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Managing parental groups: Personal impact of a group leadership course for child health care nurses.

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ABSTRACT

Aims and objectives: The aim of this study was to investigate the experience and personal impact of a group leadership course for child health care nurses.

Background: During their child's first year, all parents in Sweden are invited to participate in parental groups within the child health service, however only 49% choose to participate. Despite extensive experience, child health care nurses find managing parental groups challenging and express a need for training in group dynamics and group leadership.

Design: The study was designed as a controlled study with a pre-test post-test design where the participants form their own control group.

Methods: A group leadership course was given to 56 child health care nurses and evaluated in a pre and post intervention questionnaire, a course evaluation and an interview with the course leaders.

Results: The child health care nurses felt their group leadership skills were strengthened and the majority (96%) felt that the course had changed their way of leading parental groups. They felt that the group leader role had been clarified and that they had obtained several new tools to use in their groups.

Conclusions and relevance to clinical practice: Clarifying the role of group leader and adding knowledge about group leadership and dynamics seems to have increased the self-confidence for child health care nurses in group leadership. Improved confidence in group management might motivate the child health care nurses to further develop parental groups to attract the parents who currently choose not to participate.

Keywords

Parental support, parental groups, group leadership, training, nurses, child health services, health promotion

INTRODUCTION

Unlike many other countries, Sweden and other Scandinavian countries offer parental support groups to all parents as part of the universal child health service (CHS) programme. The CHS programme is well appreciated by the parents and 98-99% participate, although only 49% participate in the parental groups (Centre of Excellence for Child Health Service 2015). There is little research on group leadership in parental groups for parents or parents-to-be (Forslund Frykedal & Rosander 2015, Thielen 2012), but a trusting and permissive climate in these groups as well as how the groups are managed is seen to be of importance to parental satisfaction (Hjalnhult *et al.* 2014, Nolan *et al.* 2012, Petersson *et al.* 2004). Despite extensive experience of managing parental groups, child health care (CHC) nurses report feeling insecure in their group leadership role, expressing a need for more knowledge of group leadership and dynamics (Forslund Frykedal *et al.* 2015, Lefevre *et al.* 2013, Wallby 2008). Therefore the aim of this study was to evaluate the experiences and personal impact of a group leadership course on the CHC nurses.

BACKGROUND

Parental groups are led by the CHC nurse and aim to provide knowledge of children's needs and rights and strengthen the parents' social network (Swedish National board of health and welfare 1991, Swedish Paediatric Society 2015). Most parental groups are closed groups with 6-8 couples meeting 8-10 times during the child's first year (Lefevre *et al.* 2013, Wallby 2008). To become a parent is a major change in a person's life and often involves lifestyle changes (Hanna *et al.* 2002) and research shows that parents who participate in parental groups find the groups supportive and strengthening, as well as a place where they can meet new acquaintances to break unwanted isolation (Guest & Keatinge 2009, Hjalnhult *et al.* 2014, Lefevre *et al.* 2014, Nolan *et al.* 2012). Mental and behavioural disorders among

children and adolescents are high (Barlow & Parson 2003, Kieling *et al.* 2011, Who 2014) and self-rated symptoms among 15-year-old Swedish children has doubled since the 80-ies (Public health agency of Sweden 2014). Research confirms that a healthy environment during early childhood promotes physical and mental health later in life (Irwin & Hertzman 2008, Kieling *et al.* 2011, Mc Crory *et al.* 2010) and the overall objective of the parental groups in Sweden is to nurture a healthy environment for raising children (Swedish National board of health and welfare 2008).

To be a successful group leader, it is considered important for CHC nurses to have well-grounded knowledge of facilitation methods for social interaction and creating a non-restrictive group climate, in addition to knowledge of group dynamics and processes. (Andersson *et al.* 2012, Elwyn *et al.* 2004). However, most CHC nurses lack formal group leadership education or training. Parental groups are offered as a complement to individual parental support and are meant to provide possibilities for parents in the same situation to share experiences and serve as resources for each other (Forslund Frykedal & Rosander 2015). Lack of structure and active leadership in parental groups could cause this opportunity to be missed (Hjalmlhult *et al.* 2014).

METHOD

Design

The study was initially designed as a randomized controlled trial (RCT) with a pre-test post-test control group design (Kazdin 2008) following the guidelines for complex interventions (Medical Research Council 2000) and the CONSORT recommendations for RCT (The CONSORT group). The participation rate in the control group was however too low which implied that the included participants had to serve as their own control. The study is registered in Clinical Trials.gov (ID:NCT02494128).

Participants and setting

The study was conducted between September 2014 and June 2015 in the county of Skåne, Sweden. Skåne has 152 CHC centres, of which 90 are public and 62 are privately run, employing about 400 CHC nurses. A CHC nurse is a registered nurse with specialist education in paediatrics or public health care (National network for child health care coordinators/developers in Sweden, 2015). Each CHC nurse in the county starts four to six new parental groups every year (Lefevre *et al.* 2013) with parental participation varying from 32% to 79% (Centre of Excellence for Child Health Service 2015). Inclusion criteria for participating in the study were that the CHC-nurse managed at least two parental groups annually and could participate fully in the intervention.

Intervention

An external course leader working full time with leadership and group development led the courses together with a trainee. A course programme was developed by the course leader in collaboration with the research team and was followed in the same way by all groups (Figure 1). Each course comprised three sessions, three to four weeks apart. The course was based on the “Action Reflection Learning” (ARL) pedagogical model, which uses guided reflections from using learning journals, specific questions and exercises to help participants discover tacit knowledge – such as know-how, judgement, experience, insights, intuition and skills – and transform this into explicit knowledge (Rimanoczy 2008). Short theoretical lectures, exercises and reflections were used to add knowledge and create awareness of the results of personal developed and performed actions.

The participating nurses were divided into three course groups, with each group further divided into small workgroups of five or six people to work together in all sessions. Each workgroup served as a model for how groups develop and how different exercises can

influence group climate. The processes in the workgroups were highlighted and linked to theories about group processes by the course leader. Exercises used to influence the climate in the workgroups also served as examples of exercises that could be used by the CHC nurses directly in their parental groups. Homework aiming to transform insights into action in the nurses' own parental groups was given, which was submitted and then feedback was provided by the course leader via email one week before the next session.

Data collection and outcome measures

The trial was evaluated in three different ways: 1) a web based questionnaire containing 37 questions considering structure, content and extent of parental groups was used at baseline two weeks before the course, and at follow up 4-5 months after the course. The original questionnaire contained 30 predominantly multiple-choice questions, and was previously developed, piloted and evaluated by experienced professionals for use in a Swedish national survey in 2008 (Wallby 2008). Eight questions about group leadership were added in 2011 in a study focusing on CHC nurses' experiences of managing parental groups (Lefevre *et al.* 2013). The present study included an additional question in the post intervention questionnaire about if and if so how the course affected their group leadership. A letter with a unique code and url-link to enter the questionnaire was sent to the participants, followed by three e-mail reminders to those who did not respond. 2). A course evaluation form previously used for several years in further training for primary health care nurses was used. The form consisted of seven questions regarding course content and relevance. Four questions were arranged on a 5-point Likert scale ranging from 1 "poor" to 5 "excellent". Three questions were open-ended, giving the possibility for free-text responses. The form was distributed and collected by the first author at the end of session three. 3) The first author conducted a 45-minute interview with the course leaders to gather their reflections once all courses were complete. The course leaders set the date and place for the interview. They were asked to

freely reflect over their experiences of the course and the processes undergone by participants. The first author made notes during the interview.

Power and sample size

A sample size calculation based on the questionnaire using McNemars' test estimated a need of 45 CHC nurses in the study to receive a power of 80 % with a significance level of 5 %.

Randomization

E mail addresses for all 390 CHC nurses working in Skåne were requested from the Centre of Excellence for CHS (for details see Figure 2a). The public CHC-centres in Skåne belong to three different organisations and are divided according to their geographical areas including both rural and urban regions. To reflect the geographical spread, the CHC nurses were divided into three different strata according to the geographical spread (see Figure 2b). The private CHC centres in the area were added to the strata reflecting their geographical belonging. The Research and Education Center in Skåne created randomization lists by using the R ver. 3.1.1 software (RCoreTeam 2014). By using stratification, the intention was to guarantee the geographical spread, however some areas provided too few registrations, making the stratification impossible to fulfil. In all, 259 CHC nurses were assigned to the intervention group. Of the randomized CHC nurses, 64 invitations could not be sent as the managers of the healthcare centres did not answer the participation request. An information letter was sent by post to the first 75 CHC nurses on the randomization lists by the first author. When CHC nurses declined the invitation or the response period expired, new invitations were sent following the randomization lists. A total of 195 invitations were sent, resulting in 56 participants. The first author contacted the available CHC-nurses via telephone and email and provided the opportunity for them to ask questions and to confirm that they fulfilled the

inclusion criteria. They were allocated to one of the three available course groups according to their course date preferences.

Analysis

Descriptive and comparative statistical analyses were performed using IBM Statistical Package for Social Sciences (IBM, SPSS version 22). The study data was analysed per protocol. McNemars' test was used to test the differences in the perception of managing group leadership as it was a pre- and post- measurement (dependent variables) with two categories of response. . The significance level was set to $p < .05$. The results from the course evaluation were calculated using Microsoft Excel 2010 and the comments expressed in the open questions and the field notes from the interview with the course leaders were analysed by manifest content analyses (Neuman 1997). As recommended, the comments were read through to get a first impression of the text. The comments were condensed with the aim of the study in mind and comments with the same meaning were clustered under main categories (Neuman 1997). To achieve reliability, the comments and clusters were read and discussed by all authors (Graneheim & Lundman 2004) and the interview notes were sent to the course leaders to give them the possibility to confirm the notes and comment further.

Ethical considerations

The study was planned and conducted according to the guidelines of the WMA declaration of Helsinki 2013 (WMA 2013). Written and oral information was provided and electronic consent was obtained before CHC nurses received access to the baseline questionnaires. The first course session began with a short presentation of the study by the first author, opportunities to ask questions and the signing of the written consent for participation. To maintain confidentiality, a code was used in the questionnaires and the course evaluations were anonymous. The study was approved by the Regional Ethical Review Board (2014/397).

RESULT

The intervention was completed by all 56 CHC nurses who participated in the course.

However five nurses missed one course session, and one missed two, because of illness. Due to logistical problems, two of the nurses changed groups and attended one group session with another group.

Questionnaires

The questionnaire contained questions concerning the structure, content and extent of parental groups as well as the nurses' perception of parental support and managing parental groups.

The questions relevant for the evaluation of the intervention are presented in this article. The pre-intervention questionnaire was completed by all 56 CHC nurses and the post-intervention questionnaire by 47, with reasons for not answering including lack of time (n=3) and no longer working within CHS (n=1). Five nurses did not provide a reason. Sixty-four percent of the nurses worked exclusively with CHC and 36% worked with both adults and children. Different specialist educational backgrounds and experiences were represented among the CHC nurses (background characteristics, see Table 1).

Most CHC nurses invited both first-time parents and parents with more than one child to parental groups, predominantly during the child's first year (for details see Table 2).

Participation in parental groups from fathers was estimated to be between 0 to 20% and one-third of the nurses reported taking specific actions to increase their participation, such as extending special invitations, offering parental groups in the evenings or parental groups exclusively for fathers. Less than half of the CHC nurses offered tailored parental groups for young parents and parents whose first language was not Swedish. Most nurses managed their parental groups themselves, a few shared the leadership with another CHC nurse and some invited other professionals including psychologists, midwives or dental hygienists to

meetings. The majority of the CHC nurses had a programme for the meetings which changed if the parents raised other topics. Before the intervention, 50% of CHC nurses found it difficult to manage parental groups while 30% found it easy. After the intervention 36% continued to find it difficult whereas 47% found it easy, this change was however not significant ($p=0,222$) The internal loss was generally low (see table 2), but for the question focusing on whether group leadership was perceived as easy or difficult, 11 nurses did not answer. Written comments about this question showed however that the nurses found managing parental groups both easy and difficult, depending on the group constellation. They also commented that quiet groups could be difficult to engage and differences in the groups could be difficult to handle.

Almost all (96%) of the CHC-nurses believed the group leadership course affected their way of managing parental groups. They described how the course had given them new methods and exercises to use for the parents to get to know each other and to feel comfortable in the group, as well as tools to manage quiet groups and make the parents more active. They also described how the course made them reflect over their own performance and that they had become aware of their own possibilities to influence and develop the interaction in their parental groups.

Course evaluation

Fifty two of the 56 CHC nurses completed the course evaluation directly after the final session. Most nurses were content with the course, both the theoretical (96%) and practical (100%) aspects. The majority of the participants (97%) found that the course provided new knowledge, with all participants finding the course relevant and believing that they would use their newly acquired knowledge in their parental groups (for details see Table 3). Several nurses commented on how they would have liked an additional session some months later.

Almost all nurses (96%) found that the course had changed their view of group leadership in different ways, which was commented upon the course evaluation free-text by 50 CHC nurses. Three main categories emerged from the analysis of those comments: “The importance of being a group leader”; “Increased confidence” and “Received a new toolbox”.

The importance of being a group leader

The nurses described how the course had clarified their role of being a group leader, and gave examples of things they needed to do differently – for example preparing their parental group sessions in advance, having a clear structure for the session and expressing themselves in a different way than before. Twenty CHC nurses pointed out that they had realised that as group leaders, they could influence the climate, motivation and activity amongst the group members, stating that they needed to exercise more obvious leadership role: “...as a group leader, I am important to group development. I have come to realize that I need to become a clearer leader and prepare the sessions better (4)”.

Increased confidence

Not only did the nurses point out the importance of the group leader, they also commented on how they felt that they had now achieved the ability to manage the assignment. Sixteen CHC nurses stated that they felt strengthened and confident in their role as group leader and that they now felt confident enough to be a leader. One CHC nurse stated that she now dared to take control of the situation; “...I can take a step forward, take control (...) and at the same time give the group more space (2)”. Another said that now she dared to step back and let the participants do most of the talking. Some nurses explained that not only did they run the parental groups, they also managed them. One nurse commented how this confidence had made her more interested, “More feeling that ‘I can’, more interested, curious” (7). Some CHC nurses pointed out that they had become aware of their own performance and

expectations and reflected over what and how they did and said things, *“I can see my strengths and weaknesses, how I can work with them. How I can develop and revive my work with parental groups (14)”*.

Received a new “toolbox”

Several CHC nurses commented that the course leaders and other participants had given them many new methods and exercises to increase the motivation and participation of the parents in their parental groups, as well as to influence the group dynamics. *“(I) have been given good tools to make the parents participate and make their voices heard in the (parental) group, that they can participate more in setting the programme at the group sessions (42).”* Some CHC nurses commented that the variety of tools they had received was inspiring and could be used to innovate the sessions in their parental groups, highlighting how different tools should be used in different groups. One nurse expressed this as *“reassuring to have a whole box of tools for inspiration (5)”*.

Reflections from the course leaders

The course leaders pointed out that the CHC nurses had a considerable amount of expertise and that the exchange of experiences from managing parental groups was an important part of the setting. Emphasis was placed on small workgroups forming an important part of the course. Course leaders commented on how participants appeared to gain an awareness of how needs differ between groups for creating a safe and secure atmosphere. Two different categories were extracted from the notes from the interview with the course leaders, *“Increased motivation and self-awareness”* and *“The importance of practical relevance”*.

Increased motivation and self-awareness

The course leaders found the course expectations of the participants to be low and diverse. Initially, many CHC nurses showed resignation towards parental groups, focusing on limited recourses and cutbacks instead of possibilities within existing resources. The course leaders indicated that there was a fear of lacking the right characteristics to be a group leader and that some CHC nurses showed low faith in their own abilities. This however seemed to ease throughout the course, with one course leader stating, “...*some of the participants very clearly went from ‘I don’t want to’ to ‘when is the next group?’*”.

The importance of practical relevance

The course leaders found that sometimes it was difficult for the nurses to see the connection between the processes in the small workgroups and the theories about group processes in general, and felt that this had to be stated explicitly. Practice related exercises that could be tested in their own parental groups were useful and the homework appeared to serve as a good learning platform. The course leaders pointed out that practising supportive interview techniques and reflections over personal leadership seemed to be important parts of the course and commented that one requested subject was how to make group participants more involved and active.

DISCUSSION

The group leadership course aimed to provide knowledge and awareness about group dynamics, processes and leadership and the possibilities for a group leader to influence the group’s climate, promote interaction between group members and deal with the challenges that may arise. The course also aimed to increase self-awareness in the role of group leader and intended to develop the strengths of each participant.

After the course, several CHC nurses expressed feeling strengthened in their leadership role and that they now felt ready to lead. They felt that the group leader role had become clearer

and that they had gained new exercises and ideas, as well as new tools for handling difficulties in their groups. Not only does group leadership of parental groups require extensive knowledge of the subject matter (child health care), it also requires profound knowledge of how to educate and manage group processes (Forslund Frykedal *et al.* 2015). The lack of group leadership and process knowledge has previously been mentioned by CHC nurses (Forslund Frykedal *et al.* 2015, Lefevre *et al.* 2013, Wallby 2008) and it is suggested that low feelings of self-efficacy could result in poor performance and low motivation (Bandura 1982, 2001) for the CHC nurses to manage their parental groups (Forslund Frykedal *et al.* 2015). The CHC nurses found the course to be relevant to their work with parental groups and felt that they could apply their new knowledge to clinical practice. Participants had extensive expertise and meeting and sharing experiences was an important part of the course. This feeling of relevance and social learning are important fundamentals associated with successful learning (Rimanoczy 2008, Sogunro 2015) and as all nurses were working within CHS, examples and experiences were taken from their everyday clinical practice. Homework forced the participants to instantly test their new exercises in their parental groups which is likely to have increased the feeling of relevance.

Self-reflection was another important course aspect and many nurses described that they had become aware of their own leadership and gave examples of things they would like to do differently. A positive atmosphere where the participants feel confident enough to try new behaviours and express their opinions is important to successful learning (Rimanoczy 2008, Sogunro 2015) as well as for the parents in the parental groups managed by the CHC nurses. Small workgroups and interactivity are known to enhance motivation for learning and contribute to a good learning climate (Sogunro 2015), and together with several exercises on how to create a positive and safe environment it probably contributed to successful learning. Positive experiences gained from the personal and group effects of the exercises might have

encouraged the CHC nurses to reflect over their own performance as group leaders and potential outcomes for the parents' experiences of participating in the parental groups.

A strength of the present study is the concordance within the results from the various different ways of investigating the experience of the intervention; however some issues remain to be addressed. Of 195 CHC nurses only 56 chose to participate in the intervention thus the intended stratification could not be fulfilled. In accordance with earlier studies, some geographical areas were less represented in the study (Lefevre *et al.* 2014, Lefevre *et al.* 2013). Most CHC nurses did not give any reason for not participating and there was an over-representation of nurses working solely with children in the study, when compared to our earlier studies (Lefevre *et al.* 2013). It cannot be excluded that those with a greater interest in parental groups are the ones that participated in this intervention and it is possible that the results would differ if all the initially randomised CHC nurses had participated. The study was primarily set up as a randomized group controlled study, however the lack of participants in the control group made this impossible to fulfil. To use a waiting list control group design (Kazdin 2008) could possibly have attracted more participants.

The questionnaire used was originally made for a survey with the intention to learn more about parental groups within the CHS in general (Wallby 2008) and not specifically targeting group leadership. It was used in the present study to allow comparison with earlier studies, but the questionnaire might be too general to capture changes in experiences of group leadership at an early point. A specific questionnaire targeting only group leadership in parental groups combined with a self-efficacy assessment form might have better evaluated the intervention. Nevertheless, the possibility for participants to make comments gave valuable information concerning the CHC nurses' perceptions. Eleven nurses did not answer the question about perception of managing parental groups and the comments indicated that this question was difficult to answer with a short single response. An alternative for obtaining

more comprehensive answers may be qualitative interviews with the participants (SAGE 2013). Notes were made during interviews with the course leaders and an audio recorded data collection might have been a better way to capture the data. The notes were however reviewed and validated by the informants who were given an extra possibility to add comments if needed. To ensure conformability all authors have been part of the analysis in the qualitative part.

In this study the perception and experiences of the CHC nurses was the main focus, the target group for group based parental support is however the parents. To investigate how and if a course in group leadership affects the experiences, and in the long run the participation rate of the parents, is of great importance and should be considered in future studies.

CONCLUSION

Clarifying the role of group leader and adding knowledge about group leadership and dynamics in addition to providing the participants with tools and exercises to use in their parental groups seems to have increased the self-confidence of CHC nurses in group leadership. The nurses found the course relevant and useful and reported that the course had changed their group leadership in different ways. Important parts of the course seem to have been that the course was perceived as relevant to personal clinical work; using peer learning and working with own strengths and challenges in a safe and comfortable environment.

RELEVANCE TO CLINICAL PRACTICE

The importance of prevention and promotion is emphasised within healthcare (Public Health Agency of Sweden: Public health goal 6, WHO 1998) as well as the need for good living conditions among children and young people (Public Health Agency of Sweden: Public health goal 3, WHO 1998). Parents report feeling insecure and isolated in their parenthood (Feinberg & Kan 2008, Nolan *et al.* 2012) and parental groups are shown to be an appreciated way to

strengthen parents and extend their social network (Hjalmsult *et al.* 2014, Lefevre *et al.* 2014, Nolan *et al.* 2012). There are however challenges to address, such as the low participation rate amongst the parents who might benefit the most from the parental groups (Fabian *et al.* 2006, Lagerberg *et al.* 2008). As each CHC nurse spends a large amount of time every year managing the parental groups and the resources within healthcare are limited, it is important that the time spent is used well. It cannot be excluded that a greater confidence in the role as group leader may result in a greater interest for parental groups from the CHC nurses, which may result in new appreciated ways to attract parents with different needs to participate in the groups.

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“What does this paper contribute to the wider global clinical community?”

- Education in group leadership could be of value for all health personnel working with different kinds of group based health promotion to maximize and ensure the effect of group intervention.
- Important parts in a course in group leadership for nurses seem to be perception of relevance, peer learning and working with own strengths and challenges in a safe and comfortable environment.

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Before education started, the participants were contacted by the course leader via email containing detailed information about the course and the first session.

The following sessions were preceded by an email presenting details for the next session and recapitulating the homework.

<p><i>Session one: Creating a trusting climate</i></p> <ul style="list-style-type: none"> -Introduction with expectations and presentation -The “check-in” technique -How to create a trusting and allowing climate in a group -Create small workgroups (“ARL-groups”) -Theories about group leadership and group development processes -Defining own strengths and the aims of the role as a parental group leader -Training in coaching and supportive interview techniques -Defining tasks to be implemented in the nurses’ own parental groups by session two 	<p><i>Session two: The group leader as a conversational leader</i></p> <ul style="list-style-type: none"> -Reflections on the last session and expectations for the present session - reflections on the homework -Training in coaching and supportive interview techniques -How to handle different personalities in a group -Theories about strength-based development -Own development as a group leader and creating an individual development plan - Developing feedback as a technique - Methods to be used in parental groups -Defining tasks to be implemented in the nurses’ own parental groups by session three 	<p><i>Session three: Working with people in change</i></p> <ul style="list-style-type: none"> -Reflections on the last session and expectations for the present session - Reflections on the homework -Theories on the processes and different stages of change -Reflections of change -Planning and designing group meetings -Designing and presentation of a 2-hour parental group meeting in the ARL-group. -Reflecting and giving feedback to other group leaders.
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Figure 1. Intervention

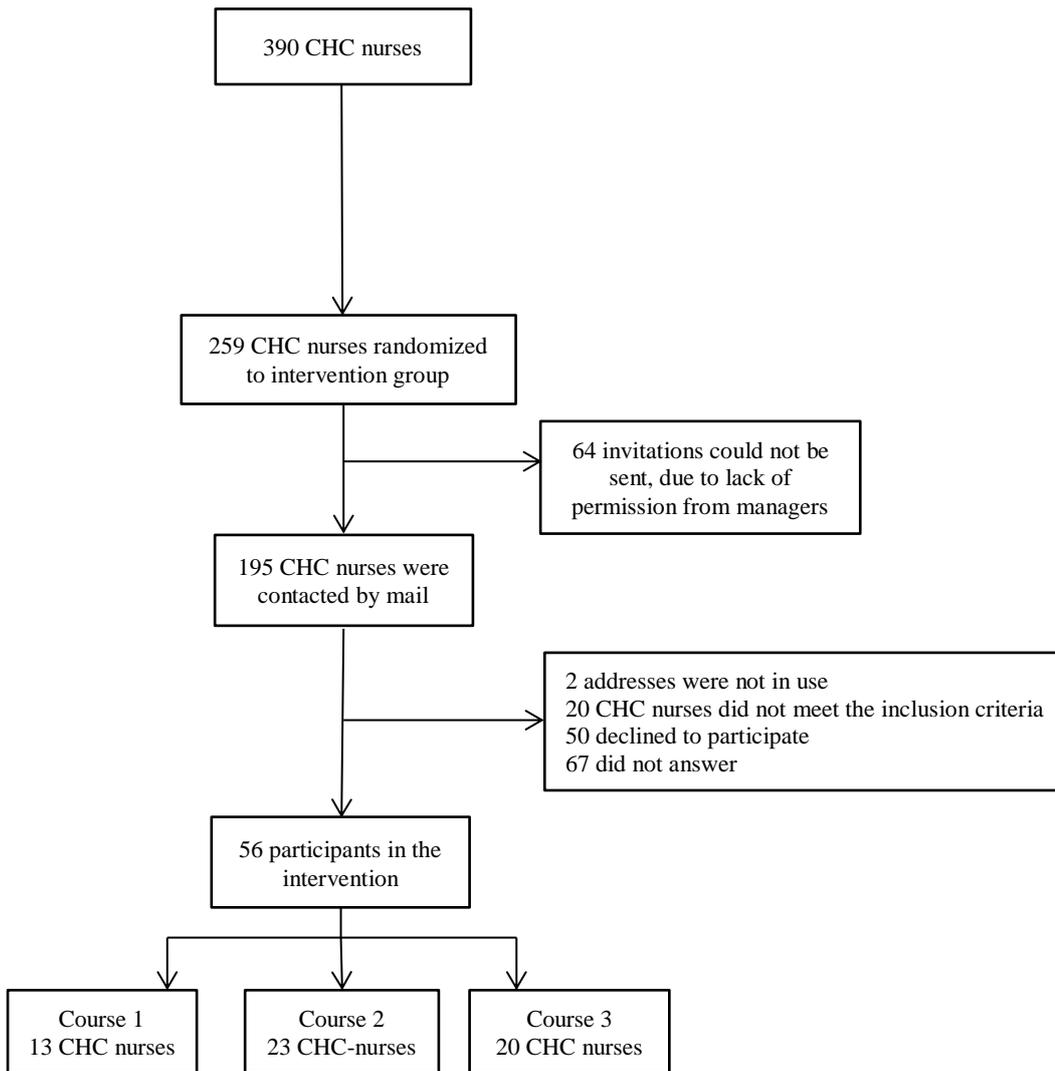


Figure 2A. Flowchart of participating CHC nurses.

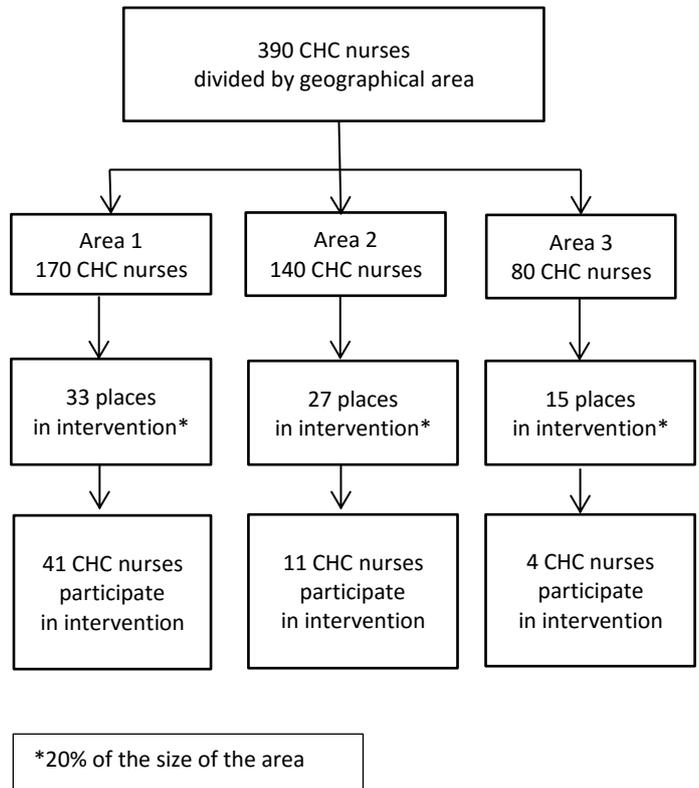


Figure 2B. Stratification.

Table 1. Background characteristics of the participating CHC nurses (n=56).

Characteristics	
Education (%)	
Public Health Care	55
Paediatric	30
Public Health Care + Paediatric	9
Public health care + Other specialist education	6
Years working in CHC (%)	
1-5	38
6-10	21
>10	41
Organization (%)	
CHC organized as Family Centre	27
CHC-centre	73
Nurses working only with children	64
Nurses working with both children and adults	36
Responsible for children under the age of 2 (%)	
20-40 children	47
41-60 children	42
61-80 children	9
81-90 children	2

Table 2. Overview of descriptive statistics. Pre- and post- measurements.

	Pre intervention	Post intervention	P value
	(n=56)	(n=47)	
	%	%	
Parental groups are offered to¹			
First time parents exclusively	-	-	-
Both first time parents and parents with more than one child (all parents)	89	87	
Missing	11	13	
Parental groups are offered..¹			
Exclusively during the child's first year	80	72	0,727
During the first year of the child but also groups adapted to parents with older children	20	26	
Missing	-	2	
Specific measures to encourage fathers to participate¹			
Yes	32	40	0,508
No	68	58	
Missing	-	2	
Offer specific parental groups²			
Young parents	45	53	
Parents with twins	11	11	
Parents with another first language than Swedish	14	19	
Parents with adopted children	7	8	
Fathers	2	2	
Single parents	14	17	
Do not offer specific groups	4	2	
	55	47	
Management of parental groups			
Always leading parental groups by oneself	52	49	
Sharing leadership with other CHC nurse	25	20	
Sharing leadership with other professionals	23	30	
Using programme			
Using and following a set programme	6	-	
Using an programme but changes after parents' wishes	38	30	
Following some set points but also follow parents' wishes	56	70	

¹McNemars test used for paired data

²It was possible to answer with more than one alternative

Table 3. Course evaluation: Participants perceptions of the course.

Likert scale*	1	2	3	4	5
-theoretical part (%)	-	2	2	40	56
-practical part (%)	-	-	-	29	71
New relevant knowledge (%)	-	-	3	35	62
Will use knowledge in clinical practice (%)	-	-	-	23	77

* 5 point Likert scale, 1= bad, 5= excellent