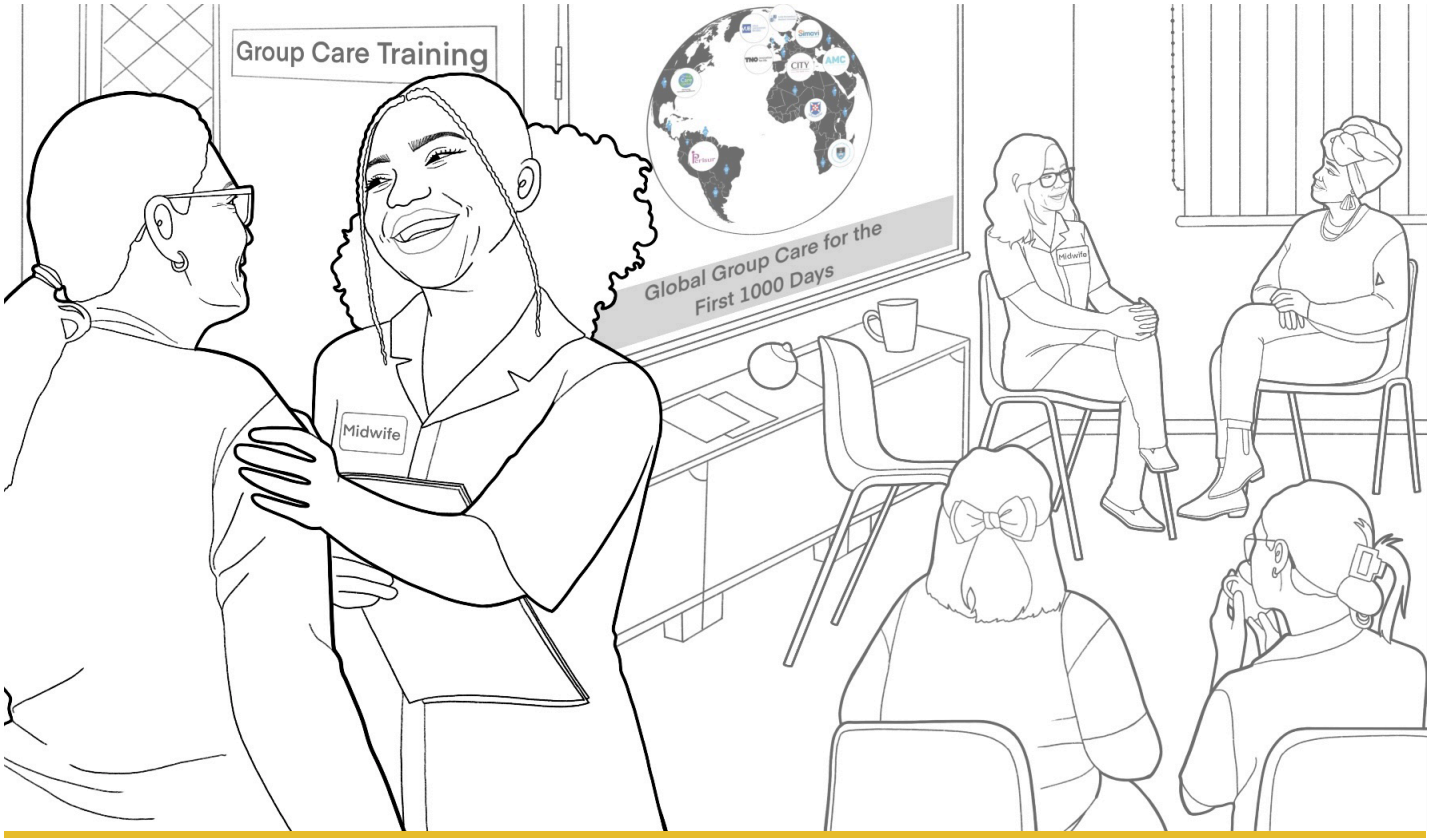
IMPLEMENTING GROUP CARE



SUMMARY

Centering-based group antenatal and postnatal care (gAPNC) can improve quality of care. Implementation benefits from enthusiasts and careful planning. A steering committee to oversee planning, implementation and evaluation keeps the fire alive and can provide support for the whole implementation team. gAPNC can be adapted to the local needs to fit as best as possible with the implementing organisation and its population. Sustainability requires ongoing training and support for practitioners. This article provides insights, tips and tricks for those that are wishing to implement gAPNC.

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MISCARRIAGE IS GENERALLINFDITHA BACKGROUND

Group care originated in the United States as CenteringPregnancy in the early 1990s and since then gAPNC has spread around the world including Iran, India, China, Australia, Iceland, UK, Ireland, Belgium, Kosovo, Mexico, Brazil, Suriname, South Africa, Ghana, Tanzania, Malawi and Zanzibar. Significant scale-up of the model has occurred in the Netherlands, Afghanistan, Nigeria and Kenya, where it has been integrated into standard care and national guidelines. Kosovo is in the process of scaling up the model in the whole country during 2024-2025. While most implementation has focused on group antenatal care (gANC), the model has also been extended into the postnatal period covering the first 1000 days and providing opportunities for inter-disciplinary working between midwives and family support workers (see Spotlight article). In some areas, postnatal-only groups (gPNC) have been implemented. gAPNC can be situated

in healthcare facilities to encourage integration and improve utilisation in low and middle-income countries. In other areas situating gAPNC in the community allows women to be cared for where they live, normalising pregnancy and building social capital. gAPNC can be adapted to local needs to make it fit as best as possible with the implementing site and its population. This article is aimed at supporting midwives, managers and key stakeholders wishing to implement and sustain gAPNC.

PREPARATION

IIn some countries, such as the Netherlands, the model was introduced via individual midwives and a bottom-up approach. However, to effectively implement gAPNC, a multifaceted and collaborative approach involving various stakeholders is beneficial.

To prepare and implement the gAPNC model, it is helpful to have a steering committee. This committee should include key people from different parts of the healthcare system. You would want administrators to handle planning and logistics, as well as midwives, nurses and doctors who provide care. It is also good to have other professionals who support women, birthing people and childcare, and even include some women, birthing people and their families to make sure the committee understands the real needs of those who will use the service. The committee helps to ensure that the gAPNC model works well with existing healthcare policies and can get the support and funding it needs. This support can come from the healthcare system's budget, grants or partnerships. The committee is also there to help organise things like finding places to meet, training staff and keeping track of how well the program is doing.

IMPLEMENTATION PLANNING: START-UP CONSIDERATIONS

GROUP COMPOSITION

When aiming to implement gAPNC, there are some start-up considerations. First, an implementation site needs to decide what the group composition will look like. Sites may propose gAPNC to all pregnant women/birthing people or parents in the site, resulting in mixed groups regarding parity, language, clinical risk etc. gAPNC may even become the default model of antenatal/ postnatal care in the site. Alternatively, groups may be specialist aimed at a specific population, such as pregnant women/birthing people with HIV, single-language groups, diabetics, teenage parents etc. It is important to consider possible consequences when deciding on a target population. A specific group composition can have positive effects on community building, with people identifying with each other's situations.

On the other hand, these specialist groups can entail limitations, such stigma from being invited to a specific group, fewer support opportunities and limited coverage and input in the discussion because of lack of diversity. In practice, it appears that the facilitators feel insecure to mix people with different backgrounds and special needs, often with the best intentions to offer good care and create a safe environment for every participant. Whereas what often happens in practice with mixed groups is that the participants support each other and work out solutions amongst themselves. Besides the question of who to invite to the gAPNC, you may want to reflect on the inclusion of birth partners.

Another aspect concerning group composition is the number of participants. According to the gAPNC model, eight to 12 participants for gANC and six to ten parent-baby dyads for gPNC is ideal, both for group interaction and for feasibility to include the medical check, which is essential to the model. It is important to consider the potential impact of deviating from this. For instance, too large a group may leave little time for interactive discussion, as the medical check takes up more time. Too small a group, on the other hand, is more affected if a participant gives birth prematurely or moves away, and can also hinder interaction, causing the facilitator to have to take much more of a leadership role rather than a facilitative role. This facilitative role generates much more information from the group.

GAPNC FACILITATORS

Next to the participants of the group, organisations that plan to implement gAPNC have to make a decision on who will facilitate gAPNC. The gAPNC model describes two facilitators to facilitate the gAPNC sessions, of which at least one should be a healthcare practitioner. Two facilitators are strongly recommended because of the combination of individual check-up and group discussion, lowering the didactic tendency (not all eyes fixed on the facilitator) and being able to observe

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everyone in a big group. To reduce costs and create a better fit with the participants, the co-facilitator could be a non-clinician. Possible co-facilitators are social workers, health visitors, auxiliary nurses, psychologists, diabetic educators, students and so on.

Early implementation always requires additional staff time, as traditional care will probably continue alongside the gAPNC. Administrators and healthcare workers need to manage schedules well, which might mean changing how they usually work to fit in gAPNC sessions. This can include moving staff hours around, changing some of their other work duties and making sure the administrative systems can manage details such as how many people attend each session and when they happen. Thus, implementing gAPNC in a well-functioning team is helpful and the attitude of the staff is important: this is a very different way to provide antenatal/postnatal care, so practitioners with an interest in quality care and improvement projects would be ideal.

CONTENT OF THE GAPNC SESSIONS

Once you have an idea on what your group will look like, you can shape the content of your gAPNC sessions. This needs to be tied to the local and national perinatal guidelines and will depend on your target population and their needs, e.g., HIV screening and discussion will not play an equal role in every site but will depend on the context and target population. When shaping the content of the programme it is important to consider the inclusion of the three core components throughout (see Essentials article). In particular, the inclusion of the medical check in a gAPNC session often comes with challenges: how best to teach participants to undertake self-checking (e.g. blood pressure, baby weighing and other relevant screening tests), how to document gAPNC in routine maternal records, how to deal with bloods tests in the group environment, and so on.

ENROLMENT

A final start-up consideration encompasses consideration of how best to reach potential service users. In some sites, this enrolment process will be straightforward. For example, when gAPNC is offered to all pregnant women/birthing people or parents at the site. In this case, midwives carrying out the booking appointment can introduce the gAPNC model. In other sites, enrolment can be complex, especially when only women/birthing people or parents with certain characteristics are to be included, or the person inviting the women/birthing people or parents is not a gAPNC facilitator. It gets even more difficult when standard antenatal/postnatal care and gAPNC are provided by different organisations, and gAPNC facilitators thus depend on others for referrals. This is often the case in obstetrician-led countries where gAPNC is organised by midwives. In these contexts, collaboration with family doctors and obstetricians, who may serve as the first point of contact for pregnant women/birthing people in the healthcare system, is essential.

Clear understanding of who has which role in this enrolment process is necessary. Within the GC_1000 study (see Article of the Month), it became clear that the importance and complexity of this enrolment process was often underestimated. In general, a collaborative approach is needed with the various professionals that pregnant women/birthing people and parents encounter to reach potential participants. Additionally, the use of social media platforms and distribution of leaflets in community centres and healthcare facilities can broaden the reach and appeal of gAPNC, providing accessible information to a diverse audience. Ensuring the availability of interpreters during enrolment and the gAPNC sessions themselves will improve diversity, as will extending the enrolment period up to 20 weeks of pregnancy. This means that some participants may join the group after the first sessions, but it also ensures that late bookers, who generally have worse maternal and neonatal outcomes, have the opportunity to join gAPNC. These strategies, combined with direct engagement and informational sessions, can help build interest and enrol participants in the program.

PRACTICAL CONSIDERATIONS

Besides the start-up considerations, there are further practical considerations when implementing gAPNC. A first element is the provision of the necessary materials including clinical materials such as a blood pressure machine, a mat to sit on during the postnatal sessions with babies, chairs that can be arranged in a circle, as well as materials to facilitate the interactive group discussions. Consider where you can store materials between sessions.

Another obvious but very important practical consideration is where the gAPNC sessions will take place. Finding a suitable location is often challenging. The space should be large enough to accommodate a group, while also allowing the creation of a private corner within the group space for the individual medical check. Thereby, the suitability of the location has to be taken into account both for the participants (accessibility), the healthcare providers (close to workplace) and the organisation (availability and cost of renting extra space). Nevertheless, practice shows that there are very creative solutions to solve this challenge. Think about schools, churches, empty waiting rooms and library to organise gAPNC. A convenient timing of the sessions may depend on the availability of a suitable location, e.g. when gAPNC is organised in a waiting room. gAPNC sessions are often run during the day (avoiding school drop-off and pick-up times) but can be run in the evening or weekends, making it easier for partners to attend. Take into account your target population and the availability of public transport. To encourage attendance, it might be helpful to clearly communicate the planned timing of the sessions from first enrolment, perhaps producing a Welcome Pack for participants. This could outline the time and place of each session, essential contact numbers and perhaps a summary of topics to be covered.


Group Care Training
Midwife
Perisur

TRAINING

Practitioners who are planning to deliver gAPNC must have specific group facilitation skills. Interactive training workshops have been developed which teach these skills by modelling the style and content of the gAPNC sessions themselves. It can be challenging for midwives and other healthcare practitioners to learn to work in a less didactic manner, but this is essential for the model to work. Once one has familiarised him/herself with this style the challenge diminishes, and it mainly brings more work satisfaction. (See Skills Spotlight article by Wiseman, et al., for more details on training).

FINANCES

gAPNC is generally a low-cost intervention but some resources may be needed which must be addressed at the planning stage. As with any implementation process, start-up costs should be considered, such as purchasing materials for interactive activities, developing and/or translating materials, training facilitators, purchasing self-check blood pressure machines, mats and pillows for clinical checks. There are also possible recurring costs, such as room rental, hourly wages of facilitators, interpreters and refreshments. Many of these costs will depend on the maternity healthcare structure and how well gAPNC fits into it. In many cases, gAPNC can be implemented within existing maternity budgets, while in other cases grants, partnerships or charities may be able to provide supplementary funds. In the long term, gAPNC might be cheaper compared to regular care, so that offsets the costs incurred at the start-up.[1]

SUSTAINABILITY AND SCALE-UP

Elaborating a plan to integrate gAPNC in the health care system as part of regular antenatal/postnatal care requires multilevel collaboration, as it is often intertwined with political decisions. gAPNC should ideally replace traditional care appointments for participants. A comparison of gANC to traditional 30-minute antenatal clinic appointments in the UK (*see Table1*) demonstrates that gAPNC can become time-saving for staff, as well as offering participants up to six times more face-to-face time with a midwife during the antenatal period compared to traditional care (18 hours versus three to four hours, depending on parity). In this way, gAPNC provides significant benefits in terms of information sharing and personalised care planning.

Table 1: **Comparison of traditional care appointments and gAPNC based on UK system**

Number of women cared for	Staff time needed for gAPNC: eight 2-hour antenatal sessions, regardless of parity, plus one postnatal reunion	Staff time needed for traditional antenatal care: 30 minutes ANC appointments[1]	Face to face time with midwife in gAPNC: eight 2-hour antenatal sessions regardless of parity, plus one postnatal reunion	Face to face time with midwife in traditional antenatal care (30 minutes ANC appointments)
6 women	2 MW (=36 hrs)	1 MW (42 appointments = 21 hours)	18 hours	4 hours (primip) 3 hours (multip)
8 women	2 MW (=36 hrs)	1 MW (56 appointments = 28 hours)	18 hours	4 hours (primip) 3 hours (multip)
10 women	2 MW (=36 hrs)	1 MW (70 appointments = 35 hours)	18 hours	4 hours (primip) 3 hours (multip)
12 women	2 MW (=36 hrs)	1 MW (84 appointments = 42 hours)	18 hours	4 hours (primip) 3 hours (multip)

[1]Assuming an even mix of primiparas (8 appoitments) and multiparas (6 appointments)

Collaborating with organisations that have a vested interest in maternal and child health, women's empowerment and community well-being can significantly contribute to the successful sustainability and scaling up of the gAPNC model. Community leaders and women's rights groups can be very important in spreading the word about gAPNC, getting community support and making sure the program meets the community's specific needs. These partnerships can also help find more resources and support advocacy efforts.

Involving policymakers at local and national level can help navigate the bureaucratic challenges often associated with healthcare innovation, ensuring smoother scalability of gAPNC initiatives. To this end, mapping gAPNC against local policy priorities can help articulate how the model addresses priorities such as improving participant's experiences and outcomes of antenatal care, increasing uptake of breastfeeding or immunisations, addressing equity issues or delivering personalised care. Ongoing evaluation of gAPNC, auditing maternal and neonatal outcomes and collecting participants' and practitioners' experiences of the model is essential to ensure that the model is working. Dissemination of local data will contribute to a wider understanding and acceptance of the model and increase interest in rolling it out as part of regular care.

Long-term sustainability also requires consideration of on-going facilitation training, accessing or developing a train-the-trainer programme and adoption by midwifery organisations and education institutions. In addition, peer support in the form of champions, mentors or communities of practice is recommended to trouble-shoot problems and maintain the fidelity of the gAPNC model.

CONCLUSION

As with any kind of implementation, starting a gAPNC comes with challenges. Fortunately, there are many experiences and studies from which lessons have been learned to facilitate gAPNC implementation. Good planning and a supporting steering committee are greatly beneficial. Evaluating the gAPNC groups and disseminating findings will support scale-up of the model. Finally, having a champion is priceless for promoting and sustaining the model in an organisation. Will you be the next gAPNC champion in your organisation? Let's work together to make gAPNC an option for pregnant women/birthing people, parents and care providers throughout the world. The road to implementation lies within every midwife's means. **TPM**

PRACTICE POINTS

1. Who do you need to engage to implement gAPNC in your setting?
2. How would gAPNC address policy priorities in your area?
3. Which groups of service users would most benefit from gAPNC?
4. Where could you access venues to deliver gAPNC? Think out of the box! Groups have been held in village halls, libraries, family centres, churches, health centres and even in tents!
5. How would you evaluate your groups?

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