A GACD Implementation Science e-Hub Case Study

GREAT for Diabetes: Group Empowerment and Training for Type 2 Diabetes in South African Primary Care

This case study was developed based on the work of

evaluating and scaling the GREAT (Group Empowerment and Training) program for diabetes in South Africa.

Project team members

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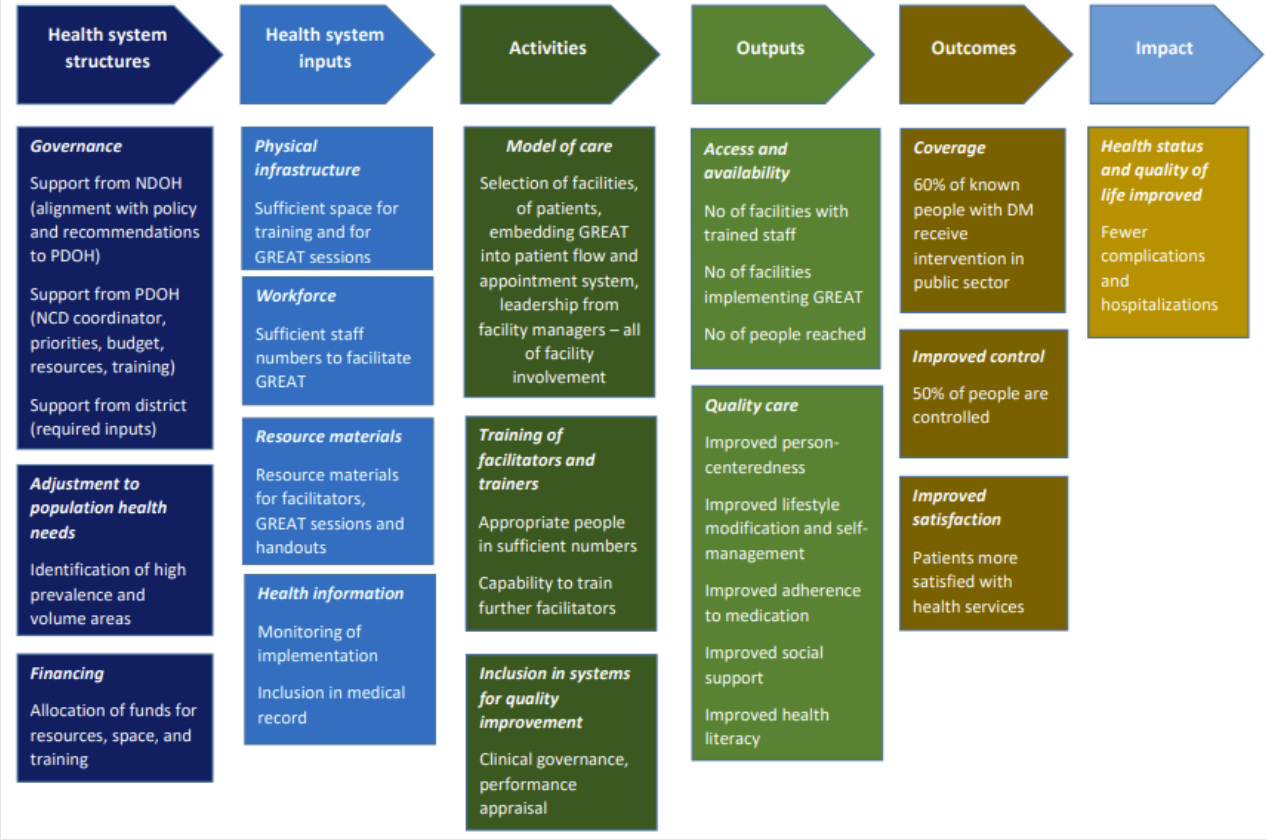

Theory of change. GREAT, group empowerment and training; NCD, noncommunicable disease; NDOH, National Department of Health; No, number; PDOH, Provincial Department of Health.

Case study summary

GREAT for diabetes is a structured, four-session, group-based education and empowerment program designed for people with poorly controlled or newly diagnosed type 2 diabetes in public sector primary care. Grounded in a guiding communication style derived from motivational interviewing, it standardises high-quality self-management support while fitting routine workflows. With World Diabetes Foundation support and National Department of Health endorsement, GREAT was implemented (2019–2022) across districts in five South African provinces, with scale-up restarted post-COVID.

Mixed-methods evaluations reported high acceptability among policy-makers, managers, clinicians and patients; good fidelity to core content (66%–94% across sessions); incremental start-up costs of ~US$494 per facility; and early reach of 588 patients at the time of the initial evaluation, with later routine implementation in the Western Cape reporting 41 groups and 252 patients (NTSS) and an estimated ~300 patients per facility per year in KESS. Facilities documented clinically meaningful improvements in HbA1c, blood pressure, weight and patient experience. A health-system logic model (theory of change) identified governance, resourcing, team-based organisation of care and routine monitoring as the decisive determinants of sustainability.

Identification and characterisation of implementation issues

Healthcare challenge: Type 2 diabetes is a leading contributor to mortality and disability in South Africa, with 75% of patients in the Western Cape not reaching glycaemic targets. Primary care is medication-replete but time-poor for behaviour change counselling; health literacy and self-management support are limited, and workloads are high.

Systemic issues: Key barriers included lack of suitable space for groups, insufficient trained facilitators, variable availability and control of resource materials, weak NCD information systems (no routine indicators for group education), and uneven managerial buy-in across provinces and facilities. COVID-19 halted groups for nearly two years, delaying adoption and reducing momentum. Bureaucratic delays (e.g., unsigned MOUs) impeded printing and distribution of materials for scale-up.

Selection, adaptation, and application of implementation strategies

Group education embedded in routine primary care: GREAT consists of four structured sessions (What is diabetes; Lifestyle change; Medicines; Avoiding complications) delivered to groups of 10–15 over 1–2 hours, using a guiding, collaborative style. Standardised visual tools (flipcharts, card games), facilitator manuals and optional patient handouts support consistent delivery. Facilities commonly targeted newly diagnosed or uncontrolled patients (often HbA1c >10%–12%) and aligned sessions with existing appointment flows to avoid penalising attendance.

Development and delivery of the stakeholder engagement strategy

Collaborative framework: National and several provincial/district managers endorsed GREAT and, where integrated into operational plans (e.g., Western Cape substructures), monitored implementation and performance. Train-the-trainer and in-house training (dietitians, diabetes educators) expanded facilitator supply; family physicians supported clinical governance, troubleshooting and local audit.

Community involvement: Patients co-created practical solutions during group discussions, extended support through community and WhatsApp networks, and disseminated learning to family and peers. Facilities engaged clinic committees and explored inclusion of community health workers to reinforce messages during household and adherence club contacts.

Evaluating implementation

Methodological framework: A convergent mixed-methods design assessed acceptability, appropriateness, adoption, feasibility, fidelity, reach and costs across ten facilities per province. Data sources included 34 key-informant interviews (national to facility level), five patient focus groups (n=35), structured session observations, facility-level reach registers and cost templates. Findings informed a logic-model programme theory spanning health-system structures, inputs, activities, outputs and outcomes.

Impact assessment: Observed facilitation quality was good; fidelity to core session content ranged 66%–94% (lowest for the medicines session, highest for complications/foot care). Sites and substructures documented reductions in HbA1c and blood pressure among participants, improved lifestyle behaviours and satisfaction, and strong attendance continuity (reported 80%–90% in NTSS). Early national reach at re-launch was 588 patients; later, NTSS recorded 41 groups/252 patients, with KESS estimating ~300 patients per facility per year once embedded.

Results and key findings

Blood glucose control and adherence: Facilities reported substantial HbA1c reductions among attendees, better medication understanding and adherence, and improved self-monitoring/problem-solving (e.g., hypoglycaemia management).

Functional outcomes and person-centred care: Participants reported dietary change, weight loss, increased activity and stronger self-efficacy. Group dynamics enhanced social support and health literacy; clinical interactions were perceived as more collaborative and responsive.

Strengths and limitations

Strengths:

- Standardised, low-cost group education embedded in routine care, using a guiding style that reliably improves self-management.
- Feasible facilitator training model (3-day workshop; in-house trainers) and adaptable logistics (fast-track pharmacy, integrated visit flow).
- Clear programme theory/logic model to steer governance, resourcing, monitoring and scale-up.

Limitations:

- COVID-19 disrupted adoption, limited early reach and curtailed observation numbers; several provinces did not sustain implementation.
- Space constraints, staff turnover and weak routine NCD information systems hindered scale; fidelity for the medicines session was lower.

- Provincial bureaucracy (e.g., unsigned MOUs) delayed material printing and further training in some settings.

Success factors and challenges

Success factors: Formal inclusion in substructure/district operational plans; visible facility-manager support; whole-team ownership (clinicians, reception, pharmacy, facilitators); clear patient selection and non-penalising patient flow; availability of complete resource sets; and local audit/feedback (e.g., HbA1c tracking) to sustain motivation and accountability.

Challenges: Space competition in facilities; facilitator loss/rotation; inconsistent monitoring (no routine indicator at many sites); scheduling barriers for working patients; and provincial financing/administrative delays for materials and training. Partner projects occasionally retained materials or trained unprepared facilitators, undermining fidelity and momentum.

Next steps

Scale-up and policy integration: Adopt GREAT as a named intervention within provincial NCD operational plans, with a routine indicator on facility dashboards; contract printing of materials under IP-protecting MOUs; expand train-the-trainer capacity via provincial People Development Centres; and extend to community platforms (CHWs, adherence clubs) to increase reach, including outside office hours.

Long-term sustainability: Institutionalise GREAT in performance agreements and clinical governance cycles; ensure two or more trained facilitators per facility; plan for space in refurbishments; develop a complementary three-session insulin-initiation group program; and maintain adjunct digital supports (e.g., WhatsApp chatbot) to reinforce learning between sessions.

References

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Key learning objectives

1. Understand how a standardised, guiding-style group education program can be embedded in routine primary care to improve diabetes self-management at scale in resource-constrained settings.
2. Recognise the centrality of governance, resourcing and whole-team workflow design—codified in a logic-model programme theory—for sustainable implementation and monitoring.
3. Learn practical strategies to maintain fidelity and reach (facilitator pipelines, protected space, routine indicators, non-penalising patient flow) and to extend impact via community and digital reinforcement.