

Care Groups and Behaviour Change: Lessons from Karamoja

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Introduction

Karamoja is one of the most food insecure areas in Uganda. Almost half of the households (46 percent) are food insecure and the prevalence of chronic malnutrition (stunting) is 39.5 percent and the prevalence of acute malnutrition is 12.4 percent (FSNA Dec 2015). Maternal and child health, nutrition and water, sanitation and hygiene (WASH) practices are sub-optimal. Concern Worldwide Uganda is implementing the Social and behavior Change (SBC) component of a large multi-sectoral programme in four districts in South Karamoja, Uganda. The Resiliency through Wealth, Agriculture and Nutrition in Karamoja (RWANU) programme is USAID-funded and led by ACDI/VOCA in consortium with Concern Worldwide and Welthungerhilfe.

Community-based initiatives that foster frequent contact between health promoters and children under five years of age and provide credible sources of nutrition and health information are seen as a mechanism through which these issues can be addressed. One such community-based initiative is the Mother Care Group approach used by Concern Worldwide in South Karamoja.

The Mother Care Group approach is a well-known intervention that has proved effective as a means to achieve behaviour change. Using this approach, Social and Behaviour Change Communication (BCC) messages are delivered primarily through peer-to-peer dialogue from Care Group Lead Mothers during home visits. Health promotion messages are kept short, simple, and practical and transmitted on a bi-monthly basis.

Overview of the Mother Care Group Approach in Karamoja

Concern is using the Care Group approach to reach mothers at household level. The Care Group approach links Concern's Health Educators and Health Promoters with Mother Care Groups (MCGs) and Household Caregiver Groups (HHCG). The MCGs are comprised of 10-15 Lead Mothers, who are volunteer community-based health educators. They regularly meet with the programme's Health Promoters for trainings on messages and behaviours that promote good health and nutrition for children and mothers. Each Lead Mother is responsible for 10-14 households who are grouped into a Household Caregiver Group. In addition to promoting positive behaviour change, the Care Groups' approach has stimulated a high degree of community participation. Furthermore, Care Groups strengthen linkages between the community and the health centres.

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Implementation of the Mother Care Group Approach in Karamoja

Care Group activities commenced in 2013 and are being implemented according to Care Group standards and will conclude in 2017. By the end of 2015 there were 342 Mother Care Groups comprising 3,471 Lead Mothers (LMs) and 41, 787 Household Caregiver Group members (HHCG). Across the four districts of Moroto, Napak, Nakapiripirit and Amudat the programme has expanded to include 49 Health Promoters (HPs), 14 Health Educators (HEs) and seven Field Coordinators (FCs) who train and support MCG and Male Change Agents (MCA) activities. The activities of MCAs will be discussed later.

Care Group meetings are held regularly over a four week period. In addition, LMs are asked to conduct home visits to each of her 10-15 neighboring households at least once per month, during which they provide health promotion messages, general advice around illness and care seeking. The health promoters train the lead mothers in the overall Care Group approach and especially on the various modules. The Lead Mothers then train their Care Group members using the information they have gained from the health promoters.

The health promoters facilitate all Care Group meetings and are expected to supervise at least one lead mother from each Care Group every month. Supervision consists of attending the Lead Mother's household caregiver group meeting, accompanying the lead mother on a household visit, reviewing her reporting forms, and providing feedback. Starting in 2016 an additional two week period was added, at the end of each month's training, for continued household monitoring of behaviour adoption by the health promoters.

As of April 2016 four modules out of seven modules have been delivered. These consist of the following: module 1 looked at infant and young child feeding practices, module 2 examined maternal health and nutrition, module 3 focused on linking agriculture and nutrition and finally module 4 examined water, sanitation and hygiene practices. The remaining modules will present lessons in relation to family planning, child health, and health user rights.

Male Change Agents

In addition to the above described Mother Care Groups the Concern team in Uganda works with Male Change Agents (MCA). This decision was based on formative research² which showed that men in Karamoja are seen as the main decision-makers within the household, control the use of income on food and health care and they influence caregivers' behaviours. Hence it is crucial that men are engaged as key allies in challenging the power imbalances that prevent the achievement of better health and nutrition outcomes for members of the household.

The MCA approach is intended to help men understand how gender norms and perceptions can negatively affect their lives and those of their wives/partners and children as well. Subsequent lessons focus on men's role in the different topics/ modules implemented as part of the Mother Care Groups. These men reinforce the messaging of the lead mothers and through their behaviours demonstrate positive health and social norms.

The approach of using Male Change Agents is leading to positive outcomes for their households and the wider community. The inclusion of men as equal partners, involved caregivers and supportive members of the community is a responsible approach that considers relationships in a much more holistic manner.

Some Preliminary Results

Concern made the decision to train Lead Mothers on screening for malnutrition using mid-upper circumference (MUAC). This decision was broadly seen as positive. A recent report noted that the working relationship between Village Health Teams and Lead Mothers was hugely positive. “ 92 percent of the VHTs mentioned that they have been working together with the lead mothers in identifying malnourished children in their community”¹.

Information gathered from the programme’s monitoring and evaluation system indicates that the Care Group approach is performing well in achieving specific child health and nutrition outcomes. Using data from the pre and post module assessments the following noticeable changes have been recorded:

- An increase of from 59 percent to 69 percent with respect to exclusive breastfeeding in the first six months
- 53 percent of mothers are starting complimentary feeding at 6 months and giving 3 meals a day while 90 percent of mothers of children 9-23 months are giving 3-4 meals a day.
- Handwashing stations: 742 mothers had set up tippy taps within a month of the start of the module on water, sanitation and hygiene.

What is even more remarkable about the last indicator is that Longaroi village in Nakapiripirit district which has a population of 1,411 (719 male and 694 female) was declared Open Defecation free in 2015. Longaroi is the first village in the entire district to be declared ODF. This represents a major achievement given the history of previous failed attempts.



Photo: Members of the Technical Support Unit in the Ministry of Water and Environment declaring Longaroi Village ODF. Photo by Felix Achunge, 2015.

Figure 1: Percentage of mothers with children aged 0-12 months who had four or more antenatal visits when they were pregnant with their youngest child

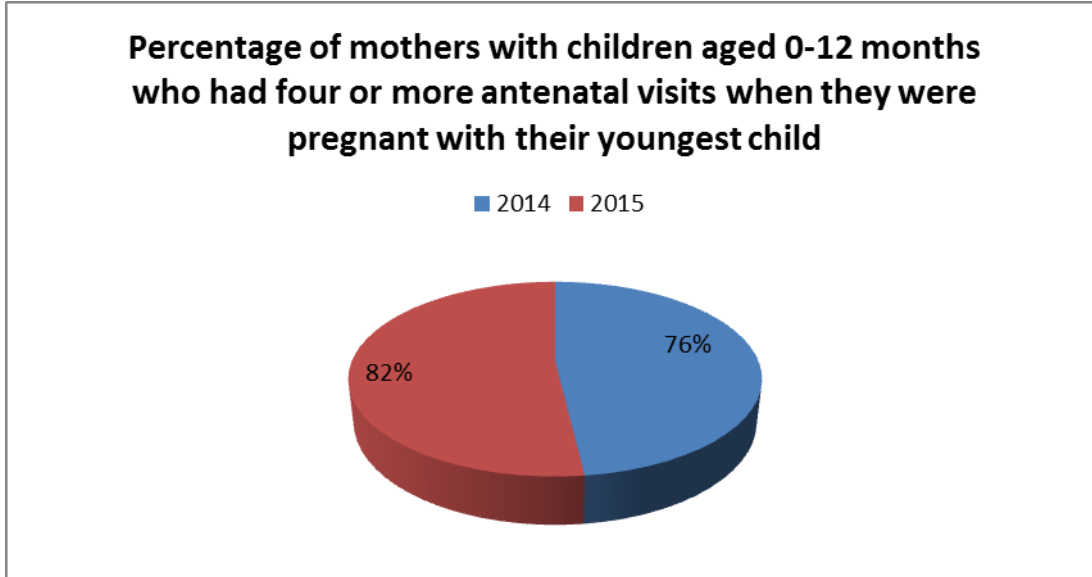
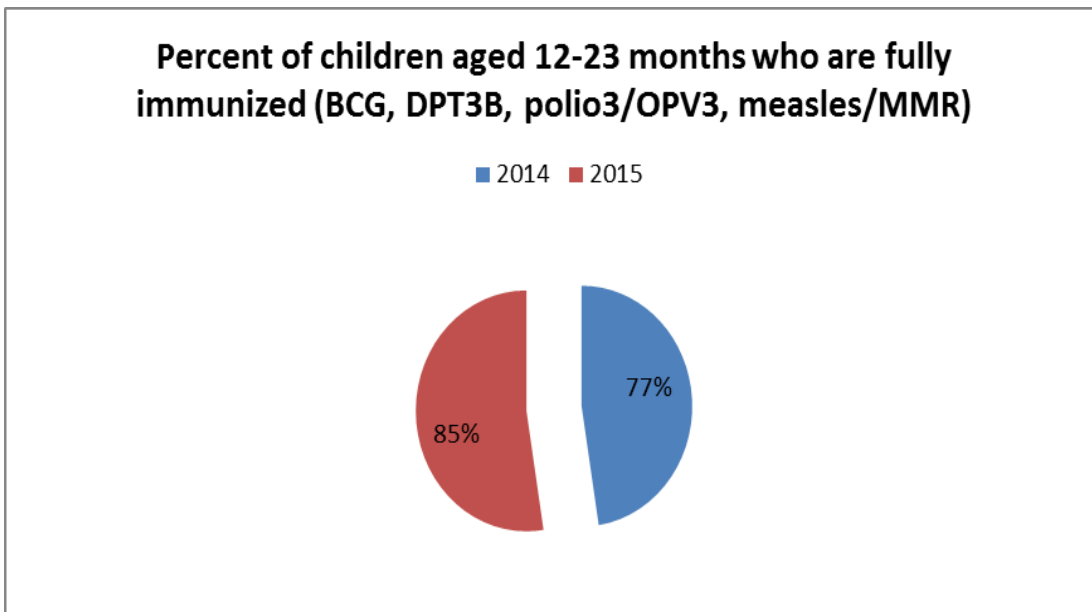


Figure 2: Percent of children aged 12-23 months who are fully immunized (BCG, DPT3B, polio3/OPV3, measles/MMR)



The outcome level performance data outlined in figures 1 and 2 illustrates that the RWANU programme is achieving success in child health and nutrition outcomes especially in the areas of antenatal visits and the immunization of children. The MCG approach is more than likely a major contributing factor.



Lessons

Empowering “Mothers” does lead to positive health outcomes

The Care Group approach in Karamoja is a good example of an intervention gradually learning to harness the power of mothers working together to improve their health and that of their children. Women’s groups have been in use now for decades, but well-delineated methods for engaging them and mobilizing them to deliver evidence-based interventions that result in scientifically demonstrated improvements in either population coverage of these interventions or improved population-level health outcomes have been lacking until recently. But as has been argued the Mother Care Group approach is starting to change this³. With reduction in home births and the uptake in antenatal care (ANC) visits the experience and evidence to date in Karamoja is broadly supportive of the notion that mothers as the primary care givers within the home are crucial to the promotion of positive health outcomes.

The Mother Care Group model can and should be modified to account for contextual factors

As with any development intervention the Mother Care Group approach must be adapted and modified to ensure it suits a particular context. The most obvious example of this is designing the modules and lessons based on the barrier analysis. The latter is used to inform what types of practices need to be changed to allow for healthy communities to thrive. This is obviously very context dependent, what might work in Burundi will not necessarily work in Uganda. But there are other less obvious contextual variables.

The standard practice is for Care Groups to meet to meet every 2-4 weeks and support individual Care Group Lead Mothers to learn progressively how to promote change with those in their catchment areas. Based on information generated from pre and post module assessments a decision was taken to extend the duration of each new lesson from four to six weeks. This modification is to allow more time for Lead Mothers to follow up with individual care group members who are struggling with behaviour change.

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The Male Change Agents is a promising addition to the toolkit of the Mother Care Group Approach

The discussions with Lead Mothers, Male Change Agents, husbands and beneficiary mothers all pointed to greater peace and harmony in the home. The frustrations and unresolved arguments that in the past created resentment are now starting to reduce. A lot of this was credited to the Male Change Agents who act as role models within the community. These men reinforce the messaging of the Lead Mothers and through their behaviours demonstrate positive health and social norms.

The approach of using Male Change Agents is leading to positive outcomes for their households and the wider community. The inclusion of men as equal partners, involved caregivers and supportive members of the community is a responsible approach that considers relationships in a much more holistic manner. With this in mind the Male Change Agent approach is a welcome addition to the toolkit of the Mother Care Group approach.

Only local ownership will drive sustainability

It is a well-known fact that local ownership is a significant factor in the sustainability of community driven initiatives⁴. It is critical that Lead Mothers feel involved at the various levels of implementing the MCG approach in order to ensure sustainability once the programme ends. There are promising signs that this is starting to take place. The various actors that were interviewed mentioned the positive health and other social dividends that the Mother Care Group is having on their lives. For example, healthy children and more harmonious family life. Therefore the ownership element is clearly starting to take hold. This needs to be cultivated and further consolidated so that this good will is not lost.

Scaling-up will require flexibility

The potential scale up of the Mother Care Approach has to be government led as it is the government's ultimate obligation to ensure that the poor, the vulnerable, the weak and the marginalized amongst its people are taken care of and their health needs are met. This will in the future reap more benefits for the government in terms of economic productivity and a healthy labour force.

However, for the scale up to be successful a genuine partnership approach will need to be taken by the Ministry of Health in collaboration with its various development partners. This will inevitably create delays as various stakeholders seek to influence the process but in the long run it will allow for buy-in and support once national policies are in place. This in turn will require over time stakeholders to adjust their interventions and re-train a cadre of community health workers, health staff, and support development of new learning content as and when the need arises.

The approach of using Male Change Agents is leading to positive outcomes for their households and the wider community.

Endnotes

¹ Assessment of the Effectiveness of Lead Mother Child Referral Tickets In Screening of Children for Malnutrition, 2015:1.

² See the Programme's Barrier Analysis Report

³ Perry H, Morrow M, Borger S, Weiss J, DeCoster M, Davis T, Ernst P. Care Groups I: an innovative community-based strategy for improving maternal, neonatal, and child health in resource-constrained settings. *Global Health: Science and Practice*. 2015;3(3):358-369. <http://www.ghspjournal.org/content/3/3/358>

⁴ Sarriot, E. G., Shamim, J., Kouletio, M., et al. The End of Magical Thinking: Sustainability Evaluation Three Years after the End of the Saidpur and Parnatipur Urban Health Project. Concern Worldwide Final Evaluation Report, 2008.

Cover Image

The photo shows Lead Mothers in Nakapiripirit district, Uganda. Photo by Megan Christensen, 2015.

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