# Implementation Experiences of Group Antenatal Care for Adolescent Girls and Young Women at High-Volume Public Health Facilities in Kampala, Uganda

*The USAID Maternal Child Health and Nutrition (USAID MCHN) Activity*

The USAID MCHN Activity is a five-year program (January 2020 to December 2024) funded by USAID/Uganda to improve maternal, newborn, and child health, and nutrition (MCHN) outcomes in Uganda. This is achieved through the provision of targeted technical support at national and subnational levels to (1) develop and roll out MCHN strategies, and high-impact practices and interventions; (2) strengthen coordination and cooperation within and between Government of Uganda (GOU) sectors; and (3) increase the use of data for planning, decision-making, and learning. The Activity also supports improved delivery of MCH and nutrition services in Kampala, particularly for the urban poor, through strengthened service delivery systems in the public and private sectors. The MCHN Activity closely collaborates with GOU structures at all levels, private sector entities, other USAID-supported activities, and development partners to support and leverage their efforts to improve MCHN outcomes in Uganda.

The MCHN Activity is implemented by a consortium led by FHI 360 that includes EnCompass LLC, Makerere University School for Public Health, Save the Children, and the Uganda Healthcare Federation.

## Key Messages

- Group antenatal care (GANC) is a service delivery model where women join peer groups designed to provide routine antenatal care (ANC) services with aims of motivating behavior change among pregnant women, improving pregnancy outcomes, and increasing pregnant women's satisfaction with maternal health services. GANC includes participation in clinical assessments, participatory facilitated learning, and reliance on peer support.
- In Kampala, GANC provided various advantages to pregnant adolescent girls and young women (AGYW), including targeted health education, and a peer-supported space for mothers to receive emotional and in-kind support (e.g., sometimes a group will collect money to help a pregnant AGYW in need), share experiences, learn how to handle stigma against young mothers, and build self-esteem and confidence.
- GANC in Kampala had numerous health service delivery- and client-related challenges affecting effective implementation. These included long waiting time at the health facility, due to the late arrival of some group members and the limited number of midwives to provide routine ANC services; poor attendance and retention of GANC members with frequent drop-outs among AGYW, in part, associated with the mobile nature of urban dwellers; inadequate specialized human resource, especially professional counsellors to support group members; heavy workload for peer mothers and midwives; inadequate privacy associated with infrastructural limitations for AGYW to share sensitive personal stories; and unmet expectations of AGYW disappointed not to receive skills and incentives for group participation.
- Adequate resources and infrastructure are needed to effectively deliver GANC. Recommendations to support GANC include allocation of a dedicated midwife to specifically attend to the groups only, while other midwives attend to the other mothers that come on the same day; dedication of professional counsellors (e.g., at least one allocated to ANC/PNC services) to handle the complex challenges adolescents face; linkage of members attending GANC to other support services through partnerships with civil society and other private organizations involved in teaching young people various hands-on skills; and allocation of more space to increase privacy.

## Introduction

Uganda has the highest teenage pregnancy rate in East Africa at 25%, and Kampala registered the second highest number of teenage pregnancies in

Uganda's 146 districts in 2020.[1] Teenage pregnancy was exacerbated by school closures, a lockdown measure used to control the COVID-19 pandemic. Increased teenage pregnancy rates were observed in 67 districts from 2019 to 2020.[2] Pregnant teenagers, 15–19 years, are at greater risk of maternal mortality, accounting for 17% of maternal mortality in the country. Pregnant teenagers are physically vulnerable during pregnancy and delivery, and societal stigma and limited access to adolescent responsive health services compounds their health-seeking challenges.

ANC is critical to monitoring the pregnancy progress and health of the mother and fetus, early detection of complications can increase the likelihood of positive birth outcomes for mother and baby, and ANC is a prioritized high impact practice to avert preventable maternal and perinatal deaths in Uganda. ANC in low-resource and under-staffed health facilities is typically offered individually and through groups. Health education is often provided to a group of pregnant or postpartum women while they wait for individual clinical assessments. GANC in Uganda builds on the original Centering Pregnancy approach (Box 1) and aims to go beyond offering health education to groups of pregnant women to organizing peer groups so women can receive routine ANC services together, develop rapport, provide social support to each other, and encourage regular ANC attendance until delivery.

GANC offers an opportunity to improve the quality of ANC services for AGYW through differentiated service delivery tailored to their unique needs: raising awareness on high-risk pregnancy and delivery and on HIV and sexually transmitted infections (STIs); and facilitating experience sharing and social support on social and economic problems commonly faced by young mothers.[3] This was especially pertinent in Kampala where there are many teenage pregnancies. USAID MCHN sought to enhance the psychosocial support for AGYW by integrating GANC with services, such as gender-based violence screening, psychosocial support, referral and linkage, and identification and counselling for early and forced marriage of AGYW.

**Box 1: Centering Pregnancy Group ANC**

The original GANC is informed by the Centering Pregnancy (CP) GANC model developed by Rising,[1] a nurse-midwife who designed GANC in response to challenges such as short individual ANC visits, the need to repeat the same basic health promotion information to each woman, and inadequate time for in-depth discussions. After the first ANC visit, women were invited to receive routine ANC with the same group of 8–12 women with similar expected delivery dates. Each group meeting was structured to begin with self-assessments (weight and blood pressure measurements), followed by a brief clinical assessment and discussion of results between each woman and the midwife, and then a group discussion on health questions and pregnancy experiences. The group discussions were tailored around the gestational age of the fetus but remained flexible to incorporate issues women wanted to bring up.

## Capacity building and logistical support for midwives and peer mothers to implement group ANC

USAID MCHN purposefully selected seven health facilities in Kampala to strengthen its GANC for AGYW. The facilities were high-volume government sites that had already piloted GANC and had some trained midwives and peer mothers (Annex). In 2022, USAID MCHN conducted seven one-day on-site trainings for midwives and peer mothers at the seven health facilities. The purpose was to ensure midwives and peer mothers knew what services should be provided for pregnant AGYW at each ANC visit, how to provide services in a supportive and responsive manner, and to

[1] UNFPA Uganda (2021) "Fact Sheet on Teenage Pregnancy, 2021." https://uganda.unfpa.org/sites/default/files/pub-pdf/teenpregnancy_factsheet_3.pdf.
[2] Ibid.
[3] FHI 360 MCHN Activity 2021. Activity report for GANC peer mothers training for GYSI integration into MCH and nutrition service delivery in Kampala.

understand their respective roles and responsibilities (Box 2). In addition, MCHN oriented the midwives and peer mothers to conduct gender-based violence screening, referral, and linkages, psychosocial support, and identification and counselling for early and forced marriage.

From 2020 to March 2022, implementing partner Infectious Disease Institute (IDI) Uganda provided a daily stipend of 15,000 Ugandan Shillings (US$4) and airtime of 50,000 Ugandan Shillings per week (US$13) to enable each peer mother to follow up group members. Kampala Capital City Authority (KCCA) took over the GANC program from IDI. KCCA continued to provide peer mothers with a stipend at the same rate but did not provide airtime to follow up group members.

## Study Description: Objectives and Methods

Makerere University School of Public Health (MakSPH), a consortium member of USAID MCHN, conducted a qualitative study in June 2022 to understand implementation experiences of GANC in Kampala. Specifically, the objectives of the study were three-fold:

***Objectives***

1. To describe the operationalization of GANC for AGYW in high-volume government health facilities in Kampala
2. To explore AGYW's perceptions of the GANC services received
3. To explore midwives and peer mothers' perceptions of the GANC services provided

***Methods***

MakSPH conducted 34 key informant interviews with 24 AGYW aged 17[4]–24 years, five peer mothers, and five midwives on-site at three facilities implementing GANC: Kitebi HC III, Kawaala HC IV, and China-Uganda Friendship Hospital (Table 1). These individuals were purposively selected by type of informant and level of care, and conveniently selected to participate in the interviews if they were on-duty midwives and peer mothers, or AGYW clients attending GANC. The trained interviewers obtained written informed consent, conducted interviews predominantly in Luganda with AGYW and English with peer mothers and midwives, and held the

**Box 2: Roles and Responsibilities of Midwives and Peer Mothers in GANC**

***Focal Person:*** Each facility has a midwife GANC focal person responsible for organizing space for group meetings, mobilizing group members, determining health education topics, preparing necessary materials (e.g., visuals, referral lists), and documenting activities (attendance, health education topics, complications identified).

***Midwives:*** Midwives are responsible for enrolling new AGYW into GANC, tracking client attendance, arranging for follow-up visits, following up community referrals, teaching mothers how to do self-care health assessments (weight, height, measuring mid-upper arm circumference, digital blood pressure, and dipstick to test for protein in urine), leading health education sessions, conducting group and one-on-one counselling sessions for psychosocial support as needed, conducting history and physical examinations, requesting relevant laboratory investigations, diagnosis and treatment, partner HIV testing, recording medical records, referrals and follow-up, and referral of clients for any additional facility or community-based services as needed.

***Peer mothers:*** Peer mothers are responsible for registering clients on the day of group meetings, supporting health education sessions, assisting clients with self-care activities, conducting group counselling sessions, providing one-on-one counselling if needed, identifying and following up mothers who have missed appointments, and linking mothers to needed services.

***Source****: MOH, STD/AIDS Control Programme, Feb 2020. GANC Participants Training Manual.*

[4] An emancipated minor if less than 18 years.

interviews in a space out of hearing range from other individuals. The interviews were audio-recorded and transcribed into English. Qualitative text was analyzed using thematic analysis, and this report highlights the salient themes identified.

*Table 1. Number of key informant interviews conducted, by informant type and level of care*

| Site and Level of Care | AGYW | Peer Mothers | Midwives |
|---|---|---|---|
| Kitebi HC III | 9 | 2 | 1 |
| Kawaala HC IV | 8 | 2 | 2 |
| China-Uganda Friendship Hospital | 7 | 1 (male health educator) | 2 |
| **Total** | **24** | **5** | **5** |

# Findings

## 1: Operationalizing GANC

***Enrolment.*** Both midwives and peer mothers can introduce and invite AGYW, 15–24 years, attending their first ANC to join GANC. One peer mother said she prioritized recruiting "vulnerable" AGYW to join GANC because the economically well-off and girls with supportive partners were more likely to already have access to information and resources. AGYW are asked for age, marital status, number of living children, job, gestational age of the fetus, and whether she would be able to dedicate the time needed to participate in GANC. If the AGYW is willing, then she is assigned to a group based on a combination of factors, including her age, socioeconomic status, and gestational age of her fetus. Midwives and peer mothers do not mention the need to seek parental consent for minors as these pregnant girls are seen as able to make independent decisions.

***Group formation.*** Groups are typically 6 to 12 people with an AGYW group leader and a secretary. Group members are encouraged to take each other's contact information. The group leader coordinates the members, reminds them of their next appointment, and sometimes collects money for making calls to mobilize missing members.

***Activities.*** GANC begins after group members have arrived and a peer mother is available to support the group. The typical order of activities is:

- **Health education** Depending on the health facility and the topic, a midwife, Village Health Team member, or peer mother can deliver the health education; varied media are used including job aides, testimonies, singing, and dancing; the group is encouraged to ask questions during the session.
- **Group sharing and support** Group members counsel, encourage, and comfort each other on their pregnancy journeys, and on associated life experiences — for example, some girls talk about being abandoned by the father of their babies or condemned by their relatives.
- **Health checks** Group members measure each other's height, weight, blood pressure, and mid-upper arm circumference with the help of a peer mother.
- **Clinical appointment** Each member meets with the midwife for a physical examination individually and counselling if needed.
- **Drug distribution** Sometimes the peer mother distributes prophylactics to the group, such as Fansidar.

**Box 3: Health Education and Discussion Topics**

***Health***

- Healthy behaviors during pregnancy (hygiene, nutrition)
- Birth preparedness (learning about the health facility, what is needed for delivery)
- Seeking care when you have danger signs
- How to look after a newborn baby (exclusive breastfeeding, immunization)
- Family planning
- Sexually transmitted diseases
- HIV prevention
- Urinary tract infections
- Menstrual cycle

***Challenges faced by pregnant teenagers***

- Financial challenges (lack of money for transport, food, delivery, baby clothes)
- Denial of paternal ownership or being abandoned by the baby's father
- Made pregnant by people close to them (incest, rape)
- Homelessness (chased away from home)
- Gender-based violence
- HIV stigma and being abandoned by her parents and the father of the child
- Same-sex relationships

**Box 3 (*continued*): Health Education and Discussion Topics**

- Sexually transmitted infections and other diseases

***Livelihoods and savings***

- Developing a post-birth plan
- Encouraging income generation and gaining a hands-on skill
- Saving money

***Frequency and duration of GANC.*** Groups meet once a month until members go into delivery. On the meeting day, group members wait until most members come and the session can begin. The typical session lasts one to two hours. The wait for individual assessments with the midwives depends on the availability of the midwives and the number of ANC clients. Following that, members may go for laboratory investigations, ultrasound scans, immunizations, and medications. Finally, members end the day by taking their records to be entered into the ANC register. In short, a GANC group member spends a whole day (approximately 8 hours) at the health facility for each visit.

## 2: Perceived benefits of GANC

***Group members learned more through GANC's health education, counselling, and peer learning.*** Many of the interviewed midwives and peer mothers believed that AGYW learn more than other clients at general ANC because the groups are taken through a comprehensive set of health topics, members have an opportunity to ask questions and have them answered, members learn from listening to each other's questions, and they learn from the group- and one-on-one counselling with peer mothers and health workers. Some of the interviewed AGYW emphasized that they practiced what they were taught in GANC health education.

***GANC provided a forum of social support to pregnant AGYW.*** Most of the interviewed AGYW highlighted how they received tangible social support through GANC. Some group members cited instances of contributing money for transport or to buy critical items for another group member. Some said they formed friendships and checked on each other outside of GANC meetings. Others offered group members connections to skill building and livelihood opportunities. Social support was especially important for girls who were abandoned by their partners or parents during their pregnancies; these girls said the group helped them realize their situation was not the worst, that life could get better, and the group encouraged them not to abandon their babies but to look after them well. The interviewed AGYW also described the peer mothers and midwives as "caring" and "concerned" for giving them reminder calls and one-on-one counselling, and for sharing their phone numbers in case of an emergency.

***Improved self-esteem.*** Midwives, peer mothers, and AGYW reported that group members gained confidence and self-esteem over time as they participated in discussions and practiced self-care. They noted that girls overcame initial fears to share and ask questions, that some girls who experienced gender-based violence were able to let go of the harmful relationship or feel empowered to move on from incest/rape, and that some girls who ran away from home were able to reconcile with their families.

## 3: Perceived challenges of GANC

***Irregular attendance and low retention of group members.*** Irregular attendance was a common problem identified by all informants across the three facilities. A group may start with 12 girls but only four or five regularly attend the GANC sessions. Kampala's dynamic population may be a reason for low retention—many girls move back to the village as they progress in their pregnancies; other reasons include a lack of money for transport to come for ANC, and a spouse or parent who does not give the AGYW permission or financial support to go to GANC. Group leaders become frustrated in mobilizing members who do not come. Peer mothers and midwives end up clustering different groups together for health education and group sharing because of dwindling group members.

***Difficulty in group bonding.*** Peer mothers and midwives shared that some AGYW "take so long to bond as a group;" that some girls "do not talk", and

others are "not friendly" despite the groups being formed around the same age range and the fetus' gestational period. Group bonding may be challenged by irregular attendance, mixing of groups to facilitate GANC sessions, and limited private space for group meetings. Many AGYW, peer mothers, and midwives said most girls prefer to discuss private or sensitive issues when they have one-on-one time with a health worker.

***Long wait time, inadequate and/or demotivated midwives.*** Most AGYW expressed that GANC had long wait times because the midwives had to attend to both clients in general ANC, other GANC groups, and will only attend to you when all your group members are present (this is challenging when members come late). According to some peer mothers, long wait times for GANC members are exacerbated by some midwives who thought the GANC process disturbed client flow and preferred to work on clients according to the order of registration. In other cases, some midwives were demotivated because they did not get a monetary incentive for running GANC.

***Peer mothers overloaded with tasks so they cannot concentrate on core GANC tasks.*** Originally peer mothers were tasked to support ANC clients with HIV screening and enrollment of HIV-positive women into the Antiretroviral Therapy clinic. Then, peer mothers were tasked to support GANC processes on days the clinic had GANC. However, due to high volumes of clients, peer mothers are also asked to support health workers in health education, measuring height, weight, blood pressure, and data records for general ANC. As a result, peer mothers are "running up and down" and have limited time to concentrate on core duties, such as timely reminders for AGYW to come to their GANC sessions.

***Lack of professional counsellors and referral options for complicated cases.*** Numerous midwives expressed that they see many complicated cases (e.g., paternity fights, rape, incest, request for abortions), yet the facility does not have access to professional counsellors or other referral options to help the AGYW.

***Unmet expectations from AGYW.*** Many AGYW joined GANC with hopes of getting opportunities to learn a livelihood skill, and receive tangible support (e.g., Mama Kits) and/or incentives (stipend for transport, lunch). They expressed disappointment in not getting these things, and some were demotivated by this and thought it was better to just attend regular ANC. Some of the girls and health workers said past projects that worked with vulnerable girls would also promise incentives in return for participation but would not meet their promises.

***Low attendance to postnatal sessions.*** Following delivery, very few AGYW attended the groups on postnatal sessions. Some believed they only needed the information and support while they were pregnant, others moved away to another area after delivery, and others returned to school.

*Figure 1. A peer mother conducts health education for members of an AGYW ANC group at Kawaala Health Center IV, Rubaga Division, Kampala. Photo Credit: Darious Kajjo/Makerere School of Public Health*

## Discussion

While GANC improved the quality of health education and social support for pregnant AGYW who were able to attend its sessions, many implementation challenges were observed. Some of the challenges were associated with the dynamics of serving a largely vulnerable AGYW population with little means for transport or independent decision-making, and many of whom live temporarily in Kampala and return to the village for delivery and postpartum. Other challenges were associated with an overcrowded and under-resourced health system with limited human resource and infrastructure to support GANC processes.

Effective implementation of GANC requires careful consideration on how to create groups to maximize retention, a key factor to building rapport, trust, and social support, and adequate resources to support the health facility, especially the human resources for health required, to provide GANC and general ANC services.

## Recommendations

1. **Identify suitable candidates for GANC to maximize retention** – Consider screening AGYW to identify interested, self-motivated candidates, residents or those who plan to deliver and stay in Kampala, and those have spouse/parental buy-in.

2. **Support airtime to facilitate early mobilization of group members important to GANC attendance –** Early mobilization for the next GANC meeting is important to give the girls enough time to make sure they are available and able to prepare for transport money. It is important to provide airtime to peer mothers so they can support mobilization, and also balance peer mothers' workload so they can prioritize this task.

3. **Ensure privacy for GANC meetings** – The facility can provide visual and sound privacy to optimize sharing and discussion in GANC meetings by allocating a separate space from general ANC, or by spreading the GANC groups over different days to allow for adequate space per group.

4. **Allocate and orient additional midwives to support GANC** – The Ministry of Health guidelines recommend a dedicated day for GANC. While this is to ensure there are dedicated midwives to support GANC, it is not possible to turn away pregnant women from general ANC, even on the days dedicated for GANC. To address staffing shortages, health facilities should recruit additional midwives in line with the Revised and Approved Staffing Norms 2022 as additional midwives deployed to support GANC will help functionalize both GANC and general ANC services. In addition, health facilities should orient new midwives on GANC to ensure their buy-in and support.

5. **Allocate a professional counsellor or social worker to support ANC/PNC services** – Professional counsellors/social workers are needed to help some of the AGYW facing complex challenges and provide health and other referrals where needed. If a facility does not have the requisite counsellor/social worker, then KCCA or partners running projects on teenage sexual and reproductive health can help with recruitment.

6. **Link GANC members to support services in partnership with civil society organizations** - Many pregnant AGYW are vulnerable and in need of holistic support beyond health care. Linking GANC group members to civil society organizations that can teach hands-on skills, provide start-up materials, and more is critical.

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## Annex: Profiles of Group ANC Implementation Kampala

| Characteristics | Komamboga HC III | Kisugu HC III | Kitebi HC III | Kisenyi HC IV | Kawaala HC IV | China Uganda Friendship Hospital | Kawempe NRH |
|---|---|---|---|---|---|---|---|
| **Facility** | | | | | | | |
| Division | Kawempe | Makindye | Rubaga | Central | Makindye | Nakawa | Kawempe |
| Level of care | HC III | HC III | HC III | HC IV | HC IV | RRH | NRH |
| No. ANC 1 services in FY22 | | | | | | | |
| <15 | 2 | 5 | 1 | 11 | 5 | 5 | 10 |
| 15-19 | 601 | 627 | 1,323 | 1,636 | 1,432 | 446 | 825 |
| 20-24 | 2,192 | 2,146 | 3,924 | 5,774 | 5,071 | 1,967 | 3,015 |
| 25-49 | 2,629 | 2,448 | 3,692 | 7,914 | 5,761 | 3,535 | 5,374 |
| ≥50 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| **Group ANC** | | | | | | | |
| Basis of peer group formation | Gestational age based on trimesters | Vulnerability status (school dropout, raped) | Age (15-19, 20-25), Gestational age | Age, Gestational age, Number of pregnancies, Social status | Age, Gestational age | Age, Gestational age | Age (15-19, 20-24), Gestational age |
| ***Cadres deployed to operationalize GANC on a typical day:*** | | | | | | | |
| No. peer mothers | 2 | 2 | 2 | 2 | 2 | 2 | 1 |
| No. midwives | 1 | 2 | 2 | 2 | 2 | 4 | 8 |
| No. MCH counsellors | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ***Services provided through GANC:*** | | | | | | | |
| Health education | √ | √ | √ | √ | √ | √ | √ |
| Self-care activities | √ | √ | √ | √ | √ | √ | √ |
| Skill building | X | X | X | X | √ | √ | √ |
| Postnatal care | X | X | √ | X | √ | X | √ |
| ***GANC Logistics at Health Facility:*** | | | | | | | |
| No. of AGWY groups (15-24 years) | 50 | 20 | 20 | 24 | 10 | 3 | 4 |
| No. members per group | 6-12 | 20 | 6-12 | 15 | 9-12 | 60 | 12 |
| Length of group sessions | 1-1.5 hours | 1 hour | 2-4 hours | 1 hour | 1.5 hours | 2-3 hours | 4 hours |
| Days | Wed, Fri | Fri | Wed, Fri | Wed, Fri | Wed, Fri | Every weekday | Thurs |