Operations Research Brief

Shifting the management of a community volunteer system (Care Groups) from NGO staff to Ministry of Health staff in Burundi

Care Groups supervised by community health workers produced similar improvements in child health and nutrition outcomes as those supervised by NGOs.

The Challenge

One of the poorest countries in the world, Burundi has a child mortality rate of 139 per 1,000 live births, well below its Millennium Development Goal of 61 per 1,000 by 2015. Children in Burundi die primarily from preventable diseases and undernutrition. Extending the reach of the public health system through a well-trained and supported community health workforce – a workforce that includes Care Group volunteers (CGVs) – is critical for increasing health care access and facilitating behavior change in reducing stubbornly high rates of child mortality and morbidity.

Overall Project Strategy

Between 2008-2013, Concern Worldwide worked with the Burundi Ministry of Health (MOH) in Mabayi District to improve maternal and child health and nutrition practices, increase access to quality child health services, and strengthen community leadership in health. To do so, Concern elected to implement Care Groups as a primary project strategy.

The Care Group is a community-based strategy for the delivery of social and behavior change interventions to improve maternal and child health.[1]

A Care Group has 10-15 volunteer mothers of children under five years of age who regularly meet with project staff to receive health training and supervision. Each CGV mother is responsible for regularly visiting 10-15 of her neighbors to share what she has learned and facilitate behavior change at the household level. Care Groups multiply the work of community health workers (CHWs), who are unpaid volunteers working within the Ministry of Health, by reaching every household with interpersonal behavior change communication. To be fully functional a Care Group requires intensive management and supervision of CGVs, which has routinely been carried out by paid NGO project staff – a strategy that is not sustainable in the long term.

Care Group Volunteers in Bukinanyana Commune sing a song about malaria prevention and early care-seeking. Photo by A. Fox, Concern Worldwide

Key Findings

> The MOH-led Integrated model performed as well as the NGO-led model for 36 of the 40 child health and nutrition indicators.

> The MOH-led Integrated model functioned similarly to the NGO-led model based on five operational indicators.

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The Mabayi Child Survival Project was funded by the U.S. Agency for International Development (USAID) through the Child Survival and Health Grants Program with US$1,600,000 and a match of $1,320,593 by Concern Worldwide and other donors. The project was implemented by Concern Worldwide in partnership with the Mabayi District Health Team.

Innovation Tested

The main innovation of this operations research study was to shift Care Group supervision responsibility from Concern project staff to MOH staff and CHWs. The study tested whether the MOH-led Integrated Care Group model worked as well as the NGO-led Care Group model in achieving similar health knowledge and behavioral outcomes at the household level. If similar, the study would provide important data demonstrating the ability of Ministries of Health to implement Care Groups as a key child health strategy, increasing their potential for sustainability and scale up.

Concern Worldwide established the MOH-led Integrated and NGO-led Care Group models in two study areas, respectively. As part of this process, the project introduced the Care Group concept to the communities, conducted a census of all households with pregnant women and children under five, and facilitated the election of CGVs by community members. Based on formative research, Concern Worldwide developed behavior change materials to be used by the CGVs to promote nutrition, malaria, diarrhea, and pneumonia management. Over a period of two years in both study areas, Care Group meetings were held twice per month; also, CGVs were asked to conduct home visits at least once per month, during which they provided health promotion messages, screened for acute malnutrition, and collected vital events data.

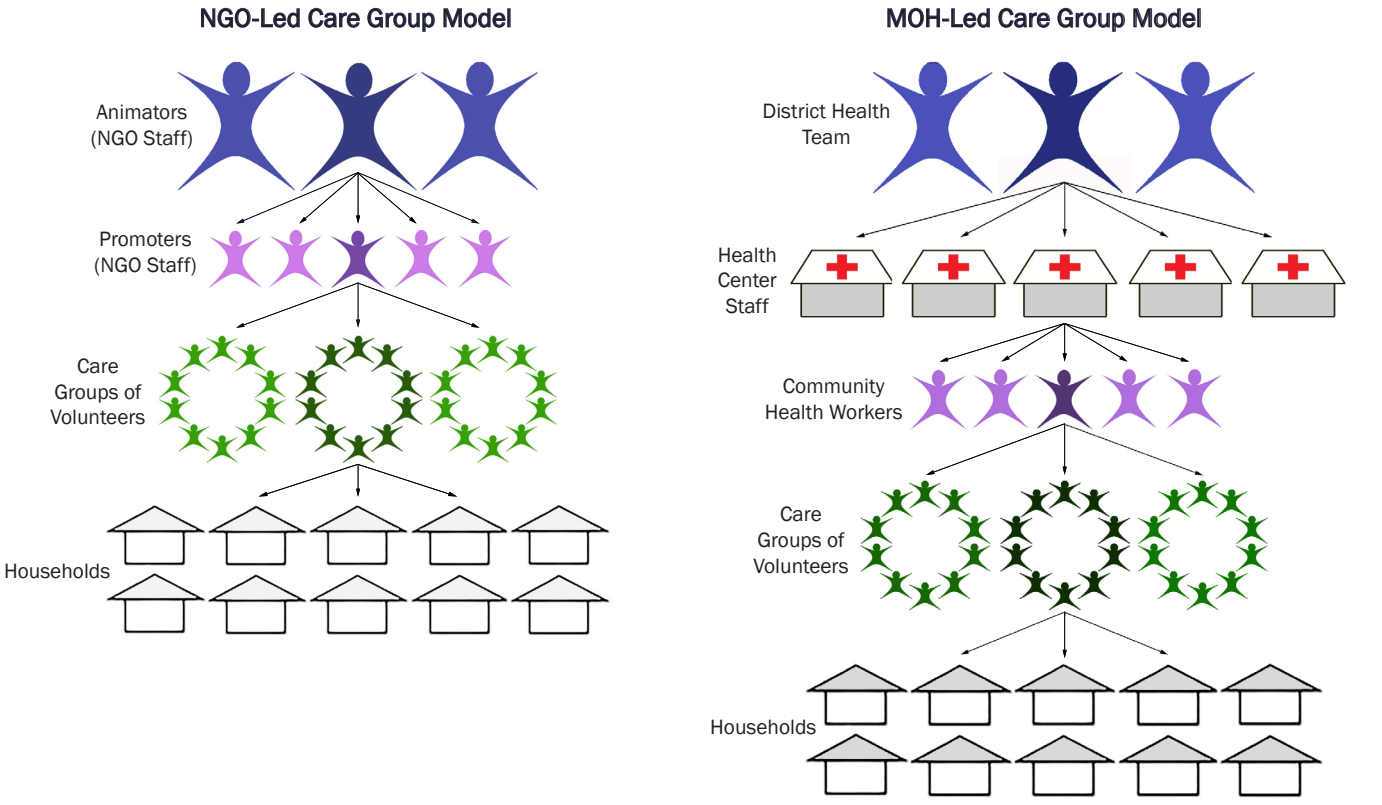
Figure 1 shows the differences in the two models. In the NGO supervision area, paid Concern project staff called "Animators" trained and supervised other paid project staff called "Promoters," who in turn trained and supervised the CGVs. Each Promoter was responsible for between six to nine Care Groups.

Under the MOH-led Intergrated model, Concern Worldwide first trained the DHT and health facility staff on the overall Care Group model and in the use of the training materials with CHWs and CGVs. Then, the health center staff nurses trained and supervised the CHWs who then trained and supervised the CGVs. Each CHW worked with the CGVs from two to three Care Groups. In their support and supervisory role the CHWs conducted follow-up household visits, reviewed CGV registers, and identified problems to solve during Care Group meetings. Concern Worldwide provided technical support as needed over the course of the project to the DHT and health facility staff in the implementation of Care Group activities.

Research Methodology

The study was conducted in rural communes in Cibitoke Province, Mabayi District. Five MOH zones were grouped

FIGURE 1: CARE GROUP MODELS



into two clusters based on population size. Clusters were randomly assigned to the intervention (MOH-led Integrated Care Groups) and comparison areas (NGO-led Care Groups). The study aimed to determine whether the MOH Integrated model:

- Achieved the same levels of health and nutrition knowledge and practices among caregivers of young children as the NGO model; and
- Functioned similarly as the NGO model.

To obtain information on health and nutrition knowledge and practices, Concern Worldwide surveyed caregivers of children ages 0-23 months in the study areas at baseline (October 2010) and endline (May 2013). The sample sizes were about 300 caregivers in each study group at baseline and about 350 in each study group at endline. The data were used to measure 40 health knowledge and practice indicators. In this brief, we highlight five indicators, which greatly impact child morbidity and mortality.

To assess functionality, the team conducted monthly monitoring of five Care Group activities carried out by the CGVs over a two-year period in each study area. These activities included the average number of Care Group meetings held per month, percentage of targeted households receiving one or more CGV visits per month, and percentage of CGVs reporting vital events information. These monitoring data from the MOH-led Integrated and NGO-led Care Groups were compared to targets set at the beginning of the study period and to each other.

The project also conducted a qualitative process evaluation at mid-term to document implementation successes, challenges, and changes.

Findings

- ***The MOH-led Integrated model performed as well as the NGO-led model for 36 of the 40 child health and nutrition indicators.***

  Caregivers in both groups reported similar changes in levels of child health and nutrition knowledge and practices for 36 of the 40 indicators from baseline to endline. For the five high-impact, child survival priority indicators, Figure 2 shows that all performed similarly across the two different Care Group models.

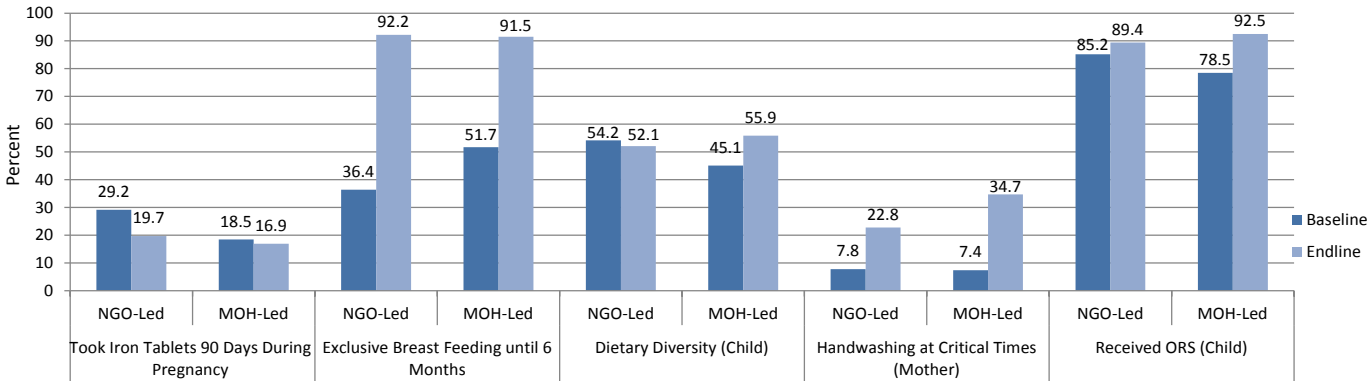
  Figure 2 also shows that both models achieved positive changes in some indicators, especially exclusive breastfeeding and handwashing, yet fell short in others, such as iron supplementation during pregnancy. Care Groups then also may need to pay attention to supply side issues (such as whether the women even receive iron tablets at the health facility) as well as demand-side factors.

- ***The MOH-led Integrated model functioned similarly to the NGO-led model based on five operational indicators.***

  Both models met or surpassed project targets for each of the five operational indicators for the period June 2011 – August 2013. For example, the project set as a target that 80 percent of CGVs would report community health information data per month to be used for national-level reporting. In fact, from 94 to 96 percent did so on average per month for the two-year time period.

  Comparing the two models based on these indicators, there was no significant difference in functionality for the two-year time period. Moreover, the number of active Care Groups and CGVs stayed constant throughout the study period: There were 51 active Care Groups in the NGO-led model with 503 CGVs and 45 active Care Groups in the MOH-led model with 478 CGVs.

FIGURE 2: CHANGES IN HIGH-IMPACT, CHILD SURVIVAL PRIORITY INDICATORS



Conclusions

The MOH-led Integrated Care Group model achieved similar health and nutrition outcomes and functioned as well as the NGO-led model, suggesting that the MOH can implement and manage Care Groups on par with NGOs. Integrating the supervisory and managerial functions of Care Groups into MOH structures is a more sustainable approach to harnessing community involvement in addressing child health needs than one that relies solely on NGOs.

In addition to showing that the MOH can take the lead in this area, the research also reinforces existing evidence that Care Groups are an effective strategy in achieving a number of key child survival priorities. The CGVs are a valuable source of health education messages in their community, and the MOH-led Integrated Care Group model demonstrates how CGVs provide a means to extend the reach of CHWs to achieve behavior change at the individual and household levels.

Care Group Volunteer Fitina Honorate conducts a home visit. Photo by A.Fox, Concern Worldwide

Recommendations

Concern Worldwide recommends that the MOH-led Integrated model be considered for scale-up and that CGVs be integrated into the community health system, with the recognition that a number of information gaps still remain. Future studies assessing the MOH-led Integrated Care Group model should document project inputs as well as the monetary and opportunity costs borne by the MOH, as cost is a key factor to consider in scale up. While NGOs will still have a role in the medium-term to build the capacity of the MOH at the district level to implement the integrated model, the study demonstrates the potential for the model to be scaled-up and institutionalized within existing MOH community health structures.

Use of Findings

The findings from this study were shared with the MOH, UNICEF, and other in-country development partners in September 2013. Concern Worldwide is continuing to work with the MOH, scaling up the approach in two new districts. The organization has developed an implementation guide[2] for integrating the Care Group model into MOH structures that other NGOs can use to implement and further test MOH-led integrated Care Groups.

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For more information about the project, contact Jennifer Weiss at Jennifer.Weiss@concern.net. The Final Evaluation is available at http://1.usa.gov/1V6VJXe.

[1] For more information about Care Groups, go to http://www.caregroupinfo.org/ and page 10 of the Maternal and Child Health Integrated Program (MCHIP) end of project report available at http://pdf.usaid.gov/pdf_docs/PA00KCDC.pdf.