Original Research Article

Efficacy of home visits by public health providers for high-risk pregnant women in Egypt

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INTRODUCTION

Maternal wellbeing has continuously been one of the major health concerns of diverse communities. The reports of World Health Organization indicate that every day, approximately 830 women die from conditions related to pregnancy that can be easily preventable. 1

High-risk pregnancy incorporates maternal conditions related to high perinatal mortality and morbidity such as diabetes, hypertensive disorders (chronic hypertension and pre-eclampsia), cardiac, renal, and autoimmune disorders. 2 There are conditions that are related to pregnancy and considered ‘high risk’ as fetal growth restriction, antepartum hemorrhage, multiple pregnancy, and prolonged pregnancy. 3

Unfavorable birth outcomes, such as preterm birth, low birth weight (LBW), and small for gestational age (SGA), can affect child development and health in a long-term manner. 4 In addition, bad birth outcome is a risk factor for maternal mental wellbeing and child abuse. 5

Antenatal care is a comprehensive program for care before birth which incorporates coordinated approach to support
women before pregnancy till delivery. This support involves medical and psychosocial aspects.6

Antenatal care-related desires of pregnant women include four fundamental categories: provision of sufficient data for women concerning their pregnancy, encouraging women to give informed decisions according to their interests, emotional support, and provision with professional care.7 Usage of a home-visit program during high-risk pregnancy is a comprehensive methodology to anticipate unfavorable birth outcomes.8

Giving domestic health permits the pregnant woman to feel more control over her life status and receive a safe and supervised health care at the same time.9 On the other hand, with the educational training and preparing provided to pregnant women at home, they learn to alter behaviors that diminish hazard of preterm birth and modify their health life style. Also, it is obvious that domestic following of mothers with high-risk pregnancy, minimizes financial burden on hospitals by decreasing the number of days of hospitalization.10

Home-care programs permit health care providers to supply maternal and fetal evaluation, planning issues concerning high-risk cases with health centers, providing the mother with information about high-risk conditions and emphasize on the achieved required service.11 Thus, this makes it easier for families to share the educational programs and have an improved understanding of effective factors of maternal and child health.12

The present study aims to assess effects of home visits by public health providers for high-risk pregnant women in Egypt to prevent adverse pregnancy outcome.

METHODS

This was a cohort study using administrative data collected in obstetrics department, Faculty of Medicine, Beni-Suef University between April 2019 and September 2020. Informed written consent was obtained from each woman to be included in this study. Target participants of our study were all high-risk pregnant women who registered their pregnancy in the obstetric clinic of the university. The study was included 500 pregnant women. Two groups were compared, home-visit group (250) and the no home-visit group (250).

High risk pregnancy was defined as

Women who had past or current physical or mental illness, primiparas under the age of 20, primiparas over the age of 35 with some unfavorable conditions such as poverty, women who were pregnant with twins.13,14

Home-visit programs for pregnant women

In this program, trained public health providers make at least one home visit to high-risk pregnant women lasting for more than 1 hour during mid- or late-term pregnancy. The contents of the home visit were as follows:

Checking women’s social support status and linking them to other services in the community, if needed.

Providing information about appropriate nutrition during pregnancy, prenatal care, dental care, and child care.

Asking women about their physical or psychological health and linking them to medical facilities if needed.

If public health providers concluded that the women required more support, they provided follow-up support by phone, made another home visit, or introduced women to further social services support.15

Outcomes

Primary outcome was birth weight.

Secondary outcomes were as follows: Parenting knowledge, repeat pregnancy, repeat birth, and gestational age at delivery, birth weight, and maternal weight gain during pregnancy.

RESULTS

Table 1 shows the baseline characteristics of prenatal mothers at pregnancy registration in the study groups.

Table 1: Comparison between the two groups as regard to baseline characteristics.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Home-visit program (n=250)</th>
<th>No home-visit program (n=250)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of mother (mean±SD)</td>
<td>31.32±5.053</td>
<td>30.22±5.326</td>
<td>0.118</td>
</tr>
<tr>
<td>Age of husband (mean±SD)</td>
<td>34.71±4.730</td>
<td>34.12±4.988</td>
<td>0.174</td>
</tr>
<tr>
<td>Parity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>198 (79.2)</td>
<td>133 (53.2)</td>
<td></td>
</tr>
<tr>
<td>≥1</td>
<td>52 (20.8)</td>
<td>117 (46.8)</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>History of Miscarriage</td>
<td>58 (23)</td>
<td>52 (21)</td>
<td>0.589</td>
</tr>
<tr>
<td>History of stillbirth</td>
<td>5 (2)</td>
<td>13 (5.2)</td>
<td>0.090</td>
</tr>
<tr>
<td>Twin pregnancy</td>
<td>33 (13.2)</td>
<td>27 (10.8)</td>
<td>0.492</td>
</tr>
</tbody>
</table>

Continued.
### Table 2: Comparison between the two groups as regard to birth and maternal outcomes.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Home-visit program (n=250, child: n=280)</th>
<th>No home-visit program (n=250, child: n=276)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth weight</td>
<td>2752.85±286.571</td>
<td>2716.62±301.128</td>
<td>0.169</td>
</tr>
<tr>
<td>Gestational age</td>
<td>38.36±1.257</td>
<td>38.09±1.309</td>
<td>0.122</td>
</tr>
<tr>
<td>LBW (&lt;2500 g)</td>
<td>52 (18.6%)</td>
<td>73 (26.4%)</td>
<td>0.039*</td>
</tr>
<tr>
<td>Preterm birth (&lt;37 weeks)</td>
<td>22 (7.9%)</td>
<td>34 (12.3%)</td>
<td>0.118</td>
</tr>
<tr>
<td>small for gestational age (&lt;10 percentile)</td>
<td>27 (9.6%)</td>
<td>40 (14.5%)</td>
<td>0.115</td>
</tr>
<tr>
<td>Sex (male)</td>
<td>Male 146 (52.1%)</td>
<td>141 (51.1%)</td>
<td>0.718</td>
</tr>
<tr>
<td></td>
<td>Female 134 (47.9%)</td>
<td>135 (48.9%)</td>
<td></td>
</tr>
<tr>
<td>Timing of home visit during pregnancy</td>
<td>Gestational age 30.20±3.122</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt;28 weeks 117 (46.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>≥28 weeks 133 (53.2%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data are represented in number (n) and (%).
did not receive home visits. Primigravidas received more home visits than multigravidas with p value (<0.001).

Table 2 shows the birth and maternal outcomes. Women from the home-visit group had a heavier birth weight 2752.85±286.571, longer gestational age 38.36±1.257, less LBW infants 52 (18.6%), less preterm birth 22 (7.9%), and less SGA infants 27 (9.6%) compared to participants who did not receive the home-visit program.

DISCUSSION

Maternal mortality may result from pregnancy related adverse outcomes. It has been concluded that about 830 women die daily around the world.16

Usage of a home-visit program during pregnancy is a fundamental strategy to prevent adverse birth outcomes. Despite the precise tool of this approach is not well discussed in research work, many authors have suggested that giving intimate psychosocial support, and upgrading communication with health care providers, social services and nutrition support can improve pregnancy outcomes. However, there are conflicting results about pregnancy outcomes from previous randomized controlled trials (RCTs) of home-visit programs.14,15 Thus, we conducted the present study to evaluate home visits by public health providers in high risk pregnancy and its influence on pregnancy outcomes.

Mean gestational age for infants of mothers in the home-visit group was 30.20±3.122 weeks. Pregnant women who received home visits were more likely to be experiencing their first pregnancy 198 (79.2%), 36 (14.4%) diagnosed with a disease and 113 (45.2%) worried about child-rearing compared with women who did not receive home visits. No statistical difference concerning those variables between both groups.

The results of the present study are compared with the study by Ichikawa et al in which the baseline characteristics of prenatal mothers at pregnancy registration in the home-visit group (n=410) and the no home-visit group (n=554) before propensity-score matching. Mean gestational age for infants of mothers in the home-visit group was 27.2 (SD=6.9) weeks. Pregnant women who received home visits were more likely to be experiencing their first pregnancy (n=333, 81.2%), diagnosed with a disease (n=163, 39.8%), and worried about child-rearing (n=192, 46.8%) or relationships with neighbors (n=64, 15.6%) compared with women who did not receive home visits. Pregnant women who did not receive home visits were more likely to smoke (n=111, 20.0%), drink alcohol (n=67, 12.1%), be unmarried (n=197, 35.6%), feel unhappy about their pregnancy (n = 111, 20.0%), or had partners who were unhappy about their pregnancy (n=85, 15.3%) compared with women in the home-visit group. After performing propensity-score matching with the comparison group, no significant difference was observed between variables.17

In spite of national and international follow up of home visits as a procedure to enhance maternal and child health and avoid abuse of mother and her child enhancing well-being of the whole family, previous systemic reviews and studies of home visiting programs which evaluated several outcomes concluded wide range of results according to way of each program and kind of outcome assessed.18-20

The present study assessed the birth outcomes among participants and revealed that women from the home-visit group had a heavier birth weight 2752.85±286.571, longer gestational age 38.36±1.257, less LBW infants 52 (18.6%), less preterm birth 22 (7.9%), and less SGA infants 27 (9.6%) compared to participants who did not receive the home-visit program.

In agreement with our findings, the study of Ichikawa et al in which women from the home-visit group had a heavier birth weight (2905.3 g, SD=499.5 g), longer gestational age (38.7 weeks, SD=1.8 weeks), higher ZBW (-0.04, SD=1.1), less LBW infants (n=85, 19.2%), less preterm birth (n=40, 9.8%), and less SGA infants (n=52, 11.7%) compared to participants who did not receive the home-visit program. After propensity-score matching, women from the home-visit group had a heavier birth weight (2933.3 g, SD=473.4 g), longer gestational age (38.6 weeks, SD=1.8 weeks), and less preterm birth (n=34, 10.9%) compared to women who did not receive the home-visit program.17

Two recent observational studies by Roman et al and Issel et al were conducted in the United States (US) using propensity score-matched analysis found home-visit programs to be effective. Both US studies concluded that implementing the home-visit program reduced the bad birth outcomes in poor women (i.e. people who received free medical care). Our finding is consistent with these studies in showing the effectiveness of the home-visit program in preventing adverse birth outcomes, although the definition of disadvantaged population is different (i.e. our definition of ‘high-risk pregnant women’ did not only focus on economic status but on medical conditions, social disadvantages and other factors).15,21

In another study by Filene et al who reported that mothers participating in home visiting programs achieved more positive outcomes overall than mothers in control/comparison groups. However, outcome-specific mean effect sizes revealed significant but small effects only on maternal life course, child cognitive outcomes, and parent behaviors and skills. In contrast, home visiting programs did not produce significant average effects on 3 frequent program targets (birth outcomes), suggesting that programs were, on average, not effective in addressing these outcomes. The non-significant effect sizes, combined with the relatively small significant effect sizes, suggest that communities may need complementary or alternative strategies to home visiting programs to have a greater impact on these important public health outcomes.22
CONCLUSION

Our findings suggest that home visits by public health nurses for high-risk pregnant women in Egypt might be effective in preventing preterm birth, but not SGA. This study adds to the evidence of the effectiveness of population-based home-visit programs as a public healthcare measure.

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REFERENCES

Institutional Ethics Committee


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