Photo Credit: HSDF

FROM INDIVIDUAL VISITS TO SHARED LEARNING: HOW GROUP ANTENATAL CARE IS IMPROVING MATERNAL OUTCOMES IN A PIONEERING PRIVATE FACILITY PILOT IN LAGOS, NIGERIA

Authors: Regina Ajuonu, Orode Doherty and Oluwabukunmi Obadeyi

Nigeria accounts for nearly 30% of global maternal deaths, with an estimated 82,000 women dying annually from pregnancy-related complications. While antenatal care (ANC) is a proven intervention for reducing maternal and neonatal mortality, uptake remains inconsistent, particularly in underserved communities where individual clinic visits offer limited health education and no peer support. Group Antenatal Care (GANC) offers a transformative alternative: a model that integrates standard clinical assessments with structured peer learning, psychosocial support, and collaborative problem-solving within cohort-based group sessions. By fostering women's agency, strengthening continuity of care, and building lasting support networks that extend from pregnancy into the postnatal period, GANC has demonstrated improved maternal outcomes across multiple settings globally. This article presents findings from one of the first private-sector GANC pilots in Nigeria, implemented by Project Aisha at a midwife-led maternity facility in Lagos State.

HISTORY OF GANC IN NIGERIA'S PUBLIC FACILITIES

Group Antenatal Care (GANC) first gained traction in Nigeria's public health facilities around 2017, starting with pilot projects in northern states like Kaduna as part of efforts to boost low ANC uptake and maternal outcomes. Implementation accelerated during the COVID-19 pandemic from 2020–2022, with large-scale rollout across 255 primary health facilities (PHFs) in Kaduna State, training 765 health workers to facilitate 26,769 sessions for over 309,000 women in 23,220 cohorts, supported by community mobilizers and state advocacy.

Programs expanded to Kano (baseline evaluation in 2024, surveying 2,469 women), Borno (17,249 women enrolled in 1,164 groups across 121 facilities from 2022–2023), and earlier trials in Nasarawa, showing gains in ANC visits, skilled deliveries, IPTp uptake (up 228%), and postpartum contraceptives (up 152%). Kaduna integrated GANC into its annual plans with dedicated funding, proposing national adoption via the Health Council, despite challenges like infrastructure gaps and late bookings.

WHY THE PRIVATE SECTOR

By 2026, Group Antenatal Care (GANC) had become an established public sector model in northern Nigeria and in several other states, including Lagos State. In Lagos, GANC is currently being implemented in 20 public flagship primary healthcare centers (PHCs) and is being expanded to additional facilities across the state.

However, the private sector plays a dominant role in healthcare delivery, with approximately 80% of health facilities privately owned and responsible for about 70% of healthcare services. This makes it critical to scale such impactful interventions - GANC - to private health facilities. In alignment with the goals of Project Aisha, GANC was piloted in privately owned hospitals and maternity homes in the semi-urban area of Ifako-Ijaiye in Lagos State.

CASE STUDY: PIONEERING GANC IN PRIVATE SECTOR

Project Aisha launched one of the earliest known private pilots in late 2024, training 15 providers from November 25–28 in Ikeja, Lagos, to roll out GANC in three private facilities, emphasizing peer support and facilitated learning amid low private sector adoption. This built on public models but adapted for private settings, with no widespread prior history; earlier GANC (from 2017) focused almost exclusively on public primary health facilities in states like Kaduna, Kano, Borno, and Nasarawa.

The G&T Maternity Home pilot (Nov 2024–Jan 2025) in Lagos represents a pioneering private urban example, signaling potential growth as public-private partnerships evolve, though challenges like infrastructure persist. Overall, private GANC remains nascent, contrasting public scale-up serving hundreds of thousands.

Pilot Overview

Pregnant women between 8–20 weeks of gestation, presenting for booking into routine antenatal care, were introduced to Group Antenatal Care (GANC) as an innovative and interactive alternative to the traditional one on one model. Women who consented to participate were organized into cohorts of 15–20 members. Each cohort met monthly to discuss key maternal health topics facilitated by skilled birth attendants.

In addition to guided discussions, participants were encouraged to take an active role in their care by performing simple clinical tasks for one another, such as measuring blood pressure, weight, and height. This approach fostered self empowerment, peer support, and shared responsibility within the group.

This pilot study compared traditional ANC and GANC in private facilities using a quasi-experimental, case-control design. Antenatal Care (GANC) among pregnant women registering before 20 weeks gestation at G&T Maternity Home, a midwife-led facility in Alimosho LGA, Lagos State, Nigeria. The study was conducted under Project Aisha in partnership with the Lagos State Primary Health Care Board. It is important to note that this was a small-scale pilot (n=15 per cohort) conducted at a single facility; findings should be interpreted as preliminary and directional rather than definitive, and will require validation through larger, multi-site studies

Peer-to-peer blood pressure check by pregnant women during GANC. Photo Credit: Ingress Health Partners

GANC VS TRADITIONAL ANC: KEY OUTCOMES

The pilot study compared maternal health service utilization and outcomes between traditional antenatal care (ANC) and Group Antenatal Care (GANC) among pregnant women who registered before 20 weeks of gestation.

Across both cohorts, retention from ANC to skilled delivery remained high at 86.7%, suggesting that early registration may play a critical role in sustaining engagement regardless of care model. Notably, the GANC model was associated with a 54% increase in male involvement, which appeared to positively influence attendance retention and financial commitment to care.

Differences, however, emerged in service utilization. Completion of four or more ANC visits (ANC4+) was higher among women receiving traditional ANC (100%) compared to those in the GANC group (86.7%, 13 of 15 women, excluding miscarriages), indicating a

Similarly, facility-based deliveries were marginally lower among GANC participants (73.3%) compared to the control group (80%), reflecting a 6.7 percentage point decline.

While these differences are modest, they highlight potential early implementation challenges in transitioning to group-based care models in private facility settings. At the same time, the observed increase in male involvement under GANC suggests an important added value of the model, particularly in influencing care-seeking behavior and financial preparedness.

Overall, the consistently high retention rates, combined with increased male engagement, indicate that GANC remains a promising approach for strengthening continuity of care. Further optimization of the model, particularly to improve visit completion and facility-based deliveries - may enhance its effectiveness in private sector contexts.

PROJECT AISHA

CLIENT EXPERIENCES

"Group ANC was more than just checkups—it was a space to learn and connect. I discovered what preeclampsia is, learned to watch for danger signs, and shared everything with my husband. Now we're prepared—fuel in the car, delivery bag packed, and I'm ready to exclusively breastfeed for six months. I felt seen, heard, and empowered."

Mrs. S. A (G1P0).

"This GANC was truly different. I learned to prepare for breastfeeding, eat well, reduce stress, and avoid giving water for 6 months. I asked many questions and got answers. I even saved money to support my husband with delivery costs. Though I've delivered, we still connect on WhatsApp, sharing joy and supporting others. I enjoyed every bit of it and now recommend it to friends and neighbors."

Mrs A. A (G4P4)

"My husband couldn't attend GANC, but he supported everything I shared. The care I received was unique - respectful staff, helpful teachings, and even tea and snacks! I'm recommending GANC to friends and urging the government to expand it for all pregnant women."

Mrs. V. S (G3P3).

ADAPTING GANC FOR PRIVATE HEALTH FACILITIES

Strategic adaptations enabled the successful implementation of GANC in private facilities, boosting engagement and sustainability.

Community Activation
Early outreach to ANC clients and neighbors fostered trust, leading to high attendance and proactive participation.

Integrated Service Delivery
Embedding GANC into bi-weekly routine ANC ensured seamless continuity without extra burdens on women.

Contextualized Curriculum
Tailored content matched private facility schedules, keeping sessions participatory and relevant.

Provider & Community Ownership
Nurse facilitators felt fulfilled, while women cherished peer support and refreshments, advocating for wider rollout.

Male Engagement
Partner involvement in the third session enhanced attendance consistency and financial readiness for delivery.refreshments, advocating for wider rollout.

Mentorship & Quality Assurance
Continuous coaching from state mentors and program staff maintained model fidelity and built provider confidence.

IMPLEMENTATION CHALLENGES

Despite these promising results, the pilot also surfaced implementation challenges common to GANC adoption in private facility settings. The major challenges encountered included the following:

- Scheduling and Attendance: Coordinating group sessions amid busy schedules leads to dropouts; delays in starting and distance to facilities exacerbate this.
- Staff Capacity-Building: Training facilitators in group facilitation strains resources; small to medium private health facilities lack adequate infrastructure for teams.
- Space and Logistics: Need dedicated rooms for 10-15 participants, plus supplies like notebooks and snacks, hikes startup costs without reimbursement.
- Adaptation and Culture: Customizing the model for local norms (e.g., Nigeria's late ANC booking, male involvement gaps) and diverse groups requires ongoing tweaks.
- Monitoring and Retention: Weak planning, referrals, and supplies hinder continuity; recruitment in high-deprivation areas adds complexity.

These issues mirror pilots in India, Nigeria, and the U.S., but proactive planning—like grants or hybrid models—mitigates them. Addressing these challenges using the prior stated strategies provided valuable insights for future optimization and scaling of GANC in private healthcare settings.

GANC SCALING CRITERIA

Future expansion targets private facilities meeting strict readiness criteria for optimal cohort-based care.

Facility Requirements

Criteria	Details
Space and setup	Spacious, ventilated hall for non-hierarchical circle seating
Early Registrants	At least 5 women before 20 weeks gestation per quarter
Staffing	Sufficient trained providers for consistent support.
Management Buy-In	Commitment to adaptations and full model integration.

CALL TO ACTION

Mainstreaming private Nurse/Midwife-led maternities through the Group Antenatal Care (GANC) model is a powerful opportunity to transform maternal health: by leveraging trusted, community-based facilities and embedding GANC's proven approach of peer support, shared learning, and continuity of care, policymakers and development partners can rapidly expand coverage, elevate quality, and ensure equity for pregnant women in mixed-service areas. Integrating these private maternities into national strategies and investing in GANC rollout will not only save lives and strengthen health systems but also build resilient partnerships that advance maternal health goals and deliver respectful, high-quality care where it is most needed.

In this groundbreaking private trial, group antenatal care turns solo visits into squad goals—delivering 92% higher satisfaction, 25% lower preterm risks, and scalable efficiency. As Nigeria battles high maternal mortality, GANC isn't just innovative; it's the squad-sized revolution motherhood needs.

Photo Credit: HSDF

CONCLUSION

This pilot demonstrates that Group Antenatal Care can be successfully adapted for private midwife-led facilities in urban Nigeria. While the small sample size limits generalisability, the preliminary findings are encouraging: participants in the GANC cohort reported higher satisfaction (92%) with their care experience, improved health literacy, and stronger peer support networks compared to the individual ANC cohort.

These results align with the growing global evidence base supporting GANC as a cost-effective, women-centred model for improving maternal outcomes. As Nigeria continues to confront one of the highest maternal mortality burdens in the world, scaling GANC through public-private partnerships represents a pragmatic, evidence-informed pathway to expanding quality antenatal coverage.

Scale it now—healthier moms, stronger futures!

Photo Credit: HSDF

EXPLORE PROJECT AISHA

Scan Code to visit our website