

Intersections

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MCC has sought to improve the health of mothers and young children since its first material aid shipments to southern Russia in the 1920s. By the 1940s, maternal and child health services were core features of MCC's hospital-based and medical relief work from Paraguay to India. From the 1960s to the 1980s, MCC's health projects increasingly focused on community-based solutions, including supporting and training midwives and community nurses. In the 1990s and early 2000s, MCC's growing focus on HIV/AIDS expanded MCC's maternal and child health work particularly in the areas of prevention of mother-to-child transmission of HIV and health services for orphans and vulnerable families. As MCC's health work moved away from clinic-based treatment programs toward more community-based prevention models over the last decade, a new approach to maternal and child health programming has become prominent in MCC health projects, particularly in Africa where most of MCC's maternal and child health work is focused.

This new approach to maternal and child health draws heavily on the "Care Group" model, originally developed in Mozambique by World Relief in 1995. Though designed for rural African contexts, care groups have now been used in dozens of countries in Africa, Asia and Latin America in both urban and rural settings with positive reports in the literature on sustainability, effectiveness at spurring desired behavior change, impact on core health measures including infant and maternal mortality and cost efficiency. Care groups focus on empowering families to make the best health decisions they can within the realities of their context, informed by high-quality peer-to-peer health education, and using peer support groups to facilitate sustained behavior change. The model is relatively low-cost and sustainable, due to its light use of highly trained clinical staff, a proactive complimentary collaboration with existing health systems and the deployment of highly contextualized behavior change promotion tailored to what is realistic and prioritized by participant mothers themselves.

Classic care groups are structured with ten to 15 neighborhood women coming together monthly for education and support, led by a volunteer mother leader elected by the group. These mother leaders meet monthly in groups of ten for training and support from a community health worker (called a promoter in the literature), who is in turn trained and supported by the full-time paid health staff of the project. In this way, a small group



Learn more

CareGroupInfo.org:

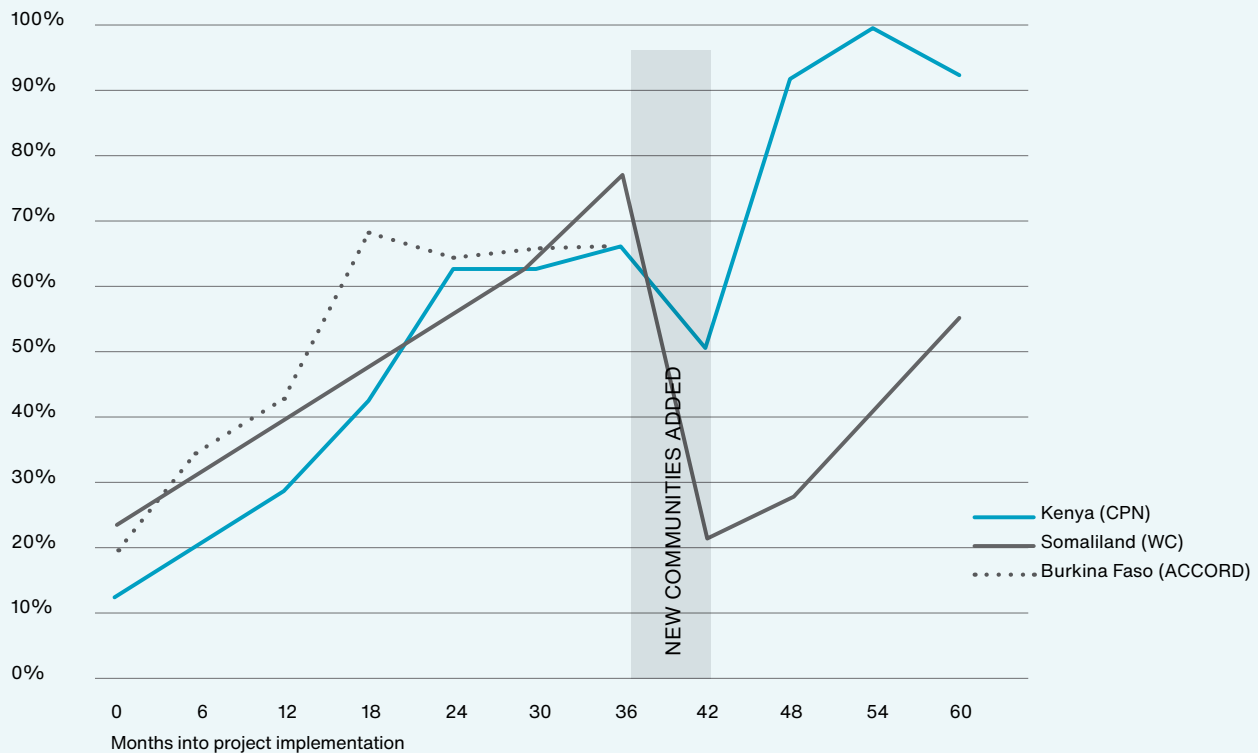
A free online resource for networking and sharing care group curricula, tools and evaluations from many different contexts.

Food Security and Nutrition Network Social and Behavioral Change Task Force. Care Groups: A Training Manual for Program Design and Implementation. Washington, DC: Technical and Operational Performance Support Program, 2014. Available in English, Spanish and French at https://www.fsnnetwork.org/resource/care-groups-training-manual-program-design-and-implementation.

of trained staff coordinate and support training and behavior change programming for hundreds (and in some cases thousands) of women, meeting monthly in groups in their neighborhoods. The curriculum used in these care groups aligns with national Ministry of Health guidelines and World Health Organization best practices and is generally shared freely between partners and projects allowing for low-cost distribution and rapid adoption of effective methods and materials in a wide variety of local languages. Curricula generally cover topics like improving the nutrition of mothers and infants, avoiding infectious diseases (through improved water, sanitation and hygiene infrastructure and practices), identifying warning signs in pregnancy, delivery and childhood (including when to seek medical care) and strengthening child protection efforts. As a modular curriculum, new topics can be added based on contextual needs or participant requests.

While MCC had used peer-support groups in community health projects since at least the 1960s, the first MCC care groups for maternal and child health began in 2016 in Somaliland (with partner World Concern). The following year, MCC added care group projects in Kenya (with the Kenya Mennonite Church’s Center for Peace and Nationhood) and Tanzania (with Naiboisho Development Initiative). Seeing the success of the model, many other MCC partners adopted care groups (including ACCORD in Burkina Faso, World Outreach International in Burundi, Mukuru Mennonite Academy in Kenya and Faith Alive Foundation in Nigeria). These care group initiatives all received support from an MCC fund established in honor of Luann Martin and her lifetime of work for women and children’s health around the world. Additional partners from South Sudan, Uganda, Ethiopia and DR Congo are considering adopting elements of care groups in their own work in the coming years.

Chart 1: Percentage of pregnant and lactating women achieving minimum dietary diversity



The fact that these projects have proven effective at saving lives in sustainable community-led ways that play to the strengths of community-based organizations accounts for their rapid spread across MCC partners. An evaluation in 2021 of the MCC-supported care group project with ACCORD in Burkina Faso showed a remarkable 83% decline in infant mortality among participating communities since the work started in 2018, despite a deteriorating economic and security situation. This one project, working across 37 villages in rural Burkina Faso, is estimated to have prevented approximately 26 child deaths per year of operation. These children’s lives were bettered—in some cases even saved—by improved nutrition, better use of available preventive health services, catching pregnancy complications early, increased vaccination rates, improved water, sanitation and hygiene (WASH) procedures and reduced cases of infectious diseases and diarrhea. “The impact has been so clear and powerful that it brought the whole community together,” says Gregoui Sawadogo, a Catholic priest who participated in the program. “Locals and displaced people, Catholics and Protestants, Muslims and Christians, health workers and traditional healers. Everyone. When we could all see that working together was saving children’s lives, how could we not come together for this?”



Perry, Henry, Melanie Morrow, Sarah Borger, Jennifer Weiss, Mary DeCoster, Thomas Davis, and Pieter Ernst. “Care Groups I: An Innovative Community-Based Strategy for Improving Maternal, Neonatal, and Child Health in Resource-Constrained Settings.” *Global Health: Science and Practice* 3/3 (2015): 358-369. <https://doi.org/10.9745/GHSP-D-15-00051>.

MCC conducted a series of project evaluations starting in 2019 to learn from the growing cohort of projects using care groups and adaptations of the model in multiple MCC programs in Africa. The articles throughout this issue of *Intersections* highlight different learnings from these projects about how communities can come together in diverse and difficult contexts, using empowering community-led models like care groups to improve the lives of at-risk mothers and children. Several key findings of these care group project evaluations that may be useful for other MCC partners considering this type of work include:

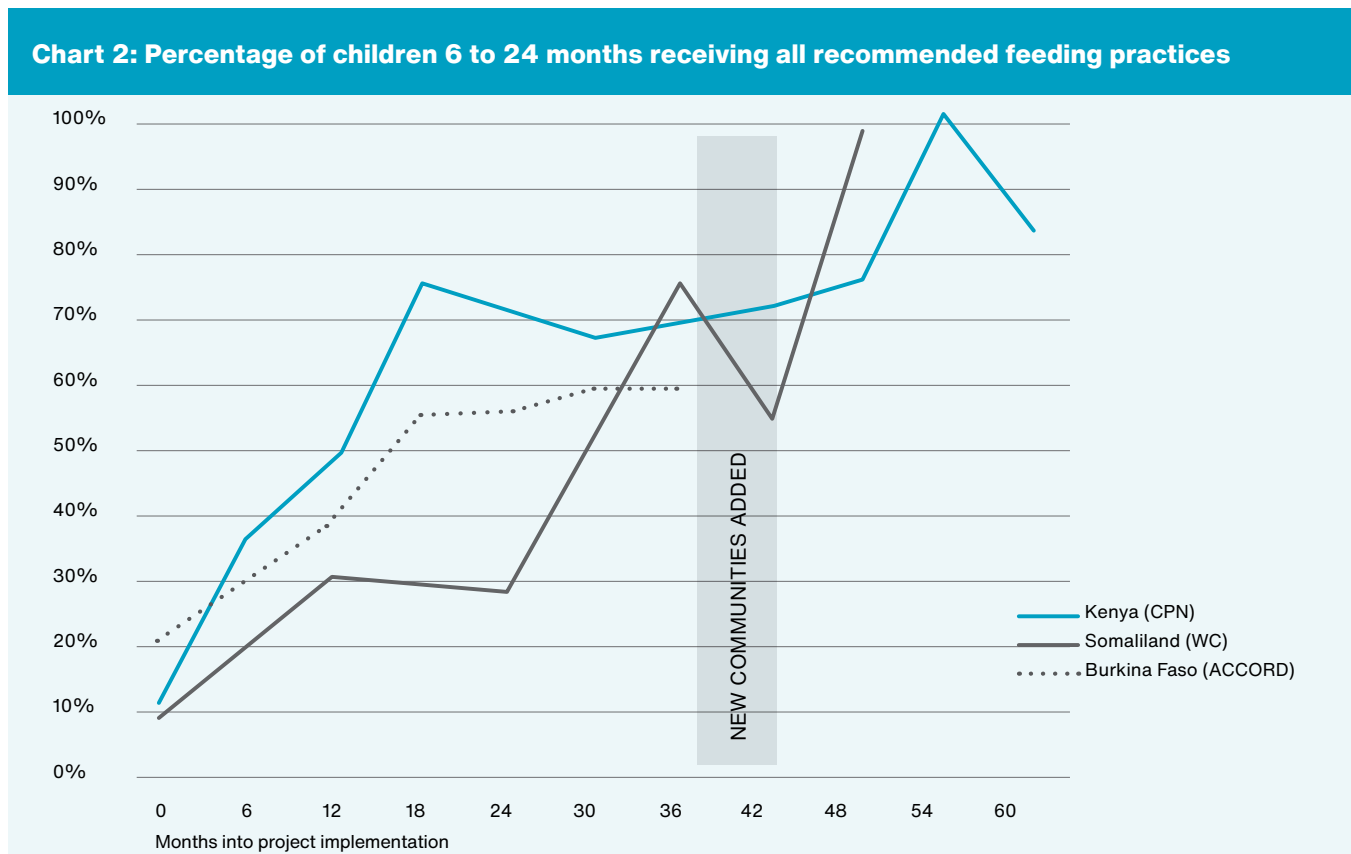
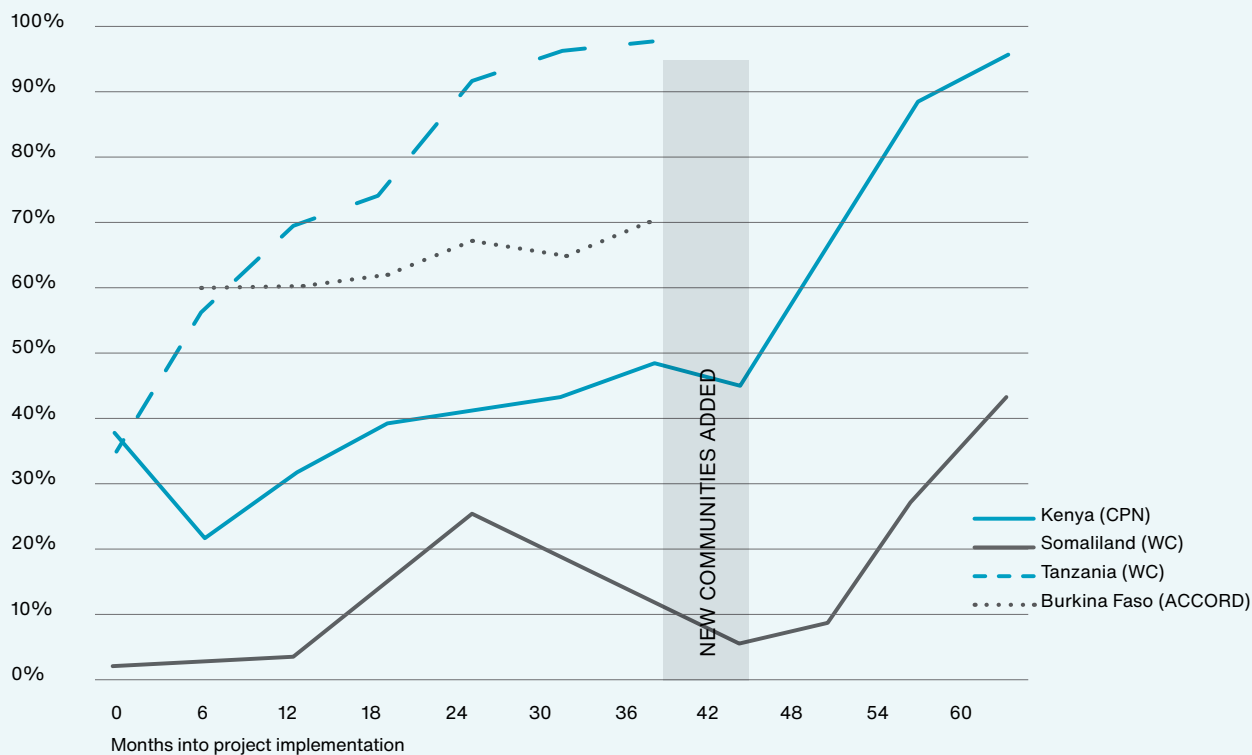


Chart 3: Percentage of participant women receiving at least four (4) antenatal care visits from a skilled health professional prior to delivery

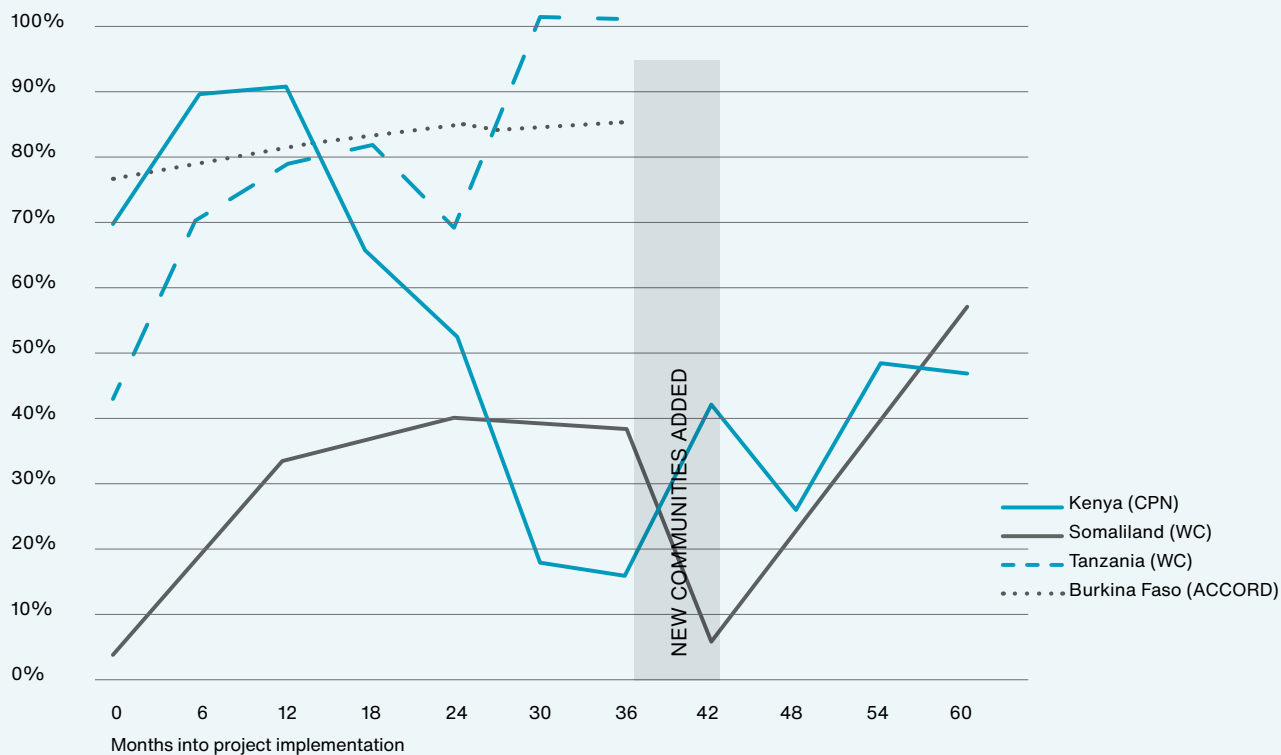


Learn more

George, Christine Marie, Emilia Vignola, Jim Ricca, Tom Davis, Jamie Perin, Yvonne Tam, and Henry Perry. "Evaluation of the Effectiveness of Care Groups in Expanding Population Coverage of Key Child Survival Interventions and Reducing under-5 Mortality: A Comparative Analysis Using the Lives Saved Tool (LiST)." *BMC Public Health* 15/1 (2015): 1-9. <https://doi.org/10.1186/s12889-015-2187-2>.

1. Care groups organized by MCC partners have been effective at creating and sustaining behavior change to improve maternal and child health across a wide variety of contexts: from highly rural Muslim-majority communities in Somaliland to dense urban informal settlements in Christian-majority Kenya; with health-specialist partners like WOI in Burundi or FAF in Nigeria, to community development partners newer to health work like NDI in Tanzania. Partners have found care groups to be highly adaptable to culture, context and local partner capacities.
2. In line with the published literature, care groups with MCC partners have been most effective at creating change in areas that are most directly under the control of the families (i.e., behaviors that families have the power to change themselves). Two examples of this are dietary diversity of mothers during pregnancy and lactation (see chart 1) and families using all recommended infant and young child feeding practices (see chart 2). Note the temporary drops in average performance on these indicators in the Kenya and Somaliland projects when new communities were added after the first three-year project cycle.
3. MCC partners witnessed significant improvements in women's access to essential health services when they coordinated closely with government health services and those health services were available. A good example of this is antenatal care visits during pregnancy (see chart 3). These visits have been demonstrated in the literature to be highly effective in reducing infant and maternal mortality by catching complications in pregnancy early so treatment can be provided. Of MCC's care group initiatives from the past six years, the Tanzania project (discussed in Paul Mosley's article in this issue) was the most integrated with government health services and saw the most rapid rise in antenatal care visits during

Chart 4: Percentage of participant pregnant and lactating women receiving recommended daily micronutrient supplements



the first three-year cycle. MCC’s care group partners in Kenya and Somaliland projects learned from this experience and changed strategies to better coordinate with government services, allowing them to achieve much greater improvements during their second three-year project cycle.

- These projects struggled most to create positive change when the recommended behaviors relied on government services that were not dependable and outside the scope of the project to influence. One example was access to micronutrient supplements for pregnant and lactating women (see chart 4). In all project areas government-run clinics were supposed to provide these supplements. However, in most sites access by pregnant and lactating women to these supplements was inconsistent, leading to low uptake by women. The only project to achieve near 100% coverage in this area was in Tanzania, where MCC partner staff worked directly with government clinics to ensure a consistent supplement supply was available.

These evaluation findings and the learnings presented in the articles below highlight both the potential and challenges of using community-led models of social and behavior change like care groups to improve health in diverse contexts. As MCC and its partners seek strategies to improve community impact, the successes, challenges and learnings from care group maternal and child health projects in Africa shared in this issue may provide a catalyst for creative thinking. While behavior change approaches like care groups cannot solve every problem, they offer a potentially powerful strategy for empowering families and communities to make the best changes they can, given the constraints they face.

Paul Shetler Fast is MCC health coordinator, living in Gosben, Indiana.

“When we could all see that working together was saving children’s lives, how could we not come together for this?”—Gregoui Sawadogo, a Catholic priest in Burkina Faso



Abdoul Nassir Sawadogo with her child Zounogo Sawadogo are participants in the MCC-supported maternal and child health care group project with local interfaith partner Action Citoyenne et Communautaire pour la Résilience et le Développement (ACCORD, a French acronym meaning Citizen and Community Action for Resilience and Development) in Forgui, Burkina Faso. In this June 2021 photo, Abdoul is feeding her daughter a local enriched porridge made of millet, peanuts, soybeans and black beans that she was taught to make in the program. (MCC photo/Paul Shetler Fast)

What makes a care group?

- Neighbor groups of 10-15 parents (mostly mothers) who meet at least monthly. They elect a volunteer peer leader to facilitate their group sessions.
- Peer leaders meet monthly as groups of 10-15 with a semi-volunteer health promoter (generally a community health worker) to receive context-adapted training and support.
- Promoters meet regular with paid staff who coordinate the groups, train promoters, ensure consistent training, triage and refer complex cases, liaise with local health system and adapt curriculum to the local context.
- The model focuses on family empowerment to support pregnant and lactating women to make informed maternal and child health decisions within the realities of their contexts, with support groups and peer-education facilitating sustained behavior change.
- The care group curriculum covers multiple topics, including strategies for improving the nutrition of mothers and infants, ways to avoid infectious diseases (through water, sanitation, and hygiene), preventive care such as vaccinations, warning signs in pregnancy, delivery, and childhood (including when to seek medical care) and child protection.
- The curriculum is contextualized to local realities, with modular elements that can be added or modified to meet contextual needs or participant requests.

Learning from using care groups in a Maasai community in Tanzania

Ebiotishu Oondomonok Ongera (EbOO), or Healthy Mother and Child in the Maasai language, was an MCC-supported project in Tanzania with Naiboisho Development Initiative (NDI) from 2017 to 2020. The project sought to reduce maternal and child mortality in a rural ward inhabited by several Maasai communities in the Ngorongoro conservation area of northwestern Tanzania.

The project established six care groups, two in each of three ward sub-villages. The care groups were composed of 75 total volunteer leaders who served over 4,300 pregnant and lactating women and attended 2,223 deliveries during the life of the project. Because Nainokanoka is in a very isolated setting with a small population, the project was able to include nearly every pregnant woman in the ward.

Consistent with the Government of Tanzania's operational objectives to increase the number of women completing antenatal care visits, delivering in health-care facilities and breastfeeding immediately after delivery and exclusively for six months, the project promoted adoption of these practices using a care group behavior change approach.

In addition to promoting these evidence-based healthy pregnancy and delivery practices, the project also secondarily provided funding to prevent stockouts of prenatal supplements (iron and folic acid) at the three health facilities in the ward, offered facility midwives opportunities for professional development and incentivized attendance at antenatal care visits with provision of liche, a nutritional porridge that can be eaten by pregnant women as well as children over six months of age.

One innovation of the project in adapting to the Maasai context in Tanzania was that care group volunteers were selected from a pool of well-respected traditional birth attendants (TBAs), rather than from the cohort of pregnant and lactating women participants. This modification of traditional care group structures by NDI was important because of the central role TBAs play in attending to pregnant women from the first trimester through delivery and for six months after. In addition, providing training to TBAs in best practices around pre-natal care provides some correctives to potentially harmful traditional practices around pregnancy and delivery that were being promoted by TBAs in the community. Of particular concern among these practices was the belief that a pregnant woman should be food deprived in her last trimester "to assure a low-birthweight baby and an easy delivery."

While there was concern about buy-in from TBAs, especially as advocates for facility-based delivery, the benefits outweighed the risks. TBAs were responsible for bringing women to all their antenatal care visits as well as accompanying them to a facility for delivery. During pregnancy, TBAs also shared teachings from training modules they received on nutrition during pregnancy and warning signs for complications (particularly pre-eclampsia and hemorrhaging), and assisted mothers in making a birth plan.

Observations during the baseline survey and early project output data indicated the need for deeper understanding of cultural factors influencing decisions around having a facility birth. There was evidence of a rapid increase in women attending facilities for antenatal visits without a corresponding rise

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“Care group volunteers were selected from a pool of well-respected traditional birth attendants (TBAs), rather than from the cohort of pregnant and lactating women participants. This modification of typical care group structures by NDI was important because of the central role TBAs play in attending to pregnant women from the first trimester through delivery and for six months after.”

“Our children learn to walk sooner than expected, they don’t have common cough all the time.”

“Children have better development compared to previous years.”

“The babies are heavy, they have enough weight.”

“Children don’t have common cold and repetitive illnesses.”

—Mothers’ responses during focus groups

in facility births, which was not entirely explainable by access barriers. A qualitative study of these dynamics found that psychosocial factors, the role of decision makers around place of delivery and lack of timely access all played into the decision for a home birth. Despite these challenges, there was significant evidence of willingness to adopt changes to cultural practices around delivery which favored better birth outcomes for mother and child.

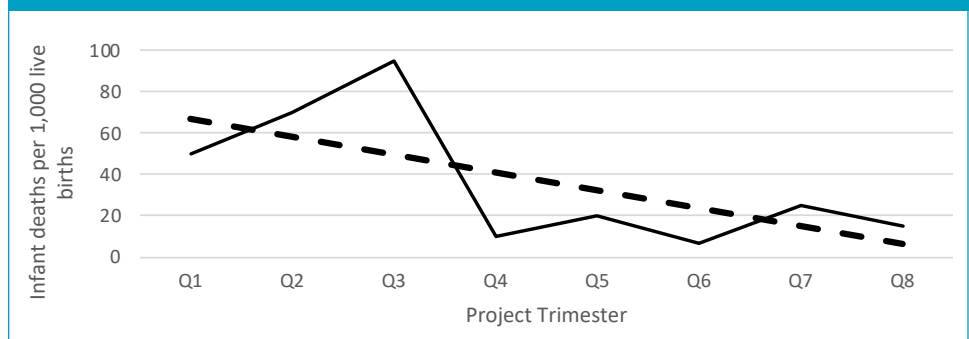
The project had several geographic advantages that increased the chances of project success as well the ability to confidently attribute success to the project intervention. The Nainokanoka ward was isolated and did not have other maternal and child health peer-based programs running at the time. Also, NDI’s ability to reach every woman in the ward due the ward’s population size and the full cooperation of the six nurse midwives at Nainokanoka’s three health facilities made the project’s activities self-reinforcing and thus more effective.

Maternal and infant mortality: High-level health outcomes are difficult to attribute to a project, particularly maternal mortality which is relatively rare, especially in a population of only 14,000. Nonetheless, a comparison can be made between the expected maternal mortality (number of maternal deaths per 100,000 live births) for the ward, based on the regional average as reported in the 2012 population census (535 maternal deaths per 100,000 live births) and the project observed rate of (134 per 100,000 live births). Translated to the duration of the project, one would have expected 8 maternal deaths in the ward during the project time period, while only three were seen, figures that translate into five maternal lives saved that can be attributed to the intervention with some confidence.

Infant mortality is a more frequent occurrence than maternal mortality in a population of this size, which allows for quarterly tracking of infant mortality trends. There was a discernable downward trend in infant mortality: while this downward movement is difficult to attribute entirely to the project, the reduced infant mortality rate is consistent with what NDI hoped to see based on the project’s theory of change. In the first quarter, the infant mortality rate in these communities hewed closely to the national rural average. Over the remaining quarters there was a downward trend that ended significantly lower by the end of the project (at 15 infant deaths per 1,000 live births compared to 50 in the first quarter).

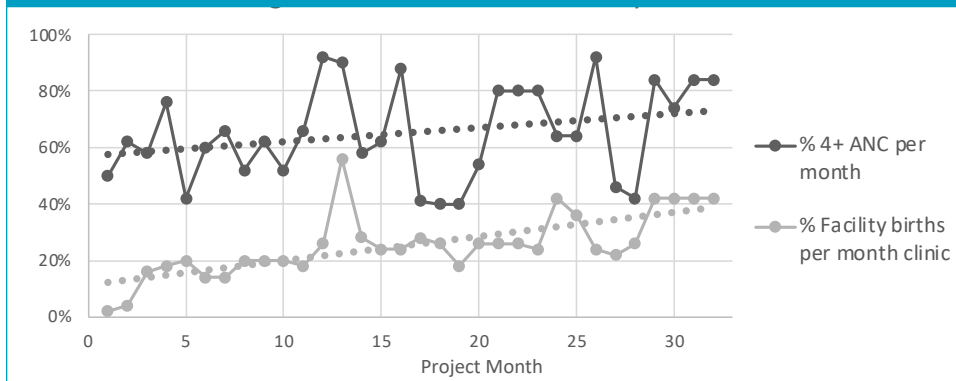
Increase in facility-assisted births and antenatal care visits: Prior to the project, the practice of going to a facility for delivery was rare, estimated

Chart 5: Quarterly infant mortality rate in the Tanzania project



at under 10% of all births in the ward at baseline. By the end of the project, facility deliveries had increased to 40%. Completing antenatal care visits was more prevalent prior to the project than facility-assisted births, at around 50%, but showed an increase of about 10% over the life of the project.

Chart 6: Percentage of participant mothers completing antenatal care visits and facility-based deliveries



Immediate and exclusive breastfeeding: Exclusive breastfeeding for the first six months of the child’s life represented a change from traditional practice which had considered three months of exclusive breastfeeding sufficient before introducing complementary foods and water. Women reported that they were now continuing to breastfeed exclusively for six months and claimed to see differences in their infants’ health. Several mothers mentioned that their babies did not have diarrhea or colds at all in the first six months, a change from what they had seen in the past. TBAs also affirmed that they were stressing exclusive breastfeeding for six months in their visits with new mothers.

TBAs and mothers also talked about the importance of having enough food and dietary diversity during pregnancy. This was an important change in understandings of maternal health, as traditional practice among Maasai was to ‘starve’ a woman in the last trimester of pregnancy to ensure that she delivered a ‘small’ baby. Women and TBA groups both emphasized the dangers of a low birthweight baby and reported that they were not avoiding food in the last trimester any longer.

Broader impact: Interviews with nurse midwives brought a surprising result. Midwives noticed that the project’s impact on mothers’ health-seeking behavior had in turn led to increased use of general clinical services by the population as a whole. Not only did nurses observe increases in women accessing antenatal services but also postnatal and ‘well child’ visits, and even men seeking care. In the words of one medical officer, “They used to go to traditional healers for many of these ailments but now have more trust in the medical clinics to care for their health needs.”

The MCC-supported EbOO care group project with NDI in Tanzania’s Nainokanoka ward has had significant impact on maternal and child health. Better trust between the community and health care providers fostered by the initiative, as well as new knowledge provided to TBAs, will allow for sustainability beyond the life of this initiative.

Paul D. Mosley is MCC Ethiopia representative. He was MCC Tanzania health programs coordinator from 2017 to 2020 while this project was active.



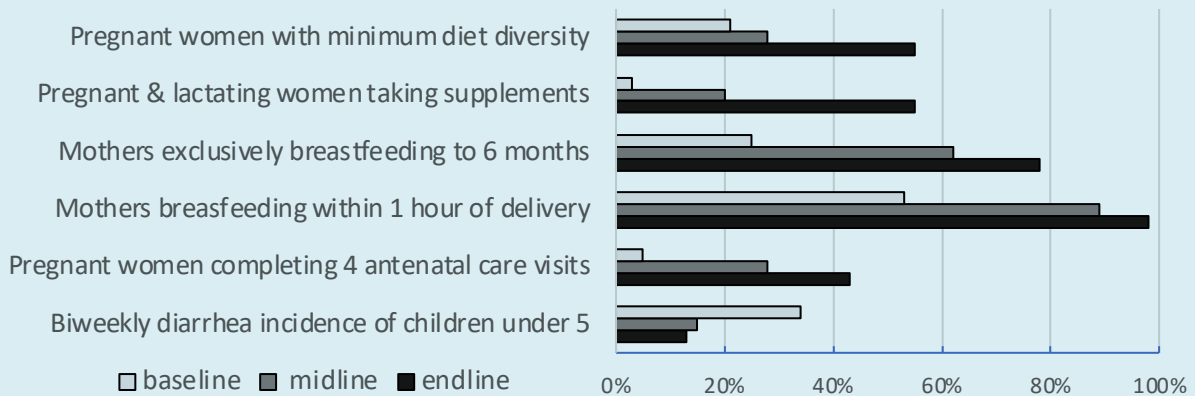
Mosley, Paul D, Saruni, Kisiaya, and Lenga, Bernadetha. “Factors Influencing Adoption of Facility-Assisted Delivery-a Qualitative Study of Women and Other Stakeholders in a Maasai Community in Ngorongoro District, Tanzania.” *BMC Pregnancy and Childbirth* 20/100 (2020): 1-16. Available at: <https://doi.org/10.1186/s12884-020-2728-2>.

Caregroups in Somaliland

From 2016 to 2021 MCC partnered with World Concern to bring the care group approach to 7,128 people in the rural Sool and Sanaag regions of Somaliland. Maternal and child health faced long odds in these communities with high rates of acute malnutrition, stunting, wasting and low use of recommended infant feeding practices, and extreme lack of access to health services. Despite the difficulties of the context, the project saw significant progress on most of the indicators families themselves could control such as feeding practices, use of nutritional supplements, improved hygiene and using available healthcare. The project also realized the importance of male involvement within the culture and innovated by organizing men's care groups to equip men with the same knowledge shared with women so that men could advocate for better support for their pregnant and lactating wives and young children.

Prepared by Paul Mosley, MCC Ethiopia representative.

Indicators of Change in Somaliland Project



Information is power when confronting intersectional health challenges in urban Burundi

Effectively addressing complex intersectional health challenges requires a deep understanding of context and the barriers to health for the specific population being served. For World Outreach Initiatives (WOI) and their MCC-supported maternal and child health care group project, that means understanding the lived realities of the poor and marginalized families they serve in dense urban settlements in Bujumbura, Burundi. Burundi is a tiny land-locked nation, the fifth smallest nation in mainland Africa. An estimated 90% of its dense population depends on farming for their livelihoods. According to the UN

Human Development Index, Burundi is ranked 185 out of 189 countries in the world, while 71% of the population lives on less than US\$2 per day. The bustling capital of Burundi, Bujumbura, lying on the shores of Lake Tanganyika, has a population of over one million residents and day laborers. Cars, bicycles, buses, tuk-tuks and pedestrians fill the streets. Goods are transported throughout the city on the back of bicycles or on the heads of men and women. Despite its struggles, Bujumbura is a city of activity, energy and hope.

In recent years, thousands of people have flocked from the rural countryside to Bujumbura in search of work. However, work is difficult to find, especially for those with limited education and skills and for women coming from the countryside. Prices are more expensive in Bujumbura and residents are required to pay rent, which is often not a part of life in the countryside. Jobseekers are forced into the poorest neighborhoods, living in small, densely packed houses. Homes do not have basic services like running water, electricity or sewer access. They do not have well-equipped bathrooms with running water or toilets. Wastewater often flows between houses. During the rainy season these areas experience flooding, due to poorly established and unmaintained drainage infrastructure. These conditions spread “dirty hand” infectious diseases. Finding enough to eat is a big concern and many are forced into begging or prostitution. The fertility rate in Burundi (births per woman) is 5.3, which for the urban poor is often too many to house, feed and educate on a very small income.

HIV and AIDS are still prevalent in these neighborhoods, even though antiretroviral (ARV) medicines are subsidized by the government. ARVs must be taken with food, or they cause an upset stomach. Due to unemployment and lack of income, many with HIV/AIDS do not have adequate food to take ARVs each day. Without ARVs, they feel weak and sick and the disease can progress. This leads to further income generation problems and marginalization, with the cycle of poverty and health challenges repeating itself.

The Burundian government subsidizes healthcare for pregnant women and children under age five. However, this does not apply to children without birth certificates. In Burundian society, unmarried women who become pregnant are highly stigmatized. These women are ashamed to go to the local government and register their children with a status of ‘unknown father.’ They feel forced to leave their child unregistered, making them ineligible for government health services and school enrollment. Additionally, many women, especially women coming from the countryside, are not aware of the birth certificate requirement to receive these services. Without these supports, healthcare is too expensive for many women to afford on their own.

WOI is a Burundian Christian organization working for those suffering in this context from intersectional vulnerability: unemployment, poverty, HIV/AIDS, food insecurity, stigma and more. WOI has been an MCC partner since 2001. WOI has identified health as a key area of focus to combat vulnerability, establishing two health clinics near the poorest neighborhoods in Bujumbura. These clinics provide a wide range of health services. During their situation assessment with MCC in 2019, WOI identified the lack of accurate and actionable health information in these neighborhoods as a key barrier to women and children accessing the healthcare they need and deserve. Many people were coming into WOI clinics with preventable

“ Effectively addressing complex intersectional health challenges requires a deep understanding of context and the barriers to health for the specific population being served.”

“ A woman may understand the importance of handwashing, but if she is not able to afford soap there will be no behavior change.”

diseases. Many others were not aware of health services available to them. In collaboration with MCC, WOI decided to implement care groups to rapidly disseminate information regarding nutrition, maternal and child health, sexual and reproductive health, sanitation, patient's rights and hygiene to empower the most vulnerable families to make informed health decisions and access available health services.

Care groups function similarly to an agricultural extension network, with information disseminated down an expanding chain of community-based educators. Each of WOI's two clinics has a doctor on staff that acts as the coordinator of the program in their commune. Both doctors work with two health mediators (total of four) who serve as care group supervisors. Each health mediator supervises three community mobilizers (total of 12). These community mobilizers promote the targeted health information to the care groups. Each care group is made up of ten community volunteer leaders (total of 120 in the project). It is the responsibility of the community volunteer leaders to then accompany a group of ten neighbor women (total of 1,200). The advantage of care groups is that information is contextualized and quickly disseminated to many vulnerable people using the group structure. Each month community mobilizers meet with their volunteer leaders to discuss what topics they will teach over the following weeks. The volunteer leaders then meet with their neighbor groups once per week to reinforce messaging and provide peer support.

“ Information does not necessarily equate to behavior change. For example, a woman may understand the importance of handwashing to her health, but if she is not able to afford soap there will be no behavior change.”

Over the first two years of the project, MCC and WOI have learned important lessons about the care group model. The first is the importance of fidelity, that is, verifying that health information is being properly passed down the chain. WOI has given periodic 'tests' to community mobilizers and volunteers to make sure they understand the information they are teaching. The crucial links in the chains are the community volunteers, as they connect the more highly trained mobilizers and the vulnerable families the program aims to reach. The volunteers have requested badges to legitimize their positions and the information they teach in their communities. They also have also asked for a small stipend to pay for their time as they organize and prepare for weekly meetings. It has proven important for the volunteers to understand and value their unique and important role, not as clinical staff who diagnose or treat patients, but as peer supports who disseminate health information and refer the sick to their local clinic.

Another lesson has been the realization that information alone does not necessarily equate to behavior change. For example, a woman may understand the importance of handwashing, but if she is not able to afford soap there will be no behavior change. WOI understands that behavior change is a long, complex process and the regular reinforcement and peer support of care groups can help in this process. WOI's initiatives have been successful in matters like promoting infant vaccination and making women aware of the health services available to them from the government. Building on these successes, WOI believes care groups could be an excellent platform to also share strategies and resources around income generation, access to credit and sustainable livelihoods.

Chadric Ndayirorere is the program officer for World Outreach Initiatives. Adam Butler is the program coordinator for MCC Burundi. Both live in Bujumbura.

Adapting care groups to unstable urban informal settlements in Kenya

The Centre for Peace and Nationhood (CPN) of the Kenya Mennonite Church (Nairobi Diocese) has been implementing community maternal and child health projects using care groups in the Mathare settlement since 2017. Mathare is one of the largest, poorest and most densely packed informal urban settlements in Africa. The project uses evidence-based behavior change communication and care group supports to increase utilization of available healthcare services, improve health-seeking behaviors and address barriers to proper health for vulnerable women and children. The current project is on track to reaching over 3,000 mothers.

The Mathare informal settlement is a high-risk and low-trust community with constant migration, high rates of crime, multiple ethnic and religious groups and frequent political unrest. Seeing high rates of maternal and child morbidity and mortality in Mathare and the struggles of more traditional maternal and child health programs, CPN began piloting care groups in 2017 and became the first organization to publish about the successful adaption of care groups to a dense urban informal settlement in Africa. Care groups were originally designed for rural African environments where participants are permanent residents, community structures are intact, residents are not constantly migrating and family structures are stable. This made adapting care groups to an informal urban settlement like Mathare a challenge. Additionally, residents in Mathare often have a mindset that perceives the community as no one's responsibility and so it was not easy for community members to come together to help find solutions to community problems. Despite these contextual challenges, care groups are thriving in Mathare and have improved maternal and child health in this informal urban settlement, even in the face of the COVID-19 pandemic.

Health education in care groups focuses on practical positive behavior change for the participant mothers. Care groups promote positive behaviors that women have control over, like the uptake of family planning, good hygiene, good sanitation, good nutrition and seeking antenatal care visits and facility-based deliveries. These behaviors have been readily adopted by participant women in the Mathare care groups (see charts 1 to 3 in Paul Shetler Fast's article above) and have even spread to non-participant community members who see the change care groups have made in these women's lives.

The care groups in Mathare are a success because they are a platform by and for women to learn and share their experiences with other women in the community. Through care groups, women can learn and support each other and discuss concerns that go beyond maternal and child health. Women have been able to set up individual birth plans to prepare to welcome their unborn children and make plans and find support to help ease the stress during the early days of recovery from childbirth. Discussing such issues in the care groups enables participants to understand family dynamics and find solutions to problems that could otherwise be overwhelming or lead to other life challenges for them and their children.

“ The care groups in Mathare are a success because they are a platform by and for women to learn and share their experiences with other women in the community. Through care groups, women can learn and support each other and discuss concerns that go beyond maternal and child health.”



Learn
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Opiyo, Judith Siambe, and Paul Shetler Fast. "Adapting Care Groups to Urban Slums: A Case Study of a Church-Based Effort to Improve Maternal and Child Health Outcomes in Mathare, Nairobi, Kenya." *Christian Journal for Global Health* 6/2 (December 2019): 33-43. Available at: <https://doi.org/10.15566/cjgh.v6i2.317>.

Mathare experiences constant migration that affects the delivery of behavior change lessons, measuring impact and conducting follow up. Political unrest and disruptive election-related activities are another significant challenge. Unrealistic expectations set by other NGOs is another challenge with which the project has had to deal. Many community members have grown dependent on handouts and believe NGOs should come with direct monetary benefits rather than expecting behavior changes from them. The care group model and CPN's approach, in contrast, has a long-term sustainability plan based on community ownership and empowerment, an emphasis which is missing from most other NGO projects in Mathare. Motivating attendance at care groups is also challenge since most community members are casual laborers, making scheduling times to meet difficult, as potential participants do not wish to sacrifice time they could be working to participate in care groups.

Being a ministry of a local church has been great benefit for CPN in the community through removing the perception that the project has endless resources, is only interested in gathering data from the community, is seeking to take advantage of community members' vulnerability or is using participants to solicit funds that never reach them. Being a church ministry has also helped when it comes to expectations of monetary support that community members have of most international NGOs. Church partners are perceived not to have a lot of money and so the community is more understanding when they learn that the project does not provide handouts.

The community members in Mathare have also been at the forefront of implementing the care group model. Community ownership of the project is essential for recruiting participants and volunteers and laying the foundation for sustainability. Community involvement is achieved by the involvement of community stakeholders and by ensuring that local government and Ministry of Health leadership are aware and supportive of the project and its activities. Coordinating with community stakeholders and relevant government bodies in turn increases security for the project team. Involving other stakeholders like the Ministry of Health has also been instrumental in integrating the project with existing health services and gaining access to government data for comparison, quality control and evaluation purposes.

Community-driven initiatives requires deep understanding and putting oneself in the context of the community to know their challenges and understand how best to work with them. Care groups work in Mathare because they meet the mothers and community where they are with respect, providing actionable information, peer-support, a sense of community and smooth integration with existing health services.

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Community collaboration for maternal and child health in interfaith Nigeria


Care groups and other social and behavior change models of community health rely on social trust, community support and the ability to plan and meet regularly over long periods of time. These conditions that help ensure care group success erode in contexts of conflict, displacement and social tension. MCC Nigeria has been walking alongside Faith Alive Foundation (FAF) in its health ministries in just such a context in Plateau State, Nigeria. The legacies of ethno-religious violent conflicts in Plateau State date to 2001, when Christian and Muslim groups in the area turned against each other. Like a flash of light, people who were coexisting as friends and neighbors took up arms against each other and the sounds of war, killings and maiming became common. Communities who had previously cohabitated and socialized together in peace too often came to see one another as enemies.

This area of Nigeria also faces high rates of infectious disease (particularly HIV) and poverty, as well as weak governmental health services. In Nigeria, over 3.6 million people are infected with HIV. Nearly two million children have been orphaned by the AIDS epidemic and 70% of Nigerians live on less than US\$1 a day. Yet it was these harsh realities that spurred medical doctors Christian and Mercy Isichei, in an act of faith, to make a difference in the lives of the people suffering around them by founding the Faith Alive Clinic and Counseling Center in 1996 (now Faith Alive Foundation, or FAF). Armed with their training as medical doctors and their faith in Jesus, the Isicheis began addressing the physical, emotional and spiritual needs of individuals and families affected by the AIDS epidemic in and around Jos. They knew they could not carry out this ministry alone, so prayed that the God who prompted them to begin Faith Alive would also send people to walk alongside them in their experiment of hope.

FAF operates in a crucible of ethno-religious tension between Christians and Muslims. In over two decades of existence, FAF has weathered many storms of violence and conflict. Though it is recognized as a Christian organization, it has earned the trust of both faiths because of its service ministering among the poor and needy regardless of religious or ethnic affiliations. There were even instances when Muslim youth volunteered to provide security for FAF staff and facilities during times of violence and threats.

Building on its decades of experience with community-based HIV/AIDS work, FAF began incorporating care groups into its MCC-supported maternal and child health work in 2020. The project aimed to include mentor mothers and participants from across faiths and ethnic divides. The mentor mothers are volunteer leaders trained to support and provide peer-education to pregnant women. Due to the ethno-religious sensitivities, having mentor mothers from both religious groups is essential for building trust and gaining access to closed communities to provide health education, peer-support and assistance in forming groups and making referrals.

These women have gained the confidence of faith leaders who are influential for buy-in and support. The mentor mothers support, encourage and facilitate pregnant women in accessing antenatal care services, which has been a long-standing challenge in the region, particularly in the Muslim community. In this community, pregnant women have traditionally been

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Dr. Chris Isichei, director and founder of Faith Alive Foundation and a physician at Faith Alive's clinic and hospital, talks with patient Idris Zabita after her appointment at the clinic in Jos, Nigeria, in 2017. (MCC photo/ Matthew Lester)

prevented from accessing healthcare services, believing that completing pregnancy and delivery at home not only saves money but also prevents women from exposing their bodies to others in medical settings. This reluctance to access health services can be dangerous in pregnancy and delivery, particularly in cases in which the mother is HIV positive. In both Muslim and Christian communities, the mentor mothers help break down barriers and reluctance and encourage women to get the care they need.

Another cultural barrier faced is the frequent lack of support during pregnancy from the father. This is a particular challenge among the Hausa Muslims, as women are expected to be kept in *purdah*, separate from men. This makes male involvement in antenatal care and delivery planning difficult. The mentor mothers help bridge these gaps, with lived cultural knowledge of navigating these challenges. They also collaborate with influential community or religious leaders who are revered and able to help find a path forward when barriers are encountered. The religious and community leaders now recognize the important role of the mentor mothers and work collaboratively to promote health education on behavioral change communication in care groups and encourage mutual coexistence and religious tolerance among their adherents.

Implementing care groups in this setting has come with myriads of challenges, ranging from skepticism about the voluntarism embedded in the

care group model to starting the project just as the COVID-19 pandemic was reaching Nigeria. However, it is the incorporation of peacebuilding within a context of ethno-religious conflict that most sets this project apart from traditional care groups, which were originally designed for relatively homogenous and stable settings. The project has required continuous training and support both on basic maternal and child health topics as well as women's roles as peacebuilding agents of change.

MCC Nigeria's strategic emphasis on incorporating peacebuilding approaches in every project has proven essential for operating successfully in the Plateau State context. The FAF care group project demonstrates the success of this model in finding the synergy between health and peace, as a workable tool for both improving the health of vulnerable mothers and children and for simultaneously breaking the cycle of distrust, violence and revenge. MCC's operating principle of responding to God's call to love God, one another and our enemies is foundational to MCC Nigeria as it seeks to incorporate peace into all its work in a context of conflict, violence and ethno-religious tension.

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The call of the church in improving maternal and child health in Kenya

My work in community health grew out of my faith calling. After studying pastoral theology in Tanzania in the mid-1990s, I came back to Kenya to teach and train in the church. Alongside teaching and training in the Kenya Mennonite Church, I had the opportunity to work with the National Council of Churches of Kenya in their Peace and Rehabilitation project as a project coordinator. During this time, HIV/AIDS was ravaging communities and the congregation where I was serving as pastor. I could not ignore the death, pain and hopelessness HIV/AIDS was causing. People were dying, families were being torn apart by stigma and shame and children were being left orphaned. As Christians, we in the Kenya Mennonite Church needed to respond.

In 2002, when MCC agreed to support Kenya Mennonite Church in starting an HIV project, I was called upon to help and I could not say no. I have been involved with health ministry ever since. As a pastor, and now as a bishop, I believe we are called to minister to the whole person and the whole community, both spirit and body.

The church is well placed to do health work. We are a full cross-section of the community: all levels of status, economic capacity, education, ability and disability, health and ill-health. We can understand the community's challenges and respond to those challenges, because we have all parts of the community represented among us. The church is a place we should be able to meet as brothers and sisters, members of one body, as described by the apostle Paul, to support one another in love.

The church has a gospel mandate to support people in living abundant life. We have no option to look the other way when people are suffering. From the ministry of Jesus, one clearly sees that the church has a responsibility beyond the spiritual. Jesus ministered to both spiritual and physical needs

“ Health cannot be left behind in the search for salvation. Only when people are healthy in body can they fully listen, come to church and engage in furthering the Gospel.”



Beryl Atieno, a health promoter with the Centre for Peace and Nationhood of the Kenya Mennonite Church, leads a training of community health volunteers in January 2019 about preventing anemia and how women with HIV can have babies who are free of the virus. The volunteers will take this information to groups of 10-12 mothers in their neighborhood, helping to spread good health practices and information in the Mathare informal settlement in Nairobi, Kenya. (MCC photo/ Matthew Lester)

simultaneously. We cannot separate these two ministries. As the body of Christ, we cannot turn away from people's physical and mental health needs. When people were hungry, Christ did not tell the disciples to ignore their physical needs and simply pray for them. As the church, we must do the same when we see people in need of healing and wholeness.

My understanding of this call was shaped by the HIV/AIDS pandemic. A great challenge of HIV/AIDS has been stigma. People did not have safe spaces to share their challenges, be vulnerable about their fears and failings or even share their HIV status. They needed brothers and sisters to accept them as they were. The church is called to be one such space.

When we embraced this vision, we had people coming from far away to find safety and to meet to encourage each other in the church. They could share openly and learn about HIV because the church was not judging and rejecting them. At our best, we became a refuge for people in their darkest days. If the church fails to be a safe space it cannot be of use to people going through difficult times.

This is often hardest for the church when ill-health or suffering is viewed by some as caused by immorality. Such perceptions were common regarding

HIV, and we sometimes see such attitudes towards young or single mothers. Some in the church believed that people with HIV were getting what they deserved. This judgmental attitude continued until we helped the church understand that Christians are called to be good Samaritans, not looking down on people but instead kneeling beside them, without judgement, bandaging their wounds in times of difficulty.

The church in Kenya has increasingly felt called to respond to the health of mothers and young children. Women are the majority in most of our churches. This alone means that the church must take seriously the needs and concerns of women. The church can start serving the needs of mothers and children today within its own walls. In our community, within its first month of life, each child is brought to the church for dedication. This begins our relationship with the parent(s) and child, and we can show them a welcome they might not receive in medical facilities or in the broader community.

The church can go beyond traditional maternal and child health projects, which leave little room for men. The church is a place to naturally bring men and women together in this work. We can provide role models and mentoring, social supports and non-judgmental healthcare. We can help shift social norms about men's roles and give men encouragement to participate in maternal and infant health as part of what it means to be a Christian man. Our men's and women's ministries can be platforms for launching and sustaining initiatives like care groups. The church must not be a place that just reinforces negative cultural patterns, like the idea that masculinity excludes caregiving and helping with housework and childcare. While it is hard for a church often led by men to change these cultural patterns, it is called to take up this task.

Training for church leaders has often not equipped them for this kind of work. Pastors are often trained only in theology, biblical studies and evangelism. Many pastors have been overly focused on those spiritual issues and not on the other aspects of their call. They have not been mentored to embrace wholistic ministry.

To fulfill this call, the church must start with self-reflection on its mandate as the church of Christ, its current capacities and how best the church can improve to live into its mission. As a partner, MCC should listen to churches as they discern who they are and what they want to do in their communities. MCC can then work with churches and church leaders to help support them as they grow beyond an exclusive focus on spiritual concerns.

My advice to churches moving to this more expansive mission is to consider maternal and child health work as a natural first step, with care groups as a model well-suited to health ministries. Jesus had a special place for mothers and children in his heart, and so should we as the church. This is both an urgent call to the present needs of the community and an investment laying the foundations for the future church. Health cannot be left behind in the search for salvation. Only when people are healthy in body can they fully listen, come to church and engage in furthering the Gospel.

Maurice Anyanga is MCC Kenya and Tanzania program officer as well as the Bishop in the Kenya Mennonite Church.



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Katherine Nyawere and her husband Geoffrey Abila holding their two-month-old daughter in November 2021 in front of the home they share with Katherine's sister's family in Mbuya, Kampala, Uganda. Katherine is a participant in the MCC-supported maternal and child health project with Reach Out Mbuya (ROM). (MCC photo/Paul Shetler Fast)

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