

INNOVATIONS IN PATIENT-CENTERED ANTENATAL CARE:

A pregnancy club for women in Eastern Uganda

High-quality, patient-centered antenatal care (ANC) is a key strategy for improving maternal and newborn health and a critical component in the continuum of care. ANC enables early diagnosis of life-threatening complications, supports healthy behaviors and practices, links women and communities with the health system, and can help to drive increased coverage of skilled birth attendance and improved health throughout the life cycle.

Many women in low and middle-income countries still face gaps in access to high-quality ANC. In many countries, fewer than half of pregnant women¹ complete the four or more antenatal care visits long recommended by the World Health Organization, let alone the minimum of eight antenatal contacts recommended in new guidelines released in 2016.² Recent evidence suggests that current models of ANC are not meeting women's needs for information and support, limiting uptake of this essential intervention.³

TESTING THE PATIENT-CENTERED MODEL

In a feasibility study in two districts in Eastern Uganda, Management Sciences for Health (MSH) is testing a patient-centered group model of antenatal care that provides a forum where pregnant women can share experiences, receive essential health information from a midwife or other skilled provider, and track and better understand the progress of their pregnancies. Through facilitated group discussion, this model builds a supportive community of pregnant women to normalize the pregnancy experience, support birth planning, and provide emotional and social support during a stressful, momentous, and often isolating time. MSH's study seeks to understand how this model can be designed and implemented in a way that is responsive to the needs both of pregnant women and of often overburdened front-line health providers. The objective is to enable the health system to sustainably and efficiently improve quality of care, increase ANC coverage, and empower pregnant women to improve their self-care.



Although Uganda has made progress, it still faces a high burden of maternal and newborn mortality. Each year, nearly 6,000 women and girls die from pregnancy and childbirth-related causes, and 45,000 newborns fail to survive their first 28 days of life.⁴

1 WHO Global Health Observatory Data. http://www.who.int/gho/maternal_health/reproductive_health/antenatal_care_text/en/

2 World Health Organization (WHO) recommendations on antenatal care for a positive pregnancy experience.

The entire guideline accessible at: <http://apps.who.int/iris/bitstream/10665/250796/1/9789241549912-eng.pdf>

3 Finlayson K and Downe S. Why Do Women Not Use Antenatal Services in Low and Middle Income Countries? A MetaSynthesis of Qualitative Studies. *PLoS Med* 2013, 10(1): e1001373

4 Ministry of Health, Government of Uganda, Situation analysis of newborn health in Uganda- Current status and opportunities to improve care and survival. Full document accessible at: <http://www.healthynetwork.org/hnn-content/uploads/Situation-Analysis-of-Newborn-health-in-Uganda.pdf>

ROLLING OUT THE MODEL IN 3 STAGES

Stage

1

HUMAN CENTERED DESIGN

“We come here for a group, we are getting relationships with other women. And that relationship is helping us to understand each other and everybody...That part of sharing problems...helps us prevent some dangers and problems we are facing in our pregnancy...”

-Pregnant woman



Partnering with M4ID, a social impact company specializing in human-centered design of health interventions in low-resource settings, MSH directly engaged key stakeholders in co-creation of a group ANC model that reflects an understanding of the cultural context and responds to local needs.

Through the human-centered design process, MSH learned from women and health providers about their needs, preferences, and expectations.

- **No one wants another health talk.**

A pregnant woman doesn't want to hear 'just another health talk' from a provider that she has no reason to like or trust. Changing the provider-patient dynamic encourages participation and attendance.

- **Knowledge enables ownership.**

Helping a woman better understand her pregnancy and impending motherhood encourages her to take more active responsibility for her health and that of her baby.

- **Sharing is learning.**

Sharing real-life experiences promotes a new and powerful form of learning.

- **Support is empowering.**

A woman is empowered when she feels supported by other women and by her health provider, and has a sense that she belongs.

Based on these findings, the M4ID team developed the concept of the 'pregnancy club.' They designed a prototype for visit flow, and tested it with women and providers. They developed materials to support the club and the ANC service: a circular mat for use in each session's opening and closing rituals and illustrated scrolls with information and messages about maintaining a healthy pregnancy.

Stage

2

IMPLEMENTING THE PREGNANCY CLUB

To generate support for the pregnancy club, MSH advocated with national Ministry of Health officials and other stakeholders, and worked closely with district health officials to select six implementation sites. A Ghanaian midwife, experienced in group approaches, trained district-level staff and two providers from each selected facility in facilitation of group ANC sessions. MSH produced the mats and scrolls out of locally available materials for each of the six sites.

Trained ANC providers began offering pregnant women the option of joining the pregnancy club. MSH shared information about this new option for ANC with communities through existing structures, such as village health teams and health facility committees, and through word-of-mouth to friends, neighbors and family of the pregnancy club members.



Stage

3

PRELIMINARY FINDINGS OF IMPLEMENTATION RESEARCH

“We teach them...how to support one another in the community. So that in case they see a pregnant mother with a problem in the community, they should be in position to help and even their family members should know what to do.”

-Midwife trained in Group ANC

After three months of implementation at six sites, MSH assessed the initial experiences with the group ANC model, using a range of research methods: focus groups and in-depth interviews, observations of pregnancy club sessions, and review of data and project registers.

This research aimed to answer the following questions:

- What are stakeholders' perceptions regarding the feasibility of adopting this service delivery model in Eastern Uganda?
- How acceptable is the model for women, health providers, and health managers?
- How does the health system have to be strengthened, and what processes and protocols need to be adjusted, to support effective implementation of a group ANC model?

MSH found that women embraced the group ANC model. They had received more and better information about pregnancy and delivery, and were particularly pleased with this benefit of club membership. In sites where the model was implemented with the greatest fidelity, women spoke about the support they received from the new friends they made in the pregnancy club. Many described a more trusting bond they had built with the pregnancy club midwife, and expressed that she be their birth attendant. (This created some challenges and concerns that she might not be on duty when labor began.)

Participating nurses and midwives felt that the pregnancy club had helped them to build stronger relationships with women. They felt that the group approach would potentially improve women's use of services, but also expressed some concern about the additional staff time and effort that this would require: if only one provider was on duty group sessions might be interrupted or delayed due to a delivery or an emergency, thereby adding to waiting times.

District Health Management Team members also appreciated the benefits of the new model for ANC, describing it as an improvement in the package of services. They also requested support to adjust the curriculum and to supervise and scale-up implementation of the model.

Although analysis of the data is still underway, the group ANC model looks very promising. The pregnancy clubs were embraced by many key stakeholders, from pregnant women themselves to midwives to district and national MOH officials. Additional refinements and health systems inputs will help improve the group ANC model's sustainability.

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