

The Care Group Approach



Health Promotion and Behavior Change through A Sustainable Community Based Strategy



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THE CARE GROUP APPROACH: Health Promotion and Behavior Change through a Sustainable Community-Based Strategy

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Contributions

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Photo Credits

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Resources

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Introduction

Background

Care groups were designed by Dr. Pieter Ernst in 1995 with World Relief in Mozambique. This community-based strategy was created to improve behavior change in a large population while maintaining low cost and sustainability. With previous experiences of working and living in underdeveloped communities, Dr. Ernst and other project leaders were able to develop a network of community health volunteers in the care group model.¹

A Care Group is a group of 10-15 volunteer, community-based health educators (Leader Mothers) who regularly meet together with Co-Promoters (PCVs) and Health Promoters (PCV Counterparts). They are different from typical mother's groups in that each Leader Mother is responsible for regularly visiting 10-15 of her neighbors, sharing what she has learned and facilitating behavior change at the household level. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication. With most volunteer programs, there is a high risk for burn-out or attrition. Care groups have a built-in support network among the Leader Mother volunteers which reduces this risk, experiencing fewer turnovers of these Leader Mothers. It is also noted that as Leader Mothers set goals together and review their progress, they create a support network and maintain motivation within the group. Lastly, Care Groups also provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits

With the project focus on building teams of volunteer women – Leader Mothers - who represent, serve and do health promotion for the community, Care Groups have been a success. In Mozambique, the majority of final project objectives were exceeded after only two years, the midterm of the project.² Results have shown an increase in immunizations of children ages 12-23 months, in the use of Oral Rehydration Treatments, of children exclusively breast-fed until 6 months, and of children's general weight, and a decrease in deaths among children.³ Care Groups have since been implemented and adapted in 14 countries by various international development organizations such as Food for the Hungry International (Mozambique, Burundi, Kenya, etc.), Curamericas, and Peace Corps (Benin).⁴

In 2009, the two organizations spearheading the use of Care Groups – Food for the Hungry and World Relief – developed official criteria to define and differentiate Care Groups from other models. The criteria was divided into those which must be present in order for the term "Care Group" to be used and those which have been helpful when included in the model but that are not necessarily required. These criteria can be found in Appendix A: Care Group Criteria.

¹World Relief, *The Care Group Difference :A Guide to Mobilizing Community-Based Volunteer Health Educators*, 2004. p.5

² Ibid. p.5.

³ Ibid. p.10

⁴ Ibid. p.6

Adapting Care Groups: Peace Corps Implementation in Benin

Care groups promote healthy behavior changes through a sustainable community based strategy, thus has been adapted and implemented around the world. It was introduced to Rural Community Health Volunteers in Benin in 2008. Peace Corps Volunteers and their Host Country National (HCN) Counterparts took upon the roles of health promoters and co-promoters, making adaptations throughout the course of the project based upon realized strategies and needed changes. Hence, this manual is being written to be a guide for Peace Corps Volunteers in hopes of clarifying the project and making it easier for you to get started and implement care groups in your community.



One PC adaptation made was to have PCVs and their HCN counterparts meet with fewer care groups and play a larger role in supporting the beginning of the project. However, it is important to maintain a facilitating role to ensure the project's sustainability. In Mozambique, projects were designed to last 5 years. A typical PC service only lasts 2 years, thus extra consideration is needed when monitoring and evaluating the project's success and where feasible, for transition to a replacement volunteer.

This manual hopes to provide PC with suggestions and insight, but remember each community is unique and requires you to adapt the model in a way that will best fit its needs and cultural context. Keeping an open mind and being creative will help the success of your project. With your ideas care groups can even be expanded to other health topics or sectors such as environmental education.

Objectives

The objectives of Care Groups are to:

- Provide equitable access to health information and care not only by covering a larger area of the community but also by the inclusion of marginalized and often less educated members of the community especially children under 5 and pregnant women
- Mobilize the community into action for the betterment of overall health
- Promote behavior change as a social movement
- Educate women on basic health issues thereby multiplying the effort without overburdening project staff
- Create a sustainable project using minimal financial resources

Fitting Care Groups into Your PC Service

Through the implementation of care groups, PCVs and their counterparts will create meaningful and lasting relationships with the women in their community. By spending time with the women during monthly or bi-monthly meetings PCVs will get to know them on more personal levels and gain a greater knowledge of the culture and the community. It can also foster the community's confidence in volunteers and their counterparts and opens up opportunities for other health projects to be realized such as promotion of immunizations, baby weighing, and PD (positive deviance) Hearth. More community members will look to PCVs and counterparts for advice. And with an ultimate design towards sustainability, Care Groups can help volunteers feel successful at the completion of their service.

Sustainability and Long Term Benefits

During our Peace Corps service it is often difficult to measure behavior changes. This can be frustrating and disappointing at times. However with a little perseverance at the beginning of the project, you will start to

see changes in attitudes and the growing motivation of those involved in the project. The importance of these beginning stages of Care Groups for the general continuation and sustainability of the project cannot be overestimated. A firm starting foundation means that the volunteer and counterpart are well-informed about their community through data-gathering and census-taking, Leader Mothers fully understand their roles and responsibilities, and the goal of the project is made clear to the general public. With these conditions in place noticeable behavior changes can occur overtime. And because of Care Group's built-in support system there is low turnover of Leader Mothers and encouragement to continue the project is usually sustained even in the absence of the health promoter.

Although the ultimate goal of Care Groups is to turn all project responsibility over to the Leader Mothers, new volunteers may find that they have inherited a Care Groups project from a previous volunteer. Such transitioning situations can be precarious times for Care Groups for various reasons: a new volunteer lacks a personal connection with Leader Mothers, they are unfamiliar with the community and culture, and since new PCVs are discouraged from doing much work in their first three months project meetings could become interrupted.

To mitigate the potentially highly disruptive effect of this transition, volunteers can utilize several different strategies. A meeting between the COS-ing volunteer, their counterpart, and the in-coming volunteer could provide a helpful introduction to the project, community data/problems/priorities, and future goals and directions. Post-visits are often overwhelming experiences for trainees but it may be useful to introduce the in-coming volunteer to the Leader Mothers at this time. Volunteers and counterparts should also always keep detailed records of the project including community data, maps, surveys, and attendance sheets. Finally in-coming volunteers may decide to use their first three months as an assessment period in which they conduct community surveys. This would be a way for the PCV to get to know the community and Leader Mothers---as well as the project's current progress---without being suddenly thrown into meetings and home visits.

In thinking about the above strategies it is important to remember that every situation is different and that a universal solution is nonexistent. Developing an effective Care Group takes lots of time, patience, and perseverance but the long-term benefits are well worth the effort. As an inherently sustainable project, Care Groups are a way for volunteers to empower local women to make a lasting impact in their community.

Funding

Care Groups are meant to be cost effective; therefore they can be established with minimal funding. Funding may be necessary if you wish to have an opening ceremony to introduce the project and selected volunteers, or provide small incentives (tokens of appreciation) to community volunteers (but remember, volunteers should sign up because they would like to promote proper health and nutrition, not for an incentive). This and other materials such as notebooks, pens, flip charts, etc. can be provided by a SPA or PCPP grant or a smaller grant if available in your country of service (i.e. GAD grants in PC Benin), depending on your needs. With your creativity you can undertake the project with very little cost if any.

How Care Groups are Established:

Care Groups are not right for every community. Therefore there are several steps necessary in ascertaining the feasibility of Care Groups in your community before implementing a Care Group program.

There are five core activities that PCVS and their counterparts should take before establishing Care Groups. These include:

1. Determining readiness for using the Care Group model.
2. Preparing the community and other stakeholders.
3. Identifying Health Promoters and providing training

4. Ensuring that logistics necessary for the program are in place.
5. Conducting a census.

Step 1: Necessary Preliminaries – determining readiness for using the Care Group Model

A. Within the program

- Technical capacity & commitment of PCV and their counterpart.
- Commitment and availability of groups of volunteers (Leader Mothers). Can we get Leader Mothers within the target group who have the time, interest and ability to work as volunteer Leader Mothers in the Care Groups?
- Support of community leaders.
- Financial resources (minimal) to cover expenses for educational and other materials such as Leader Mother uniforms.
- Enough time to establish and train volunteers. The longer the project period the greater the probability that the Care Group structure will stay firm and act as a channel through which other projects can be introduced that would also benefit the community.
- Good monitoring and supervision system in place to carry out a day-to-day follow-up and make changes in a timely way when necessary.
- Good communication skills and system in place in order to collaborate with stakeholders in the community, volunteer Leader Mothers and Beneficiaries.
- Supportive working environment (e.g. community leaders, Leader Mothers, counterparts/work structure are receptive to project).

B. External factors that can influence the Care Group

- **Distribution of beneficiaries:** How close or scattered are they geographically? In densely populated communities, it is easier to establish and manage Care Groups.
Consider three main factors when deciding whether Care Groups would work well within a particular project area:
- **Volunteer pool:** Is there a large enough population from which to draw sufficient Leader Mothers – are there 10 groups (of 10 households each) within walking distance?
- **Reasonable travel:** Are households and villages spaced to make it easy for Leader Mothers to visit their assigned households and to walk to the Care Group meetings? Can the PCV and their counterpart travel between Care Group meeting sites and conduct field supervision using available and cost efficient means of transportation?
- **Volunteer availability:** Do women in the program site have time in their daily lives to attend twice monthly Care Group meetings and carry out their volunteer responsibilities? Can they commit to spending roughly 5 hours per week on volunteer activities?

The Care Group model is not well-suited to sparsely populated or remote locations (such as regions with homestead farms). These environments strain Leader Mothers' time and financial resources, increasing the likelihood of dropouts.

On the other hand, urban areas also present several challenges to the Care Group model, particularly in regards to volunteer drop out. WR does not have experience implementing the Care Group model in densely populated urban areas, such as slum communities.

Urban challenges to volunteer retention include:

- Many slum areas have transient populations that lack strong identity with their urban community.
- More women are likely to have some form of paid employment — jobs with inflexible schedules compete with volunteer commitments.
- When formal employment is available, volunteers may have greater expectations that project staff will pay them.

Questions to consider:

What is the population density of the project area?

What is the population size the project will target?

How far must volunteer Leader Mothers travel to care group meetings? Is this reasonable, given their time and resources?

How far must PCVs and their counterparts travel to care group meetings? Is this reasonable, given the project's budget and PCV Counterpart's workload?

Is it safe for PCV and their counterparts to travel to care group meetings?

Are there densely populated urban sites within the project area? Will the project include these?

- **Seasonal variations:** Farming season, rainy season. During the farming season, many people work on their farm and attendance of Care Group meetings may drop. Participants may come late to meetings and there may be lower rates of the CG Leader Mothers to reach their beneficiary groups. Be creative – for example one PCV took her Care Group meeting out into the cashew fields. Also try to assure that critical health lessons do not occur during these months of low attendance!
- Availability of infrastructure: Roads, health facilities and other services.
- Work ethic and strategic approach applied by other projects/NGOs. Some organizations provide a lot of incentives to volunteers in their programs. Others hand out goods (e.g., food) to the Beneficiaries and that may make it harder for Care Groups to work on voluntary basis. Government partners who are getting several kinds of benefits from other organizations such as per diems for every meeting they are attending, material and financial support for government programs may not only be suspicious of the program but may not be willing to buy into the Care Group model which is based mainly on voluntary work.
- Supportive beliefs and practices in relation to women’s role as educators in the community should be studied well and addressed appropriately in the project in consultation with community leaders before finalizing criteria for their selection. Be sure to have in place policies and procedures to avoid nepotism – choosing people just because of their family connections.
- Appropriateness of Care Group education for the target audience: getting adequate number of volunteer Leader Mothers, training needs of Leader Mothers, etc.
 - ❖ Can we get Leader Mothers within the target group who have the time, interest and ability to work as volunteer Leader Mothers in the Care Groups?
 - ❖ What do we want these Leader Mothers to do? Teach their peers on health and nutrition education to make informed decisions regarding the health of their children, encourage them to make commitments, support the maintenance of behavior change?
 - ❖ What will the Leader Mothers need in order to meet these objectives? Initial training? Refresher training? Educational materials, supervision? Meeting space etc.?
 - ❖ How many Leader Mothers will be needed to reach the target group in the geographic area?
 - ❖ How will the project train and support that many Leader Mothers?
 - ❖ Will the Leader Mothers need incentives? What types of incentives?
 - ❖ How long will the Leader Mother education continue?

Step 2: Preparing the community and other stakeholders.

It is necessary that the community leaders and community members have information about the Care Groups and how they work. They should also be informed about the PCVs and Health Promoters working in the community and their role in the project. We need the community leaders to not only know about the program but to be an active participant in it. The community’s role in the establishment of Care Groups includes the following:

1. Recognizing Leader Mother’s participation to improve the lives of people in their community;
2. Providing support and encouragement to the Leader Mothers for the work they are doing in the community;
3. Monitoring Health Promoters and Leader Mother’s performance; and
4. Participating in some of the Care Group meetings.

To ensure the promotion and acceptance of Care Groups, it is wise for you and your counterpart to introduce the Care Group Approach to the head(s) of your community and other important community members (mayor, elders, presidents of local groups, etc.) Their support is vital for mobilizing the community and for the overall success of the program. Husbands or *chefs de famille* might be less skeptical of the project and more likely to support women to participate if they feel that the community supports the project. Similarly, if Leader Mothers feel the community supports Care Groups, they will take the project and their role more seriously.⁵ Consider holding opening ceremonies to introduce the Leader Mothers and to get the whole community involved.

Step 3: Identify Project “staff”

PCV’s HCN Counterparts serving as Health Promoters – they must be dynamic teachers, motivated, etc. **PCVs serve as Co-Promoters** and work side by side with their counterpart in the establishment of Care Groups. Both Promoters and Co-Promoters must receive training on providing health education, message, behavior change communication, etc to effectively work with and train the Leader Mothers who comprise the Care Groups.

Once you have decided that Care Groups are feasible in your community, it is important to find a responsible community counterpart to work with. This counterpart will serve as the Health Promoter and will be invaluable when performing the community census, selecting Leader Mothers, translations, and the overall promotion of the project. When selecting a counterpart it is important to choose someone from the community who knows most of the families and can speak their language(s). You want someone qualified, and respected in the community, but also someone who will have the time to commit, thus you should clearly explain the project, the counterpart’s role and time commitment from the beginning. Although you may choose to work with someone other than your assigned counterpart, keep your official counterpart informed of your activities---this is not only respectful but they may also be able to aid you in the evolution of the project. A good counterpart is someone who is reliable, knowledgeable and well-respected by both men and women. In some cultural areas, it may be advantageous for your counterpart to be a woman, because of cultural barriers of men working with their (or other men’s) wives.

After you have selected a counterpart, brain storm together about other resource people in your community and surrounding area, for example: Does your community have community health workers? Are there any local NGOs working on health issues that work with your community?

Step 4: Ensure that the logistics necessary for the project are in place

Such as office supplies and educational materials to be used by the Health Promoters and PCVs.

Step 5: Conducting a census

Once the community is on board it is imperative to undergo a survey or community census to register all households with pregnant women and children under 5 in the project site. If you have completed your community assessment (PACA) during your first three months of service, you can refer back to the community map to help you. If not, you can do the map in combination with the census. Although your chosen counterpart may believe they know everyone in the community, it is still important to go to each household personally. In my own experience, I noticed that members of a different ethnicity or a newlywed were often overlooked by my counterpart. When you approach the household, explain to them your purpose and the project’s goals. Ask them if there is a child under the age of five living in their household

⁵ *Peace Corps Mali*. Hearth and Nutrition Guide. 2008

and explain that the care giver of that child and expecting mothers are targeted beneficiaries. Ask them the following questions:

- What is their name, husband's name and other aliases? In some communities, parents are referred to as their child's name or the wife of so and so. Ex. Rissikatou Boni is known in the community as Maman Sakina or *femme de maçon*.
- How many children do they have? This is useful for monitoring and evaluation to know how many direct and indirect beneficiaries are in the project. This is especially useful if you decide to writing a grant proposal.
- Ask the name and age of the youngest child. This will indicate to you if the child should be attending monthly growth monitoring sessions.
- Check the immunizations: This is important again for monitoring and evaluation.
- Ethnicity and languages spoken.
- Career: this can be used to determine the availability of the women. Ex. If she is an agricultural worker you are aware that she may be very busy or unavailable during the rainy months.

When obtaining the above information, it may be useful to ask for the children's identity cards. Most of the questions you ask are reported in these cards. In your records, you may want to put in some of your own observations or other characteristics of the family. Examples: if force feeding is preformed in the household, if they sleep under mosquito nets, if you know of a child that died recently, etc.

A more in-depth census can be conducted which will help greatly during monitoring and evaluating the project. Questionnaires can be used to gather more information about your community. Some techniques in collecting data are:

- 1) Knowledge, Practices and Coverage (KPC)
- 2) Barrier Analysis (BA)

Both can be used as a baseline study. A baseline study is conducted at the beginning of Care Groups. It will give you a picture of your community's health at that point in time and help you determine what knowledge, attitudes, and behaviors you may want to address within Care Groups. Knowledge, Practices, and Coverage (KPC) surveys give you a profound look at what your community knows, what behaviors they practice (good or bad), and how, where, and from whom your community is getting their health information. Depending on what behavior you are looking to follow, your KPC can include questions on breastfeeding, child nutrition or nutrition in general, immunizations, hygiene such as hand washing and waste disposal, HIV/AIDS, malaria, diarrhea and much more. You can make it as thorough or simple as you like. These surveys assist in identifying and prioritizing problems that exist within your community. If you have outlined your impact-level objectives (knowledge, attitudes, skills, and behavior you want to monitor) make sure you place questions in your KPC that are relevant to those objectives. For example if one of your impact-level objectives is to increase the percentage of children who are completely vaccinated by their first birthday you would verify the information by requesting to see the vaccination card or booklet and record the information in your KPC survey. Throughout the life of the project you will monitor this.

Barrier Analysis (BA) is a rapid assessment tool used in community health and other community development projects to identify behavioral determinants associated with a particular behavior so that more effective behavior change communication messages and support activities (e.g., changing social norms) can be developed.⁶ This method was developed by Food for the Hungry to develop ways to overcome barrier to behavior change. Behavioral determinants are reasons why someone does or does not do a behavior. In Barrier Analysis participants are asked a series of questions to identify eight determinants or barriers that can block people from changing their behavior. The eight determinants are⁷:

1. Perceived Susceptibility

⁶ Food for the Hungry, *Barrier Analysis: A Tool for Improving Behavior Change Communication*, Website http://barrieranalysis.fhi.net/what_is/what_is_barrier_analysis.htm

⁷ For explanations of what each barrier means refer to the Barrier Analysis website or the Barrier Analysis Facilitator's Guide by Food for the Hungry, Dec 2004.

2. Perceived Severity
3. Perceived Action Efficacy
4. Perceived Social Acceptability
5. Perceived Self-Efficacy
6. Cues for Action
7. Perception of Divine Will
8. Positive and Negative Attributes

For example you are teaching mothers with children under 6 months about exclusive breastfeeding. You come upon a mother who gives water to her baby. She tells you her mother-in-law says that it's important to give water to the baby. If the mother-in-law has influence the baby's mother and believes that giving water to a baby under 6 months is a good idea, the mother will give water to her baby. The mother believes that exclusive breastfeeding is not a socially acceptable behavior in her household and extended family. This determinant is called perceived social acceptability and will prevent her from practicing exclusive breastfeeding. BA is a great tool; however it's only limited to studying one behavior. If you want to study more than one you must conduct a separate Barrier Analysis survey for each behavior. For the Barrier Analysis survey template please see Annex IV.

When conducting a survey/questionnaire it is imperative that your questions are formed in a way they will be understood. Especially in rural communities, you must be sensitive to a population that is for the most part illiterate and uneducated. In Benin, if you are asking about the last time a woman had her period, you must ask her when was the last time she washed the cloth she uses when she is bleeding. She will not understand period, menstruation, nor any other technical term used by the health community. Speak with your local health workers who can give you the right terminology to use in your community. For survey ideas, please see Annex III.

Also it is extremely important to be culturally sensitive. If you or your counterpart is male, women may ask you to address their husbands and then you would proceed to ask them the questions. There may be other instances where there is a language barrier and either a husband or neighbor would translate for you.

While you are conducting your house-to-house survey, it is a great idea to map out the houses. This will allow you to indicate which ones have Beneficiaries and to identify groups of 10 households. If there is more than one targeted woman in a household, use your good judgment to identify them together or as different households.

Tips:

- Usually a census is carried out by PCVs, their counterparts, and community leaders. Households interested in participating in the Care Group program should be registered.
- The registration should be recorded in a registration book. The record should include the name, address, age, number of children and their ages, if the woman is pregnant, etc., if the woman is interested in participating in the program.

How are Care Groups Organized?

- ◆ Households with children <5 years and pregnant women are identified by a census and grouped in blocks of 10⁸.
- ◆ One volunteer Leader Mother is selected from each block in a community; she is responsible for visiting the 10 HH in her block.
- ◆ 10⁹ Leader Mothers form a Care Group that meets monthly or biweekly.

⁸ Blocks of 10 are a suggestion – the PCV and his/her counterpart should ascertain, in collaboration with Beneficiaries, the appropriate number of households under each Leader Mother's "care".

⁹ Suggested number only – depends on community and can range from 5-15 Leader Mothers per Care Group.

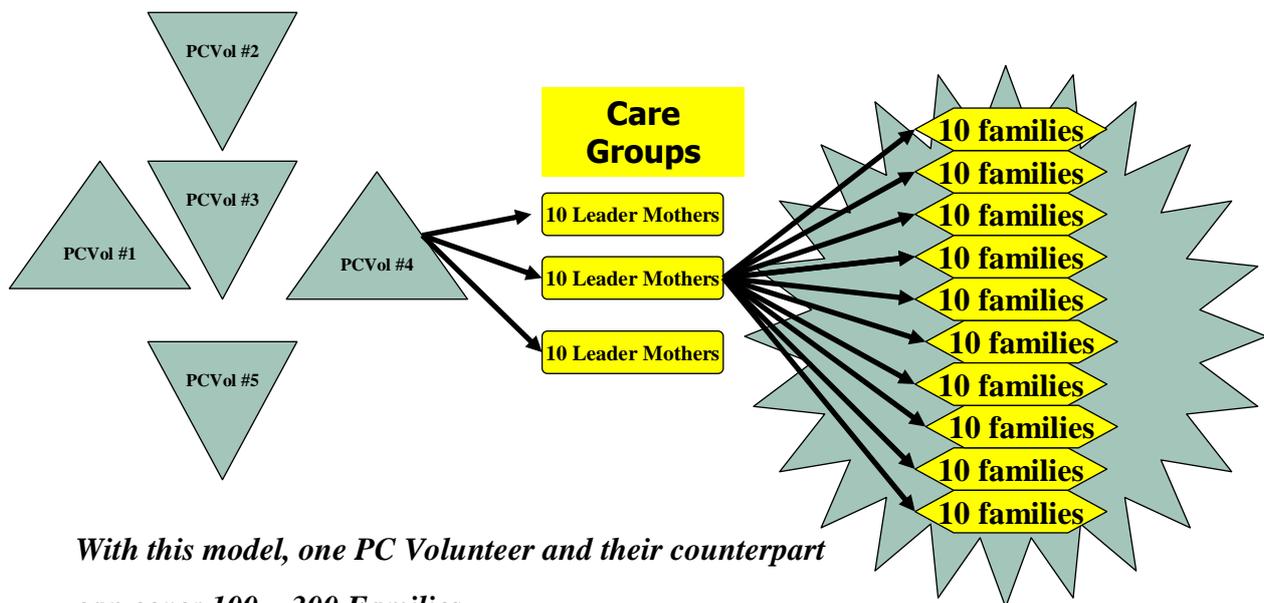
- ◆ The Health Promoter and Co-Promoter trains the Leader Mothers during their Care Group meetings, teaching lessons that they pass on to the Beneficiaries during home visits.
- ◆ Leader Mothers should not participate in more than one Care Group.



PCV Volunteers + Counterparts

Each PC Volunteer & their counterpart educates and motivates 1-3 Care Groups. Each Care Group has 10 Leader Mothers.

Each Leader Mother educates and motivates pregnant women and mothers with children 0-5 years of age in 10 households every two weeks (then monthly).



Care Groups meet once every two weeks or once every month depending on the size of the population the project covers and project resources. Obviously, more often – every two weeks – is better if volunteer Leader Mothers are willing. These meetings are facilitated by the PCV who serves as the co-promoter and the PCV counterpart who serves as the health promoter. Meetings last for a maximum of 2 hours. During the meetings, goals are set by the care group and PCVs and his/her counterpart educate the Care Groups through visual aids, stories, songs, dance, etc. to promote the following topics:

- Nutrition education
 - Breast feeding
 - Supplementary feeding
 - Promotion of Vitamin A

- Nutrition during pregnancy
- Proper feeding techniques
- Health education
 - Malaria
 - Sanitation and Hygiene
 - Managing diarrhea
 - Immunizations
 - Reproductive health and family planning
 - Sexual transmitted diseases and HIV/AIDS
- Importance of growth monitoring (baby weighing) and potential need for nutrition rehabilitation (i.e. “Positive Deviance/Hearth Model”)
- Importance of immunization
- Data Collection through verbal reporting of vital events (pregnancies, births, deaths, etc) and illnesses
- Discussion of progress and challenges and
- Discussion of lessons learned and alternative strategies
- Peer support and motivation occurs throughout meetings



Leader Mothers visit their block of 10 women during the time between meetings. Each Leader Mother re-teaches the month’s lesson to the women, using visual aids when applicable. Leader mothers can address any mothers’ concerns immediately or bring them up during the meetings if they are unsure of how to deal with a difficult situation (if it is a time sensitive situation she may seek out the PCV in her community for advice).

Leader Mothers promote health activities to the community such as the following:

- Growth monitoring (baby weighing)
- Nutrition rehabilitation (i.e. “Positive Deviance/Hearth Model”)
- Immunization Campaigns

Key Actors in the Care Group Model:

- ◆ PCVs – serve as co-promoters
- ◆ Health Promoters – PCV counterparts
- ◆ Leader Mothers
- ◆ Beneficiary Mothers

Role of the Health Promoters

The primary role of the health promoters is to train Leader Mothers on specific maternal and child health topics. They live in the communities in which they serve so they can both facilitate the establishment of the Care Groups and maintain relationships with community leaders. The health promoters are responsible for developing education materials such as flip charts, songs and skits that will be used by the Care Groups. They both train and supervise Leader Mothers.

Promoters are expected to read thoroughly the sessions beforehand and should be well versed on the topic that they are to teach the Leader Mothers. The promoter should be able to reach the site prior to the meeting to organize the meeting place and meet and coordinate with the Co-Promoter (e.g., deciding who

will teach what part of the session). Here is a list of things that are expected to be accomplished by the promoter:

- Take attendance, recording it in the Care Group Register. Call each person by name and mark on the attendance sheet for those who showed up to the meeting.
- Ask participants about their day, the past days since you had a meeting with them, and any other relevant questions about their community, school or church to create rapport.
- Ask them to provide a report on their last month's performance. How many mothers in their group have they trained, how many have not been reached and why, challenges they had, questions that might have risen by their beneficiary mothers, the answers they have provided, etc. Record in the Care Group register which mothers were reached.
- Ask participants to review what was discussed during the last meeting.
- Go through performance group's assignments such as skits, music, etc., given during the previous week.
- Answer questions raised by the group during the previous session.
- Train the Leader Mothers on the day's session.
- Tell the Leader Mothers which parts of the session they should do (at a minimum) with their beneficiary mothers.
- At the end of the training ask them to split in to groups of 3 Leader Mothers and practice going over what they will do in their groups. Other members (the other three) should give feedback. Take turns. The Promoter should go around to each group to observe them, give coaching, and answer any questions they might have.
- Before concluding the day's session, ask the group if they have any questions on the session. If they do not want to ask the question in the presence of others, remind them to use the question box at any time during the week.
- Give assignments for the next meeting and keep a record of those given the assignment. Remind them of the day and time for the next meeting.

Remember – don't exceed the expected time allotted for the meeting and make sure that the training is as friendly as it could possibly be.

Role of the PCV (Co-Promoters)

The roles and responsibilities of PCV/Co-promoters are as follows:

1. PCVs assist the Health Promoter in mobilizing Care groups to attend regular meetings, and conduct follow-up visit with Leader Mothers who miss meetings
2. Assist in the development of educational materials such as flip charts, songs and skits that will be used by the Care Groups.
3. They participate in monthly meetings and co-facilitate trainings.
4. They serve as an on-site consultant for Leader Mothers in case a LM encounters any problem as they train their cluster of 10 beneficiary mothers,
5. They actively participate in co-facilitating community dialogue and other activities of the project such as baby weighings, PD/Hearth, cooking demonstrations, etc.
6. They assist in supervising and monitoring the works of Leader Mothers.

The health promoter and co-promoter (PCV and their counterpart) should meet once a month to discuss and plan for activities for the month. They should also meet the day before and day after the Care Group.

Selecting Leader Mothers

Once your census is completed and your targeted beneficiaries are identified you are ready to select Leader Mothers. Begin by grouping the households in tens based on proximity. If when completing your census, two mothers seemed very interested in becoming Leader Mothers or if they were recommended by community leaders, your counterpart, etc., try to divide the said candidates into two different groups. Also be aware of clusters of different ethnicities and try to keep them in the same group.

Next, at a time when most women would be home and able to spare a few minutes, go to the households and invite the women to meet in the cluster of ten that you had chosen. During the meeting explain the project again, the goals, and the responsibilities of the Leader Mother. It is important that you explain that the Leader Mother must be available and motivated; she does not have to be literate. Other key components are:

- Must be acceptable to the target group – elected by the group.
- Personality conducive for training and the work they will be doing
- Positive attitude and desire to serve neighbors
- Motivated to become and stay involved
- Ability to communicate clearly and persuasively
- Good personal skills, including listening skills
- Socio-cultural background similar to that of the target group
- Nonjudgmental attitude
- Strongly motivated to work toward improving maternal and child health
- Self confident with potential for leadership
- Have the time and energy to devote to this work

Have the group make a decision together and make sure the selected Leader Mother is willing to accept this role. Inform her of the date, time, and location of her first Care Group meeting.

If you are in a larger community it may not be feasible to conduct a census by going to each individual household and meet with the selected clusters of 10 households. In a case such as this, you may choose to hold a community meeting and encourage interested women to attend. During this meeting you will explain the project, its goals and benefits (improving child health in the community), and the responsibilities of Leader Mothers (time commitments, expectations, and that it is a volunteer position i.e. no pay). Take the names of potential Leader Mothers, but gain insight from your counterpart, local community heads, and the women in the community before choosing the Leader Mothers. When a decision is met, inform the Leader Mother and confirm that she willingly takes upon this role.

Role of Leader Mothers

- Participate in all meetings of her Care Group
- Keep records of the beneficiary mothers she teaches
- Work on assignments given to her by the promoter/ co-promoter related to the education session he/ she is covering (e.g. skits, songs, etc) during the Care Group training sessions
- Be responsible for teaching aids and other materials given to her by the project for the purpose of the project activity.
- Teach the beneficiary mothers for which she is responsible the monthly sessions provided to her. Make sure that all the members are reached with the session of the month.
- Be available for counseling and discussions related to the project with the beneficiary mothers and keep confidentiality of these discussions except sharing this information with the co-promoter/ promoter.

- Bring questions raised by the beneficiary mothers (that she cannot answer) to the co-promoter or promoter and subsequently provide the Promoter/Co-promoters response to the beneficiary mothers.
- Provide reports (oral) of her activities to the promoter or co-promoter during regular meetings.
- Provide any relevant information that would help to meet the project objectives to the promoter and co-promoter.
- Be a model to her group.

Establishing and working through the Care Groups

Hold an Opening Ceremony

An opening ceremony is not crucial to the success of Care Groups. However, a ceremony exemplifies the support of the community and the legitimacy of the project. During the ceremony, the Leader Mothers are introduced and given a token of appreciation. A piece of fabric, badge, or certificate encourages the Leader Mothers that they are vital to the project's success.



The First Care Group Meeting and Those to Follow

When scheduling the first Care Group meeting, be sure to select a time that most women will be available. Avoid market days, holidays, and the hours when women are busy in the field or doing household chores. Refer to your PACA results to determine the best time. If you have not done so, this is a great time to conduct PACA in your community. Once you have agreed on a day, time and place, you may have to remind Leader Mothers location day or two before the meeting.

During the meeting re-introduce yourself and your counterpart and the objectives of Care Groups. Review the roles and responsibilities of each Leader Mother and answer any questions that may arise. As a group discuss and develop goals. If the Leader Mothers give their insight into what the community needs they will be more likely to actively reach toward obtaining the goals. Encouraging Leader Mothers to provide contributions increases their team working abilities and networking, thus decreases their dependency on the Health Promoters.¹⁰

During the first 1 or 2 Care Group sessions, the Health Promoter & the PCV trains Leader Mothers on the project objectives and their role in the program. This is essential to avoid unnecessary expectations from the Leader Mothers in the future. It is advisable to involve community leaders in these meetings. In addition to learning about the purpose of the group, they must be aware of how their contribution to the program would help to reduce the magnitude of Malaria in their project sites (and or other health behaviors). Among others things, we need to emphasize the following in this meeting:

1. The overall objectives of the project and their role as volunteers;
2. Leader Mother as a role model for her group: In their new role as experts and agents of change in sensitive subjects, peer educators will expose themselves to the opinions of others. They will be asked personal and complicated questions from friends and peers and given the responsibility of answering with accurate, up-to-date information or providing professional referrals. In addition, they will be given

¹⁰ World Relief. *The Care Group Difference: A Guide To Mobilizing Community-Based Volunteer Health Educators*. 2004. P. 49

the responsibility of maintaining confidentiality concerning what they hear and pressure to ‘practice what they preach.’

3. The importance of sharing their concerns and challenges with the health promoter
4. Reporting their performance to the health promoter.
5. Meeting procedures (meeting with the mothers they represent and meeting with the Health Promoter during training sessions): Reaching all beneficiary mothers and the quality of the message.
6. General overview of the Lessons that will be covered during the Care Group meetings – malaria, nutrition, HIV/AIDS etc.
7. Health Promoters – monitoring Leader Mother performance
8. Others: selecting venue for the meeting, dates and time

Set shared goals for the care group to achieve together rather than setting separate goals for individual volunteers.¹¹ Working together towards shared goals increases the care groups’ likelihood of having greater commitment and support in reaching those goals as well as creates a sense of solidarity among the group. Since all Leader Mothers are part of a care group, goals set for the care group also set for them. Some examples are all Leader Mothers must have a latrine, targeted households with children under the age of 2 attend monthly baby weighing sessions, or all women have their children immunized. Be creative in your goal setting, but remember to be realistic. Perhaps some of the goals set won’t be obtained until after your PC service.

The Health Promoters (PCV and Counterpart) will give an oral quiz at the end of each session on the content of the lesson given to the care group. As a group set up the time and location for the next meeting. During the meetings, review the shared goals and the progress that is being made. Discuss any difficulties, give oral quizzes, encourage group discussions and the teaching of one another. Be creative during meetings by using visual aids, songs, skits, dance, etc to ensure the lessons are learned.

Household Visits



Leader Mothers are responsible to make household visits to each of the women in her cluster. During the household visit she will re-teach the lessons learned during the Care Group meetings held with the PCV. She may use visual aids or demonstrations (i.e. washing hands). During her time with each mother, she should note any observations she would like to address at the next meeting, vital statistics such as a new pregnancy, deaths, move, etc. She should allow the women to feel comfortable in her presence and allow them to express any concerns or health related questions they may have.

Continuation of Care Group Meeting and Activity Ideas

During the meetings, review the shared goals and the progress that is being made. Discuss any difficulties, give oral quizzes, encourage group discussions and the teaching of one another. Use visual aids, skits, songs. Introduce and promote outside activities such as growth monitoring, immunizations, or PD Hearth.

If you have decided to give incentives such as badges or wrap (pagne) they are a great way to recognize the efforts of Leader Mothers. During a meeting if the Leader Mother answered a question right, you can reward her by placing a star sticker on her badge or creating a point system that can be redeemed, making

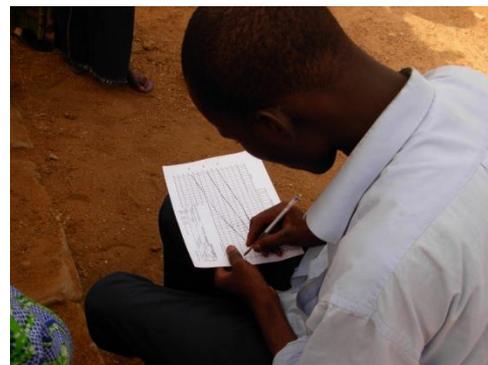
¹¹ Ibid. p. 49

sure to give each Leader Mother a chance to answer questions correctly. This also promotes the participation of all Leader Mothers.

Monitoring and Evaluation

Monitoring and evaluation (M&E) is essential for a successful project. Monitoring tells us if our project is on track and making progress, while evaluation tell us if the project is on the right track and having the impact we had hoped for. M&E must be planned from the start, not as an afterthought. Before you start your project, ask yourself and your counterpart several questions:

- What aspects of the project will you want to track or monitor?
- How will you do that?
- Once the event has taken place, what will you want to evaluate?
- How will you go about that?



In fact, the very act of doing the monitoring and evaluation plan pushes us to think harder and become clearer on our project goals and objectives than we might have otherwise.

Below is a chart based on the Care Groups project in Mozambique which will give you an idea on how to organize your monitoring and evaluating system.

METHODOLOGY	WHO COLLECTS DATA	WHAT DATA MEASURES	HOW DATA IS USED	FREQUENCY & TIME COMMITMENT
Household Count				
Count of Beneficiary households & direct Beneficiaries	1) Health Promoter & Co-Promoter 2) Community (CSA, CSC, CPS, NGO)	Number of Beneficiaries	1) Number of Leader Mothers needed 2) Number of blocks of households	Beginning and middle of project Time commitment varies
Monthly Care Groups Statistics				
Leader Mothers orally report vital events of their households Health Promoter & Co-Promoter report to community	1) Leader Mothers 2) Health Promoter & Co-Promoter 3) Community	Vital statistics such as births, deaths, pregnancies, etc.	1) Discuss in Care Group Meetings 2) Share results with community	Monthly; reporting & tabulation = 30 mins. during Care Group Meeting Reporting = 30 mins during community meeting
Field Visits				
Accompany Leader Mothers on home visits	Health Promoter & Co-Promoter	Leader Mother's Performance	1) Track effectiveness of Leader Mothers teaching strategies 2) Re-evaluate 3) Share results individually	Monthly/biweekly 1 week for data collection & tabulation

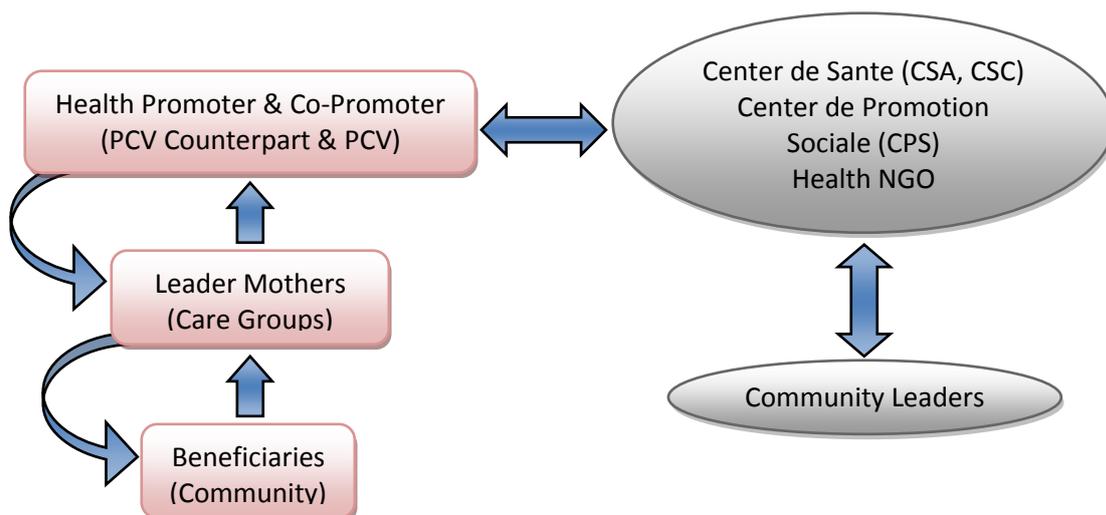
Conducting a baseline survey is essential in monitoring and evaluating your project. They will give you a starting point and an overall picture of the health of your community. Most important, you will compare that information with the information that you will receive during the life of the project. This will give you a great picture of which objectives have been met and what you need to re-evaluate. You may add other forms of monitoring and evaluating methods like one-on-one surveys, focus groups, or local rapid assessments (LRA). LRA is a segment of your baseline survey that is used to sample random households in

each Care Group. This type of survey is used after completion of a topic. For example over the past three months your Care Groups have taught their households about breastfeeding (including immediate, exclusive, and supplementary breastfeeding). If you conducted a baseline study simply use the same questions that cover the topic of breastfeeding. Please refer to Appendix III – Survey Example “Breast Feeding and Nutrition” section for questions.

Part of their role as Leaders Mothers is to monitor the Beneficiaries in their block. Once your Leader Mother’s have started home visits, they will verbally report their observations to the entire Care Group during the monthly meetings. As part of their household visits, Leader Mothers take note of pregnancies, births, and deaths of young children and women of child-bearing age. They will also report on any symptoms and illnesses affecting their households and their response (whether they sought treatment or not). The Health Promoter and Co-Promoter can also monitor the Beneficiaries by conducting a home visit. Monitoring the Beneficiaries will determine whether they have learned the knowledge and changed their behavior. It will also show the effectiveness of the Leader Mothers and whether you need to re-evaluate teaching methods and/or health messages.

The Health Promoter and Co-Promoter will monitor the Leader Mothers. During the monthly meeting, give oral quizzes to measure how well the Care Group has learned the lesson. When giving oral quizzes ask each individual volunteer a different question, but have the answer contribute to a group score for passing the quiz. Records of immunizations and attendance of group monitoring sessions are also good indicators of the projects success. You can also conduct supervisor field visits where you will accompany Leader Mothers on their home visits to evaluate their performance. This ensures complete coverage and avoids households that are looked over due to different ethnicities, new marriages, or changes in address. Your Leader Mothers will also gain a boost of confidence when you encourage the work they are doing.

The following chart shows the flow of information in a Care Group Project



Care Groups gather information from the Beneficiaries and pass on the information to the Health Promoter and Co-Promoter during the monthly/biweekly Care Group meetings. The Health Promoter and Co-Promoter accumulate all the information from every Care Group they supervise. The aggregated information is then presented to the Centre de Santé, Centre de Promotion Sociale, Health NGO, or other organization that will benefit from the information. These organizations along with the Care Groups share the information with the community leaders. Information flows back and forth between the Centre de Santé, the community leaders and the Health Promoters. Information also flows downward from the Health Promoters to the Care Groups and from the Care Groups down to the Beneficiaries. Remember this chart is just to give you an idea of how information can be shared. Adapt the chart so that it best suits your community.

Linking to Health Services and the Community

Care Groups function best when they are linked to groups in the community that publicly support and take part in their work.¹² Whether you work at the Centre de Santé, the Centre de Promotion Sociale or at an NGO, you can incorporate these important groups into your project. Sharing information with the community will increase community involvement in the success of Care Groups. They will recognize the positive impact Care Groups have and provide public support. Praise from the community raises Leader Mothers' self-esteem and helps convince them that their work is important.

In order to build links between Care Groups and these community groups invite health workers, center staff, and NGO staff to your initial Care Group meetings or meet with them at their place of work. Explain the project goals and objectives, expectations of role players in the project, and ask them any suggestions they may have for the project and how they can contribute. Sometimes it's best to have an idea of what you want them to contribute such as knowledge about the health system, visual aids, or simply their expertise on a health topic.

Building Relationships with the Centre de Santé

Care Groups advocate for the community by bringing information to the Centre de Santé while they also assist the Centre de Santé in promoting health services and activities. Since Care Groups are constantly working within the community they have firsthand knowledge about community needs. Meeting regularly with health providers, Care Groups can present their findings to the Centre de Santé and be part of the

¹² World Relief. *The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators*. 2004. P. 81

solution to improving health services. They can encourage health providers to become more active in the community while at the same time referring Beneficiaries to the Centre de Santé for treatment.

Reporting to the health centers can help identify disease trends and develop strategies to combat increases. For example, if the Care Groups have recorded an increase in measles among child under 5 years old and informed the local health center, the health center can conduct a localized vaccination campaign in the affected area to stop the spread of measles. Once the campaign has been organized the Centre de Santé can utilize the Care Groups to publicize the upcoming vaccination during home visits and rally mothers to bring their children.¹³ The Centre de Sante can also utilize the Care Groups during the event by organizing the people as they arrive and educate the community as they wait for the vaccine.

Building Relationships with Religious Leaders

Including religious leaders can enhance your project. Religion is very important to the Beninese people and many Beninese people are in close contact with religious leaders in their community. Care Groups can utilize the religious leaders in the community in many ways. Religious leaders can:

- Publicly support the Care Groups and their efforts
- Promote healthy practices and behavior change in public meetings (such as during sermons).¹⁴
- Recognize symptoms and encourage community members to seek proper treatment. Many times when a family member is sick, the family will call on a religious leader to pray over the sick person or seek spiritual advice. This is the perfect opportunity for religious leaders to promote the health practices.
- Stop unhealthy traditional healing practices that they are involved in.

According to the Care Groups project in Mozambique, “many pastors reported pride in being able to refer people to effective treatment, knowing that it increased their own credibility within the community.”¹⁵

Working together with the community creates a two-way relationship. Care Groups increase the community’s access to health information and services, advocates on behalf of the community, and unites all members of the community closer together.

Sample Care Group Program Timeline

Steps and Duration	Key Event	Notes
1: 1 month	Select a counterpart and begin community mobilization	Introduce project to village leaders, gain their support
2: 1-2 months	Conduct census and identify Beneficiaries	Time needed varies with population size
3: 1 month	Select Leader Mothers	Number of Leader Mothers determined by household count/proximities of household
4: 1 month	Hold opening ceremony	Re-introduce the project to the community to gain full support
5: 1 month	Hold first Care Group meeting	Discuss goals and develop curriculum outline
6: 3-12 months	Leader Mothers begin household visits and the re-teaching of lessons Leader Mothers discuss their successes, difficulties and provide support to one another	1 lesson every month; if time permitted, 1 lesson every 2 weeks Leader Mothers report vital statistics during the meeting
7: 2-3 months	Make household visits with Leader	Ensures Leader Mothers understand their

¹³ Ibid. P. 90

¹⁴ World Relief. *The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators*. 2004. P. 85

¹⁵ Ibid. P. 85

	Mothers	roles and provides empowerment and confidence
8: 3-12 months	Promote and emphasize other community activities	Local baby weightings, immunizations, PD Hearth, etc
9: 3-12 months	Periodically monitor and evaluate the information learned by Leader Mothers and beneficiary households	Through Care Group meetings, visits with Leader Mothers and observations

Troubleshooting

Care Groups were created in such a way as to effectively deal with health issues while minimizing potential problems. However as we all know all too well, some problems are unforeseeable. Here are some strategies to use when they arise.

Attendance

With any project attendance is always a major issue. If you haven't already done so, conducting PACA, specifically Seasonal Calendar and Daily Activities Schedule which will determine the most suitable day and time to have meetings and variations year-round. Praise one another as a regular part of Care Group activities. If a Leader Mother has gone to every meeting for 6 months, the entire Care Group will give her "WABA" hand salute, dance or sing in her praise. Bring food or have refreshments when the Care Group meets goals. If a fixed location is causing some Leader Mothers to miss meetings, change the location. I found that changing the location each month to meet at each Leader Mothers homes worked well. Leader Mothers took responsibility in ensuring that others came and also provided snacks. Encourage Leader Mothers to support each other in a variety of ways in and outside the Care Group meetings.

If a Leader Mother is unavailable to attend a monthly meeting, set up a time to meet with them, even if it involves joining them in the field, and discuss what they missed. The Health Promoters will may have to do this in the beginning of the project. But as time passes, have other Leader Mothers visit those who were absent and teach them the lesson. The Leaders Mothers gain more practice in teaching, gain more confidence in each other, and rely less on the Health Promoters

Home Visits

House hold visits may be time consuming and in some months (rainy season) women may not be present as often. During your care group meeting develop strategies together to ensure complete coverage. One strategy could be to use the waiting time at the pump to an advantage. Some women will sit for hours until it's their turn to receive water at the pump. Meanwhile Leader Mothers may also be waiting, thus the time together could be used to discuss the month's lesson. If multiple women from the same block are together, Leader Mothers may choose to discuss the lesson with them and evoke a group discussion.

Encourage Leader Mothers to work together to be more effective in home visits. If a Leader Mother encounters a difficult household or question, she can call on another Leader Mother for help. This way they are not alone in advocating new health practices.

Weak Leader Mothers

After several months of meeting and home visits, you will notice who the "strong" Leader Mothers are and who are the "weak" ones. Pair up strong and weak Leader Mother. Together they will visit their assigned households. The weak Leader Mother will benefit from the joint visits and gain confidence to perform better in the future. **NOTE:** This classification is for the Health Promoters use only. Do not share with the individual or make public. To avoid this simply pair up every Leader Mother in the Care Group so no one suspects that their performance is weak.

If a Leader Mother expresses her desire to continue working but needs to reduce the number of households, select a 2nd Leader Mother from the same block who will pick up the slack.

Scheduling Conflicts

Do not worry if you have to reschedule a Care Group meeting because of a village ceremony or other community event; just choose the next earliest available time to meet. For example your market happens every six days and you have fixed your meeting for the 1st Sunday of every month. Next month you notice that the market will fall on your meeting day. Together decide whether to move the meeting to the Saturday before or the Monday after.

Building relationships with the community will reduce problems. Whether it's a weak volunteer, a difficult household or a community event standing in the way, seeking the help of community leaders and the entire Care Group will make it easier to deal with problems as they appear.

Conclusion

“More than a dozen grannies had gathered under the tree to meet the final evaluation team for the Vurhonga I CSP. As the evaluation team and grannies talked together about what had happened in their village, one of the team members asked a question. “Vurhonga is only a child in your village — it is less than four years old. But we have been teaching things that are different from the ways that you have lived for many years. How long will it be before you forget what Vurhonga taught and return to the old ways?”

The grannies talked together for a while and then one of them replied. ‘We have a question for you. A person has been a slave for many years, but somebody buys them and gives them their freedom. How long will it be before they go back to be a slave again?’”¹⁶

Care Groups is a powerful undertaking that if thoroughly organized from the start could engender significant and positive change in a community. It promotes behavior change as more than just an individual decision but as a social movement involving the whole community starting from the grass roots level. Widespread community empowerment is the heart and soul of the Care Group approach.

Care Groups share their empowerment with Leader Mothers, with Beneficiaries, with community leaders, with health workers, until the entire community is gathered together in the process of change. And empowerment is long-lasting. Like a stone thrown into a pond, the ripple effects of Care Groups keep going, even though the stone can no longer be seen. Transformed communities are the lasting difference.

¹⁶ World Relief. *The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators*. 2004. P.9

Appendix I – Care Group Criteria

Care Group Criteria

Criteria for Care Groups	Rationale
Required:	
1. The model is based on peer-to-peer health promotion (Mother-to-mother for MCH and nutrition behaviors.) CG Volunteers should be chosen by the mothers within the group of households that they will serve or by the leadership in the village.	Care Groups are not the same as Mothers Clubs where mothers are simply educated in a group. An essential element is having women serve as role models (early adopters) and to promote adoption of new practices by their neighbors. There is evidence that “block leaders” (like CG volunteers) can be more effective ¹ in promoting adoption of behaviors among their neighbors than others who do not know them as well. CG Volunteers should be mothers of young children or other respected women from the community. We believe that CG volunteers who are chosen by their neighbors (or by a consensus of the full complement of [formal and informal] community leaders) will be the most dedicated to their jobs, effective in their communication, trusted by the people they serve, and most willing to serve others with little compensation.
2. The workload of CG volunteers is limited: No more than 15 HH per CG volunteer.	Having one volunteer trained to serve 30 or more households is more in line with the traditional CHW approach, and more regular and sustained financial incentives are required for that model to be effective. In the CG model, the number of households per CG volunteer is kept low so that it fits better with the volunteer’s available time and allows for fewer financial incentives to be used. In addition, there is evidence that the ideal size for one’s “sympathy group” – the group of people to whom you devote the most time – is 10-15 people. ²
3. The Care Group size is limited to 16 members and the project attains at least 70% monthly attendance. Coverage is monitored.	To allow for participatory learning, the number of CG volunteers in the CG should be between 6 and 16 members. As with focus groups, with fewer than six members, dialogue is often not as rich and with more than 16, there is often not enough time for everyone to contribute and participate as fully. A low attendance rate at Care Group meetings is often an indication that something is wrong somewhere, either with the teaching methodology or the promoter attitude, and helps the organization to identify problems early in the project. Attendance should be monitored.
4. CG volunteer contact with her assigned beneficiary mothers is monitored and should be at a minimum once a month, preferably twice monthly.	In order to establish trust and regular rapport with the mothers with which the CG volunteer works, we feel it is necessary to have at least monthly contact with them. We also believe that overall contact time between the CG volunteer and the mother (and other family members) correlates with behavior change. We recommend twice a month since the original CG model was based on this meeting frequency (after experimentation to see which meeting frequency aided the most in retention of material).
5. The plan is to reach 100% of households in the targeted group on	In order to create a supportive social environment for behavior change, it is important that many mothers adopt the new practices being promoted. Behavior change is much more

¹ Burn, S.M. (1991). Social psychology and the stimulation of recycling behaviors: The block leader approach. *Journal of Applied Social Psychology*, 21, 611-629.

² See Gladwell, M. (2002). *The Tipping Point*, Little, Brown, & Co publishers, pp. 175-181.

Criteria for Care Groups	Rationale
at least a monthly basis, and the project attains at least 80% monthly coverage of households within the target group. Coverage is monitored.	likely to happen when there is regular, direct contact with <u>all</u> mothers of young children (rather than reaching only a small proportion of mothers), and probably more likely when there is contact with all households in a community (but this approach will probably be more costly).
Required:	
6. Care Group Volunteers (e.g., "Leader Mothers," "Mother Leaders") collect vital events data on pregnancies, births, and death.	Regular collection of vital events data helps CG volunteers to discover pregnancies and births in a timely way, and to be attentive to deaths happening in their community (and the causes of those deaths). Reporting on vital health events should be done during Care Group meetings, so that the data can be recorded by the CG leader (usually using in a register maintained by her) and discussed by the CG members. The point of discussion should be for CG members to draw connections between their work and the health events in the community (e.g. what can we do to prevent this kind of death in the future?). This should be done on at least a monthly basis, so that the information is not forgotten by volunteers over longer periods of time.
7. The majority of what is promoted through the Care Groups is directed towards reduction of mortality and malnutrition (e.g., Essential Nutrition Actions, Essential Hygiene Actions).	This requirement was included mainly for advocacy purposes. We want to establish that the Care Group approach can lead to large reductions in child and maternal mortality, morbidity, and malnutrition so that it is adopted in more and more settings to achieve the health MDGs. While the cascading or multiplier approach used in Care Groups may be suitable for other purposes (e.g., agriculture education), we suggest that a different term be used for those models (e.g., "Cascade Groups based on the Care Group model").
8. The Care Group volunteers use some sort of visual teaching tool (e.g., flipcharts) to do health promotion at the household level.	We believe the provision of visual teaching tools to CG volunteers helps to guide the health promotion that they do, gives them more credibility in the households and communities that they serve, and helps to keep them "on message" during health promotion. The visual nature of the teaching tool also helps mothers to receive the message by both hearing it and seeing it.
9. Participatory methods of BCC are used in the Care Group with the CG Volunteers, and by the volunteers when doing health promotion at the household or small-group level.	Principles of adult education should be used in Care Groups and by CG volunteers since they have been proven to be more effective than lecture and more formal methods when teaching adults.
10. The Care Group instructional time (when a Promoter teaches CG Volunteers) is no more than two hours per meeting.	CG members are volunteers, and as such, their time needs to be respected. We have found that limiting the CG meeting time to 1-2 hours helps improve attendance and limits their requests for financial compensation for their time. (This instruction should include interactive and participatory methods.)
11. Supervision of Promoters and at least one of the Care Group Volunteers (e.g., data collection, observation of skills) occurs at least monthly.	For Promoters (who teach CG Volunteers) and CG volunteers to be effective, we believe that regular, supportive supervision and feedback is necessary on a regular basis (monthly or more). For supervision of Care Group volunteers, the usual

Criteria for Care Groups	Rationale
	pattern is for the Promoter to supervise through direct observation at least one volunteer following the CG meeting.
Suggested:	
1. Formative research should be conducted, especially on key behaviors promoted.	A review of the most effective projects in terms of behavior change for both exclusive breastfeeding and hand washing with soap (by the CORE Group Social & Behavioral Change Working Group) found that they included formative research (e.g., Barrier Analysis, Doer/NonDoer Analysis) on the behaviors. We believe that more systematic use of formative research on behaviors will lead to the best adoption rates. Formative research also helps assure that the behaviors promoted by project staff are more feasible by community members.
2. The Promoter:Care Group ratio should be no more than 1:9.	For Promoters to know and have the trust of those with which they work, it is best to limit the number of volunteers with which they work to about 150, or nine groups (assuming a CG size of between 6 and 16 members). Some social science research confirms that our maximum "social channel capacity" – the maximum number of people with whom we can have a genuinely social relationship – is about 150 people (and 9 groups x 16 people/group = 144).
3. Measurement of many of the results-level indicators should be conducted annually at a minimum.	We have found that regular measurement of at least some key results-level indicators on an annual (or better) basis is helpful in knowing what is changing and what is not in time to do something about it.
4. Care Group Volunteers should only be assigned to visiting households that can be reached during regular daily activities.	It's preferable that the Leader Mother not have to walk more than about 30 minutes to get to the furthest house that she visits so that regular visitation is not hindered. (In many CG projects, the travel time is less than this.) This also makes it more likely that she will have a prior relationship with the people that she is serving.
5. Social/educational differences between the Promoter and CG Volunteer should not be too extreme (e.g., having bachelor-degree level staff working with CG volunteers).	We believe that keeping the educational difference between the Promoter and CG volunteers to a modicum is useful in that it makes it more likely that the Promoters will use language/concepts that the CG Volunteers can understand. It also helps to keep costs of the model low.

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Appendix II – Sample Care Group Data Collection Tool

ANNEX 4: Care Group Register

Monthly Care Group Report for the Month of _____ / _____ (month/year)												
Care Group Number : _____						Care Group President: _____						
Community : _____						Promoter: _____						
Number of LMs Reporting this month: _____						Number of LMs in this group: _____						
Leader Mothers	Children						Women					
	 No. of Children 0-23m seen	 Deaths of children 0-23m	 Malnourished	 VIA distributor	 Deworming Meds distributed	 No. of children attending GM/P	 No. of Women Seen	 Women currently pregnant	 Pregnant women receiving prenatal care	 Total Lactating Mothers this month	 No. of lactating mothers who received Iron	 Total live births
LM #1 SELF												
LM #2												
LM #3												
LM #4												
LM #5												
LM #6												
LM #7												
LM #8												
LM #9												
LM #10												
LM #11												
LM #12												
LM #13												
LM #14												
TOTAL												

Appendix III – Survey Example (Child Survival Technical Support Website)

KPC₂₀₀₀ Rapid Core Assessment Tool on Child Health (CATCH)

Statement from the CORE Monitoring and Evaluation Working Group

About the Rapid CATCH

The CORE Monitoring and Evaluation Working Group (MEWG) strongly suggests that PVOs include all the *Rapid CATCH (Core Assessment Tool on Child Health)* questions in their surveys. Even if some of these core questions do not relate specifically to project interventions, they provide information on critical, life-saving, household behaviors and care-seeking patterns. This information can be used as follows:

1. To inform the implementing PVO and its local partners (MOH, USAID mission, NGOs, etc.)
2. To provide a basis for comparability between projects within a given country, as well as across countries
3. For advocacy at both the national and international levels

If the *CATCH* questions are not included, it is suggested that the logic for that decision be stated. The MEWG believes that collecting, analyzing, interpreting, using, and sharing this information has the potential to save the lives of children and mothers.

This questionnaire targets mothers of children less than 24 months of age.

1. RECORD INTERVIEW DATE

DAY	MONTH	YEAR
<input type="text"/>	<input type="text"/>	<input type="text"/>

2. How old are you?

RECORD AGE OF RESPONDENT IN YEARS: ____

3. How many children living in this household are under age five? _____

4. How many of those children are your biological children? _____

5. READ ONE OF THE FOLLOWING QUESTIONS BASED UPON MOTHER'S RESPONSE TO Q.4:

ONLY 1 CHILD UNDER FIVE: “What is the name, sex, and date of birth of that child?”

MORE THAN 1 CHILD UNDER FIVE: “What are the names, sexes, and dates of birth of your two youngest children?”

	NAME	SEX	DATE OF BIRTH
1		1. MALE 2. FEMALE	___ / ___ / ___ DD MM YY
2		1. MALE 2. FEMALE	___ / ___ / ___ DD MM YY

ALL SUBSEQUENT QUESTIONS PERTAIN TO THE YOUNGEST CHILD UNDER AGE TWO

Anthropometry

What we know: In poor countries, malnutrition is a contributing factor in more than half of all under-five deaths. Body dimensions (weight and height) reflect the overall health and well-being of individuals and populations. The prevalence of low weight-for-age (underweight) can be used to assess nutrition interventions and is a required indicator for all projects funded under USAID's Title II (Food Assistance) Program.

6. May I weigh (NAME)?

1. YES
2. NO → **SKIP TO Q.8**

7. IF MOTHER AGREES, WEIGH THE CHILD AND RECORD WEIGHT BELOW. *RECORD TO THE NEAREST TENTH.*

___ . ___ KILOGRAMS

Maternal and Newborn Care

8. Before you gave birth to (NAME) did you receive an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?

1. YES
2. NO → **SKIP TO Q.10**
8. DON'T KNOW → **SKIP TO Q.10**

9. How many times did you receive such an injection?

1. ONCE
2. TWICE
3. MORE THAN TWO TIMES
8. DON'T KNOW

10. Now I would like to ask you about the time when you gave birth to (NAME). Who assisted you with (NAME'S) delivery?

- A. DOCTOR
- B. NURSE/MIDWIFE
- C. AUXILIARY MIDWIFE
- D. TRADITIONAL BIRTH ATTENDANT _____
(NAME)

- E. COMMUNITY HEALTH WORKER
- F. FAMILY MEMBER _____
(SPECIFY RELATIONSHIP TO RESPONDENT)

- G. OTHER _____
(SPECIFY)

Y. NO ONE

Breastfeeding and Nutrition

11. Did you ever breastfeed (NAME)?

- 1. YES
- 2. NO → **SKIP TO Q.13**

12. How long after birth did you first put (NAME) to the breast?

- 1. IMMEDIATELY/WITHIN FIRST HOUR AFTER DELIVERY
- 2. AFTER THE FIRST HOUR

13. I would like to ask you about the types of liquids and foods that (NAME) consumed yesterday during the day or at night. Did (NAME) have. . .

READ EACH OF THE FOLLOWING AND PLACE A CHECK MARK IN THE BOX NEXT TO EACH ITEM CONSUMED.

	LIQUID/FOOD	CONSUMED IN LAST 24 HOURS?
A	Breastmilk?	
B	Plain water?	
C	Other liquids?	
D	Mashed, pureed, solid, or semi-solid foods?	
E	Anything else? SPECIFY: _____ _____ _____	

Child Immunization

IF OPTION A IS CHOSEN, OMIT QUESTION 16 FROM THE QUESTIONNAIRE. IF OPTION B IS CHOSEN, OMIT QUESTIONS 14 AND 15.

14. Do you have a card where (NAME’S) vaccinations are written down?

IF ‘YES’ ASK ‘May I see it please?’

- 1. YES, SEEN BY INTERVIEWER
- 2. NOT AVAILABLE (lost/misplaced, not in home) → **SKIP TO Q.17**
- 3. NEVER HAD A CARD → **SKIP TO Q.17**
- 8. DON’T KNOW → **SKIP TO Q.17**

15. RECORD INFORMATION EXACTLY AS IT APPEARS ON (NAME’S) VACCINATION CARD.

	DAY	MONTH	YEAR
BCG	<input type="text"/>	<input type="text"/>	<input type="text"/>
POLIO 0	<input type="text"/>	<input type="text"/>	<input type="text"/>

16. Did	POLIO 1	<input type="checkbox"/>					
	POLIO 2	<input type="checkbox"/>					
	POLIO 3	<input type="checkbox"/>					
	DPT 1	<input type="checkbox"/>					
	DPT 2	<input type="checkbox"/>					
	DPT 3	<input type="checkbox"/>					
	MEASLES	<input type="checkbox"/>					
	VITAMIN A	<input type="checkbox"/>					

(NAME) ever receive an injection to prevent measles?

1. YES
2. NO
8. DON'T KNOW

Malaria Prevention

17. Do you have any bednets in your house?

1. YES
2. NO → **SKIP TO Q.20**
8. DON'T KNOW → **SKIP TO Q.20**

18. Who slept under a bednet last night? **CIRCLE ALL THAT APPLY.**

- A. CHILD (NAME)
- B. RESPONDENT
- C. OTHER INDIVIDUAL(S) _____
(SPECIFY)

19. Was the bednet ever soaked or dipped in a liquid to repel mosquitoes or bugs?

1. YES
2. NO
8. DON'T KNOW

Integrated Management of Childhood Illnesses (IMCI)

20. Sometimes children get sick and need to receive care or treatment for illnesses. What are the signs of illness that would indicate your child needs treatment? **DO NOT PROMPT. CIRCLE ALL MENTIONED.**

- A. DON'T KNOW
- B. LOOKS UNWELL OR NOT PLAYING NORMALLY
- C. NOT EATING OR DRINKING
- D. LETHARGIC OR DIFFICULT TO WAKE
- E. HIGH FEVER
- F. FAST OR DIFFICULT BREATHING
- G. VOMITS EVERYTHING

- H. CONVULSIONS
- I. OTHER _____
(SPECIFY)
- J. OTHER _____
(SPECIFY)
- K. OTHER _____
(SPECIFY)

21. Did (NAME) experience any of the following in the past two weeks?

READ CHOICES ALOUD AND CIRCLE ALL MENTIONED BY RESPONDENT.

- A. DIARRHEA
- B. BLOOD IN STOOL
- C. COUGH
- D. DIFFICULT BREATHING
- E. FAST BREATHING/SHORT, QUICK BREATHS
- F. FEVER
- G. MALARIA
- H. CONVULSIONS
- I. OTHER _____
(SPECIFY)
- J. OTHER _____
(SPECIFY)
- K. NONE OF THE ABOVE → **SKIP TO Q.24**

22. “When (NAME) was sick, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?”

- 1. LESS THAN USUAL
- 2. SAME AMOUNT
- 3. MORE THAN USUAL

23. When (NAME) was sick, was he/she offered less than usual to eat, about the same amount, or more than usual to eat?

- 1. LESS THAN USUAL
- 2. SAME AMOUNT
- 3. MORE THAN USUAL

HIV/AIDS

24. Have you ever heard of an illness called AIDS?

- 1. YES
- 2. NO → **SKIP TO Q.26**

25. What can a person do to avoid getting AIDS or the virus that causes AIDS?

CIRCLE ALL MENTIONED.

- A. NOTHING
- B. ABSTAIN FROM SEX
- C. USE CONDOMS
- D. LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER

- E. LIMIT NUMBER OF SEXUAL PARTNERS
- F. AVOID SEX WITH PROSTITUTES
- G. AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS
- H. AVOID INTERCOURSE WITH PERSONS OF THE SAME SEX
- I. AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY
- J. AVOID BLOOD TRANSFUSIONS
- K. AVOID INJECTIONS
- L. AVOID KISSING
- M. AVOID MOSQUITO BITES
- N. SEEK PROTECTION FROM TRADITIONAL HEALER
- O. AVOID SHARING RAZORS, BLADES
- W. OTHER _____
(SPECIFY)
- X. OTHER _____
(SPECIFY)
- Z. DON'T KNOW

Hand-washing Practices

26. Before we end, I'd like to ask one more question. When do you wash your hands with soap/ash?
DO NOT PROMPT. CIRCLE ALL MENTIONED.

- A. NEVER
- B. BEFORE FOOD PREPARATION
- C. BEFORE FEEDING CHILDREN
- D. AFTER DEFECACTION
- E. AFTER ATTENDING TO A CHILD WHO HAS DEFECCATED
- X. OTHER _____
(SPECIFY)

Appendix IV – Barrier Analysis Survey

Barrier Analysis Questionnaire on
--

[Topic]

[Age/Cultural/Gender Group]

Interviewer's Name: _____ Questionnaire No.: _____

Who was Interviewed:

Date: ____/____/____ Community: _____ GROUP: Doer NonDoer

Mother Tongue: _____ Language of Interview: _____

Age of respondent: ____ years Gender of Respondent: Male Female

Discuss CONFIDENTIALITY:

- **Purpose of study**
- **They can choose to participate or not participate in the study. No services will be withheld nor will they be discriminated against if they choose not to participate.**
- **Everything they say will be held in strict confidence and will not be shared with anyone else.**
- **Ask the person if they wish to participate. If not, thank them for their time.**

(Doer/NonDoer Screening Questions)

1. [Question to find out if they are doing the preventive action. This could be put at the beginning of the questionnaire if it's not a sensitive question.]

- a. Yes
- b. No
- c. Don't Know / Won't say

(IF [doing the behavior], ASK:)

2. [Question on "dose" of behavior (e.g., how many times in past week).]

- **If #1 = YES then mark the respondent as a DOER at the top of page one.**
- **If #1 is NO or Don't Know / Won't Say then mark the respondent as a NONDOER at the top of page one.**

(Perceived Severity)

3. How serious a disease/problem is [name of disease or problem]: Very serious, somewhat serious, a little bit serious, or not serious at all?

- a. Very serious
- b. Somewhat serious
- c. A little bit serious
- b. Not serious at all

(Perceived Susceptibility)

4. Do you think that [people in your group] can [get the disease]?

- a. Yes
- b. Possibly / sometimes
- c. No
- d. Don't Know

5. Do you think that [people in your group] can [get the disease] if they were to [not do the preventive action]?
- a. Yes
 - b. Sometimes / Possibly
 - c. No
 - d. Don't Know
6. Do you think that it's possible that **you** could [get the disease] if you [did not do the preventive action]?
- a. Yes
 - b. Possibly
 - c. No
 - d. Don't Know

(Perceived Self Efficacy)

7. With your present knowledge and skills, do you think that you could [do the preventive action] over the next 12 months?
- a. Yes
 - b. Possibly
 - c. No
 - d. Don't Know
8. What would make it **easier** (or does make it easier) for you to [do the preventive action] over the next 12 months?
9. What would make it **more difficult** (or does make it more difficult) for you to [do the preventive action] over the next 12 months?

(Perceived Action Efficacy)

10. Do you think [do the preventive action] over the next 12 months would help you to avoid getting [the disease]?
- a. Yes
 - b. Possibly
 - c. No
 - d. Don't Know

(Perceived Social Acceptability / Social Norms)

11. Would most of the people that you know approve of your [doing the preventive action] over the next 12 months?
- a. Yes
 - b. Possibly
 - c. No
 - d. Don't Know
12. Who are the people that **would approve** of your [doing the preventive action] over the next 12 months?
13. Who are the people that **would disapprove** of your [doing the preventive action] over the next 12 months?

(Cues)

14. If you wanted to [do the preventive action], how difficult would it be for you to remember to [do the preventive action] most of the time? Very difficult, somewhat difficult, a little bit difficult, or not difficult at all?
- a. Very difficult
 - b. Somewhat difficult
 - c. A little bit difficult
 - b. Not difficult at all

(Perception of Divine Will)

15. Do you think that **God approves** of [people in your group doing the preventive action]?
- a. Yes
 - b. Possibly / maybe
 - c. No
 - d. Don't Know
16. Do you think that **God approves (or would approve)** of you [doing the preventive action] over the next 12 months?
- a. Yes
 - b. Possibly / maybe
 - c. No
 - d. Don't Know

(Positive and Negative Attributes of the Action)

17. What are the **advantages** of (or would be the advantages of) your [doing the preventive action] over the next 12 months? ***(Write all responses below.)***
18. What are the **disadvantages** of (or would be the disadvantages of) of your [doing the preventive action] over the next 12 months? ***(Write all responses below.)***

THANK THE RESPONDENT FOR HIS / HER TIME!