

Improving Retention in the Maternal, Newborn, and Child Health Continuum of Care through Group Antenatal and Postnatal Care Model

Lessons from the USAID Afya Pwani Project in Kenya



Summary

Antenatal care (ANC) is an integral part of maternal health care, but ANC services are still low in low- and middle-income countries (LMICs), and the quality of care can be poor. LMICs continue to bear a disproportionate burden of adverse pregnancy and newborn outcomes. The provision of high-quality ANC and postnatal care (PNC) optimizes the experiences of pregnant women and newborns. ANC provides an opportunity to offer appropriate clinical care and emotional support for pregnant women and is associated with increased utilization of subsequent health services, such as institutional delivery and PNC.¹ Group ANC, which brings together pregnant women of similar gestational age for group learning and peer support, moves beyond the benefits of individual ANC and is associated with improved attendance, satisfaction with care, and health outcomes for pregnant women and newborns.²

Between 2018 and 2020, the USAID Afya Pwani project, in partnership with the county government of Kilifi, Kenya, enrolled 11,169 women in ANC groups. The project enrolled 7,034 pregnant women aged 25 years and above in 218 Mama Kwa Mama (Mother for Mother) groups and 4,135 adolescent girls and young women (AGYW) in 121 Binti Kwa Binti (Daughter for Daughter) groups. Afya Pwani implemented the approach in 93 health facilities in Kilifi county. At the end of the project, 4,767 women had completed 13 monthly visits- 1 visit per month for over 13 months. The groups enhanced retention of enrolled women over 13 months, achieving 96% overall retention in cascade. Uptake of skilled deliveries stood at 97%, 96% of children under one year were fully immunized as recommended by the Kenya expanded program of immunization (KEPI), thus attaining the fully immunized status (FIC), and 86% uptake of voluntary family planning (FP) services. The groups also enhanced socio-economic empowerment by increasing income opportunities for women, supporting personal development, and expanding women's financial inclusion. The project also supported 30 groups to register as self-help groups and five groups to register as community-based organizations (CBOs). The retention shows incredibly high participation, acceptability, and ownership.



BACKGROUND

The maternal, newborn, and child health continuum of care³ supports an integrated MNH approach, with the mother-baby dyad at the center. It articulates critical linkages in time (when care is given along the lifecycle) and place (where, or at what level of the health system, care is delivered), to move towards greater coverage of critical, evidence-based interventions. When women and newborns receive high-quality care during pregnancy, at the time of birth, and in the early postnatal period, women stay healthy, and babies get the best start in life. Emphasizing the mother-baby dyad offers a practical approach: Women and families are more satisfied with coordinated, combined care; and the same provider is often responsible for both preventative and life-saving interventions that protect both women and their newborns.⁴

Kenya is among the countries facing challenges in reducing maternal, neonatal, and child morbidity and mortality in Sub-Saharan Africa. However, the government has significantly lowered Kenya's maternal mortality ratio (MMR) from 2000 to 2017 by 51.6%, from 708 to 342 deaths per 100,000 live births. This reduction translates into an annual reduction of 2.86%, which remains below the 6.4% annual reduction needed to achieve the Sustainable Development Goals (SDGs)⁵. The KDHS 2014 survey highlighted Kilifi county as a high-priority reproductive, maternal, newborn, child, and adolescent health (RMNCAH) county - one of the 15 counties contributing to 98% of the total burden of maternal death in Kenya. The county MMR was at 250/100,000 compared to the national MMR of 362/100,000. It also reported low skilled birth attendance (SBA) of 52% against a national average of 62% and a low PNC of 38% despite most postnatal deaths occurring within 48 hours of delivery due to maternal complications.⁶

Increasing ANC quality and completion, institutional delivery, and immunization uptake, and reducing the unmet need for FP are key strategies to reduce maternal, neonatal, and child morbidity and mortality.⁷ An effective continuum of maternal care (CoC) ensures mothers receive essential health packages from pre-pregnancy to delivery and during postnatal care, which improves mothers', newborns', and children's survival and achievement of optimum outcomes.⁸ Retention in the CoC requires an integrated service delivery system that coordinates the critical components of maternal services (from pre-pregnancy to delivery and postnatal care) with a continuous stream of quality services at each level.⁹ However, marked disparities exist between high-income, upper-middle-income, and lower-middle-income countries in the coverage of these services. For example, SBA in lower-middle-income countries is less than 50%, while it is more than 90% in most high-income and upper-middle-income countries. In Africa, the proportion of mothers receiving SBA (51%) is lower than that of any professional ANC (78%).¹⁰ Kenya and Kilifi county trends are similar to those in Africa more broadly, with high ANC coverage of 96% and 95%, respectively, and low SBA at 62% and 52% (KDHS 2014), respectively.

The low continuum of care completion rate indicates that women are not getting the maximum possible health benefits from existing health services. The barriers to uptake of services include poverty, distance to facilities, lack of information, inadequate and poor-quality services, and cultural beliefs and practices. The World Health Organization (WHO) recommends group ANC as a health system intervention that provides an alternative to individual ANC and can improve utilization and quality of care for pregnant women.¹¹

APPROACH

Traditional ANC consists of short, one-on-one meetings between a clinician and a pregnant woman, often with a one-way flow of information and a narrow focus on physical assessment. In contrast, group ANC brings together a group of pregnant women of similar gestational age and supplements their clinical care with group learning and peer support, fostering deeper relationships, enhancing women's knowledge, and encouraging self-care. The group care model's success in high-income countries suggests that group ANC could be adapted to improve care outcomes and experiences for women in LMICs.¹²

The USAID-funded Afya Pwani project implemented an integrated approach of group ANC and traditional ANC. The group ANC was implemented in line with the WHO framework for quality of care that puts women at the center of service provision and aims to improve women's access to and engagement and satisfaction with care. The project further implemented a differentiated care model through an enhanced group ANC/PNC service package to improve retention in the MNCHFP cascade in Kilifi county. The project dubbed the Mama Kwa Mama (MKM) groups and Binti Kwa Binti (BKB) groups. MKM is a peer support structure made up of different cohorts of pregnant women (both HIV positive and negative; first-time mothers and non-first-time mothers) who are 25 years and older. Each group consists of between five and 30 women. The BKB group offers a targeted approach that provides adolescent and youth-friendly services to pregnant and postnatal young girls and women below 24 years.

Objectives of Mama Kwa Mama Groups

- To motivate behavior, change among pregnant women to ensure good health seeking practices during pregnancy and intrapartum and postpartum periods.
- To ensure an effective transition to positive labor and birth while enhancing client retention across the reproductive health cascade.
- To empower pregnant women to advocate for quality maternal, newborn and child health.
- To aid clients in achieving positive motherhood outcomes (maternal self-esteem, competence, autonomy) within the accepted social cultural norms.

The MKM groups build on the Kenya Ministry of Health (MOH) guidelines and borrow heavily from the centering model of care and added service enhancements utilizing the WHO CoC to support retention. Centering¹³ is a model of group health care with three components – healthcare, interactive learning, and community building – provided in a group facilitated by a health provider and a co-facilitator who is a nurse or other appropriate staff member. The groups integrate health assessments with tailored group educational activities and peer support, motivating behavior change among pregnant women, and increased women's satisfaction

Afya Pwani adopted the health belief model framework¹⁴ to better understand and address the needs within the four levels of the model's constructs: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. It utilized social capital to address obstacles and demystify negative beliefs and practices.

The approach incorporates health promotion, clinical management, and social-economic empowerment. It also fulfilled the critical elements for woman-centered care¹⁵, including the need for respect and safety; empowerment, involvement, and participation of women; a collaborative, inclusive approach to the provision of health care; and information sharing and decision making. Most patients appreciated the ease and flexibility of scheduling, reduced waiting time, and long-term social bonds that developed within the groups. In these groups, the women are retained up to nine months post-delivery to foster exclusive breastfeeding, FP, PNC, and immunization services. Through facilitated group discussion, this model builds a supportive community of pregnant women to normalize the pregnancy experience, fosters birth planning, and provides emotional and social support during a stressful, meaningful, and often isolating time of pregnancy.

The project also introduced skills and livelihood coaching within the Mama Kwa Mama and Binti Kwa Binti groups to empower women. This effort increased income opportunities for women, supported personal development, and expanded women's financial inclusion. The project engaged mentors to build livelihood skills for the group members. The mentors coached the groups to develop business plans and position themselves to access available local resources like the National Government Affirmative Action and Women Entrepreneurship funds. The project supported the groups to meet monthly until all mothers were nine months postnatal, culminating in a graduation ceremony transitioning from facility-based (clinical) management groups into community entrepreneur/ empowerment groups.

The graduation ceremony provided an opportunity to celebrate and showcase the women who successfully went through the maternal, newborn, and child health continuum of care. During the graduation, the facilities invited current MKM and BKB group members, local administration, community leaders, and the county and sub-county health management teams (S/CHMTs) to enhance facility and community ownership. The facility conducted dialogues to identify existing barriers to group ANC and group PNC in the health facilities. The women traced their journey and involvement in the groups, reiterated the benefits of attending the group meetings, and affirmed their commitment to being role models and agents of change in MNCHFP.

IMPLEMENTATION PLANNING

The steps below outline the implementation planning process Afya Pwani followed for the Mama Kwa Mama and Binti Kwa Binti

STEP 1: Sensitize county and sub-county health management teams on the group ANC/PNC model to achieve buy-in.

STEP 2: Conduct community and health facility sensitizations to attain buy-in.

- The project engaged the community gatekeepers (Chief, Sub-chief, and Village elders) to identify pregnant women and mobilize them for intake visits, national registration linkage, and administrative support.
- The county and sub county health management teams (S/CHMTs) identified ten champions per sub-county (five in the community and five in the health facilities). The characteristics of the champions included.
 - A community health volunteer or a health care provider trained in maternal, newborn, and child health.
 - Persons who are passionate about improving maternal, newborn, and child health in their community or health facilities.
 - Self-proclaimed advocates for Maternal, newborn, and child health.
 - Persons with political goodwill and strong leadership skills.
 - Ability and willingness to mentor peers.

The role of the champions included:

- Lead the implementation of Mama Kwa Mama and Binti Kwa Binti groups in their primary health facilities.
- Conduct mentorship sessions for the peers on the above interventions.

STEP 3: Developed an implementation guide, standard operating procedures (SOPs), and reporting tools to ensure uniformity in implementation and developed monitoring and evaluation SOPs to review the process and enhance quality.

- The project also used the MOH 510 (Permanent immunization register) and MOH 511 (Child welfare clinic register), to collect quantitative data on immunization, which were summarized into the monthly MOH 710 (Immunization Services Uptake Summary). Similarly, quantitative data on delivery, Postnatal care and family planning were collected from the MOH 333(Maternity register), MOH 406 (Postnatal care register) and MOH 512 (Family Planning Services register) respectively, summarized on MOH 711. The data from the monthly summaries were uploaded on the National DHIS
- The project designed and rolled out the Mama Kwa Mama activity reporting tool to collect qualitative data and quantitative data and the Mama Kwa Mama longitudinal register for longitudinal follow-up.

Scope of Community and Facility Sensitization

- Communicating skills/ soft skills
- Provision of targeted ANC and PNC information, messaging, and services
- Fostering group cohesion
- Privacy & confidentiality
- Making the MKM and BKB clients aware of other activities that can promote retention.

STEP 4: Built capacity of the identified champions to implement ANC/PNC concept and the developed tools.

STEP 5: Introduced and scaled up to group ANC/PNC in a phased approach.

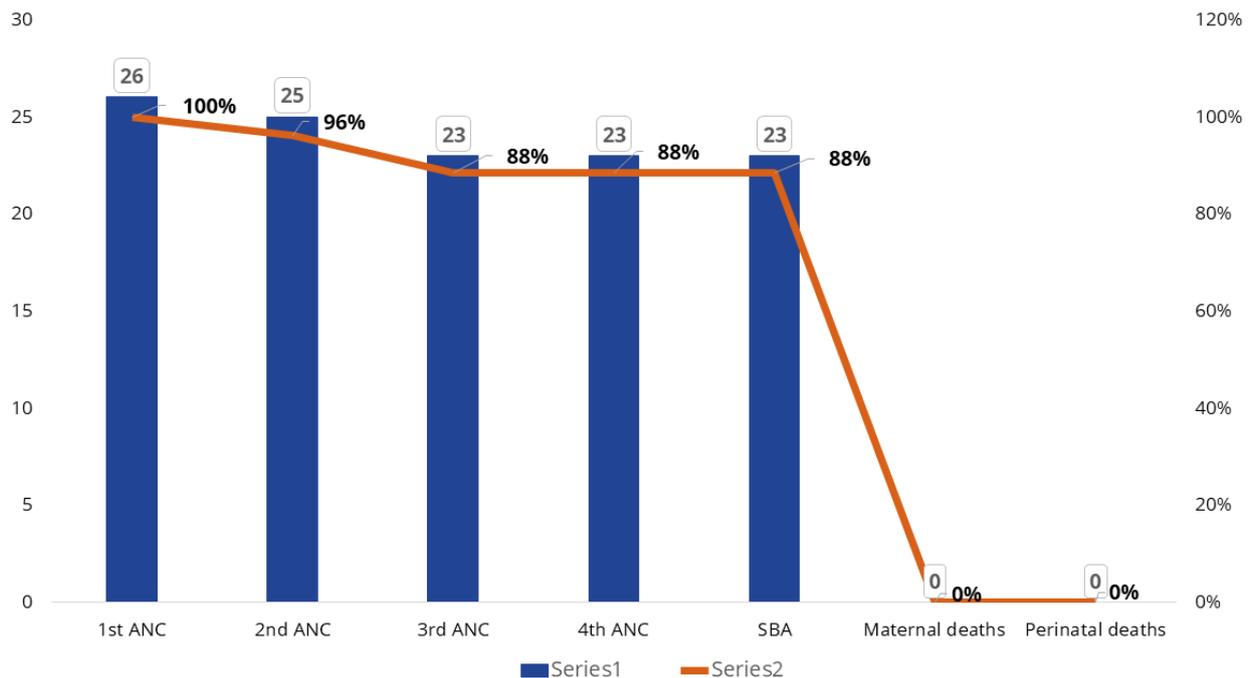
GROUP ANC IMPLEMENTATION EXPERIENCE

In systematic evidence synthesis, the project adopted a "generic" model of group antenatal care for low-and middle-income countries (LMIC) as recommended by Sharma et al. 2018. The model proposes: i) group sizes of ranges 5 to 30 women, of similar gestational age or willingness and availability to participate in group care, ii) the "intake" visit follows the regular one-on-one format for first ANC visit, which follows the facility's standard protocol, iii) consistency of group members that ensures that topics discussed are relevant to each session, promotes trust and cohesion among women, and a sense of belonging and commitment to the group, iv) group leadership throughout the course of the group- a health care provider who is the clinical focal lead and one of the group members , v) use of facilitative leadership style, vi) a plan for each group session that includes specific content for clinical care and client education, although, the session plan is flexible enough to make sure that the discussion is always relevant to the women and addresses their specific needs, vii) group sessions follows clinical assessment, education, skills building and support group or counselling providing opportunities for women to provide feedback about the group experiences.

The Afya Pwani Group ANC Model

The Afya Pwani project, in partnership with the Kilifi county department of health, piloted and later scaled up the group model of care to 93 health facilities across the seven sub-counties of Kilifi county. The project piloted the "generic model" for group ANC in Ganze health center. The pilot served to test and establish the feasibility and acceptability of the model. The project team provided technical assistance to the providers to enroll 26 pregnant women into the group in June 2017. Subsequently, Afya Pwani supported routine monthly meetings where clients received clinical services and targeted health education messages. The group provided an opportunity for the pregnant women to learn from each other, create lifelong bonds and robust peer support systems. The group achieved 88% (23/26) retention at 4th ANC and skilled delivery despite a nationwide industrial action experienced in the country (June-Dec 2017). Graph 1 below indicates the uptake of services among the clients enrolled in the pilot Mama Kwa Mama group.

Graph 1. MNH service uptake and outcome among pilot Mama kwa Mama group at Ganze HC, June – Dec. 2017



Learnings from the Pilot Phase

The pilot demonstrated the feasibility and the acceptability of the group ANC approach. It also informed the co-creation of a "generic model" for Kilifi county through a participatory process. The modifications made to the pilot model include:

- Client segregation - The pilot at Ganze HC informed the project on the need to segregate the groups into age-appropriate cohorts due to many teenage pregnancies in Kilifi county. Group segregation followed the criteria below: pregnant women 25 years and above formed the Mama Kwa Mama groups. Binti Kwa Binti groups targeted girls and young women aged 10-24 years, further cohort by age into groups for 10-14 years, 15-19 years, and 20-24 years. The project-based age segregation on the evidence that the age groups have diverse needs and vulnerabilities. Most pregnant adolescents and young women lacked adequate knowledge about sexual health and family planning due to the existing cultural barriers.
- Uniform starting point/enrollment date to maintain a cohesive closed group by introducing group enrollment during the Maternity open days.
- Expanded follow-up beyond delivery to include postnatal follow-up, immunization, and family planning.
- Added activities included partner involvement and support, telephone support intervention, GBV screening, self-care activities, and skills and livelihood training.
- Graduation approach: provided for the transition from clinical/socio-economic poverty to empowered women and girls.
- Documentation and reporting: The project utilized a black book in the pilot phase of the group model. A consultative forum convened by the county developed, validated, and disseminated reporting tools (Instructions for conducting an open maternity day, Maternity open day reporting tool, Longitudinal register for Mama Kwa Mama and Binti Kwa Binti groups, Graduation checklist, and reporting tool) to strengthen the monitoring and evaluation.

The Afya Pwani group model implementation followed the steps below:

STEP 1: Intake Visit

The project recruited women into group ANC at the time of their first ANC contact. The intake visits followed the Maternity Open Day⁶ (for high- and mid-volume facilities) and the regular one-on-one format for ANC (for low-volume facilities).

The healthcare provider confirmed the pregnancy during this visit, performed antenatal screening and a physical exam, and collected a comprehensive history.

STEP 2: Client Enrollment into Groups

Pregnant women were invited to receive ANC in a group setting by joining five to 30 women of a similar age cohort with similar

due dates. The women received sensitization on the benefits of group ANC and the roles and expectations for group participation. Participation in the group was voluntary. Once a woman accepted participation, she was expected to attend all her ANC sessions in a group setting. High-risk women received additional appointment dates depending on need.

The facility attached each group to two focal persons, a health care provider to represent the clinical component and a community lead.

STEP 3: Group Scheduling

The health providers utilized the **patient-centered** care approach, providing care respectful of pregnant women, responsive to their needs and individual patient preferences, and ensuring that patient values guide all clinical decisions. For instance, the appointment scheduling was a consultative decision between the clients and the service providers. The focal person and the group members agreed to each group session's day, date, and time to ensure total attendance and convenience. The group sessions were tailored to match the minimum of four ANC visits recommended by global and local guidelines.

Once the clients had agreed upon the days and slots, the health care providers maintained the calendar for the clients' convenience and provided quality services. The facility ensured that a health care provider was always available to attend to the walk-in clients requiring services. The ANC/PNC model promoted self-awareness, social support, and adherence to the national standards and maternal and newborn health guidelines.

STEP 4: Preparing for Mama Kwa Mama Group Sessions

The steps below guided the facilities' preparation for the group sessions.

1. Reviewed clients' records in the ANC/PNC register	
<ul style="list-style-type: none"> • The health care provider planning the group meeting reviewed clients' records/data and ANC profile results and identified <ul style="list-style-type: none"> ◦ Women who were due for follow up tests/investigation, who were scheduled for specific services, or who had any missing records, including lab results. ◦ High-risk pregnant women requiring to follow up. • ANC women with malnutrition for enrolment into the Integrated Management of Acute Malnutrition (IMAM) program. The program's objectives in managing acute malnutrition include i) to prevent malnutrition by early identification, public health interventions, and nutrition education, and ii) to treat acute malnutrition to reduce associated morbidity and mortality. 	
2. Scheduled Mama Kwa Mama and Binti Kwa Binti clients	
<ul style="list-style-type: none"> • The health care provider called or sent text reminders to clients due for clinic visits. • The provider rescheduled visits for those not able to attend the group visit. 	
3. Assembled essential commodities	
<ul style="list-style-type: none"> • Tetanus Toxoid immunization • Iron & Folic Acid • Mebendazole tablets • SP Tablets • Supplementary feeding commodities 	<ul style="list-style-type: none"> • Antimalarial drugs • Antiretroviral drugs • Immunization Antigens as per the KEPI Schedule • Family Planning commodities
4. Assembled essential equipment/tools	
<ul style="list-style-type: none"> • Pregnancy wheel • Fetoscope/doppler • Measuring tape • Thermometer • Adult/ Paediatric weighing scale • Digital BP Machine • MUAC tape • Teaching aids, i.e., flip charts, fliers, cue cards • Heightometer 	<ul style="list-style-type: none"> • Examination couch • Stethoscope • Chairs and tables • Cabinets • Handwashing facilities • IPC buckets • Glasses • Safe drinking water • Registers, mother-child booklets • Reporting tools
5. Prepared group meeting space	



- In advance of the group meetings, facilitators sent reminders to the speakers invited to the groups, i.e., PHO, WASH Officers, Life Skills trainers, and CBO leads.
- The health care providers facilitating the group activity met briefly to discuss the outline of the day's activity, identify who would lead the sessions, and divide the tasks equally. They also chose the various teaching modalities for the specific session topics.
- Identified the registration table and prepared the Mama/Binti Longitudinal register and black book for documentation of group minutes by the group's secretary/chair.
- Ensured availability of adequate chairs for a circular sitting arrangement.
- Prepared appropriate teaching aids, i.e., fliers, flip charts.

STEP 5: Initial Group Visit

During the first group session, the women decided whether they wanted support persons or pregnancy' buddies' (husbands, mothers, mothers-in-law, or sisters) to participate in the sessions. Also, the group members discussed and agreed on whether the groups would remain exclusively for health and psychosocial support or if their goal also included economic empowerment.

The groups collectively agreed on the group norms to guide their sessions. Furthermore, with the support from the community leaders, the groups selected three leaders: a chair lady, a secretary, and a treasurer. The chair lady guided the group's day-to-day running. The secretary was the custodian of all group documentation, and the treasurer received contributions/monies and kept the account books. The groups utilized the money voluntarily contributed to lend out to members as capital for small-scale businesses at interest through the Savings and internal lending communities (SILC) and Voluntary Savings and Lending Association (VSLA) to strengthen economic empowerment and livelihoods for the group members and their families. At the end of the group cycle, the members shared out the profits from the interest earned. The group focal person provided a report book from the facility to the secretary to document the group proceedings and provided technical guidance to the chair lady to complete the Longitudinal register for Mama Kwa Mama groups.

STEP 6: Conducting a Group Session



Nurse Beatrice Mbodze during a health education session to Mama kwa Mama group clients at Sabaki dispensary. Photo Credit: Baraka Ngala, April 2020.

Each group session lasted 2-3 hours, providing more provider-client contact time than an individual ANC session. The sessions had three main parts: physical assessment, learning and education, and peer support. Each group ANC session began with triaging the clients and a physical evaluation by a healthcare provider following the WHO¹⁷ and Kenya FANC guidelines.¹⁸ Sessions took place in a private area of the group space (like a corner) or a separate room, and care was taken to ensure that each woman's audible and visual privacy and confidentiality were protected. After clinical assessments, the women came together for the remainder of the session for group activities and discussion.

During the discussions, the women and providers sat together in a circle and took turns sharing, making sure that everyone had a chance to speak without interruption. The group leaders used a **facilitative leadership** style to promote the discussion. Using this style, they did not lecture to the women like in a classroom but instead helped to lead a discussion of the topics planned for the session and contribute to the discussion themselves along with the women. This part of the sessions provided an opportunity for women to talk about how they felt, ask questions, share information with each other and the providers, build supportive relationships, and learn about pregnancy and birth. The health education sessions also focused on empowering the groups and clients to know and claim their rights.

The table below provides a sample guide for group session flow. However, the content of the sessions varied according to the cohort-specific requirements.

Time	Activity	Responsible Partner
1-2 Hours	Triaging	Health care provider
	Individual clinical care/immunization	Health care provider
20 Minutes	Group registration, welcoming	Group leader
10 Minutes	Prayers/ice breaker	Group member
30 Minutes	Group health education	Health care partner
30 Minutes	Peer-led support session	Mentor mother or community health volunteer (CHV) Nurse (consulted)
30 Minutes	Additional activities that can promote retention, i.e., Income Generating Activity (IGA), Kitchen gardens, Linkage to CBOs	Group Leads Mentor mother/CHV Nurse (Consulted)
10 Minutes	Closing activity, Experience sharing, Question & Answer	Health care provider

The group sessions also included additional activities to promote retention, as noted in the table above. These are supportive services which are outside the range of services that clients normally receive and which directly or indirectly contribute to improved maternal or infant outcomes. These services include telephone support interventions, male involvement, psychosocial support groups, and income-generating activities. The community teams provided existing and updated mapping of available CSOs that clients could refer to for nutritional, psychological, medico-legal, or financial support, among others. These services also help to ensure that a complete referral takes place.

STEP 7: Skills and Livelihood Training

The project built the women's capacity to attain economic freedom and the power to make decisions that benefit themselves, their families, and their communities through skills and livelihood sessions. The sessions targeted groups in the postnatal phase and occurred over three months with one session a month. The project engaged trained and certified local artisans trainers to provide vocational/handcraft skills training support. In addition, introduced the women to i) small microfinance entrepreneurship program (SMEP) to enable them to access small loans; ii) Savings and Credit Cooperatives (SACCOs) to encourage savings and use pooled funds to extend loans to members at reasonable rates of interest and to provide financial services, iii) social services training to position them to access women entrepreneurship funds¹⁹ (WEP) and National government affirmative action funds (NGAAF)²⁰, and iv) Kenya Youth entrepreneurship program (KYEOP).²¹

The livelihood sessions imparted the women with skills and knowledge to:

- Set up demonstration kitchen gardens,
- Rear chicken, goats
- Prepare liquid soap
- Prepare bar soap
- Make re-useable face masks
- Make Uteos (plaited baskets or trays used for sifting grain)
- Make brooms from locally available material
- Make mats from papyrus reed
- Hair dressing

The training covered the following areas:

- Starting your business - conducting a rigorous business plan development and informal market research to assess the need for the proposed product/services,
- Managing your business- plans on running the business, sharing profits, and expected challenges, and developing of a contingency plan,
- Growing your business- finding strategies to sustain and expand the business.

STEP 8: Graduation/Transition Phase

The graduation ceremony provided an opportunity to celebrate and showcase the women who successfully went through the Maternal, newborn, and child health continuum of care. The groups' focus shifted from clinical services to the community. The



Mama kwa Mama group clients and their healthy babies at Gotani Health centre preparing for their graduation ceremony. Photo Credit: Rose Mwanziwe.

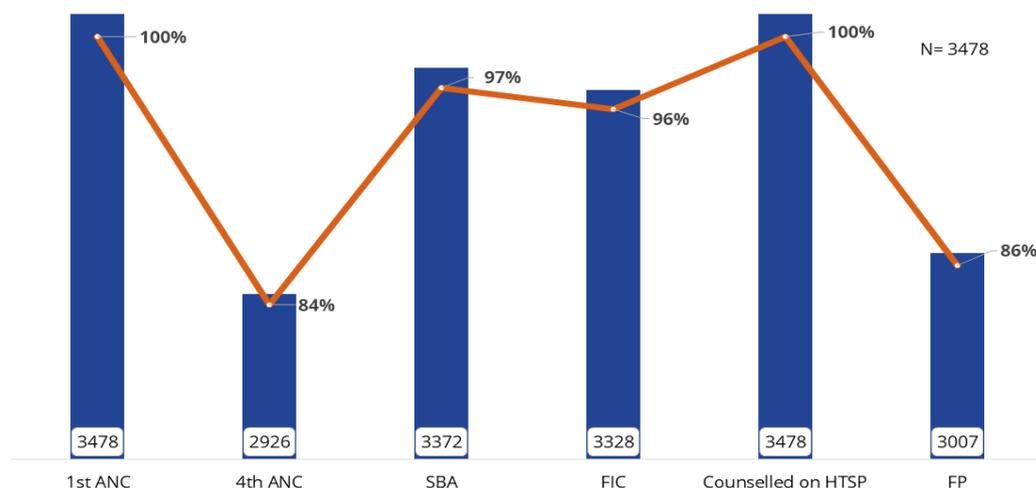
facilities invited current Mama and Binti Kwa Binti group members, local administration, community leaders, and SCHMTs to enhance facility and community ownership during the graduation. The health care providers conducted dialogues to assess the experiences, knowledge gained, and milestones achieved during the group sessions. The participants traced their journey and involvement in the groups and reiterated the benefits of attending group meetings. Each group member was expected to have attended at least 13 group sessions (four ANC contacts and nine PNC contacts) by the time of transition. The women traced their journey and involvement in the groups, reiterated the benefits of attending the group meetings, and affirmed their commitment to being role models and agents of change in maternal, newborn, and child health.

PERFORMANCE AND KEY LESSONS

Participation

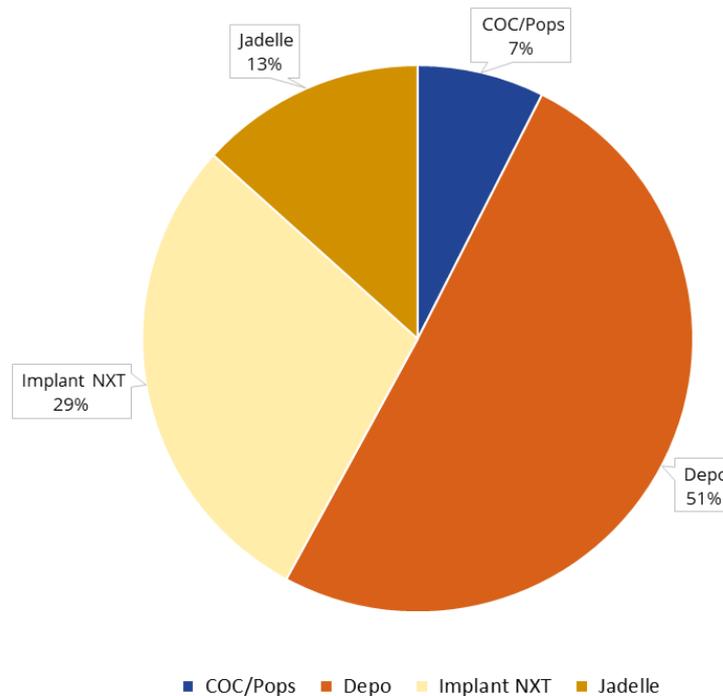
The project enrolled 11,169 women (7,034 pregnant women aged 25 years and above in Mama Kwa Mama groups and 4,135 adolescents and young women in Binti Kwa Binti groups) in a total of 338 groups in 93 health facilities across Kilifi county, Kenya from 2018 to 2020. Annual graduation rates reflect a high retention rate, with over 95% of the women graduating after 13 months. Cumulatively 4,767 women completed 13 monthly visits and graduated from the groups. In comparison, 6,252 were in various points in the continuum of care at project closure. (4230 women in the antenatal period and 2023 women in the postnatal period). The youngest group client was 13 years, whereas the eldest was 46 years, with a group median of 26 and a mean of 26 years. Analysis of the cohort (3478 women) who completed and graduated with the project support showed a high utilization of services; 84% (2926) completed at least 4 ANC visits, and 97% (3372) of the women had a hospital delivery. All the women received counseling on healthy timing and spacing of pregnancy (HTSP) during the antenatal and postnatal period, consequently 86% (3,478) took up a contraceptive method after delivery, as shown in the graph below.

Figure 2. Outcomes and uptake of MNCHFP service among MKM and BKB graduands



The group ANC/PNC education sessions provided information on contraception along the continuum of care and promoted individual choice of a contraceptive method by the clients. Consequently, 86% of the women took up a contraceptive method as shown in the graph above. The contraceptive mix is detailed in the chart below. The high uptake of long-term contraception can be attributed to the increased onsite clinical mentorship of health care providers on long-acting reversible contraceptives (LARC).

Figure 3. Contraceptive mix among clients in MKM and BKB in Afya Pwani supported sites.



The groups also enhanced socio-economic empowerment through increasing income opportunities for women, supporting personal development, and expanding women's financial inclusion. The project supported 129 coaching sessions in 62 facilities reaching 2,070 clients. The skills and livelihood coaching primed the groups to transition into income-generating groups post-graduation. Cumulatively, the groups contributed over Ksh. 100,000, (USD 1,000). The groups made individual contributions as capital for business or for Voluntary Savings and Loaning Association (VSLA) to strengthen economic empowerment and livelihoods for the group members and their families. With the support of the livelihood coaches, the groups developed business plans and started income-generating activities, including goat and chicken rearing, liquid soap making, broom making from locally available materials, Neem soap making, tents and chairs hire, cereal supply, brick making, Dera businesses, stalls (vegetables, small food vendors) mask making, and Uteos.²² Additionally, women in 30 groups registered with the social services department, self-help groups, and CBOs.

The group members selected three group leaders during the group lifespan. The health care providers empowered the leaders to conduct non-clinical activities within the health facilities. As a result, some women were elevated as leaders in other domains of their lives.

Health care providers leveraged the group ANC to intensify awareness creation interventions and utilized the group clients' exceptional perceptions around MNCH services to increase acceptance and utilization of maternal and child health services. They also supported the group graduands to become maternal and child health champions. The project leveraged the groups to empower clients to know and claim their rights while promoting the provision of respectful maternity services in the health facilities.

Most male partners to the women, fathers to the adolescent girls, male community members, and leaders expressed their appreciation for the group model during the graduation ceremonies. The model provided an opportunity for women to receive education to change the power dynamic within relationships and promote couple communication and shared decision-making while altering male partners' perceptions of reproductive health.

Mumina Alaso is a 37-year-old woman and among the 35 beneficiaries of the Umoja Mama kwa Mama group at Kiwandani dispensary, established in September 2018. Like many women her age, Mumina had previously delivered at home, and had never taken up a contraceptive method. She was naïve about skilled deliveries and the importance of child spacing. However, this changed when she attended a Maternity Open Day and joined a Mama kwa Mama group. She was enrolled in a group with 34 women who completed the maternal newborn and child health continuum of care. Through this group, she attained four ANC visits, skilled delivery, fully immunized status for her children, and planned her family. "I am grateful for the intensive health education and respectful maternity care services I received as a member of the group," says Mumina. She added, "My group members bestowed me the group chairperson role. This has seen me rise to the cadre of a community health volunteer currently attached to Kilifi county hospital. I am a proud ambassador for maternal and newborn health. Besides, we successfully registered our group as a CBO, started a joint tent and chair hire venture, and are currently engaged in implementing strategies to curb teenage pregnancies."

Sustainability

This integrated model aligns with the Kenya maternal and newborn health model 2009. Based on its acceptability and positive impact, the Kilifi Department of Health has included the Mama Kwa Mama and Binti Kwa Binti groups in its annual work plan and institutionalized intake visits and monthly meetings in most health facilities.

The Afya Pwani project also built health facilities' capacity on the Linda Mama²³ process and sensitized communities on the importance of Linda Mama registration. As a result, most facilities receive help from Linda Mama reimbursements. Consequently, the project advocated using the funds to support the Mama Kwa Mama and Binti Kwa Binti groups.

Lessons Learned

The group ANC/PNC model improves maternal and newborn health outcomes by providing a safe space where pregnant and postnatal women can share experiences and receive essential health information from a midwife or other skilled providers. Besides, it gives a platform to increase access to and uptake of MNCH services for improved MNCH outcomes by providing structured education/information and care packages. In addition, it provides an avenue for livelihood, women's empowerment, and advancing conversations on safe motherhood. The model was widely acceptable by the community and local leaders, who also recognized the group champions. In addition, its implementation is feasible as demonstrated.

This approach should be scaled up to all the facilities in Kilifi county. Besides, future programming should include livelihood packages in targeted communities to increase agency and empowerment for sustained change.

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- Maternity Open Days provide an opportunity for mobilized pregnant women and their families to interact with health care providers and visit the maternity unit to demystify birthing practices and mitigate any fears regarding childbirth in a facility.
- WHO recommendations on antenatal care for a positive pregnancy experience (WHO, 2016)
- National Guidelines for Quality Obstetrics and Perinatal care (GOK)
- Women Enterprise Fund is a Semi-Autonomous Government Agency under the Ministry of Public Service, Youth and Gender Affairs that promotes the realization of 1st and 5th Sustainable Development Goals on poverty reduction, gender equality and women empowerment respectively.
- The National Government Affirmative Action Fund (NGAAF) is a semi-autonomous government agency (SAGA) under the Ministry of Public Service, Youth and Gender Affairs, in the State Department of Gender Affairs. The Fund also provides an avenue for promotion of enterprise and value addition initiatives.
- A national project designed to equip young people between the ages of 18 to 29 with various skills through training. These trainings focus on life skills, business as well as internship opportunities or work experience that will help them live better lives
- Plaited baskets or trays used for sifting grain
- Linda Mama is a public funded health scheme by the National Hospital Investment Fund (NHIF) that ensures that pregnant women and infants have access to quality, affordable health services. Linda mama's goal is to achieve universal access to MNH services and contribute to the country's progress towards universal health care.

Cover Photo: Nurse Rahab Wamugi leads Binti kwa Binti group members in a session on "Exercises during pregnancy" at Junju Dispensary. Photo Credit: Anne Kipsuto, January 2020.

Project Overview: The USAID Afya Pwani Project was a 5-year USAID-funded integrated project implemented from June 2016 to July 2021 across five counties (Kilifi, Mombasa, Kwale, Taita Taveta, and Lamu) along the Kenyan coastline. The project was implemented by a consortium comprising of Pathfinder International (Prime), Palladium International, and Plan international. The project was implemented to improve and increase access and utilization of quality health services through strengthened service delivery and institutional capacity of county health systems. The project aimed to increase access and utilization of quality HIV services, focused Maternal, Newborn, and Child Health (MNCH), Family Planning (FP), Water, Sanitation and Hygiene (WASH), Nutrition Services and strengthened Health Systems in seven sub-counties of Kilifi county.

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The contents of this publication are solely the responsibility of Pathfinder International.

Suggested Citation: "Improving Maternal, Newborn and Child Health Outcomes through Group Antenatal and Postnatal Care Approach: Lessons from the USAID Afya Pwani Project in Kenya", 2021. Watertown, MA, USA: Pathfinder International

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