Childcare; school, work issues	14-18 weeks pp (4 months) *	Return to school/work Contraceptive initiation/ continuation Immunizstions
13	Baby development Feeding issues Oral health	18-22 weeks pp (5 months)	Contraceptive initiation/ continuation Family and other social support Postpartum depressive symptoms Immunisations
14	Interpersonal relationships Negotiation skills; contraception use Baby development	22-26 weeks pp (6 months) *	Contraceptive initiation/ continuation Family and other social support Postpartum depressive symptoms Immunisations
15	Safety issues Baby feeding	9 months postpartum	Contraceptive initiation/ continuation Family and other social support Immunisations
16	Baby development Personal goals Nutrition and exercise	1 year**	Immunisations Return to work/school
17	Parenting skills Nutrition Language development Baby behavior	15 months	Self-esteem /self-worth Healthy foods
18	Self-care goals Toilet training Contraception	18 months	Self-esteem /self-worth Contraceptive initiation/ continuation
19	Celebration!	2 years	

Appendix 10: List of key items you will need for training

1	A trainer who is skilled to provide Group Care training
2	The staff or persons who will be trained should be available to attend the full training
3	A room that can accommodate 12-20 people
4	Appropriate seating placed in a circle flip chart or writing board
5	Tools for Health Assessment in Group Care such as a blood pressure machine for self-assessments, weighing scale (mom or baby), laboratory forms etc.
6	Availability of bathroom and drinking water
7	Bring (examples of) materials that will probably be used in Group Care sessions, for example: a discussion about good nutrition would include pictures of foods that would make up a balanced diet

Appendix 11: Group Facilitator self-evaluation checklist

Group Care: Facilitator Self-Evaluation	
A. Group Care session number: _____	B. Date: ____/____/_____
C. Length of this session[3*]: _____ minutes	D. Virtual or in-person:
E. Group name or number:	
F. Number and professional category of the facilitators:	
G. Number of women expected: _____	H. Number of women in attendance today: _____
I. Number of support people in attendance: _____	
J. Number of women needing additional care and/or a referral today: _____	

Key Practices Evaluation			
1.	Did the group start and end at the scheduled time?	☐ YES	☐ NO
2.	Were the two regular facilitators, including a clinician, present?	☐ YES	☐ NO
3.	Did health assessments take place in Group Care?	☐ YES	☐ NO
4.	Did all women participate in collecting their own health data?	☐ YES	☐ NO
5.	Did discussion take place in a circle?	☐ YES	☐ NO
6.	Did women have informal time to talk with each other?	☐ YES	☐ NO
7.	Did you follow the lead of the women and adjust the session plan to respond to the women's needs and interests?	☐ YES	☐ NO
8.	Were you both well-prepared today? For example, you knew the material and led interactive discussions and activities.	☐ YES	☐ NO
9.	Did you ask open-ended questions to promote discussion?	☐ YES	☐ NO
10.	Did you have a formal opening and closing?	☐ YES	☐ NO
11.	On average, how long did a health assessment take for each patient?	_____minutes	
12.	Overall, to what extent was this session more like a class/lecture or more like a discussion?	Mostly a class/lecture	
		Half class/lecture and half discussion	
		Mostly a discussion	

3 * Count from time you start the group to when you finish group (do not count preparation and follow up/clean up time)

13.	Overall, what was the level of engagement and connectedness (sharing ideas, feelings, and experiences) among women throughout this session?	Very Low level of engagement	
		Medium to high level of engagement	
		Very High level of engagement	
14.	Overall, how much time did you, the facilitators, speak compared to women?	We spoke a lot more than the women	
		We spoke equal amounts of time	
		Women spoke a lot more than we did	

REFLECTION QUESTIONS: (these questions are optional, but many facilitators find this exercise useful for their own reflection and it would also enrich our evaluation)

What went well today?

What could have gone better?

What is our plan for the next session?

Appendix 12: Vertical and Horizontal scale-up worksheets

Vertical scale-up (institutionalisation) worksheet

What are the policy, political, legal, regulatory, budgetary, programmatic, operational or other health systems changes needed to institutionalise Group Care at the national or sub-national level?

Use this worksheet in team or Steering Committee meetings, and in convenings with stakeholders. The worksheet can be revised over time to monitor progress, check on elements that are not moving forward, and to document successes.

Element	Comments
Who will advocate for changes needed (for sustainability)?	
What resources are needed? Also comment on potential sources of resources	
What mechanisms are in place for monitoring and evaluating / assessing policy, legal, organisational, and institutional strategies for scaling-up?	

Horizontal scale-up (expansion/replication) worksheet

What's needed to implement Group Care in different sites or extended to serve larger and/or different population groups?

Use this worksheet in team or Steering Committee meetings, and in convenings with stakeholders. The worksheet can be revised over time to monitor progress, check on elements that are not moving forward, and to document successes.

Element	Comments
Have other sites been identified? If so, what are they? Have they been approached?	
Have specific population groups been identified for Group Care? If so, who are they?	
Who are other key stakeholders?	
Have key stakeholders been approached?	
What resources are needed? Also comment on potential sources of resources	
What (social) media/communication resources are needed?	
What organisations and institutions need to be engaged?	
What tools are needed to expand to other sites or different populations (eg website content, curriculum, job aids)	
Does the capacity to monitor and evaluate expansion exist? In your organisation? In the health system? Other places?	

Appendix 13: Worksheets for tracking sustainment and sustainability of Group Care implementation

Worksheet for tracking sustainment of Group Care implementation

DATE COMPLETED:	
Sustainment element *What are the elements that make current Group Care implementation possible?*	**Where are you now?** **What do you need at this moment to keep implementation active?** **What's working well and why?**
FINANCIAL RESOURCES FOR GROUP CARE	
Financial resources available to continue Group Care at sites where implemented	
Financial resources available to scale up Group Care beyond sites where implemented	
TRAINING ISSUES	
Refresher training and support for *existing* trainers	
Training and supporting *new trainers*: estimated 3 to 4 in-country trainers	
Training and supporting *new group facilitators*	
POLICIES AND PROTOCOLS	
Policies to support Group Care at country level *General guidelines for implementing decisions and actions within health systems- to promote wellness and ensure that specific health goals are met*	
Protocols to support Group Care at site level ***W**ritten directions and orders, consistent with the department's standard of care, that are to be followed (these are very localised)*	
PAYMENT FOR SERVICES	
Logistics for how health systems/ services will receive payment for services	
STEERING COMMITTEES	
Continuity of/ support for Steering Committees at existing sites	
Establishment of new Steering Committees (at local, district, national levels)	

DATA	
Using Group Care data for decision making	
Plans for continued data gathering for evaluation	
Plans for dissemination of results	
CHANGES IN HEALTH SYSTEMS	
Clinical care changes needed in health systems to change the model of clinical care (name and discuss)	
Other systems issues (e.g. scheduling, staffing, spaces for groups, data systems)	
COMMUNITY OF PRACTICE	
Participation in a Community of Practice (local, regional, global)	

Worksheet for tracking Sustainability in the implementation of Group Care

DATE COMPLETED:	
Sustainability element *What are the elements that will sustain Group Care into the future (1, 5, 10 years and beyond)?*	**Plans to Sustain beyond X DATE**
FINANCIAL RESOURCES FOR GROUP CARE	
Financial resources available to continue Group Care at sites where implemented	
Financial resources available to scale up Group Care beyond sites where implemented	
TRAINING ISSUES	
Refresher training and support for *existing* trainers	
Training and supporting *new trainers*: estimated 3 to 4 in-country trainers	
Training and supporting *new group facilitators*	
POLICIES AND PROTOCOLS	
Policies to support Group Care at country level *General guidelines for implementing decisions and actions within health systems- to promote wellness and ensure that specific health goals are met*	

Protocols to support Group Care at site level ***W**ritten directions and orders, consistent with the department's standard of care, that are to be followed (these are very localised)*	
PAYMENT FOR SERVICES	
Logistics for how health systems/ services will receive payment for services	
STEERING COMMITTEES	
Continuity of/ support for Steering Committees at existing sites	
Establishment of new Steering Committees (at local, district, national levels)	
DATA	
Using Group Care data for decision making	
Plans for continued data gathering for evaluation	
Plans for dissemination of results	
CHANGES IN HEALTH SYSTEMS	
Clinical care changes needed in health systems to change the model of clinical care (name and discuss)	
Other systems issues (e.g. scheduling, staffing, spaces for groups, data systems)	
COMMUNITY OF PRACTICE	
Participation in a Community of Practice (local, regional, global)	

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