

TESTING THE INTEGRATED CARE GROUP MODEL IN BURUNDI

Concern Worldwide is implementing a five year, USAID-funded Child Survival project (2008 – 2013) in Mabayi Health District, Cibitoke Province, Burundi. The project aims to achieve sustainable and equitable uptake of key child health and nutrition services by improving household health and nutrition practices, improving access to quality child health care services, at both health center and community level, and strengthening community leadership in health.

To achieve these objectives, Concern is building the capacity of community health actors through a cascade training structure under the Care Group model, a promising methodology for achieving saturation coverage of every beneficiary household through an extensive volunteer network equipped to deliver health messages at the household level.

OPERATIONAL RESEARCH

Within the Child Survival project, Concern is also carrying out innovative operations research to test the effectiveness and sustainability of an Integrated Care Group model, as compared with the well-established and proven Traditional Care Group model.

The Integrated Care Group Model was designed by Concern Worldwide Burundi to reduce the dependence of Care Group implementation on full-time, paid NGO staff, while increasing integration with the local MOH structure. This is achieved through task shifting of Care Group facilitation from NGO staff to appropriate MOH staff and Community Health Workers (CHWs), while satisfying the established Care Group criteria, which include details on functionality and supervision of groups and meetings, and the purpose, teaching

methods and contents of meetings.¹ 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, particularly by national Ministries of Health, without external donor funding particularly in under-resourced health system settings.

KEY RESEARCH QUESTIONS

There are four primary research questions that this study will aim to answer:

1. Does the Integrated Care Group Model achieve the same improvement in the **knowledge** of key child health and nutrition behaviors among caregivers of children 0-23 months as the Traditional Care Group Model?
2. Does the Integrated Care Group Model achieve the same improvement in the **practice** of key child health and nutrition behaviors among caregivers of children 0-23 months as the Traditional Care Group Model?
3. Does the Integrated Care Group Model achieve the same level of Care Group **functionality** as the Traditional Care Group Model?
4. Does the Integrated Care Group Model achieve the same level of Care Group **sustainability** as the Traditional Care Group Model?

¹ For the complete 2012 criteria see <http://www.caregroupinfo.org>



This study will also aim to test two hypotheses:

Hypothesis 1: There is no significant difference in the coverage of the knowledge and practice of key health and nutrition behaviors among caregivers of children 0-23 months reached by the Integrated Care Group Model as compared to the Traditional Care Group Model after two years of implementation.

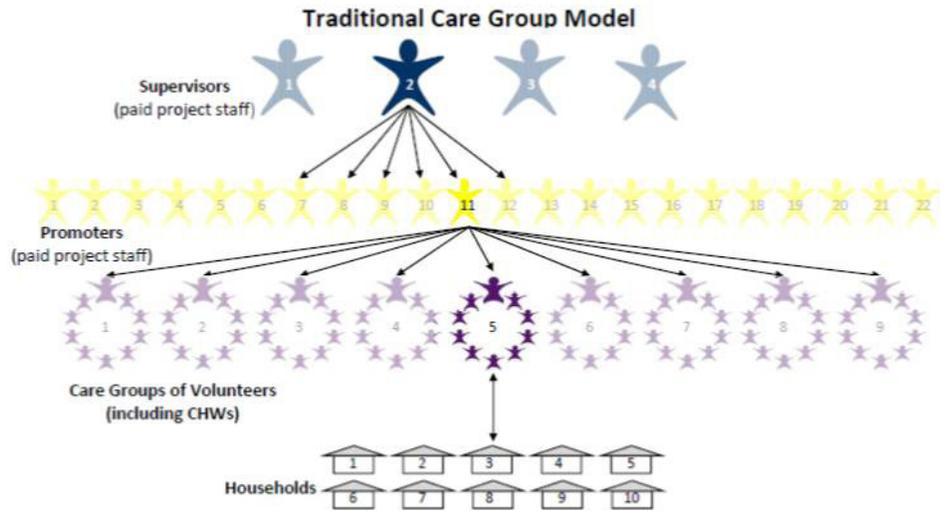
Hypothesis 2: There is no significant difference in the functionality or sustainability of Care Groups implemented through the Integrated Care Group Model as compared to Care Groups implemented through the Traditional Care Group Model after two years of implementation.

MEASUREMENT METHODOLOGY

In order to assess the first two research questions, a baseline Knowledge, Practice and Coverage study was conducted at the beginning of the project on caregivers of children aged 0 to 23 months and will be collected again at the end line. To assess the third research question, data is collected through monthly monitoring systems which will provide data against five key operational monitoring indicators to assess functionality.

The functionality indicators are as follows:

- Average number of Care Group meetings per month in the previous quarter
- Percentage of Care Groups with at least 80% Volunteer attendance in at least one meeting per month in the previous quarter
- Percentage of households with children of less than 5 years of age or women of reproductive age that have received at least one household visit by a Care Group Volunteer per month in the previous quarter
- Percentage of trained CHWs that



submitted completed monthly reports on Care Group Activities information and Community-Health Information Systems (C-HIS) to Health Centers per month in the previous quarter

- Percentage of Care Group Volunteers that reported on C-HIS data to CHWs/ Health Promoters per month in the previous quarter

Analysis will focus on identifying any significant difference (15% or more) between the two models for these indicators.

The fourth research question, on sustainability, will be measured during the last six months of the project, in which Concern Worldwide will withdraw the support of the Health Promoters and Animators from both models. Performance against all five functionality indicators will then continue to be measured.

IMPLEMENTATION MECHANISMS OF THE TRADITIONAL CARE GROUP MODEL

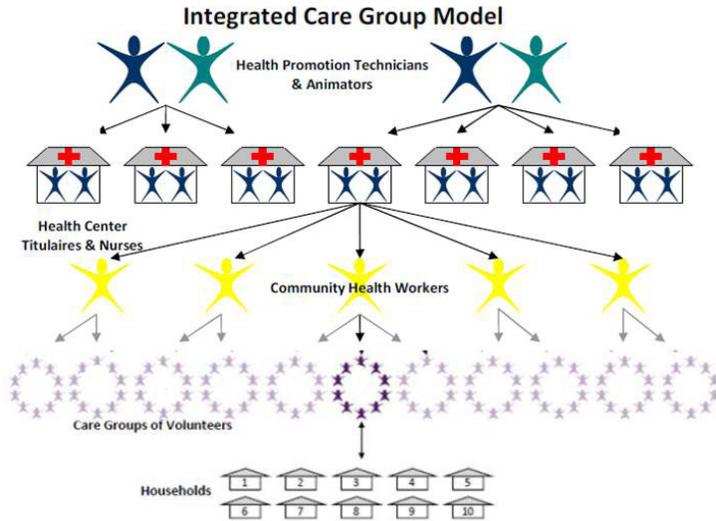
In the Traditional Care Group model, Care Group volunteers are trained and supervised by Health Promoters (full-time, paid NGO staff), who are supervised by Supervisors (full-time, paid NGO staff). Each Health Promoter is in charge of training and supporting approximately nine Care Groups. CHWs are part of the Care Groups along with the other Care Group volunteers, but they do not have the responsibility to facilitate the Care Groups themselves. CHWs are however mentored by the Health Promoters, which will allow CHWs to take over the facilitation of the Care Groups after project completion and withdrawal of external support. The diagram above depicts the structure of the Traditional Care Group Model.²

2. Note: This description is only intended to give an overview of the most common structures of the Traditional Care Group Model. It is acknowledged that these structures and mechanisms have varied across projects and organizations.



Marie Claire Nduwimana, a Concern Worldwide health promoter conducts a Care Group meeting in the traditional area of Bukinanyana commune, Burundi

Photo: Adele Fox, Concern Worldwide



IMPLEMENTATION MECHANISMS OF THE INTEGRATED CARE GROUP MODEL

In the Integrated Care Group model, Care Group volunteers are trained and supervised by CHWs, who are trained and supported by *Technicien de Promotion de Santé* (TPS)³ and *Titulaires*⁴ (both full-time, paid MOH staff) in conjunction with Health Animators (full-time, paid NGO staff). This adjustment to the training and supervision of Care Groups uses fewer NGO salaried staff and emphasizes the engagement and responsibility of the MOH to ensure their active participation from the beginning of the project implementation. Each CHW is responsible for training and supporting only two to three Care Groups, which limits the time and transportation demands on the CHW. Instead of investing the majority of time, effort, and funds into the training of Care Groups by paid NGO staff, in the Integrated Care Group model's project staff build the capacity of CHWs to train Care Groups directly and build the capacity of MOH staff to provide training, supervision and support to CHWs in the facilitation of Care Groups. The diagram below depicts the structure of the Integrated Care Group model as implemented by Concern Worldwide Burundi in the context of the Burundian health system.

PRELIMINARY RESULTS TO DATE

The Care Groups became operational in June 2011 with 50 Traditional Care Groups comprised of 509 volunteers and 43 Integrated Care Groups comprised of 483 volunteers.

Table 1 on the next page shows the results from the Traditional and Integrated areas against all five indicators from the

first year of Care Group implementation. Results from the first four quarters of data collection on Care Group functionality, show that the majority of Care Groups under both the Traditional and Integrated models are achieving the target for each indicator. There is no significant difference between the two models in terms of the frequency of meetings, attendance at meetings, or reporting of health data. The greatest difference between models is evident in indicator three, which measures the percentage of households receiving at least one visit per month. Under Indicator 3, the Traditional Model has performed consistently better than the Integrated Model over the year and significantly better (>15%) in one quarter, while Care Groups in the Integrated area have also not reached the target percentage in the first two quarters.



Photo: Adele Fox, Concern Worldwide

Community health worker, Anita Hatungimana, conducts a Care Group in an integrated area of Mugina commune, Burundi

3. Health Promotion Technicians (English translation) are the primary full-time, paid MOH staff with responsibility for community-based promotion and outreach.

4. *Titulaires* are the head nurse of each health center.

	Key Operational Indicator	Target	June –August 2011		September - November 2011		December 2011 – February 2012		March – May 2012	
			Traditional Care Groups	Integrated Care Groups	Traditional Care Groups	Integrated Care Groups	Traditional Care Groups	Integrated Care Groups	Traditional Care Groups	Integrated Care Groups
1	Average number of Care Group meetings per month	2	1.7	2	2	1.8	1.8	1.9	1.7	2
2	% of Care Groups had at least 80% Volunteer attendance in at least one meeting per month	80%	81%	93%	82%	88%	87%	84%	88%	97%
3	% of households that have received at least one household visit by a Care Group Volunteer per month	80%	96%	78%	87%	76%	90%	84%	97%	91%
4	% of trained CHWs submitted completed monthly reports to Health Centers per month	80%	89%	87%	90%	87%	97%	93%	97%	99%
5	% Care Group Volunteers who have submitted reports to CHWs/Health Promoters per month	80%	94%	98%	95%	93%	96%	96%	97%	97%

DISCUSSION

The results to date show no significant difference between the two Care Group models against the majority of functionality indicators, suggesting that the Integrated model is performing adequately in comparison to the Traditional Model and may constitute a promising alternative.

It is notable that Care Group members in the Traditional model are conducting more home visits than those in the Integrated Model. One possible explanation for this may be the role that Health Promoters play in motivating volunteers, assisting with problem solving and providing ongoing encouragement and motivation. CHWs have demonstrated that they are able to carry out this role effectively too, suggested by the satisfactory statistics

against indicator three over two quarters of the year. However, they carry out this role in addition to their regular job and with a lower level of experience or education than the full time, paid NGO staff Health Promoters, therefore, it is possible that they contribute a lower level of input and that this in turn influences the performance of the volunteers.

A qualitative review with a range of stakeholders will be carried out in September 2012 to assess the responses of MOH staff and community members to the implementation of both models. Routine data will continue to be collected for the remainder of the project, including the final six month period of the project during which Concern will withdraw its support in order to monitor and evaluate sustainability. In

light of both the quantitative and qualitative findings adaptations may be made to the functionality of the Integrated model to better fit the reality and set more achievable targets likely to be sustained into the future, such as reducing the frequency of care group meetings. If the Integrated model is found to be a viable community health strategy, Concern Worldwide Burundi will engage in national level advocacy for scale up.



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