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International Journal of Family & Community Medicine

Case Study

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Study of mothers support groups in Colombo district, Sri Lanka – a case study

Volume 8 Issue 1 - 2024

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Received: January 20, 2024 | **Published:** March 15, 2024

Executive summary

Sri Lanka has achieved significant progress in maternal and child health indicators over the years. However, nutritional indicators have remained stagnant due to various reasons, contributing to both under and over-nutrition and impacting the country's economic and social landscape. Mothers' Support Groups (MSGs) have emerged as a powerful community initiative to address health and nutritional challenges. These groups, established in 2002, aim to promote good health practices through community mobilization and empowerment. Despite their proven effectiveness, the COVID-19 pandemic and economic crises have impacted MSG activities. This case study examines the establishment, development, and challenges of MSGs in the Colombo district, offering recommendations for improvement.

Introduction

Sri Lanka has been able to reach a remarkable status in health indicators including Maternal and Child Health over the last few decades. However, the nutritional indicators, while having shown some improvements, have largely remained stagnant over the years due to various reasons. Both under and over-nutrition contribute to certain diseases and poor status of health among the population adding to both economic and social burdens to the country. In addition, other public health problems too, are causing significant morbidity and mortality and community support is essential in addressing those effectively. In this context, Mothers' Support Groups (MSGs) are a powerful initiative in improving health and nutritional status in communities and there are proven shreds of evidence where MSGs have shown both direct (improvement in weight in underweight children, reduction of overweight/obesity, reduction of mosquito breeding sites) and indirect impacts on health (through better income management and environmental safety).[1]

What are mothers' support groups?

MSGs are groups of approximately 5-20 people who come together to learn about and discuss health and nutrition issues relevant to their communities and promote good practices. These people support each other to improve awareness and practices in uplifting their communities' nutritional and health status. Priority is given to members with children aged 0–5 years. Members meet at least once a month to discuss topics based on priority issues identified by themselves, under the guidance of the Public Health Midwives (PHMs). Accordingly, relevant activities or projects are undertaken to provide support to their own community.[2] Members of MSGs provide information, share experiences, advocate, and extend support to enable people to promote best practices in collaboration with health staff.

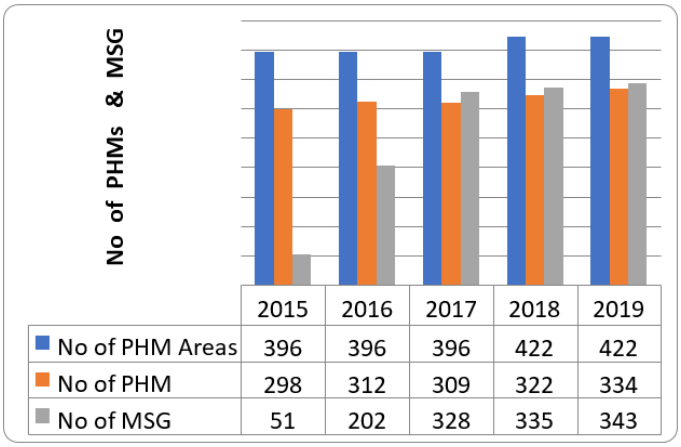
The mothers' Support Groups concept was introduced to Sri Lanka in the year 2002 in Hambantota District. Since then, the concept has evolved and been successfully implemented in many parts of the country with the objective of promoting good health, well-being and nutrition practices through community empowerment and mobilization of local communities.[3] A guideline on MSG activities was published by the Health Promotion Bureau of Ministry of Health in 2015 with the aim of strengthening, streamlining, and expanding the work of MSGs.

Both the Medical Officer of Maternal and Child Health (MO/MCH) and the Health Education Officer (HEO) play key roles in guiding the establishment, development, and expansion of MSGs in collaboration with the Medical Officers of Health (MOH). MSGs are facilitated by the local PHM in collaboration with the Public Health Inspector (PHI). The initial target was to establish one MSG per PHM and in estate areas, one MSG per estate division. This could then be further expanded, to more groups per PHM/ estate division.

The objective of this case study was to review the functioning of MSGs in the Colombo district and to provide recommendations for identified problems. These results will help regional health administration and public health experts to improve community empowerment and mobilization in the district. Key informant interviews were conducted with RDHS, three MOOH, a matron, two HEOOs, and SPHI. Also, three PHMs who have successfully initiated MSGs in their respective areas were interviewed. A meeting was held with several members of an MSG in the Piliyandala MOH area. A review of the available literature was helpful in this regard.

Situation analysis

Several MSGs were established in the Colombo district before 2015 by some enthusiastic PHMs with the support of HEOs. An attempt was made by the district health administration to implement the MSGs in an organized manner after the publication of the guideline by the ministry. The progression of MSGs is illustrated in the following figure.



	2015	2016	2017	2018	2019
No of PHM Areas	396	396	396	422	422
No of PHM	298	312	309	322	334
No of MSG	51	202	328	335	343

There was a steady progression of MSGs activities up to 2019 in the Colombo district. Social restrictions enforced due to COVID - 19 pandemic significantly affected MSGs activities and the number of functioning MSGs was reduced to less than 20 in the district. The economic crisis which followed the pandemic too had an adverse impact on the MSGs. Despite these setbacks, the district health administration continued to support MSGs as they were identified as a successful means of community empowerment. To this effect, the Regional Director issued a circular requesting all the MOOH to reorganize the MSGs in their respective divisions. The importance of community organizations like MSGs is more relevant at present since all indicators related to the nutrition of the community show a downward trend. On the other hand, health officials encounter various practical difficulties in reorganizing MSG activities in the present context.

Problem analysis

The following categories of problems related to the establishment, development, and expansion of MSGs in the Colombo district were identified.

Problems at the policy level

MSG concept needs to be incorporated into preventive sector programs and projects at the policy level.

Problems at the central level

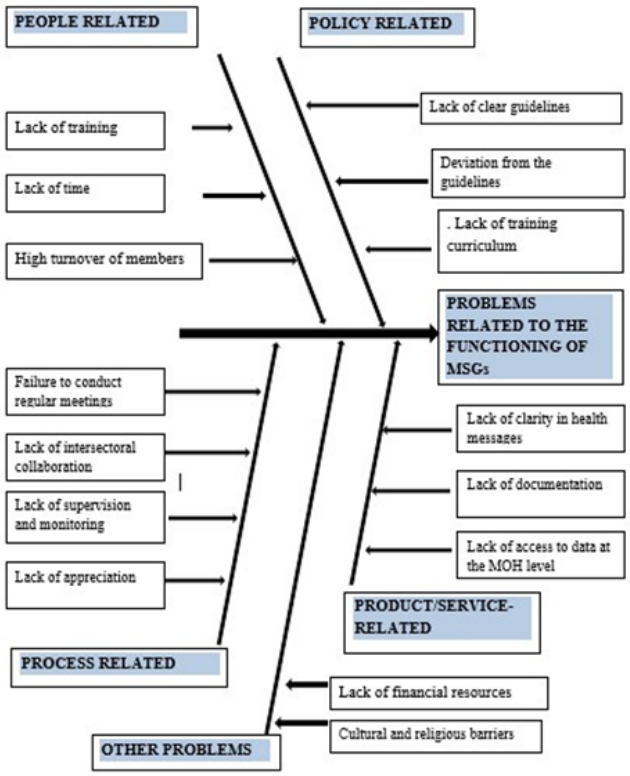
Health Promotion Bureau is supposed to conduct annual review meetings at the district/provincial level based on district data submitted by the MOMCH / HEO of each district. Also, Appraisal of the MSGs with the best performance at the National level must be done by FHB. These activities are not yet regularly done.

Problems at the provincial /district level

During the pandemic, both the provincial and district-level health administrations had to pay attention to other priority issues. Both the MO/MCH and the HEO play key roles in guiding the MSG activities. Further advice and support must be provided by the other relevant technical officers at the District and Provincial levels (Community Care Physician, Medical Officer – NonCommunicable Diseases, Regional Supervisory Public Health Nursing Officer). It was apparent that some of the mentioned staff didn't give their support in this regard. The lack of supervision authority for HEOs restricts their services at the field level.

Problems related to the functioning of MSGs

A number of problems that may hinder the proper functioning of MSGs were observed. Identified problems were prioritized using the nominal group technique by three registrars in medical administration. The importance of the problem, the feasibility of providing solutions, and sustainability were considered in the scoring. Following the discussion, "Problems related to the functioning of MSGs" was selected for further analysis. Root cause analysis of factors affecting the functioning of MSGs was done and the following major categories of factors were identified in the analysis.



Policy related problems

I. Lack of clear guidelines on the composition, selection of members, and appointment of members to the posts of the MSG.

Most often members are selected by the PHM. Appointments have been by selection and not by election.

II. Deviation from the guidelines when functioning.

Office bearer positions are not consistent among the groups and only a few groups had filled all three posts (Group Leader, Secretary, and Treasurer). Monthly meetings are not held regularly and there are lapses in the documentation.

III. Lack of training curriculum

Training has not been based on a particular curriculum and training guidelines specify only the strengthening of communication and problem-solving skills of MSG members. Duration and topics of training are not defined.

People related problems

I. Lack of training

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DOI: 10.15406/ijfcm.2024.08.00345

Training carried out by the PHMs was limited to the office bearers of MSGs and not extended in turn to their respective MSG members. Office bearers do not have the capacity for doing TOT as they have not gone through a rigorous process of training.

II. Lack of time

Many members, especially those who are employed, experience a lack of time to participate in meetings and actively contribute to nutrition and health promotion work in their areas.

III. High turnover of MSG members

Turnover is defined as the number of members dropping out of the groups. Some groups experience a high turnover of their members due to various reasons. Frequent replacement of members hinders the progress of the group.

Process related problems

I. Failure to conduct regular meetings.

Meetings seemed regular at the early stages in many MSGs, being conducted once a month. The regularity seems to have waned with time due to many reasons including lack of supervision by relevant officers.

II. Lack of intersectoral collaboration

Collaboration with other stakeholders (Grama Niladhari, Agricultural Officers, Samurdhi Officers, Development Officers, and Social Welfare Officers, etc) is very useful in further improving the health and nutrition status of communities. The MOH, PHM, and PHI play a big role in guiding the development of these collaborations. Involvement of PHIs is especially lacking in many instances.

III. Lack of supervision and monitoring

There are three separate types of forms used at the field level to monitor and review the progress of the MSGs, but they are not properly attended to by the relevant officials. Also, the awareness and enthusiasm of some supervising officers are questionable.

IV. Lack of appreciation

As per the guidelines, appraisal of the best-performed MSGs must be done at the MOH, District, Provincial and National levels based on their performance indicators and the innovative activities conducted. These performance appraisal activities are not yet streamlined.

Product/service-related problems

I. Lack of clarity in health messages

Some of the health messages circulated are not focused and are technically incorrect.

II. Lack of documentation

Minutes of meetings have been maintained by only a few MSGs. Very few MSGs have any sort of record (list) of their target persons/families (under 5 children, pregnant and lactating women, households with social issues). Also, there is no recorded follow-up of progress.

III. Lack of easy access to secondary data at the MOH level

MSG group members never see the immediate results of the work they do in the field. Secondary data needs to be disseminated so that corrective action can be taken immediately by field teams including the PHM, MSGs, and officers of other sectors in a multi-sectoral approach.

Other problems

Lack of financial resources

Group members are not paid for meetings and projects undertaken through the group since it is a voluntary group formed by the local community. In the socio-economic backdrop of these MSGs, some sort of remuneration is necessary.

Cultural and religious barriers

Religion and cultural practices play an important role in the lives of women in these communities regarding their reproductive health. Muslim women follow the practice of remaining in the house for 45 days following a birth of a child. Also, regarding the detection of early pregnancy (before 8 weeks), it was stated that such questions cannot be asked of Muslim newlywed mothers due to cultural reasons.

Proposals

I. Prepare guidelines for composition, selection, and appointment to posts of MSGs.

II. Prepare a training curriculum for MSG members.

Design or make use of existing manuals to formulate an effective, practical training program using participatory approaches for adult training with sound pre- and post-evaluation.

III. Capacity building of office bearers by training them to be TOTs.

IV. Start retraining existing MSG members as well as new members using the new curriculum.

V. Reorganize and streamline MSGs.

Initiate registration of the MSGs as Community Based Organizations (CBO). Design a simple, practical constitution to be used by them. Provide ID cards to all members. Print record books and minutes books, to ensure that recording is a guided process.

VI. Set up a database on all aspects of MSGs including profiles, activities completed, and changes in the community. It should be constantly updated.

VII. Prepare and circulate uniform health messages among groups.

VIII. Dividing the households of the villages between MSG members based on at-risk households rather than covering all.

IX. Include monitoring of MSG activities in the routine monitoring and supervision activities list of the RDHS.

X. Make evaluation and appreciation of MSG activities a MOH monthly conferences agenda item.

XI. Link MSGs with NGOs working in the preventive health sector.

XII. Having an NGO partner to anchor and support the MSGs is prudent for sustainability.

XIII. Conduct an awareness campaign about MSGs among officers of other sectors.

XIV. Undertake an analysis of secondary data on the achievement of mandated objectives of setting up the MSGs coverage (data on growth monitoring, increase in detection of pregnancy before 8 weeks, and anaemia rates among pregnant mothers).

Recommendations

I. Capacity building of office bearers and members by training them to be TOTs.

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II. Registration of the MSGs as Community Based Organizations (CBO) and provision of ID cards to all members.

III. Print and distribute record books and minutes books.

IV. Set up a database of profiles of MSG members, activities completed, and changes in the community.

V. Prepare and circulate uniform health messages among groups.

VI. Divide the households of the villages between MSG members based on at-risk households.

VII. Include monitoring of MSG activities in the routine monitoring and supervision activities list of the RDHS.

VIII. Make evaluation and appreciation of MSG activities a MOH monthly conferences agenda item.

IX. Link MSGs with NGOs working in the preventive health sector.

X. Conduct an awareness campaign about MSGs among officers of other sectors in the district.

XI. Analysis of secondary data on the achievement of MSGs and dissemination of them.

Conclusion

MSGs in Sri Lanka have emerged as a vital community-led approach to address health and nutritional challenges. With over 5,300 functioning groups nationwide, they present a sustainable mechanism for implementing national health initiatives. However, challenges at various levels, exacerbated by the COVID-19 pandemic and economic crises, necessitate strategic interventions for their effective functioning. Strengthening MSGs through capacity-building, standardized guidelines, improved monitoring, and intersectoral collaboration is crucial for enhancing community health and nutrition outcomes amidst ongoing socio-economic challenges.

Acknowledgments

None.

Conflicts of interest

The author declares there is no conflict of interest.

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