International Centering-Based Group Care Conference

ABSTRACTS

CenteringZorg
Samen weet je meer
10 Jaar
GC 1000 group care in the first 1000 days

Inspiration session round 1

Bonobo

It takes two to tango! The selection behaviour among recruiters.

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Background: Although the Group Antenatal Care (GANC) model has been widely accepted by participants and has been associated with positive effects on pregnancy outcomes, organisations perceive the implementation and sustainment of GANC as challenging. Besides scheduling, finding appropriate spaces for the sessions, and staffing, recruitment of participants appears to be the main implementation challenge. Recruiting women for GANC is time consuming and drains energy from what is supposed to be the main concern: the actual delivery of care.

Indeed, not all women are willing to participate in Group Care. However, it takes two to tango! Recruiters also have a significant influence. They make a selection based on assumptions they have about the likelihood of participation. These assumptions are misleading and do not predict whether or not a woman will participate. All women, regardless of her background or characteristics, can benefit from or be interested in GANC and should be able to choose what type of care they wish to receive.

Workshop: During this workshop, we aim to make participants understand that recruiters are inclined to differentiate to whom they offer GANC. This “selection” is based on preconceptions about who is more or less in need of GANC, inclined to refuse to participate or drop out of the program.

At the start of the session, we will ask participants to state how they experience the recruitment for GANC using one word. Then, on one side of the circle, we ask them to write down on a piece of paper, to whom they would definitely suggest GANC or insist just that bit more. And, on the other side to whom they would rather not suggest it or insist less. Before discussing the input, the group-facilitators will hold two short role-plays that demonstrate how a recruiter can fall into the trap of "selecting participants". Based on the cases and the information from the first part of the session, we start the discussion. With the aim of raising awareness of selection and coming up with tools to avoid it. At the end of the session, we ask participants to share their magic words to convince women (and their partners) to participate.

References:

Based on the research of Talrich F., of which the results have not yet been published.

Additional references:

1. Berman, R., Weber Yorga, K., & Sheeder, J. (2020). Intention to participate in group prenatal care: Moving beyond yes or no. *Health promotion practice, 21(1),* 123-132.
2. Hackley, B., Applebaum, J., Wilcox, W. C., & Arevalo, S. (2009). Impact of two scheduling systems on early enrollment in a group prenatal care program. *Journal of Midwifery & Women's Health*, *54*(3), 168-175.
3. Van De Griend, K. M., Billings, D. L., Frongillo, E. A., Messias, D. K. H., Crockett, A. H., & Covington-Kolb, S. (2020). Core strategies, social processes, and contextual influences of early phases of implementation and statewide scale-up of group prenatal care in South Carolina. *Evaluation and Program Planning*, *79*, 101760.
4. Wagijo, M. A. R., Crone, M. R., van Zwicht, B. S., van Lith, J. M., Schindler Rising, S., & Rijnders, M. E. CenteringPregnancy in the Netherlands: Who engages, who doesn't, and why. *Birth*.

Gorilla

10 lessons learned from scaling up Group ANC in Kenya and Nigeria

Stephanie Suhowatsky, Senior Technical Advisor, Maternal Health, ANC-PNC Research Collective (ARC), Technical Leadership and Innovations. Jhpiego

Research on Centering Pregnancy/Group ANC (G-ANC) in LMICs has reported positive outcomes. Yet, few countries have moved from research to adoption of G-ANC as a routine way to provide ANC services. Four sub-national governments have adopted it (e.g., 3 states in Nigeria, 1 county in Kenya). In Nigeria, Kano, Kaduna, and Nasarawa states have adopted G-ANC based on the findings of the cluster randomized controlled trial (Grenier et al, 2019) and are transitioning conventional, individual ANC into G-ANC as the "predominant model of care" in over 1,000 facilities. Seven other states are transitioning to G-ANC. Technical assistance is provided by TA Connect and state-level partners (e.g., Jhpiego in Nasarawa State). Machakos County in Kenya also has adopted and is scaling up G-ANC. Inspired by the experience from one of their facilities, Ekalakala Health Center, that converted their ANC services fully into G-ANC, the county health management team with Jhpiego are replicating the Ekalakala model in 12 facilities. Implementation research on the scaleup process in Machakos is being conducted. The work is funded by the Bill and Melinda Gates Foundation.

Scaleup experience has generated learning at the client, provider, facility, and health systems levels. No similar experience on wide-spread scaleup of G-ANC in LMIC settings has been published to date, so the workshop will offer conference participant opportunity to learn, ask questions and share their own experiences.

The learning outcomes: This 45-minute session will synthesize the lessons learned to share with participants so they can apply it in their own facility or project. By the end of the workshop, participants will:

- Know about how and where G-ANC has been adopted by sub-national governments as the new conventional service delivery model

- Know the top 10 lessons learned from scaleup in different settings that they can apply in their facilities and projects to make scaling up easier and moret sustainable

The process/activities (including room lay-out):

- Room will be prepared with a poster describing the scaleup activities in different countries (also as a handout)
- Session will open with brainstorm on 3 reasons participants think G-ANC has not been scaled up in LMIC settings, and the answers mapped
- Review the 10 lessons learned that while physically moving around the room (provide handout)
- Open for questions and experience sharing

Audience participation: Opening activity, as well as interactive session

Maximum number of participants: 20

Name of any sponsor: Bill and Melinda Gates Foundation

References:

1.Grenier, L., Suhowatsky, S., Kabue, M. M., Noguchi, L. M., Mohan, D., Karnad, S. R., Onguti, B., Omanga, E., Gichangi, A., Wambua, J., Waka, C., Oyetunji, J., & Smith, J. M. (2019). Impact of group antenatal care (G-ANC) versus individual antenatal care (ANC) on quality of care, ANC attendance and facility-based delivery: A pragmatic cluster-randomized controlled trial in Kenya and Nigeria. PloS one, 14(10), e0222177. https://doi.org/10.1371/journal.pone.0222177

2. Novick, G., Womack, J.A. and Sadler, L.S. (2020), Beyond Implementation: Sustaining Group Prenatal Care and Group Well-Child Care. Journal of Midwifery & Women's Health, 65: 512-519. https://doi.org/10.1111/jmwh.13114

Inspiration session round 2

Auditorium

The tree of the community building: What does the core component of community building mean to you?

Anne Batchelder, Ashley Gresh, Elizabeth T. Abrams, and Crystal L. Patil

Background: Community building, the third core component of Centering-based group care, includes socializing and consistency of group members and facilitators11/15/2022 12:30:00 PM.[1–3] In a large US-based clinical trial, higher fidelity, as measured by group involvement or connectedness and the degree to which the learning was facilitative (vs. didactic), was associated with lower odds of preterm birth and intensive utilization of care.[4] In our work in Malawi, we used a measure of peer connectedness that related to satisfaction, and was a significant predictor of more ANC visits. While these studies are promising community building is the least conceptualized core component of group healthcare. At present, no

standardized measures of community building fidelity exist. Moreover, rigorous research is needed to capture the diffusing impacts of community building.

Learning Outcomes: Participants will leave this workshop with a nuanced understanding of the core component of community building.

Audience Participation: Drawing on qualitative methodologies, facilitators will guide participants through an interactive learning process that harnesses the collective wisdom of Centering-based group healthcare experts. Through a shared vision, participants will grow a "tree of the community building." Each will leave this workshop with a visual depiction of our collective understanding of community building and its impacts on patients, partners, facilitators, communities, clinics, and health systems.

To achieve our objectives, we run this workshop in three phases. Phase 1 will use brainstorming and free listing to define community building (5 minutes). Participants will then silently create piles of the words/phrases based on relatedness (5-10 minutes). In Phase 2, we will break into small groups and assign labels to each pile (10 minutes). Then the groups will decide where words/phrases belong on the tree (10 minutes). The roots represent resources needed to support community building. The trunk represents the activities within a 2-hour group session. The branches represent community building outputs, or its effects on participants and facilitators. The leaves represent effects on partners, communities, clinics, and health systems. Phase three (10 minutes) is a large group debriefing to compare trees. To close, each participant will write a reflection on a picture of a seed to about what they consider essential to community building and why. They will share it verbally and then affix it to the community tree (5 minutes).

Maximum number of participants: 20

Name of any sponsors: NIH NINR Grant #R01 NR018115

References:

1. Rising SS, Kennedy HP, Klima CS. Redesigning prenatal care through CenteringPregnancy. *Journal of Midwifery & Women's Health*. 2004;49(5):398-404. doi:10.1016/j.jmwh.2004.04.018
2. Patil CL, Abrams ET, Klima C, et al. CenteringPregnancy-Africa: A pilot of group antenatal care to address Millennium Development Goals. *Midwifery*. 2013;29(10):1190-1198. doi:10.1016/j.midw.2013.05.008
3. Rising SS, Quimby CH. *The CenteringPregnancy Model: The Power of Group Health Care*. Springer Publishing Company; 2017.
4. Novick G, Reid AE, Lewis J, Kershaw TS, Rising SS, Ickovics JR. Group prenatal care: model fidelity and outcomes. *American Journal of Obstetrics and Gynecology*. 2013;209(2):112.e1-112.e6. doi:10.1016/j.ajog.2013.03.026

Inspiration session round 3

Auditorium

The group care ship: Lessons from the situational analysis on Group Care in Suriname

Manodj Hindori (Perisur Foundation), Ashna Hindori-Mohangoo (Perisur Foundation)

Background: Suriname is one of the eight countries participating in the research project *'Group Care in the first 1000 days'*, funded by the European Union. Group Care (GC) is an innovative model of care for pregnant women, mothers of babies, and their partners. GC brings between eight and twelve participants together in groups, to discuss the needs of mothers and their babies and families, to share experiences, and to empower each other. International research revealed that women participating in GC have better birth outcomes. In Suriname antenatal GC is called *SamenZwanger*.

Methodology: In March and April 2021, a situational analysis was conducted to analyze the context of GC in Suriname, and to identify success factors for the implementation of GC in vulnerable communities of districts Paramaribo and Wanica. 65 interviews were held with stakeholders including policy makers, health care professionals, pregnant women, mothers of babies, partners, and community leaders.

Results: There is a gap in continuum of care for women who receive antenatal care in a primary health center but who deliver in a hospital. These women and their newborns are left without proper care in their communities. This increases the risk for adverse outcomes during the postpartum period. Women from deprived communities have higher poverty levels, live in crowded houses, and experience more domestic violence. Their stress level often leads to postnatal depression. Cultural factors play an important role in the limited use of contraceptives. Teenage pregnancies occur often, leading to school dropouts. Despite these difficulties, most women responded enthusiastically on the GC-model and expressed their willingness to participate in group sessions.

Conclusions: Notwithstanding the many challenges women in vulnerable communities are facing, they are positive about the GC-model and see it as a helpful way to be better engaged in the health of themselves and their babies.

Description of the interactive presentation
After a brief introduction, the audience will be divided in groups, ideally consisting of 5 to 6 participants. Each group will discuss how group care can help pregnant women and mothers with babies to address one of the outcomes of the situational analysis:

- Group care and domestic violence;
- Group care and postnatal depressions;
- Group care and cultural factors;
- Group care and the use of contraceptives;

- Group care and teenage pregnancies.

Each group will draw a ‘Group Care Ship’ on a flipchart. Underwater of the ship the group draws the dangers, threads and risks for the outcome in reference. Above the ship the group draws approaches within group care that can contribute to tackle these dangers. At the end of the interactive presentation each group will explain its Group Care Ship to the audience. A winner may be selected.

Gorilla

A healthy heart: what about yours and what about group care?
Bénédicte Manderlier RN MSc, nursing researcher and heart failure nurse, Universitair Ziekenhuis Brussel, Belgium
Karen Van den Bussche RN PhD, nursing researcher, Universitair Ziekenhuis Brussel, Belgium

Background and aim: Did you know that cancer patients have the same cardiovascular risk as patients without cancer but who are 10 years older? Therefore, the European Society of Cardiology (ESC) recommends long-term follow-up in specific cardio-oncology clinics. This long-term surveillance should include patient education, cardiovascular risk factor optimization, promotion of a healthy lifestyle, and symptom review (Lyon et al. 2022).
A research team of the Universitair Ziekenhuis Brussel in Belgium is conducting a research project in collaboration with Group Care Belgium. The aim of the project is the translation of the Group Care concept to a specific cardiology population: breast cancer patients with/or at high risk of cardiovascular diseases due to cardiotoxic oncology treatment.
Based on extensive literature and guideline review an implementation plan and session outline (including educative topics) was developed. Currently, interviews with experts from specific domains are ongoing to validate the content of the sessions.

Activities: Different topics will be presented on four tables, each including a question on which a maximum of 4 participants per table are asked to share their expertise. Common ground will be sought with CenteringPregnancy, such as nutrition or physical activity. Similar to Group Care, the participants can visit the heart failure nurse to assess and discuss their blood pressure and cardiovascular risk factors.
What's in it for the participants? The participants will (1) gain knowledge about the increased risk of cardiovascular diseases in breast cancer patients due to cardiotoxic treatment, (2) assess their own cardiovascular health and risk, and (3) know the correct way to take a blood pressure - and why it is not that simple.

What's in it for the researchers? The team would like to gain insights on suitable Group Care methods to be used during the different sessions with our cardio-oncology group.

Funding: Support given in the framework of the joint call 2020 of the Funds for research in cardio-oncology managed by the King Baudouin Foundation and the UZ Brussel Foundation.

References:

1. Lyon et al. (2022) 2022 ESC Guidelines on Cardio-Oncology *Eur Heart J*, 23(10), DOI: 10.1093/eurheartj/ehac244

Posters

GCCP06

Adapting Group ANC to unique contexts: Experience in Afghanistan, Ethiopia, and India

Stephanie Suhowatsky, Senior Technical Advisor, Maternal Health, ANC-PNC Research Collective (ARC), Technical Leadership and Innovations. Jhpiego

- **What did you do:** Jhpiego has piloted Group ANC (G-ANC) in three unique contexts. Adaptations have been tested for feasibility, acceptability and effectiveness to improve the quality of care and increase retention. First, two different G-ANC models has been tested in India. Second, a health post level G-ANC model led by health extension workers in Ethiopia to increase access and coverage of ANC. Third, G-ANC was successfully introduced in Afghanistan in several health centers in 2019.
- **Why did you do this:** G-ANC was seen as a way to improve the quality of ANC, but had to be adapted for unique contexts and piloted to assess feasibility. ANC in India is primarily provided at the community-level, so a facility-based and community-based model were created and tested in 2019-2020 for feasibility. The community model allowed rolling admission and cohorts of mixed gestational ages. G-ANC was introduced in Ethiopia in 2021 as a 6-meeting model in health posts, the lowest level of the health system, to increase access. G-ANC in Afghanistan was adapted mainly for cultural acceptability (e.g., no singing), and the 5-meeting model included antenatal depression screening and referral.
- **What did you find:** In India, both models faced implementation challenges and low retention across meetings (15% ANC4 among G-ANC participants in facility-based model; 26% in community-based model). The Ethiopia pilot among 54 women in 5 health posts found 56% attended 4 meetings (ANC4). A total 122 of 218 (56%) enrolled women participated in G-ANC in the Afghanistan pilot, and 72% of participants achieved ANC4. Fidelity to G-ANC in LMIC principles was not measured during these pilots. Implementation research will be conducted on G-ANC at health posts in Ethiopia, and G-ANC in Afghanistan will be introduced in urban areas in 2023.
- **What is your take home message:** Adaptations of G-ANC to unique contexts produced unanticipated results. Pilots are helpful to explore feasibility, coverage and acceptability.

GCCP07

Group Antenatal Care: what are the mechanisms of effect? Findings of a realist review

Christine McCourt (presenting); Giordana da Motta, Penny Haora, Louise Hunter, Juliet Rayment, Meg Wiggins, Anita Mehay, Angela Harden. City, University of London and University College London, Institute of Education.

Background: Group antenatal care (gANC) is a complex intervention which includes self-checking, more time with care providers, relationship-building, clinical checks in the group space, information sharing and community-building. The mechanisms of effect are not fully understood: what works, for whom, in what context?

Objectives: To articulate implicit and explicit theories of effect in gANC literature

Methods: A Realist Review exploring the mechanisms of effect of gANC: a systematic approach incorporating all types of data (research and non-research), analysed and synthesised to generate Context-Intervention-Mechanism-Outcome (CIMO) configurations. This approach aims to deepen understanding of how an intervention or programme works, for whom and in what contexts.

Results: Six key theories of effect were identified: social support, peer learning, active participation in health, education, satisfaction with care and changing professional practice. Theory relating to impact on professional practice was relatively undeveloped but some studies identified that changing professional-client relationships may be an important mechanism of effect. Context was not sufficiently well described to understand fully what works for whom in what circumstances, although there are indications that it has particular benefits for those who are typically underserved by maternity services. Most sources shared similar implicit or explicit theories of effect. However, conceptualisation of educational mechanisms drew on two somewhat different areas of pedagogical theory. Using an adapted version of Beattie's model of health promotion, we identified a key variation in terms of how individualised or collective these theories were.

Conclusions: A realist review of existing literature identified 6 key theories of effect. These are likely to be interactive in practice and more than the sum of their parts. Combining review findings with feasibility research in the UK, we identified a set of core values that can provide a guide to fidelity when implementing and adapting group care in different settings.

GCCP08

The role of experiential-based training and local trainers in implementing and sustaining group antenatal care with high fidelity in Malawi

Crystal L. Patil, Ashley Gresh, Esnath Kapito, Li Liu, Elizabeth T. Abrams, Dhruvi Patel, Heidy Wang, Rohan D. Jeremiah, Kathleen F. Norr, and Ellen Chirwa

What did you do? We are conducting an effectiveness-implementation trial of a Centering-based group ANC model in Blantyre District, Malawi (IRB # 2018-0845; COMREC P.10/18/2498). Here, we describe the experiential learning-based basic training workshops (2019 and 2021) and the mentor training workshop (2021) that produced local trainers.

Why did you do this? The positive effects of the CenteringPregnancy group antenatal care (ANC) model on perinatal outcomes in the United States has led to its implementation in many low-and middle-income countries. Facilitative discussion using interactive learning is a core component of group ANC. Training local facilitators and trainers lays a critical foundation for delivery and sustainment of the model. However, there is little rigorous research describing best practices for facilitator training and none that is guided by a theoretical framework. Kolb's experiential learning theory provided a theoretical framework to guide the development of training workshops that allowed trainees to experience, reflect on, and practice the facilitation skills needed to deliver this evidence-based model of care.

What did you find? We created blueprints for conducting facilitator trainings and to train local midwives to serve as trainers. Our Kolb-based approach to training effectively built confidence and buy-in. Importantly, when training workshops were conducted by trained Malawian midwife mentors, new facilitators were able to initially offer group ANC with higher fidelity to the core components compared to those trained by US-based trainers.

What is your take home message? The blueprints can be adapted for use in designing and implementing group healthcare across settings. Compared to facilitators trained by US-based trainers, those trained by local trainers had higher initial and sustained levels of fidelity.

GCCP09

Group antenatal care increases satisfaction with care and attendance in Malawi

Elizabeth T. Abrams, Ellen Chirwa, Esnath Kapito, Ashely Gresh, Li Liu, Cecilia Chang, Rohan D. Jeremiah, Kathleen F. Norr, and Crystal L. Patil,

What did we do? We are conducting a randomized trial to compare outcomes from those assigned to a centering-based group antenatal care (ANC) model compared to individual care in Malawi. Here, we compare satisfaction with ANC and health system utilization. Pregnant women (n=1731) were recruited from six clinics and in late pregnancy, 1409 women answered the 10-item satisfaction questionnaire (range 10-40). Attendance is the number of visits attended (range: 1 - 8+ visits). Accounting for the clustered data structure within clinics, we used multi-level hierarchical regression models to assess type of ANC effect on outcomes while adjusting for personal and clinic factors.

Why did we do this? Perinatal morbidities and mortality, preterm birth, and new HIV infections rates remain high in many African countries.

What did you find? Participants' mean age was 23.9 years (SD=5.5); 38.4% were primigravida, 65.4% completed primary school, and 93.3% had a partner. Randomization was successful. Women in group ANC had higher satisfaction scores (34.4 ± 8.0 vs 32.5 ± 8.1; p<0.001); scores were higher among older and more educated women and those who had formed connections with other women at ANC. Those in group attended more visits than those in individual ANC (5.9 ± 1.7 vs 5.21 ± 1.6; p<0.001). Satisfaction with care, education, partner status and clinic volume and location (urban, peri-urban, rural) were significant predictors of attendance.

Take home message: The impact of greater ANC attendance on improved perinatal outcomes is well-established. Group ANC was associated with greater satisfaction with care and more ANC visits in Malawi. Increasing satisfaction with care also related to more ANC visits. Widespread adoption of group ANC can substantially improve quality of ANC, trust in health system, and perinatal health. The Ministry of Health supported this study and is discussing adoption of group ANC nationally.

This study (2019-2023) has ethical approval (IRB # 2018-0845; COMREC P.10/18/2498).

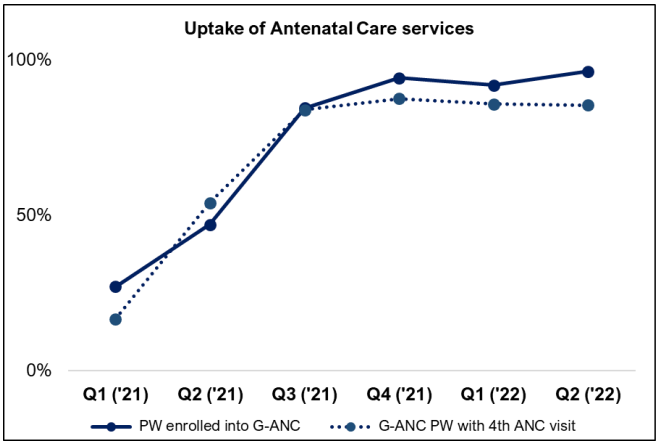
GCCP010

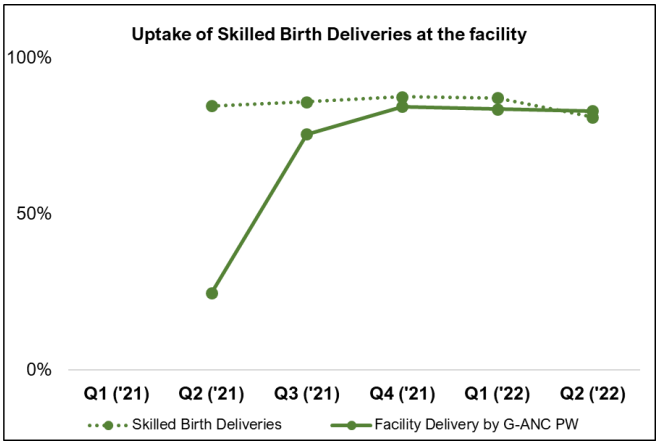
From Pilot to Scale – Adaptations, and Results from the GANC implementation in Nigeria

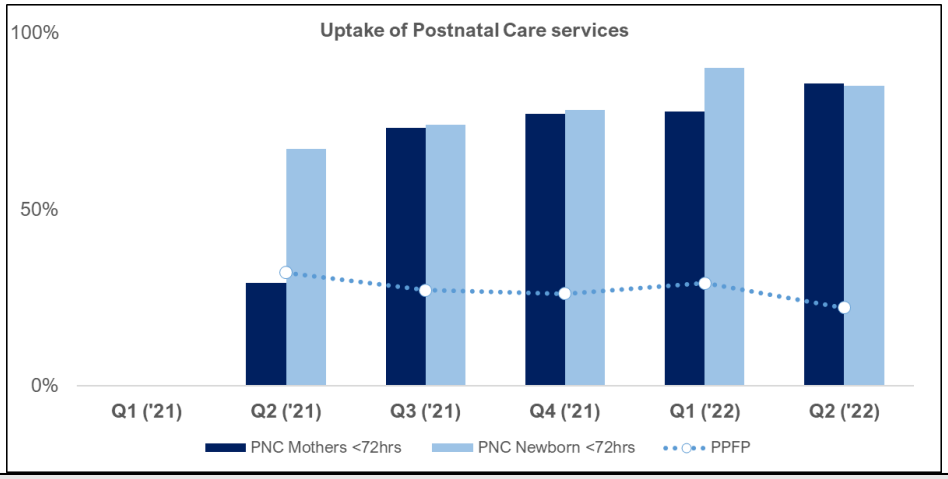
Olayiwola Jaiyeola, Technical Advice Connect (TAConnect), Nigeria

Background: Following the RCT in Nigeria and Kenya, Group Antenatal Care (GANC) has been proven as a transformative model of care that provides a positive pregnancy experience. However, very few LMIC are implementing GANC at scale. TAConnect, with funding from BMGF is currently supporting 7 states in Nigeria to adapt, adopt, implement, and sustain G-ANC as an alternative model for ANC service delivery. This poster highlights the approach, adaptations, and results from the scale up implementation.

Methodology: We adopted a bottom-up approach with a State-led program design and implementation. This facilitated revision of relevant policies to incorporate G-ANC as an alternative model of care and integration into existing systems and structures to foster sustainability. This was followed by development of manuals and pictorial cards that were adapted to suit context and trainings of service providers and clinical mentors to ensure quality service delivery. Facilities were selected based on service readiness assessment findings while a phased implementation approach was adopted for iteration and to curate lessons for scale. The States also made adaptations to the RCT approach to reflect context and realities of real live implementation. Data management was anchored on existing NHMIS tools and national DHIS2.







ADAPTATIONS TO THE RCT MODEL DURING SCALE UP INTERVENTIONS		
RCT		SCALE-UP
Enrolment was done by research assistants	**Enrolment**	Enrolment was done by existing facility healthcare providers
Pregnant women within 16-20 weeks gestational age at ANC1	**Eligibility**	Initially pregnant women between 16-20 weeks GA, but later extended to preg. women who are more than 20weeks GA at ANC1
8-15 women in a cohort	**Cohort Size**	Started with enrolment of 8-15 women in a cohort, but later adapted to 5-20 women to navigate the challenge with cohort size in LVFs and HVFs
Not Used	**Cohort Calendar**	Developed to support correct placement of PW into cohorts of similar GA
Pictorial take-action booklets were given to PW to take home for sensitization of others within the community	**Job Aids**	Pictorial take-action booklets used during meetings are left at the facility *(not to be taken home)* for financial sustainability
Residential Didactic Training	**Training Approach**	Low Dose High Frequency training, Onsite Training, Step down trainings have been used to rapidly scale up
GA - Gestational Age, LVFs - Low Volume Facilities, HVFs - High Volume Facilities, PW - Pregnant Women		

Results: A total of 3280 HCWs were trained across 1103 Health facilities implementing GANC in 4 supported states. A total of 726,946 pregnant women have been enrolled in 57643 cohorts. Results show improved retention in care and increased uptake of key outcomes such as SBA and PPFP.

Conclusion: GANC can be sustainably implemented at scale in LMICs through a government-led approach that leverages existing systems and structures. However, despite the successes, there are challenges impacting against the fidelity of the model that require a system strengthening approach to mitigate.

GCCP012

Group well-child care: a scoping review and conceptual framework

Ashley Gresh, Deborah Wilson, Ada Fenick, Crystal L. Patil, Tumaini Coker, Sharon Schindler Rising, Nancy Glass, Rheanna Platt

Objective: To present a conceptual framework of group well-child care to guide future practice and research that was created using scoping review methods.

Methods: We conducted a scoping review using Arksey & O'Malley's (2005) six stages: identifying the research question and relevant studies; study selection; charting, collating, and summarizing the data; reporting results; and completing a consultation exercise. We used constructs from the Consolidated Framework for Implementation Research (CFIR) and the quadruple aim of health care improvement (improved clinical outcomes; improved patient experience; improved clinician experience; and reduced per capita cost of healthcare) to guide the development of the conceptual framework.

Results: The resulting conceptual framework is a visual depiction of the key concepts of group well-child care, beginning with a call for a system redesign of well-child care to improve outcomes while acknowledging the theoretical antecedents structuring the rationale that supports the model. Inputs of group well-child care include health systems contexts; administration/logistics; clinical setting; group care clinic team; community/patient population; and curriculum development and training. The core components of group well-child care included: structure (e.g., ideal group size, facilitators); content (e.g., health assessments, service linkages); and process (e.g., interactive learning and community building). We found clinical outcomes in all four dimensions of the quadruple aim of healthcare that were impacted by group well-child care.

Conclusions: Our conceptual framework can guide group well-child care model design and implementation and identifies several outcomes that can be used to harmonize model evaluation and research. Future research and practice can use the conceptual framework as a tool to standardize model implementation.

GCCP013

Development, Implementation, and Evaluation of a Model for Antenatal Group Care in Suriname: Results from Perisur

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Why did we do this: To evaluate a model for antenatal group care (GC) in Suriname.

What did we do: In 2014, antenatal GC was introduced by the Perisur network and implemented in three hospitals in Paramaribo. This innovative health care model included nine antenatal and one postnatal interactive group sessions of two hours facilitated by trained midwives and offered in addition to regular one-on-one care. Women self-selected participation and completed socio-demographic and evaluation forms at the first and last session, respectively. Birth outcomes were collected from medical records.

What did we find: During 2015-2021, in total 21 groups were implemented with the majority at one hospital (18 groups; 214 women; 67% of partners participated). Median [IQR] number of sessions attended by women and partners were 8 [7-10] and 5 [0-8], respectively. Participating women were less often teenagers (2.8% vs. 13.8%; p<0.001), more often 35+ years (18.3% vs. 11.4%; p=0.002), more often primiparous (55.2% vs. 34.2%; p<0.001), more often Creole (32.5% vs. 23.5%; p=0.003) or mixed (33.7% vs. 13.3%; p<0.001), less often Tribal (6.4% vs. 27.6%; p<0.001) or Indigenous (1.0% vs. 3.8%; p=0.038).
Except for domestic violence and abuse, the topics discussed during the group sessions were rated as very useful by many participants (range 71%-94%). The topics breastfeeding (94%), delivery (94%), care for the baby and parenthood (93%), normal changes during pregnancy (91%), and nutrition (91%) were evaluated as very useful by more than 90% of participants. Rates of preterm birth <37 weeks (8.9% vs. 14.0%; p=0.050) and low birth weight <2500 grams (7.3% vs. 15.1%; p=0.003) were significantly lower than average hospital rates.

What is our take home message: Antenatal GC was successfully developed and implemented in Suriname, was positively evaluated by participants, and resulted in lower rates of adverse birth outcomes. Reaching more vulnerable women/couples and integrating GC as routine care are important next steps.