

Integrating Care Groups into MOH Systems: A User's Guide for Implementation



Background and Purpose

Care Groups are an evidence-based social and behavior change methodology that have contributed to improved health and nutrition outcomes in a number of settings. However, due to the intensive management and supervision responsibilities of Care Group activities fulfilled by NGO project staff, it may be difficult for local actors, such as the Ministry of Health (MOH), to sustain or scale-up Care Groups at the end of an NGO-lead project.

Concern Worldwide designed the MOH-led Integrated Care Group model to reduce the dependence of Care Group implementation on NGO staff, while increasing integration with the local MOH structure. This is accomplished through shifting responsibility for Care Group facilitation and supervision from NGO staff to CHWs and MOH staff, while still satisfying the established Care Group Criteria. The intention of developing this adjusted method of implementation is to increase the feasibility of the Care Group model to be scaled up and sustained by national Ministries of Health in under-resourced health system settings.

From 2011-2013, Concern Worldwide Burundi conducted Operations Research to assess whether the MOH-led Care Group model resulted in the same improvements in key child health and nutrition outcomes as the NGO-led Care Group model. Concern also compared key process indicators around Care Group functionality, such as Care Group meeting attendance and home visitation rates. The cluster-randomized trial found that the MOH-led Care Group model was as effective as the traditional model in achieving specific child health and nutrition outcomes; and that both Care Group models achieved the same level of participation and coverage. The study concluded the MOH-led Care Group model is a viable approach to scale-up and sustain Care Group activities through existing MOH systems.

The purpose of this document is to provide Care Group implementers with detailed information on how Concern Worldwide integrated the Care Group model into the Ministry of Health (MOH) system in Burundi; in the hopes that this integrated approach may be replicated and tested in other contexts. We assume readers already are familiar with how to implement the NGO-led Care Group model. The content of this document therefore focuses on key differences between the MOH-led approach and how Care Groups are normally implemented. For those interested in learning more about Care Groups, visit www.caregroupinfo.org

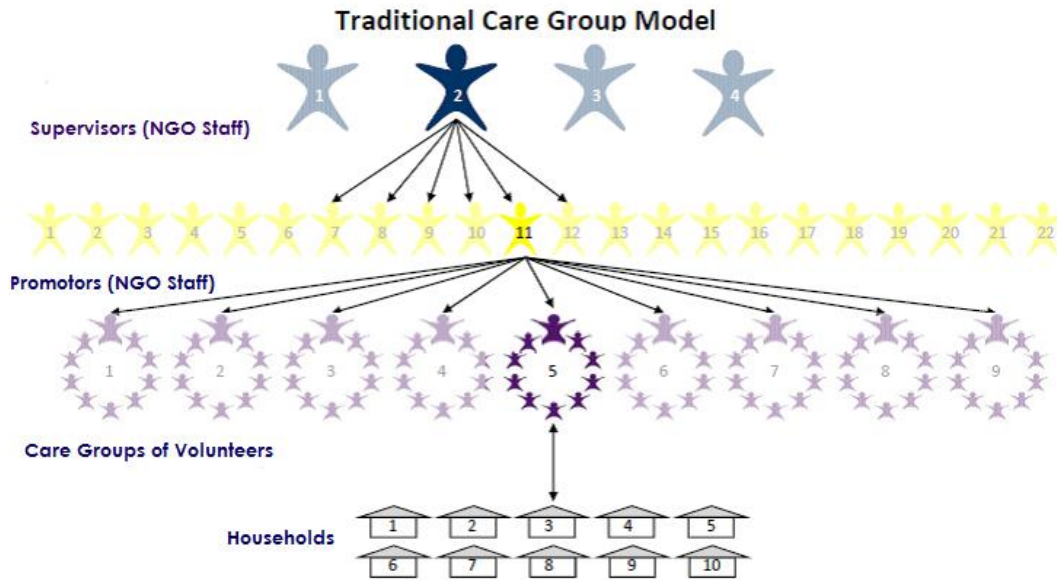
Comparing the NGO-led and MOH-led Care Group Models

As Care Groups are traditionally implemented, NGO project staff supervise and facilitate all Care Group activities: Care Group Volunteers¹ are trained and supervised by Promoters, who facilitate all Care Group activities. Each Promoter trains and supports approximately five to nine Care Groups. Promoters are in turn supervised and supported by more senior-level project staff such as NGO Supervisors. **Figure 1** depicts the structure of the traditional NGO-led Care Group model.²

¹ In other contexts, Care Group Volunteers may be referred to as Lead Mothers.

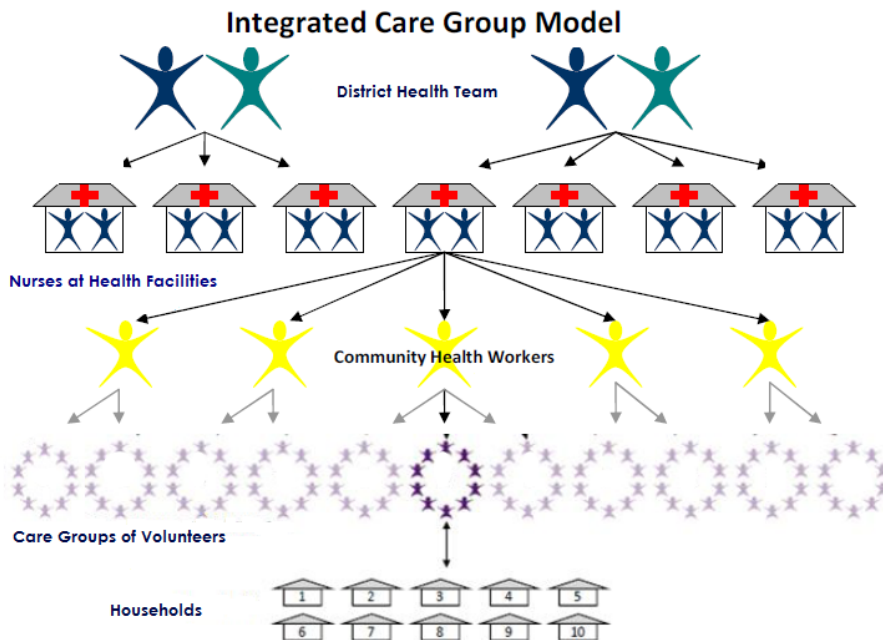
² This description is only intended to give an overview of the most common structures and mechanisms for implementation of the Traditional Care Group model. It is acknowledged that these structures and mechanisms have varied across projects and organizations. For example, CHWs may be included in the Care Groups along with the CGVs.

Figure 1: Structure of an NGO-led Care Group Model



In the MOH-led Care Group model, the primary actors responsible for facilitating Care Group implementation are existing health workers within the MOH system. In Burundi, MOH-recognized CHWs (who are unpaid and are required to be able to read and write) serve as Promoters and the health facility staff, specifically one designated Nurse at each health facility, serve as Supervisors. Therefore, instead of investing the majority of time, effort, and funding into the training and facilitation of Care Groups directly by project staff, emphasis is given to building the capacity of MOH staff to provide training, supervision and support to CHWs in the facilitation of Care Groups. **Figure 2** illustrates the structure of the MOH-led Integrated Care Group model as conceptualized and implemented by Concern Worldwide in the context of the Burundian health system.

Figure 2: Structure of an MOH-led Integrated Care Group Model



The main ways that Integrated Care Groups are implemented differently from traditional Care Groups are outlined here:

	NGO-led Care Groups	MOH-led Care Groups
Ratio of Promoters to Care Groups	1 Promoter:5-9 Care Groups	1 CHW: 1-2 Care Groups <i>Because CHWs are volunteers and may have additional responsibilities for the MOH, their workload must be carefully considered. In Burundi, CHWs are also responsible for community case management activities. In consultation with the District Health Team, we decided that CHWs are responsible for 1-2 Care Groups, which we found was a reasonable amount of work for CHWs to manage in addition to their other responsibilities.</i>
Supervision	Supervision structure is through NGO staff: <i>Program Manager, Supervisors, and Promoters using supportive supervision and QIVC techniques</i>	Supervision structure is through MOH system: <i>Within the Burundian MOH, CHWs are supervised by the Head Nurse at each health facility. However, we found that the Head Nurse often does not have sufficient time to supervise community-level activities. In collaboration with the District Health Team, we identified another, more junior Nurse at the health facility who could supervise all CHW activities, including Care Groups. We call this Nurse the 'focal point' in Burundi. For purposes of this document, we refer to this Nurse as the 'Community Health Nurse'.</i> <i>The Community Health Nurse supervises at least one CHW facilitating a Care Group meeting per month. In addition, the Community Health Nurse facilitates a monthly meeting with all CHWs at the health facility, part of which includes time to review any problems and provide support in their resolution. CHWs, in turn, supervise Care Group Volunteers, by accompanying them on household visits, reviewing their registers, and trouble-shooting problems during Care Group meetings. Each CHW was expected to supervise at least one Care Group Volunteer from each of his/her Care Groups per month.</i> <i>We found that QIVC use is challenging for Community Health Nurses and CHWs, at least during the initial implementation of Care Group activities. NGO staff conduct periodic QIVC to monitor the quality of Care Group activities at all levels, and we anticipate that this function will eventually be handed over to the MOH as time goes on.</i>
Reporting	Reporting structures are through NGO staff <i>Care Group Volunteers report to Promoters, who in turn report to Supervisors, and the Program Manager</i>	Reporting structures are through MOH systems <i>CHWs compile reports with birth and death data, incidence of childhood illnesses and malnutrition, and Care Group activities based on Care Group Volunteer registers and submit monthly report for each of their Care Groups to the Community Health Nurse. The Nurse compiles a report for all of the CHWs in their catchment area and submits to both Concern and the District Health Team. In this way, data from Care Group registers are directly incorporated into the MOH Health Management Information System (HMIS).</i>
Training Methodologies	NGO staff facilitate Care Group trainings at all levels: <i>Supervisors train Promoters, who in turn train Care Group Volunteers during the Care Group meetings</i>	NGO staff provide quarterly one-day Training of Trainers to the District Health Team on three months' worth of BCC modules. The District Health Team then cascades these trainings down through the MOH system as follows: <ul style="list-style-type: none"> • <i>The District Health Team provides quarterly one-day trainings to the health facility Nurses on the same modules.</i> • <i>The Community Health Nurses train the CHWs within their health facility catchment areas on those same topics on a monthly basis.</i> • <i>CHWs provide that same training to their Care Groups during their twice-monthly Care Group meetings.</i>

Key Steps in Implementing the MOH-led Care Group Model

In many ways, MOH-led Care Groups are established and implemented in the same way as traditional Care Groups: beginning with a community census to identify target households, followed by the election of Care Group Volunteers, formation of Care Groups, and routine contact with Neighbor Women through routine home visits or small group meetings. However, the establishment of MOH-led Care Groups requires several additional processes to build the capacity of key MOH actors in the implementation of Care Groups prior to beginning their activities. The steps to implement the MOH-led Care Group model are detailed here:

- 1.) District Health Team Orientation (2 days): As the lead MOH entity in the district, the District Health Team is responsible for overseeing implementation of all Care Group activities. The first step in implementing MOH-led Care Groups is for NGO staff to therefore provide a comprehensive orientation to the District Health Team on the overall concept of Care Groups, how they function, the roles and responsibilities of the District Health Team in Care Group implementation, supervision and reporting mechanisms, and, perhaps most importantly, how Care Groups will contribute to existing community health priorities in the district. During this orientation, the District Health Team also advises on which indicators they would like Care Group Volunteers to collect for the Health Management Information System. This orientation is an essential step to ensuring buy-in and ownership from the MOH for the implementation of all Care Group activities.
- 2.) Health Facility Staff Orientation (2 days): The District Health Team then leads an orientation on MOH-led Care Groups for health facility staff, including the Head Nurse of each health facility as well as the Community Health Nurse. NGO staff should participate in this training; however it is important that the District Health Team take the lead. Topics covered are the same as those discussed during the District Health Team orientation.
- 3.) Sensitization for Community Leaders (1 day): The involvement of community leaders, such as locally elected officials, village chiefs, and elders is extremely important to the functioning of all Care Groups. The District Health Team leads an orientation session for all community leaders, during which the concept of Care Groups is introduced and community leaders are engaged to support Care Group implementation. In Burundi, CHWs also participated in this initial sensitization meeting; however they also receive additional in-depth training on their roles and responsibilities at a later stage.
- 4.) Sensitization for Local Population (1 day): The community leaders then lead a sensitization meeting for the population their village, in collaboration with the Community Health Nurse. During this meeting, the concept of Care Groups is introduced to the general population and community members learn what the main activities will be and how Care Groups will improve the health of children in their family and community.
- 5.) Community Census: Once all stakeholders are oriented to the concept and purpose of Care Groups, activities to commence Care Group activities may begin. As in all Care Group projects, the first step is to conduct a community census to identify all households with a pregnant woman and/or a child 0-23 months. The Community Health Nurse leads this process within their health facility catchment area, in strong collaboration with local leaders and CHWs. The total time to conduct a census will vary on the size of the target population, and NGO staff will provide technical assistance to support this process.
- 6.) Election of Care Group Volunteers: Based on the results of the census, the Community Health Nurse will facilitate the election of Care Group Volunteers with support from NGO staff and local leaders.

- 7.) CHW Training (3 days): Once Care Group Volunteers are elected, CHWs are trained in Care Group implementation by the Community Health Nurse. The first day of the training covers the overall concept and purpose of Care Groups, as well as an introduction to participatory methods and how to facilitate Care Group meetings. The second day covers all of the Care Group tools, registers, reporting forms, and supportive supervision processes. The third day consists of practice using the Care Group tools, and facilitating meetings using participatory methods. NGO staff attend this training and provide technical support to ensure the quality of CHW training.
- 8.) Care Group Volunteer Training (3 days): The Community Health Nurse facilitates a training for all newly-elected Care Group Volunteers, with participation by the CHWs as well as NGO staff. The first day of the training covers an overview of the Care Group approach, how to do home visits and facilitate small group meetings, as well as an overview of behavior change skills including negotiation. The second day covers the Care Group registers and reporting forms. The third day consists of practice with the tools and with the delivery of behavior change messages.

The steps outlined above are the initial steps to operationalize the MOH-led Care Group model, and may be tailored to different contexts as required.

Roles and Responsibilities of Key Actors in the MOH-led Care Group Model

Although MOH-led Care Groups are implemented through the MOH system, there is still a role for NGO staff to lead in the overall design and facilitation of the model, at least until the model reaches scale. This section describes the roles of all key actors in implementing the MOH-led Care Group model, including both NGO staff and MOH personnel

NGO Staff:

- Conduct formative research to develop behavior change modules
- Develop behavior change modules in collaboration with District Health Team; prints modules
- Develop and reproduce Care Group registers and reporting forms
- Orient the District Health Team and Health Facility staff, including both the Head Nurse and Community Health Nurse, on how to implement the Care Group model
- Train the District Health Management Team in Care Group modules on quarterly basis
- Provide technical support and trouble-shooting on supportive supervision, reporting systems, and participatory methods
- Conduct periodic supervision of Care Group activities using QIVCs and feedback to District Health Team and Health Facility staff
- Provide technical support to Community Health Nurse to train CHWs in the Care Group modules (as required)

District Health Team:

- Participates in formative research to develop behavior change modules
- Assists in the development of behavior change modules and Care Group registers and reporting forms

- Receive one-day Training of Trainers on Care Group modules from NGO staff on quarterly basis
- Provide one-day training to Community Health Nurses on Care Group modules on quarterly basis
- Monitor quality of Care Group activities through supervision of health facility personnel, including Community Health Nurse
- Monitor Care Group activities and health indicators reported from Care Group registers and take appropriate action

Community Health Nurse:

- Receive one-day training on BCC modules from District Health Team on quarterly basis
- Facilitate monthly meetings with CHWs at the health facility, which include training on BCC modules as well as review of reports, small group supportive supervision and trouble-shooting
- Conduct at least one supervision to a CHW / Care Group meeting per month
- Compile monthly reports submitted by CHWs and submit to DHT and NGO staff

CHWs:

- Attend monthly meetings at health facility to receive training on BCC module, submit reports, and trouble-shoot any problems
- Facilitate two Care Group meetings for each Care Group per month
- Conduct at least one supervision visit to a Care Group Volunteer from each Care Group per month
- Compile Care Group Volunteer reports and submit to health facility

Care Group Volunteers:

- Conduct two home visits per month to their Neighbor Women³
- Attend two Care Group meetings per month
- Submit reports based on their activities and home visit register data

Neighbor Women

- Receive home visits from Care Group Volunteers
- Participate in small group meetings with their Care Group Volunteer and fellow Neighbor Women

Notes on Adapting the MOH-led Model in Other Settings

This document describes how the MOH-led Care Group model was implemented in the context of the Burundian health system. While most government health systems may have similar structures, supervisory roles may differ, as might the roles and responsibilities of CHWs. In Burundi, there is

³ In Burundi, Care Group Volunteers conduct two home visits per month. In other Care Group projects, Volunteers may conduct home visits as well as facilitate small group meeting among the Neighbor Women.

just one cadre of CHW; however other countries might have multiple official cadres with a range of different responsibilities and skill levels.

We recommend that implementers collaborate with MOH counterparts to assess the most optimal way that Care Groups may be integrated into the MOH system. We also recommend implementers further engage with the MOH to identify and advocate for ways to further integrate Care Groups into the official community health system.

The Added Value of Integrated Care Groups

This document provides detail on how to implement the MOH-led Care Group model, and in doing so, demonstrates how Care Groups may be scaled-up and sustained through MOH systems. In addition, Concern has also seen first-hand the added value of the Integrated Care Group model, beyond simply the potential for scale and sustainability.

By empowering MOH personnel to implement Care Groups directly, the MOH-led model builds the capacity of MOH actors in key areas such as behavior change and participatory methods. Integrated Care Groups strengthen the overall community health system, by extending the reach of Community Health Workers to reach every target household on at least a monthly basis, a task that is often unachievable due to the size of the target population and human resource constraints. By effectively formalizing Care Group Volunteers into the community health system, as extensions of CHWs, the linkages between communities and health facilities are strengthened. Health Management Information Systems frequently lack household-level data, and data from Care Group Volunteer registers serves to strengthen real-time data monitoring and action. Integrated Care Groups also strengthen additional community-level activities, such as community case management (CCM). In Burundi, CHWs are also responsible for the provision of CCM, and Care Group Volunteers were able to identify sick children during household visits and refer them to the CHW for prompt treatment.

MOH-led Care Groups are a promising strategy to both scale-up and sustain Care Group activities through MOH systems, and also serve to strengthen community health systems more broadly. We encourage other implementers to replicate, adapt, and test this approach in other contexts.

For more information on the Integrated Care Group model, please contact:

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