Bijlage 3A. Inhoudelijk stageverslag “A qualitative descriptive study on the implementation fidelity of CenteringParenting in the Netherlands”.

A qualitative descriptive study on the implementation fidelity of CenteringParenting in the Netherlands

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Youth healthcare in the Netherlands

In the first year of their child's life, parents visit the youth healthcare clinic about 8 to 10 times to have their baby's health, growth and development checked (Muller, 2002; Wieske, Nijnuis, Carmiggelt, Wagenaar-Fischer & Boere-Boonekamp, 2012). It is important that the care provided in those clinics is positively experienced by parents. In general, this system was appreciated by parents in 2014 with a rate of 7/10 (CBS, 2014). However, nowadays there are many other possibilities to talk about parenting and your child, such as via the internet. Countless negative feedback can be found online in forums (Muller, 2002). Also through communication on social media channels, help with parenting is often requested from the direct network around a parent. This so-called 'pedagogical civil society' is increasingly heard in the world of youth care (van der Klein, Bulsink & van der Gaag, 2012). There is always room for improvement of youth healthcare and with policy documents that use the term of 'pedagogical civil society' more frequently over 'the individual approach', first steps are taken towards the strengthening of those social networks (Hilhorst, Zonneveld & de Winter 2013).

Group Medical Appointments (GMA's) like CenteringParenting is a method of healthcare that offers this room for improvement in the experience of youth healthcare by parents (Kok, 2018). Group Medical Appointments (GMA) were originally designed for its effectiveness in time and money (Seesing, Zijlstra, Pasmans, L'Hoir, Drost, van Engelen & van der Wilt, 2013). The name 'CenteringParenting' already shows, the method focuses on the centering of parenting in a group and increases social support (Centering Healthcare Institute, n.d.). However, it is important that this method is implemented as intended, so that the aims will be achieved. This study focuses on that part of CenteringParenting: the implementation fidelity.

CenteringPregnancy

CenteringParenting is the successor to CenteringPregnancy, a group-based prenatal care model that has been offered in the Dutch healthcare since 2012 (Rijnders, Detmar & Herschderfer, 2016). The basis of the sessions is similar in both Centering methods: to participate in an active group setting, focused on the needs of participants with the help of structured sessions (Bloomfield & Rising, 2013). Research into CenteringPregnancy shows

that it has many positive outcomes such as lower rate of preterm births, better health skills among participants, more knowledge about pregnancy and their own health, felt more prepared for delivery and started breastfeeding more often (Manant & Dodgson, 2011).

CenteringParenting

Since 2014 there is a new group-oriented healthcare method in the Netherlands for mothers and fathers?: CenteringParenting (Vlasblom, van Sleuwen, Beltman & Rijnders, 2016). This method has been transferred from the USA where it was developed by Sharon Schindler Rising in 1993 (Rising, 1998). The traditional one-on-one youth healthcare appointments are replaced with CenteringParenting sessions in which 6-8 participants (mostly mothers) actively engage in care with their babies during the first year after birth, guided by trained supervisors (Bloomfield & Rising, 2013).

CenteringParenting can be seen as a GMA and is not only developed for its effectiveness in time and money but the aim of CenteringParenting is to result in better care experience for parents, their child, and the facilitator than individual care offers (ZonMw, 2018b). CenteringParenting aims to achieve this goal through three main components: health assessment, interactive learning and community building (Centering Healthcare Institute, n.d?.).

Several studies have been conducted on the results of CenteringParenting, for example in the USA and Canada. Those results are promising and show that the immunization rate is growing and parents reported improvements in parenting experiences after CenteringParenting (Johnston, McNeil, van der Lee, MacLeod, Uyanwune & Hill, 2017). In the Netherlands there has been a small pilot study to the process- and effect evaluation of CenteringParenting, which also had positive outcomes. Parents mentioned that they valued sharing their experiences, that they received enough information about healthy and safe growing up and that they get to know more people in the same situation (Vlasblom et al., 2016). CenteringParenting also reaches vulnerable parents, who are difficult to reach with other interventions (Vlasblom et al., 2016). All in all, CenteringParenting promises many positive results, but in order to achieve those results, it must be assured that the method is implemented as intended.

In 2018 a small pilot study into the implementation fidelity of CenteringParenting in the Netherlands was conducted, however the focus of that study was mainly on developing an instrument to measure the implementation fidelity (Kok, 2018). It is therefore important to use this instrument on a larger scale with more depth and descriptions to examine the overall implementation fidelity of CenteringParenting in the Netherlands, which this study focuses on.

Implementation fidelity

Implementation fidelity is critical to translate evidence-based interventions into practice in a successful way (Breitenstein, Gross, Garvey, Hill, Fogg & Resnick, 2010). Regarding testing implementation fidelity, we often use the terms ‘adherence’ and ‘competence’ of the program (Cross & West, 2011). Adherence of the program is the degree to which the setting of the program is consistent with the original implementation plan dictated by the developers, which can also be referred to as ‘program fidelity’ (Cross & West, 2011; Novick, Reid, Lewis, Kershaw, Rising & Ickovics, 2013), whereas competence of the program focuses on the execution of the facilitators’ skills (Cross & West, 2011; Novick et al., 2013). These two concepts are related but can be measured separately in a reliable way (Cross & West, 2011).

The CenteringParenting methodology cannot be divided into these fixed concepts because it offers some freedom of interpretation and actions to the facilitators of the sessions. This is necessary as the core of CenteringParenting is that the care provided must meet the needs of individual parents or families (ZonMw, 2018b). This is also called an ‘unprescribed’ innovation and it is less easy to work with the terms adherence and competence of the program (Mowbray, Holater, Teague & Bybee, 2003; Munter, Wilhelm, Cobb & Cordray, 2014). The solution to measure the implementation fidelity of an unprescribed innovation is to first make core elements and activities explicit and to, second, check to what extent the facilitators adhere to the core elements of program and in what way (Bellg, Borrelli, Resnick, Hecht, Minicucci, Ory, Ogedegbe, Orwing, Ernst & Czajkowski, 2004; Borrelli, 2011; ZonMw, 2018b).

The implementation guide of CenteringParenting consists of 38 core elements that should occur in CenteringParenting sessions, ranging from elements about the setting and surroundings to elements about the themes of the session (CenteringParenting Implementation Guide, 2014; Kok, 2018). We provided an overview of the CenteringParenting elements and the corresponding method of checking the presence of the elements in Appendix I. Namely, some elements only appear in the individual conversations with one of the facilitators, some elements show the group dynamics and other elements are predetermined.

Kok (2018) studied the prioritization of those 38 elements in order from most important to least important in a small study based on a survey which was filled in by trainers of CenteringParenting. Eight of the elements are described as ‘most essential’ by the trainers (Kok, 2018). The eight elements that were marked as ‘most essential’ all fit to a certain main component of this study (Kok, 2018). The two elements that are part of the first component

'health assessment' are that at least one of the facilitators is medically responsible (1), and that there is attention for the mental and physical health of the child and the mother (2). The four elements that can be placed under the second component 'interactive learning' are: facilitators will not give any didactic lessons, only on request of the group (3); facilitators ask open, deepening questions (4); the facilitators use the cycle of question > confirm > acknowledge > advices/solutions > summary > evaluation (5), and the facilitators discuss other topics on participants' request (6). The third component of CenteringParenting is 'community building' and the two essential elements that are part of that component are: the facilitators intervene when an unsafe situation occurs (7) and the group space is large enough so that everyone can sit in a circle (8). One of the sub-research questions of this study focusses on the presence of these eight most essential elements.

Objective of this study

The aim of this study is to investigate to what extent CenteringParenting is implemented as intended (adherence to the 38 essential elements), what explanations and descriptions can be given for the presence or absence of those elements and what opportunities there are for improvement of implementation and further development of CenteringParenting. In principle, the intention is that CenteringParenting is further implemented in youth healthcare organizations in the Netherlands and that we can offer current organizations handles to improve their execution of CenteringParenting (ZonMw, 2018a).

Research questions

The current study focuses on the implementation of the CenteringParenting program in the Netherlands, resulting in the two following research questions:

1. In what way do facilitators use the 38 essential elements in performing CenteringParenting in the Netherlands and what stands out?
2. Which explanations can be given for the presence or absence of those essential elements of CenteringParenting in the Netherlands?

The sub-question this study also answers is:

a. In what way are the eight most essential elements (according to Kok, 2018) present in CenteringParenting sessions in the Netherlands?

Methodology

Research design

The current study is based on data obtained by TNO as a part of the research to the evaluation of the organization and implementation of CenteringParenting in the Netherlands (ZonMw, 2018b). This study has aspects of a qualitative corpus analysis as it is an in-depth investigation into communicative situations, which are the CenteringParenting sessions (Hasko, 2012). This study notes in what way the 38 core elements (including the 'eight most essential elements') of CenteringParenting are present or absent. It will focus on the descriptive explanations of why these elements are not or partly present and answers clarifying questions such as 'did this occur', 'how often', 'in which way', 'which topics' and 'which activity is used' (see Appendix I and III).

Procedure

Muladvicele youth care institutions in four collaborating regions in the Netherlands where the CenteringParenting program is implemented received an email from TNO with the request to cooperate with this research (ZonMw, 2018b). Out of five regions in which the CenteringParenting program is implemented, four regions were willing to participate: region Groningen, region Oss, region Amersfoort, and region Zeeland (Vlasblom et al., 2016). In total six different organizations were participating. After having approved, it was discussed at which CenteringParenting session data could be collected. A TNO researcher visited the participating locations, filled in the checklist on site during the walk-in of the session, and installed the audio equipment. The audio recordings focus on the facilitators, however the parents had to approve as well. For this reason all participating parents signed an informed consent form, which informed them about the purpose of the research and the storing and use of the data. After the consent signing, the researcher left the room to not influence the session by their presence (Peräkylä & Ruusuvuori, 2008). After the session five short questions to evaluate the session were asked by the researcher to the facilitators of that session (see Appendix II).

An ethical check has taken place (checklist ethical aspects of research from DPECS of the EUR) that mainly showed that participants receive an information letter in advance of the research, participants can withdraw at any time from this research.

Participants

The participants are the facilitators of the CenteringParenting sessions. These participants are approached in advance of the research by TNO with the request to be part of this research. It is explained to them that the goal of this study is to improve development and implementation of CenteringParenting in the Netherlands. The facilitators will be recorded after approval. They also give permission to ask five questions of the checklist after the session by the researcher who is on site (see Appendix II, this research will not use the results of those five questions). In total 30 sessions were recorded and 32 checklists are collected, with the important note that some facilitators have been recorded several times, facilitating different sessions. Due to the size of this qualitative dataset, it was decided in consultation with TNO to study 20 of those recordings and checklists. The facilitators have all followed one or more CenteringParenting training(s) and are mainly women.

Four out of the five regions in the Netherlands that have implemented CenteringParenting were willing to participate in this research, which are region Groningen, region Oss, region Amersfoort and region Zeeland (Vlasblom et al., 2016).

Measurement instruments

The measurement of implementation fidelity of the CenteringParenting program in the Netherlands is based on a list developed by Kok (2018; see also Appendix I). The checklist contains 38 elements essential to the implementation of the CenteringParenting program. The extent to which facilitators adhere to these 38 essential elements is studied using audio recordings (covering 26 items) and using a checklist (covering 12 items).

The audio analysis scheme (Appendix III) is developed with TNO based on the audio analysis scheme from the research of Kok (2018) but expanded for the current study. The scheme consists of 26 elements to be detected in three ways: (1) by listening to the individual conversations (green; 5 items; example: 'the individual visit to the doctor does not take longer than five minutes'), (2) by listening to the group conversations (pink; 17 items; example: 'there is attention for the mental and physical health of the child AND the mother'), and (3) some elements are predetermined (blue; 4 items; example: 'the group consists of parents with babies of maximum 4 weeks age difference'). This audio analysis scheme has been used as a tool for listening to the recordings, although a bigger scope of the three aims of CenteringParenting was kept in mind during the analysis to note striking things that appeared form the recordings.

The checklist (Appendix II) was designed by TNO and Kok (2018). The checklists contain 12 essential elements of CenteringParenting which cannot be observed in the audio-

recordings (yellow in Appendix I; 12 items; example: 'the medical assessment takes place in the first 30-45 minutes'). The researcher observed the setting and filled in the checklist on-sight before the start of the session. Afterwards there are also five short questions on the checklist for the facilitators that engaged in the session (Appendix II).

For all elements on the list (Appendix I) it is noted whether these are present or not in the recorded session and for the majority of the elements an explanation or description is noted (see the elements with ** behind them in Appendix I or the third column of Appendix III). For some elements (highlighted in yellow in Appendix III) the presence is noted per facilitator as in most sessions both of the facilitators carry a recording device. All remarkable things are noted in a comment box during analyzing.

There are no validity data available of these measurement instruments, as these have only been tested in a small pilot with the checklists in the research of by Kok, 2018. This explorative study will try to provide more information about the validity and reliability of the measurement instruments and all steps of this research will be described in detail so that this research can be recreated.

Data analyses

To store all the data in a structured way, we will use an excel sheet to collect all the data out of the checklists and audio recordings. Overall the more of the 38 elements are present, the better, but some elements might not occur in the sessions (for example 'unsafe situations' mentioned in element 22). Because the CenteringParenting program is an unprescribed innovation, there is no fixed limit of what is 'good enough' (Mowbray et al., 2003).

Depth on the presence or absence or specific interpretation and descriptions of the 38 elements will be were? obtained from the recordings and checklists. This qualitative descriptive data will be were? coded using the coding program ATLAS.ti, which makes analyzing easier because patterns, differences and similarities will become visible (Evers, 2015). Thematic codes will be used at the level of the elements, such as the code 'T cycle' which indicates use of the cycle by a facilitator described in element 16 (Appendix I and III). The open codes that will be used will be more in-depth, for example the codes 'O step I cycle', 'O step II cycle' and 'O step III cycle', which indicate that those step of the cycle of element 16 are completed in that specific part of the data. This necessary qualitative explanation of elements ensures that it becomes clear what the weaknesses and the strengths in the process of the implementation of CenteringParenting are, resulting in recommendations regarding improvement of the CenteringParenting trainings for facilitators.

Results

Basic characteristics of the sessions

For this research there is listened to a total of 40 (partly overlapping) audio recordings of 20 sessions. 9 of those sessions where recorded in region Amersfoort, 2 in region Zeeland, 1 in region Groningen and 8 in region Oss. On average, the audio recordings lasted 2 hours, 16 minutes and 12 seconds with the group part average of 1 hour, 3 minutes and 5 seconds. On average there were 6 mothers present per session and all sessions had two facilitators. Of these two facilitators, one was always medically trained (such as a youth healthcare physician or youth healthcare nurse). In addition, the babies were of ages between 1 – 14 months old, but within each session there was a maximum of 4 weeks of age difference between the babies. Some recordings are the same group at a later time, and therefore also the same facilitators. A total of 22 facilitators can be heard but the facilitation was consistent for the groups (no more than 4 different people in front of the group). For more descriptive details, see table 1a below.

Table 1a
Overview basic characteristics of the CenteringParenting sessions

	Location	**Age kids (in months)**	**Number of mothers present**	**Number of fathers present**	**Length group part**	**Average length one-on-one conversation**
A17-1	Amersfoort	1-2	7	0	63 min 30 sec	4:58
A17-2	Amersfoort	9-11	7	0	57 min 20 sec	6:55
A17-3	Amersfoort	0-2	6	0	75 min 5 sec	5:52
A17-4	Amersfoort	0-2	8	0	45 min 40 sec	9:26
A18-5	Amersfoort	2	5	0	34 min 25 sec	Unknown
A18-6	Amersfoort	3	6	0	86 min 25 sec	9:17
A18-10	Amersfoort	4	6	1	76 min 50 sec	4:38
A18-15	Amersfoort	1-2	3	0	76 min 5 sec	8:03
A18-18	Amersfoort	12	3	2	91 min 4 sec	4:20
Z17-1	Zeeland	1-2	5	1	35 min 5 sec	11:29
Z18-2	Zeeland	1-2	5	2	39 min 10 sec	11:55
G18-1	Groningen	11-12	6	0	66 min 35 sec	1:29
O17-1	Oss	3	7	0	70 min 18 sec	7:05
O18-2	Oss	11	7	0	53 min 29 sec	6:16
O18-3	Oss	6	8	0	67 min 8 sec	5:44
O18-4	Oss	0-2	3	1	60 min 20 sec	8:11
O18-6	Oss	0-2	5	0	61 min 0 sec	7:29
O18-7	Oss	0-2	3	0	69 min 30 sec	6:57
O18-8	Oss	12	5	2	64 min 36 sec	6:04
O18-9	Oss	14	7	0	68 min 23 sec	4:51
Averages		**9-10**	**5,6**	**0,45**	**63 min 5 sec**	**6 min 49 sec**

Since we strive for structure and overview in the amount of recorded data, it was decided to discuss the detailed descriptive results based on the three different aims of CenteringParenting as discussed in the introduction (health assessment, interactive learning, community building). As Kok (2018) showed, many of the 38 elements can be subdivided into those three aims. Additionally some practical points of the sessions will be discussed, as well as the performance of the facilitators in the sessions and this research contains a review of the Centering Healthcare training in combination with the collected data (since a CenteringPregnancy training was followed by the researcher during this study). For the presence or absence per element, see Appendix IV. For the total score per session over all of the elements, and the average region score, see Appendix V. In some cases, the total number of sessions in which the element did or did not occur may deviate from 20, that is because nothing could be heard about that element in that specific session or it did not apply there.

Presence of health assessment in the sessions

The health assessment of the babies usually takes place in the first 30-45 minutes of the sessions, 3 of the 20 sessions were an exception to this (these were usually first sessions which meant that at the beginning of the session time was taken to do an introduction, to draft group rules together and to get to know each other). In every session at least one facilitator is medically responsible. It should be mentioned that vaccinations are usually done at the end of the session due to the crying of the babies. According to the CenteringParenting guide, about 5 minutes per baby should be taken into account for the one-on-one conversation, but this takes on average 6 minutes and 49 seconds (vaccinations excluded). Overall, only 5 of the 19 sessions in which time was measured could achieve to stay under a length of 5 minutes on average. Also because facilitators have difficulties to keep the one-on-one conversation under five minutes, vaccinations are done after the session (so that it does not delay the whole group too much). The questions that were asked to facilitators after each session (see bottom of Appendix II) also showed that time monitoring was often mentioned as an aspect that could have done better (9 of the 23 facilitators answered ‘time management’ to the question ‘name one aspect that could have been done better’).

In the health assessment the facilitator first checks the health, development and growth of the baby and there is room for parents to ask specific questions about their child (for example about skin rashes or other abnormalities). Many of the facilitators also asked the question to parents if they had any questions that are specific for their child or rather discussed one-on-

one, that cannot be discussed in the group or be written on the waiting room (especially in region Oss). Only in 3 of the 20 sessions there was no waiting room (also called ‘container’ which is a whiteboard where mothers can write down subjects they have questions about). It is up to the medical facilitator to assess whether the subject parents have questions about can be better be discussed in the group or one-on-one. It turned out that in slightly more than half of the sessions (10 out of 19) that was properly assessed by facilitators, but there were also many sessions when the medically trained facilitator delved deeper into topics such as feeding, sleeping and crying (which could have also been discussed in the group). One of the facilitators said in the open questions afterwards that there might be more questions asked by parents when it is their first child [session O18-4].

The discussed topics in the health assessment are in line with the CenteringParenting guide (such as heart defects, hip dysplasia, preferred posture and skull formation). However, some health subjects that could have been checked or talked about in the health assessment of the CenteringParenting sessions were not mentioned at all, for instance autism spectrum disorders, female genital mutilation and child abuse. At the same time, there is always room for mother to bring up subjects like this during the health assessment.

Another big part of the health assessment during CenteringParenting sessions is the attention for the mental and physical health of the mother (or father). Only in 1 session of the 20 there was no attention for the health of the mother [session O18-2]. In most of the sessions there was a activity focused on the mental health of the mother (for example about stress and relaxation), or the opening activity was focused on the health of the mother, her relationship, or her goals. It is striking that in only one session [A18-5] of the 20 the self-assessment form for mothers was used (which contains questions about the state of mind of the mother, what she wants to achieve and perhaps physical goals). Another striking aspect is that many facilitators confirm the improvement of the weight, length and (health) development baby to the parents. The facilitators constantly use positive affirmative language such as ‘completely neat’, ‘that goes great’ and ‘he fits nicely on the average line’. Most of the facilitators confirm during the health assessment that the child is doing well.

As addressed before, CenteringParenting differs from regular care at a youth healthcare center because parents have more time to ask their questions, with more attention for the parent and the opportunity to share advices and experiences with other new parents. To continue to the results that are part of the next aim of CenteringParenting (interactive learning), I would like to quote a statement made by a trainer during the Centering Healthcare training:

“*Centering is much more than just that medical part!”*

Presence of interactive learning in the sessions

There are several ways in which facilitators try to stimulate interactive learning in CenteringParenting sessions. Relevant topics are discussed through activities, discussions are led by de facilitators and facilitators have an exemplary function. The intention is that healthy snacks are promoted by facilitators and present during the sessions, although more often none (it can be forgotten while discussing the group rules in the first session, 9 out of 19 sessions) or a combination of healthy (such as fruit) and unhealthy (such as cookies) snacks were present (6 out of 19 sessions) during the CenteringParenting sessions. As mentioned before: a whiteboard is used as a 'waiting room' for other topics the parents want to learn about. In almost all of the sessions the waiting room was used to request other topics (in 90% of the sessions), and the facilitators listened to these requested topics because they were all discussed (100%) in the same session or in a few cases a picture was taken of what was left in the waiting room and that was taken along to the next session [session A17-1]. A topic that raises a lot of questions is nutrition and food which is a theme that plays a huge role in the first year of the baby's' life (for example: how much do you give, breastfeeding or bottles, how to reduce milk and increase solid food, the Rapley method). Also in a lot of the sessions questions were asked about crying, sleeping and the use of a pacifier.

When the first part of the session starts, parents are immediately actively involved, because they are supposed to help measuring and weighing their child at the start of the session. According to the CenteringParenting guide, parents should weigh and measure their baby themselves with help of one facilitator, or at least: help the facilitator with measuring and weighing their baby. In most of these sessions, the facilitator took the lead in measuring and weighing the baby and in some sessions the parent(s) helped. However, in most of the sessions this is done by the facilitators mainly (in 13 out of the 18 sessions), while it should be done by the parent mainly. This might be explained by the normal way of working of the facilitators in the youth healthcare center because in the regular care the facilitators do the weighing and measuring by themselves so they are used to that. Another way of actively learning and involving the parents in the health assessment of their child is to give them insight in what is written down in the medical file of their child. Facilitators do this well (in 17 out of 19 sessions) by mentioning and repeating what they are typing and to ask questions based on what they see in the medical file and note additional information. You can hear it in the recordings by facilitators saying 'I'm going to write that down', and 'let's look at this together'.

The group sessions starts with an opening activity (in 16 of the 20 sessions) such as throwing a little ball around and pass everyone with a certain question such as ‘what did you give your child for Sinterklaas?’ [session A17-2] or ‘what is the best adviceadvice you have received in the past week or month?’ [sessions A17-2 and A18-6]. This opening activity is done so that the session does not start immediately with a specific subject and it becomes hard or dull, but that you start actively together. The facilitators usually also participate in these kinds of activities to let go of that role of adviser and get to know each other better. During the rest of the sessions activities are used to talk about certain subjects in an informative, relaxed, interactive way together. In 14 of the 20 sessions the medical trained facilitator also explained a certain medical issue or development step that matches the age of the baby (for example the ‘van Wiechenschema’ which focuses on the psychical and motorial learning).

During all of the activities and conversations, it is the task of facilitators to start discussions, to ask open deepening questions and to keep the conversation organized without giving immediate advice. Giving direct advice is also called ‘didactic teaching’ in CenteringParenting and facilitators must try to avoid this. In this data there has been made a distinction between didactic teaching randomly by facilitators or as a response to a question of one of the participants. It is striking to hear that didactic teaching is coming back in all of the sessions (100%), a little bit more in response to questions (80 times in total) than randomly (78 times in total) but still. On the other hand, this is how the facilitators always worked in the regular care so switching their mindset and way of working takes time. It is good to realize as a facilitator that in any subject you want to emphasize the underlying meaning of the issue more and to make mothers active and aware themselves instead of saying what is ‘good’ or ‘bad’. Giving advice would also no longer be necessary as the facilitators should try to get the answers to questions out of the group. They can stimulate that by asking open and in-depth questions which did happen in all of the sessions for example questions like ‘can you give an example of that?’, ‘why would that be, do you think?’ and ‘what is your perspective on that?’. In all sessions, open questions occurred. On average 4 open questions were asked by a facilitator per session, and 2 closed questions by a facilitator per session. With closed questions is meant: questions that can be answered with one or a few words (like yes, no, good, bad). Another very important part of activating learning in the CenteringParenting sessions is to use the cycle of question > confirm > acknowledge > advices/solutions > summary > evaluation. The cycle was often started (in all sessions), but only rarely completed (only 4 times in total). For instance: the cycle could also start of without a question (which happened 51 times in these 20 sessions) or with a question of a participant (which happened 47 times in total). Also the

order of the steps of the cycle was mixed sometimes and in many situations the facilitators forgot to summarize or evaluate what has been said in that particular discussion. In those 20 sessions, there were 40 facilitators to lead the sessions, 6 of those 40 never used the cycle (note: in total there were 22 different facilitators so some of them did muladvicele sessions).

A disadvantage mentioned by mothers and facilitators of CenteringParenting is that many parents will compare their child and parenting with others. In a lot of sessions, facilitators accentuate that every child (and their development) is different and that you as a parent need to make the choices that feel right for you and your child (there is not only one right path in parenting). In some sessions, facilitators also appoint the goals of the mothers and what they want to achieve for themselves and their child (not with the self-assessment form as discussed above). The own strength of mothers and the goals they strive for are emphasized.

Presence of community building in the sessions

The third aim of CenteringParenting is community building by means of delivering care in a group of peers. By forming a group together with other mothers with a child of the same age (also known as 'peers'), a new social network is created which becomes stronger as time passes. The group cohesion is assessed on the basis of the different activities, the way in which each other interacts and the openness and support of the group. Activities you can think of include using coins to put in trays with situations that are most applicable to you, discussing foods and when you can give them to your child with the help of cards, and enter into discussions based on propositions (sometimes with splitting the group in smaller groups for some minutes). In most of the sessions (90%), group cohesion was clearly present (if the group has just been formed, it is more challenging to determine whether there is group cohesion right away). There was often a pleasant atmosphere in the group, with a lot of friendliness and the parents laughed and joked with each other. This happened during the sessions (with the facilitators joining them) but also at the informal moments in between (in all of the sessions there was time for informal contact between participants): during the break or during the walk-in. An example of this can be heard on recording A17-4, which is the fourth CenteringParenting session of that specific group and a mother points out her sex drive and whether other mothers recognize that and are also not very active on that area yet. This mother was of Turkish ethnicity, which shows that although there are many differences between the mothers (in age, ethnicity, upbringing and educational level) (sensitive) topics can openly be discussed with one another in a confidential environment. Most of the groups also have contact with each other outside of the sessions, for example through a group app or by meeting separately. The

facilitators promote the use of a group app so that they can ask each other questions there and take the questions to the next session if they cannot resolve it with the moms together in the group app.

As mentioned before, different activities are used to discuss topics to keep the sessions fun, active and diverse. On average 1 or 2 activities are used per session, but in an exceptional case, three activities were done [session A18-6] or none at all [sessions Z17-1 and Z18-2]. What is notable when no activities are used, is that a sort of classroom setting is created with an 'ask your questions here' attitude which takes some power away from the interactive learning. The group grows closer together over time and learns from each other as they share their experiences, ideas and advices. What is often mentioned by parents and facilitators during these sessions is that they like it a lot that you can all monitor the growth, development and change of each other's baby so well with the CenteringParenting sessions. According to the CenteringParenting guide, the last meeting is when the children are 14 months old, but many parents and facilitators would like to continue afterwards. For example, it can be heard on the G18-1 recording that a facilitator will try to arrange a meeting again when the children are around 1,5 years old.

Other elements of CenteringParenting that are related to community building and group feeling are that facilitators intervene in unsafe situations (such as laughing at someone and insulting) which luckily did not occur at all (or at least not audible) in these 20 sessions. Facilitators also intervene if someone is left out in the group session and specifically involve all participants. This happened in about half of the sessions (in 11 of the 20 sessions) but could also be due to the fact that the quieter and shyer mothers give their opinion less quickly, so that facilitators specifically involve them. In the other sessions, no excluding of any participants was heard. An example of where a facilitator specifically involves a mother was when they talked about the help of partners but a single mother was part of the group. The facilitator asked her if she might got some help from someone else [session A17-1]. Moreover, the group part usually starts when the group is complete (in 18 out of 19 sessions, the exception was session A18-10) and all of the babies (100%) have a maximum of 4 weeks of age difference (so that the parents are at the same level in terms of development of the baby and the parents experience a lot of recognition among each other). In addition, if new mothers want to join the group (and if it was discussed on the audio), they were allowed to (it was discussed in 6 of the 20 sessions and new mothers were allowed to join in all 6). The facilitation of the groups was always consistent (as mentioned before, 100%), in a little more than half of the sessions (11 out of the 20 sessions) the involvement of partners in the sessions was determined by the group and

mothers were expected to alternate in taking healthy snacks with them to the sessions for the whole group (which did not always go that way as remarked before).

To get to know each other better and create more group feeling together, a certain layout of the room is applied in CenteringParenting sessions. In almost all sessions (80%) the group space is large enough so everyone can sit in a circle and in 16 of the 20 sessions they created an open circle (on the ground) without tables in the middle. This makes contact with each other more direct and provides a clear view of everyone, with the facilitators facing each other while leading the group. In the first four sessions it is the intention that mothers wear a nametag (with their name and the name of their baby) and they are given the opportunity to decorate it themselves. This wearing of a nametag happened in about three quarters of the sessions in which that would be recommended (10 out of 13 sessions). It is also the intention that there will be no disrupting factors during the session, although unfortunately that did not work out well. In a fourth of the sessions there were no disrupting factors (25% so 5 of the 20 sessions), but in the remaining 15 sessions there were people who came in the room, phones that rang (from mothers and facilitators), unpleasant temperature or smell in the room and even an older child that was present who repeatedly disrupted the session. When a sessions was disturbed, it was disturbed by 2.6 disturbing factors on average.

To ensure that the health assessment that takes place one-on-one fits with the aim of community building of CenteringParenting, a number of elements try to ensure this. First of all, the medical assessment should take place in the same room (shielded by plants or a screen) or in a connecting room with the door open. This was the case in 70% of the sessions listened to. An excuse to close the door was for instance that the doctor could not hear the heartbeat of the child well enough because of the noise in the adjoining room. Secondly, the individualistic doctor's visit is limited, since only things that could not be done in the group are discussed one-on-one (like specific health issues of the child or mother). But it has already been shown that this is often a huge challenge for facilitators. The questions that could be among more mothers should be discussed in the group and must be written on the 'waiting room' but this does not always happen. In about half of the sessions the facilitator answered the question of the mother automatically or decided to answer it one-on-one because it could safe time (so they did it correctly in 10 out of the 19 sessions). The questions asked after each session (Appendix II) show that facilitators find it hard to estimate whether something is a group subject or a rather personal issue. In addition, the facilitators often say that the 5 minutes per individual visit is not able to or difficult to achieve for them. Although some facilitators try different set-ups of the sessions to prevent this, which will be explained under the heading 'practical points'.

Practical points

As remarked in the previous paragraphs: the time aspect is a major stumbling factor for facilitators. Only 5 of the 20 sessions achieved to keep the health assessments within five minutes per child but that did not include the vaccinations. A solution was used by region Zeeland: to let two medically trained facilitators supervise the session so that health assessment and vaccinations could be done simultaneously in two rooms which saves a lot of time. However, in that situation there are some small differences between facilitators and if there are not two medically trained facilitators, this is not an option. Another solution that appeared in region Oss was that the facilitators withdrew during the break together to discuss the rest of the session and to prepare vaccines in advance [session O17-1]. This saved time because preparing the vaccines together in the break is quicker than let one facilitator do it after the group part and it creates a safe environment for the mothers to talk during the break.

A number of practical points about time management is that in most groups all dates of meetings were known from the beginning (in 80%) so that mothers could plan around it and in addition, in most sessions a reminder was given for the next session (in 17 out of 20 sessions, sometimes in response to mothers who asked about it). A clear issue that emerged from the checklists was that more than half of the sessions did not start and end on time, mothers came in late pretty often as well (10 out of the 19 sessions did not meet the time aspect). In 6 of the 20 sessions they started and ended too late, and in 4 out of 20 sessions they started on time but there was a delay afterwards, so it may be necessary to make clear rules about this and to become stricter in complying with these rules. Creating group rules together is also audible in some sessions, since it usually happens in the first session. Agreements are made together with the mothers about canceling sessions, involving partners in sessions, bringing snacks and confidentiality. By discussing this extensively together, the most suitable rules can be created for the group. For example, the involvement of partners for CenteringParenting sessions is more difficult for single mothers and it can be disruptive if mothers often arrive late or leave earlier (which was quite common in these sessions and what facilitators also indicated as issue they are struggling with). Furthermore, the number of mothers in the group is a point that is important for the entire CenteringParenting process. A group that is too large (9 mothers or more) may cause a lot of chaos and the dominant types dominate while the shy mothers may fade into the background, and a group that is too small can provide too little input (5 mothers or less). On average, in just over half of the sessions (11 out of 20), between 6-8 mothers were

present. However, there is no direct link visible in this research between the number of mothers present and the total score on the elements.

Performance of the facilitators

Something that stood out in the data is the difference between facilitators within one session. In most of the session there was one facilitator who gave more direct advice and therefore gave more didactic lessons. As a result of this way of working, more participants also directed their questions to that facilitator. Also asking more in-depth and open questions is often done more by one facilitator than the other in a session, for example in session A18-10 where the first facilitator asked 13 open questions and the second facilitator 0. Moreover, the cycle of question > confirm > acknowledge > advices/solutions > summary > evaluation is often used more by one facilitator than the other. However, there are a few sessions in which the collaboration between two facilitators goes very well, with great interaction together and complementing each other well (for example session O18-3). Because the facilitators sometimes work from different organizations or functions, they may still have the role of a leader and assistant in mind. In the questions afterwards a facilitator who is an assistant at the youth health center stated that she is used to being in that assistant role, and that she still has to get used to equality between facilitators and an equal amount of input. She also mentioned that she would like to receive more help with creating the feeling that she can really 'say something' and have 'informative input' so to receive training in advising. The facilitators have the same role but sometimes it does not feel that way according to some facilitators. There is a lot of difference in performance per facilitator, of course this innovation is 'unprescribed' (ZonMw, 2018b) which makes those differences in the supervision of the sessions possible, but is important to strive for balance and complementing each other as facilitators.

Besides the difference in facilitating the session, there is also a difference in how much the facilitators themselves participate in the sessions. Some facilitators take part in every activity and also have informal conversations with the participants while others are more concerned with only the steering role during a session. Sharing personal advices or experiences as a facilitator can help for a more open atmosphere, can stimulate sharing and can create more group feeling, although it should not become a therapy session for everyone. It is a completely different way of working than how the facilitators work in regular care, which can cause some difficulty switching. However, in the questions after the session a facilitator mentions that she experience the CenteringParenting sessions as a nice variety compared to her 'normal work' [session A18-6].

One of the things that could be examined with this data is whether the performance of facilitators improves over time. This can be examined for eight different facilitators (four from region Amersfoort and four from region Oss). Their performance in the sessions is compared on elements like giving insight in the medical file, giving didactic lessons, ask open or closed questions, use of the cycle, and the length of the one-on-one conversations if the facilitator was medically trained. Also the overall presence of the elements per session is examined on if there are more elements present in later sessions of that facilitator. First of all it must be cited that two of the eight facilitators that we can compare only had two sessions to compare, which is not very reliable and can be based on chance. Secondly, there was not a clear improvement overall in their performance for any of the facilitators. It was notable though that some facilitators grow in some of the elements like asking more open questions every session or using the cycle more and more. It must be taken into account that the performances of facilitators can be influenced by the other facilitator, the age of the children (the older, the more taking care of them during the session), the number of mothers present, the interaction and group cohesion of the group and other disruptive factors.

Centering Healthcare training

During this research a Centering Healthcare training was followed, namely the CenteringPregnancy training. This differs slightly from the CenteringParenting training in content but not in terms of facilitating the Centering sessions. Because a youth healthcare nurse was also present at the CenteringPregnancy training, we had ample opportunities to practice with CenteringParenting subjects. The training is given the same way CenteringParenting sessions could be facilitated, think of an opening- and closing activity, using the cycle, guiding discussions and use activities to discuss relevant themes. It generally provides a good atmosphere, a lot of enthusiasm, and a good example of how CenteringParenting sessions could be facilitated. In the training the emphasis is on the behavior of facilitators themselves, with corresponding quote of one of the trainers:

"*70% of what happens in a group session, is a result of the facilitators."*

The training therefore accentuates that a facilitator must be enthusiastic about CenteringParenting to be able to convey it properly, enthusiastic but sincere, the method should not be persuaded up on parents. It is also explicitly stated that direct advice is not the intention of facilitators and that it is about learning parents the underlying idea behind certain topics (which can often be: do what feels right for you and your child) instead of spelling it out for the parents. In addition, it is also important according to trainers that facilitators remain neutral

or pay attention to different views on certain subjects (such as having respect for a mother who does not want to vaccinate her child, which happened in session A18-15). Even if there are participants with a very strong opinion of their own, facilitators can try to get them to be empathized more in the other by asking 'can you imagine that …'. In addition, the trainers hammer on the fact that Centering is about making mothers aware of underlying ideas of their choices, not focus too much on the smallest details, stimulate the parents to become interactive themselves and the group process. The group should offer a safe environment to talk about parenting challenges and that the parents really benefit from it and go home with a satisfied feeling.

During the training the trainers share a lot of advices with facilitators on how to get a session back on 'light' track after a tough topic is discussed (such as child abuse), what are fitting activities for certain topics, how you keep the sessions 'fun', and how you can start with a good foundation (following the core elements of the facilitator guide for example 'make group rules together'). The trainers also emphasize that facilitators should never skip the break during a session (even though there is a lack of time) because you will then eliminate the possibility of informal chatting between participants. Nonetheless, the sessions often offer more opportunities for informal contact between participants, such as during the walk-in what emerged from the sessions that were listened to in which facilitators occasionally skipped the break in a session. About the use of the cycle (question > confirm > acknowledge > advices/solutions > summary > evaluation) the trainers point out that the steps of summarizing and evaluation are very important. During the summarizing step you can easily repeat certain advices and ideas as a facilitator or not mention them so that the correct advice is summarized, and facilitators can even add their own advices or advice that was still missing. The evaluation step is important so that you can make sure as a facilitator that the mother is satisfied with the help you offered, that she can resolve her issue or that she is reassured. The last element that was accentuated several times in the Centering training is the fact that it is essential to create group rules with the group. By setting clear rules together about for example: using your phone, arriving late, canceling a session, confidentiality, involvement of partners, listening when anyone talks, bringing snacks for the group and using the waiting room for questions, fewer problems will arise in the sessions with regard to these topics.

What is also part of the training and what is certainly worth mentioning is that the trainers also offer help for recruiting enough parents for the Centering sessions. Furthermore, they are realistic about implementing CenteringParenting (or CenteringPregnancy) in your organization: it takes some extra time and effort but it will pay off. The trainers also offer help

as the Centering Healthcare Foundation and via a communication channel where everyone can ask other experience experts for help (also with regard to recruitment of parents and applying for subsidy). The training is therefore very comprehensive and the advices are valuable.

Conclusion

There are a number of core elements that do not score very well at this moment, however the overall average was still a score of 7.7 out of 10%. But it could be asked ‘to what extent the elements that are not doing so well, are needed’. The biggest issues seem to be with the following core elements: keeping the medical one-on-one visit under five minutes; trying to involve parents more actively by weighing and measuring their baby; limiting the one-on-one conversation at the doctor; using a self-assessment form; trying to avoid to give didactic lessons; using the whole cycle of question > confirm > acknowledge > advices/solutions > summary > evaluation; trying to prevent disrupting factors; starting and ending the sessions on time; trying to have 6-8 participating mothers per session; and discussing the involvement of partners more often. It is difficult to say to what extent these elements need to be better trained or are perhaps not extremely essential for the smooth running of CenteringParenting sessions in the Netherlands. In particular, the use of the entire cycle and stopping didactic teaching could already cause a lot of change within the sessions. Perhaps it may be possible to discuss with professionals from the field how these ‘lacking’ elements can be improved and to what extent they should be addressed more in the training of CenteringParenting.

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Appendix I.

Table 1. *List of the 38 essential elements of CenteringParenting* (Kok, 2018).

	Type of element	Element of CenteringParenting
1	**Known beforehand**	At least one of the facilitators is medically responsible (what is the function of the facilitators)* + **
2		The group consists of parents with babies of maximum 4 weeks age difference
3		New mothers can join the group when the group approves
4		The dates for all meetings are known from the start
5		Facilitation of the group is consistent, meaning the facilitators guide several sessions (for example a maximum of 4 facilitators per group)
6	**Individual audio**	The individual visit to the doctor does not take longer than five minutes
7		Participants are actively involved in care activities: parents weigh and measure the baby themselves*
8		Participants gain insight in what data about the child is written down in the medical file
9		The individual visit to the doctor is limited to that research which, given the nature, cannot be done in the group (such as listening to the heart of the baby)*
10	**Group audio**	The discussed topics are in line with the content of the CenteringParenting guide (predetermined themes are discussed)*
11		There is attention for the mental and physical health of the child AND the mother* + **
12		There is time spent on self-assessment (use of self-assessment form)
13		Facilitators will not give any didactic lessons, even on request of the group* + **
14		Facilitators use activities to start the conversation*
15		Facilitators ask open, deepening questions* + **
16		The facilitators use the cycle of question > confirm > acknowledge > advices/solutions > summary > evaluation* + **
17		Other topics are requested by participants*
18		Other topics are dealt with when there is a request of the group (for example the questions of the 'waiting room')* + **
19		The group session starts when the group is complete (unless someone is late)
20		Doctor gives group explanation of medical issue of the day (for example: 'van Wiechenschema')*
21		Facilitators use activities to enhance group cohesion, for example a joint closing activity in which parents get to know each other better*
22		Facilitators intervene when an unsafe situation occurs such as non-respectful communication like discrimination or laughing at someone* + **
23		There are no disrupting factors, such as annoying sounds, strangers walking in and out, people looking into the room*
24		There is time for informal contact between group members
25		Facilitators involve all participants and jump in when someone is not included*
26		Participants receive a reminder of the next meeting (time and date)
27	**Checklist**	The medical assessment takes place in the first 30-45 minutes
28		There are at least 2 facilitators (who did the CenteringParenting training)
29		Healthy snacks & drinks (no soft drinks, or 'light' version) are present
30		Input of participants is stimulated by means of a 'waiting room' (flip-over)
31		The start and end of each meeting is on time
32		The group consists of 6-8 mothers and their baby (and possible partner)
33		The involvement of the partners is determined by the group (how, when, etc.)
34		The group session takes place in an open circle, without a table in the middle
35		The medical examination is in the same room or open adjoining room if the room really is too small
36		The group space is large enough so that everyone can sit in a circle**
37		There are no other / older children present during the sessions, expect during the medical assessment
38		Participants wear a name tag (at least during the first 4 sessions of the group)

* a qualitative explanation of this element is needed, for example: 'did this happen', 'how often', 'in which way', 'which topics' and 'which activity is used'.
** this is one of the eight 'most essential elements' according to Kok (2018)

Appendix II.

Table 2. *Checklist of the presence of 12 elements of CenteringParenting, to be filled out by the researcher on-site* (Kok, 2018).

Element	Proof of presence	Yes/no
The medical assessment is in the same space, or an open attached space when the group area is too small	The medical assessment is within the 2 hours of the session	
	The medical assessment is in either: > Within the group area with enough privacy, for instance by means of shielding with a plant or folding screen > An attached room with the door open	
Healthy snacks and drinks are present	The majority of the snacks are healthy, such as vegetables or fruit. Unhealthy snacks are: cookies, chips, chocolate, bars (such as Mars, Snickers, Celebrations) and candy.	
	There is coffee, tea and water to drink, no soft drinks. When there are soft drinks, they are the 'light' version.	
The beginning and ending of every session is on time	The beginning was on time	
	The ending was on time	
Participants wear a name tag	At least during the first 4 sessions of the group	
There is a maximum of one partner per mother	When participants walk in, one can see who is joining them	
The group session takes place in an open circle, without table in the middle	The only material in the middle of the circle is something for the babies to lie down on and material for the activities.	
The group space is large enough so that everyone can sit in a circle	All participants and facilitators are able to comfortably sit in the circle, with the babies in the center.	
The group consists of 6-8 participants	Count	
There are at least 2 facilitators	Count	
There are no other/older children present during the sessions, except during the medical assessment in the first 30-45 minutes	Count when the participants walk in	
Input of participants is stimulated	For instance by means of a 'waiting room' (flip-over or alike, to write down questions or topics)	

Questions after the session for the facilitator(s):

1. How did it go today?
2. What grade do you give the session today on a scale of 1-10?
3. Name one aspect that could have been done better.
4. Name one aspect that went well.
5. What could help you with CenteringParenting in the future? Think of refresher training, intervision and support?

Appendix III.

Table 3. *Audio analysis coding scheme* (based on the audio analysis scheme of Kok, 2018)

PART I. Predetermined elements

Element uit implementatiegids	Bewijs van aanwezigheid	Score	Kwalitatieve codering
1: At least one of the facilitators is medically responsible	Noteer de functie van de begeleiders (indien mogelijk) zoals jeugdverpleegkundige, jeugdarts, cb-assistente, etc.	1 = One or more medical facilitator(s)	**+ toelichting kolom welke functies**
	NIET AANWEZIG: geen van begeleiders is medisch geschoold.	0 = No medical facilitator	
2: The group consists of parents with babies of maximum 4 weeks age difference	Noteer hoe oud de baby's in de groep zijn, en of ze meer dan vier weken van elkaar verschillen.	1 = Age difference < 4 weeks	
	NIET AANWEZIG: je hoort dat de baby's 4 weken of meer van elkaar verschillen qua leeftijd.	0 = Age difference > 4 weeks	
3: New mothers can join the group when the group approves	Noteer of er nieuwe moeders bij de groep mogen komen als ze iemand hebben die dat graag wil.	1 = new mom can join group	**Let op: noteer -99 als je hier niks over hoort.**
	NIET AANWEZIG: je hoort dat de er een nieuwe moeder graag bij de groep wil, of deze aangedragen wordt maar de moeders daar niet positief op reageren en dit liever niet willen.	0 = new mom can't join group	
4: The dates for all meetings are known from the start	Er is te horen op de audio dat alle data al vast staan en gepland zijn.	1 = dates set	
	NIET AANWEZIG: je hoort dat ze de data nog moeten plannen samen.	0 = dates not set	
5: Facilitation of the group is consistent, meaning the facilitators guide several sessions (max 4 facilitators)	Er wordt gesproken over de komende sessies en wie die precies begeleiden en waarom. Of welke sessies al begeleid zijn door anderen en waarom (maar maximum 4 niet overschreden).	1 = facilitators consistent	
	NIET AANWEZIG: je hoort dat moeders klagen omdat de begeleiding steeds wisselt of je hoort gesprekken over het wisselen / stoppen / uitvallen van begeleiding. Maximaal 4 begeleiders op 1 groep wordt overschreden.	0 = facilitators not consistent	

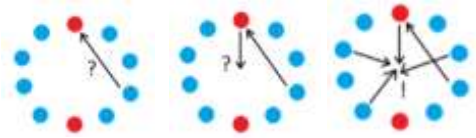
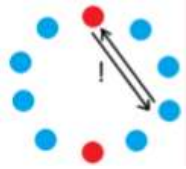
PART II. Individual conversation elements

Element uit implementatiegids	Bewijs van aanwezigheid	Score	Kwalitatieve codering
6: The individual doctors' visit does not take longer than five minutes.	Timen van het bezoek per deelnemer, dan het gemiddelde berekenen. Dat <5 minuten is goed, let op: inclusief vaccinaties.	1 = <5 min visit	
	NIET AANWEZIG: het bezoek duurt langer dan 5 minuten.	0 = >5 min visit	
7: Participants are actively involved in care activities: parents weigh and measure the baby themselves	Vrouwen (en eventueel partners) worden actief betrokken bij het meten en wegen van hun baby. Dit is te herkennen aan uitspraken door de begeleider als: "Kunt u aflezen wat de lengte/gewicht van uw kindje is", "U mag zelf uw kindje op de weegschaal leggen en het gewicht aflezen", "U mag deze week uw kindje weer zelf meten zoals de vorige keer", "Welk gewicht en lengte heeft uw kindje nu?", "Wat heeft u net voor gewicht gemeten?"	1 = Involvement	**+ toelichting hoe ze betrokken worden of hoe ze niet of nauwelijks betrokken worden**
	NIET AANWEZIG: de begeleider zegt dingen als: "Ik heb gemeten dat het gewicht en lengte van uw kindje … is", "Breng je kindje maar hier heen, dan meet en weeg ik hem of haar even"	0 = No involvement	

8: Participants gain insight in what data about the child is written down in the medical file	De deelnemers krijgen te weten welke gegevens er allemaal in het dossier wordt opgeschreven en wat er allemaal gecheckt wordt. Dit is te merken wanneer de begeleider uitspraken doet zoals: “Kijk hier zie je … en dat houdt in dat …”, “Wat we nu doen is … en dat houdt in dat…”, “Ik kijk nu naar … en daardoor zien we …”, “Je ziet dat je kindje … doet, daardoor zie je dat de fijne motoriek aan het ontwikkelen is”, “Ik kijk nu naar … van je kindje”	**LET OP:** gesplitst voor de begeleiders! 1 = Insight medical sight	**+ toelichting over welke informatie genoteerd wordt en wat daarvan ook besproken wordt**
	NIET AANWEZIG: je hoort dat de begeleider bezig is / aan het typen / schrijven is, maar hij of zij zegt verder niks over wat zij aan het doen is.	0 = No insight medical file	
9: The individual visit to the doctor is limited to that research which, given the nature, cannot be done in the group (such as listening to the heart of the baby)	Tijdens het individuele bezoek bij de arts wordt er gehandeld naar wat nodig is. Er wordt bijvoorbeeld alleen naar het hartje geluisterd, vaccinaties gegeven of persoonlijke doorverwijzingen. Uitspraken van arts zijn: “We gaan nu even naar het hartje luisteren en dan zijn we klaar” “Je kan je vraag zo in de groep stellen”	1 = Limited doctor visit	**+ toelichting over welke dingen besproken worden bij de arts (wat ook in groep kan bijv.)**
	NIET AANWEZIG: Als er ook individuele vragen gesteld / beantwoord worden over de gezondheid van de baby / als er andere medische handelingen worden verricht die ook in de groep zouden kunnen. Als ouder zegt: “Ik heb trouwens ook een vraag over …”	0 = Not limited doctor visit	

PART III. Group conversation elements

Element uit implementatiegids	Bewijs van aanwezigheid	Score	Kwalitatieve codering
10: The discussed topics are in line with the content of the CenteringParenting guide (predetermined themes are discussed)	De onderdelen die behandeld moeten worden volgens de CPa richtlijnen komen aan bod tijdens de sessie. Te herkennen aan bijvoorbeeld: “Jullie kindje is nu .. oud, dat betekent dat we het moeten gaan hebben over …” “Deze week krijgt jullie kindje .. vaccinatie volgens het rijksvaccinatieprogramma” “De planning voor vandaag / de komende weken is…”	1 = Follow topic guidelines	**+ toelichting welke onderwerpen aan bod komen van die gepland stonden**
	NIET AANWEZIG: er wordt niet vastgehouden aan de richtlijnen van de CPa guide, te merken aan bijvoorbeeld: “waar willen jullie het vandaag over hebben?” “wat zullen we centraal stellen vandaag?” “we zouden het over .. moeten hebben vandaag, maar …” “we wijken vandaag af van de guide want …”	0 = Not follow topic guidelines	
11: There is attention for the mental and physical health of the child AND the mother	Er worden lijsten gebruikt als ‘voortgangsverslag van moeder’, ‘hoe voel je je vandaag?’ en ‘mijn eigen doelen’. Dit is te herkennen door vragen van begeleiding als: “Pakken jullie even je voortgangsverslag erbij” “Hoe is de afgelopen week voor jullie zelf verlopen” “we focussen nu even op jullie als moeders…” “ook voor jullie als moeder is er veel verandering, hoe gaat het met …”	1 = Focus on mother	**+ toelichting op welke manier de focus op de moeder ligt (en niet alleen op de baby)**
	NIET AANWEZIG: er wordt op geen enkel moment stilgestaan bij de mentale of psychische gezondheid van de ouder.	0 = No focus on mother	
12: There is time spent on self-assessment	Er wordt gewezen op de zelfbeoordelingsformulieren in het Ouderboek (die moet ingevuld worden), en er wordt de moeder geleerd het eigen gewicht te meten, hoe ze de gezondheid kunnen bijhouden. Dit kan je herkennen aan: “hebben jullie het zelfbeoordelingsformulier ingevuld?”, “had iemand nog hulp nodig bij het zelfbeoordelingsformulier?”, “We hebben jullie geleerd om zelf …”	1 = Self-assessment form	**Let op: dit is niet hetzelfde als element 7. Hier focus op zelf-beoordelings-formulier + toelichting wat voor andere**

	NIET AANWEZIG: er is totaal geen focus op zelfbeoordeling, geen zelfbeoordelingsformulier gebruikt.	0 = No self-assessment	**zelf-beoordeling.**
13: Facilitators will not give any didactic lessons, only on request of the group	Slechts op uitnodiging van de groep wordt er UITEINDELIJK op een didactische manier uitleg gegeven (dus het beste is om de vraag eerst terug te leggen in de groep, pas als zij er echt niet uitkomen of alles bediscussieerd hebben de didactische les starten op aanvraag).  Dan kan er bijvoorbeeld een vraag uit de groep komen als: “Maar hoe vind jij dat het moet?” “Maar wat is het goede antwoord?” “Wat is het beste om te doen?” “Hoe moeten we dat aanpakken?” “Waar kan ik terecht?” Of je hoort de begeleider dingen zeggen als: “Wat wij aanraden vanuit ons vak is …” “Het beste wat jullie kunnen doen is …” “Het goede antwoord is …”	**LET OP:** gesplitst voor de begeleiders! Dus 2 aparte variabelen (voor b1 en b2): Didactic on request = 1 Never didactic = 2	**+ toelichting: hoe vaak gebeurd dit op aanvraag van de groep of juist niet op aanvraag per begeleider?** Noteer dit per vraag! **LET OP:** dit staat voor coderen los van de cyclus uitwerking bij element 16 (dus stel de didactische les is deel van de cyclus, noteer ditzelfde fragment dan bij element 16 en focus dan of de cyclus goed doorlopen is):
	NIET AANWEZIG: als de begeleider op didactische manier iets gaat uitleggen, zonder dat daar specifiek naar gevraagd was. Dus er komt een vraag en de begeleider antwoord meteen met dingen als: “Het zit zo …” “Het beste kun je daarmee…” “Dat is …” “Dat is fout, want …” 	Didactic without request = 0	
14: Facilitators use activities to start the conversation	Er wordt een werkvorm gebruikt bij het beginnen van de sessie. Dit is te herkennen aan dat de sessie niet meteen met een onderwerp begint. Voorbeelden kunnen zijn: (bij een eerste sessie): “kunnen jullie even kort jezelf en je baby voorstellen?” “wat zie je terug van je partner en jezelf in je baby?” “we gaan nu in groepjes korte gesprekjes met elkaar voeren en zorg dat je een niet-voor-de-hand-liggende overeenkomst met elkaar ontdekt” “wat voor goed advies heb je de afgelopen week gehad, wil je dat met ons delen”	1 = Opening activity	**+ toelichting: noteer welk type activiteit wordt gebruikt**
	NIET AANWEZIG: de sessie begint meteen met een onderwerp (denk aan slapen, eten, stress, ontwikkeling baby). Zoals: “Pak je zelfbeoordelingsformulier er even bij” “We gaan het vandaag hebben over…” “Jullie baby is nu … weken dus we gaan het vandaag hebben over …”	0 = No opening activity	
15: Facilitators ask open, deepening questions	Worden vragen gesteld door begeleider als: “Hoe…?” , “Kun je dat toelichten?” “Wat (zijn voorbeelden van) …?” “Wanneer (zou je) …”, “op wat voor manier …?” en “kun je me meer vertellen over …” of “waar ben je al geweest om meer info te vinden over dit onderwerp?”	**LET OP:** gesplitst voor de begeleiders! 1 = Open questions	**+ toelichting: noteer welke vragen er gesteld worden, wat voor type vragen en hoe vaak!**
	NIET AANWEZIG: Er worden gesloten vragen gesteld door de begeleider waar alleen ‘ja’ en ‘nee’ op geantwoord kan worden zonder verdere toelichting zoals: “Doe jij dit?” of “Helpt het jou om …”	0 = Closed questions or no questions at all	

16: The facilitators use the cycle of question > confirm > acknowledge > advices/solutions > summary / evaluation	Begeleiders doorlopen de volgende cyclus als er een vraag komt, of zonder vraag (als bepaald onderwerp besproken wordt). De verschillende stappen zijn als volgt te herkennen:  I. <u>Bevestiging:</u> "als ik je goed begrijp vraag je je af of…" en "dus ik begrijp dat je je zorgen maakt over…" [bij geen vraag kan deze stap wellicht ontbreken] II. <u>Erkenning:</u> "zijn er anderen die dit herkennen", "zijn er anderen die deze zorg ook hebben", "wie weet hier meer vanaf", "wie heeft dit ook meegemaakt" of vanuit de groep: "oh ja!!" of "dat heb ik ook wel eens ja!" III. <u>Advices / oplossingen:</u> "heeft iemand een idee hoe we dit aanpakken" of "hoe pakken we dit aan" of "hoe zorgen we er voor dat …" of "wat zouden advices kunnen zijn" of "weet iemand het antwoord op deze vraag?" IV. <u>Samenvatting:</u> "we hebben gehoord dat jij soms last hebt van …, advices die uitgeprobeerd kunnen worden zijn .. en …" of "in de groep heerst soms onzekerheid over …, wellicht kun je … proberen aangezien dat bij sommige anderen werkt". V. <u>Evalueren:</u> "is je vraag zo beantwoord?" en "kun je iets met deze advices?".	**LET OP:** dit element wordt gesplitst voor hele, gedeeltelijke, geen gebruik van de cycle (en gestart met een vraag of niet) waarbij: yes = 1, no = 0, daarnaast ook voor de begeleiders opgesplitst! **a.** Whole cycle used (with question), **b.** Cycle started, based on question **c.** Cycle started, without a question	**+ toelichting: Noteer of de hele cyclus wordt doorlopen (en hoe vaak) waar de cyclus eindigt als dat niet zo is, hoe ver gaan de begeleiders per vraag door in deze cyclus en waar loopt het vast (per vraag).**
	NIET AANWEZIG: De cycle wordt niet compleet doorlopen, er wordt bij een bepaald concept gestopt, of direct antwoord gegeven. Bij direct didactisch het goede antwoord geven: vul dat in bij element 13. Bij een deel van de cirkel doorlopen: vul dat hier in, en geef aan waar gestopt is.	**d.** No cycle use at all	
17: Other topics are requested by participants	Er worden vragen gesteld of onderwerpen genoemd door deelnemers die niet op de planning staan. Deze kunnen op de audio te horen zijn of worden op de flipover als 'wachtkamer' geschreven. Voorbeelden zijn: "Ik had eigenlijk nog een vraag over iets heel anders …" "Mag ik wat vragen over …" "Zou je deze vraag in de groep willen stellen / op de wachtkamer willen schrijven?"	1 = Request other topics 0 = no requests for other topics	**+ toelichting: Noteer hoe vaak andere onderwerpen request worden + welke?**
18: Other topics are dealt with when there is a request of the group (for example the questions of the 'waiting room')	Er wordt gehouden aan de richtlijnen in de CPa guide, maar andere onderwerpen kunnen besproken worden als daar behoefte aan is (en er ruimte voor is). Zo worden bijeenkomsten aangepast aan de behoeften van de deelnemers. Uitspraken zijn bijvoorbeeld: "Ik heb vernomen dat er vragen zijn over…" "Als we naar de wachtkamer kijken, zien we dat … speelt" "Ik zie dat er zorgen zijn over…" "Vind je het goed als we die vraag parkeren op de wachtkamer voor de volgende keer?" "Ik zie niets op de wachtkamer staan, maar wellicht heeft iemand nog andere vragen?" "Mochten er nog vragen zijn die je deze bijeenkomst besproken wilt hebben, vergeet ze dan niet op de wachtkamer te schrijven"	**LET OP:** gesplitst voor de begeleiders! 1 = Dealing with other topics 2 = There were no other topics given	**+ toelichting: Noteer hoe vaak + welke topics beschreven worden en wat wordt met de overige topics gedaan?**

	NIET AANWEZIG: er wordt niet terug gekomen op andere onderwerpen / de waiting room wordt niet besproken door de begeleiding.	0 = Not dealing with other topics	
19: The group session starts when the group is complete	Er wordt gewacht met het openen van de groepsbijeenkomst totdat iedereen het medisch onderzoek heeft gehad. Een uitzondering kan zijn als een deelnemer zelf te laat is, dan kan er gestart worden. Bijv.: “Iedereen is langs geweest voor controle, nu kunnen we beginnen” “Kom er allemaal bij zitten, we zijn klaar met controles” “We wachten nog even op …, dan starten we”	1= Start with everyone (unless someone is late)	
	NIET AANWEZIG: er wordt al gestart met de inhoudelijke sessie terwijl er bijvoorbeeld nog een moeder bij de arts zit. Voorbeeld: “… is nog even bezig bij de arts, maar ik wil vast beginnen met het eerste onderdeel”	0 = Start incomplete	
20: The doctor comes into the group for explanation of the medical themes of the day (for example: ‘van Wiechen-schema’)	Het kan zijn dat de jeugdarts de groep ook begeleid, of dat deze er (even) los bij komt zitten. Denk aan uitspraken als: “Ik wilde nog even het van Wiechen-schema met jullie doornemen” “ik wil jullie nog wat uitleg geven over het medische aspect waar ik me vandaag op richt” “Als we je kind scoren zou dat rond de 15 en 20 punten moeten zijn op 14 maanden” “per onderdeel kan een kind 0, 1, 2 punten krijgen bij het van Wiechen-schema”	1 = Explanation in group 0 = No explanation in group	**+ toelichting: welke uitleg wordt er gedaan door de arts (welk onderwerp).**
21: Facilitators use activities to enhance group cohesion, for example a joint opening / closing activity in which parents get to know each other better	Er worden werkvormen (activities) gebruikt om gezonde discussies te faciliteren. Bij nummer 14 is genoteerd of er een openingsactiviteit gedaan is. Hier kun je noteren of er een sluitingsactiviteit gedaan wordt bijvoorbeeld: dit is te herkennen aan dat er een werkvorm gebruikt wordt om een sessie te sluiten in plaats van direct einde na een gesprek.	1 = One or more activities are used	**+ toelichting: Noteer hoeveel werkvormen er te horen zijn op de audio opname en welke!**
	NIET AANWEZIG: Er worden over de gehele sessie geen werkvormen gebruikt en de sessie eindigt met een afsluitende zin, niet met een werkvorm. Dus het onderwerp wordt direct afgesloten.	0 = No activities are used	
22: Facilitators intervene when an unsafe situation occurs such as non-respectful communication like discrimination or laughing at someone	In principe zouden er geen disrespectvolle situaties moeten ontstaan. Voorbeelden van als dat wel zo zou zijn: uitlachen, onderbreken van verhaal, discriminatie, neerbuigend of negatief over een ander praten, etc. “Jij kan het echt niet omgaan met …” “Dat slaat echt nergens op want …” “Ik volg jouw advies niet want …” Het is van belang dat de begeleider dan ingrijpt door bijvoorbeeld te zeggen: “Zullen we gewoon even naar elkaar luisteren zonder direct negatief te zijn” “Als we nou even kijken naar wat jullie bindt” “Laten we dit later even apart bespreken”.	**LET OP:** gesplitst voor de begeleiders! 1 = No unsafe situation occurred 2 = Intervene in unsafe situation	**+ toelichting: Leg uit wat er precies gebeurde en hoe vaak dit gebeurde + of de facilitator dus ingreep of niet!**
	NIET AANWEZIG: er wordt niet ingegrepen door begeleiding als er een onveilige situatie ontstaat.	0 = Not intervene in unsafe situation	
23: There are disrupting factors, such as annoying sounds, strangers walking in and out, people looking into the room	Te merken door veel achtergrond ruis op de audio te horen, extra stemmen, deuren die open en dicht gaan, wellicht uitspraken als:” “Oh sorry dat ik stoor maar…” “Oh mijn telefoon gaat af, sorry …” “Waarom zit zij nou zo door het raam te kijken” “Sorry voor het lawaai, de locatie is niet optimaal”	1 = No disruptive factors 0 = Disruptive factors	**Toelichting: Noteer hoe vaak dit voor komt + op welke manier.**

24: There is time for informal contact between group members	Er is ruimte voor informeel contact tussen de deelnemers. Dit is te horen aan geklets, gelach, geroezemoes, voornamelijk op de achtergrond te horen tijdens het medisch onderzoek. **NIET AANWEZIG:** er wordt van deelnemers verwacht dat ze stil zijn, zich rustig houden en niet gezellig met elkaar kletsen.	1= Informal contact 0 = No informal contact	
25: Facilitators involve all participants and jump in when someone is not included	Begeleiders kunnen inspringen als het opvalt dat een bepaalde ouder niet goed mee doet, dit kan bijvoorbeeld door diegene specifiek aan te spreken, specifiek iets te vragen, of te vragen of er iets anders aan de hand is. Een voorbeeld is:" "Anita wat zou jij doen in deze situatie?" "Anita heb jij ook zo'n soortgelijke situatie wel eens meegemaakt?" "Laten we allemaal een mogelijk antwoord bedenken op deze kwestie en dan lopen we ze één voor één langs".	**LET OP:** gesplitst voor de begeleiders! 1 = Include someone specifically 0 = Not include somone specifically [hoeft niet fout te zijn]	**+ toelichting: Noteer hoe vaak zo'n situatie voor komt en of er ingegrepen wordt (hoe vaak) + op welke manier! Helaas niet hoorbaar of er iemand totaal niet aan het woord komt.**
26: Participants receive a reminder of the next meeting (time and date)	Bij het afsluiten van de sessie noemt de begeleider wanneer de volgende sessie is, dit kan door bijvoorbeeld: "Ik zie jullie donderdag .. om … uur weer" "Let op: volgende week ontmoeten we elkaar op maandag om … uur" "Door de vakantie is de volgende samenkomst … om .. uur"	1 = Reminder next session	

Appendix IV.

Presence or absence of the 38 elements overall.

1	At least one of the supervisors is medically trained	100%
2	The group consists of parents of babies with a maximum of 4 weeks of age difference	100%
3	New mothers can join the group after the group gives its approval	100%
4	All dates for the meetings are known for the participants beforehand	80%
5	Facilitation of the group is consistent, which means there are a maximum of 4 different facilitators per group	100%
6	The individual visit to the doctor takes no longer than 5 minutes	26.32%
7	Parents are actively involved in weighing and measuring their baby	27.78%
8	Participants gain insight into what information about the child is written down in the medical file	89.47%
9	The individual visit to the doctor is limited to that research which, given the nature, cannot be done in the group (such as listening to the heart of the baby	52.63%
10	The discussed topics are in line with the content of the CenteringParenting guide (predetermined themes are discussed)	95%
11	There is attention for the mental and physical health of the child AND the mother	95%
12	There is time spent on self-assessment (use of self-assessment form)	5%
13	Facilitators will not give any or as few as possible didactic lessons, even if there is a request of the group	5%
14	Facilitators use activities to start the conversation	80%
15	Facilitators ask open, deepening questions	100%
16	The facilitators use the cycle of question > confirm > acknowledge > advices/solutions > summary > evaluation	100%
17	Other topics are requested by participants	90%
18	Other topics are dealt with when there is a request of the group (for example the questions of the ‘waiting room’)	100%
19	The group session starts when the group is complete (unless someone is late)	94.74%
20	Doctor gives group explanation of medical issue of the day (for example: ‘van Wiechenschema’)	70%
21	Facilitators use activities to enhance group cohesion, for example a joint closing activity in which parents get to know each other better	90%
22	Facilitators intervene when an unsafe situation occurs such as non-respectful communication like discrimination or laughing at someone	-
23	There are no disrupting factors, such as annoying sounds, strangers walking in and out, people looking into the room	25%
24	There is time for informal contact between group members	100%
25	Facilitators involve all participants and jump in when someone is not included	100%
26	Participants receive a reminder of the next meeting (time and date)	85%
27	The medical assessment takes place in the first 30-45 minutes	84.21%
28	There are at least 2 facilitators (who did the CenteringParenting training)	100%
29	Healthy snacks & drinks (no soft drinks, or ‘light’ version) are present	84.62%
30	Input of participants is stimulated by means of a ‘waiting room’ (flip-over)	85%
31	The start and end of each meeting is on time	47.37%
32	The group consists of 6-8 mothers and their baby (and possible partner)	55%
33	The involvement of the partners is determined by the group (how, when, etc.)	55%
34	The group session takes place in an open circle, without a table in the middle	80%
35	The medical examination is in the same room or open adjoining room if the room really is too small	70%
36	The group space is large enough so that everyone can sit in a circle	90%
37	There are no other / older children present during the sessions, expect during the medical assessment	95%
38	Participants wear a name tag (at least during the first 4 sessions of the group)	76.92%

* light orange elements are ‘eight most essential elements’ according to Kok (2018)

Appendix V.

Total score on the 38 elements per session.

	Total score on all 38 elements per session
A17-1	77.14%
A17-2	75.76%
A17-3	94.12%
A17-4	68.57%
A18-5	72.41%
A18-6	79.41%
A18-10	80%
A18-15	74.29%
A18-18	78.79%
Z17-1	54.55%
Z18-2	60%
G18-1	82.35%
O17-1	81.82%
O18-2	70.97%
O18-3	83.87%
O18-4	83.33%
O18-6	79.41%
O18-7	80.56%
O18-8	74.29%
O18-9	81.25%
Average	**76.64%**

Average total score per region.

	Average total score per region
Amersfoort	77.83%
Zeeland	57.28%
Groningen	82.35%
Oss	79.44%