Communication Skills Training for Mothers to Improve Child Health in Uganda

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Sector(s): Gender, Health

Fieldwork: Innovations for Poverty Action (IPA)

Location: Southwest Uganda

Sample: 5,516 households in 412 villages

Target group: Parents Men and boys Women and girls

Outcome of interest: Women's/girls' decision-making Gender attitudes and norms Food security Nutrition

Intervention type: Information

AEA RCT registration number: AEARCTR-0000073

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Partner organization(s): Innovations for Poverty Action (IPA)

In low- and middle-income countries (LMICs), over 130 million children experienced stunting before reaching age five in 2019. In Uganda, researchers conducted a randomized evaluation to test the impact of a communication training program targeting mothers on child health investments. The intervention increased spousal discussion about the family's health, nutrition, and finances. The training program boosted children's intake of animal-sourced foods, as well as household spending on these foods; it also increased the birthweight of newborns. However, it did not increase households' adoption of measured health-promoting behaviors or improve other child anthropometric measures, suggesting that providing communication skills training in addition to health knowledge training had modest impacts on child health.

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In LMICs, over 130 million children experienced stunting before reaching age five in 2019. Health and nutrition investments during the child's early years are key to improving child survival and wellbeing. However, women and men's decision-making about these investments may differ: prior evidence indicates that women are more inclined to allocate additional funds towards children's health and nutrition than men. Women's level of bargaining power within their households may impact decision-making, however, they could have more influence over family choices with more bargaining power. Can communication skills training, in addition to health knowledge training, that targets mothers enhance dialogue with their husbands and thereby strengthen their influence over investments in child health and nutrition?

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In Uganda, inadequate child health outcomes are a major policy concern in a setting where women often experience limited power to make decisions within their households. In 2013, the under-five mortality rate, which is the probability a newborn will die before turning five years old, was 62 deaths per 1,000 live births. Similarly, in 2011, one in three children experienced stunting before reaching age five. Among married women in the same year, 42 percent shared not having the power to influence large household purchases and 29 percent considered it acceptable for their husband to beat them if they argued with him.



Woman holding a baby in conversation with a health worker in Uganda.

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In collaboration with Innovations for Poverty Action, researchers conducted a randomized evaluation to test the impact of a communication training program targeting mothers on household investments in family nutrition and child health outcomes. In southwest Uganda, 412 villages (comprising 5,516 households) were assigned to one of the following groups:

1. *Men's Health and Nutrition (MHN, 105 villages):* fathers in these villages received village-level health training sessions on how to improve children's health and well-being.
2. *Women's Health and Nutrition (WHN, 105 villages):* mothers in these villages received village-level health training sessions on how to improve children's health and well-being.
3. *Women's Communication and Health & Nutrition curriculum (WCommHN, 98 villages):* mothers in these villages received village-level health training sessions on how to improve children's health and well-being as well as a 45-minute training focused on assertive communication. The communication training aimed to enhance women's spousal dialogue and

increase women's say in household decisions regarding child health and nutrition investments. The activities included role-playing exercises and discussions on effective communication about household budgeting.

4. *Comparison group (104 villages):* parents in these villages received no training.

The health knowledge training consisted of nineteen one-hour classes held every two weeks over the course of ten months, and covered topics including safe antenatal and birthing practices, breastfeeding, nutrition needs, sanitary food and water preparation, and family planning. Participants also received an incentive to participate: fathers received UGX 1,000 (US$0.40) at each session and mothers received UGX 1,000 (US$0.40) every other session.

Researchers collected measurements of health indicators prior to the intervention between August 2012 and January 2013, and endline data between March and September 2014. Researchers measured changes in women's assertiveness and communication with their partners, frequency of spousal discussions about household health and nutrition issues, the spouse's knowledge of child health and nutrition needs, household health behaviors, changes in food spending and intake, and anthropometric measurements of young children.

The evaluation, which received IRB approval from Northwestern University, ensured voluntary participation and minimal risk to participants. Rigorous informed consent protocols and participant rights were strictly upheld throughout, allowing individuals full control over their involvement and data collection. Standard practices were aligned with established survey norms like the Demographic and Health Surveys (DHS), ensuring ethical standards were met.

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The communication training program for mothers increased discussions between spouses about the family's health, nutrition, and finances. The training program did not, however, affect the adoption of health-promoting behaviors or child anthropometric outcomes (such as height-for-age or weight-for-age) in the short run, except for the birthweight of newborns.

Spousal relationships: Women assigned to the WCommHN intervention group reported improvements in their relationships. Women communicated better with their partners, had fewer arguments, and stated that their husbands were more likely to share the household's finances with them. They were also significantly more likely to make decisions about the family's health and expenses jointly with their husbands. However, these improvements in spousal communication and shared decision-making were perceived by women; men did not perceive the same changes.

Spousal communication: The communication training program boosted spousal discussion about health and nutrition but had no impact on husbands' health knowledge. While mothers in all three intervention groups stated increased frequency in conversations with their partners about household health, nutrition, and budgeting relative to the comparison group, the WCommHN intervention had the largest impact. The WCommHN intervention improved women's discussion index by 0.2 SD of the comparison group. The communication training increased the proportion of women that talked about the household's finances with their spouse by 6.9 percentage points from a base of 63 percent (an 11 percent increase). While both WCommHN and WHN interventions increased women's health knowledge by comparable amounts (0.4 SD), this did not impact husbands' health knowledge in either intervention group. Researchers and prior evidence[1] suggest that women may have communicated more information about the importance of health and nutrition but their husbands did not retain it.

Health-promoting behaviors: The share of households implementing recommended health behaviors around newborn and maternal health and sanitary practices was significantly higher in the health knowledge training group (WHN) than the comparison group, but the addition of communication training did not improve these outcomes further. The fact that most of these behaviors can be plausibly implemented by women without needing to negotiate much with their partners might have limited the potential for additional measurable impacts of the communication training.

Food intake: The communication training program boosted the consumption of animal-sourced foods through increasing spending on meat and fish. In WCommHN villages, women and children increased their intake of animal-sourced foods by 0.134 SD relative to the comparison group. One year after the intervention, 21 percent of children living in WCommHN villages reported consuming any animal-sourced food compared to 16 percent in households in the WHN and comparison groups (a 31 percent increase). The intervention increased spending on meat and fish by UGX 226 (US$0.09) per person for households in WCommHN villages, relative to the comparison group average of UGX 931 (US$0.37) per person (a 24 percent increase). Researchers suggest that women may have applied their newly acquired communication skills to shift household spending towards these foods.

Child health outcomes: The combination of communication and health knowledge training improved the birthweight of newborns relative to the WHN group, suggesting improved maternal nutrition. The average weight of newborn babies in WCommHN villages was 0.23 kilograms higher than in comparison villages (a 7 percent increase). However, child anthropometric measurements did not improve in either WHN or WCommHN villages relative to the comparison group four to nine months after the intervention.

The mixed impacts of the intervention suggest that solely focusing on women's communication skills may not completely resolve household decision-making disparities, particularly in cases where spouses have different preferences and exert control over separate spheres of household decision-making. Offering parallel communication skills training for husbands and encouraging transparent and engaged spousal dialogue from both sides might be more effective.

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1. Conlon, J. J., Mani, M., Rao, G., Ridley, M., and Schilbach, F. (October 2022). Learning in the Household. Working Paper.