Care Groups: A Training Manual for Program Design and Implementation was developed by Food for the Hungry (FH) and adapted by members of the Food Security and Nutrition (FSN) Network Care Groups Forward Interest Group and Social and Behavioral Change Task Force (SBCTF) and by World Relief (WR).

The Technical and Operational Performance Support (TOPS) Program is made possible by the generous support and contribution of the American people through the United States Agency for International Development (USAID). The contents of this training manual are those of the authors and do not necessarily reflect the views of USAID or the United States Government.

Recommended Citation

Food Security and Nutrition Network Social and Behavioral Change Task Force. 2014*. Care Groups: A Training Manual for Program Design and Implementation*. Washington, DC: Technical and Operational Performance Support Program.

About TOPS and the FSN Network

The TOPS Program, funded by the USAID's Office of Food for Peace (FFP), is strengthening the capacity of FFP grantees to deliver high quality and effective food aid by fostering collaboration, innovation, and knowledge sharing about improved food security and nutrition practices. TOPS supports the activities undertaken by the Food Security and Nutrition Network.

The FSN Network is an open community of practice of food security and nutrition implementers seeking to share information, shape agendas, understand and influence donor priorities, build consensus on promising practices, and widely diffuse technical knowledge.

Contact

Technical and Operational Performance Support Program
2000 L Street, NW
Washington, DC 20036
Email: the.tops.program@gmail.com
URL: www.fsnnetwork.org

Contents

Abreviations and Acronyms ..... **i**

Preface ..... **iii**

Objectives of the Care Group Training Manual iii

Planning for a Care Group Training iii

Acknowledgements iii

Getting Started ..... **iii**

Fitting This Training into a Broader Scheme 1

Identifying a Planning Team 1

Selecting Facilitators 1

Selecting Participants 1

Selecting a Location 1

Recommended Seating Arrangement 2

Conducting a Learning Needs and Resource Assessment (LNRA) 2

Preparing Materials, Supplies and Equipment 2

Care Group Training Sample Agenda 4

Lesson 1: Opening Session **5**

Steps 5

Lesson 1 Handout 1: Care Group Approach Training Objectives 8

Lesson 2: Introduction to Care Groups **9**

Facilitator's Notes 9

Steps 9

Lesson 2 Handout 1 and Flip Chart 1: Care Group Key Terms 15

Lesson 2 Handout 2: Care Group Diagrams 16

Lesson 2 Flip Chart 2: Care Group Calculations Game 17

Answer Key to Lesson 2 Flip Chart 2: Care Group Calculations Game 18

Lesson 2 Handout 3: Results from Care Group Operations Research 19

Lesson 2 Handout 4: Care Group Effectiveness 20

Lesson 2 Flip Chart 3: Undernutrition Happens Early 23

Lesson 2 Handout 5: Causes of Death in Children under 5 Years of Age 24

Lesson 3: Care Group Criteria **25**

Steps 25

Lesson 3 Handout 1: Care Group Program Criteria Worksheet 27

Lesson 3 Handout 2: Establishing Care Group Criteria 29

Lesson 3 Handout 3: Additional Facilitator's Notes on Care Group Program Criteria 34

Lesson 4: Using Formative Research to Strengthen Care Groups..... 42
Steps 42
Lesson 4 Handout 1: Barrier Analysis Description 45
Lesson 4 Handout 2: The Twelve Determinants of Behavior Change 48
Lesson 4 Handout 3: Example Behavior Statements and Determinants 50
Lesson 5: Organizing Communities into Care Groups and the Numbering System.....52
Steps 52
Lesson 5 Handout 1: Three Approaches to Forming Care Groups 59
Lesson 5 Handout 2: Key Questions for Forming Care Groups 61
Lesson 5 Handout 3: Community Map 62
Lesson 5 Flip Chart 1: Care Group Numbering System 63
Lesson 5 Flip Chart 2: Numbering System Practice Codes 64
Answer Key to Lesson 5 Flip Chart 2: Numbering System Practice Codes 65
Lesson 5 Handout 4: Numbers for the Numbering Game 66
Lesson 5 Handout 5: Making Sense of the Numbering System 67
Lesson 6: Care Group Roles, Responsbilities and Job Descriptions.....68
Facilitator's Notes 68
Steps 68
Lesson 6 Handout 1: The "Who's responsible?" Game 71
Answer Key to Lesson 6 Handout 1: The "Who's responsible?" Game 73
Lesson 6 Handout 2: Care Group Team Essential Responsibilities 75
Lesson 6 Flip Chart 1: Importance of Care Group Volunteer Qualities/Selection Guidelines 77
Lesson 6 Handout 3: Examples of Care Group Volunteer Qualities/Selection Guidelines 78
Lesson 7: Volunteer Motivation and Incentives.....79
Steps 79
Lesson 7 Handout 1: Programmatic Reasons to Keep Care Group Volunteers Motivated 83
Lesson 7 Handout 2 and Flip Chart 1: Three Volunteer Motivators 84
Lesson 7 Handout 3: Ideas for Ways to Help Volunteers Feel Connected, Valued and Effective 85
Lesson 8: Behavior Change and Care Groups: What Happens in a Care Group Meeting, Neighbor Group Meeting and Home Visit..... 87
Steps 87
Lesson 8 Handout 1: Example Modules and Lessons Outline 95
Lesson 8 Handout 2: Care Group and Neighbor Group Lesson Steps 96
Lesson 8 Handout 3: Facilitation Cues 97
Lesson 8 Handout 4: Bi-Monthly Training Meeting Structure 98
Lesson 8 Handout 5: Example Bi-Monthly Training Meeting Agenda 100

Lesson 9: Home Visits: The Audience, Timing and Content..... 101
Facilitator's Notes 101
Steps 102
Lesson 9 Handout 1: Purpose of a Home Visit 105
Lesson 9 Handout 2: Role Play: Steps in a Home Visit using the Negotiated Behavior Change Process 106
Lesson 9 Handout 3: Steps in Conducting a Home Visit 110
Lesson 9 Handout 4: Home Visit Role Play Scenarios 111
Lesson 10: The Meeting Schedule..... 112
Facilitator's Notes 112
Steps 112
Lesson 10 Flip Chart 1: Behavior Change Meeting (Learning Event) Table 115
Lesson 10 Handout 1: Behavior Change Meeting (Learning Event) Facilitation Responsibilities 116
Lesson 11 Flip Chart 2: Behavior Change Meeting (Learning Event) Table for the Training Puzzle Game 118
Lesson 11: Supportive Supervision: Checklists and Supervisory Work plans..... 119
Steps 119
Lesson 11 Flip Chart 1: Definition of Supportive Supervision 128
Lesson 11 Handout 1: Supervisor's Checklist for Supervising a Promoter 129
Lesson 11 Handout 2: Coordinator's Checklist for Supervising a Supervisor 133
Lesson 11 Handout 3: Manager's Checklist for Supervising a Coordinator 136
Lesson 11 Handout 4: Categories in the Supervisor's Checklist for Supervising Promoters 139
Lesson 11 Handout 5: Supportive Supervision Table 140
Lesson 11 Flip Chart 2: Blank Supportive Supervision Table 141
Lesson 11 Handout 6: Activities to Plan For 142
Lesson 11 Handout 7: Example Work Plans 143
Lesson 12: Quality Improvement and Verification Checklists (QIVCs) and Giving feedback.... 145
Facilitator's Notes 145
Steps 146
Lesson 12 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Meeting Facilitation 151
Lesson 12 Handout 2: Quality Improvement and Verification Checklist (QIVC) to Evaluate Positive Feedback 153
Lesson 12 Handout 3: Role Play Part 1: Meeting/Education Event 155
Lesson 12 Handout 4: Role Play Part 2: Giving Feedback 156
Lesson 12 Flip Chart 1: How to Score the Quality Improvement Verification Checklist (QIVC) 157
Lesson 12 Handout 5: Steps for Giving Feedback to Workers 158

Lesson 13: Calculating Scores and Using Data From the Quality Improvement and Verification Checklist (QIVC)..... 159

Steps 159

Lesson 13 Flip Chart 1: Individual and Program Performance Goals 164

Lesson 13 Flip Chart 2: Quality Improvement and Verification Checklist (QIVC) Score Calculations 165

Lesson 13 Handout 1: Analyzing Quality Improvement and Verification Checklist (QIVC) Scores 166

Answer Key to Lesson 13 Handout 1: Analyzing Quality Improvement and Verification Checklist (QIVC) Scores 167

Lesson 13 Flip Chart 3: Graph of Sarah's Care Group Volunteers 168

Lesson 13 Handout 2: Monitoring Quality Improvement and Verification Checklist (QIVC) Scores 169

Answer Key for Lesson 13 Handout 2: Analyzing Quality Improvement and Verification Checklist (QIVC) Scores 171

Lesson 13 Handout 3: Quality Improvement and Verification Checklist (QIVC) Scores for Six Promoters 174

Lesson 14: Care Group Monitoring Information System: Introduction to Registers..... 175

Facilitator's Notes 175

Steps 175

Lesson 14 Handout 1: Care Group Management Information System Information Sources 179

Lesson 14 Flip Chart 1 and Handout 2: Flow of Information in the Care Group Monitoring Information System 180

Lesson 14 Handout 3: Blank Care Group Register 181

Lesson 14 Handout 4: Example Completed Care Group Register 182

Lesson 14 Handout 5: Blank Neighbor Group Register 183

Lesson 14 Handout 6: Register Quiz 184

Answer Key to Lesson 14 Handout 6: Register Quiz 185

Lesson 15: Care Group Monitoring Information System: Promoter, Supervisor and Coordinator Reports..... 186

Facilitator's Notes 186

Steps 186

Lesson 15 Handout 1: Blank Promoter Report 193

Lesson 15 Handout 2: Blank Supervisor Report 195

Lesson 15 Handout 3: Blank Coordinator Report 197

Lesson 15 Handout 4: Example Completed Promoter Report 199

Lesson 15 Handout 5: Example Completed Supervisor Report 204

Lesson 15 Handout 6: Example Completed Coordinator Report 207

Lesson 15 Handout 7: Report Quiz 210

Answer Key to Lesson 15 Handout 7: Report Quiz 211

Lesson 16: Planning for Sustainability..... 212
Facilitator's Notes 212
Steps 212
Lesson 16 Flip Chart 1: A Definition of Sustainability 215
Lesson 16 Flip Chart 1: Categories of Sustainability 216
Lesson 16 Flip Chart 3: Aspects of Care Groups that Might be Sustained 217
Lesson 16 Handout 1: Examples of Improving Care Group Sustainability 218
Lesson 17: Planning for Care Groups..... 220
Facilitator's Notes 220
Steps 220
Lesson 17 Handout 1: Blank Care Group Planning Table 222
Lesson 17 Handout 2: Example Completed Care Group Planning Table 225
Lesson 18: Introducing the Care Group Approach to Others..... 228
Steps 228
Lesson 18 Handout 1: Example Talking Points about the Care Group Approach 231
Lesson 18 Handout 2: Delivering an Introductory Talk 232
Lesson 19: Training Closing..... 233
Steps 233
Appendix 1: Pre-/Post-Test..... 235
Answers to Pre-/Post-Test 237
Appendix 2: Learning Resource and Needs Assessment..... 238
Appendix 3: Training Feedback Forms..... 240
Daily Feedback Form: Evaluation for Day _____ 240
End of Training Feedback Form 241
Appendix 4: Care Groups Definition and Criteria..... 242
Appendix 5: Example Review Activities..... 249
Appendix 6: Curriculum Development and Overview..... 250
Part 1: Designing New Curriculum for Your Program 250
Part 2: Care Group Lesson Lists 253
Part 3: Considerations for using Another Organization's Materials for Your Program 256
Appendix 7: How to Hire Care Group Promoters..... 259
Appendix 8: Care Groups and the Preventing Malnutrition in Children Under 2 Approach (PM2A)..... 264
Appendix 9: Monitoring the Impact of Care Group Projects..... 267
Appendix 10: Care Groups and Low Social Capital Settings: The Example of Curamericas in Guatemala..... 275

Contents

Abreviations and Acronyms

AIDS	acquired immune deficiency syndrome
ARI	acute respiratory infection
BCC	behavior change communication
CDC	community development committee
CHW	community health worker
CG	Care Group
CGV	Care Group Volunteer
CL	community leader
CS	child survival
CSHGP	USAID Child Survival and Health Grants Program
DHS	Demographic and Health Survey
EBF	exclusive breastfeeding
EHA	Essential Hygiene Actions
ENA	Essential Nutrition Actions
FAQ	frequently asked question
FH	Food for the Hungry
FSN	Food Security and Nutrition (Network)
HIV	human immunodeficiency virus
HWWS	hand washing with soap
IMC	International Medical Corps
ITN	insecticide-treated bednet
KPC	Knowledge, Practices and Coverage (survey)
LNRA	Learning Needs Resources Assessment
LQAS	Lot Quality Assurance Sampling
M&E	monitoring and evaluation
MB	mother beneficiaries
MCHIP	Maternal and Child Health Integrated Program
MCHN	maternal and child health and nutrition
MOH	Ministry of Health
MPH	Masters in Public Health (degree)

NG	Neighbor Group
NGO	nongovernmental organization
NW	Neighbor Women
OR	operations research
ORS	oral rehydration solution
PEPFAR	U.S. President's Emergency Program for AIDS Relief
PLW	pregnant and lactating women
PM2A	Preventing Malnutrition in Children Under 2 Approach
PVO	private voluntary organization
QIVC	quality improvement and verification checklist
RHF	recommended home fluid
SBCTF	Food Security and Nutrition Networks Social and Behavioral Change Task Force
SBCWG	CORE Group Social & Behavioral Change Working Group
TOPS	Technical and Operational Performance Support (Program)
U.S.	United States
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WASH	water, sanitation and hygiene
WR	World Relief
WRA	women of reproductive age

Preface

Objectives of the Care Group Training Manual

This manual was developed as a training resource for designing, training, implementing and monitoring Care Group (CG) programs. It seeks to help CG approach implementers to clearly understand the structure of the CG approach, how to establish CGs, how to monitor the work of CGs and assess their impact, and how to maintain the quality of the approach through supportive supervision and quality control.

Planning for a Care Group Training

This training would be most useful if implemented after funds for the health program are secured and key health management personnel have been hired, but before community staff are hired. Certain lessons also could be used or adapted to train new staff or for staff refresher training to address weaknesses in the program discovered at midterm evaluation or at any time. When feasible, it might work best to do this training in shorter sessions to allow for better absorption and retention of the material. Certain lessons may not be needed for all groups.

Acknowledgements

This training manual was adapted from: M. Hanold, C. Wetzel, T. Davis, S. Borger, A. Cutherell, and M. DeCoster. 2012. *Care Groups: A Training Manual for Program Design and Implementation*. Washington, DC: Food for the Hungry.

This training manual was authored by Mitzi Hanold, Carolyn Wetzel, Thomas Davis, Jr., Sarah Borger, Andrea Cutherell, Mary DeCoster, Melanie Morrow and Bonnie Kittle.

Special acknowledgement goes to Dr. Pieter Ernst and World Relief (WR) for developing the Care Group model in 1995.

The authors also would like to acknowledge the Food Security and Nutrition (FSN) Network's community of practice members for their active and generous participation in reviewing, field testing, editing, writing annexes and contributing examples from their experience, including Mary Helen Carruth (Medical Teams International), Lisa Firth (Samaritan's Purse), Marianne Stone-Jimenez (Consultant), Todd Nitkin (Medical Teams International), Erin Pfeiffer (Food for the Hungry [FH]), Sarah Bauler (FH), Alexandra Rutishauser-Perera (International Medical Corps [IMC]), Jennifer Weiss (Concern, International), Jennifer Burns (IMC), Rob Broadhurst (medical student), Diane DeBernardo (formerly IMC), Marcus Catsam (Consultant), Adugne Kebede (World Vision), Elizabeth Arlotti-Parrish (ACDI/VOCA) and Debbie Dortzback (WR).

Special thanks go to Cindy Pfitzenmaier (Project Concern International), Sarah Bauler (FH) and Bonnie Kittle (consultant) for their active involvement in editing and pilot-testing the entire manual. TOPS wishes to acknowledge Rachel Elrom for her skillful editing and formatting of the document. Many thanks to all participants in the FSN Network's Care Groups Forward Interest Group for their strong interest, encouragement, suggestions and support for this project.

Lastly, TOPS sincerely thanks everyone who contributed to this important tool for improving social and behavior change programming around the world.

Getting Started

Fitting This Training into a Broader Scheme

This training is most useful as part of an organization's broader plan to support behavior change. Organizations should start by making sure that headquarters and field staff, managers and implementers are all familiar with the Care Group (CG) approach. Following training, staff at all levels can look for ways to integrate the concepts and tools into their work. For information about how to link the CG approach into a food security program, such as the Preventing Malnutrition in Children Under 2 Approach (PM2A), see **Appendix 8: Care Groups and the Preventing Malnutrition in Children Under 2 Approach (PM2A)**.

Identifying a Planning Team

This training requires a lot of planning, and you will find it helpful to have a team to handle many of the details. The planning team should include people who are:

- Familiar with the training materials and the CG approach
- Familiar with the participants (or organizations) that will be invited
- Knowledgeable about the training site

Selecting Facilitators

Workshop facilitators should have experience with the CG approach, supportive supervision and the quality improvement and verification checklist (QIVC), as well as adult education methodologies and participatory learning. Ideally, the ratio of facilitators to participants should be at least 1 to 10 to maximize facilitator-participant interaction, especially during group work. So, for a group of 20–25 participants, two co-facilitators are recommended.

Selecting Participants

This manual is intended for use by organizations that have already decided that CGs are the right approach for their program and context and by organizations that are considering the approach and want to learn more about the implementation process. The people who will benefit the most from this training include maternal and child health and nutrition (MCHN) program staff, including implementers, designers, technical staff and program managers.

For organizations that are unfamiliar with the CG approach and are still deciding if a training course is the appropriate next step, *The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Educators*, written by World Relief and published by the CORE Group in 2004, provides a very useful overview.

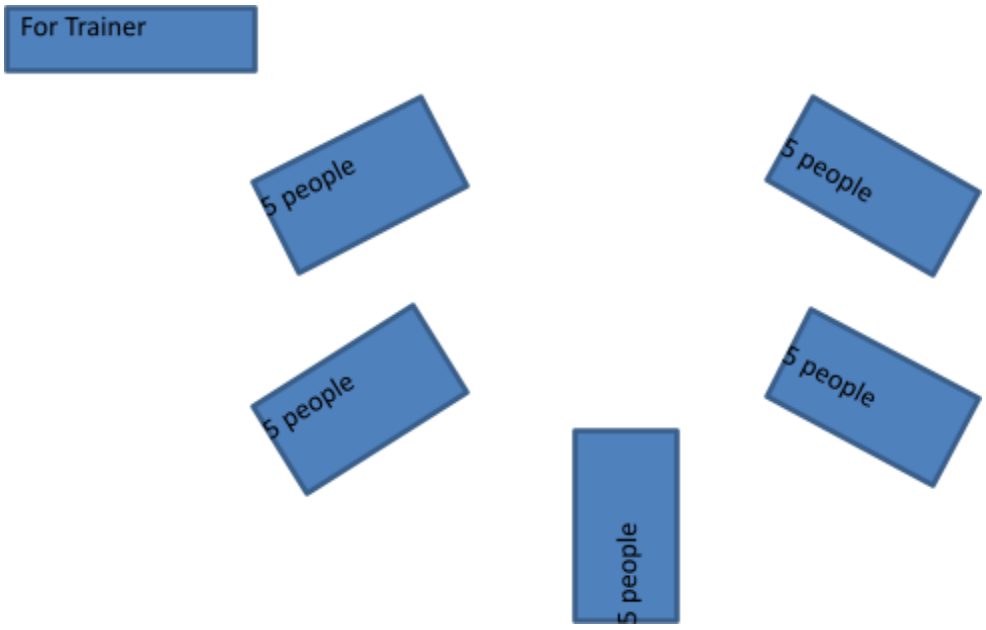
Selecting a Location

The workshop should be conducted in a comfortable setting, such as a conference room, that is large enough for plenary sessions and for small groups to work without disturbing each other, since participants will work in small groups for most of the tasks. Therefore, setting up small groups at

the beginning of the each day of training will ensure that participants are seated in a way that promotes maximum sharing, minimizes time spent reorganizing seating for small group work and enhances learning. To facilitate sharing and learning among participants, the trainer should devise different seating arrangements each day, or participants will sit in the same place each day.

Recommended Seating Arrangement

Front of Room with Flip Chart Stand



Conducting a Learning Needs and Resource Assessment (LNRA)

Workshop planners will benefit from learning about participants' experiences and interests before the workshop. Several weeks prior, send a set of questions to registered participants. Members of the workshop planning team may need to follow up with participants to encourage them to submit their responses. Share participant responses with all facilitators prior to the workshop. An example LNRA is provided in **Appendix 2: Learning Needs and Resource Assessment**.

Preparing Materials, Supplies and Equipment

Nearly all the materials you need to conduct the CG workshop are included in this manual, except for some flip charts and index cards that facilitators must prepare ahead of time. The checklists and materials lists found later in this section will help you prepare the necessary materials for the training.

The following is a list of supplies and equipment that should be available for the training.

Handouts to Copy

- 1 copy of this CG training manual per participant (ideally, but if that is not feasible, provide all the handouts for each of the lessons you will be including in the training)
- 2 copies of the Pre-/Post-Test (found in **Appendix 1**) per participant (can be copied double-sided)
- 1 copy of the workshop evaluation (found in **Appendix 3**) per participant (can be copied double-sided)

Supplies

- 1 reusable name tag per participant
- 2–3 pads of flip chart paper
- 1 flip chart stand
- 2 rolls of masking tape
- 1 stapler with staples
- 1 magic marker per participant
- 4 magic markers for each trainer (multiple colors, preferably wide-tipped)
- 1 small notepad per participant
- 1 pen per participant
- 1 pair of scissors
- 1 ream of copy paper
- 100 note cards or 3×5 cards (a couple of different colors, if available)
- Post-its (4–5 packs)

Equipment

- LCD projector and screen (optional)
- Printer that can be connected to a laptop (printer driver)
- 1–2 large garbage cans

Cell phone for training facilitatorServices

- Internet access
- Water, tea and coffee for the trainer and participants, especially during the two breaks
- Lunch, preferably in an area close to but not in the training room

Care Group Training Sample Agenda

DAY ONE

Lesson 1: Opening Session
Morning Break
Lesson 2: Introduction to Care Groups
Lunch
Lesson 3: Care Group Criteria
Afternoon break
Lesson 4: Using Formative Research to Strengthen Care Groups
End of the Day Evaluation
DAY TWO
Q&A from Day 1
Lesson 5: Organizing Communities into Care Groups and the Numbering System
Morning Break
Lesson 6: Care Group Roles, Responsibilities and Job Descriptions
Lunch
Energizer/Review
Lesson 7: Volunteer Motivation and Incentives
Afternoon Break
Lesson 8: Behavior Change and Care Groups: What Happens in a Care Group Meeting, Neighbor Group Meeting and Home Visit
End of Day Evaluation
DAY THREE
Q&A from Day 2
Lesson 9: Home Visits: The Audience, Timing, and Context (with Morning Break)
Lunch
Energizer/Review
Lesson 10: The Meeting Schedule
End of Day Evaluation

DAY FOUR
Q&A from Day 3
Lesson 11: Supportive Supervision: Checklists and Supervision Work Plans
Morning Break
Lesson 12: Quality Improvement and Verification Checklists (QIVCs) and Giving Feedback
Lunch
Energizer/Review
Lesson 13: Calculating Scores and Using Data from the Quality Improvement and Verification Checklist (QIVC)
Afternoon Break
Lesson 14: Care Group Monitoring Information System: Introduction to Registers
End of Day Evaluations
DAY FIVE
Q&A from Day 4
Lesson 15: Care Group Monitoring Information System: Promoter, Supervisor and Coordinator Reports
Morning Break
Lesson 16: Planning for Sustainability
Lunch
Energizer/Review
Lesson 17: Planning for Care Groups (Optional)
Afternoon Break
Lesson 18: Introducing the Care Group Approach to Others
Lesson 19: Training Closing

Lesson 1: Opening Session

Achievement-Based Objectives

By the end of this lesson participants will have:

- Discussed training expectations
- Begun to learn about the background and experience of others in the training
- Completed the pre-test

Duration

2 hours

Materials Needed

- Attendance sheet
- Name tags for each participant
- Pre-/Post-Test (available in Appendix 1)
- Lesson 1 Flip Chart 1: Getting to Know You
- Lesson 1 Flip Chart 2: Our Expectations
- Lesson 1 Handout 1: Care Group Approach Training Objectives
- Lesson 1 Flip Chart 3: Care Group Approach Training Schedule
- Lesson 1 Flip Chart 4: Care Group Approach Training Norms and Procedures
- Flip chart paper and markers

Steps

1. Welcome and Introduction to the Workshop

    1a. Explain that since the success of the project depends on people changing their behaviors, we need to use effective behavior change activities. One of the most effective behavior change activities is the Care Group (CG) approach. Many organizations have decided to use the CG approach to promote healthy behaviors, particularly those behaviors associated with reducing morbidity and mortality due to childhood malnutrition. The basic purpose of the workshop is to learn about the CG approach and how to implement it.

2. Collecting Baseline Information from the Participants

    2a. Explain that before we begin the workshop, we would like to collect some data using a pre-test so we can assess the effectiveness of the workshop when it is finished.

    2b. Pass out the pre-test, located in **Appendix 1**, or use one that you have developed. Give participants sufficient time to complete the pre-test, then collect it.

- Remind participants to put their names at the top of the paper.
- Ask them to circle "Pre-".
- Let participants know that the pre-test is a set of multiple-choice questions, and they should circle the letter of the one answer that they think best answers the question.

3. Introducing Participants

3a. Write some getting-to-know-you questions on **Lesson 1 Flip Chart 1: Getting to Know You**, such as the participant's name, organization, country (if at a regional workshop), workplace, prior experience working with CGs and one thing they want to learn about CGs.

Note: This is an opportunity to collect additional information from the participants that you may need for the training. You can also ask "silly" information (such as favorite color, birth month, or height) that you can use each day as a way to organize seating arrangements so that the trainees are seated with different people each day. Add these types of questions to the flip chart.

3b. Use a creative way to pair up each participant with someone he/she does not know, and ask each pair to interview each other about the getting-to-know-you questions on the flip chart. Tell participants to write down the responses on a sheet of paper.

3c. Then ask each participant to introduce the person he/she met to the rest of the workshop participants and facilitators.

4. Expectations

4a. Show **Lesson 1 Flip Chart 2: Our Expectations**.

Note: Facilitators should review the expectations from the Learning Needs and Resources Assessments (LNRAs) prior to the start of the training so that any expectations listed by participants in the LNRAs can be included in this flip chart.

4b. Ask a volunteer to read the flip chart.

4c. Ask participants if they want to add any other expectations to the list.

5. Training Objectives

5a. Review **Lesson 1 Handout 1: Care Group Approach Training Objectives**.

5b. Point out any of the expectations listed on Lesson 1 Flip Chart 2 that probably will NOT be met during this training.

6. Training Schedule

    6a. Before the training begins, adjust the sample agenda found earlier in this manual to fit the scheduled days, dates and times of your training, as necessary, and write it on **Lesson 1 Flip Chart 3: Care Group Approach Training Schedule**.

    6b. Show the flip chart to participants and review it with them. Discuss any logistical issues, such as per diem, breaks and meals.

7. Learning Norms and Procedures

    7a. Brainstorm with the group the norms and procedures the group wants to follow to create the best learning environment. Record these on **Lesson 1 Flip Chart 4: Care Group Approach Training Norms and Procedures**.

8. Roles of the Facilitators

    8a. Mention that many people may want to replicate the training for their colleagues. Ask that participants who intend to replicate this workshop raise their hands.

    8b. Explain that the facilitators will be modeling the Learning-Centered Adult Education (Vella) methodology during this workshop, and from time to time they will be making comments specifically about facilitation techniques that participants may find helpful to use when they replicate the training.

9. Asking Questions during the Training

    9a. Set up a flip chart entitled “Parking Lot” for any questions that might arise at any point during the training, and let participants know its purpose.

    9b. Ask participants to set aside a page near the back of their notepads and label it “Ideas to Remember”. Suggest that they use this sheet to write down any ideas that come up throughout the training.

Lesson 1 Handout 1: Care Group Approach Training Objectives

Achievement-Based Objectives

By the end of this training, participants will have:

- Analyzed the structure of the Care Group (CG) approach
- Examined the criteria for CGs (what is or is not part of the CG approach)
- Identified the steps in a CG meeting
- Identified ways to use formative research in the CG approach
- Practiced using data from quality improvement and verification checklists (QIVCs)
- Examined tools used to monitor the work and impact of the CG approach

Lesson 2: Introduction to Care Groups

Achievement-Based Objectives

By the end of this lesson participants will have:

- Analyzed why Care Groups (CGs) are so effective
- Diagrammed the structure of a CG

Duration

2 hours

Materials Needed

- Flip chart paper, index cards and markers
- 1 printed copy of World Relief (WR)'s 2004 publication *The Care Group Difference*, downloaded from http://www.coregroup.org/storage/documents/Diffusion_of_Innovation/Care_Manual.pdf
- Optional: Projector and laptop to play the CG video
- Lesson 2 Handout 1 and Flip Chart 1: Care Group Key Terms
- Lesson 2 Handout 2: Care Group Structure Diagrams
- Lesson 2 Flip Chart 2: Care Group Calculations Game
- Answer Key to Lesson 2 Flip Chart 2: Care Group Calculations Game
- Lesson 2 Handout 3: Results from Care Group Operations Research
- Lesson 2 Handout 4: Care Group Efficacy
- Lesson 2 Flip Chart 3: Undernutrition Happens Early
- Lesson 2 Handout 5: Causes of Death in Children under 5 Years of Age

Facilitator's Notes

If participants are still trying to decide if the CG approach is right for them, the activities in Steps 5–8 would be relevant. If they are already implementing the CG approach or have already decided to implement CGs, those activities will be less relevant.

Steps

1. Introduction

    1a. Tell participants that the main objective of this training is to help them understand CGs and how to implement the CG approach.

    1b. Ask participants: How many of you have already had experience working on a project that used the Care Group approach? How many of you have read or heard about the approach before?

2. What are Care Groups?

   2a. Ask participants: What have you heard about Care Groups? As they respond, write their ideas on flip chart paper. Add the following points if participants do not mention them:

   - The CG approach is a community-based strategy for promoting behavior change.
   - Dr. Pieter Ernst and WR/Mozambique developed the Care Group approach in 1995. Since then, WR and Food for the Hungry (FH) have pioneered and championed the approach.
   - The CG approach is now used by at least 24 organizations in 21 countries.
   - A CG is a group of 10–15 community-based volunteers that regularly meet together with project staff for training and supportive supervision.
   - CGs are different from typical mother's groups in that each volunteer is responsible for regularly meeting with 10–15 of her neighbors, sharing what she has learned and facilitating behavior change at the household level.
   - CGs create a multiplying effect and equitably reach every beneficiary household through neighbor to neighbor peer support using interpersonal behavior change activities. Behavior change is enhanced through peer support, resulting in the creation of new community norms.
   - Care Group Volunteers (CGVs) provide greater peer support to one another, develop stronger commitments to health activities and find more creative solutions to challenges by working as a group compared to individual volunteers expected to work independently.
   - CGs provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits.

   2b. For more information, encourage participants to refer to *The Care Group Difference*, published by WR in 2004. Have one printed copy available for them to see during breaks.

   2c. Also encourage participants to visit www.caregroupinfo.org for a wide variety of resources on CGs.

3. The Care Group Approach and Structure

   3a. Refer participants to **Lesson 2 Handout 1 and Flip Chart 1: Care Group Key Terms** and display the flip chart. Explain that though many organizations have given different names to the different groups/people, Lesson 2 Handout 1 shows the terms that we will be using throughout the training. Review each term with participants.

   3b. Using index cards of different colors, sizes and shapes, create a diagram of a typical CG structure on the wall in the front of the room that follows **Lesson 2 Handout 2: Care Group Structure Diagrams**.

3c. As you place the cards, say the name of each staff member/volunteer and his/her main role (for example, the Coordinator supervises 3–6 Supervisors), as shown in Lesson 2 Handout 1. Engage participants who have prior experience/knowledge of the approach. Emphasize that CGs are a behavior change activity. Be sure to point out which people are typically paid staff and which are volunteers.

3d. After explaining the staffing structure of the CG approach, briefly explain the main responsibilities of each person, including training, supervision, behavior change meetings with Promoters and behavior change meetings with Neighbor Women (NW).

3e. Once the full diagram is on the wall, ask the participants what questions they have about the CG approach and respond. If a particular topic will be covered in depth in a later lesson, defer discussion of those points until later.

4. Activity: The Care Group Calculations Game

4a. Divide participants into pairs. Ask each pair to calculate how many mothers they would reach given the different scenarios listed in **Lesson 2 Flip Chart 2: Care Group Calculations Game**. Answers can be found in **Answer Key to Lesson 2 Flip Chart 2: Care Group Calculations Game**.

5. Activity: Alternative Care Group Diagram

5a. Give out markers and a sheet of flip chart paper to each small group.

5b. Ask the groups to draw their own representations of the CG model in one village, using the following breakdown (or another breakdown devised by the facilitator).

- 5 CG Promoters
- 6 CGs per Promoter
- 10–15 CGVs per CG
- 10–15 NW per CGV

5c. Ask participants to diagram this in a different way than what is shown in Lesson 2 Handout 2.

6. Optional: How effective are Care Groups?

6a. Give participants copies of **Lesson 2 Handout 4: Care Group Effectiveness**. Say: Here's the best proof I've seen of the effectiveness of Care Groups.

6b. Go through some of these points, depending on the comfort level of the participants with graphs and charts.

6c. Direct participants to Figure One, and share with them the following.

- On this figure, we have compared how child survival projects perform on 14 different Rapid CATCH indicators.[1] One of these is an impact indicator (underweight), but most are results-level behavioral indicators or coverage indicators.
- The bars show the amount of gap closure for each indicator. For example, if you started at 20% exclusive breastfeeding, or EBF, and increased that to 40%, you would have closed 20 of 80 possible percentage points, or 25% gap closure (20 ÷ 80 = 25%). Looking at gap closure is one of the best ways to compare performance across projects.
- The blue bars show the average indicator gap closure for each of these indicators for 58 child survival projects ending between 2003 and 2009 that did not use Care Groups.
- The tan bars show the average indicator gap closure for each of these indicators for nine Care Group projects. What can you see about the difference? (Wait for answers.)
- Care Groups projects out-performed the average child survival project in terms of indicator gap closure on all indicators except hand washing with soap, or HWWS where there was a slight non-significant difference. The average gap closure was in the 35 to 70% range for the nine Care Group projects as compared with 25 to 45% with all the other Child Survival and Health Grants Program, or CSHGP, projects.
- There were only nine Care Group projects to compare to, but the difference between those nine projects and the 58 other projects is statistically-significant for EBF.
- So what this shows is that Care Groups are outperforming the other methods we generally use for behavior change.

6d. Direct participants to Figure Two, and share with them the following.

- In case you might think that these results are atypical, here's a graph showing the estimated mortality reduction in 13 CSHGP-funded Care Group projects in eight different countries.
- The average estimated reduction in under-5 mortality was 30% in Care Group projects. This is almost double what non-Care Group projects often achieve.
- Most of these are 5-year projects. We see this as compelling evidence that these Care Group Volunteers, coached and trained by paid community health workers or Promoters, make a dramatic difference.

6e. Direct participants to Figure Three, and share with them the following.

- Figure Three shows performance of World Relief's Care Group project in Cambodia, represented by the gold bars, compared to the other Care Group

[1] Rapid CATCH indicators are a set of priority health indicators, as defined by the U.S. Agency for International Development (USAID), for their Child Survival and Health Grants Program (CSHGP) portfolio.

projects represented by blue bars and non-Care Group projects represented by tan bars.

- The Care Group model in Cambodia showed even better performance than in other countries in Latin America and the Caribbean, Asia and Africa, even in hand washing. In Asia, for example, Care Groups have been used in Cambodia, Indonesia and the Philippines. This was despite an initial strong concern by World Relief national staff that the model would not be effective in their context.
- Staff in Cambodia were concerned that women would not agree to work as volunteers, but this was not a problem in the project, and they saw some of their best results to date.

6f. Ask the group: Why do you think Care Groups are so effective? Write this information on a flip chart, and keep it posted for the remainder of the training. If participants do not mention any of the following, add them to the flip chart: multiplied effort, complete coverage, mother-to-mother support, peer motivation, changed communities, cost effectiveness, sustainability, and behavior change in a large part of community, reduced child death and malnutrition.

7. Activity: Why do some Care Groups focus on pregnant women and children under 2 or on the first 1,000 days?

7a. Tell participants: Some CGs focus on pregnant women and mothers of children under 2, also known as the first 1,000 days.

7b. As participants: Why do you think it would be important to focus on this age group?

7c. Ask participants to discuss this question in small groups and then report back. Write correct answers on a flip chart, and add the following points if participants do not mention them.[2]

- The 1,000 days between the beginning of a woman's pregnancy and her child's 2nd birthday offer a unique window of opportunity. The right nutrition during this 1,000-day window can have a profound impact on a child's ability to grow, learn and rise out of poverty. It can also shape a society's long-term health, stability and prosperity.
- For infants and children under 2, the consequences of undernutrition are particularly severe, often irreversible**.**
- During pregnancy, undernutrition can have a devastating impact on the healthy growth and development of a child. Babies who are malnourished in the womb have a higher risk of dying in infancy and are more likely to face lifelong cognitive and physical deficits and chronic health problems.
- For children under 2, undernutrition can be life threatening. It can weaken a child's immune system and make him or her more susceptible to dying from common illnesses such as pneumonia, diarrhea and malaria.

[2] This information comes from The First 1000 Days Initiative (http://www.thousanddays.org/about/).

7d. Show and explain to participants the graph on undernutrition found in **Lesson 2 Flip Chart 3: Undernutrition Happens Early**. Note to participants that this graph dramatically illustrates the importance of early childhood nutrition.

Project Coverage and Focusing on Women of Reproductive Age (WRA)

When Dr. Pieter Ernst of WR developed the CG approach he expected to reach all women of reproductive age (WRA). Why, then, do some projects narrow the scope to pregnant women and mothers of children under 2? This may be due to grant funding requirements or it could potentially lower costs, thus allowing for a larger project area with the same budget and for an immediate focus on the most vulnerable. On the other hand, this could actually increase costs by complicating the identification and enrollment of participating households. It also can make early identification of pregnant women more difficult.

In any case, aim to reach and enroll 100% of targeted households, and do not fall into the trap of only reaching the 80% who are easiest to reach because you will miss the most vulnerable. 100% coverage of WRA is still the ideal.

8. Activity: Why do Care Groups focus on household behaviors?

8a. Give participants copies of **Lesson 2 Handout 5: Causes of Death in Children under 5 Years of Age**. While at their tables or in small groups, ask participants to spend 10 minutes looking at the diagram and discussing what it means.

8b. After 10 minutes, request a volunteer to share ONE group's interpretation. Mention the following points if the volunteer does not.

- The diagram shows the proportion of all under 5 deaths that could be prevented with a specific intervention.
- 57% of under 5 deaths could have been prevented with interventions that rely on household behavior change, including behaviors related to breastfeeding; using insecticide-treated material; complementary feeding; clean delivery; water, sanitation and hygiene (WASH); newborn temperature management; and consuming zinc, vitamin A and oral rehydration solution (ORS).

8c. Ask participants to share questions they have about why CGs focus on the first 1,000 days and household behavior change.

9. Wrap Up

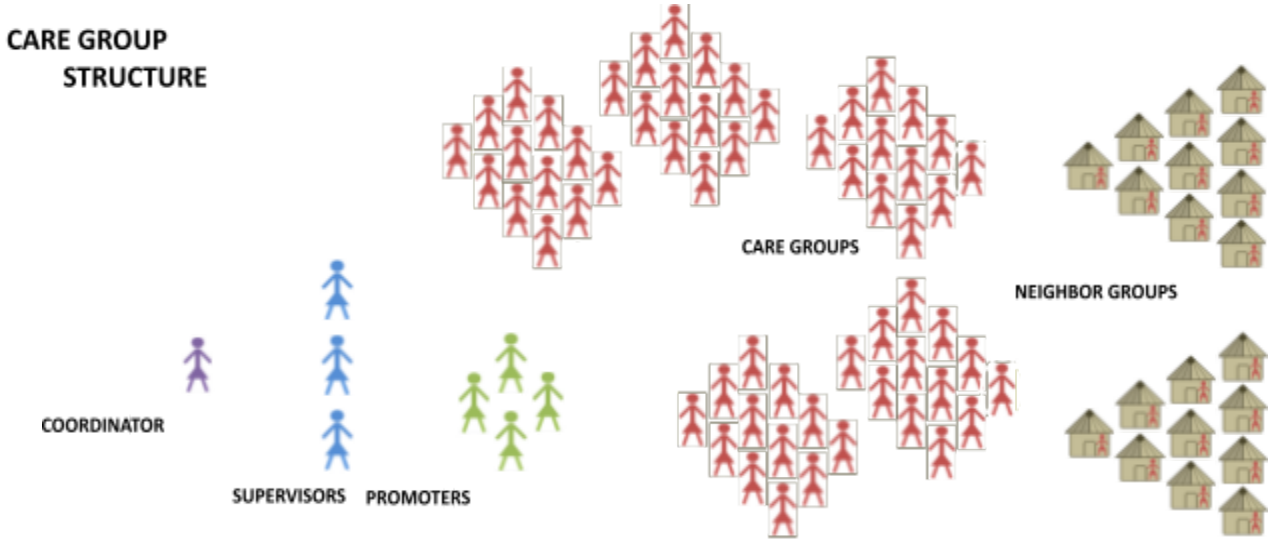
9a. Thank the group for their comments.

9b. Tell participants: Now that we have a better idea of the structure of Care Groups and what makes them effective, we are going to discuss how you should plan for implementing the Care Group approach.

Lesson 2 Handout 1 and Flip Chart 1: Care Group Key Terms

Term	Description
Care Group (CG)	A group of 10–15 Care Group Volunteers (CGVs) led by a Promoter
Care Group Volunteer (CGV)	Volunteers who meet with the Promoter Usually nominated for that position by the Neighbor Women (NW)
Promoter	A community member hired to train and supervise the CGVs in their community
Supervisor	Hired to directly supervise and train Promoters in each community and to monitor the CG program
Coordinator	Hired to directly supervise Supervisors and monitor the CG program Reports to the project manager
Neighbor Group (NG)	A group of 10–15 women that meets with the selected CGV The CGV shares new health lessons with them every 2 weeks as a group or individually (through home visits)
Neighbor Women (NW)	Women in the NG who meet with the CGV once every 2 weeks to hear a new health lesson
Supportive supervision	A process of observation and feedback from each successive level in the CG approach that contributes to strong and mutually respectful working relationships, builds skills and productivity, and creates a sense of unity in working together toward common goals
Pregnant and lactating women (PLW)	The primary beneficiaries of the CG approach Aim to make sure that all or nearly all PLW are part of a CG structure (usually as NW or CGVs)
Quality improvement and verification checklist (QIVC)	A monitoring tool focused on improving the quality of a worker's performance Assesses how a worker carries out various aspects of his/her job, such as a CG meeting Seeks to encourage workers, improve his/her performance and monitor progress Results of several QIVCs used to identify "system problems"

Lesson 2 Handout 2: Care Group Diagrams



Each **Coordinator** (paid staff) is responsible for 3–6 Supervisors.

A project may hire multiple Coordinators (overseen by a **Manager**) if needed to meet the desired coverage.

ervisor (paid staff) is responsible for 4–6 Promoters.

moter (paid staff) supports 4 to 9 Care Groups.

re Group has 10–15 Care Group Volunteers that are elected by Neighbor Group members.

are Group Volunteer shares lessons with 10–15 **Neighbor Women** and their families, known as a **Neighbor Group**. (There is a maximum of 15 Neighbor Women in each Neighbor Group.)

Each Promoter reaches about 500 to 1,200 women.

Lesson 2 Flip Chart 2: Care Group Calculations Game

How many mothers would be reached in each scenario?

1. 30 Promoters, 6 CGs per Promoter, 10 CGVs per CG, 12 NW per CGV
2. 15 Promoters, 5 CGs per Promoter, 10 CGVs per CG, 10 NW per CGV
3. 3 Promoters, 7 CGs per Promoter, 12 CGVs per CG, 12 NW per CGV
4. 20 Promoters, 5 CGs per Promoters, 8 CGVs per CG, 9 NW per CGV
5. 18 Promoters, 6 CGs per Promoters, 11 CGVs per CG, 10 NW per CGV

Answer Key to Lesson 2 Flip Chart 2: Care Group Calculations Game

1. 30 x 6 x 10 = 1,800 CGVs
   1,800 x 12 = 21,600 NW
   1,800 CGVs + 21,600 NW = 23,400 mothers total (remember that CGVs are mothers, too)

2. 750 CGVs + 7,500 NW = 8,250 mothers

3. 252 CGVs + 3,024 NW = 3,276 mothers

4. 800 CGVs + 7,200 NW = 8,000 mothers

5. 1,188 CGVs + 11,880 NW = 13,068 mothers

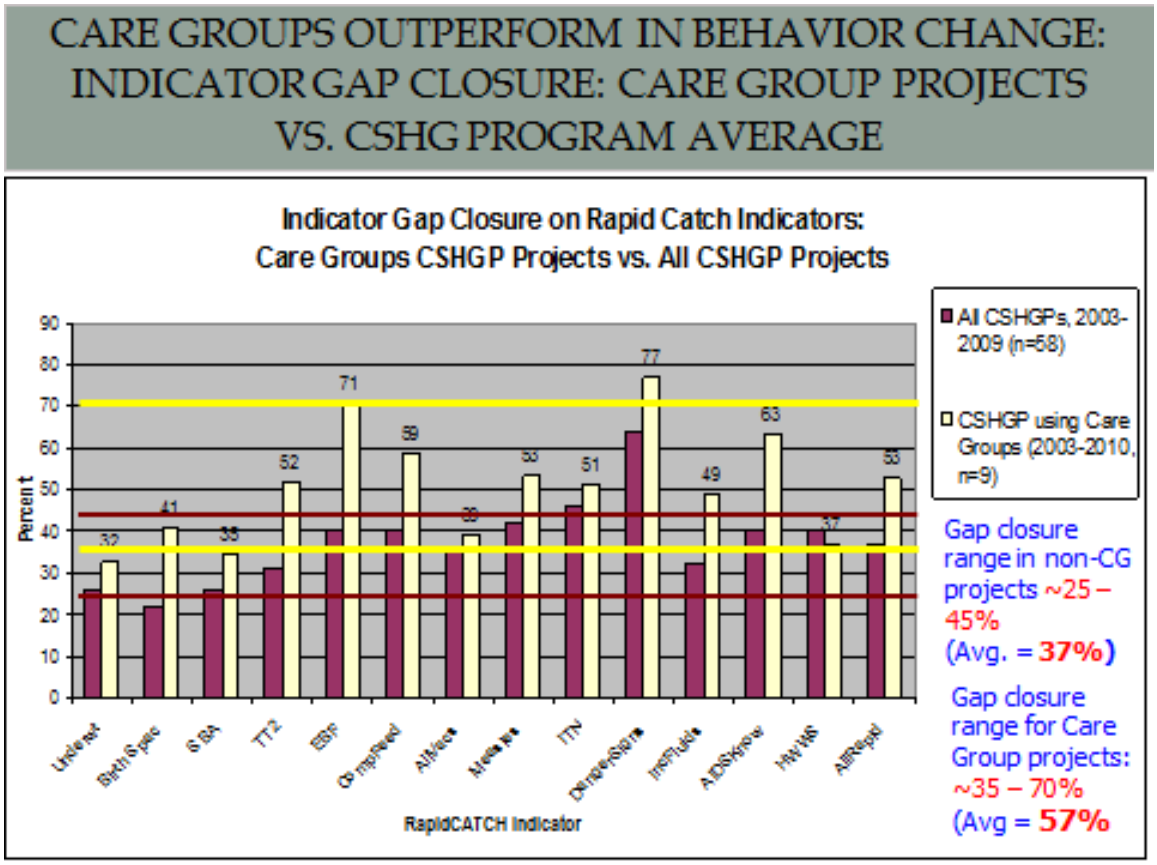
Lesson 2 Handout 3: Results from Care Group Operations Research[3]

% of Care Group Volunteers (CGVs) who say they have gained more respect from [each group listed below] since they began participating in the project	% of CGVs
… from health facility personnel	25
… from their extended family	41
… from their parents or husbands' parents	48
… from their husbands	61
… from their community leaders	64
… from other women/mother beneficiaries	100
% of CGVs who say that it is okay for a husband to hit his wife if he is not satisfied with her (final level shown; baseline was ~64%)	3

[3] C. Wetzel and T. Davis, Jr. *Results of Care Group Operational Research conducted April to May 2010 as part of the project: Achieving Equity, Coverage, and Impact through a Care Group Network*. Funded by USAID, Cooperative Agreement: GHS-A-00-05-00014-00. Operations research conducted in Sofala Province, Mozambique. Lot Quality Assurance Sampling used to sample CGVs. Questionnaire developed by Food for the Hungry (FH) to gather data on motivation for volunteering.

Lesson 2 Handout 4: Care Group Effectiveness

Figure One



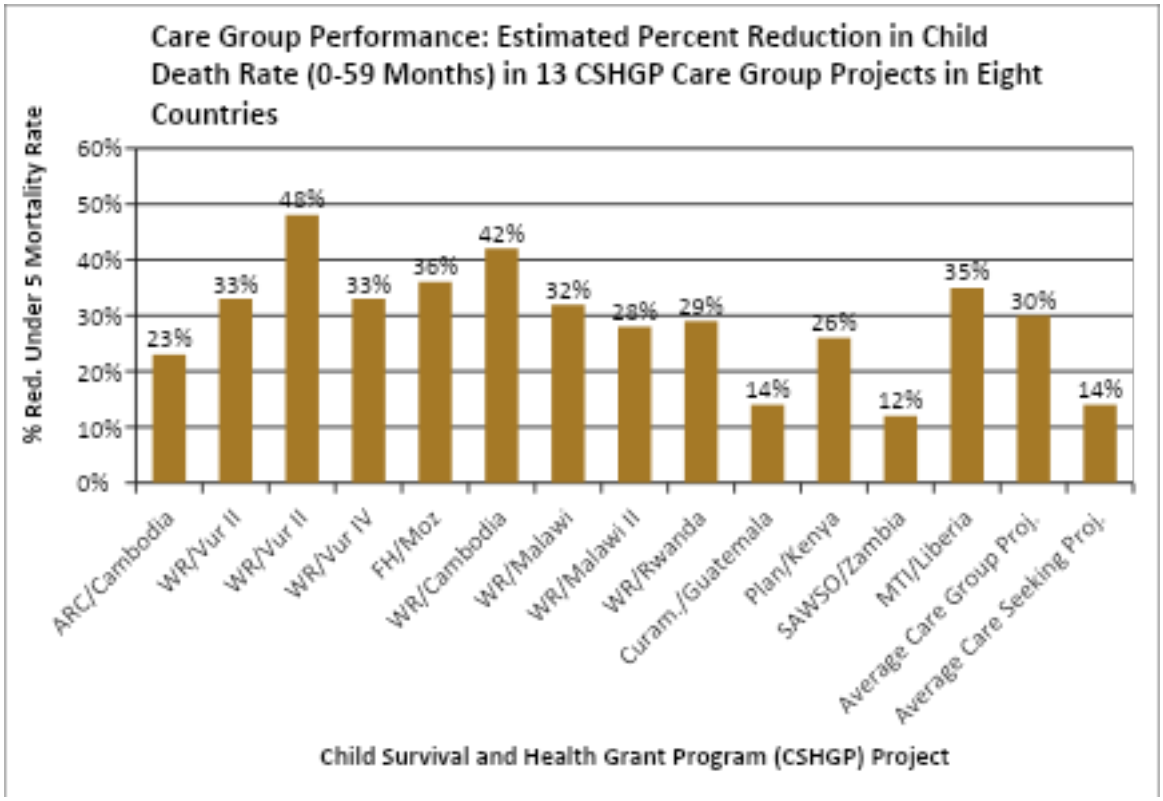
Notes:

- The U.S. Agency for International Development (USAID)'s Child Survival and Health Grants Program (CSHGP) has supported community-oriented health projects implemented since 1985. The purpose of this program is to contribute to sustained improvements in child survival and health outcomes by supporting the innovations of private voluntary organizations (PVOs) and nongovernmental organizations (NGOs) and their in-country partners in reaching vulnerable populations.
- Rapid CATCH Indicators are priority health indicators as defined by USAID for the CSHGP portfolio. For a full list of Rapid CATCH indicators and their definitions, please see: http://mchipngo.net/controllers/link.cfc?method=tools_kpc.
- Acronyms used above include:
  - SBA: skilled birth attendant
  - TT2: two tetanus toxoid vaccines
  - EBF: exclusive breastfeeding

  - All Vacs: youngest child received all childhood vaccines
  - ITN: child slept under insecticide-treated bednet last night
  - Danger Signs: maternal knowledge of child danger signs
  - AIDS Know: maternal knowledge of HIV risk reduction
  - HWWS: Hand washing with soap

- For the complete definition of indicators, please see: http://mchipngo.net/controllers/link.cfc?method=tools_mande.
- Data are drawn from final evaluations from all CSHGPs that ended between 2003 and 2010 (reported and collated by Maternal and Child Health Integrated Program [MCHIP]).
- Gap closure refers to "closing the gap" between indicators at the beginning of a program and how much that indicator improved. For example, if you started at 20% exclusive breastfeeding (EBF) and increased to 40%, you would have closed 20 (40 - 20 = 20) of the 80 possible percentage points, or 25% gap closure (20 ÷ 80 = 25%). Looking at gap closure is a useful way to compare performance across projects.

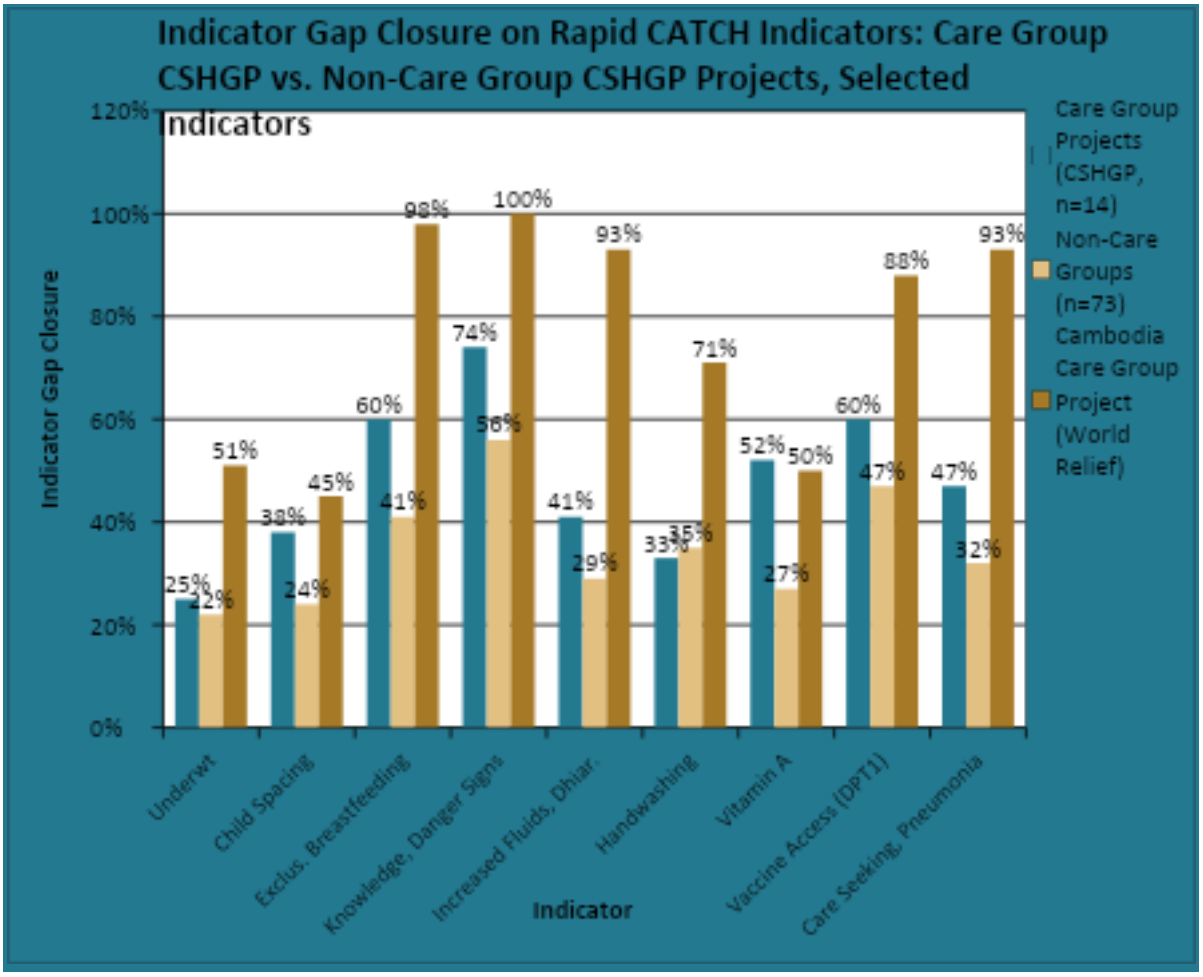
Figure Two



Notes:

- Data were drawn from final evaluations from all CSHGPs that ended between 2003 and 2010. Mortality was estimated using LiST: the Lives Saved Tool, an evidence-based tool for estimating intervention impact created by the Johns Hopkins Bloomberg School of Public Health (available at http://www.jhsph.edu/dept/ih/IIP/list/index.html).
- All LiST calculators used for this study are publically posted at http://www.caregroupinfo.org/docs/PVO_Lives_Saved_Calculators_Bellagio.zip.

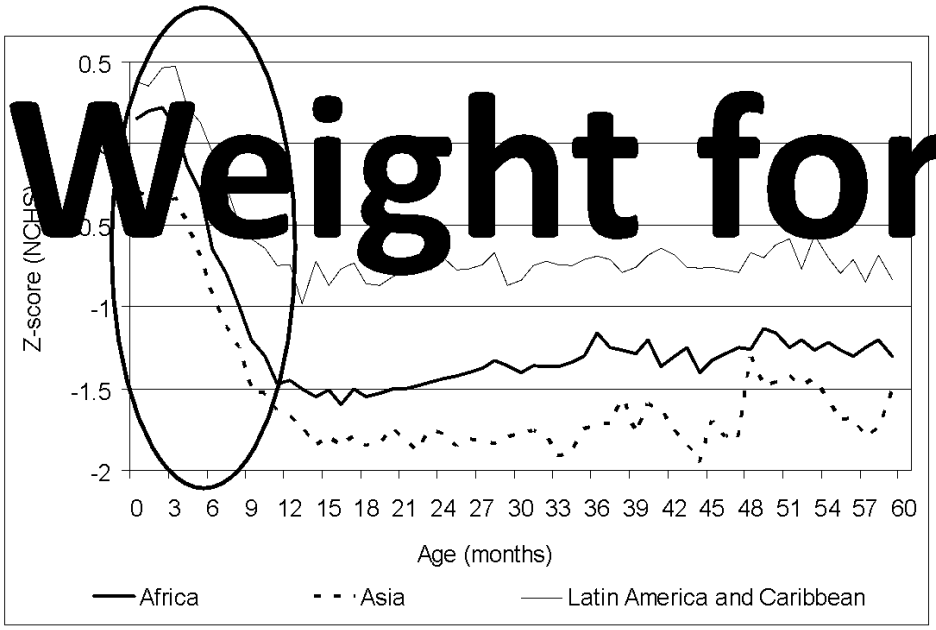
Figure Three



Notes:

- Figure Three shows performance of World Relief (WR)'s CG project in Cambodia (gold bars) as compared with other CG (blue bars) and non-CG (tan bars) projects.
- The CG model in Cambodia showed even better performance than in other Latin American and the Caribbean, Asian and African countries, even in hand washing, despite an initial strong concern by WR national staff that the model would not be effective in their context. In Asia, CGs have been used in Cambodia, Indonesia and the Philippines.

Lesson 2 Flip Chart 3: Undernutrition Happens Early[4]



Notes:

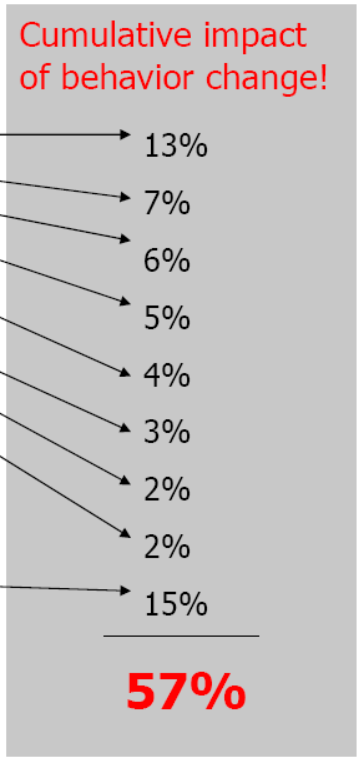
- This graph shows how infant growth drops off dramatically (and very similarly) after about 3 months of age.
- This underscores the importance of working with pregnant and lactating women (PLW) to reduce infant malnutrition and promote exclusive breastfeeding (EBF) in the first 6 months, appropriate complementary feeding, good hand washing and prevention of illnesses from exposure to contaminated food and water.

[4] Roger Shrimpton, Cesar G. Victora, Mercedes de Onis, Rosângela Costa Lima, Monika Blössner, and Graeme Clugston. 2001. Worldwide Timing of Growth Faltering: Implications for Nutritional Interventions. *Pediatrics*, Vol. 107, No. 5. Available at http://www.who.int/nutgrowthdb/publications/growth_faltering.pdf.

Lesson 2 Handout 5: Causes of Death in Children under 5 Years of Age[5]

Table 2: **Under-5 deaths that could be prevented in the 42 countries with 90% of worldwide child deaths in 2000 through**

	Estimated under-5 deaths prevented	
	Number of deaths (~10^3)	Proportion of all deaths
Preventive interventions		
Breastfeeding	1301	13%
Insecticide-treated materials	691	7%
Complementary feeding	587	6%
Zinc	459(351)*	5% (4%)*
Clean delivery	411	4%
Hib vaccine	403	4%
Water, sanitation, hygiene	326	3%
Antenatal steroids	264	3%
Newborn temperature management	227(0)*	2% (0%)*
Vitamin A	225(176)*	2% (2%)*
Tetanus toxoid	161	2%
Nevirapine and replacement feeding	150	2%
Antibiotics for premature rupture of membranes	133(0)*	1% (0%)*
Measles vaccine	103	1%
Antimalarial intermittent preventive treatment in pregnancy	22	<1%
Treatment interventions		
Oral rehydration therapy	1477	15%
Antibiotics for sepsis	583	6%
Antibiotics for pneumonia	577	6%
Antimalarials	467	5%
Zinc	394	4%
Newborn resuscitation	359(0)*	4% (0%)*
Antibiotics for dysentery	310	3%
Vitamin A	8	<1%



Notes:

- The diagram shows the proportion of all deaths of children under 5 years of age that could be prevented with a specific intervention.
- 57% of under-5 deaths could have been prevented with interventions that rely on household behavior change, including breastfeeding; insecticide-treated material; complementary feeding; zinc supplementation; clean delivery; water, sanitation and hygiene (WASH); newborn temperature management; vitamin A; and oral rehydration solution (ORS).
- The Care Group (CG) approach works to change the household practices that can dramatically reduce these preventable deaths.

[5] G. Jones, R. Steketee, Z. Bhutta, S. Morris, and the Bellagio Child Survival Study Group. 2003. How many child deaths did we prevent this year? *The Lancet* 362: 65–71.

Lesson 3: Care Group Criteria

Achievement-Based Objectives

By the end of this lesson participants will have:

- Identified the criteria of the Care Group (CG) model
- Listed reasons why each of the three CG criteria are important

Duration

2 hours

Materials Needed

- Lesson 3 Handout 1: Care Group Program Criteria Worksheet
- Lesson 3 Handout 2: Establishing Care Group Criteria
- Lesson 3 Handout 3: Additional Facilitator's Notes on Care Group Program Criteria

Steps

1. Introduction

    1a. Tell participants: Now that you have learned the structure of the Care Group approach and become familiar with the terms associated with the Care Group model, we need to look more carefully at what distinguishes the Care Group approach from other behavior change models that might, at first glance, seem to be the same.

    1b. Ask participants: What other models have you seen or heard of that seem to have similar structures or criteria to the Care Group model? Answers could include mother-to-mother support groups, youth peer groups and other.

2. Care Group Criteria

    2a. Explain to participants: While it is true that Care Groups may seem similar to other approaches, the Care Group model has been studied and modified since its creation in 1995 to make it as effective as possible. During that time certain criteria of the approach have been shown to be critical to its effectiveness. This means that for everyone who uses the Care Group approach to have the same results, each group needs to be aware of the critical features. In this lesson we are going to identify those critical Criteria and explain why they are so important.

    2b. Refer participants to **Lesson 3 Handout 1: Care Group Program Criteria Worksheet**. Explain that in the first column are some of the criteria that Food for the Hungry (FH) and World Relief (WR) consider to be critical to the effectiveness of the CG approach. Give the participants 3 minutes to review these. PLEASE NOTE THAT FOR THIS EXERCISE, NOT ALL CRITERIA ARE CONSIDERED. The full list of criteria is provided in **Lesson 3 Handout 2: Establishing Care Group Criteria** and in **Appendix 4: Care Groups Definition and Criteria**.

2c. Assign each small group three to five criteria to review. Instruct participants to fill in the second column: “Why is this important?” for their assigned criteria. They should note their response in the space within the column.

2d. Once small groups have finished, discuss each characteristic, one by one, together. Have each small group report on their findings. Offer some ideas from **Lesson 3 Handout 2: Establishing Care Group Criteria** and **Lesson 3 Handout 3: Additional Notes for Facilitator Reference on Care Group Program Criteria** as needed, if the groups do not mention these ideas on their own.

2e. As an additional or alternate activity, you may want to have participants review **Appendix 4: Care Groups Definition and Criteria**. Lead a discussion of the elements of the Care Group Minimum Criteria Reviewer Checklist, and go through each item and ask “Why is this important?”

3. Wrap Up

3a. Tell participants that it is important to review all of these criteria developed by FH and WR staff in 2009 (and updated in 2010) to give practitioners a clear definition of what a CG program is and what it is not.

3b. Tell participants that programs that do not meet the definition of a CG program are encouraged to either adjust their plan so that they can meet the criteria or to refer to their program by another name, such as a Cascade Group.

Lesson 3 Handout 1: Care Group Program Criteria Worksheet

Note: This worksheet does NOT contain all of the Care Group (CG) Criteria, just a representative sample for the purposes of this activity, to start thinking about CG Criteria and why they matter.

Criteria	Why is this important?
1. Essential Information	
The model is based on mother-to-mother health promotion. Care Group Volunteers (CGVs; e.g., "Leader Mothers," "Mother Leaders") should be chosen by the mothers within the group of households that they will serve or by the leadership in the village.	
The intended group ideally is all women of reproductive age (WRA; or at least all pregnant women and mothers of young children).	
Respect for women: The implementing agency needs to successfully create a project/program culture that conveys respect for the population and volunteers, especially women.	
Coverage of intended group: CG behavior change activities should aim to reach 100% of households in the intended group at least once per month.	
CGs will have between 10 and 15 CGVs.	
Each CGV will be responsible for no more than 15 households (of Neighbor Women [NW]).	
CGVs should be chosen by the mothers within the group of households that they will serve or by the leadership in the village.	
The weekly workload of CGVs is limited to no more than 15 households per CGV.	

Criteria	Why is this important?
2. Supportive Supervision	
A Promoter should not supervise more than nine CGs (i.e., the Promoter to CG ratio should be no more than 1:9).	
A Promoter should supervise at least one CGV from each CG per month (preferably one CGV from each CG every 2 weeks) using supportive supervision.	
Supervisors provide regular supportive supervision and feedback to Promoters on a monthly (or more) basis.	
3. Behavior Change Meetings	
CGVs meet with their assigned NW twice per month (recommended), or at least monthly.	
Meetings between Promoters and CGVs should last no more than 2 hours per meeting.	
The CGVs use visual teaching/educational tools (e.g., flipcharts).	
Participatory education methods are used with the CGVs and when doing health promotion at the household or small-group level.	
4. Monitoring & Evaluation and Formative Research	
Formative research should be conducted, especially on key behaviors promoted.	
CGVs collect “vital events data” on pregnancies, births and deaths.	

Lesson 3 Handout 2: Establishing Care Group Criteria[6]

Rationale for this Document

World Relief (WR) staff developed the Care Group (CG) model in Mozambique in 1995. Food for the Hungry (FH) adopted the model in Mozambique in 1997 after discussions with WR project staff, and both organizations have pioneered use of the model since then. A CG is a group of 10–15 volunteer, community-based health educators who regularly meet together with project staff for training and supervision. They are different from typical mother's groups in that each volunteer is responsible for regularly visiting 10–15 of her neighbors, sharing what she has learned and facilitating behavior change at the household level. CGs create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication, including promotion of health service utilization. They also provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits.

Since 1995, WR, FH, and more than 24 other private voluntary organizations (PVOs) in more than 21 countries have "adopted the model," but the degree to which organizations adhere to the original components of the model varies greatly. While there has been increased attention to the model and its effectiveness in lowering child deaths (e.g., mentioned in the UNICEF's 2008 State of the World's Children report), there is a danger that the wide variations in what is called a "Care Group" by various agencies will lead to misunderstandings about the model and the use of less effective strategies that do not fit within the model. These variations, in turn, could lead to fewer opportunities to advocate for the CG model and its role in child survival since the term "Care Groups" may come to mean many different things to different people, and will probably develop a very mixed track record. There are already situations in which individuals and organizations are defining CGs as "any group where you are teaching mothers" or "any group where you are teaching people to teach other people." Given the excellent and low-cost results seen in the USAID Child Survival and Health Grants Program (CSHGP) and Title II food security projects in terms of decreased child mortality and morbidity using Care Groups, we feel that it is important to define official criteria for the Care Group model.

During meetings between WR and FH staff members on April 23, 2009, the CG criteria in the table below were agreed upon as a draft list. The list is divided into those that we feel should be required to be present when using the term, "Care Group," and other criteria that we feel have been helpful when included in the model, but that should not be considered required. Edits to this list were then made by the two founders of the model, Dr. Pieter Ernst and Dr. Muriel Elmer. During the CORE Group Spring Meeting in April 2010, this list was presented to other community health practitioners and revisions were made based on their input.

Of course there is no way to enforce the use of these criteria—people will use the term how they wish—but by having two organizations that are recognized as having a history of using and promoting CGs extensively (one organization being the original developer), defining formal

[6] The Care Group criteria and this handout were created by Alyssa Davis, MPH, and Muriel Elmer, PhD, formerly of WR; Pieter Ernst, MD, Rachel Hower, MPH, and Melanie Morrow, MPH, of WR; and Tom Davis, MPH, Carolyn Wetzel, MPH, and Sarah Borger, MPH, of FH. This document was last revised on November 12, 2010.

criteria should provide a stronger basis for recognition of the model and lead to better adherence to the most effective components of the model. We also hope that by informing donors and others about these criteria, they will use the criteria to decide to what degree a proposed implementation strategy is really based on the CG model. The CORE Group Social & Behavioral Change Working Group (SBCWG) has helped with the dissemination of this document, and we expect this will further legitimize the list, and will lead to better compliance with the recommended criteria. The table below gives the required and suggested criteria along with a rationale for each.

Criteria for Care Groups	Rationale
Required	
1. The model is based on peer-to-peer health promotion (mother-to-mother for maternal and child health and nutrition [MCHN] behaviors.) Care Group Volunteers (CGVs; e.g., "Leader Mothers," "Mother Leaders") should be chosen by the mothers within the group of households that they will serve or by the leadership in the village.	CGs 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 CGVs) can be more effective[7] in promoting adoption of behaviors among their neighbors than others who do not know them as well. CGVs should be mothers of young children or other respected women from the community. CGVs 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,[8] and we believe they will be more effective in their communication, trusted by the people they serve, and most willing to serve others with little compensation.
2. The workload of CGVs is limited: No more than 15 households per CGV.	Having one volunteer trained to serve 30+ households is more in line with the traditional community health worker (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 CGV 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.[9]
3. The CG size is limited to 16 members and attendance is monitored.	To allow for participatory learning, the number of CGVs in the CG should be between six 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 (less than 70%) at CG 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.

[7] S.M. Burn. 1991. Social psychology and the stimulation of recycling behaviors: The block leader approach. *Journal of Applied Social Psychology*, 21, 611–629.

[8] Operations Research on CGs in Sofala, Mozambique, showed that CGVs chosen by the mothers that they serve were 2.7 times more likely to serve for the life of the project (p=0.009).

[9] See M. Gladwell. 2002. *The tipping point*, Little, Brown, & Co publishers, pp. 175–181.

Criteria for Care Groups	Rationale
4. CGV contact with her assigned beneficiary mothers—and CG meeting frequency–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 CGV works, we feel it is necessary to have at least monthly contact with them. CGs should meet at least once monthly, as well. We also believe that overall contact time between the CGV and the mother (and other family members) correlates with behavior change. We recommend twice a month contact between CGVs and beneficiary mothers, as well as twice a month CG meetings, 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 at least a monthly basis, and the project attains at least 80% monthly coverage of households within the target group. Coverage is monitored.	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 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). There is sometimes a combination of group meetings and individual household contacts with beneficiary mothers, but at least some household visits should be included. For group meetings with beneficiary mothers, any mothers that miss meetings should receive a household visit. Household visits are helpful in seeing the home situation and in reaching people other than the mother, such as the grandmother, daughter or mother-in-law.
6. CGVs collect vital events data on pregnancies, births and death.	Regular collection of vital events data helps CGVs 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 CG 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 CGs creates behavior change directed towards reduction of mortality and malnutrition (e.g., Essential Nutrition Actions [ENA], Essential Hygiene Actions [EHA]).	This requirement was included mainly for advocacy purposes. We want to establish that the CG 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 Millennium Development Goals. While the cascading or multiplier approach used in CGs 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 CG model”).
8. The CGVs 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 CGVs 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.

Criteria for Care Groups	Rationale
9. Participatory methods of behavior change communi-cation (BCC) are used in the CG with the CGVs and by the volunteers when doing health promotion at the household or small-group level.	Principles of adult education should be applied in CGs and by CGVs since they have been proven to be more effective than lecture and more formal methods when teaching adults.
10. The CG instructional time (when a Promoter teaches CGVs) is no more than 2 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 CGVs (e.g., data collection, observation of skills) occurs at least monthly.	For Promoters (who teach CGVs) and CGVs to be effective we believe that regular, supportive supervision and feedback is necessary on a regular basis (monthly or more). For supervision of CGVs, the usual pattern is for the Promoter to supervise through direct observation at least one volunteer following the CG meeting.
12. All of a CGV's beneficiaries should live within a distance that facilitates frequent home visitation and all CGVs should live less than a 1-hour walk from the Promoter meeting place.	It is preferable that the CGV not have to walk more than 45 minutes to get to the furthest house that she visits so that regular visitation is not hindered. (In many CG projects, the average travel time is much less than this.) This also makes it more likely that she will have a prior relationship with the people that she is serving. Before starting up CGs, the population density of an area should be assessed. A low CGV: Mother Beneficiaries and low Promoter:CG ratio should be used when setting up CG in rural, low population density areas. If an area is so sparsely populated that a CG volunteer needs to travel more than 45 minutes to meet with the majority of her beneficiary mothers then the CG strategy may not be the most appropriate one to use.
13. The implementing agency needs to successfully create a project/program culture that conveys respect for the population and volunteers, especially women.	During operations research conducted near the end of the FH Sofala CG project, CGVs ("Leader Mothers") were asked who respected them now that did not respect them before. 86% mentioned other mothers/women, 64% mentioned community Leaders, 61% mentioned their husbands, 45% mentioned their parents or in-laws, 41% mentioned extended family members and 25% mentioned health facility staff. We believe that an important part of this model is fostering respect for women, and implementers need to make this an explicit part of the project, encourage these values among project staff, and ideally measure whether CGVs are sensing this respect.
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 SBCWG) found that they included formative research (e.g., Barrier Analysis, Doer/Non-Doer 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.

Criteria for Care Groups	Rationale
2. The Promoter:CG 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 six 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. Social/educational differences between the Promoter and CGV should not be too extreme (e.g., having bachelor-degree level staff working with CGVs).	We believe that keeping the educational difference between the Promoter and CGVs to a modicum is useful in that it makes it more likely that the Promoters will use language/concepts that the CGVs can understand. It also helps to keep costs of the model low.

Lesson 3 Handout 3: Additional Facilitator's Notes on Care Group Program Criteria

1. **The intended group ideally should be all women of reproductive age (WRA), or at least pregnant women and mothers of young children.**

Why is this important?

- The model is based on mother-to-mother health promotion.
- Pregnant women and young children are most vulnerable to death and disease, so health interventions can have the greatest impact with these groups.
- Ideally a program would reach all WRA, but grant requirements or other constraints may prevent this.

2. **The plan is to reach 100% of households in the intended group (and attain at least 80% monthly attendance).**

Why is this important?

- In order to create a "new social norm" (not one person changing behavior, but many encouraging each other) a program needs to reach most or all of the households with women who could get pregnant, are currently pregnant or have young children (under 5).
- People are more likely to change when others around them are hearing the same message and talking about making their own changes.
- The World Relief (WR) CG manual says, "Changed communities: In a participating community, there is at least one Care Group Volunteer for every 10–15 households who is leading the way to better health practices. Behavior change becomes more than an individual decision—it becomes a social movement involving the entire community."[10]
- While creating a new social norm everyone in the community hears the message together. This way the community as a whole can make changes together.
- Community learning helps to increase change.

3. **Each CG should have no more than 15 volunteers.**

Why is this important?

- The larger the group, the less time there is for participants to ask questions and for CGVs to discuss and interact with participants.
- If there are 15 or fewer people, you can more easily interact with each of them.
- When groups become larger than 15 people, a few people begin dominating conversation and others stop talking. A group larger than 15 makes encouraging,

Group Size and Participation

Source: Jenny Rogers (1989)

3–6 people:	Everyone speaks
7–10 people:	Almost everyone speaks
	Quieter people say less
	One or two may not speak at all
11–18 people:	5 or 6 people speak a lot
	3 or 4 others join in occasionally
19–30 people:	3 or 4 people dominate
30+ people:	Little participation is possible

[10] Megan Laughlin and the World Relief Health Team. 2010. *A Guide to Mob The Care Group Difference.* MD: World Relief.

discussing and addressing the issues of others and having good facilitation and participation much more difficult.

4. **Care Group Volunteers (CGVs) should have responsibility for no more than 15 households (with Neighbor Women [NW]).**

Why is this important?

- CGVs are volunteers and must be able to sustain the activities required by the program. If you ask too much of them, they will not stay in the program.
- Many practitioners find it works better with an even lower maximum number of households; 10–12 households seems to be the right size for many CGVs.

We want CGVs to form strong bonds with the households (of NW) they meet with. For example:

- Being someone's close friend requires a certain amount of time and emotional energy. We begin to emotionally overload if we care for 10–15 people because we cannot take the emotional strain and energies needed to do so.
- In the same manner, we want our CGVs to invest in the people that they meet and have time and energy to get involved in the lives of those they visit.

Example from Ethiopia

In one of Food for the Hungry (FH)'s programs in Ethiopia, the local partner already had a group of 20 people meeting every week. So, it added more participants and began teaching some of the health practices to a larger group, up to 50 people at a time. As a result, there was very little behavior change among the members of this group because it was so big that people were not able to interact, ask questions or relate to the facilitator. And, because the participants were not among the facilitator's 10–15 closest neighbors, they were not able to directly "see the behaviors", so he did not serve as a role model for them.

Based on previous research, 16 households is too many for CGVs to handle. We suggest 10–15 households per CGV. If you exceed this number, the quality of CGV interactions greatly reduces. And, the more households you add, the greater the dropout rate and the greater the reduction of change.

You may ask, how can we reach almost all (80–100%) households if CGVs only can reach 10–15 houses?

- We need to make sure that we have a sufficient number of CGVs so we can have saturation coverage, effectively reaching almost all the households in our intended group.
- Do not overburden CGVs with too many households. Make sure your budget includes the right number of CGVs to cover your entire community.

5. **When possible, CGVs should be chosen by the mothers in their groups.**

Why do you think this is important?

Sympathy Groups

In his book, *The Tipping Point*, Malcolm Gladwell explains what sympathy groups are and why they are so important:

"Make a list of all the people you know whose death would leave you truly devastated. Chances are you will come up with around 12 names. That, at least, is the average answer most people give to that question. Those names make up what psychologists call our sympathy group. Why aren't groups any larger? Partly it's a question of time. ...To be someone's friend requires a minimum investment of time. More than that, though, it takes emotional energy. Caring about someone deeply is exhausting. At a certain point, at

- People will choose someone they respect and are willing to listen to. A volunteer chosen by an outsider is less likely to be accepted by the community.
- The community will be somewhat reluctant to listen to an outsider's ideas. If a volunteer is "one of their own" they are already comfortable and ready to listen to messages.
- Research has found that using a neighbor to discuss sensitive topics is more effective than using an outsider.

Chosen CGVs probably do not already practice the behaviors we want them to. It is the Promoter's responsibility to help CGVs change their own behavior.

- It is very important for the Promoters to really invest in sharing and encouraging CGVs to change and for Promoters and Supervisors to model that change.
- The CG model relies on peer to peer promotion. The chosen CGVs will be role models (early adopters) of the behavior.
- If the CGVs have made changes in their own lives that their neighbors witness, they will be much more effective at supporting behavior change than those who do not "practice what they preach".

Example from Guatemala: Curamericas Global

Exclusive breastfeeding (EBF) promotion really took off after one of the Promoters exclusively breastfed her own baby. Staff and volunteers were equally amazed at how beautiful and healthy the baby girl was and how well she was growing. They said they did not really believe EBF could work until they saw it with their own eyes. After they became convinced, it was a lot easier for everyone to wholeheartedly promote EBF.

- It is very important that project staff and volunteers try out the behaviors first and believe in their value so they can be good role models for NW.
- Once CGVs are convinced that the changed behavior works, their influence and credibility in the community and their ability to be role models will greatly increase.
- Encourage but do not force project staff and CGVs to try the key practices. Excessive pressure can provoke resistance. Change takes time; it will not happen overnight.
- The more CGVs teach others about changing behavior the more likely they will change their own behavior.

Note: Sometimes it is not possible for mothers to select their CGVs. There are successful examples, such as WR's Vurhonga projects in Mozambique, where mothers did not select their CGVs. If it is not possible to use CGVs, perhaps because you are expected to use the MOH's community workers, do not give up—you can still have great results. Project staff should be aware that in this case the community workers or volunteers may have to work harder to gain the trust and respect of the households they serve and should address this concern in CG meetings.

6. All of a CGV's beneficiaries should live within a distance that facilitates frequent home visitation, and all CGVs should live less than a 1 hour walk from the Promoter's meeting place.

Some restructuring of groups may be needed if volunteers and groups do not fit this requirement.

This makes sure we respect the time and workload of the volunteer.

7. **Each Promoter should be responsible for no more than nine CGs.**

- For Promoters to know and have the trust of those they work with, it is best to limit the number of CGVs they work with to about 150, or nine CGs (assuming a CG size of 10–15 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
- Remember that nine CGs per Promoter should be the maximum. The actual number will be context specific, depending on factors that include geography and population density (how much travel time the promoter has between CGs), whether the Promoters work full time or part time and other duties the Promoters may have.
- For example, consider a Promoter working full time who has 8 CGs that meet every 2 weeks. That is 8 group meetings × 2 contacts every 2 weeks = 32 sessions per month. Suppose that each CG session takes about a ½ day, including travel time. This equals 16 total work days and leaves only 4 more days per month for report writing, biweekly meetings with Supervisors, supportive supervision visits with CGVs, and any meetings with local leaders, health center staff and village health committees—a very full schedule!
- In more densely populated or peri-urban areas, where travel time between groups is minimal, it might be possible for a Promoter to meet with more CGs per day, which also would free up time for additional supportive supervision visits.

8. **Promoters will supervise at least one CGV from each CG per month (preferably one CGV from each CG every 2 weeks).**

Why do volunteers need to be supervised?

- Volunteers sharing inaccurate information or failing to perform their responsibilities can do more harm than good.
- Projects are responsible to their donors to make sure we meet our program goals.
- Promoters will supervise with a quality improvement and verification checklist (QIVC). This encourages the volunteers and makes them feel that their work is valued.

9. **The amount of CGV contact with their assigned beneficiary mothers and CG meeting frequency should be at least once per month, preferably twice monthly.**

Home Visits and Group Meetings with NW: What is the right balance?

Many practitioners recommend that CGVs hold one group meeting of NW and make one home visit per month. This seems to be the ideal combination, where feasible.

Group meetings are an opportunity for NW to reinforce learning and provide one another with peer support, which more quickly strengthens behavior changes and changes community norms.

Home visits allow NW to discuss private concerns with CGVs. Also, CGVs have the opportunity to share educational messages and key practices with others in the home, such as fathers, grandparents and other relatives. This provides a powerful opportunity to support the whole family and to increase family support for the changes we want to promote.

This way you get the benefits of both the support group environment and the home visits.

Why is this number of home visits and group meetings important?

- Regular visits with NW and their families build trust and sympathy (as in the sympathy groups discussed at the end of point 4).
- Regular meetings build strong relationships between CGVs and their neighbors. The better the relationship between CGVs and NW, the greater the behavior change, as the CGVs walk them through stages of change.
- Regular meetings enable good relationships over an extended period of time. The more often CGVs and NW meet, the more they will develop deep relationships and the more the program becomes sustainable, as meeting and discussing heath habits become part of the fabric of the community.
- Frequent contact allows CGVs to follow up on previous lessons and facilitates greater encouragement and monitoring of activities. For example, the CGV could say: “Two weeks ago you committed to washing your hands after using the latrine. How is that going? Have you been able to do this every time you go to the latrine?”
- Regular meetings help to build community ownership of the groups after the program funding has ended.

10. CGVs use visual teaching tools such as flip charts to promote health and nutrition in each household.

Why is this important?

- Flip charts guide discussions to make sure that CGVs share messages consistently.
- The pictures serve as reminders, while the words help the literate to remember the key practices for each picture.
- The pictures are attractive and make people curious. They not only aid CGVs in teaching, but encourage beneficiaries to listen, watch and learn.

11. CGVs use participatory learning methods in a non-formal educational setting to conduct health promotion at each household.

The educational setting is non-formal. CGVs are not in a school or university setting, which facilitate formal education.

What is participatory learning?

- It is not just giving information. It is more than a two-way dialogue between the facilitator and the participants.
- It includes seeing, hearing, doing, discussing and critical thinking. It is a more active method of learning.
- It involves mother-to-mother support and sharing experiences, learning from one another, mutual encouragement and helping each other find ways to overcome barriers to practicing the new behaviors.
- CGVs help household members interact with the learning through discussion, drawing, writing, acting and verbally responding, which are more effective than just telling people what to do.
- Active, participatory methods help participants connect with the material emotionally and mentally so that they remember much more and are motivated to use what they have learned.

12. CGVs will collect information on pregnancies, births and deaths at each household and report it to the Promoters.

Why is this important?

- Collecting this information will help CGVs become more aware of epidemics and health behaviors in their community, as well as how their work affects others.
- This information can be used to help alert local health clinics and communities of areas that need more assistance or interventions.
- Working together, CGs, with Promoter support, identify what the CGVs can do to respond to a situation.
- CGs need to be designed in a way that allows for CGVs to be trained by the Promoter's example in problem solving and understanding the health statistics they gather in the community. This way, when the program is over, CGVs know exactly how to interpret the information they gather.

Verbal Autopsies to Discover Causes of Death

In some projects, Promoters or other project staff may conduct a verbal autopsy, also called a social autopsy. Verbal autopsies discuss circumstances of a health event, signs of illness, care-seeking behaviors and barriers to care seeking that were experienced to learn more about probable causes and circumstances when a child or woman dies. This helps identify steps that can be taken to prevent additional deaths from the same or similar causes.

For example, one project found that maternal deaths increased on the weekend because clinics were closed because MOH health care providers were not working. The project worked with the community to establish a system whereby project health providers were on call during weekends to assist with emergencies.

Verbal autopsies should be used with great care and conducted by very well-trained staff so that neither the family members, volunteers, nor staff members feel they have been blamed for the death. When done

too soon after a loss or done with insensitively, the verbal autopsy experience can be a traumatizing event for the bereaved family. When done sensitively by well-trained and empathetic staff, it can help the bereaved family members feel that their loss has been acknowledged with respect and that sharing their experience may help others in the future.

How does this level of data collection contribute to larger health initiatives?

- If the community has community development committees (CDCs) or similar organizations, such as village health committees, often one or more CGV become a member. CGVs are able to provide updates on vital statistics and health information gathered by their CGs to these community organizations. This data equips CDCs to make well-informed decisions regarding issues affecting community members' health.
- The Ministry of Health (MOH) can rely on CGs to help with their community mobilization efforts. For example, MOH staff can call on CGVs to rally households for immunization campaigns or weighing sessions. After the MOH communicates to CG leaders, CGVs spread the news to their assigned households, generating a greater turnout for the event.

How do CGVs' collect data?

- During home visits and group meetings, ask about family members' health.
- Take note of beneficiary births, deaths or pregnancies.
- Ask about circumstances surrounding health events, such as symptoms and the family's response.
- At one CG meeting each month, verbally report vital events to the entire group.
- Illiterate CGVs should easily be able to recall vital statistics because these events are generally infrequent among their 10–15 assigned households.
- A literate CGV (often the CG leader or Promoter) records the information on an information sheet and turns it in to the Promoter.

How do Promoters make use of collected data? Promoters should:

- Immediately discuss the household vital statistics with CGVs as they report the information
- Ask reporting CGVs to give a possible reason for the health event
- Invite the other CGVs to share their understanding of the health event
- Discuss the health event with CGVs, learn from their insight and correct any false information, if necessary
- Help CGVs link health practices or environmental factors to effects on health and disease

Examples of Promoter Problem Solving

Remind the CGV: "You remember that your neighbor had a lot of bleeding in her last pregnancy. We will need to watch her (for danger signs / to get help) in case that happens with the next baby."

Ask the CG: "We had two children die and another 22 are sick. Do you know what's happening here?"

- Identify actions CGVs can take in the future, based on lessons learned from the discussion

This reporting process is discussed in depth in **Lesson 14: Care Group Monitoring Information System: Introduction to Registers** and **Lesson 15: Care Group Monitoring Information System: Promoter, Supervisor and Coordinator Reports**.

13. Formative research should be used to help intended behavior change communication activities.

Conducting formative research, specifically a Local Determinants of Malnutrition study or a Barrier Analysis, may help your program to focus on the specific barriers the community faces in changing the behaviors of interest. 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 feasible for community members.

14. The workload of a CGV is limited to No more than 15 households per volunteer.

- The criteria documents require a maximum of 15 households per CGV, though 10–12 households works better, in the experience of many practitioners.
- Care should be taken not to overload a CGV. She has other work to do, and if her CG responsibilities are overwhelming she may have to resign.

Lesson 4: Using Formative Research to Strengthen Care Groups

Achievement-Based Objectives

By the end of this lesson participants will have:

- Defined "formative research"
- Heard/read a description of Barrier Analysis (BA), including a list of the 12 determinants of behavior change
- Identified ways that formative research could be used in a Care Group (CG) approach to improve behavior change

Duration

1 hour 30 minutes

Materials Needed

- Lesson 4 Handout 1: Barrier Analysis Description
- Lesson 4 Handout 2: The Twelve Determinants of Behavior Change
- 12 index cards with behavior statements and determinants
- Lesson 4 Handout 3: Example Behavior Statements and Determinants

Steps

1. Introduction

    1a. Tell participants that the main objective of this lesson is to help them understand how to use the results of formative research to improve the chances that Neighbor Women (NW) will adopt new behaviors.

    1b. Ask participants: How many of you have already had experience using formative research either on a project using the Care Group approach or one that doesn't use the Care Group approach?

    1c. Ask some participants what type of formative research they used.

2. What is formative research?

    2a. Ask participants what they know about formative research. Add the following points if participants do not mention them.

        - Formative research focuses more on quality than quantity.
        - Formative research is more likely to answer the questions of why, who and how.
        - Formative research can use many different research methods.
        - Formative research is often not expressed in percentages.

3. Formative Research using a Barrier Analysis

3a. Explain that this lesson and the CG approach primarily will use a research method called Barrier Analysis, or BA. Ask how many participants are familiar with this method.

3b. Tell participants: To "even the playing field" for people who are not familiar with Barrier Analysis, we will reference a short description of the approach.

3c. Distribute **Lesson 4 Handout 1: Barrier Analysis Description**. Ask participants that are already familiar with BA to underline anything that is new to them. Answer any questions.

3d. Distribute **Lesson 4 Handout 2: The Twelve Determinants of Behavior Change**. Explain that the BA survey identifies which of the 12 determinants is more critical to changing the behavior. Since many of the determinants are barriers, they are considered obstacles to behavior change.

3e. Allow time for the participants to read the description of determinants, then ask volunteers to give one example for each determinant. For example, an example for Cue for Action could be: Mothers can't remember all the times that they should wash their hands.

3f. Remind participants that when they do a BA, some of the 12 determinants will be revealed as significant. This means that programmers should address those determinants (obstacles) in some way in their projects so that the priority group is more likely to adopt the new behavior.

4. Using Barrier Analysis Results in the Care Group Model

4a. Ask one or two participants that have experience using BA (or any other formative research results) to describe what the research results revealed and how those results were used in their CG model (or other program) to help remover a barrier to behavior change.

4b. Share with the group the following example: In the research conducted by Concern in Uganda, mothers said they thought that community leaders did not approve of hand washing. To address this they incorporated a picture of community leaders washing their hands into the Care Group flip chart.

4c. Remind the group that the results of formative research do not just inform which pictures are used, but also can inform the story that is told during the CG meeting. Results also can inform other aspects of the project's strategy (such as placing hand washing reminder pictures on the inside of the door of a latrine or in the kitchen).

5. Activity: Practice Using Formative Research

5a. Divide participants into pairs. Give each pair an index card with a behavior statement on it along with a determinant (or explanation of a formative research result). Examples of behavior statements and related determinants can be found in **Lesson 4 Handout 3: Example Behavior Statements and Determinants**.

5b. Each pair of participants should discuss the meaning of the research and propose how they would address the findings listed on the card.

5c. Pairs will then share their ideas with other pairs at their table. Ask a few pairs to share their suggestions with the entire group.

6. Wrap Up

6a. Remind the participants that to be useful the results of the formative research have to be acted upon. Sometimes results may influence the flip chart pictures used, sometimes the text used in the CG meeting, and sometimes other aspects of the project.

Lesson 4 Handout 1: Barrier Analysis Description[11]

Purpose

Barrier Analysis[12] (BA) is a rapid assessment tool that can help organizations identify why a promoted behavior has low coverage or has not been adopted at all. It is usually used at the beginning of a program to determine key messages, strategies and activities for boosting behavior change in food security, child survival and other community development programs. It can also be used in an ongoing program to determine how to improve the promotion of specific behaviors that continue to show low adoption rates.

Details of Use

Overview. BA explores 12 behavioral determinants: perceived self-efficacy/skills, perceived social norms, perceived positive consequences, perceived negative consequences, access, perceived barriers/enablers, cues for action/reminders, perceived susceptibility, perceived severity, perceived divine will, culture and policy. Ninety respondents are selected (45 "Doers" and 45 "Non-Doers" of the behavior) and asked a series of questions to identify which determinants are impeding or enabling them to do the behavior. This comparison of people who do and do not do a behavior is very helpful in identifying which of the determinants are the most important ones to focus on during the behavior change plan. The tabulation table allows the user to make statements such as "Doers of the behavior are 5.2 times more likely to say that their husband approves of the practice than Non-Doers." Project staff members then use these results to develop key activities and messages to make changes related to each determinant found to be important (e.g., to convince wives that husbands approve of the practice).

There are seven steps in developing a BA:

1. Define the goal, behavior and intended group
2. Develop the behavior question
3. Develop questions about determinants and pretest questionnaire
4. Organize the data collection
5. Collect field data for BA
6. Organize and analyze the results
7. Use the BA results

Usual Audiences. The audience can include mothers of young children, farmers, youth, school children and others. The BA also can be used among service providers, such as nurses, midwives and extension agents.

---

[11] This handout is based on the TOPS handout "Barrier Analysis: A Food Security and Nutrition Network SBC Task Force Endorsed Method/Tool."

[12] Davis, Thomas. 2004. *Barrier Analysis Facilitator's Guide*. http://barrieranalysis.fhi.net/annex/Barrier_Analysis_Facilitator_Guide.pdf

Level of skill needed. The tool is meant for use by project management staff and community-level implementers. Past experience with social and behavior change programs is helpful, as well as skill in conducting interviews, developing questionnaires and using MS Excel. Analysis is done manually with markers, paper and a computer loaded with an MS Excel BA Tabulation Table (which can be downloaded[13]).

Time/staff required. BA can be done quite rapidly by trained personnel. Training in BA is usually done as part of the 6.5 day *Designing for Behavior Change* training. If you have a team of 10 people available to carry out BA, the data collection for each behavior you study can usually be done in about 9–10 communities in 1–2 days (total). Tabulation of the data usually can be done in a single day. A larger group can generally analyze more behaviors in the same amount of time.

Common constraints/difficulties. The BA cannot be used on behaviors that are brand new, where no "doers" can be found. The facilitator in the process should be skilled in helping people to think of activities that focus on each determinant identified to be important. (Otherwise project staff often may default to repeating the same message as before.)

Evidence for Efficacy of the Method/Tool

- Barrier Analysis was designed by Food for the Hungry (FH) staff in 1990 using the scientific literature on behavior change. The main theories that support the method are the Health Belief Model and the Theory of Reasoned Action. Knowledge is not enough to change behavior. There are many different determinants of behaviors that should be explored when putting together a behavior change plan.

- "Powerful to Change Analysis[14]" was conducted by the CORE Group Social & Behavior Change Working Group (SBCWG) in order to compare those projects that successfully boosted behavior change for different practices (e.g., exclusive breastfeeding [EBF], hand washing with soap) in comparison with those that did not. Those projects that showed the highest levels of behavior change used formative research tools like BA and Doer/Non-Doer Analysis.

- BA has generally been used to improve health, nutrition and hygiene practices at the household and community levels, working with health personnel, community health workers, mothers and caregivers. However, the methodology has recently been updated based on determinants of agricultural and natural resource management practices, and the latest *Designing for Behavior Change* manual (available on the Food Security and Nutrition Network website) includes these modifications. BA should be useful to better understand all types of behavior at the community level, including behaviors related to value chains. It has been applied in both developing and industrialized countries.

- BA is practical because it can be applied in a short time frame, does not require a lot of time or money and produces enough information to design behavior change communication

[13] The MS Excel file can be downloaded www.caregroupinfo.org/docs/BA_Tab_Table_Eng_9_30_10.xls. An instruction sheet for use of the BA Tabulation Table is available at www.caregroupinfo.org/docs/BA_Analysis_Excel_Sheet_Tab_Sheet_Explanation_Sept_2010.doc.

[14] For an example, see http://www.coregroup.org/storage/Social_Behavior_Change/EBF_Final_Report_and_Annex.pdf.

(BCC) messages, strategies and activities for food security, child survival and other types of programs. BA is most useful at the beginning of a project to focus on key practices most linked with impact and later in a project to focus on other practices where widespread adoption has not occurred.

Resources

- *Designing for Behavior Change: For Agriculture, Natural Resource Management, Health and Nutrition*. 2013. Produced by TOPS, FSN Network and CORE Group. Download from: http://www.coregroup.org/resources/384-designing-for-behavior-change-for-agriculture-natural-resource-management-health-and-nutrition
- Bonnie Kittle. 2013. *A Practical Guide to Conducting a Barrier Analysis*. Download from: http://www.caregroupinfo.org/docs/Practical_Guide_to_Conducting_BA_Latest.pdf
- Barrier Analysis Narrated Presentation: http://caregroupinfo.org/vids/bavid/player.html

Lesson 4 Handout 2: The Twelve Determinants of Behavior Change

The first four determinants listed below should always be explored in formative research on determinants. These four are more commonly found to be significant, especially for health and nutrition behaviors.

1. **Perceived positive consequences:** what positive things a person thinks will happen, as a result of doing a behavior. Responses to questions related to positive consequences may reveal advantages (benefits) of the behavior, attitudes about the behavior and perceived positive attributes of the behavior.

2. **Perceived negative consequences:** what negative things a person thinks will happen as a result of doing the behavior. Responses to questions related to negative consequences may reveal disadvantages of the behavior, attitudes about the behavior and perceived negative attributes of the behavior.

3. **Perceived social norms:** the individual's perceptions that people important to him/her think that he/she should do the behavior. Social norms have two parts: who matters most to the person on a particular issue and what he/she perceives those people think he/she should do.

4. **Perceived self-efficacy/skills:** an individual's belief that he/she can do a particular behavior, given his/her current knowledge and skills, or the set of knowledge, skills or abilities necessary to perform a particular behavior.

5. **Access:** the degree of availability (to a particular audience) of the needed products (e.g., fertilizer, insecticide-treated bednets [ITNs], condoms) or services (e.g., veterinary services, immunization posts) required to adopt a given behavior. This also includes an audience's comfort in accessing desired types of products or using a service.

6. **Cues for action/reminders:** an individual's perception that he/she is able to remember when to do the behavior and an individual's perception that he/she can remember how to do the behavior. This also includes key powerful events that triggered a behavior change in a person (e.g., "my brother-in-law got AIDS", "the drought happened"). An example of reminders is posters on the doors of latrines reminding users to wash their hands afterward.

7. **Perceived susceptibility/risk:** a person's perception of how vulnerable he/she feels to the problem. For example, does he/she feel that it is possible that his/her crops could have cassava wilt, or how likely is it that he/she will get HIV.

8. **Perceived severity**: the belief that the problem (which the behavior can prevent) is serious. For example, a farmer may be more likely to apply fertilizer to his fields if he perceives that "weak soil" will result in a poor harvest, and a mother may be more likely to take her child for immunizations if she believes that measles is a serious disease.

9. **Perceived action efficacy:** the belief that by practicing the behavior one will avoid the problem or that the behavior is effective in avoiding the problem. For example: If I sleep under a mosquito net, I won't get malaria.

10. **Perceived divine will:** a person's belief that it is God's will (or the gods' will) for him/her to have the problem and /or to overcome it. Numerous unpublished BA studies have found this determinant to be important for many behaviors (particularly for health and nutrition behaviors).

11. **Policy:** laws and regulations that affect behaviors and access to products and services. For example, the presence of good land title laws (and clear title) may make it more likely for a person to take steps to improve their farm land, or a policy of automatic HIV testing during antenatal visits may make it more likely for women to have HIV testing.

12. **Culture:** the set of history, customs, lifestyles, values and practices within a self-defined group. Culture may also be associated with ethnicity or lifestyle, such as "gay" or "youth" culture.

Lesson 4 Handout 3: Example Behavior Statements and Determinants

Behavior Statement	Determinant	Respondents said:
Nutrition		
Mothers of children 6–12 months of age feed them meals each day that are the consistency of thick porridge.	Perceived self-efficacy/skills	The mother cannot make the porridge thick enough.
Mothers of children 9–23 months of age feed them meals containing foods from at least 4 of the 7 food groups each day.	Perceived self-efficacy/skills	The mother cannot remember the different food groups.
	Cues for action/reminders	
Mothers of children 9–23 months of age feed them at least three cooked meals that contain a staple food per day.	Access	There is not enough time.
Mothers of children under 24 months of age continue to breastfeed their children.	Culture	We do not do that here.
Mothers of children under 6 months of age feed them only breast milk.	Perceived negative consequences	People will think I'm a bad mother.
Mothers breastfeed their newborns within 1 hour of birth.	Perceived divine will	Religious practice calls for Koranic verse plus honey to be the first thing a newborn consumes which can take long time.
Health		
Mothers with children under 5 years of age who do not want to become pregnant use a modern contraceptive method.	Perceived social norm	The husband wants many children.
Pregnant women give birth at a health facility.	Perceived action efficacy	The mother and infant would be better off at home.
Mothers of sick children under 24 months of age seek medical attention at a health facility within 24 hours of noticing symptoms of fever, diarrhea or difficulties breathing.	Access	There is no money for transport.
Mothers of children under 5 years of age ensure that their children sleep under an insecticide-treated bednet (ITN) each night.	Perceived negative consequences	Children might suffocate or feel too hot sleeping under an ITN.
Mothers of children under 5 years of age that have diarrhea give them oral rehydration solution (ORS).	Perceived severity	Diarrhea is not a serious disease.
Water, Sanitation and Hygiene (WASH)		

Behavior Statement	Determinant	Respondents said:
Mothers of children under 5 years of age wash their hands with soap at the five critical times each day.	Cues of action	The mother can't remember to wash before cooking.
Heads of households ensure that household-generated garbage is disposed of in a designated place at least once per week.	Perceived susceptibility/risk	The father does not think he is at risk of vector-borne diseases.
Mothers/caregivers of children under 5 years of age treat/chlorinate the drinking water consumed by the family in the home all the times.	Perceived negative consequences	It costs too much to treat/chlorinate water at all times.
Mothers of children under 5 years of age store household drinking water in a closed/ tightly covered container.	Perceived action efficacy	Mothers think that a cloth over the container is enough.
Mothers of children under 5 years of age defecate in a latrine at all times.	Perceived negative consequences	Mothers fear they will fall in the latrine.
Intended wives/partners who are members of savings and loan groups decide together with their spouses/partners how to spend the money they borrowed from the savings and loan group.	Culture	I wouldn't know how to initiate this discussion. We don't do that here.
	Perceived self-efficacy/skills	
Parents of daughters 5–14 years of age ensure that their daughters attend elementary school.	Perceived negative consequences	I need my daughters at home to help me.
Intended youth (male and female) 18–30 years of age use a condom every time they have sex with a non-regular partner.	Cues for action	I get too caught up in the moment to remember.
	Perceived negative consequences	My boyfriend won't like it or me.

Lesson 5: Organizing Communities into Care Groups and the Numbering System

Achievement-Based Objectives

By the end of this lesson participants will have:

- Identified three different ways to identify the intended participants for Care Groups (CGs) and Neighbor Groups (NGs)
- Practiced organizing the beneficiary population into NGs and CGs through a census, community list or community gathering
- Identified which people and groups are linked to which number
- Practiced identifying CG actors and groups by the number system

Duration

2 hours

Materials Needed

- Lesson 5 Handout 1: Three Approaches to Forming Care Groups
- Lesson 5 Handout 2: Key Questions for Forming Care Groups
- Lesson 5 Handout 3: Community Map
- Lesson 5 Flip Chart 1: Care Group Numbering System
- Lesson 5 Flip Chart 2: Numbering System Practice Codes
- Answer Key to Lesson 5 Flip Chart 2: Numbering System Practice Codes
- Lesson 5 Handout 4: Numbers for the Numbering Game (write each number on an index card and color code the index cards to help visually depict the groups)
- Lesson 5 Handout 5: Making Sense of the Numbering System

Steps

1. Introduction

    1a. Explain to participants: Now that we have explained the Care Group approach to our collaborating partners and to the leaders of the community, we need to work with the community to identify the members of the Neighbor Groups and to establish the Care Groups. Before you can do this, you have to confirm who your intended audience is for inclusion in the Care Group approach.

    1b. Ask participants: Who is the priority group for your project?

    1c. Ask participants: What might be some other priority groups that could be selected for this approach? Answers can include women of reproductive age (WRA), pregnant woman, mothers of children under 5 years of age or mothers of children under 2 years of age.

2. Priorities When Organizing Care Groups and Neighbor Groups

2a. Tell participants that they will now learn how to form CGs. One of the most important things to keep in mind when forming CGs is to make sure that the Care Group Volunteers (CGVs) and Neighbor Women (NW) live close together.

2b. Ask participants: Why is this important? Why do we need Care Group Volunteers and Neighbor Women to live close to each other? Tell participants that it is preferable that the CGVs do not have to walk too far, usually not more than 45 minutes to get to the farthest house that she visits so that regular visitation is not hindered. In many CG projects, the average travel time is much less than this. This also makes it more likely that CGVs will have prior relationships with the people they serve, which will help to foster behavior change. It is also important that women not have to walk over 1 hour to get to the CG meeting. Whatever way that projects decide to form CGs, they should place a high priority on ensuring that they assemble women by geographic proximity.

Adapting CGs in Emergency Situations

The project run in Samburu, Kenya, by International Medical Corps faced a lot of difficulties during the 2011 famine because the coverage of the program was not optimal. A lot of mothers moved with their livestock to areas where groups were not present, so there were higher numbers of defaulters from the group. This could have been prevented by ensuring that the areas where the mothers moved also were covered by the CG program.

2c. Ask participants: If after attempting to form Care Groups you find that women are walking more than 1 hour to attend Care Group meetings, what should you do? Tell participants that if women are walking more than 1 hour to attend CG meetings, the problem should be raised with project management. Management should then review the coverage strategy and adjust it to allow for smaller CGs, composed of CGVs who live closer together.

2d. Tell participants that another important factor in forming CGs is to make sure that all (or nearly all) of the intended beneficiaries, such as pregnant and lactating women (PLW) or WRA, are in CGs.

2e. Ask participants: Why is this important? Why do we need to ensure that nearly all of our intended beneficiaries are a part of a Care Group? Tell participants that 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 likely to happen when there is regular, direct contact with all 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, though this approach will probably be more expensive.

3. Three Approaches to Forming Care Groups

3a. Explain to participants that based on experience from other countries, there are three different approaches recommended to identify the intended audience and form them into CGs. They are:

- Census
- Community list
- Community gathering

Working with WRA

Projects working with all WRA may find it works well to assume that almost all households will include a woman of reproductive age, and will find forming CGs to be a very simple process.

3b. Briefly explain to participants each method as follows. More information can be found in **Lesson 5 Handout 1: Three Approaches to Forming Care Groups**.

- Census: A census requires a lot of work, but is necessary to form CGs in areas where you and other members of the community don't know who the PLW (or WRA) are in this community. This may be the case in many of the communities you'll work in.
- Community list: If active programs in your geographic areas that work with PLW (or WRA) already exist, they might have a recent census or list you could use. In some communities, community leaders are well organized and already maintain a list of residents or they can recall by memory where all the PLW or WRA live.
- Community gathering: If community participation and communication is high, community leaders could call all women in the intended beneficiary group together (such as asking all who are pregnant or have children under 5 years of age) to a central meeting place on a particular day for a community gathering.

3c. To decide which approach is best for their program there are some key questions participants need to consider. Display **Lesson 5 Handout 2: Key Questions for Forming Care Groups** and have a participant fill in the answers as you discuss the key questions.

3d. Note that in many settings where pregnancy is concealed until it is obvious, it may be difficult to enroll pregnant women through this CG approach. This is one reason why some organizations, including World Relief (WR), prefer to simply enroll all women of childbearing age.

3e. Ask participants: What if a locality doesn't have enough (neighbor) women that are eligible to participate in the CG program to form a group with 6–16 women? Tell participants: If there are not enough women to form a Neighbor Group and elect a Care Group Volunteer, the Care Group Promoter should report this problem to his or her supervisor. Potentially another Care Group Promoter covering a nearby set of Care Groups has too many eligible women in his or her area, requiring that he or she form groups larger than the intended number. In this case some Neighbor Women could be shifted around to make groups closer to the idea group size.

3f. Ask participants: What if after forming women into Care Groups there are 5 Care Group Volunteers left? Should these volunteers make their own Care Group or be added to another Care Group? Tell participants: Five women are too few to make up one Care Group. If there is a nearby Care Group it would be best to assign the Care Group Volunteer to two different Care Groups to gain a closer-to-ideal group size.

Experience of Curamericas Working in an Area of Guatemala with Very Low Social Capital

Low social capital refers to communities experiencing low levels of community engagement, connectedness and trust, usually due to traumatic events.

Curamericas started a CG project in communities with very low levels of trust, even of their own neighbors, much less project staff. This made start-up slower and more challenging. It was important to have a lot of patient, respectful dialogue with community leaders to avoid making promises the project might not be able to keep, thereby raising false expectations, and to find shared goals the project and community could work toward. It also was important to have all staff prepared to give clear and consistent messages about the purpose and design of the CG project. Despite initial resistance, the project found that the process actually helped rebuild social capital, making the community stronger, healthier and more resilient.

For more information, see **Appendix 9: Care Groups and Low Social Capital Settings: The Example of Curamericas in Guatemala**.

4. Activity: Practicing Forming Neighbor Groups and Care Groups

4a. Refer the participants to **Lesson 5 Handout 3: Community Map**. Explain to participants that this is a village and all the houses that are circled have either a pregnant woman or a lactating woman living there. The lines represent roads.

4b. Working in pairs, have participants form the WRA or PLW into NGs of 6–8 women. This number is purposefully low to leave space in the group for more women to join, if necessary. Participants should then put a star next to one woman to represent that she has been selected to be the CGV.

4c. When all the pairs are finished, go around the room and ask how many NGs were formed and how many CGs.

5. Monitoring Care Group Volunteers, Neighbor Women, Care Groups and Promoters

5a. Tell participants: Now that we have formed women of reproductive age or pregnant and lactating women into Neighbor Groups and Care Groups we need to create a way to monitor the program activities.

5b. Tell participants that a special numbering system is used to track the monitoring register and reports that different people submit to the project. This way, Supervisors and Maternal and Child Health and Nutrition (MCHN) Coordinators can accurately track who is doing what and how well each group and each person is performing.

5c. Show participants **Lesson 5 Flipchart 1: Care Group Numbering System**. Explain how the numbers and letters relate and how they allow programs to identify each member of the CG team. Present the following points, and remind participants about which numbers and letters refer to what/whom.

- There are from 1 to 4 digits in the numbering system. Each digit stands for an individual or group. These digits allow you to track each Promoter, CGV and neighbor woman reached by your program.
- The **first digit is a number** and stands for the Promoter.
  - Each Promoter is assigned his/her own specific number.
  - For example, if a project employed 37 Promoters, the first digit would range from 1 to 37.
- The **second digit is a number** and stands for the Care Group.
  - Each Promoter will number the CGs he/she is responsible for.
  - In most programs, Promoters are responsible for five to nine CGs, but no more than nine. Therefore, the second digit should range from 1 to 9, depending on the project design.
  - For example, if Promoter 2 has eight CGs, his/her CGs would be numbered 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7 and 2.8.
- The **third digit is a letter** and stands for the Care Group Volunteer.
  - Each CGV will receive a separate letter.
  - In most programs, CGs are composed of 10–15 CGVs. Therefore, the third digit should range from A through O, depending on the project design.
  - For example, in CG 4, supported by Promoter 3, there are 12 CGVs. They would be numbered 3.4.A, 3.4.B, 3.4.C, 3.4.D, 3.4.E, 3.4.F, 3.4.G, 3.4.H, 3.4.I and 3.4.J.
- The final, **fourth digit is a number** and stands for the Neighbor Woman.
  - Each NW who meets with a CGV is assigned a number by the CGV.
  - In most programs, the NG is comprised of 10 to 15 NW. Therefore, the fourth digit will range from 1 through 15, depending on the program design.
  - For example, CGV F in CG 6, supported by Promoter 1, meets with

Modifying the Numbering System

Ladd from ACDI/VOCA suggests adding a letter at the beginning of the CG numbering system to represent the region, province, chiefdom or other name for the project area. This would allow the project to look at project areas and groups within them and compare those groups against other areas to see if there are differences. Doing so would enable the project to work to improve those areas that are not doing as well.

eight NW. They would be numbered 1.6.F.1, 1.6.F.2, 1.6.F.3, 1.6.F.4, 1.6.F.5, 1.6.F.6, 1.6.F.7 and 1.6.F.8.

6. Activity: Numbering: Check for Understanding

   6a. Display **Lesson 5 Flip Chart 2: Number System Practice Codes** and ask participants to work in pairs to state what each code indicates.

   6b. Once finished, ask pairs to share their answers with the larger group. Check answers against the **Answer Key to Lesson 5 Flip Chart 2: Number System Practice Codes**

   6c. Depending on the level of understanding of the participants, continue this exercise by writing other feasible codes on a flip chart and request that participants (either individually or in tables/pairs) try to interpret the codes.

7. Activity: Fun with Numbers

   7a. Using **Lesson 5 Handout 4: Numbers for the Numbering Game**, make index cards by writing one number per index card and color-coding each position. Distribute two or three cards to each participant. When distributing the index cards, take care to give each participant a card for a separate group.

   7b. Start by asking Promoter 3 (i.e., whoever received the Promoter paper) to come to the front of the room.

   7c. The Promoter will then call a meeting with all of his/her CGVs (i.e., everyone who has a CGV number associated with Promoter 3 should come to the front of the room).

   7d. CGV 3.3.C will then call a meeting of NW (i.e., everyone who has a NW number associated with that CGV should come to the front of the room).

   7e. Then, CGV 3.3.F will call her meeting of NW in the same way.

   Note: This activity will allow participants to visually see how the coding logically follows and tracks the CGs.

8. Wrap Up

   8a. Wrap up this lesson by reviewing information with participants in a question and answer format.

   - Ask participants: What are the three options for identifying the Care Group intended audience? They should answer census, list and community gathering.

   - Ask participants: What are two things that need to be considered when forming your Care Groups and Neighbor Groups? They should answer proximity of CGVs to NW and making sure that at least 80% of the intended population is reached.
   - Ask participants: For which groups/people do we create a numbering code? They should answer Promoters, CGs, CGVs and NW.

- Ask participants: Why do we need to create number codes for these people/groups? They should answer to more easily track the activities of each group.

Lesson 5 Handout 1: Three Approaches to Forming Care Groups

Approach 1: Census

1. The first step is to select your census takers and provide them with the materials they need to take a census and create maps.
    - Make a map of the entire community, with the neighborhoods subdivided into sections of 50 to 100 houses. There are two methods for creating a community map:
    - Walking through the community and visiting houses
2. Meeting with a group of people who know the neighborhoods well and can create a map of their neighborhoods
3. After the map is created, we then need to add details and identify houses, neighborhood boundaries, community boundaries, roads, landmarks of interest (such as rivers) and buildings of interest (such as schools, churches and clinics).
4. Then, identify the households that have pregnant women and mothers of young children (or WRA).
5. Give each identified house a number.
6. Write the mother's name and household information on a community census list, making sure that the number of her house on the map is the same as her number on the census list. For example, in the table below, Leena Samuel's house is marked 1 on the map and 1 on the community census list, and the intended beneficiaries are households with pregnant women and children under 2.

Number	Mother's Name	Pregnant (Yes/No)	Household has a child under 2? (Yes/No)	Commu-nity Area	Tempo-rary Group #	Elected Care Group Volunteer
1	Leena Samuel	Yes	No	Kivo	1	
2	Niragira Regine	No	Yes	Kivo	1	
3	Nicole Nduwayo	No	Yes	Kivo	1	
4	Nzoyisenga Claudine	Yes	No	Kivo	2	
5	Alice Nzomukunda	No	Yes	Kivo	2	✔A

7. When the women you want to form into a Neighbor Group (NG) have been identified based on their geographic proximity, gather them together. Review the profile and job description of a Care Group Volunteer (CGV) with the women and ask them to elect a CGV from among them.

8. Mark the woman elected as the CGV by placing a check mark in the column titled “Elected Care Group Volunteer” and assign her a letter. You learned how to assign codes and therefore track all volunteers and health workers earlier in the lesson.

9. If you wish to form a NG with 10 women (for example), you should organize the women into groups of 11. One will be elected as the CGV and 10 will remain as NW.

Approach 2: Forming Care Groups Based On Lists

1. If community leaders do not feel it is necessary to use a map to group women into CGs because they know or have accurate lists of all women eligible for participation, they can simply use those lists.

2. Even if the community leaders think they know everyone, it is important to verify the existence of all women listed by community leaders.

3. It is more difficult to tell how close the CGVs and NW are to each other using this method.

Approach 3: Community Gatherings to Create Care Groups

1. If community participation and communication is high, community leaders can call all WRA (or other groups of intended beneficiaries such as PLW) to a central meeting place on a particular day.

2. If a woman is ill or cannot attend, she could appoint someone to represent her (and to take her prenatal visit card or child’s health card to the community gathering).

3. Women could be asked to group themselves first into neighborhoods, then into smaller groups.

Lesson 5 Handout 2: Key Questions for Forming Care Groups

Can you provide project staff or do you have staff on the ground that can identify all the WRA or PLW in the project area?

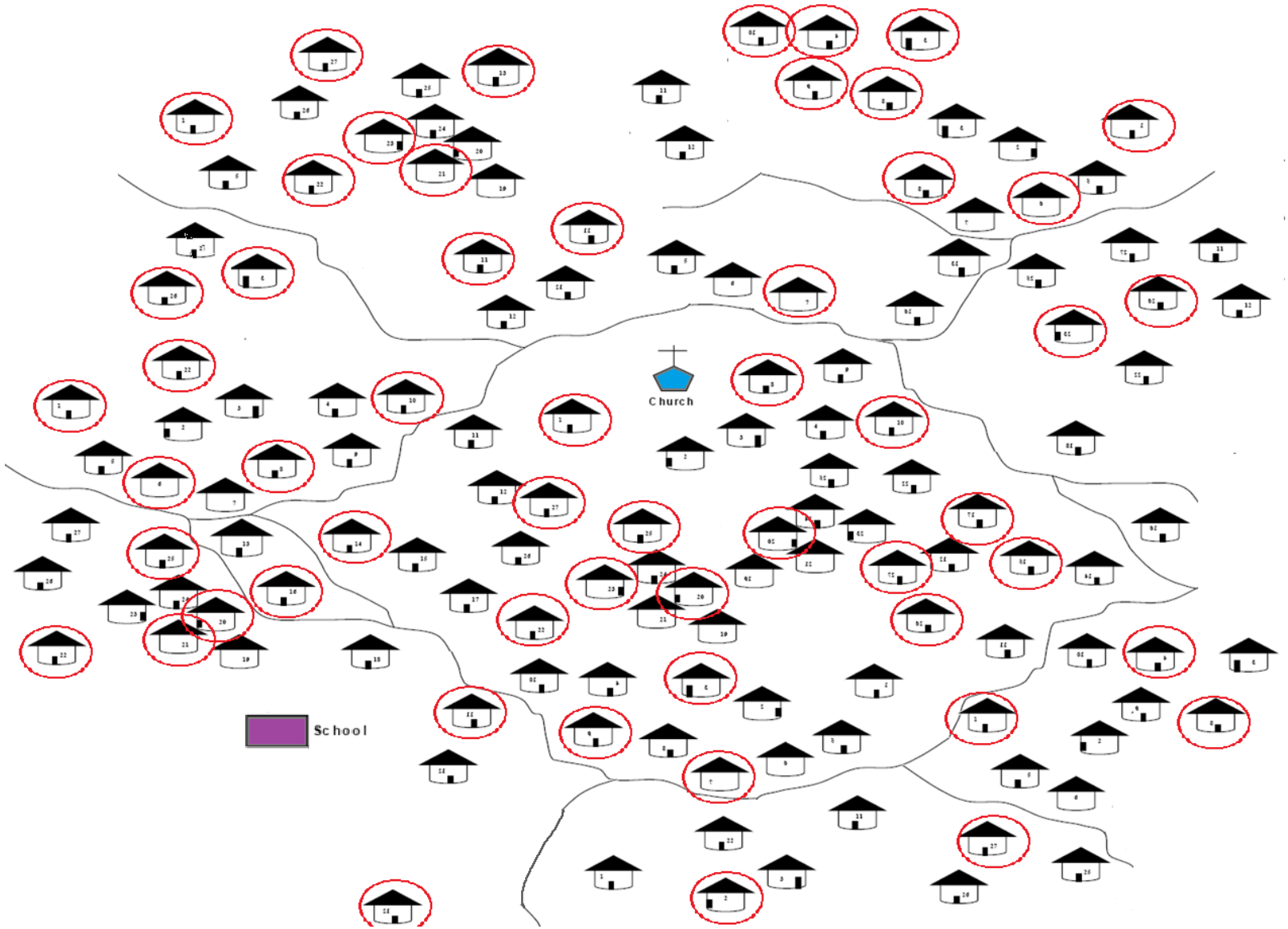
When was the last census conducted in the project area?

Is there a list of every household in the project area?

Is there another active program(s) in the project area that works with pregnant and lactating women (PLW) or women of reproductive age (WRA)?

If a community leader called all the WRA or PLW to meet on a specific day and time, how many would be willing and able to show up?

Lesson 5 Handout 3: Community Map



Lesson 5 Flip Chart 1: Care Group Numbering System

7. 6. A. 1

7 = Promoter number

6 = Care Group number

A = Care Group Volunteer number

1 = Neighbor woman number

Lesson 5 Flip Chart 2: Numbering System Practice Codes

37. 2. C. 3

5. 9. D. 6

17.4. A. 10

20. 7. J. 4

9. 1.H.7

Answer Key to Lesson 5 Flip Chart 2: Numbering System Practice Codes

37. 2. C. 3 = 37th Promoter, 2nd CG, CGV “C”, 3rd NW

5. 9. D. 6 = 5th Promoter, 9th CG, CGV “D”, 6th NW

17. 4. A. = 17th Promoter, 4th CG, CGV “A”, 10th NW

20. 7. J. 4 = 20th Promoter, 7th CG, CGV “J”, 4th NW

9. 1. H. 7 = 9th Promoter, 1st CG, CGV “H”, 7th NW

Lesson 5 Handout 4: Numbers for the Numbering Game

Write the following names and numbers on separate index cards, and distribute them to the participants for the numbering game. Make up other combinations if you want to give the participants more practice understanding the numbering system.

Promoter 3

CGV 3.3.A	CGV 3.3.E	CGV 3.3.I
CGV 3.3.B	CGV 3.3.F	CGV 3.3.J
CGV 3.3.C	CGV 3.3.G	
CGV 3.3.D	CGV 3.3.H	

NW 3.3.C.1	NW 3.3.C.4	NW 3.3.C.7
NW 3.3.C.2	NW 3.3.C.5	NW 3.3.C.8
NW 3.3.C.3	NW 3.3.C.6	NW 3.3.C.9

NW 3.3.F.1	NW 3.3.F.4	NW 3.3.F.7
NW 3.3.F.2	NW 3.3.F.5	NW 3.3.F.8
NW 3.3.F.3	NW 3.3.F.6	NW 3.3.F.9

Lesson 5 Handout 5: Making Sense of the Numbering System

This example is for a Care Group (CG) program with the following ratios/group sizes. You should adapt this tool to match your program specifications.

- 9 Supervisors
- Supervisor to Promoter ratio = 1:4
- Promoter to CG ratio = 1:6
- Each CG has 12 CG Volunteers
- Each CG has 13 Neighbor Women

MCHN Supervisor #	Promoter (Name & Number)			Care Group #
MCHN Supervisor 1	Promoter	Leonie	1	1-6
	Promoter	Sylvestre	2	1-6
	Promoter	Yves	3	1-6
	Promoter	Janine	4	1-6
MCHN Supervisor 2	Promoter	Dieudonne	5	1-6
	Promoter	Jean-Claude	6	1-6
	Promoter	Janine	7	1-6
	Promoter	Leonie	8	1-6
MCHN Supervisor 3	Promoter	Mamadou	9	1-6
	Promoter	Raphael	10	1-6
	Promoter	Sylvestre	11	1-6
	Promoter	Yves	12	1-6
MCHN Supervisor 9	Promoter	Anne-Marie	34	1-6
	Promoter	Sylvestre	35	1-6
	Promoter	Yves	36	1-6
	Promoter	Mitzi	37	1-6

	Care Group	
Promoter # 7	7.6.A	CG Volunteer
Care Group #7.6	7.6.B	CG Volunteer
	7.6.C	CG Volunteer
	7.6.D	CG Volunteer
	7.6.E	CG Volunteer
	7.6.F	CG Volunteer
	7.6.G	CG Volunteer
	7.6.H	CG Volunteer
	7.6.I	CG Volunteer
	7.6.J	CG Volunteer
	7.6.K	CG Volunteer
	7.6.L	CG Volunteer

	Neighbor Group	
CGV 7.6.F	7.6.F.1	Neighbor Woman
	7.6.F.2	Neighbor Woman
	7.6.F.3	Neighbor Woman
	7.6.F.4	Neighbor Woman
	7.6.F.5	Neighbor Woman
	7.6.F.6	Neighbor Woman
	7.6.F.7	Neighbor Woman
	7.6.F.8	Neighbor Woman
	7.6.F.9	Neighbor Woman
	7.6.F.10	Neighbor Woman
	7.6.F.11	Neighbor Woman
	7.6.F.12	Neighbor Woman
	7.6.F.13	Neighbor Woman

Supervisors are not included in the coding system	*Promoters* are identified by their individual **number**	*Care Groups* are identified by the Promoter **number** and the Care Group **number.**	*CG Volunteers* are identified by the Promoter **number**, the Care Group **number**, and the CG Volunteer **letter**	*Neighbor Women* are identified by the Promoter **number**, the Care Group **number**, the CG Volunteer **letter**, and the Neighbor Women **number**

Lesson 6: Care Group Roles, Responsbilities and Job Descriptions

Achievement-Based Objectives

By the end of this lesson participants will have:

- Distinguished the essential responsibilities for Care Group Volunteers (CGVs), Promoters, Supervisors and Maternal and Child Health and Nutrition (MCHN) Coordinators
- Listed essential qualities of CGVs

Duration

1 hour 45 minutes

Materials Needed

- Flip chart paper and markers
- Lesson 6 Handout 1: The "Who's responsible?" Game
- Answer Key to Lesson 6 Handout 1: The "Who's responsible?" Game
- Lesson 6 Handout 2: Care Group Team Essential Responsibilities
- Lesson 6 Flip Chart 1: Importance of Care Group Volunteer Qualities/Selection Guidelines
- Lesson 6 Handout 3: Possible Care Group Volunteer Qualities/Selection Guidelines

Facilitator's Notes

Review and adapt as necessary the essential responsibilities for each position so they match those of participants' Care Group (CG) programs. For example, the CGV essential responsibilities, below, indicate that CGVs should visit each home and lead one group session per month. If a program has decided that all CGV behavior change promotion will occur via home visits, then you would change the essential responsibilities to reflect this.

When facilitating this training for a particular project, be sure to modify the titles of the individuals serving in these particular roles prior to introducing this lesson and playing the game if they are different from those used in this manual.

When working with participants who have not yet started a CG program, emphasize that the roles and responsibilities mentioned here are guidelines and not meant to be prescriptive.

Steps

1. Introduction

    1a. Tell participants: Now that we have learned how to organize communities into Care Groups and how to number them so we can monitor their work, we need to identify their specific duties, tasks and responsibilities.

    1b. Ask participants: Why is it important to know each Care Group team member's responsibilities? Answers should include: so we can be sure their work will result in

behavior change, so we can supervise them well and so we can monitor the quality of their work.

1c. Ask participants: Who are the different members of the Care Group team? What are their titles? Answer should include: CGV, Promoter, Supervisor and Coordinator. List these on a flip chart as they are mentioned.

2. Activity: Care Group Team Member Major Activities

2a. Ask participants: What do you think are the major activities the Care Group Volunteer will do?

2b. Ask the participants to discuss this question within their small groups. Give participants 5 minutes for the discussion.

2c. Repeat this activity for Promoters, Supervisors and Coordinators.

3. Activity: Who's responsible?

3a. Tell participants that they will now participate in a game that requires them to decide who among the CG team members is responsible for specific tasks.

3b. Distribute **Lesson 6 Handout 1: The "Who's responsible?" Game** and have the participants work either in pairs or individually (if they already have some CG experience/exposure). Give participants about 20 minutes to complete the game.

3c. Refer participants to **Answer Key to Lesson 6 Handout 1: The "Who's responsible?" Game** and have them correct their own work.

3d. Refer participants to **Lesson 6 Handout 2: Care Group Team Essential Responsibilities**. Give them a few minutes to review the handout and compare it with their game results.

3e. Ask participants: Which Care Group team members do you seem to be most clear about regarding their responsibilities? Which ones are not so clear? Are there any responsibilities that you are confused about or have issues with? Discuss any issues that arise.

4. Activity: Care Group Volunteer Selection Guidelines

4a. Explain to participants: Now that we have a better idea of the responsibilities of each Care Group team member, let's focus a bit more on Care Group Volunteers. Selecting the right Care Group Volunteers is critical to the effectiveness of the Care Group approach as a behavior change strategy.

4b. Ask participants: Given the responsibilities of the Care Group Volunteer, what should be the requirements for being a Care Group Volunteer? Write this question on a flip chart, and ask each small group to take 3 minutes to discuss potential answers.

4c. Explain to participants: Over the years several nongovernmental organizations, or NGOs, using the Care Group approach have developed some suggested Care Group Volunteer selection guidelines. We'd like to now give you a chance to reflect on these recommendations and to decide for yourselves which are essential, desirable or unnecessary.

4d. Provide each table with a copy of **Lesson 6 Flip Chart 1: Importance of Care Group Volunteer Qualities/Selection Guidelines**. Refer participants to **Lesson 6 Handout 3: Possible Care Group Volunteer Qualities/Selection Guidelines**.

4e. Ask each table to discuss the guidelines in Lesson 6 Handout 3 and determine the relative importance of each criterion—essential, desirable or unnecessary—by writing its number in the appropriate column. Give participants 15 minutes to do this.

4f. Once finished, ask participants to do a gallery walk to see how the other groups categorized the guidelines.

4g. Discuss with the larger group which items most tables agreed on and which had significant differences of opinion.

4h. Explain to participants that each project will decide on the selection guidelines for themselves and that this should also be done in dialogue with the community.

Note: Some projects are experimenting with using males (e.g., fathers) as CGVs in certain settings. This is complicated and potentially problematic, since the model relies heavily on peer (mother-to-mother) support. If projects vary in significant ways from CG criteria listed in **Lesson 3**, the authors of this manual highly recommend that another name besides Care Group be used, such as cascade group.

Lesson 6 Handout 1: The "Who's responsible?" Game

Instructions: Read the task in the left-hand column and put an **X** in the one column indicating who is most likely responsible for that task.

Task/Responsibility	CGV	Promo-ter	Super-visor	Coordi-nator
1. Meets once per month with a group of Neighbor Women (NW) to share behavior change practices using an education flip chart				
2. Reports to the Promoter on a bi-weekly basis the number of NW he/she has visited or who attended the behavior change meeting				
3. Meets monthly with the local leadership committee in each community for coordination, monitoring and evaluation (if these committees exist)				
4. Monitors and reports vital events that have occurred in her NG, such as births, deaths and severe illness				
5. Prepares a monthly report using the information provided by Supervisor				
6. Mobilizes NW to participate in community activities that will benefit their families, such as immunization campaigns, food distribution or latrine construction				
7. Models the health, nutrition and sanitation behaviors she is teaching NW				
8. Coordinates local-level activities and maintains cooperation with other community-level institutions, such as the village council, churches and schools				
9. Completes monthly reports based on volunteer and NW registers				
10. Monitors behavior change among the CGVs				
11. Attends meetings organized by the Supervisor				
12. Maintains a filing system in the project office so copies of Promoter reports and quality improvement and verification checklists (QIVCs) are easily accessible				
13. Responsible for the performance and professional development of the Promoters who report to him/her				
14. Models leadership to all staff and intentionally develops the Supervisor's leadership potential				
15. Reviews flip chart lesson plans with Promoters every 2 weeks to ensure they understand the information well and can teach the information in a participatory manner				

Task/Responsibility	CGV	Promo-ter	Super-visor	Coordi-nator
16. Assesses staff capacities and coordinates initial or ongoing trainings based on need and program goals				
17. Visits, monitors and evaluates at least one CGV from each CG each month, and supervises CGVs' work by accompanying them on home visits and observing them leading group meetings				
18. Collects Promoter reports on a monthly basis, reviews the reports and ensures the information presented is reasonable and complete				
19. Ensures that the project is well represented in regular provincial/state/national-level meetings and forums				
20. Prepares a monthly report using the information provided by Promoters				
21. Plays a lead role in the recruitment, orientation and training of new technical program staff				
22. Supervises each Promoter who reports to him/her in the field at least twice per month, conducts QIVCs and completes all sections of the Promoter supportive supervision checklist every quarter				
23. Ensures that supervisors and promoters have the supplies necessary				
24. Supervises each Supervisor who reports to him/her in the field, conducts QIVCs and completes all sections of the Supervisor supportive supervision checklist				
25. Attends CG meetings held by the Promoter				
26. Ensures internal and external reporting and documentation requirements are completed on-time and accurately				
27. Facilitates/organizes participatory learning sessions with each of their CGs				

Answer Key to Lesson 6 Handout 1: The "Who's responsible?" Game

Instructions: Read the task in the left-hand column and put an **X** in the one column indicating who is most likely responsible for that task.

Task/Responsibility	CGV	Promo-ter	Super-visor	Coordi-nator
1. Meets once per month with a group of Neighbor Women (NW) to share behavior change practices using an education flip chart	X			
2. Reports to the Promoter on a bi-weekly basis the number of NW he/she has visited or who attended the behavior change meeting	X			
3. Meets monthly with the local leadership committee in each community for coordination, monitoring and evaluation (if these committees exist)		X		
4. Monitors and reports vital events that have occurred in her NG, such as births, deaths and severe illness	X			
5. Prepares a monthly report using the information provided by Supervisor				X
6. Mobilizes NW to participate in community activities that will benefit their families, such as immunization campaigns, food distribution or latrine construction	X			
7. Models the health, nutrition and sanitation behaviors she is teaching NW	X			
8. Coordinates local-level activities and maintains cooperation with other community-level institutions, such as the village council, churches and schools		X		
9. Completes monthly reports based on volunteer and NW registers		X		
10. Monitors behavior change among the CGVs		X		
11. Attends meetings organized by the Supervisor		X		
12. Maintains a filing system in the project office so copies of Promoter reports and quality improvement and verification checklists (QIVCs) are easily accessible			X	
13. Responsible for the performance and professional development of the Promoters who report to him/her			X	
14. Models leadership to all staff and intentionally develops the Supervisor's leadership potential				X
15. Reviews flip chart lesson plans with Promoters every 2 weeks to ensure they understand the information well and can teach the information in a participatory manner			X	

Task/Responsibility	CGV	Promo-ter	Super-visor	Coordi-nator
16. Assesses staff capacities and coordinates initial or ongoing trainings based on need and program goals				X
17. Visits, monitors and evaluates at least one CGV from each CG each month, and supervises CGVs' work by accompanying them on home visits and observing them leading group meetings		X		
18. Collects Promoter reports on a monthly basis, reviews the reports and ensures the information presented is reasonable and complete			X	
19. Ensures that the project is well represented in regular provincial/state/national-level meetings and forums				X
20. Prepares a monthly report using the information provided by Promoters			X	
21. Plays a lead role in the recruitment, orientation and training of new technical program staff				X
22. Supervises each Promoter who reports to him/her in the field at least twice per month, conducts QIVCs and completes all sections of the Promoter supportive supervision checklist every quarter			X	
23. Ensures that Supervisors and Promoters have the supplies necessary				X
24. Supervises each Supervisor who reports to him/her in the field, conducts QIVCs and completes all sections of the Supervisor supportive supervision checklist				X
25. Attends CG meetings held by the Promoter	X			
26. Ensures internal and external reporting and documentation requirements are completed on-time and accurately				X
27. Facilitates/organizes participatory learning sessions with each of their CGs		X		

Lesson 6 Handout 2: Care Group Team Essential Responsibilities

These are guidelines. Each program will establish its own job descriptions for each staff member and volunteer.

Care Group Volunteer (CGV)

1. Meets with 10 Neighbor Women (NW) at least once per month to promote behavior change using an educational flip chart
2. Visits each neighbor woman at home once per month (according to the need and the relevance of the behavior) to negotiate behavior change
3. Reports to the Promoter on a bi-weekly basis the number of NW she visited and who attended the behavior change meeting
4. Monitors and reports vital events that have occurred in the community, such as births, deaths and severe illness
5. Mobilizes NW to participate in community activities that will benefit their families, such as immunization campaigns, food distribution or latrine construction
6. Attends Care Group (CG) meetings provided by the Promoter
7. Reports problems that cannot be solved at the household level to local leadership, and request support and collaboration from the Promoter
8. Models the health, nutrition and sanitation behaviors she teaches NW

Promoter

1. Coordinates local-level activities and maintain cooperation with other community-level institutions, such as the village council, churches and schools
2. Meets with the local leadership committee in each community to coordinate, monitor and evaluate (if these committees exist)
3. Facilitates CG meetings with his/her Care Group Volunteers (CGVs) every two weeks following the lesson plans in the educational materials provided
4. Attends training and reporting meetings provided by the Supervisor and the module training sessions to accurately replicate trainings given by the CGVs, sharing correct information and demonstrating skills learned
5. Models the health, nutrition and sanitation behaviors he/she teaches CGVs in his/her own homes
6. Supervises each CGV at least quarterly by accompanying them on home visits and observing them leading group meetings
7. Assists with other program activities, such as national vaccination days, distribution of vitamin A and deworming medicine, and weighing children under 5
8. Completes monthly reports based on the CGV registers and NW registers

Supervisor

1. Coordinates with project partners, project staff, the Ministry of Health (MOH) and other stakeholders on upcoming community- and regional-level activities and needs
2. Responsible for the performance and professional development of Promoters that report to him/her
3. Reviews flip chart lesson plans with Promoters and ensure they understand the information well and can teach the information in a participatory manner
4. Collects Promoter reports on a monthly basis, reviews the reports and ensures the information presented is reasonable and complete
5. Prepares a monthly report using the information provided by Promoters
6. Maintains a filing system in the project office so copies of Supervisor and Promoter reports, and quality improvement and verification checklists (QIVCs) are easily accessible
7. Supervises each Promoter that reports to him/her, conducts QIVCs and completes all sections of the Promoter supportive supervision checklist every quarter
8. Ensures that Promoters and CGVs have the supplies necessary to do their jobs (e.g., registers, flip charts, lesson plans)

Coordinator

1. Leads program planning and provides strategic direction to program managers
2. Ensures that internal and external reporting and documentation requirements are on-time and accurate
3. Assesses staff capacities and coordinates initial or ongoing trainings based on need and program goals
4. Plays a lead role in the recruitment, orientation and training of new technical program staff
5. Models leadership to all staff and intentionally develops the Supervisor's leadership potential
6. Prepares a monthly report using the information provided by the Supervisor
7. Supervises in the field each Supervisor who reports to him/her at least once per month, conducts QIVCs and completes all sections of the Supervisor supportive supervision checklist every quarter
8. Ensures that the project is well represented in regular provincial/state/national-level meetings and forums

Lesson 6 Flip Chart 1: Importance of Care Group Volunteer Qualities/Selection Guidelines

Essential	Desirable	Not Necessary

Lesson 6 Handout 3: Examples of Care Group Volunteer Qualities/Selection Guidelines

Note: The following list of qualities is not meant to be prescriptive; it contains examples that other projects have used. Your project team may have different ideas of what may or may not be considered necessary. For example, in some project areas literacy levels are very low, so only a few volunteers will know how to read and write.

1. Willing to work as a volunteer
2. Desires to serve his/her neighbors
3. Female
4. Positive attitude (hopeful and optimistic)
5. Is a mother or grandmother
6. Models good hygiene, sanitation and nutrition practices
7. Respected by the community
8. Capable of leading a discussion with 8–12 women
9. Expresses an interest in health issues
10. Is not addicted to alcohol
11. Does not smoke
12. Knows how to read and write
13. Has permission from her husband to be a volunteer
14. Married or widowed
15. Religious and devoted (any religion)
16. Has children
17. Has a bicycle
18. Has children in good health
19. Has had at least 3 years of primary education
20. Has a good (moral) man for a husband
21. Has good social relationships with community leaders
22. Is between 18 and 40 years of age
23. Has good relationships with existing community health workers

Lesson 7: Volunteer Motivation and Incentives

Achievement-Based Objectives

By the end of this lesson participants will have:

- Explained why it is important to keep Care Group Volunteers (CGVs) motived
- Identified ways that the Care Group (CG) approach typically helps to keep CGVs motivated
- Listed practical, creative ideas to make CGVs feel motivated

Duration

1 hour

Materials Needed

- Flip chart paper and markers
- Lesson 7 Handout 1: Programmatic Reasons to Keep Care Group Volunteers Motivated
- Lesson 7 Handout 2 and Flip Chart 1: Three Volunteer Motivators
- Lesson 7 Handout 3: Ideas to for Ways to Help Care Group Volunteers Feel Connected, Valued and Effective

Steps

1. Introduction

    1a. Tell participants: Now that we've talked about the responsiblities of each member of the Care Group team, let's talk about what distingquishes the Coordinators, Supervisors and Promoters from the Care Group Volunteers.

    1b. Ask participants: What is a significant difference between these two groups? Answer should include: The first group (Coordinators, Supervisors and Promoters) are all paid staff, whereas CGVs are not paid.

    1c. Explain that in this lesson we are going to talk about how to keep CGVs happy and motivated to work.

2. Why Care Group Volunteers are Good for the Program

    2a. Ask participants: Why are Care Group Volunteers the strength of a Care Group program? Answers may include:

    - They work without monetary payment, allowing for greater adoption of practices by program intended beneficiaries with lower cost to the program.
    - They provide sustainable service that do not require new grants or or other sources of income.

- They already have close relationships with their neighbors. They will always be part of this community and have a long-term investment in the community and people they serve.
- They have children of their own and know the local practices.
- They have a common language, history and experiences with their neighbors.
- They are learners along with their neighbors. What they learn can be easily shared with and observed by their neighbors.

2b. Explain to participants: For the good of the program, sometimes an ineffective volunteer must be removed. Project goals should include retaining high-quality volunteers, mentoring those that are weak and removing those that are long-term low-quality performers. For example, if you are teaching about exclusive breastfeeding and the volunteer is teaching incorrect information to the Neighbor Women, malnutrition might increase! Volunteers should be supervised and helped to gain skills and adopt the new behaviors themselves, making sure they are meeting regularly for training and are equipped with correct information.

3. Activitiy: Keeping Care Group Volunteers Motivated

3a. Ask participants: Why is it important to keep volunteers happy and motivated? List their answers on a flip chart.

3b. Pass out **Lesson 7 Handout 1: Programmatic Reasons to Keep Care Group Volunteers Motivated** and explain each reason.

3c. Ask participants to compare the reasons that they gave on the first flip chart to each topic on Lesson 7 Handout 1.

Experience with Incentives

Concern Worldwide has successfully used giveaways, like t-shirts and tools for work (registers and teaching materials), as incentives for CGVs. These are referred to as non-monetary incentives, but they serve as extrinsic motivators that support intrinsic motivation (through having tools for work and feeling supported and valued by project staff).

3d. Ask participants to raise their hands if they have ever done any volunteer work. Instruct participants to tell the person next to them what volunteer work they did and why they did it. Ask them to share with each other what motivated them to work without pay. After a few minutes, ask participants to return to the larger group and to share some reasons that kept them motivated to work voluntarily.

3e. Show **Lesson 7 Handout 2 and Flip Chart 1: Three Volunteer Motivators** and explain that, based on research by McCurley and Lynch, there are three common motivators to volunteerism: **feeling connected, feeling valued and feeling effective**. Cover the responses to each category until after the participants have given their own ideas, then reveal.

- First explain why **feeling connected** is important to volunteer motivation.
  - Explain to participants: Volunteers need to feel like they are part of a group; they need to feel connected to others and to the group as a whole.
  - Ask participants in their small groups to identify how the CG approach helps CGVs feel connected. Ask two or three participants to share their answers with the larger group.
  - Uncover the three relationships that affect connectedness on Lesson 7 Handout 2 and Flip Chart 1, and compare them to participants' responses.
- Next explain why **feeling uniquely valued** is important to volunteer motivation.
  - Explain to participants: Volunteers need to feel like they have something to offer the program, that their personal skills and life experiences are valued.
  - Ask the participants in their small groups to identify how the CG approach helps CGVs feel valued. Ask two or three participants to share their answers with the larger group.
  - Uncover on Lesson 7 Handout 2 and Flip Chart 1 the ways volunteers feel uniquely valued, and compare them with participants' responses.
- Lastly explain why **feeling effective** is important to volunteer motivation.
  - Explain to participants: Volunteers need to feel like they are making a difference; they need to feel effective. Volunteers will become discouraged and quit if they believe that their time and effort is not being used well. This means that volunteers should be continually reminded that they are working on something that matters, as well as be provided with feedback on their success and the success of the program.
  - Ask the participants in their small groups to identify the tools the CG approach uses to help CGVs feel effective. Ask two or three participants to share their answers with the larger group.
  - Uncover the tools listed in Lesson 7 Handout 2 and Flip Chart 1, and compare them with participants' responses.

4. From Theory to Practice

   4a. Explain to participants: It is one thing to talk about motivation theoretically and another thing to implement it. So let's begin to think practically within the context of our Care Group programs.

   4b. Divide participants into small groups, and give each group a marker and some blank flip chart paper. Ask each group to brainstorm and write down actions to help CGVs feel more connected, valued and effective. Remind the groups that their ideas should

be sustainable and that the program budget is limited, so they should focus on ideas that are free or very low cost.

4c. After about 15 minutes, ask small groups to post their ideas on the walls. Have the groups do a gallery walk and note the most creative and feasible ideas. Ask each small group to "star" those ideas.

4d. Review the most creative and feasible ideas with the entire group.

4e. Refer participants to **Lesson 7 Handout 3: Ideas for Ways to Help Volunteers Feel Connected, Valued and Effective** for more ideas.

Understanding CGV Motivation

ADRA began implementing CGs through its JENGA II project in South Kivu, Democratic Republic of Congo, in September 2012. At the beginning of the CG program, local staff did not understand that CGV training is conducted at the village level and requires no budget other than for making flip charts for the CGVs. The local staff initially felt that CGVs would not attend the training without tea, meals or some other incentives, even though the 2-hour training was relatively short. Now there is a clear understanding among local staff that CGVs are motivated intrinsically, for example by the satisfaction of helping their neighbors, community recognition and the benefits to themselves and their families from what they are learning.

5. Wrap Up

5a. Explain to participants: Many nongovernmental organizations have fallen into the trap of thinking that they have to provide many tangible (costly) incentives to ensure that CGVs are happy and motivated. With more reflection and creative thinking, we can learn to use other more sustainable and effective means to keep our volunteers feeling connected, valued and effective.

Lesson 7 Handout 1: Programmatic Reasons to Keep Care Group Volunteers Motivated[15]

1. Intellectual Capital

You have spent time, money and effort training Care Group Volunteers (CGVs). When a CGV leaves or stops working for the program, the organization loses all of the CGV's experience, training and skills. The Care Group (CG) loses its continuity. Just as a family feels loss when someone dies or goes away on a long trip, a CG can feel a similar loss when a CGV stops participating for whatever reason.

2. Financial Investment

When CGVs leave the program, Promoters and CG colleagues must reinvest time, money and energy to retrain a new person. New materials, specifically flip charts, might be needed. The new time and energy spent puts a strain on the organization or CG, which can lower satisfaction.

3. Neighbor Women Satisfaction

If Neighbor Women know their CGV has been working in their community for many years they are more likely to believe her, especially if they have seen her bring change to the community and make a difference. New CGVs lack the same trust, time and relationship with the Neighbor Women, making it harder to reach program goals.

4. Reaching Program Goals of Reducing Death from Malnutrition/Child Stunting

With each staff turnover, we have to refocus time or retrain. This moves us away from our intention of focusing on behavior change to reduce malnutrition.

[15] The headings in bold can be written on a flip chart.

Lesson 7 Handout 2 and Flip Chart 1: Three Volunteer Motivators[16]

1. The Need to Feel Connected

The three relationships that affect connectedness are:

- The relationship between a volunteer and her Promoter
- The relationship between a volunteer and and the women in her community
- The relationship volunteers share with each other

2. The Need to Feel Uniquely Valued/Valuable

- Care Group team members know each volunteer by name, as well as her family situation.
- Care Group team members regularly give sincere and specific praise to the volunteer, both in private and in front of others.
- Promoters encourage each volunteer's strengths and show tolerance and understanding of her weaknesses.

3. The Need to Feel Effective

Tools the Care Group program uses to help volunteers know that they are effective and are part of an effective program include:

- Supportive supervision forms
- Quality improvement and verification checklists (QIVCs)
- Training pre- and post-tests
- Behavior change tracking tools
- Baseline and follow-up surveys

[16] Only the headings in bold should be listed on the flip chart.

Lesson 7 Handout 3: Ideas for Ways to Help Volunteers Feel Connected, Valued and Effective

Ways to Feel Connected

- Celebrate group achievements, such as recognizing when all Care Group Volunteers (CGVs) are present at three meetings in a row.
- Invite special guests to Care Group (CG) meetings that can speak on how the program has impacted them personally, such as testimonies from community members that have seen malnutrition decrease in their homes.
- Provide CGVs with goods (such as hats and shirts) that identify them as part of a larger group.
- Hold regular staff meetings so CGVs have the opportunity to ask questions, clarify their roles and participate in decision making.
- Bring up with project management concerns CGVs raise during meetings so they feel that their voices are important.
- Develop a program identity, for example, by using slogans, team phrases and a formal program name.
- Share life events, such as weddings or funerals, together. Foster an environment where CGVs can support each other through these life events.
- Arrange site visits to other programs so CGVs have a better understanding of the big picture of what they are working toward.

Ways to Feel Uniquely Valued/Valuable

- Identify a “Care Group of the Month” to be recognized at a monthly meeting. Specify the reasons that volunteers received the award.
- Rotate special roles (e.g., committee secretary) so that more people have the opportunity to hold unique positions.
- Express concern for the individual needs of volunteers.
- Spend time each year discussing the positive things Promoters have seen in the lives of the volunteers.
- Provide a special celebration annually.
- Give annual certificates or awards that highlight volunteers’ special qualities (e.g. most inspirational).
- Learn each volunteer’s name, address her by name, and thank her regularly.
- Provide time at CG meetings so that volunteers have the opportunity to voice their individual experiences, challenges and concerns.
- Share life events, such as weddings or funerals, together. Foster an environment where CGVs can support each other through these life events.

Ways to Feel Effective

- Ask volunteers or community members to share their testimonies on how the program has changed their lives.
- Provide consistent and objective feedback on each volunteer's performance.
- Hold annual community celebrations to share program results and to recognize what has been accomplished over the previous year.
- Invite local leaders to provide words of encouragement.
- Ask volunteers for their opinions when deciding how to address any special needs of a beneficiary.
- Create posters that show volunteers' progress toward targets.
- Hang a banner to celebrate major accomplishments.
- Let volunteers know when a person from outside of the community notices their work.
- At each volunteer training, provide quarterly updates of recent evaluations, field visits or surveys.
- Hold discussions where volunteers can share their success stories with each other. We often focus on the troubles we are having, but we need a balance. Many times we need the know about successes to keep us motivated.

Lesson 8: Behavior Change and Care Groups: What Happens in a Care Group Meeting, Neighbor Group Meeting and Home Visit

Achievement-Based Objectives

By the end of this lesson participants will have:

- Named the two most critical behavior change responsibilities of Promoters and Care Group Volunteers (CGVs)
- Reviewed an outline of a typical set of Care Group (CG) meeting modules
- Identified the different elements of a typical CG lesson
- Matched facilitation cues to the steps of a CG meeting
- Reviewed the agenda of a bi-monthly meeting between Supervisors and Promoters
- Contrasted the various types of meetings

Duration

1 hour 30 minutes

Materials Needed[17]

- Flip chart paper and markers
- Lesson 8 Handout 1: Example Modules and Lessons Outline
- Lesson 8 Handout 2: Care Group and Neighbor Group Lesson Steps
- Lesson 8 Handout 3: Lesson Facilitation Cues (make 5–6 copies and cut pictures apart without the titles of the steps)
- Larger-scale versions of each facilitation cue, as found in Lesson 8 Handout 3
- Lesson 8 Handout 4: Bi-Monthly Training Meeting Structure
- Lesson 8 Handout 5: Example Bi-Monthly Training Meeting Agenda

Steps

1. Introduction

    1a. Tell participants: Now that we've discussed the Care Group structure, Care Group team members and their responsibilities, how to organize communities into Care Groups and how to keep Care Group Volunteers motivated, we need to look at the main behavior change activities of the Promoters and Care Group Volunteers.

    1b. Ask participants: What are the most critical responsibilities that Promoters and Care Group Volunteers have that result in changed behaviors? Answer should include group meetings and home visits.

[17] In the near future it is hoped that video of a CG meeting will be available. When this happens, it should be incorporated into this lesson as a way to demonstrate the steps and the quality of a behavior change meeting.

1c. Explain to participants that healthy behaviors are introduced first by the Supervisors to the Promoters, then by the Promoters to the CGVs. This usually happens at monthly or bi-weekly meetings, with only one lesson being taught at each meeting. CGVs then introduce the new behaviors to their Neighbor Women (NW) during Neighbor Group (NG) meetings and home visits. Since these are critical behavior change activities, projects need to make sure that those meetings are as effective as possible.

2. Care Group Module and Lesson Process

2a. Explain to participants: Typically there are four to six modules used to train CGVs to promote healthy behaviors among NW, each of which is related to a specific theme, such as healthy pregnancy and delivery, newborn care and nutrition, or infant nutrition. Each module is then divided into different lessons. One lesson is taught each meeting.

2b. Refer participants to **Lesson 8 Handout 1: Example Modules and Lessons Outline**. Explain that this is one program's set of modules and lesson plans. Nongovernmental organizations (NGOs) can choose to take the modules and lesson plans that already have been developed and are available on the CG website (www.caregroupinfo.org) and adapt them to their specific cultural contexts. Or, NGO staff can develop their own modules and lessons. However, NGOs should keep in mind that meetings should not last longer than 2 hours and visual aids and participatory learning methods should be used during each lesson.

2c. Tell participants: Let's see how this would work in reality. (Write the following information on a flip chart.) If you have five modules with a total of 22 lessons and a new lesson is introduced every 2 weeks, how long would it take to cover all of the lessons? They should answer 44 weeks, or approximately 11 months.

2d. Ask participants: Is there anything you can think of that might prevent a program from being implemented so smoothly? At the community level, for example, there are holidays and local events that will disrupt the program, which could lead to implementation taking longer than originally planned. So, you always need to plan for more time to cover all the modules and lessons.

3. Care Group and Neighbor Group Lesson Structure

3a. Explain to participants: Over the years, Food for the Hungry has refined the behavior change process that takes place during the lessons. Specific steps are followed in each lesson. To help Promoters and Care Group Volunteers remember these steps, a picture called a "facilitation cue" has been assigned to each step. Facilitation cues are reminders to facilitators as they help others learn new skills and practices.[18] In the past we assigned words and letters to these steps, but now we just use the pictures as reminders. But, before we look at the facilitation cues, let's break down the steps in a typical lesson and the approximate amount of time spent on each step.

[18] Mitzi Hanold, Food for the Hunger, PowerPoint presentation on facilitation cues, available at http://www.caregroupinfo.org/vids/CGFacilitation/story.html.

3b. Refer participants to **Lesson 8 Handout 2: Care Group and Neighbor Group Lesson Steps** so they can follow along and see how much time should be allocated to each step.

3c. Review and explain the steps in the lesson.

- Step 1. Lesson objectives
  - Each lesson begins with the behavior, knowledge and belief objectives that will be covered. Most objectives are behavioral objectives, written as action statements. These are the behaviors that we expect the CGVs and NW to practice based on the key messages in the flip chart.
  - All of the materials needed for the lesson are listed under the objectives section in the agenda. Materials with an asterisk (*) should be brought by the Promoter.
- Step 2. Game or song
  - Each new lesson starts with a game or a song.
  - Ask participants: Why do you think this approach was chosen to start each lesson? Answers should include that games help mothers to feel relaxed and forget the worries of their day. Also, games build a sense of safety, and when women feel safe they are more likely to share their experiences, talk openly about their struggles and consider trying new practices at home.
- Step 3. Attendance and troubleshooting and Vital Events
  - Note who is present at the meeting. Find out if there are any vital events to report (births, deaths or new pregnancies).
  - During CG meetings only, discuss any problems CGVs had teaching the last lesson to NW.
  - At this point, the Promoter also discusses any materials needed for the next meeting and asks CGVs and NW to bring the items needed for the activity.
  - Ask participants: Why is this step important? Answers should include, to monitor who is attending the lesson regularly and who is not, and to help volunteers overcome challenges they may have.
  - During both the CG meetings and NG meetings, this step should also be used to ask how it went for volunteers and NW, trying out the behaviors or taking the actions they committed to last time. This provides an opportunity to troubleshoot any barriers that come up in practicing the new behavior.
- Step 4. Behavior change promotion through pictures
  - The Promoter or CGV reads the story printed on the flip chart, using the images to share the story. The story in each lesson is followed by discussion

questions. Discussion questions are used to discuss the problems faced by the two main characters in the lesson. Use the story and discussion questions to find out the current practices of the women in the group.

  - It is important that these pictures be informed by the formative research that should have been conducted to better understand the barriers to behavior change. For example, if mothers say that their own mothers and mothers-in-law do not approve of exclusive breastfeeding (EBF), then the flip chart picture should show a grandmother helping her daughter (the child's mother) to breastfeed or refusing to let her daughter give water to an infant.

- Step 5. Activity (demonstrate the behavior)

  - Ask participants: Do people usually change their behaviors if you just tell them to? They should answer, no, not usually.
  - Tell participants: Behavior change will be much more likely if you arrange for Care Group Volunteers and Neighbor Women to try out the new behavior in a safe environment. That is the purpose of this part of the lesson. Talking alone will not be as effective as demonstrating and practicing. Therefore, each lesson includes an activity. The Promoter is responsible for organizing materials for each lesson's activity.
  - The activity uses materials provided by CVG or NW from their own homes to create, as much as possible, a "real life" situation.
  - Keep in mind that some behaviors cannot be demonstrated during the meeting.

- Step 6. Discuss potential barriers and solutions

  - Ask participants: Why do you think discussing potential barriers to practicing the new behavior is so important? Answers should include that it gives the CGVs and NW an opportunity to seriously consider what it will take to try the new behavior.
  - When CGVs and NW discuss barriers during each lesson, they have to really imagine doing the behavior within their household context. This takes the women beyond just hearing about the behavior. It also leads to the next step, which is also critical.
  - In this step everyone is engaged in helping to figure out how to overcome the barriers they mention. It is not the only the responsibility of the Promoter to offer up solutions. Brainstorming solutions is a group responsibility and will help to empower the women to become effective problem solvers.

- Step 7. Practice and coach

  - For CG meetings between Promoters and CGVs: This is the opportunity for each CGV to practice teaching a lesson to someone else and for the Promoter

to give advice about the CGV's facilitation skills. This helps the CGVs become familiar and comfortable with the flip charts and the messages.

  - For meetings between CGVs and NW: This opportunity allows NW to practice telling each other the key messages they learned, and provides a chance to practice how they might tell other family members about the lessons they have learned.

- Step 8. Request a commitment to try out the new behavior

  - Ask participants: Why do you think we ask Care Group Volunteers and Neighbor Women to commit to trying the new behavior, or to at least take a step towards trying the behavior? Why is this important?

  - Tell participants: Studies have shown that when someone promises to do something they are much more likely to do it. The facilitation cue for commitment should reflect how people make a promise in the local culture.

4. Facilitation Cues

   4a. Tell participants: Now that we've discussed the steps of lessons given in meetings between Promoters and Care Group Volunteers, let's look at the pictures that help Promoters remember the steps.

   4b. Ask participants: What are these pictures called? They should answer "facilitation cues".

   4c. Before the training, make 5–6 sets of the pictures found in **Lesson 8 Handout 3: Facilitation Cues**, but without the lesson step names. Give a set of pictures to each table of participants. Ask the participants to examine the pictures and decide which step in the meeting the picture seems to best prompt. Put the pictures in the order just described and shown in Lesson 8 Handout 2. Ask the participants to check their work by referring to Lesson 8 Handout 3.

   4d. Share with participants that if they have good Internet access, they might enjoy viewing an interactive narrated presentation on facilitation cues found at http://www.caregroupinfo.org/vids/CGFacilitation/story.html, that they can watch as homework.

5. Neighbor Groups as Peer Support Groups

    5a. Share with participants the following information on the importance of peer support as part of the CG approach.

    - Peer support is an important element in the success of the CG approach, and we need to be mindful of it and not to take it for granted. CGVs receive and give one another much needed support at their regular CG meetings, facilitated by the Promoter. The same thing happens at NG meetings, facilitated by the CGV. CGVs will have modules to cover and behaviors to promote, which will be much more effective if they do not rush through the material, but allow plenty of time for participation and sharing of experiences and concerns.

    - This peer support that CGVs and NW give and receive can be highly rewarding and contributes powerfully to motivation and the desire to stay actively involved. It is key in building new social norms and support for the new behaviors being promoted. This support helps mothers through major transitions (such as, becoming a mother or a death), joys and sorrows, and all the large and small challenges life and motherhood brings. Peer support also has been shown to prevent depression. Though the effects of peer support are not easy to separate out from other project interventions and may be difficult to quantify, the power of mother-to-mother support should never be underestimated. It is an important ingredient that makes the CG approach so successful.

6. Activity: Delivering a Lesson during a Home Visit

    6a. Remind participants that some projects use both NG meetings and home visits to deliver the lessons. Some use only home visits, and others use only group meetings and provide home visits only to women who missed a NG meeting.

    6b. Tell participants: Suppose you wanted to adapt the steps and facilitation cues to a home visit context, either as a one-on-one visit with a neighbor woman or as a shorter lesson to the entire household. There are considerations to make, but this is certainly doable.

    6c. If the facilitator's project has an established procedure for delivering a lesson during the home visit, you can share that information with participants rather than having them do the activity in Step 6d.

    6d. If the facilitator's project does not have an established procedure: Instruct participants: Discuss in your small groups whether or not you would adapt the steps for a home visit and, if so, what you would change. On a piece of paper, list the steps you would use to deliver a lesson during a home visit and post the paper on the wall. Then circulate around the room to see what the other groups decided.

    6e. Discuss how to modify each step with the entire group, as follows.

- Step 1. Lesson objectives: It probably is important to tell the neighbor woman and her household the objectives or topic of the current lesson.
- Step 2. Game or song: Including either a game or song may depend on the activity. For example, some women will want to learn the hand washing song or the whole household will enjoy the game. Other times, creating a safe and comfortable atmosphere with a little relaxed conversation and greeting everyone in the family might be more beneficial.
- Step 3. Attendance and troubleshooting: Of course, it would seem a little silly to take attendance with only one neighbor woman present in her own home. But, you would want to know if she has important news, such as a new pregnancy, and this would be a great time to find out if she needs a little support and troubleshooting with her attempts to try out new behaviors from previous lessons.
- Step 4. Behavior change promotion through pictures: This step should definitely be carried out. In many cases, most of the household, including adults and older children in addition to the NW, will be interested in hearing the story and seeing the pictures from the flip chart.
- Step 5. Activity (demonstrate and practice the behavior): Whether this step is carried out will depend on the activity. But, where possible, you should demonstrate the behavior.
- Step 6. Discuss potential barriers and solutions: This step should be carried out, as it can be a very important discussion to have with influential household members for certain behaviors where influencers have a big role in determining whether the behavior is practiced or not.
- Step 7. Request a commitment to try out the new behavior: Yes, this step should be carried out. Remember, the commitment can be to take a small action, or first step, towards adopting the new behavior, such as “I will tell my husband what I have learned and talk with him about building a latrine.” The neighbor woman does not have to promise to build the latrine this week.

7. Bi-Monthly Meeting between Supervisors and Promoters

   7a. Tell participants: Now that we have reviewed in detail what takes place during the meetings between Promoters and Care Group Volunteers and between Care Group Volunteers and Neighbor Women, let’s take a bit of time to look into what happens during the training meeting between the Supervisors and their Promoters.

   7b. Ask participants to review **Lesson 8 Handout 4: Bi-Monthly Training Meeting Structure** and **Lesson 8 Handout 5: Example Bi-Monthly Training Meeting Agenda**. Ask participants to identify the similarities and differences between this type of meeting and the meetings between Promoters and CGVs.

8. Wrap Up

8a. Wrap up this lesson by reminding the participants that they should choose learning opportunities that require participants to actively engage in the learning process by talking to each other, practicing activities, playing games, laughing, singing, discussing and reflecting on the information. Whatever their role as a teacher or facilitator, they must always remember to be intentional about how they teach others. A successful training is one where the participants learn by discovering things on their own and by learning from their colleagues as well as from the facilitator. If the only person they hear from is the facilitator, a great learning opportunity will be lost. When preparing a bi-monthly training meeting or the next CG training, always plan for and encourage interaction and discussion amongst participants and be mindful of the importance of modeling good participatory training skills.

Lesson 8 Handout 1: Example Modules and Lessons Outline[19]

Module 1: Care Group Orientation and Essential Nutrition Actions (ENA) (7 Lessons)

Please note that the Essential Nutrition Actions recommendations have been updated. For the most recent information please see:

http://www.coregroup.org/component/content/article/413

This module introduces the Care Group (CG) model and discusses nutrition for pregnant and lactating mothers, anemia prevention and breastfeeding.

- Lesson 1: Introduction to the Program
- Lesson 2: Teaching Methods
- Lesson 3: Nutrition and Care during Pregnancy and Breastfeeding
- Lesson 4: Anemia Prevention
- Lesson 5: Immediate Breastfeeding
- Lesson 6: Exclusive Breastfeeding from Birth to 6 Months
- Lesson 7: Encouraging Mothers to Breastfeed

Module 2: Essential Nutrition Actions (ENA): Complementary Foods and Micronutrients (6 Lessons)

This module provides education about complementary feeding, good feeding practices and how to use dish drying racks. Additionally, participants will learn about vitamin A, nutrient-rich foods and monitoring child growth.

Module 3: Essential Care for Mothers and Newborns: Pregnancy and Postpartum (6 Lessons)

This module covers antenatal care, postpartum care for mothers and newborns, and a brief introduction to family planning.

Module 4: Essential Hygiene Actions (EHA): Personal Hygiene, Environmental Hygiene and Management of Diarrhea (6 Lessons)

This module includes diarrhea prevention, hand washing, creating a Tippy-Tap (hand washing station), disposing of feces, deworming, water purification, proper feeding of sick children and proper food storage.

[19] http://www.caregroupinfo.org/blog/narrated-presentations-on-care-groups-and-care-group-tools/care-group-curricula

Lesson 8 Handout 2: Care Group and Neighbor Group Lesson Steps

Step #	Step name	Time Allocated
1	Lesson objectives	5 minutes
2	Game or song	5 minutes
3	Attendance, troubleshooting and Vital Events	5 minutes
4	Behavior change promotion through pictures	30 minutes
5	Activity (demonstrate the behavior)	15–30 minutes
6	Discuss potential barriers and solutions	15 minutes
7	Practice and coach	20 minutes
8	Request a commitment to try out the new behavior	10 minutes

Total time: 2 hours or less

Lesson 8 Handout 3: Facilitation Cues

1. Objectives



2. Game or song



3. Attendance and troubleshooting



4. Behavior change promotion through pictures



5. Activity



6. Discuss barriers and solutions



7. Practice and Coach



8. Ask for a commitment



Lesson 8 Handout 4: Bi-Monthly Training Meeting Structure

What are the objectives?

- To encourage and improve Promoters' work
- To review this month's health lesson
- To discuss troubles or problems Promoters have encountered
- To coach and mentor the Promoters, giving them the ability to overcome these problems
- To alert the Promoters to upcoming program events
- To gather Care Group meeting attendance and vital information from the Promoters' last meetings with the Care Group Volunteers

Who attends?

- The Supervisor and his/her Promoters

Where is it held?

- At the office or another quiet place where nine or 10 people can sit comfortably
- If the project office is far from the communities where Promoters work, the Supervisor should travel there; in some projects the Promoters rotate hosting the meeting

How often does this meeting happen?

- Twice per month ideally (this will vary from program to program)

How long are these meetings?

- The meeting lasts about 6 hours (length will vary)
- The Supervisor should be mindful to be well organized and prepared so that the meeting will make good use of the Promoters' time (some must travel great distances)
- Some Promoters may have to arrive the day before and return home the day after

What is the cost?

- Refer to your staff budget
- A day-long meeting might include lunch (if budgeted)

What should the Supervisor bring?

- Flip chart for this month's health lesson and lesson plans
- A schedule of upcoming program information
- His/her work plan for the next month

- Regional monthly report form (to be filled out during the meeting by getting information from the Promoters)

What should the Promoter bring?

- Flip chart for this month's health lesson and lesson plans
- Attendance registers from their last meetings
- Quality improvement and verification checklists (QIVCs) used in the last month
- Completed monthly report from their last meetings
- Their work plans for the next month

Lesson 8 Handout 5: Example Bi-Monthly Training Meeting Agenda

Example meeting duration: 2 hours 10 minutes		
Activity	**Objective**	**Ideas/Materials/Activities**
1. Review of the flip chart lesson (20 minutes)	To reinforce key health practices To reinforce activities that accompany the teaching of the lesson	Use the lesson plan template to help you remember each part of the lesson, including the game, discussion of barriers and activity. Demonstrate/model the teaching of the entire lesson.
2. Practice and coaching (1 hour – 1 hour 30 minutes)	To ensure Promoters are able to teach the lessons effectively	Break up the Promoters into pairs so they can teach the lessons to each other while the Supervisor observes and coaches them.
3. Collect and review Promoter reports (20 minutes)	To gather information on vital events and attendance for quarterly reports To meet monthly and quarterly targets	Promoters fill out the report using their completed registers. Registers track attendance, vital events and other key program elements. (Registers that are made with carbon copies can allow the Promoter to turn in one copy of their report to the Supervisor and retain a copy for their own records.) The Supervisor and the Promoters create a community- or district-level report.
4. Discuss solutions to problems that have arisen (30 minutes)	To help staff overcome problems, such as poor attendance or vital events that need intervention (e.g., Cholera outbreak)	Discuss good things that are happening, as well as the challenges. Work together to solve challenges and find a way forward.
5. Discuss plans for upcoming community or organization events (20 minutes)	To prepare staff and the community for upcoming events To ensure that no other events are planned that conflict with activities	Consider possible problems that could arise during these events. Work with the Promoters to create plans to overcome these problems. If a conflict is found, work together to reschedule events, if possible.
6. Review of Promoters' four-week work plan (5 minutes)	To ensure that Promoters are preparing all of their given activities and are scheduling them in advance	Promoter share the four-week work plan, prepared in advance. The Supervisor makes a copy of the work plan to have on file for him/herself.
7. Supportive supervision scheduling (5 minutes)	To let each Promoter know when the Supervisor will come for a planned visit	The Supervisor informs the Promoters of when they will receive their scheduled visit over the next month. Ensure both the Promoters and the Supervisor note the visit time and place.

Lesson 9: Home Visits: The Audience, Timing and Content

Achievement-Based Objectives

By the end of this lesson participants will have:

- Reviewed the Care Group Volunteer (CGV) role and responsibilities and pointed out the expectations related to home visits
- Defined the purpose of the home visit
- Identified the audiences and timeframes for a home visit
- Listed the qualities of an effective home visit
- Listed the components of the home visit
- Practiced conducting a home visit using previously learned communication skills and the steps in negotiated behavior change

Duration

2 hours 30 minutes

Materials Needed

- Lesson 6 Handout 2: Care Group Team Essential Responsibilities
- Lesson 9 Flip Chart 1: Purpose of a Home Visit
- Lesson 9 Handout 1: Purpose of the Home Visit
- Lesson 9 Flip Chart 2: Qualities of an Effective Home Visit
- Lesson 9 Handout 2: Role Play: Steps in a Home Visit using the Negotiated Behavior Change Process
- Lesson 9 Handout 3: Steps in a Home Visit
- Lesson 9 Flip Chart 3: Difficulties in Conducting Home Visits
- Flip chart paper and markers

Facilitator's Notes

Step 4 is a role play using the script in **Lesson 9 Handout 2: Role Play Dialogue: Showing Steps in a Home Visit using the Negotiated Behavior Change Process**. The role play requires three participants. If there are only one or two facilitators, enlist the help of as many participants as necessary to carry out the role play. Provide the participants chosen with the role play ahead of time to give them an opportunity to practice.

Steps

1. Introduction

    1a. Ask participants: If we only hold monthly Neighbor Group meetings with mothers, how many mothers do you think will adopt the new behavior? They should answer, not very many.

    1b. Ask participants: Why do you think not many mothers will change their behaviors after participating in a just a monthly Neighbor Group meeting? They should give answers like, because they will encounter difficulties when they try the behavior at home, maybe they will forget or maybe they are not really convinced.

    1c. Explain to participants that in many programs as part of their responsibilities, CGVs conduct home visits to their Neighbor Women (NW) after the Neighbor Group (NG) meeting. Home visits are the second part of the Care Group (CG) behavior change strategy. They allow CGVs to see if the NW are practicing the behavior(s) talked about in the NG meeting and to provide support if NW are encountering problems.

    1d. Refer participants back to the section on CGVs in **Lesson 6 Handout 2: Care Group Team Essential Responsibilities** and ask them to recall the frequency of home visits. Each CGV should visit each neighbor woman at least once per month, after the NG meeting.

2. Purpose of a Home Visit

    2a. Ask participants: What do you think is the purpose of a home visit? Keep in mind that a home visit should happen after the meeting the Neighbor Group meeting.

    2b. Brain storm potential answers with the participants for about 5 minutes, and write their ideas on **Lesson 9 Flip Chart 1: Purpose of a Home Visit**.

    2c. Refer participants to **Lesson 9 Handout 1: Purpose of a Home Visit**. Compare and contrast the information on the handout with what participants listed on Lesson 9 Flip Chart 1.

    2d. Tell participants that it is the job of the Promoter to help CGVs conduct effective home visits, during which mothers are strongly encouraged and assisted to adopt the new behaviors. This is what makes the CG approach more effective than other approaches. The Promoter will join CGVs from time to time on a home visit and use a quality assurance tool called a quality improvement and verification checklist (QIVC) to help make the home visit as effective as possible.

3. Qualities of an Effective Home Visit

    3a. Ask participants: Have any of you ever been visited at home by a community health volunteer, visiting nurse, church member or other such community leader? Thinking about one such home visit, how you did you feel about it? Was it a positive

experience? What made it positive? How did the person doing the visit act? (Skip these questions if no participant has experienced a home visit.)

3b. Ask participants to brainstorm the qualities of a good home visit. List them on **Lesson 9 Flip Chart 2: Qualities of an Effective Home Visit**. The list should include the signs of respect discussed earlier, such as:

- Show respect by calling the mother by her name.
- Ask if the time of the visit is convenient.
- Ask about the welfare of family members.
- Be culturally sensitive.
- Provide context-specific information.
- Show interest in understanding the mother's particular situation.
- Do not be intrusive.
- Be patient.

3c. Explain to participants that CGVs should show all these signs of respect to make the home visit as successful as possible and to increase the chances that the mother will try the new behaviors.

4. Role Play: Steps in an Effective Home Visit

4a. Explain to participants that you now will look at how a home visit should be conducted. The facilitators will demonstrate a simple home visit through a role play using a script provided in this lesson. The role play will include the steps in negotiated behavior change participants learned about in **Lesson 8: Behavior Change and Care Groups: What Happens in a Care Group Meeting, Neighbor Group Meeting and Home Visit**. The participants will observe and try to identify the different elements.

4b. Use **Lesson 9 Handout 2: Role Play: Steps in a Home Visit using the Negotiated Behavior Change Process** to conduct the role play. Ask participants to be mindful of the negotiated behavior change steps they observe.

4c. After the role play, ask participants to name the negotiated behavior change steps they observed. List these on a flip chart.

4d. Facilitator asks participants: What did you observe in this home visit that is different from the typical home visit? Point out that this role play focused on promoting behavior change through negotiated behavior change.

4e. The facilitator will then refer participants to **Lesson 9 Handout 3: Steps in a Home Visit** and ask them to identify which of the steps in the process correspond to the steps in negotiated behavior change they learned about in Lesson 8. They should identify steps 5–10.

Ask participants: Can you foresee any difficulties the Care Group Volunteer might have in conducting a home visit like this? What might these difficulties be? 6. Wrap Up

6a. Wrap up with a discussion of the lessons learned through the home visit role play

Lesson 9 Handout 1: Purpose of a Home Visit

1. Get to know the neighbor woman better. Allow time for individual dialogue.
2. Get to know the other members of the family. Engage any influencing groups.
3. Demonstrate to the neighbor woman that you (as the Care Group Volunteer) care about her as an individual.
4. Learn about the context in which the behaviors will be practiced so you will be better able to suggest ways to overcome obstacles.
5. Check if the neighbor woman and/or her family practice the behavior.
6. Negotiate with the neighbor woman about trying the new behavior. Help her to identify practical ways to overcome any barriers.

Lesson 9 Handout 2: Role Play: Steps in a Home Visit using the Negotiated Behavior Change Process

Conduct the role play in the order the steps are listed. Read the role play by line, from left to write. If a space in the table is blank, skip to the line under the next role.

Step	Care Group Volunteer Name: Rosemary	Neighbor Woman Name: Mary	Mother-in-Law Name: Fancy
1. Greet the neighbor woman in a friendly manner and, if they are present, introduce yourself to/greet the head of household.	Good morning, Mary. How are you doing? Did you remember that I was going to visit you today?	Hi, Rosemary. Yes, I remembered. Welcome. Come in.	
	How is your husband? Is he here now?	Oh, he's fine. But he's at work now.	
	Please tell him I said hello.	OK, I will. Thanks.	
2. Ask if other members of the family are present who might need to participate in the discussion (influencing groups).	Is your mother-in-law at home now? I would like her to join us if she can.	Yes, she's here. Let me get her.	
	(When mother-in-law arrives) Hello, my name is Rosemary and I'm here to talk with Mary about what she can do to keep the family healthy. We have been meeting with other mothers in the neighbor-hood these past few months to talk about this. I think your input will be important in this discussion.		Hi my name is Fancy. Yes, Mary has told me a bit about the meetings. I also think it's important to talk about ways to keep the family healthy.
3. Talk with the neighbor woman about changes in the health of the children, such as any cases of diarrhea. If a child is sick, observe the mother and refer the child to the health center for care, if necessary.	How are Paul and Timothy doing?	Both the kids are doing well now, thanks. But, last week Paul had a bout of diarrhea.	
	Hmm, I'm sorry to hear that. Tell me about what happened.	Well, it started on Monday. He had several loose stools for 2 days.	
	Hmm. That sounds serious. What did you do?	Well the first day I didn't do anything since all children get diarrhea from time to time. But then he got very weak and I got scared.	
	What did you do then?	I talked with my husband and we decided to wait another day to see what would happen.	

Step	Care Group Volunteer Name: Rosemary	Neighbor Woman Name: Mary	Mother-in-Law Name: Fancy
	I see. During this time, what were you giving Paul to eat and drink.	Well, I remembered the lesson, so I prepared the oral rehydration solution and gave that to him. I also encouraged him to eat. But he refused.	
	I am so pleased you prepared the oral rehydration solution. It's also important that children with diarrhea continue to eat. Then what happened?	As I said, even though I gave him the oral rehydration solution because he wasn't eating and the diarrhea continued, he got very weak. On the third day we finally decided to take him to the clinic where they gave him some medicine and he got better quickly.	
	I am glad you decided to take him to the clinic. How do you feel about that decision, Fancy?		Well, I wish we had taken Paul to the clinic sooner, like after the first day. The clinic is fairly close. But my son didn't approve.
4. Review the key points of the last (prior) Neighbor Group meeting.	Mary, can you tell me what you remember about the lesson about seeking help at the clinic when a child has diarrhea?	Hmm. We talked about how dangerous diarrhea in children can be and that it's important to go to the clinic. And that's what we did.	
	That's true. Do you remember what we said about when you should take a sick child to the clinic, as in how quickly?		I think Mary told me that it's important to go right away, like during the first day, 24 hours.
	That's right, Fancy. Good memory! If a child passes three loose stools in a day or has blood in the stool, it's very important to go to the clinic immediately. Waiting at home, even if you are giving oral rehydration solution, can be dangerous. A young child can easily die if the diarrhea is bad enough.		

Step	Care Group Volunteer Name: Rosemary	Neighbor Woman Name: Mary	Mother-in-Law Name: Fancy
5. Ask the mother about her experience trying to practice the new behavior.	What prevented you from going to the clinic more quickly?	Well my husband thought we should wait. He didn't think it was that serious.	
6. Listens to/reflect on what the mother says.	*Reflecting on Mary's response:* Hmm, I see.		
7. Identify difficulties/ obstacles to behavior adoption, if any, along with the causes of the difficulty.		Well if he doesn't agree then we can't go.	Yes, he needs to give Mary the money to buy the medicines.
8. Neighbor woman suggests different feasible ways to overcome the obstacles.	I see. So in the future it would be important to make sure your husband understands how serious diarrhea in children can be. How do you think we could help him understand this? What can you do?	I could arrange for you to talk to him.	
9. Solicit doable actions: Present options and negotiate with the mother to help her select one that she can try.	Fancy, is there anything you can do?		Well, I could also talk to him about the importance of seeking health care quickly, and if this happens again, I can remind him that we shouldn't wait. If he doesn't agree then I will try to convince him.
10. The neighbor woman agrees to try one or more of the solutions and repeats the agreed-upon action.	Those are all great ideas! Which of these solutions do you want to try?	I will talk to him about the importance of going to the clinic quickly when one of the kids has diarrhea and what can happen if we wait too long. Fancy, can you help me?	Yes, I can help you, for sure.
11. Set a date for the follow-up visit.	That sounds like a fine plan. I can also lend you the flip charts from the lesson. When do you think you'll have time to talk with him?	The picture will help to convince him. I'll try to do it this week. OK?	
	Yes, that's fine. Then would it be OK if I passed by the week after next, say 2 weeks from today, to see how things went?	Yes, that would be fine.	Yes, no problem.
12. Congratulate the neighbor woman on her	Well, Mary, I want you to know that it was great that	Thanks for the visit, Rosemary.	Yes, thanks for including me in the discussion. We

Step	Care Group Volunteer Name: Rosemary	Neighbor Woman Name: Mary	Mother-in-Law Name: Fancy
good work, and thank the neighbor woman for making time to talk with her and remind her when you will be coming back for a follow up visit.	you remembered to give oral rehydration solution to Paul when he had diarrhea. That really helped him a lot. Keep up the good work. And I'll see you 2 weeks from today.		look forward to seeing you again.

Lesson 9 Handout 3: Steps in Conducting a Home Visit

1. Greet the neighbor woman in a friendly manner and, if they are present, introduce yourself to/greet the head of household. Show a sincere interest in the situation of each family member to create confidence and reassure the family.
2. Ask if other members of the family are present who might need to participate in the discussion (influencing groups).
3. Talk with the neighbor woman about changes in the health of the children, such as any cases of diarrhea. If a child is sick, observe the mother and refer the child to the health center for care, if necessary.
4. Review the key points of the last (prior) Neighbor Group meeting.
5. Ask the mother about her experience trying to practice the new behavior.
6. Listens to/reflect on what the mother says.
7. Identify difficulties/obstacles to behavior adoption, if any, along with the causes of the difficulty.
8. Discusses with the neighbor woman different feasible ways to overcome the obstacles.
9. Recommend/solicit doable actions: Present options and negotiate with the mother to help her select one that she can try.
10. The neighbor woman agrees to try one or more of the solutions and repeats the agreed-upon action.
11. Set a date for the follow-up visit.
12. Congratulate the neighbor woman on her good work, and thank the neighbor woman for making time to talk with her and remind her when you will be coming back for a follow up visit.

Lesson 9 Handout 4: Home Visit Role Play Scenarios

1. The mother can't remember to wash her hands before she prepares food.
2. The mother thinks it's too expensive to buy soap for hand washing.
3. The mother doesn't have easy access to water for hand washing.
4. The mother thinks seeking care at a health facility can be expensive.
5. The mother thinks the (poor) service at the clinic isn't worth going there for a child with diarrhea.
6. The mother feels that oral rehydration solution (ORS) will make the child vomit.
7. The mother doesn't think that ORS will help the child regain health.
8. The mother can't remember how to make ORS.
9. The mother says it's difficult to treat water when chlorine isn't available in the market.
10. The mother can't remember how to treat the water.
11. The mother thinks her current water storage container (wide opening) is adequate.
12. The mother says her husband thinks it's too expensive to buy a jerry can to carry water home in.

Lesson 10: The Meeting[20] Schedule

Achievement-Based Objectives

By the end of this lesson participants will have answered the five key questions related to the different types of training (meetings) that takes place in a Care Group (CG) program.

Duration

1 hour 40 minutes

Materials Needed

- Lesson 10 Flip Chart 1: Behavior Change Meeting (Learning Event) Table (also serves as the Key for the game)
- Lesson 10 Handout 1: Behavior Change Meeting (Learning Event) Facilitation Responsibilities
- Lesson 10 Flip Chart 2: Behavior Change Meeting (Learning Event) Table for the Training Puzzle Game (one copy for each team printed on a flip chart)
- Sets of answers to Lesson 10 Flip Chart 2 written on Post-its or index cards (one set of answers for each team)
- Masking tape

Facilitator's Notes

You will need a large area to play the puzzle game. If necessary, move outside or move chairs away from the center of the room to give more room. Display **Lesson 10 Flip Chart 1: Behavior Change Meeting (Training Event) Table**. Leave this flip chart on the wall for the duration of this lesson.

Steps

1. Introduction

1a. Tell participants: We have discussed what the Promoters and Care Group Volunteers do to promote new and healthier behaviors among Neighbor Women and reviewed the contents of meetings between Promoters, Care Group Volunteers and Neighbor Women. In this lesson we are going to look at the bigger picture and learn about all the different levels of training that need to take place in the Care Group program. Specifically we are going to answer the following questions (while pointing to the Lesson 10 Flip Chart 1):

- Who is the facilitator?

[20] Many programs refer to these meetings as "trainings". However, since many people associate remuneration with training, some programs have opted to call them meetings or behavior change meetings. In these meetings the participants learn about the behaviors to be promoted.

- Who is attending the learning event/meeting?
- How long is the learning event/meeting?
- How often does the meeting occur?
- What materials are needed to conduct the meeting?
- Where does the meeting typically take place?

2. Overview of Care Group Meeting Structure

   2a. Using Lesson 10 Flip Chart 1 as a reference and **Lesson 10 Handout 1: Behavior Change Meeting (Learning Event) Facilitation Responsibilities**, answer the questions above for each CG team member. Explain that all members of the CG team from the Manager to the Care Group Volunteer (CGV) have responsibilities as facilitator and learner.

   2b. Explain that the table is meant only as a guide and that each program will create their own schedule of learning events/meetings.

   2c. Answer any questions from participants.

3. Activity: Training Puzzle

   3a. Divide the participants into three or four teams of equal numbers. Post/tape copies of **Lesson 10 Flip Chart 2: Behavior Change Meeting (Learning Event) Table for the Training Puzzle Game** in different places around the room. Give each team a set of the correct responses as found in Lesson 10 Flip Chart 1 written on Post-its or index cards with masking tape, mixed up and faced down. Ask the teams not to turn over the papers until you tell them to begin.

   3b. Have the teams line up, one team member behind the other (so, three or four rows of participants, one row for each team), standing 10–15 feet away from the flip charts that are taped to the wall.

   3c. Tell participants that the object of the game is for each team to complete the flip chart training table correctly by affixing all of the pieces of paper with responses to the table on the flip chart. Only one team member can be up at the team's training table flip chart at a time affixing a response. Other members of the team can make changes to the flip chart, but only during their turn.

   3d. Once all the teams have finished, note the order they finished and assign points accordingly. Compare each team's responses to Lesson 10 Flip Chart 1 and determine which team got the most correct responses. Assign 3 (or 4) points to the team with the most correct answers, 2 (or 3) points to the team with the second-highest number of correct answers, and so on. The team with the most points (points for order of completion + points for number of correct responses) wins the game.

4. Wrap Up

   4a. Wrap up this lesson by asking participants: What were the most important things you learned during this lesson?

Lesson 10 Flip Chart 1: Behavior Change Meeting (Learning Event) Table

This table is meant as a guide. Each program will develop its own schedule.

Facilitator	People in Attendance	Length of the Event	Frequency	Materials	Location
Manager	Coordinators, Supervisors and Promoters	5–7 days	Before each module distribution	New flip chart and lesson plan	Central location Large enough for the entire Care Group team
Supervisor	Promoters	½ day	Every 2 weeks or monthly	Review of this week's lesson in the flip chart and lesson plan	Central to the Promoters or in the project office
Promoters	Care Group Volunteers	2 hours	Every 2 weeks or monthly	Flip chart and lesson plan	Typically in the village of the Care Group Volunteers
Care Group Volunteers	Neighbor women	2 hours or less	Every 2 weeks or monthly	Flip chart	In the village near to where the Neighbor Women live

Lesson 10 Handout 1: Behavior Change Meeting (Learning Event) Facilitation Responsibilities

When the Manager Facilitates

- The Manager conducts a 5–7 day meeting for the Coordinators, Supervisors and Promoters to learn each new module before it is introduced to the Care Group Volunteers (CGVs) and Neighbor Women (NW).
- Depending on the level of expertise the Manager has about the topics covered in the module, it may be helpful to invite an experienced community health care provider to co-facilitate the meeting and/or be available to answer questions that arise.
- This meeting includes the technical basis for the module, training on the use of the lesson plan and several days of coaching of and practicing by each Coordinator, Supervisor and Promoter.
- Normally this meeting happens about every 3 months, assuming each module is about six lessons, or before the distribution of each module.
- Inviting personnel who work in the health facilities where the Care Group (CG) program is operating to attend the 5–7 day module training is an excellent way to promote collaboration between the government health system and the CG community health system. It also equips health facility staff with knowledge and tools to share the same behavior change practices when community members seek facility services.
- In larger CG programs, the distances required for staff to travel to bring all the Coordinators, Supervisors and Promoters together may be prohibitive, or there may be too many staff members to run an effective meeting. (It is not recommended to train more than 25 people at one time.) In these cases, the Manager should only train the Coordinators and Supervisors in the module content and then have the Coordinators and Supervisors train the Promoters in their region.

When the Supervisor Facilitates

- The Supervisors review this current lesson with the Promoters every 2 weeks (in some programs once per month) and spend time coaching them so they are ready to replicate the lesson with the CGVs.
- Remember this is the second time the Promoters will receive training on the module. The first training they received was the training by the Manager.

When the Promoter Facilitates

- The Promoters will teach a new lesson to the CGVs every 2 weeks (or once per month) and spend time coaching them so they are ready to teach others.
- This meeting includes discussion, games, activities and a time for discussing barriers and making commitments. Promoters will repeat with the CGVs everything that learned from their Supervisor and Manager.
- The materials needed are a flip chart and a lesson plan. The lesson plan is like a teacher's manual that guides the literate facilitator.
- Examples of detailed lesson plans that give literate staff extensive details about games to play with each lesson, activities to include and the procedure for the facilitator to go through each time she teaches are available at www.caregroupinfo.org.

When the Care Group Volunteer Facilitates

- CGVs teach a new lesson to their Neighbor Groups (NGs) every 2 weeks (or once per month). Remember that the steps in each meeting are objectives, game or song, attendance and troubleshooting, story and behavior change promotion through pictures, activity, discussion of potential barriers, practice and coach, and make a commitment.
- Most CGVs are not literate, so their only tool is the flip chart. However, they will model everything they saw and heard the Promoter say, so it is important that the Promoters model the correct facilitation behavior during each meeting.

Lesson 11 Flip Chart 2: Behavior Change Meeting (Learning Event) Table for the Training Puzzle Game[21]

Facilitator	People Attending	Length of the Event	Frequency	Materials	Location
Manager					
Supervisor					
Promoters					
Care Group Volunteers					

[21] See Lesson 10 Flip Chart 1 for the answers to the puzzle game.

Lesson 11: Supportive Supervision: Checklists and Supervisory Work plans

Achievement-Based Objectives

- By the end of this lesson participants will have:
- Defined supervision
- Distinguished supportive supervision from supervision
- Reviewed supportive supervision checklists
- Listed the different supportive supervision responsibilities of their position and those they supervise
- Prepared an example 4-week work plan for their position

Duration

2 hours

Materials Needed

- Flip chart paper, masking tape and markers
- Lesson 11 Flip Chart 1: Definition of Supportive Supervision
- Lesson 11 Handouts 1: Supervisor's Checklist for Supervising a Promoter
- Lesson 11 Handout 2: Coordinator's Checklist for Supervising a Supervisor
- Lesson 11 Handout 3: Program Manager's Checklist for Supervising a Coordinator
- Lesson 11 Handout 4 : Categories in the Supervisor's Checklist for Supervising Promoters
- Lesson 11 Handout 5: Supportive Supervision Table
- Lesson 11 Flip Chart 2: Blank Supportive Supervision Table (three or four copies)
- Three or four sets of 12 Post-its/index cards/pieces of paper with supportive supervision table answers written on them
- Lesson 11 Flip Chart 3: Blank Work Plan
- Lesson 11 Handout 6: Activities to Plan For
- Lesson 11 Handout 7: Sample Work Plan Schedules

Steps

1. Introduction

    1a. Tell participants: Now that we have discussed the Care Group structure, the content of the behavior change meetings and the schedule, there is another very critical topic that we need to cover. It is the one thing that is always the weak link in a program, especially in government services. What do you think it is? Yes, supervision. We always have the best of intentions when it comes to supervision, but quite often we fail to deliver. In this lesson we are going to be talking about a specific kind of supervision, called supportive supervision.

2. Defining Supervision and Supportive Supervision

2a. Have participants break into pairs and brainstorm a short definition of supervision. After a few minutes, ask participants to share their definitions. Write on a flip chart key words from each definition shared, then summarize the definitions given.

2b. Ask participants: In what ways is supportive supervision different from regular supervision? Tell participants to discuss again in pairs. After a few minutes, ask several participants to share their ideas.

2c. Display **Lesson 11 Flip Chart 1: Definition of Supportive Supervision**. Review the definition with participants, highlighting key phrases as noted below.

- It is a continuous process, not a onetime event.
- It is a planned and designed process.
- The purpose is to mentor and coach a worker so he/she can effectively accomplish the job.
- Three things the worker will gain from supportive supervision are: independence, self-confidence and skills.

2d. Ask participants to think about a Supervisor they had, and consider the following questions.

- What was it like? Did you receive supportive supervision visits or meet regularly with your Supervisor?
- Which of these aspects was missing?
- Do you think you could be a Supervisor who did these things?

2e. Tell participants: Remember that in order to change others we first have to change ourselves. I would encourage you to put the definition of supportive supervision on the wall of your office and practice doing these things with those you supervise.

3. Review of Supportive Supervision Checklists

3a. Explain that in a Care Group (CG) program using two different types of supervision tools is recommended. One is the supportive supervision checklist and the other is quality improvement and verification checklist (QIVC). Write these on a flip chart. Explain the difference between the two to participants.

- The supportive supervision checklist monitors and supports all aspects of a staff member's work
- The QIVC tracks the quality of a specific task, such as a behavior change meeting.

Tell participants: In this lesson we will present the supportive supervision checklist.

3b. Ask participants: For those of you who have supervised field workers before, what are the different things that you need to watch, observe and review on a supportive supervision visits?

3c. Refer participants to **Lesson 11 Handout 1: Supervisor's Checklist for Supervising a Promoter**, **Lesson 11 Handout 2: Coordinator's Checklist for Supervising a Supervisor** and **Lesson 11 Handout 3: Program Manager's Checklist for Supervising a Coordinator**.

3d. Ask participants: How do these actions compare to the Promoter's essential responsibilities? Answers should include that these categories should be reflective of the duties presented in **Lesson 6: Care Group Roles, Responsibilities and Job Descriptions**. Refer back to this lesson and discuss if the staff are confused or if they feel that there is any disconnect between the two.

3e. Each of these checklists is divided into categories. As an example, refer participants to **Lesson 11 Handout 4: Categories in The Supervisor's Checklist for Supervising Promoters**. Read the introduction at the top and go over the categories with participants. Ask participants: Why is it important to have a checklist for supportive supervision visits?

- A supportive supervision checklist makes it clear what a Supervisor is expected to do when they visit program staff.
- There are too many tasks for a Supervisor to do in just one supportive supervision visit. The checklist helps the Supervisor remember what he/she did last time and what still needs to be done.
- Recording behaviors over time helps us to see how we are improving and can provide encouragement to staff. It also helps us to see where there is more room to grow.
- Supportive supervision checklists help us identify and troubleshoot smaller problems before they become larger issues.

Example

Note to facilitators: Adjust the example as appropriate or use other examples from your own experience.

When I visit our project offices in the field, I am always surprised when I go to the latrine and see there is no soap or when I look for a place to wash hands and see that they have no hand washing station in the office compound. I can tell the minute I walk into the compound how the program is doing by the cleanliness and the health actions taken by the leaders of the program.

3f. In summary, during supportive supervision visits the Supervisor should:

- Watch what staff are doing
- Look at the reports and registers
- Talk to the people the staff work with, including Neighbor Women (NW), local community leaders and health center staff
- Observe the staff at home

3g. Ask participants: Why is observing the Promoter's household important? Tell them: If we don't practice what we are teaching, no one will listen to us. Someone may say

that that's a lot to ask the Promoter. If it's a lot to ask of the Promoter, then it's a lot to ask the mother in the community. To be effective facilitators and leaders in the Care Group program, staff must practice what they preach by putting into practice what they are learning. Therefore, also ask Promoters if they do the following practices.

- Do you have mosquito nets in your home and regularly sleep under them?
- Do you have a hand-washing station with soap near the latrine in your home?
- Did you wash your hands with soap before your last meal?

3h. Tell participants: We listen to people we trust who are open about their own lives. We listen to people that have tried the new practices and can tell us personally about them. One of the strengths of the Care Group model is that the Care Group Volunteers try the new practices first, then share with others their own experience and encourage them to try the new practice, too. If someone comes to you trying to sell something that they do not believe in or have not tried, their arguments will not be effective. In fact, you'll feel the practice is a waste of time.

4. Supportive Supervision Responsibilities and Work Plans

4a. Tell participants: Now that we have reviewed all of the checklists, we will look at an overview of the supportive supervision responsibilities of each staff member. To help us remember the key decisions related to supportive supervision, we developed a table.

4b. Refer participants to **Lesson 11 Handout 5: Supportive Supervision Table**. Review the sections of the table and answer questions.

4c. Point out to participants that many of the positions listed in Lesson 11 Handout 5 make surprise supervision visits from time to time. Ask participants: What's the purpose of surprise visits? Listen to their responses, then add the following if not already covered.

- Surprise visits ensure that work is being done appropriately every day and help Supervisors get a sense of the day to day working conditions. Workers can make special preparations for a meeting when they know someone is coming to visit. However, we want our workers to carefully prepare for each and every meeting.
- The working environment of a community worker is unstructured and depends a lot on personal discipline and motivation. Even the best employee may have a rough week and feel tempted to do personal tasks when he/she should be meeting with CGs or visiting a Promoter. Knowing that surprise visits could occur at any time can provide that additional motivation a community worker needs to accomplish his/her assigned task.
- Surprise visits should be part of routine, standard supportive supervision procedures. Let staff members know this and that no one is being singled out for

surprise visits. Many staff members appreciate that their Supervisor takes an interest in their work.

Surprise Visits

Some people have expressed concern about surprise visits, wondering whether it will weaken the relationship between workers and supervisor, giving the impression that workers are not trusted or respected. Food for the Hungry (FH) has not had this experience. Surprise visits can help workers remain disciplined about their work and help them avoid rumors that they are not doing their jobs properly. Surprise visits should be random in terms of the choice of the worker the supervisors visit in a given period, thus more equitable in the long run and not based on the level of trust a supervisor has for a given person.

4d. First, explain the manager's supportive supervision responsibilities.

- The Manager supervises the maternal and child health and nutrition Coordinator once or twice each quarter (about once every 6 weeks). The Manager visits the Coordinator in the office while he/she is carrying out all of his/her regular activities.
- Once per year, the manager visits one Coordinator without scheduling the visit. This is called a surprise visit.
- The Manager also observes the bi-monthly meetings led by the Supervisor.
- The Manager may visit the Promoters' homes and talks with them about the program.
- The Manager may observe the Neighbor Group (NG) and CG meetings.
- Every time the Manager visits the Coordinator, he/she will use the appropriate supportive supervision checklist.
- The Manager should know how to use the QIVC for behavior change meeting session feedback and should observe others using it, but is not required to use this on his/her visits.

4e. Next, explain the Coordinator's responsibilities.

- The Coordinator supervises each Supervisor once per month. Every third visit is a surprise. Every time he/she supervises the Supervisor, he/she will use the appropriate supportive supervision checklist and the QIVC.
- The Coordinator supervises the Supervisor in the office to review his/her reporting and filing systems, office supplies, etc., as listed on the supportive supervision checklist.
- The Coordinator should also observe the bi-monthly meetings done by the Supervisor to train Promoters, and uses the QIVC for meeting facilitation.

- The Coordinator visits the Promoters' homes and talks with them about the program.
- The Coordinator also observes the NG and CG meetings.

4f. Next, explain the Supervisor's supportive supervision responsibilities.

- Almost all of the Promoter's work is done in the community, so 90% of the supervisory observations are done in the community. Every time the Supervisor visits the Promoter, he/she will use the appropriate supportive supervision checklist and the QIVC.
- The Supervisor supervises each of his/her Promoters two times per month: one scheduled supervisory visit and one surprise visit.
- The Supervisor supervises his/her Promoters in their homes for that section of the supportive supervision checklist.
- The Supervisor supervises Promoters as they teach CGVs, using a QIVC for meeting facilitation to help them improve.
- The Supervisor sometimes observes NG and CG meetings. There are other sections on the supportive supervision checklist. The Supervisor also, for instance, visits the health facility and the community leaders. They should use the checklist to guide them in planning work responsibilities.

4g. Lastly, explain the Promoter's supportive supervision responsibilities.

- The Promoter visits CGVs in their homes. This is the "model" mother in the community, so the Promoter should be able to see by her home and her practices that she is following the things she is teaching. If not, the Promoters need to help her overcome the barriers that she is facing that prevent her from practicing the new behaviors. It is not a requirement to be a Promoter, but Promoters need to really help their CGVs to try the new behaviors and practice what they teach.
- The Promoter supervises CGVs, only using the QIVC for meeting facilitation, as they teach NGs. After the observation, the Promoter and CGV return to the CGV's home to give feedback using the QIVC. It is during this home visit that the Promoter also can ask about her nutrition, health and hygiene practices and observe her home.
- Ideally the Promoter would visit each CGV once per quarter. If he/she has nine CGs (the maximum) and if each CG has 15 CGVs (the maximum), this would be 135 total supervisory visits per quarter, or 45 supervisory visits per month. In this case she probably will not be able to follow this guidance. If she does two (or sometime three) supervisory visits per day, this would take more than 20 days. But, remember, most Promoters do not have this many volunteers, and not all volunteers will need to be supervised this frequently. As we will learn, the better performing CGVs can be supervised less frequently.

- Every time the Promoter observes a CGV, he/she should use a QIVC to improve, encourage and monitor the volunteer's work.

A Story Illustrating the Value of Inspections

Years ago, a highly trusted worker dipped into the *botiquin* (community medicine chest) cash to pay for her sick mother's insulin. She had hoped to pay it back before a routine inspection of the *botiquin* at the end of the month, but she was not able to return the money in time. As a result, she lost her privileges to handle money for quite a while.

Despite this there were no hard feelings between her and her employers as she knew the inspection was coming—it was part of the system for all workers who managed the sale of medicines, and she understood the value of the inspection. The inspections (and consequences) were applied equitably, not just to those workers that were trusted the least. Her employer gave her some grace, realizing that she was in a difficult spot with her mother and because she was remorseful. The system worked as designed.

5. Activity: Work Plans

5a. Tell participants: Next we are going to be putting your work into a work plans. What is a work plan?

- Very simply, it is a plan that gives details on the tasks that you will be doing over a period of time in the future.
- All the tasks that are given to you as a worker in the Care Group program can seem overwhelming, so planning your time out for a 4-week period helps you to do the work effectively and efficiently.

5b. Explain what CG work plans should include:

- Time for gathering and reporting data for monthly or quarterly reports
- Trainings (those the employee is receiving and conducting)
- Supportive supervision visits (those the employee is receiving and conducting)
- Dates of special health events (e.g., vaccination days)
- Visits to health facilities and other work related tasks

5c. Explain to participants that they will now do an activity to help them learn to use the work plans. Assign each small group one of the Care Group Team roles (Supervisors in one group and all Coordinators another.) Managers may visit both groups and help them as they develop a sample work plan.

5d. Provide each group with a copy of **Lesson 11 Flip Chart 23 Blank Work Plan** and refer them to **Lesson 11 Handout 6: Activities to Plan For**. Ask participants to create a work plan schedule on the flip chart using the list of activities in Lesson 11 Handout 6. They should fill up the entire schedule with the activities they know they will participate in.

There might be additional activities that each group participates in that are not listed in Lesson 11 Handout 6.

5e. Remind participants that they are working full time at 8 hours per day and 5 days per week. If an activity takes only 2 hours, they will need to add two or three other activities on that day to reach a full day's work. Remind them to be realistic about which activities can be done in a given period of time.

5f. Instruct participants to work on a piece of notebook paper first, then copy their final work plan onto the flip chart. When they are finished, have each group paste its work plan on the wall for everyone to see.

5g. Visit each group and help them with the work plan. It may take some time for them to organize their responsibilities this way. If one group is faster than other groups, ask them to develop a work plan schedule for the CGVs. If the participants are having trouble, work through the CGV schedule together at the front of the room. Once all work plans are posted, have the different groups walk around and appreciate the work of the other groups.

5h. Use the sample schedules found in **Lesson 11 Handout 7: Sample Work Plan Schedules** as guides to review and discuss the participants' work plans.

5i. Review with participants:

- When should the Promoter fill out the work plan?
- How will the Promoter know when the Supervisor is going to come visit him/her for supportive supervision?

6. Wrap Up

6a. Wrap up by telling participants: Supervision is usually the weak link in most programs and the reason why staff do not feel valued or perform up to standard. Supportive supervision is one of the keys to the success of the Care Group approach, so it's critical that it be done well and on schedule.

Lesson 11 Flip Chart 1: Definition of Supportive Supervision

Note: The following definition should be written in a large font and with noticeable colors on the flip chart so its importance is clear to participants.

Supportive supervision is an on-going process designed to mentor and coach a worker so he/she gains the independence, self-confidence and skills needed to effectively accomplish the work.

Lesson 11 Handout 1: Supervisor's Checklist for Supervising a Promoter[22,23]

Name of Promoter being supervised: _____

Name of Supervisor completing the form: _____

Quarter: _____ Year: _____

Every Visit: Take time to find out how the Promoter is doing, how you can support him/her, and what challenges or success he/she has encountered since your last visit.

Instructions: Place a "**Y**" for Yes (the task was done) or an "**N**" for No (the task was not done). Write "**n/a**"(not assessed) if the item could not be (or was not) assessed for some reason. The gray cells are further instructions and do not require a written check mark.

Visits during quarter:	1	2	3	4	5	6
Visit date:						
1. Observe the Promoter Teaching Care Group Volunteers						
1a. Observe a behavior change meeting and fill out the quality improvement and verification checklist (QIVC) for meeting facilitation						
1b. Review the QIVC for meeting facilitation with the Promoter in private afterward						
1c. Talk to some of the Neighbor Women (NW) to assess their participation level, their interest in the program, and the quality and consistency of the Promoters' work.						
1d. Visit some of the NW that the Care Group Volunteer (CGV) reported meeting to verify that they received the lessons as the CGV reported						
1e. Did the majority of the NW you visited say that they participated in the lesson that should have been during the period?						
2. Review the Promoter's Registers of Care Group Volunteers and Neighbor Women (once per quarter)						
2a. Is the Promoter keeping the CGV and NW registers in a safe, dry place?						
2b. Has the Promoter always marked attendance for the CGVs over the last 3 months?						

[22] Each Promoter is supervised twice per month. This checklist is used throughout the quarter and turned in at the end of the quarter. Use a new form each quarter.

[23] Note: Some of the elements in this checklist may be better assessed by people on your team other than the Supervisor (e.g., monitoring and evaluation [M&E] statistician, logistician).

Visits during quarter:	1	2	3	4	5	6
Visit date:						
2c. Did the Promoter (or CGV or someone else) always mark attendance for the NW over the last 3 months?						
3. Review the Promoter's Monthly Reports						
3a. Has the Promoter completed the monthly reports correctly (e.g., there are few errors)?						
4. Observation of the Promoter's Equipment (transport, scale, storage area, other materials)						
4a. Is the Promoter maintaining his/her motorbike/bicycle in a fully functioning condition?						
4b. Is the weighing scale working properly?						
4c. Were all other materials (e.g., flip charts, MUAC strip, lesson plans, blank reporting forms) stored in a safe and dry place?						
4d. Does the Promoter have sufficient amounts of all materials needed?						
5. Review of Visits and Interviews with Care Group Volunteers						
5a. Randomly select 3–5 CGVs to visit and interview them. Were those selected all found, and did they confirm that they were attending teaching lessons and generally understood what they were learning?						
6. Review of Visits and Interviews with Neighbor Women						
6a. Randomly select 3–5 NW to visit and inter-view them. Did the selected NW confirm that they attend meetings and generally understand what they are learning?						
6b. Ask selected NW about their children. Did the NW verify that their children were being weighed regularly?						
6c. Ask selected NW about danger signs. Were all NW able to mention most of the danger signs during child illness?						
7. Review of Visit to Community Leaders or Participate in a Community Leadership Meeting and Interview the Leaders						
7a. Ask community leaders about the Promoters' activities and their coordination. Were they aware of the Promoter's activities in the community?						

Visits during quarter:	1	2	3	4	5	6
Visit date:						
7b. Did the community leaders say that they have been coordinating with the Promoters?						
7c. Ask community leaders if they are actively resolving problems that arise related to the program?						
8. Review of Visit to the Health Worker at the Nearest Health Facility						
8a. Visit local health workers at the nearest facility. Are the health workers aware of the work of the Promoter?						
8b. Has the Promoter been referring patients to the health center for care?						
9. Review of Visit to the Promoter's Home						
9a. Observe: Does the Promoter have a latrine with a lid and a roof?						
9b. Observe: Does the Promoter have a hand washing station?						
9c. Observe: If there is a hand washing station, is there water?						
9d. Observe: If there is a hand washing station, is there soap/ash available						
9e. Observe: Does the Promoter have a system for purifying drinking water?						
9f. Observe: Does the Promoter have a system for keeping animals (including chickens) away from the child's play area?						
9g. Observe: Does the Promoter have a mosquito net for every bed or sleeping mat?						
9h. Observe vaccination card: Are the Promoter's youngest child's vaccinations up to date?						
TOTAL YES:						
PERCENT YES:						

Important: Providing Feedback at All Levels

- Ask the Promoter/Supervisor/Coordinator how he/she feels he/she is doing in the role in general.
- Thank and encourage the Promoter for each of the things that he/she is doing correctly, according to the performance you have observed using this checklist.
- For mistakes, always ask before telling: Ask the Promoter/Supervisor/Coordinator what he/she feels he/she is not doing well. For each correct observation on a mistake, give advice on how to improve (e.g., “Yes, that’s right, your scale was not functioning properly. Next time you can notify me by text when you have a problem with it so we can get it fixed more quickly.”).
- Summarize areas for improvement based on observations.
- Ask the Promoter/Supervisor/Coordinator to make a verbal agreement to improve these things prior to the next meeting (e.g., “Do you agree to work on these things before our next meeting so you can improve?”).
- Signs of respect:
  - Be careful to correct the Promoter/Supervisor/Coordinator in private and to not embarrass or humiliate him/her in front of the people he/she works with.
  - Respect the Promoter/Supervisor/Coordinator and what he/she already knows and does.

Lesson 11 Handout 2: Coordinator's Checklist for Supervising a Supervisor[24]

Name of Supervisor being supervised: _____

Name of Coordinator completing the form: _____

Month: _____ Year: _____

Every visit: Take time to find out how the Supervisor is doing, how you can support him/her, and what challenges or successes he/she has encountered since your last visit.

Instructions: Place a "**Y**" for Yes (the task was done) or an "**N**" for No (the task was not done). Write "**n/a**" (not assessed) if the item could not be (or was not) assessed for some reason. The grayed cells include further instructions and do not require a written check mark.

Visits during quarter:	1	2	3
Visit date:			
1. Observe the Supervisor Reviewing a Lesson with Promoters (once per quarter)			
1a. Did the Supervisor review the Promoter lesson plan and clearly explain stories, games and activities that accompany the information?			
1b. Did the Supervisor facilitate one or more practice sessions with the Promoters?			
1c. Did the Supervisor ask the Promoters review questions to check it they understood the lessons?			
1d. Privately ask the Supervisor review questions. Did the Supervisor understand the lessons?			
2. Check the Supervisor's Reporting and File System			
2a. Review the latest Supervisor report, Promoter reports, Care Group (CG) registers and Neighbor Group (NG) registers. Did the reported numbers in the reports match up and were they consistent?			
2b. Review the Supervisor's filing system. Was it well organized, and did it have copies of all reports sent and received (including the Supervisor reports, Promoter reports, quality improvement and verification checklists [QIVCs], and checklists for supervising the Promoters)?			
2c. Review the Supervisor report and ask questions of the Supervisor. Did he/she understand each section clearly?			
2d. Review the Supervisor's bi-weekly work plans for all Promoters. Were they completed properly and up-to-date?			
2e. If a surprise visit. Was the Supervisor following his/her own bi-weekly work plan and Promoter visit plan?			

[24] All activities listed here should be completed on a quarterly basis for each Supervisor. Each Supervisor should be visited three times each quarter, with every third visit a surprise. Check off what you do in each visit. Start with a new form every quarter.

Visits during quarter: / Visit date:	1	2	3
3. Check the Supervisor's Equipment and Office Supplies			
3a. Was the Supervisor's computer and flash drive up-to-date for virus protection?			
3b. Was the date of the last computer back-up file recent (e.g., last month)?			
3c. Was the printer working well (i.e., ink available, test page prints, printer disk stored)?			
3d. Would the Supervisor's computer power-up, and was it connected to a surge protector with all cables clear of moisture and exposed connections?			
3e. Was the Supervisor's motorcycle in proper working condition?			
3f. Ask the Supervisor about Promoters' transport and repair processes. Are all motorcycles/bicycles in good condition or being rapidly repaired?			
4. Follow a Supervisor While He/She Supervises a Promoter			
4a. Review copies of the Supervisor's checklist for supervising a Promoter. Is the Supervisor correctly using that checklist to supervise Promoters?			
4b. Review QIVCs. Is the Supervisor properly using the QIVC for educational session facilitation?			
4c. Randomly select one of the Promoter's CGs to visit, then randomly select 1–3 Care Group Volunteers (CGVs) listed as members of the CG. Interview them. Is the frequency of teaching correct, and do they understand their role well?			
4d. Can the CGVs selected accurately name all of the NW in their groups?			
4e. Ask the CGVs to explain the flip chart pictures and age-specific counseling card images. Do they associate the correct practices with the images?			
4f. Does the Supervisor appear to be very familiar with the roads and paths in the area?			
5. Assist the Supervisor with Staff Development (once per quarter)			
5a. Assist the Supervisor to develop and follow-up on staff development plans in a private area.			
5b. Is the Promoter making progress toward identified program and personal objectives? (Refer to the supportive supervision checklists for Promoters, Promoter reports, QIVCs, training post-test scores and attendance records.)			
5c. Counsel Promoters with the Supervisor, document unacceptable behavior and specify improvements expected, if necessary. (Be sure to keep notes/documentation in the same folder with this form, or at the bottom of this form to make it easier to follow up).			

Visits during quarter: / Visit date:	1	2	3
6. Visit the Community Ministry of Health (once per quarter)			
6a. Visit key ministry of health (MOH) personnel in the area. Are they aware of project objectives and activities?			
6b. Are either monthly or quarterly reports being provided to the MOH district office by the Supervisor?			
6c. Update key MOH personnel of project achievements, impact, challenges and solutions.			
7. Visit Local Businesses that the Supervisor has Provided Receipts For and Check Reported versus Actual Costs (once per quarter)			
7a. Visit local businesses and review receipts provided for commune level activities incurred at those businesses. Did prices match current local prices at the business?			
7b. Talk to Promoters, CGV, other staff and NW. Does it appear that goods and services reported have been provided through the program (e.g., insecticide-treated bednets [ITNs]) have reached intended beneficiaries?			
8. Receive Suggestions from the Supervisor on Program Activities, Communication and Support Services			
8a. Request feedback, ideas and suggestions from the Supervisor on how to improve programming and support services. Keep these notes in the same folder with this form (or in a few lines at the bottom of the form).			
9. Provide Feedback to the Supervisor Regarding His/Her Performance			
9a. Review the Supervisor's professional development plan. Use the supportive supervision checklists for Supervisors, monthly reports and training post-test scores to evaluate the Supervisor's progress toward identified program and personal objectives.			
9b. Counsel the Supervisor, identify outstanding performance, document unacceptable behavior and specify improvements expected. Keep these notes in the same folder with this form (or in a few lines at the bottom of the form).			
TOTAL YES:			
PERCENT YES:			

Lesson 11 Handout 3: Manager's Checklist for Supervising a Coordinator[25]

Name of Coordinator being supervised: _____

Name of Manager completing the form: _____

Month: _____ Year: _____

Every visit: Take time to find out how the Coordinator is doing, how you can support him/her, and what challenges or success he/she has encountered since your last visit.

Instructions: Place a "**Y**" for Yes (the task was done) or an "**N**" for No (the task was not done). Write "**n/a**" (not assessed) if the item could not be (or was not) assessed for some reason. The grayed cells include further instructions and do not require a written check mark.

	Visits during quarter:	1	2
	Visit date:		
1. Ensure the Coordinator Manages His/Her Team of Supervisors Well			
1a. Ask if there are any personnel problems the Coordinator is managing and provide support and/or suggestions to resolve difficulties.			
1b. Talk to one or two Supervisors privately about instructions they have received about project implementation. Does it appear that the Coordinator is communicating instructions related to project implementation clearly and in a timely manner?			
1c. Review the Coordinator's work schedule. Does it appear that the Coordinator is meeting quarterly with his/her team and visiting them at least once a month in the field?			
1d. Ask the Coordinator about what he/she is doing to build team unity and develop the Supervisors' capacity. Does it appear to be adequate?			
1e. In private, assist the Coordinator to develop and follow-up on Supervisors' development plans.			
1f. Use the checklists for supervising a Supervisor, monthly reports, quality improvement and verification checklists (QIVCs), training post-test scores and attendance records to evaluate the Supervisors' progress toward identified program and personal objectives. Keep these notes in the same folder with this form.			
1g. If needed, counsel a Supervisor with the Coordinator present, document unacceptable behavior and specify improvements expected. Keep these notes in the same folder with this form.			

[25] All activities listed here should be completed on a quarterly basis for each Coordinator. Each Coordinator should be visited one or two times per quarter, plus one surprise visit. Check off what you do in each visit. Start with a new form each quarter.

Visits during quarter:	1	2
Visit date:		
2. Check the Coordinator's Reporting and File System		
2a. Use the latest report you received from the Coordinator and have him/her show you the Supervisors' reports he/she used to create the report. Were the reported numbers supported by the local documents?		
2b. Review the Coordinator's filing system. Is it well organized and does it have copies of all reports sent and received? (Folders should exist for Supervisor's reports, QIVCs, checklists for supervising the Supervisor and other forms.)		
2c. Review the Coordinator's last monthly report and discuss issues of poor Care Group (CG) performance and/or errors in filling out the format. Document plans/ideas to improve CG performance. Keep these notes in the same folder with this form (or in a few lines at the bottom of the form).		
2d. Does the Coordinator have biweekly, up-to-date work plans on file for his/her Supervisors?		
2e. (If during a surprise visit) Was the Coordinator following his/her own bi-weekly work plan and Supervisor's visit plan?		
2f. Was the Coordinator properly using the checklist for supervising a Promoter to follow up on any necessary actions?		
3. Visit Regional Ministries of Health		
3a. Interview 1–2 key ministry of health (MOH) personnel at the regional level. Were they aware of project objectives and activities?		
3b. Were program activities that were planned to be done in coordination with the MOH being properly carried out?		
3c. Were either monthly or quarterly reports being provided to the MOH regional office by the Coordinator?		
3d. Were MOH key personnel generally aware of project achievements, impact, challenges and solutions? (Discuss these with them.)		
4. Attend a Meeting between a Coordinator and His/Her Supervisors (once per year)		
4a. Did the Coordinator communicate respectfully with his/her Supervisors?		
4b. Prior to the meeting, ask the Coordinator for a copy of the agenda. Was the agenda for the meeting followed?		
4c. Was technical and program information communicated correctly to the Supervisors?		
5. Visit Care Groups (at least once per year)		
5a. Randomly select one CG to visit, then randomly select 1–3 Care Group Volunteers (CGVs) listed as a member of the group. Talk to the CGVs. Is the frequency of teaching correct, and do they understand their role?		
5b. Ask the CGVs to explain the flip chart pictures. Can they associate the correct practices with the images?		

Visits during quarter:	1	2
Visit date:		
5c. Was the Coordinator generally familiar with the roads and paths in the area?		
6. Receive Suggestions from the Coordinator on Program Activities, Communication and Support Services		
6a. Request feedback, ideas and suggestions from the Coordinator on how to improve programming and support services. Keep these notes in the same folder with this form (or in a few lines at the bottom of the form).		
7. Provide Feedback to the Coordinator Regarding His/Her Performance		
7a. Review the Coordinator's professional development plan. Use checklists for supervising Coordinators, monthly reports and training post-test scores, and evaluate district movement toward indicator targets to evaluate the Coordinator's progress toward identified program and personal objectives.		
7b. Counsel the Coordinator, identify outstanding performance, document unacceptable behavior and specify improvements expected.		
TOTAL YES:		
PERCENT YES:		

Lesson 11 Handout 4: Categories in the Supervisor's Checklist for Supervising Promoters

1. Observe Promoter teaching Care Group Volunteers
2. Review the Promoter's register of Care Group Volunteers and Neighbor Women
3. Review the Promoter's monthly reports
4. Observe the Promoter's equipment
5. Visit Care Group Volunteers
6. Visit Neighbor Women
7. Visit community leaders or participate in a community leadership meeting
8. Visit the health worker at the nearest health facility
9. Visit the Promoter's home

Lesson 11 Handout 5: Supportive Supervision Table

Person Supervising	Person being Supervised	Location/ Meetings	Frequency	Supportive Supervision Tools
Manager	Each Coordinator	Observes all locations and meetings listed below	Two times every 3 months, including one surprise visit per year	Supportive supervision checklist
Coordinator (supervising 3–6 Supervisors)	Each Supervisor	Office, bi-monthly meeting and those listed below	Once per month (every third visit is a surprise visit)	Supportive supervision checklist and QIVC
Supervisor (supervising 4–6 Promoters)	Each Promoter	Promoter's home, Care Group meeting and those listed below	Twice per month: one scheduled visit and one surprise visit; QIVC at least once per quarter	Supportive supervision checklist and QIVC
Promoter (supervising 50–135 Care Group Volunteers [CGVs])	Each CGV	CGV's home and Neighbor Group (NG) meeting	One CGV from each Care Group (CG) every 2 weeks	QIVC

Lesson 11 Flip Chart 2: Blank Supportive Supervision Table

Person Supervising	Person being Supervised	Location/ Meetings	Frequency	Supportive Supervision Tools
Manager				
Coordinator				
Supervisor				
Promoter				

Lesson 11 Handout 6: Activities to Plan For

The Promoter

- Teach all eight Care Groups (CGs) every 2 weeks.
- Spend at least a ½ day writing reports before meeting with the Supervisor.
- Attend two bi-monthly meetings with the Supervisor (about a ½ day per meeting).
- Supervise eight or more Care Group Volunteers (CGVs) every 2 weeks.
- Receive a supportive supervision visit twice each month during his normal activities.
- Attend the community development committee meeting once per month (½ day).
- Visit the health facility at least once per month.

The Care Group Volunteer

- Teach 10–15 neighbors in a Neighbor Group every 2 weeks, followed by teaching one-on-one in each neighbor's home during the next 2 weeks (alternating). This meeting is about 1 ½ hours when in a group and 1 hour during the home visit.
- Attend a 2 hour training once every 2 weeks.
- Receive a supportive supervision visit at least once every 6 months.

The Supervisor

- Be in charge of five Promoters (in this example).
- Train the five Promoters every 2 weeks with a ½ day training (bi-monthly training meeting).
- Compile the data from the Promoters after the bi-monthly training meeting (½ day of reporting).
- Supervise each of the Promoters twice per month.
- Spend 3 days per month writing and completing reports.

Lesson 11 Handout 7: Example Work Plans

Example Monthly Work Plan for Care Group Volunteers

(Reminder: volunteers do not work an 8 hour day! Never plan a meeting longer than 2 hours with volunteers.)

	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1	Attend training #1 with the Promoter		Teach my Neighbor Group Lesson 1		
Week 2	Attend training #2 with the Promoter	Teach Neighbor Women #1 Lesson 2	Teach Neighbor Women #2 lesson 2	Teach Neighbor Women #3 Lesson 2	Teach Neighbor Women #4 Lesson 2
Week 3	Teach Neighbor Women #5 Lesson 2	Teach Neighbor Women #6 Lesson 2		Teach Neighbor Women #7 Lesson 2	Teach Neighbor Women #8 Lesson 2

Example Monthly Work Plan for Promoters

	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1	Teach Care Group #1 Teach Care Group #2	Supervise two Care Group Volunteers with QIVC	Teach Care Group #3 Teach Care Group #4	Prepare reports for bi-monthly meeting	Bi-monthly meeting Supervise one Care Group Volunteer
Week 2	Supervise two Care Group Volunteers with QIVC	Supervise two Care Group Volunteers	Teach Care Group #5 Teach Care Group #6	Supervise two Care Group Volunteers	Teach CG #7 Teach CG #8
Week 3	Vaccination day Teach Care Group #1	Supervise two Care Group Volunteers	Teach Care Group #3 Teach Care Group #4	Supervise one Care Group Volunteer Teach Care Group #2	Community meeting Supervise one Care Group Volunteer
Week 4	Supervise two Care Group Volunteers with QIVC	Supervise two Care Group Volunteers	Teach Care Group #5 Teach Care Group #6	Supervise two Care Group Volunteers	Teach Care Group #7 Teach Care Group #8

Example Monthly Work Plan for Supervisor

	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1			Supervise Promoter #5	Prepare for bi-monthly training	bi-monthly meeting Reporting
Week 2	Supervise Promoter #1	Supervise Promoter #2	Supervise Promoter #3	Supervise Promoter #4	Supervise Promoter #5
Week 3	Vaccination day	Report writing	Supervise Promoter #4	Prepare for bi-monthly training	Bi-monthly meeting Reporting
Week 4	Supervise Promoter #1	Supervise Promoter #2	Supervise Promoter #3	Report writing	Report writing

Lesson 12: Quality Improvement and Verification Checklists (QIVCs) and Giving feedback

Achievement-Based Objectives

By the end of this lesson participants will have:

- Reviewed two quality improvement and verification checklists (QIVCs)
- Observed a simulated use of the QIVC
- Completed and scored two QIVCs
- Reviewed the steps for giving positive feedback

Duration

2 hours

Materials Needed

- Lesson 12 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Meeting Facilitation
- Lesson 12 Handout 2: Quality Improvement and Verification Checklist (QIVC) for Giving Feedback
- Lesson 12 Handout 3: Role Play Part 1: Meeting/Education Event
- Lesson 12 Handout 4: Role Play Part 2: Giving Feedback
- Lesson 12 Flip Chart 1: How to Score the Quality Improvement Verification Checklist (QIVC)
- Lesson 12 Handout 5: Steps for Giving Effective Feedback
- Flip chart paper and markers

Facilitator's Notes

Prepare to present a short role play of a Care Group Volunteer (CGV) demonstrating a behavior, such as how to make oral rehydration solution (ORS). If there are two facilitators at a training, it would be best if they did the role play together, with one facilitator playing the role of the CGV and the other playing the role of the Promoter. If there is only one facilitator, choose a very competent participant to play the role of the CGV. Either way, practice the role play ahead of time. You also will need to ask a few female participants to play the role of Neighbor Women (NW) who are attending the education session.

Review **Lesson 12 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Meeting Facilitation**, **Lesson 12 Handout 2: Quality Improvement and Verification Checklist (QIVC) for Giving Feedback**, **Lesson 12 Handout 3: Role Play Part 1: Meeting/Education Event**, **Lesson 12 Handout 4: Role Play Part 2: Giving Feedback** and the role play instructions in Step 4 so the person playing the CGV knows what good things to do and can choose two or three things deliberately to do wrong. This way the person playing the Promoter knows how to give appropriate feedback.

It is very important that the person playing the CGV role not try to act like a clown during the skit to entertain the audience. This needs to be a learning activity that shows the good and poor things CGVs could do and how the Supervisor works with them to improve. Remember that if you model a poor example of giving appropriate feedback, the participants will do exactly what they saw you do. Practice, practice, practice! Make sure you have practiced giving appropriate feedback before training others.

In terms of discussing the QIVC, a group discussion is not usually possible in normal work situations, but is a good way to help staff learn how to score and evaluate an observation fairly. In many cultures Supervisors are more prone to mark "no" for very tiny faults instead of marking "yes" if the facilitator in general completed the given task. Remind participants that this is a tool to encourage and improve the ability of workers. The QIVC is not a tool used to fail a worker or shame them into change.

Steps

1. Introduction

    1a. Tell participants: Now that we have discussed the supportive supervision checklist, we need to introduce the other supervision tool, the quality improvement and verification checklist.

    1b. Explain: Although the Care Group approach has been proven to be very effective as a behavior change strategy, if it isn't executed with a high level of quality, it won't produce the desired results and levels of malnutrition won't decline. Also, when we monitor implementation we tend to focus on quantity rather than quality.

    1c. Ask participants: What quantitative things do you think a Care Group program would monitor? Answers could include how many meetings were held and how many people attended.

    1d. Tell participants: How well the meeting was facilitated and how well the Care Group Volunteers participated also are critical elements. To focus our attention on how well tasks and activities are implemented, Food for the Hungry has developed a tool called the quality improvement and verification checklist, or QIVC. This session is divided into two parts. For part of this lesson we will look at the QIVC, how to use it, how to give effective feedback and how to use the results of the QIVC to make programmatic decisions.

2. The Quality Improvement and Verification Checklist Tool and How It Is Used

    2a. Refer participants to **Lesson 12 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Meeting Facilitation** and **Lesson 12 Handout 2: Quality Improvement and Verification Checklist (QIVC) for Giving Feedback**. Explain that while we will be using these QIVCs during this session, there are many other QIVCs that focus on other aspects of the Care Group (CG) program. Other QIVCs created by Food for the Hungry (FH) can be found at http://www.caregroupinfo.org/docs/QIVC_Files.zip.

2b. Explain that the QIVC for educational session facilitation has three main purposes:

- To encourage a facilitator
- To monitor a facilitator
- To improve a facilitator's performance

Write these on a flip chart.

2c. Ask participants: Who are the facilitators in the Care Group program? Answers should include that facilitators are those who teach others, including Managers, Supervisors, Coordinators, Promoters, and CGV. This means that the QIVC can be used to encourage, monitor and improve the work of each one of these CG team members.

2d. Explain to participants that the QIVC is the ONLY tool used to supervise CGVs. The Promoter does not use a supportive supervision checklist at this level since CGVs are not employees.

2e. Explain to participants: The QIVC rapidly increases facilitation performance. For example, in the Dominican Republic, health Promoters' performance improved by 38% in months when QIVCs were used.[26] Small improvements in performance can cause large changes in impact. However, QIVCs are only useful for tasks that can be observed and have multiple steps.

2f. Ask participants: What are some activities in our program that you can observe? Which of these activities is a process with multiple steps? Answers include teaching CG lessons to Neighbor Women (NW), teaching CG lessons to CGVs, teaching CG lessons to Promoters, teaching CG lessons to Supervisors, growth monitoring and promotion, and individual counseling sessions.

3. Review the Quality Improvement and Verification Checklist

3a. Go through each point on Lesson 12 Handout 1 with participants. Make sure that they understand what each question means.

3b. Explain to participants that most questions have a yes or no answer. After reading the question, they should decide if the answer is "yes" or "no" and mark the corresponding box.

3c. If the question is not relevant for a particular training, then ~~draw a line through the YES or NO boxes~~. For example:

- In question 11, if the topic was exclusive breastfeeding (EBF), the facilitator would have a difficult time demonstrating this activity. It is possible for the facilitator to demonstrate proper breastfeeding attachment, but EBF is not something that needs to be demonstrated during the lesson. You would mark a line through the ~~yes or no.~~

[26] T. Davis, 1991. *Report data, International Child Care (1992)*.

- In question 16, if participants do not mention any barriers, ~~cross out this line~~ when monitoring the worker.

3d. Tell participants: QIVCs should be adapted to fit the culture and design of each CG program. After using the QIVC for 3 or 4 months, ask staff and volunteers to meet together to discuss the checklist. If specific questions are not appropriate or applicable to your situation, adapt or revise them as needed. However, be cautious. The QIVC was designed to ensure participatory teaching methods are used in each lesson. Make sure your final version continues to reinforce the key principles of participatory learning.

3e. Explain that the QIVC can be used during regularly planned supervisory visits along with the supportive supervision checklist. It can also be used on its own.

4. Activity: Quality Improvement and Verification Checklists in Action

4a. Explain to participants: Now we're going to learn how the QIVC would be used in the field. You are going to watch a role play of the Care Group Volunteer facilitating a meeting with her Neighbor Group and how the Promoter, who has come to watch, provides feedback to the volunteer. During the role play keep an eye on your copy of the QIVC and see for yourself how well the Care Group Volunteer conducted the meeting. Then, when the Promoter gives feedback, use the other QIVC to see how well she does.

4b. Explain to participants that the QIVC is only completed after the event, not during. This is done so the person filling out the QIVC can be attentive during the event being evaluated and not be distracted by filling out the QIVC.

4c. Explain that the role play will be done in two parts. In the first part a CGV facilitates a meeting with Neighbor Women. In the second part the Promoter gives feedback to the CGV. Instruct participants to fill out the pertinent QIVC after each role play. Answer any questions.

4d. After completing **Lesson 12 Handout 3: Role Play Part 1: Meeting/Education Event** ask each participant to fill out and score their copies of Lesson 12 Handout 1. Show the instructions in **Lesson 12 Flip Chart 1: How to Score the Quality Improvement Verification Checklist (QIVC)**. Ask some participants to share the scores they gave. Repeat this process after **Lesson 12 Handout 4: Role Play Part 2: Giving Feedback** using Lesson 12 Handout 2.

4e. Ask the participants the following questions. They should answer the questions based on what they saw in the skit. Write their responses on a flip chart.

- What should you say to the CGV when you visit her and plan to use a QIVC? Answers should include:
  - Don't worry!
  - This is not a test, but a tool to help you improve.

  - Teach as you normally do.

- What comments did the Promoter make during the educational lesson? Answers should include:
  - None! The Promoter should observe only and not interrupt or make comments to the facilitator.
  - After the session, the Promoter can address the participants as appropriate.
- Where did the Promoter talk about each of the points in the QIVC with CGV? Answers should include:
  - In private, not in front of other people.
- Why did the Promoter explain the checklist to the CGV? Answers should include:
  - Because it is also a method for improving and encouraging the worker's performance.
  - The actions we consider to be perfect performance should not be kept secret from the worker.
  - All workers should know exactly what is expected of them.
- How should the Promoter speak to the CGV? Answers should include:
  - The Promoter needs to be gentle so the CGV does not feel shame.
  - Even if the CGV did very poorly on the checklist, the Promoter should emphasize areas where he has shown some improvement.
  - Ask the CGV which areas she wants to work on.
  - Focus on asking, not on telling.

5. More on Giving Feedback

5a. Ask participants the following questions and discuss: We have talked a lot about positive feedback. What's wrong with negative feedback? Wouldn't the worker improve faster if we told her everything that she did wrong? What is your opinion?

5b. Refer participants to **Lesson 12 Handout 5: Steps for Giving Effective Feedback**. Tell participants that they will now review exactly how feedback should be given after an observation.

5c. Working in pairs, have participants review the handout and compare the points to what they observed in the role play. Ask some participants to share their observations.

5d. Ask participants and discuss responses: How is this way of giving feedback different from the way it is usually done? Which way do you think will result in improved performance? Which approach will results in sustained high motivation? Why?

The Importance of Giving Positive Feedback

(From "Positive Image, Positive Action: The Affirmative Basis of Organizing" by David Cooperrider)

Most people worldwide believe that pointing out mistakes will eliminate failures and improve performance. However, studies have shown that the opposite is true especially when it comes to learning new tasks.

In one experiment, for example, Kirschenbaum (1984) compared three sets of bowlers:

- Group A did not receive any lessons, but tried to learn how to bowl on their own.
- Group B was videotaped. All of the good things they did while bowling were compiled, and the mistakes were deleted from the tapes. These positive tapes were reviewed with each bowler pointing out the things they had done well to help them improve.
- Group C also was videotaped. All of the bowling mistakes they made were compiled, and the good things they did were deleted off the tapes. The mistake tapes were reviewed with this group, pointing out areas they needed to improve.

Group B improved significantly more than all the others, and the unskilled bowlers in Group B (average of 125 pins) improved substantially (more than 100%) more than all other groups.

Since then, these results have been replicated with other athletic activities, giving the same results. Pointing out the things people do well helps them learn new skills and improves their performance in mastering new tasks.

6. Wrap Up

   6a. Tell participants: Next we will look at how to use the results of the QIVC to make programmatic decisions.

Lesson 12 Handout 1: Quality Improvement and Verification Checklist (QIVC) for Meeting Facilitation

Name of facilitator:_____

Date: _____

Evaluator: _____

Community: _____

Methods	**Yes**	**No**
1. Did the facilitator seat people so that all could see each other's faces?	❒	❒
2. Did the facilitator sit at the same level as the other participants?	❒	❒
3. Did the facilitator introduce the topic well (who he/she is, topic, time)?	❒	❒
4. Did the facilitator speak loud enough so that everyone could hear?	❒	❒
5. Did the facilitator use proper eye contact with everyone?	❒	❒
6. Did the facilitator changes his/her voice intonation (not monotone)?	❒	❒
7. Did the facilitator speak slowly and clearly?	❒	❒
8. Did the facilitator ask about the current practices of the participants?	❒	❒
9. Did the facilitator read each caption aloud to the participants?	❒	❒
10. Did the facilitator explain the meaning of each picture?	❒	❒
11. Did the facilitator demonstrate any skills that he/she was promoting?	❒	❒
12. Did the facilitator verify that people understood the main points using open-ended questions?	❒	❒

Discussion	**Yes**	**No**
13. Did the facilitator ask the participants open-ended questions?	❒	❒
14. Did the facilitator give participants adequate time to answer questions?	❒	❒

15. Did the facilitator ask participants if there were barriers that might prevent them from trying the new practices? …… ❒ ❒
16. Did the facilitator encourage discussion among participants to solve the barriers mentioned? …… ❒ ❒
17. Did the facilitator encourage comments by paraphrasing what people said (repeating statements in his/her own words)? …… ❒ ❒
18. Did the facilitator ask participants if they agree with other participants' responses? ❒ ❒
19. Did the facilitator encourage comments by nodding, smiling or other actions to show he/she was listening? …… ❒ ❒

Discussion (continued)	**Yes**	**No**
20. Did the facilitator always reply to participants in a courteous and diplomatic way?	❒	❒
21. Did the participants make lots of comments? ……..	❒	❒
22. Did the facilitator prevent domination of the discussion by one or two people? ……	❒	❒
23. Did the facilitator encourage timid participants to speak/participate? ……..	❒	❒
24. Did the facilitator summarize the discussion? ……..	❒	❒
25. Did the facilitator reinforce statements by sharing relevant personal experience or by asking others to share personal experience? ……	❒	❒
26. Did the facilitator ask each person to make a commitment? …….	❒	❒
27. Did the facilitator ask each person about previous commitments? ……..	❒	❒

Content	**Yes**	**No**
28. Was the content of the educational messages correct? …….	❒	❒
29. Was the content of the educational messages relevant? ……..	❒	❒
30. Was the content of the educational messages complete? ……	❒	❒

31. Provide an overall evaluation of the facilitator's performance in the space below. Include specific observations, including comments about content/educational messages.

Score: _____

Comments:

Lesson 12 Handout 2: Quality Improvement and Verification Checklist (QIVC) to Evaluate Positive Feedback

Name of the person using this list: _____

Name of the person evaluated: _____

Community: _____ Date: _____

Number of yeses: _____ Number of lines: _____

Present grade: _____% Previous grade: _____%

Before the Evaluation Begins	**Yes**	**No**
1. Did the evaluator explain the purpose of the QIVC (to improve and measure work quality)? ……	❒	❒
2. Did the evaluator tell the person evaluated not to fear, that this is not a test, but rather something to help him/her improve? ……	❒	❒
3. Did the evaluator advise the person being evaluated not to say anything to the evaluator while being observed? ……	❒	❒
During the Observation	**Yes**	**No**
4. Did the evaluator avoid making comments to the person evaluated during the health lesson? ……	❒	❒
5. Did the evaluator mark all the questions (yes or no) during or right after the observation? ……..	❒	❒
Feedback	**Yes**	**No**
6. Did the evaluator give the feedback in a private place? …….	❒	❒
7. Did the evaluator ask the person evaluated to note his/her comments? ……..	❒	❒
8. Did the evaluator discuss each positive point on the form? …….	❒	❒
9. Did the evaluator encourage the person evaluated on to the things he/she did correctly?		

…… ❒ ❒

10. Did the evaluator use positive body language when providing positive feedback to the person?
…… ❒ ❒

11. Did the evaluator use many encouraging words (e.g., excellent, very good) when providing positive feedback to the person?
…… ❒ ❒

12. Did the evaluator avoid the use of too many mixed comments (e.g., "This was excellent, but you have to …") when providing feedback? ……..
❒ ❒

13. Did the evaluator always respond to the comments from the person evaluated in a courteous and diplomatic manner?
……. ❒ ❒

Feedback (continued)	**Yes**	**No**

14. Did the evaluator mention the area(s) where the performance of the person evaluated was better than the majority of other people? …….
❒ ❒

15. Did the evaluator discuss the most important negative points on the form? ……. ❒ ❒

16. Did the evaluator often ask the person evaluated to discuss the negative points in his/her performance self-evaluation before providing an opinion? …….. ❒
❒

17. Did the evaluator use several examples to explain the correct manner of performing the parts of the process that were done incorrectly? ……... ❒
❒

18. Did the evaluator maintain control of the evaluation process in an appropriate manner?
……. ❒ ❒

19. Did the evaluator help the person evaluated find solutions to the problems he/she has (e.g., in the community), where possible?
……. ❒ ❒

20. Did the evaluator keep the attention of the person evaluated? …… ❒
❒

21. Were the evaluator's suggestions correct?
…….. ❒ ❒

22. Were the evaluator's suggestions appropriate for the context of the person being evaluated?

…….

❒ ❒

23. Were the evaluator's suggestions complete?
……. ❒ ❒

24. Were the evaluator's suggestions very specific?
…….. ❒ ❒

At the End of the Evaluation	**Yes**	**No**
25. Did the Evaluator ask the person evaluated to give a summary of the things that should be improved? ……	❒	❒
26. Did the Evaluator complete this list if the person evaluated could not remember all the things that needed improvement? …….	❒	❒
27. Did the Evaluator ask the person evaluated to indicate his/her commitment to improve these things? ……	❒	❒
28. Did the Evaluator ask the person to give a summary of the positive things that he/she did? …….	❒	❒
29. Did the Evaluator complete this list if the person evaluated could not remember all the things he/she did that were positive? …….	❒	❒

Score: _____

Additional Comments:

Lesson 12 Handout 3: Role Play Part 1: Meeting/Education Event

The Care Group Volunteer (CGV) is in the middle of a meeting. She is preparing to demonstrate (activity) how to make oral rehydration solution (ORS) for children with diarrhea. (This means she has already the lesson objectives, game or song, attendance and troubleshooting, and story and pictures steps.) She has the sugar, salt, container of drinking water, and container to mix the solution in (a 1 liter bottle). She has prepared a space for the Neighbor Women (NW) to sit in front of her in a semi-circle so all the women can see each other. As the CGV is getting ready, her Promoter arrives, and they have the following discussion.

Promoter: Good morning Maria. How are you doing?

CGV: Welcome! I'm fine. It's good to see you.

Promoter: I've come to pay you a visit and to observe your meeting. During this visit I will be completing the QIVC for educational session facilitation. Remember the QIVC will help improve your work as a facilitator. It's not a test, so there's no need to be nervous. [She shows the QIVC to the CVG.] This is the same form that we have used before.

CGV: Yes, I remember. I was just getting ready to show the women how to prepare ORS. The women will be joining me here. Since you are here, if I have any questions or problems, I'll be sure to ask for your help.

Promoter: Actually, Maria, I will just be watching you and not participating at all. Just carry on as if I wasn't here. Afterward we will talk about how the meeting went.

The CVG sits down and calls the NW to join her. The Promoter sits to the side holding her quality improvement and verification checklist (QIVC). Once all the NW are sitting, one last woman arrives and sits behind everyone else, a little outside the group. The CGV conducts a 5–10 minute instruction of how to prepare ORS, reminding the NW what they learned from the story and the flip chart that were covered prior to the demonstration. She makes sure everyone but the mother sitting a little outside the group has a chance to participate. The CGV does most everything well, but she does not ask the NW if they have any prior experience making ORS, and she does not verify at the end if they all understood. The demonstration ends, and the CGV thanks the NW for coming.

Lesson 12 Handout 4: Role Play Part 2: Giving Feedback

The Care Group Volunteer (CGV) and the Promoter privately discuss the educational session. The Promoter uses the following outline to discuss the CGV's performance.

- Ask, "How do you think you did?"
- Agree with positive points and mistakes the CGV mentions, as appropriate. Probe as needed: "What things did you do well? What things would you have done differently?"
- Review the positive things on the quality improvement and verification checklist (QIVC) (everything marked yes).
- If not mentioned earlier, ask the CGV about areas that you marked "no". For example, "Tell me about the woman who came in last, I thought she seems excluded from the group." Or "How did you think you did in reviewing the mother's prior experience in making ORS?"
- Reinforce things that the CGV says that could help her improve in these areas. Do not concentrate too much on what the CGV did wrong, but rather what she did well, helping her come up with ways to overcome areas where she did poorly.
- Ask the CGV to summarize the things that you discussed today (positive things and areas to improve).
- Give the CGV her score, and summarize anything that was missed.
- Ask her to commit to changing these things.
- Thank the CGV.

Lesson 12 Flip Chart 1: How to Score the Quality Improvement Verification Checklist (QIVC)

1. Count the number of “yes” responses.
2. Divide the number of “yes” responses by the total number of answered questions (questions answered with either a “yes” or “no” response).
3. Do not count the questions that are not applicable (those that are ~~crossed out~~).

Lesson 12 Handout 5: Steps for Giving Feedback to Workers

1. Give feedback in private.
2. Ask the person being evaluated to take notes.
3. Discuss each positive point.
4. Encourage the worker on the things he/she did well.
5. Use positive body language.
6. Do not use mixed comments.
7. Respond to the worker in a courteous and diplomatic manner.
8. Mention the areas where the worker is doing better than others.
9. Discuss each negative point on the form, but remember to give three positive comments for every one comment about an area to improve.
10. Ask the worker to discuss his/her performance before giving your opinion.
11. Offer several examples to explain the correct manner of performing the tasks where the worker received a “no” on the quality improvement and verification checklist (QIVC).
12. Maintain control of the evaluation.
13. Help the worker find solutions to problems when possible.
14. Keep the worker’s attention.
15. Focus on what is correct, appropriate, complete and specific.
16. At the end of the evaluation, ask the worker to summarize the things he/she will improve.
17. If he/she forgot any areas, remind him/her of them.
18. Ask the worker to make a commitment to improve these issues.
19. Ask the worker to give a summary of the things he/she did well.
20. Add to this list if the worker forgot any positive areas.

Lesson 13: Calculating Scores and Using Data From the Quality Improvement and Verification Checklist (QIVC)

Achievement-Based Objectives

By the end of this lesson participants will have practiced scoring and analyzing the QIVC to evaluate staff and volunteer performance over a period of time.

Duration

1 hour 30 minutes

Materials Needed

- Lesson 13 Flip Chart 1: Individual and Program Performance Goals
- Lesson 13 Flip Chart 2: Quality Improvement and Verification Checklist (QIVC) Score Calculations
- Flip chart paper and markers
- Calculator (optional)
- Lesson 13 Handout 1: Analyzing Quality Improvement and Verification Checklist (QIVC) Scores
- Answer Key to Lesson 13 Handout 1: Analyzing Quality Improvement and Verification Checklist (QIVC) Scores
- Lesson 13 Flip Chart 3: Graph of Sarah's Care Group Volunteers
- Lesson 13 Handout 2: Analyzing Quality Improvement and Verification Checklist (QIVC) Scores
- Answer Key for Lesson 13 Handout 2: Analyzing Quality Improvement and Verification Checklist (QIVC) Scores
- Lesson 13 Handout 3: Quality Improvement and Verification Checklist (QIVC) Results for Six Promoters

Steps

1. Introduction

    1a. Tell participants: Now that we have become familiar with QIVCs and seen how they are used, we need to see how their use would allow us to make decisions to improve the overall program.

    1b. Ask participants: Why isn't it enough to just use the QIVCs to improve an individual's performance? Answers should include, because if many individuals are having the same or similar problems or are performing very poorly, then this means that something bigger—something more systemic—is not going well.

    1c. Tell participants: In this lesson we will look into how to use the QIVC data to improve our programs.

2. Activity: Performance Targets and Calculations

2a. Tell participants: In this session we will focus on monitoring workers' performance. The QIVC is a representation of perfect performance. Very few people will reach perfection (100%) during an observation. We want all of our facilitators, including staff trainers, Promoters and Care Group Volunteers, to reach and maintain a score of 80% or above on each QIVC. We can't expect all of the Care Group team members to get 80% or above on each QIVC, so our target is 80%.

2b. Display and talk through **Lesson 13 Flip Chart 1: Individual and Program Performance Goals**.

2c. Explain to participants that there are two types of calculations that programs need to make. Display **Lesson 13 Flip Chart 2: Quality Improvement and Verification Checklist (QIVC) Score Calculations** and explain the two calculations to participants.

2d. **Program performance score:** Using Lesson 13 Flip Chart 2, explain how to calculate the program performance score. Then practice using the example of Maria's Promoters in the text box. Write answers on a flip chart by step. Ask participants: What does this score tell us? They should answer the overall performance of a group.

Example:
Maria's Promoters
1. Samuel – 80%
2. Robert – 50%
3. Richard – 60%
4. Sonya – 85%
5. Kathy – 75%
6. Henry – 82%

- Number of individual QIVCs: 6
- Number of scores that are 80% or above: 3
- Program performance score: Number of scores that are 80% or higher divided by total number of individual QIVCs: 3 ÷ 6 = 50%

2e. **Average score for individuals**: Then explain how to calculate the average score. Use the same example of Maria's Promoters to practice. Write answers on a flip chart by step.

- All the scores added together: 80 + 50 + 60 + 85 + 75 + 82 = 432
- The sum of all the scores divided by the number of scores: 432 ÷ 6 = 72%

2f. **Calculating QIVC scores:** Refer participants to **Lesson 13 Handout 1: Analyzing Quality Improvement and Verification Checklist (QIVC) Scores** and ask them to make the calculations for the three examples. Review the correct response using **Answer Key to Lesson 13 Handout 1: Analyzing Quality Improvement and Verification Checklist (QIVC) Scores**.

2g. Ask participants the following questions.

- Which one of these groups has reached our target? Why? Participants should answer that Abebe's Promoters reached the target because more than 80% of Promoters in that group reached or exceeded an 80% score on their QIVCs.

- Why is it important to calculate the average score for individuals as well as the program performance score? Answers should include:
  - If you only look only at the average scores, it would appear that Tesfaye's group is doing the best. However, half of his Promoters have not reached the target.
  - Abebe's Promoters have an average that is 8 percentage points lower, but he has reached the target for his workers.
  - Moges' Promoters have the same average score as Abebe's group, but his workers are doing very poorly, with only 16% of them reaching the target.
  - Averages do not give you enough information.
  - We want all of our workers to improve, so we need to pay attention to the percentage of people reaching the target so we can spend more time helping them to improve.
  - In order to monitor progress we need to record scores for all of our workers and check for problems regularly.

3. System Problems and People Problems

   3a. Tell participants that there are two types of problems that QIVCs can detect: system problems and people problems**.** What is the difference?

   - System-wide problems are problems that all workers share. Most likely it is a problem with the way the workers were trained or a skill they are having trouble mastering (for example, storytelling or asking for commitments).
   - People problems are problems with individual workers. The QIVC shows which workers are not improving. People problems require that you work one-on-one to help them improve. One low score is not bad; we are looking for improvement over a long period of time. However, if you continue to see one worker doing poorly you will need to intervene. If a worker continues to score poorly, even after multiple observations and feedback, you need to remove that worker from the Care Group (CG) (according to your organization and national policies).

   3b. Ask participants: Why do we need to monitor system and people problems?

   - If staff is not teaching effectively (if they are poor facilitators) it will greatly impact the effectiveness of the messages shared during the CGs.
   - If in turn, Care Group Volunteers (CGVs) are modeling the poor teaching skills that they learned from the Promoter, then it will impact whether the Neighbor Women (NW) hear the information and change their behaviors.
   - The success of the CG program is dependent upon the strength of the workers.

3c. Refer to **Lesson 13 Handout 2: Analyzing Quality Improvement and Verification Checklist (QIVC) Scores**. Explain how to read the charts on the handout.

- The numbers refer to the questions on the QIVC for educational session facilitation.
- A "1" means the response was "yes", a "0" means the response was "no", and "N/A" means the question wasn't answered (not applicable).

3d. Ask participants to work in pairs to answer the last three questions at the bottom of Lesson 13 Handout 2. If they have extra time they can answer the average score and percentage of score questions. Review the answers using **Answer Key to Lesson 13 Handout 2: Analyzing Quality Improvement and Verification Checklist (QIVC) Scores**.

4. Frequency of Supervising with the QIVC

4a. Ask participants: How often should you use the QIVC?

- For CGVs, Promoters, Supervisors and Coordinators with unacceptable scores (less than 80%):
  - Their supervisor should visit them every month until the score is 80% or above. These are our head facilitators.
- For workers with acceptable scores (80% or above at least twice in a row):
  - Use the QIVC less frequently to see if they are able to maintain this standard.
  - For example, observe them once every quarter or every other quarter after they have a score 80% or above for two quarters in a row.

4b. Ask participants: Looking at **Lesson 13 Handout 3**, how frequently should each of these staff members be observed?

- Gabriella is doing well. Use the QIVC at the next visit. If she scores above 80% again, observe her once each quarter or every other quarter.
- Kwaasi is doing well. Use the QIVC next month, then decrease to once a quarter or every other quarter if he scores 80% or above again.
- Dorothy is doing well. Use the QIVC at the next observation and then decrease if her scores stay about 80%.
- We need to work on an improvement plan for Tom. Look at the questions on the QIVC where he scored poorly. Advise him on the things that he should improve. Retrain him if necessary. Make an action plan.
- Mario and Joseph do not need any more QIVCs this quarter. Use QIVCs with them every other quarter.

5. Recording QIVC Scores and Monitoring Progress

   5a. Share the following options for recording QIVC scores with participants.

   - Make a flip chart with Promoter (or Supervisor) scores listed for each quarter (the Manager needs to decide whether or not names should be included on this poster). Hang the poster in the Manager's office or the district office.
   - The Supervisor keeps a record in his files using graph paper (or a MS Excel spreadsheet) to record scores after each observation.
   - Purchase a manila file folder for each worker. Include all of their QIVCs in this folder and add scores onto a simple chart in the inside cover so you can see improvements over time. Bring each worker's file to all of his/her observations so you can share progress.

   5b. Show participants the graph in **Lesson 13 Flip Chart 3: Graph of Sarah's Care Group Volunteers**. Tell participants that this is one way they can monitor workers' progress. The graph makes it very easy to understand at a glance how workers are performing. Ask participants to respond to the following two questions related to Sarah's graph.

   - How many CGVs have reached the standard score?
     - Participants should answer that two of them reached 80% (Jean and Desire), and that Vanessa is close behind, but Yvan is doing very poorly.
     - Add that you do not need to calculate scores over time for individual workers if you put their scores on a graph. We can see the 80% line and find those who are above and below the line. Remember we are hoping that all workers improve to the point where they reach 80% or above. During the first months of observations, we can expect them to have lower scores, and that is OK because we are looking for improvement over time.
   - What percentage of CGVs reached the standard by quarter 4? Participants should answer 50%.

6. Wrap Up

   6a. Train all of the staff and volunteers who will be either using QIVC's as the observer, or who will be observed with QIVCs, about the checklist's purpose and how to use it (just as you received training here).

   6b. Remind participants: When training Care Group Volunteers you will need to make the training extremely simple. It is best to develop a basic pictorial QIVC for monitoring and training them. That way, they can learn the pictures and their meaning and do not need to be literate to understand the monitoring tool.

Lesson 13 Flip Chart 1: Individual and Program Performance Goals

Individual Performance Goal

Each person scores 80% or higher on the quality improvement and verification checklist (QIVC).

Program Performance Goal

Of all of the QIVCs done in a quarter, 80% of them to have a score of 80% or higher.

Lesson 13 Flip Chart 2: Quality Improvement and Verification Checklist (QIVC) Score Calculations

Program Performance Score

Definition: The percentage of total QIVCs conducted that quarter that were scored 80% or higher

How to calculate:

1. Count the number of individual QIVC scores for that quarter.
2. Count the number of scores that are 80% or above during that quarter.
3. Divide the number of scores that are 80% or above by the total number of QIVC scores for that quarter.
4. Remember, do not add scores, just count them.

Average QIVC Scores

Definition: The average QIVC score among the ones conducted that quarter

How to calculate:

1. Add all the scores together.
2. Divide the sum of all scores by the total number of QIVCs completed that quarter.

Lesson 13 Handout 1: Analyzing Quality Improvement and Verification Checklist (QIVC) Scores

For each example calculate both the individual averages and the Program Performance Scores

Example 1: Tesfaye's Promoters

- What is the Individual Average?

Abebe – 90%	Kebede – 85%
Asnake – 100%	Bogale – 60%
Tesfaye – 77%	Yetayesh – 55%

- What is the Program Performance Score (percentage of scores greater or equal to 80%)?

Example 2: Abebe's Promoters

- What is the Individual Average?

Meseret – 81%	Alem – 85%
Mihret – 80%	Gossa – 83%
Hiwot – 10%	Maru – 82%

- What is the Program Performance Score (percentage of scores greater than or equal to 80%)?

Example 3: Moges' Promoters

- What is the Individual Average?

Lulu – 75%	Fantansh – 55%
Misrak – 65%	Belete – 85%
Assefa – 70%	Taye – 68%

- What is the Program Performance Score (percentage of scores greater than or equal to 80%)?

Answer Key to Lesson 13 Handout 1: Analyzing Quality Improvement and Verification Checklist (QIVC) Scores

Example 1: Tesfaye's Promoters

- Average: 78%
- Percentage of scores greater than or equal to 80%: 50%

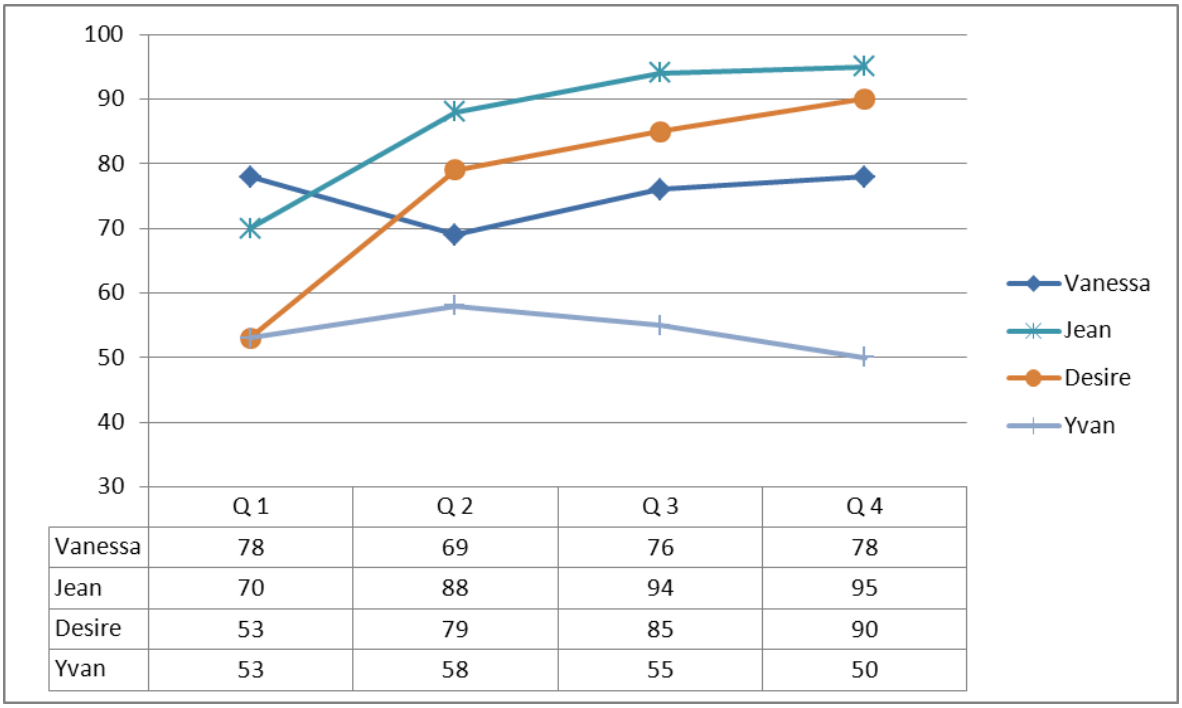
Example 2: Abebe's Promoters

- Average: 70%
- Percentage of scores greater than or equal to 80%: 83%

Example 3: Moge's Promoters

- Average: 70%
- Percentage of scores greater than or equal to 80%: 16%

Lesson 13 Flip Chart 3: Graph of Sarah's Care Group Volunteers



	Q 1	Q 2	Q 3	Q 4
Vanessa	78	69	76	78
Jean	70	88	94	95
Desire	53	79	85	90
Yvan	53	58	55	50

Lesson 13 Handout 2: Monitoring Quality Improvement and Verification Checklist (QIVC) Scores

Quarter 1 QIVC Scores (1 = yes; 0 = no; Skip = N/A)

Question	Abebe	Kebede	Asnake	Bogale	Tesfaye	Yetayesh	Mesele	Total
1	1	0	1	1	1	0	1	71%
2	1	1	1	1	1	1	0	86%
3	0	1	1	0	0	0	1	43%
4	1	0	1	1	1	1	0	71%
5	1	1	0	1	0	0	0	43%
6	0	1	1	1	1	1	1	86%
7	1	1	1	0	1	1	0	71%
8	0	1	1	1	0	0	1	57%
9	1	1	0	1	1	1	1	86%
10	1	1	1	1	1	1	1	100%
11	0	0	0	0	0	0	0	0%
12	1	1	1	1	0	1	1	86%
13	1	1	1	1	1	1	1	100%
14	0	1	1	0	1	0	0	43%
15	1	1	0	1	1	1	0	71%
16	0	N/A	1	1	0	1	N/A	60%
17	0	1	0	1	1	1	1	71%
18	0	1	1	1	0	0	0	43%
19	1	1	0	1	1	1	1	86%
20	0	1	1	0	0	1	0	43%
21	0	1	1	1	1	1	1	86%
22	1	0	1	1	1	1	0	71%
23	0	1	1	1	1	1	1	86%
24	1	1	0	1	1	0	0	57%
25	1	0	1	0	1	1	1	71%
26	1	1	1	1	1	1	1	100%
27	1	1	1	1	1	0	1	86%
28	0	0	0	1	1	1	0	43%
29	0	1	N/A	1	1	1	1	83%
30	1	1	1	0	1	1	0	71%
Total yes	19	25	23	25	23	24	17	
Total questions	30	29	29	30	30	30	29	
Percentages	**57%**	**79%**	**72%**	**77%**	**73%**	**70%**	**55%**	

Average score = _____

Percentage of scores ≥ 80% = _____

What system problems are there?

What do you propose as solutions to these system problems?

What people problems do you see?

What do you propose as solutions to these people problems?

Answer Key for Lesson 13 Handout 2: Analyzing Quality Improvement and Verification Checklist (QIVC) Scores

Quarter 1 QIVC Scores (1 = yes; 0 = no; Skip = N/A)

Question	Abebe	Kebede	Asnake	Bogale	Tesfaye	Yetayesh	Mesele	Total
1	1	0	1	1	1	0	1	71%
2	1	1	1	1	1	1	0	86%
3	0	1	1	0	0	0	1	43%
4	1	0	1	1	1	1	0	71%
5	1	1	0	1	0	0	0	43%
6	0	1	1	1	1	1	1	86%
7	1	1	1	0	1	1	0	71%
8	0	1	1	1	0	0	1	57%
9	1	1	0	1	1	1	1	86%
10	1	1	1	1	1	1	1	100%
11	0	0	0	0	0	0	0	0%
12	1	1	1	1	0	1	1	86%
13	1	1	1	1	1	1	1	100%
14	0	1	1	0	1	0	0	43%
15	1	1	0	1	1	1	0	71%
16	0	N/A	1	1	0	1	N/A	60%
17	0	1	0	1	1	1	1	71%
18	0	1	1	1	0	0	0	43%
19	1	1	0	1	1	1	1	86%
20	0	1	1	0	0	1	0	43%
21	0	1	1	1	1	1	1	86%
22	1	0	1	1	1	1	0	71%
23	0	1	1	1	1	1	1	86%
24	1	1	0	1	1	0	0	57%
25	1	0	1	0	1	1	1	71%
26	1	1	1	1	1	1	1	100%
27	1	1	1	1	1	0	1	86%
28	0	0	0	1	1	1	0	43%
29	0	1	N/A	1	1	1	1	83%
30	1	1	1	0	1	1	0	71%
Total yes	19	25	23	25	23	24	17	
Total questions	30	29	29	30	30	30	29	
Percentages	**63%**	**86%**	**79%**	**83%**	**77%**	**80%**	**59%**	

Average score = *75%*

Percentage of scores ≥ 80% = *43%*

What system problems are there?

There are weaknesses in the QIVC for Meeting Facilitation Question Numbers 3, 5, 11, 14, 18, 20, 28

- *#3 Did the facilitator introduce the topic well?*
- *#5 Did the facilitator use the proper eye contact with everyone?*
- *#11 Did the facilitator demonstrate skills that s/he was promoting?*
- *#14 Did the facilitator give participants adequate time to answer questions?*
- *#18 Did the facilitator ask participants if they agree with other participants' responses?*
- *#20 Did the facilitator always reply to participants in a courteous and diplomatic way?*
- *#28 Was the content of the educational messages CORRECT?*

What do you propose as solutions to these system problems?

- *Coach staff during the practice and coaching session to make sure they are 1) introducing the topic well, 2) using proper eye contact and 3) including the appropriate activity (#11).*
- *During staff trainings, demonstrate (model) the best way to introduce a topic, proper use of eye contact and good discussion techniques (#3,5,14,18,20 and 28).*
- *Set up a separate training where you teach facilitators how to deal with problem participants (so that they can respond appropriately) #20.*
- *Review your materials to find out why many workers are not sharing correct information (#28). Retrain all workers on technical information.*
- *Review these questions specifically on the QIVC before the observation, reminding the facilitator to do these actions when "casting a vision" for performance.*
- *Ask the facilitators to commit to making these changes.*
- *Help facilitators develop ways to remember to do the new things. Ask them, "How will you remember?"*
- *Reconsider your trainings: Are you rushing through the trainings so that people don't understand? You may need to shorten the training and spend more time going over practical examples (increase discussion and allow for more questions).*

What people problems do you see?

Abebe and Mesele are scoring poorly, worse than others.

What do you propose as solutions to these people problems?

- *Consult with the Promoter (if you are the Supervisor) to see what issues might explain the problems*
- *Observe the Promoter (if you are the Supervisor) teaching the CGVs; identify any weaknesses;*
- *Find out the problem with each worker. Are they getting positive feedback from their observer? Why haven't they improved?*
- *Review the questions they have missed. Are they scoring poorly on questions that were skipped (not applicable questions)?*
- *Is the worker unwilling to make changes?*

- *Ask the person for a plan of how they will improve and chart progress.*

Lesson 13 Handout 3: Quality Improvement and Verification Checklist (QIVC) Scores for Six Promoters

After reviewing the data shown below, how often would you recommend that the Supervisor visit these Promoters?

Quarter	Gabriella	Kwaasi	Dorothy	Tom	Mario	Joseph	Total
Q1	68%	74%	53%	47%	74%	89%	68%
Q2	74%	79%	68%	53%	79%	89%	75%
Q3	84%	89%	89%	53%	95%	100%	86%

Lesson 14: Care Group Monitoring Information System: Introduction to Registers

Achievement-Based Objectives

By the end of this lesson participants will have:

- Practiced completing a Care Group (CG) register
- Interpreted the information in the register
- Practiced teaching others how to use the CG registers

Duration

2 hours

Materials Needed

- Lesson 14 Handout 1: Care Group Management Information System Information Sources
- Lesson 14 Flip Chart 1 and Handout 2: Flow of Information in the Care Group Monitoring Information System
- Lesson 14 Handout & Flip Chart 3: Blank Care Group Register
- Lesson 14 Handout 4: Example Completed Care Group Register
- Lesson 14 Handout 5: Blank Neighbor Group Register
- Lesson 14 Handout 6: Register Quiz
- Answer Key to Lesson 14 Handout 5: Register Quiz

Facilitator's Notes

This is a relatively challenging lesson to facilitate. Be sure to take time to prepare well beforehand, and ensure that all participants understand the information by the end of the lesson. When possible, try to have hard copies of a CG register and a Neighbor Group (NG) register. And, be sure that participants have **Lesson 14 Handout 3: Blank Care Group Register** and **Lesson 14 Handout 5: Blank Neighbor Group Register** at the beginning of the lesson. Be sure to go over both box by box. The register quiz at the end of this lesson may be particularly helpful for field staff.

Steps

1. Introduction

    1a. One of the most important responsibilities of each of the CG team members is the collection and sharing of data.

    1b. Ask participants: Why is this such an important task? Tell them that collecting and sharing data helps us monitor the program and assess the effectiveness of each team member and the program as a whole. Therefore, data collection and reporting will be covered over two lessons.

2. Overview of the Care Group Management Information System (CGMIS)

   2a. Refer participants to **Lesson 14 Handout 1: Care Group Management Information System Information Sources** and explain it to them in detail.

   2b. Tell participants: This information is critical to your Care Group project as it allows you to monitor attendance at Neighbor Group and Care Group meetings, which are the two most important aspects of the Care Group approach. If women are not attending these meetings, we know our program will not be successful. Collecting information on vital events on all members of Neighbor Groups and Care Groups also allows your program to track maternal, child and infant mortality—data that would otherwise be expensive and time intensive to collect.

   2c. Display **Lesson 14 Flip Chart 1 and Handout 2: Flow of Information in the Care Group Monitoring Information System** and have participants follow along on their copies. Describe the overall flow of information for the CGMIS from the top of the diagram to the bottom. Explain that all of the information will come from the NG and CG registers. This information will be compiled as it is passed down the chain of command and eventually given to the Maternal and Child Health and Nutrition (MCHN) Coordinator and/or manager.

Collecting Information on Vital Events

In most projects Care Group Volunteers (CGVs) collect data on vital events (such as births, child deaths and maternal deaths). Medical Teams International also has them collect data on referrals at the household level in their CG in Liberia. The project did this to see the number of referrals at the household level and compare it to the number recorded at the health facilities. It gave the project insights into the effectiveness of the referral process.

World Relief (WR) tracks new pregnancies, as well, to facilitate follow up with pregnant women on important behaviors during pregnancy.

Others have collected data on childhood illnesses and malnutrition. It is important to only collect data that is going to be used by the project for a specific purpose and to avoid overburdening the Volunteers with reporting on too many events.

   2d. Explain to participants: In this lesson, we will teach you how to use and complete Neighbor Group and Care Group registers. In the next lesson, we will teach you how to create Promoter, Supervisor and Coordinator reports from these registers.

3. How to Use the Registers

   3a. Refer participants to **Lesson 14 Handout 3: Blank Care Group Register** and **Lesson 14 Handout 4: Blank Neighbor Group Register**. Remind participants that the two registers are very similar.

   3b. First review the CG register in Lesson 14 Handout 3 with participants. Then refer participants to **Lesson 14 Handout 4: Example Completed Care Group Register** for an example of the following information.

- The top two rows are the title and description of the register.
- On the upper left corner, write the number of the group using the code from the numbering system.
- On the top center of the register is the key, which displays the meaning of the symbols and letters that will used to fill out the register.
- In Column 1 write the letter of the Care Group Volunteer (CGV) of the CG
- In Column 2 write the name of the CGV of the CG
- In Column 3 write the date the CGV was registered to participate in this CG
- In the first cell of Column 4, the Promoter should fill out the date of that month's meeting and the lesson taught that month. Each lesson has the module number and the lesson number. Therefore, 2.3 means that Module 2 Lesson 3 was taught.
  - In the lines beneath this date the Promoter should indicate if the Volunteer attended the teaching session by placing a "✔" for attended, an "X" for absent, and a "·" if the CGV was visited at home.
  - Next to this line, the Promoter should fill record any births or deaths that occured this month. Use the codes from the key: "CB" for child born, "CD" for child death and "MD" for maternal death.

3c. Next review the NG register in **Lesson 14 Handout 4** with participants.

- The top two rows are the title and description of the register.
- On the upper left corner, write the number of the group using the code from the numbering system.
- On the top center of the register is the key, which displays the meaning of the symbols and letters that will used to fill out the register.
- In Column 1 write the number of the neighbor woman of the NG.
- In Column 2 write the name of the neighbor woman of the NG.
- In Column 3 write the date the neighbor woman was registered to participate in this NG.
- In the first cell of Column 4, the CGV fills out the date of that month's meeting and the lesson taught. Use the same rules with this column as for the CG register.

3d. Remind participants that if CGVs are illiterate, the Promoter will need to fill out both registers during CG meetings. In this case, during the attendance step of a CG meeting the Promoter would:

- First, take attendance of the CGVs

- Second, ask each CGV to report on:
  - Any new members in their NG
  - The maternal age (i.e., months of pregnancy) or child age (if the mother has a young child) of any new members
  - Attendance at the last NG meeting
  - Any vital events

3e. Tell participants: If other women in the community become pregnant, they should be invited to join the group as long as the group size doesn't exceed 15, which is the maximum size of Neighbor Groups. For this reason, you may want to design your Care Group program to start with small Neighbor Groups of around 10 women so there's enough room in the groups for new women to join.

3f. Tell participants: If a Care Group Volunteer dies or wishes to drop out of the program, the Neighbor Group should quickly elect a woman from their group to replace her. The previous Volunteer's name should be crossed off the Care Group register, and the newly elected Care Group Volunteer's name should be added in an empty row. In the Neighbor Group register, the previous Care Group Volunteer's name should be crossed off and replaced with the new Care Group Volunteer. The letters continue sequentially.

4. Activity: Check for Understanding: Register Quiz!

4a. Divide participants into pairs.. Distribute **Lesson 14 Handout 6: Register Quiz**, and have participants complete the quiz in their groups using the example of the completed CG register in Lesson 14 Handout 4. For more advanced groups, ask participants to come up with more difficult questions than are listed in Lesson 14 Handout 6.

4b. After a few minutes, tell the two groups to swap answers and grade the other's quiz.

4c. Review answers together using **Answer Key to Lesson 14 Handout 6: Register Quiz**.

5. Wrap Up

5a. Wrap up this lesson by explaining that learning to use the registers takes time and often is more easily learned on the job.

Lesson 14 Handout 1: Care Group Management Information System Information Sources

The Care Group Management Information System (CGMIS) is based on two basic information sources:

- Neighbor group (NG) register
- Care Group (CG) register

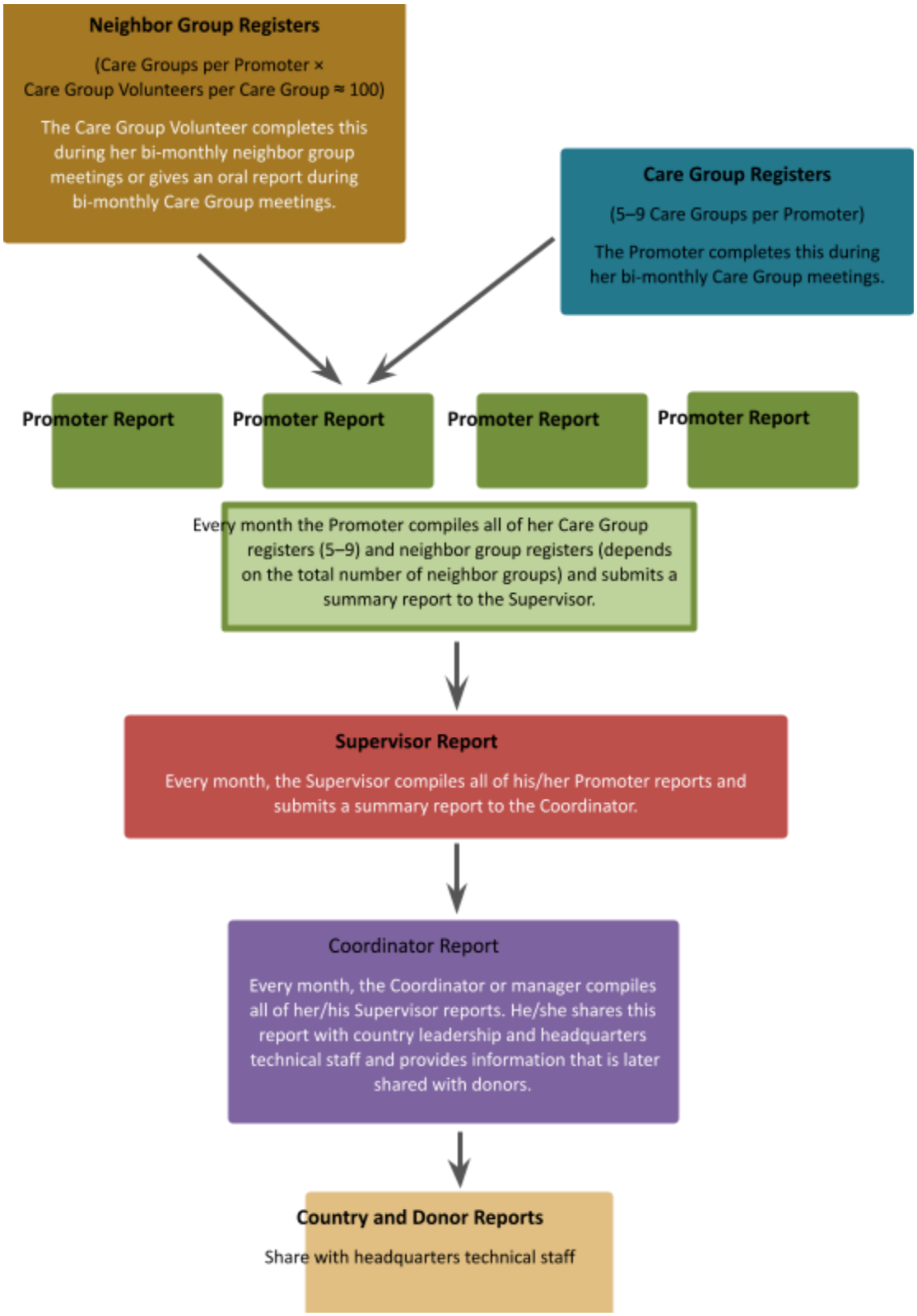
These registers are very similar to one another and collect four types of information from either the NGs or CGs:

1. **Date** when the members joined (registration information)
2. **Attendance** at group meetings or home visits
3. **Vital events** of group members (maternal deaths, deaths of children under 2 and child births)
4. **Lessons** in the CG curriculum that have been covered

Note on register variations: Some CG programs adapt these registers to collect more information (such as immunization coverage, antenatal care attendance and childhood illness). Before deciding whether to collect more information, the program should first consider the following:

- The registers should be as simple as possible. Adding additional fields to the registers will require Care Group Volunteers (CGVs) and Promoters to spend more time filling out the registers during their bi-monthly meetings with NGs and CGs (respectively), which may take away time from teaching the curriculum. Detailed registers may also create a temptation to falsify information if the CGVs and Promoters find the registers too burdensome to fill out each meeting.
- The denominator for indicators collected through the CGMIS only can be women participating in the groups or their children. If a CG program includes nearly all pregnant women in the project area, then the CGMIS can be used to measure a proxy of maternal mortality during the life of the project. On the other hand, a CG program could not easily track the use of modern family planning methods, since it is unlikely that all women of reproductive age would participate in a CG program.

Lesson 14 Flip Chart 1 and Handout 2: Flow of Information in the Care Group Monitoring Information System



Lesson 14 Handout 3: Blank Care Group Register

Care Group Register

This is a Care Group (CG) register: CGs are led by Promoters; the members are Care Group Volunteers (CGVs).

Group # (use the code from the numbering system):		Key:	✔ Attended group meetings	X Absent	• Received home visit
			CB Child Birth	CD Under 2 child death	MD → Maternal death

CGV Letter	Promoter (group leader) name: / CG Volunteer name:	Date of Registry in Care Groups	Month:				Month:				Month:				Month:			
			Date: / Lesson:	Births or Deaths?	Date: / Lesson:	Births or Deaths?	Date: / Lesson:	Births or Deaths?	Date: / Lesson:	Births or Deaths?	Date: / Lesson:	Births or Deaths?	Date: / Lesson:	Births or Deaths?	Date: / Lesson:	Births or Deaths?	Date: / Lesson:	Births or Deaths?
Total attended/visited (add all ✔ and •)																		
Total registered (add all CGVs still in the CG)																		
Maternal Deaths (add all MDs)																		
Deaths in Children Under 2 Years Old (add all CDs)																		
Child Births (add all CBs)																		

Lesson 14 Handout 4: Example Completed Care Group Register

Care Group Register

This is a Care Group (CG) register: CGs are led by Promoters; the members are Care Group Volunteers (CGVs).

Group # (use the code from the numbering system):	8.5

Key:	✔ Attended group meetings	X Absent	• Received home visit
	CB Child Birth	CD Under 2 child death	MD → Maternal death

CGV Letter	Promoter (group leader) name: Rachel White / CG Volunteer name:	Date of Registry in Care Group	Month: May				Month: June				Month: July				Month: August			
			Date: May 3 / Lesson: 1.1	Births or Deaths?	Date: May 15 / Lesson: 1.2	Births or Deaths?	Date: Jun 1 / Lesson: 1.3	Births or Deaths?	Date: Jun 18 / Lesson: 1.4	Births or Deaths?	Date: Jul 4 / Lesson: 1.5	Births or Deaths?	Date: Jul 20 / Lesson: 1.6	Births or Deaths?	Date: Aug 6 / Lesson: 1.3	Births or Deaths?	Date: Aug 20 / Lesson: 2.0	Births or Deaths?
A	Leena Samuel	Apr 19, 2011	✔		•		✔		•		✔		•		✔		•	
B	Martha Abdul	Apr 20, 2011	✔		•		✔		•		•	CB	•		✔		•	
C	Anne Maria Andrews	Apr 20, 2011	✔		X		X		•		✔		•		✔		•	
D	Mitzi Hanold	Apr 20, 2011	✔		•		✔		•		✔		•		✔		•	
E	Anne Story	Apr 22, 2011	✔	CB	•		✔		•		✔		•		✔		•	
F	Janine Linda	Apr 22, 2011	✔	CD	•		•		•		✔		•		✔		•	
G	Leonie Divine	Apr 22, 2011	✔		•		✔		•		✔		•		✔		•	
H	Janet Learner	Apr 22, 2011	✔		•		✔		X		✔		•		✔		•	
I	Marie Leroy	Apr 23, 2011	✔		•		✔		•		✔		•		✔		•	
J	~~Mary Smith~~	~~Apr 23, 2011~~	✔		•		✔			MD								
K	Leslie Jackson	Jul 2, 2011									✔		•		•	CB	•	
Total attended/visited (add all ✔ and •)			10		9		9		8		10		10		10		10	
Total registered (add all CGVs still in the CG)			10		10		10		9		10		10		10		10	
Maternal Deaths (add all MDs)			0				1				0				0			
Deaths in Children Under 2 Years Old (add all CDs)			1				0				0				0			
Child Births (add all CBs)			1				0				1				1			

Lesson 14 Handout 5: Blank Neighbor Group Register

Neighbor Group Register

This is a Neighbor Group (NG) register: NGs are led by Care Group Volunteers (CGVs); the members are (usually) mothers.

Group # (use the code from the numbering system):	

Key:	✔ Attended group meetings	X Absent	• Received home visit
	CB Child Birth	CD Under 2 child death	MD → Maternal death

NW #	CGV (group leader) name: / Neighbor Woman (NW) name:	Date of Registry in Neighbor Group	Month:				Month:				Month:				Month:			
			Date: / Lesson:	Births or Deaths?	Date: / Lesson:	Births or Deaths?	Date: / Lesson:	Births or Deaths?	Date: / Lesson:	Births or Deaths?	Date: / Lesson:	Births or Deaths?	Date: / Lesson:	Births or Deaths?	Date: / Lesson:	Births or Deaths?	Date: / Lesson:	Births or Deaths?
Total attended/visited (add all ✔ and •)																		
Total registered (add all CGVs still in the CG)																		
Maternal Deaths (add all MDs)																		
Deaths in Children Under 2 Years Old (add all CDs)																		
Child Births (add all CBs)																		

Lesson 14 Handout 6: Register Quiz

1. What is the Promoter number for this Care Group?

2. What lesson was taught on July 4, 2011?

3. Why is Mary Smith's name crossed out?

4. When did Martha Abdul have her baby?

5. How many U2 child deaths happened during the period of time tracked by this register?

6. Why isn't attendance filled out for Leslie Jackson until July 4, 2011?

Answer Key to Lesson 14 Handout 6: Register Quiz

1. What is the Promoter number for this Care Group?

8

2. What lesson was taught on July 4, 2011?

1.5

3. Why is Mary Smith's name crossed out?

She died

4. When did Martha Abdul have her baby?

Between June 18 and July 4, 2011

5. How many child deaths happened during the period of time tracked by this register?

1

6. Why isn't attendance filled out for Leslie Jackson until July 4, 2011?

She joined the group later

Lesson 15: Care Group Monitoring Information System: Promoter, Supervisor and Coordinator Reports

Achievement-Based Objectives

By the end of this lesson participants will have:

- Practiced completing Promoter, Supervisor and Coordinator reports
- Practiced teaching others to use these reports

Duration

2 hours 15 minutes

Materials Needed

- LCD projector, pointer and example reports (blank and completed) or flip charts of a blank register and a blank Promoter Report (pgs 1 & 2)
- Lesson 14 Flip Chart 1 and Handout 2: Flow of Information in the Care Group Monitoring Information System
- Lesson 15 Handout 1: Blank Promoter Report
- Lesson 15 Handout 2: Blank Supervisor Report
- Lesson 15 Handout 3: Blank Coordinator Report
- Lesson 15 Handout 4: Example Completed Promoter Report
- Lesson 15 Handout 5: Example Completed Supervisor Report
- Lesson 15 Handout 6: Example Completed Coordinator Report
- Lesson 15 Handout 7: Report Quiz
- Answer Key to Lesson 15 Handout 7: Report Quiz

Facilitator's Notes

For this session it might be useful to project (via LCD) the forms so that everyone is looking at the same report as you explain it. Be sure to have a pointer, as well.

Steps

1. Introduction

    1a. Tell participants: Now that we've looked at the registers, we need to see how that information is used by the other members of the Care Group team to create the reports.

    1b. Refer participants back to the diagram from **Lesson 14 Flip Chart 1 and Handout 2: Flow of Information in the Care Group Management Information System**. Explain: Now we're going to learn how the paid staff members from a Care Group program—Promoters, Supervisors and Coordinators—create their monthly reports using information from the Care Group and Neighbor Group registers.

1c. Ask participants: Who can remind the group what four types of information are collected in the registers? They should answer registration, attendance, curriculum and vital events. Explain that reports compile this information at different levels.

2. The Promoter Report

2a. Refer participants to **Lesson 15 Handout 1: Blank Promoter Report** and project the report using the LCD projector and pointer. Review each page of the report, and explain that all information comes directly from the registers of the Care Groups (CGs) and Neighbor Groups (NGs) under that Promoter.

2b. Remind participants that Promoters are typically responsible for five to nine CGs, each CG contains 10–15 Care Group Volunteers (CGVs), and each CGV leads a NG of 10–15 women. This means that each Promoter may be responsible for tracking information from around 1,000 women. Therefore, it is very important that project staff and Promoters know how to use the registers to complete their monthly reports.

2c. Explain that all reports, starting with the Promoter reports, are divided into two sections. The first page summarizes information from all CGs under that staff member. This information comes from the CG registers. The remaining pages of the report summarize the information from NGs under that staff member using the NG registers.

- Promoter Report: Page one (summarized information from all CGs)
  - Review the content of the headings.
- CG information: The Promoter:
  - Writes the numbers for each of her CGs in the top row of the table
  - Copies the summary information from the bottom of the CG register in the column below each CG number
  - Records the number and average score of CGVs observed with a quality improvement and verification checklist (QIVC)
  - Reviews calculations for average QIVC score (the sum of each score divided by the total number of scores available)
- Page two through the end (summarized information from NG)
  - Each CG has its own table. The first row includes the letters of the CGVs within that CG.
  - In the column under each CGV letter, the Promoter copies the summary information from the bottom of the NG registers.

3. The Supervisor Report

3a. Refer participants to **Lesson 15 Handout 2: Blank Supervisor Report**. Tell participants that all information for this report comes from the Promoter reports.

3b. Page one: CG information: The Supervisor:

- Writes the number for each Promoter he/she is responsible for in the top row of the table
- Copies the information from the "**Total**" column of the first page of the Promoter report, the CG information table, into the columns below the Promoter numbers
- Records the number of times he/she supervised each Promoter, along with the QIVC for educational session facilitation score
- Reviews calculations for:
  - Percentage of attendance (number who attended divided by number registered)
  - Percentage of Promoters who completed the planned number of QIVCs
  - Average CGV attendance
  - Expected number of CGVs to be registered: This number will be different for each Supervisor. The Supervisor calculates the expected number CGVs for each Promoter separately, then adds up all of the Promoters' targets for the total. To calculate the Promoter target, the Supervisor multiplies the number of CGs for which the Promoter is responsible by the expected number of CGVs per CG.
  - Percentage of intended attendance reached (number who attended divided by the planned number)

3c. Page two through the end—NG information: Each Promoter has his/her own table. The first row of the table includes the CG numbers under that Promoter.

3d. The Supervisor:

- Copies the "**Total**" column from the Promoter's NG information tables (in pages two through the end of the Promoter report) into the column under each CG
- Reviews calculations for:
  - Percentage of attendance (number who attended divided by number registered)
  - Expected number of Neighbor Women (NW) to be registered: This number will be different for each Supervisor. The Supervisor calculates the expected number of NW for each Promoter separately, then adds up all the Promoters' targets for the total. To calculate the Promoter's target, the Supervisor multiplies the number of CGs for which the Promoter is responsible by the expected number of CGVs per CG by the expected number of NW per CGV.
  - Percentage of attendance target reached (attendance divided by the planned number)

4. The Coordinator Report

4a. Refer participants **to Lesson 15 Handout 3: Blank Coordinator Report**. Tell participants that all information for this report comes from Supervisor reports.

4b. Page one: CG information: The Coordinator:

- Writes the name of each Supervisor he/she supervises in the top row of the table
- Writes the CG numbers under each Supervisor in the second row
- Copies the information from the "**Total"** column on the first page of the Supervisor report, in the CG information table, into the columns below the Supervisors' names
- Records the number of times he/she supervised each Supervisor, along with the QIVC for educational session facilitation score
- Reviews calculations for:
  - Percentage of attendance (number who attended divided by number registered)
  - Percentage of Promoters who completed the planned number of QIVCs
  - Average CGV attendance
  - Target number of CGVs to be registered, calculated adding up their Supervisors' targets for CGVs
  - Percentage of attendance target reached

4c. Page two through the end—NG information: Each Supervisor has his/her own table. The first row of the table lists the numbers of the Promoters under that Supervisor.

4d. The Coordinator:

- Copies the "**Total**" column from the Supervisor's NG tables (in pages two through the end) into the column under each Promoter
- Reviews calculations for:
  - Percentage of attendance (number who attended divided by number registered)
  - Intended NW to be registered, calculated by adding up the Supervisors' targets for NW
  - Percentage of attendance target reached (attendance divided by planned number)

5. Review Completed Reports

5a. Refer participants to **Lesson 15 Handout 4: Example Completed Promoter Report**, **Lesson 15 Handout 5: Example Completed Supervisor Report** and **Lesson 15 Handout 6: Example Completed Coordinator Report**.

5b. Start with the Promoter report in Lesson 15 Handout 4. State that the report is for Promoter Rachel White (Promoter 8). The report includes information from CG 8.5, the register we reviewed in **Lesson 14 Handout 4: Example Completed Care Group Register**. Make sure participants understand how the information from **CG 8.5** appears in this Promoter report.

- Ask participants: Where in the Promoter report do you think Care Group register 8.5 will be recorded? Answers should include the first page because all CG information is summarized on the first page.
- Remind participants that the "**Total"** fields at the bottom of the CG register supply the data needed for column 8.5 on the first page of the Promoter report (highlighted in green).
- Remind participants that the columns on the first page summarize information about other CGs (8.1, 8.2, 8.3, etc.).
- Pages two through the end summarize information from the NG registers. Each table represents a different CG. Each column within a table represents a different CGV. Remind participants that the information for these tables comes from the "Total" fields from the bottom of each NG register.

5c. Next, review Lesson 15 Handout 5, the Supervisor report for Kelly Hughes. Show how the "Total" columns from Rachel White's Promoter report are included in the two different sections of the Supervisor report. Rachel White's CG information is summarized on the first page of the Supervisor report. Rachel White's NG information is summarized in the second section of the Supervisor report, in a table on page 3. These columns and tables are highlighted in green.

- Explain that the other Promoters' CG information is summarized in a column on the first page. The other Promoters' NG information is summarized in a table in the second section of the report.
- Review the calculations for:
  - Percentage of attendance (number who attended divided by number registered)
  - Percentage of Promoters who completed target QIVCs
  - Average CGV attendance
  - Target number of CGVs to be registered
  - Percentage of attendance target reached

5d. Finally, review Lesson 15 Handout 6, the completed Coordinator report. As with the Supervisor report, show participants the following.

- The "Total" columns from Kelly Hughes' Supervisor report are included in the two different sections of the Coordinator report.
  - Kelly Hughes' CG information is summarized on the first page of the Coordinator report.
  - Kelly Hughes' NG information is summarized in the second section of the Coordinator Report, in a table on page 2.
  - These columns and tables are highlighted in green.
- Explain that other Supervisors' CG information is summarized in a column on the first page, and other Supervisors' NG information is summarized in a table in the second section of the report.
- Review calculations for:
  - Percentage of attendance (number who attended divided by number registered)
  - Percentage of Promoters who completed target QIVCs
  - Average CGV attendance
  - Target number of CGVs to be registered
  - Percentage of attendance target reached

6. Activity: Check for Understanding: Report Quiz

6a. Divide participants into pairs. Distribute **Lesson 15 Handout 7: Report Quiz**.

6b. Have the participants complete the quiz using the completed reports in Lesson 15 Handouts 4, 5 and 6.

6c. After a few minutes, have participant pairs grade each other's quiz. Review answers together using **Answer Key to Lesson 15 Handout 7: Report Quiz**.

6d. Optional: If some of the participants are already very experienced with reporting, ask them to review the completed reports (Handouts 4, 5 and 6) and develop additional quiz questions for the rest of the group.

7. Wrap Up

7a. Wrap up by telling participants: Mastering the registers and reports takes time. The more you work with them the better you will understand them.

Lesson 15 Handout 1: Blank Promoter Report

Promoter Monthly Report

Note: *This report template is modeled after a program with 8 Care Groups per Promoter and 14 Care Group Volunteers per Care Group. It can be easily adapted to fit your program specifications. Additional copies of the second page will be needed for each promoter report, based on the size of your program.*

Promoter Name:		Reporting Period:	
Promoter #:		Province/District:	

Page #: __1__

Summary of Care Group Registers (Care Group Volunteers [CGVs])

Care Group Number										Total
CGVs attended 1st meeting/home visit										
CGVs registered 1st meeting/home visit										
CGVs attended 2nd meeting/home visit										
CGVs registered 2nd meeting/home visit										
CGV maternal deaths										
CGV under 2 child deaths										
CGV births										
# CGVs observed with a QIVC*										
Average QIVC score (%)										
Comments:										

** **Note:** Each Promoter should conduct a supportive supervision visit using the quality improvement and verification checklist (QIVC) for 1 CGV in each Care Group every 2 weeks. If a Promoter has 8 Care Groups, then he/she would visit 16 CGVs each month.*

Promoter Name:	

Page #: ____

Summary of Neighbor Group Registers (Neighbor Women [NW])

Care Group #:															
CGV letter															Total
NW attended 1st meeting/home visit															
NW registered 1st meeting/home visit															
NW attended 2nd meeting/home visit															
NW registered 2nd meeting/home visit															
NW maternal deaths															
NW under 2 child deaths															
NW births															

Care Group #:															
CGV letter															Total
NW attended 1st meeting/home visit															
NW registered 1st meeting/home visit															
NW attended 2nd meeting/home visit															
NW registered 2nd meeting/home visit															
NW maternal deaths															
NW under 2 child deaths															
NW births															

Lesson 15 Handout 2: Blank Supervisor Report

Supervisor Report

Note: *This template is modeled after a program with 4 Promoters per Supervisor and 8 Care Groups per Promoter. Additional copies of the second page will be needed for each supervisor report, based on the size of your program*

Page #: __1__

MCHN Supervisor name:		Reporting period:	
Promoter #s Supervisor is responsible for:		State/Province/District:	
Communities:			

Summary of Care Group Volunteers (CGVs) per Promoter

Promoter number						Total		
# of supervision visits to this Promoter								
QIVC score: Group education (%)						Average score:		
Care Group #s (1 through 8)						% attendance		
CGVs attended 1st meeting/home visit						A		(A ÷ B) × 100 =
CGVs registered 1st meeting/home visit						B		
CGVs attended 2nd meeting/home visit						C		(C ÷ D) × 100 =
CGVs registered 2nd meeting/home visit						D		
CGV maternal deaths								
CGV under2 child deaths								
CGV births								
# of CGVs observed with QIVC								

Comments:	% of Promoters who completed all 16 QIVCs this month		
	Average CGV attendance this month: (A + C) ÷ 2	E	
	Goal # of CGVs to be registered by this Supervisor	F	
	% of attendance goal reached this month: (E ÷ F) × 100		

MCHN Supervisor name:	

Page #: ____

Summary of Neighbor Women (NW) by Promoter and Care Group

Promoter number											
Care Groups #s responsible for										Total	% attendance
NW attended 1st meeting/home visit										A	(A ÷ B) × 100 =
NW registered 1st meeting/home visit										B	
NW attended 2nd meeting/home visit										C	(C ÷ D) × 100 =
NW registered 2nd meeting/home visit										D	
NW maternal deaths											
NW under 2 child deaths											
NW births											
Comments:									Average NW attendance this month: (A + C) ÷ 2	E	
									Goal # of NW to be registered by this Promoter	F	
									% of attendance goal reached this month: (E ÷ F) × 100		

Promoter number											
Care Groups #s responsible for										Total	% attendance
NW attended 1st meeting/home visit										A	(A ÷ B) × 100 =
NW registered 1st meeting/home visit										B	
NW attended 2nd meeting/home visit										C	(C ÷ D) × 100 =
NW registered 2nd meeting/home visit										D	
NW maternal deaths											
NW under 2 child deaths											
NW births											
Comments:									Average NW attendance this month: (A + C) ÷ 2	E	
									Goal # of NW to be registered by this Promoter	F	
									% of attendance goal reached this month: (E ÷ F) × 100		

Lesson 15 Handout 3: Blank Coordinator Report

Coordinator Report

Note: *This report template is modeled after a program with 4 Supervisors reporting to the Coordinator and 4 Promoters per Supervisor. Additional copies of the second page will be needed for each coordinator report, based on the size of your program.*

MCHN Coordinator name:		Reporting period:	
Name of Supervisors the Coordinator is responsible for:		State/Province/District:	
Communities:			

Page #: __1__

Summary of Care Group Volunteers (CGVs) per Supervisor

Supervisor name						Total		
# of supervision visits to this Supervisor								
QIVC score: Group education (%)						Average score:		
Promoter and Care Group #s responsible for						% attendance		
CGVs attended 1st meeting/home visit						A		(A ÷ B) × 100 =
CGVs registered 1st meeting/home visit						B		
CGVs attended 2nd meeting/home visit						C		(C ÷ D) × 100 =
CGVs registered 2nd meeting/home visit						D		
CGV maternal deaths								
CGV under2 child deaths								
CGV births								
# of CGVs observes with QIVC								
# of Promoters who completed all 16 QIVCs								

Comments:	Average CGV attendance this month: (A + C) ÷ 2	E	
	Goal # of CGVs to be registered by this Coordinator	F	
	% of attendance goal reached this month: (E ÷ F) × 100		

MCHN Coordinator name:	

Page #: __

Summary of Neighbor Women (NW) by Supervisor and Promoter

Supervisor name								
Promoter #						Total		% attendance
NW attended 1st meeting/home visit						A		(A ÷ B) × 100 =
NW registered 1st meeting/home visit						B		
NW attended 2nd meeting/home visit						C		(C ÷ D) × 100 =
NW registered 2nd meeting/home visit						D		
NW maternal deaths								
NW under 2 child deaths								
NW births								
Comments:			Average NW attendance this month: (A + C) ÷ 2			E		
			Goal # of NW to be registered by this Supervisor			F		
			% of attendance goal reached this month: (E ÷ F) × 100					

Supervisor name								
Promoter #						Total		% attendance
NW attended 1st meeting/home visit						A		(A ÷ B) × 100 =
NW registered 1st meeting/home visit						B		
NW attended 2nd meeting/home visit						C		(C ÷ D) × 100 =
NW registered 2nd meeting/home visit						D		
NW maternal deaths								
NW under 2 child deaths								
NW births								
Comments:			Average NW attendance this month: (A + C) ÷ 2			E		
			Goal # of NW to be registered by this Supervisor			F		
			% of attendance goal reached this month: (E ÷ F) × 100					

Lesson 15 Handout 4: Example Completed Promoter Report

Promoter Monthly Report

Note: *This report template is modeled after a program with 8 Care Groups per Promoter and 14 Care Group Volunteers per Care Group. It can be easily adapted to fit your program specifications. Additional copies of the second page will be needed for each promoter report, based on the size of your program.*

Promoter Name:	Rachel White	Reporting Period:	May-11
Promoter #:	8	Province/District:	California, Los Angeles

Page #: __1__

Summary of Care Group Registers (Care Group Volunteers [CGVs])

Care Group Number	8.1	8.2	8.3	8.4	8.5	8.6	8.7	8.8		Total
CGVs attended 1st meeting/home visit	12	11	9	12	10	10	11	12		87
CGVs registered 1st meeting/home visit	12	12	10	13	10	11	12	13		93
CGVs attended 2nd meeting/home visit	12	12	10	10	9	11	12	10		86
CGVs registered 2nd meeting/home visit	12	12	10	13	10	11	12	13		93
CGV maternal deaths	0	0	1	0	0	0	0	0		1
CGV under 2 child deaths	1	0	0	0	1	0	0	0		2
CGV births	0	0	0	0	1	1	0	0		2
# CGVs observed with a QIVC*	2	3	2	1	2	1	1	1		13
Average QIVC score (%)	89	80	62	90	89	75	70	90		81
Comments:										

** **Note:** Each Promoter should conduct a supportive supervision visit using the quality improvement and verification checklist (QIVC) for 1 CGV in each Care Group every 2 weeks. If a Promoter has 8 Care Groups, then he/she would visit 16 CGVs each month.*

Promoter Name:	Rachel White

Page #: 2

Summary of Neighbor Group Registers (Neighbor Women [NW])

Care Group #:	8.1														
CGV letter	A	B	C	D	E	F	G	H	I	J	K	L			Total
NW attended 1st meeting/home visit	11	12	13	10	11	12	13	12	12	13	14	12			145
NW registered 1st meeting/home visit	11	12	14	12	12	13	16	12	12	15	15	15			160
NW attended 2nd meeting/home visit	10	12	10	11	11	14	12	12	11	14	13	14			143
NW registered 2nd meeting/home visit	11	2	14	11	12	12	16	12	12	15	15	15			159
NW maternal deaths	0	0	0	1	0	0	0	0	0	0	0	0			1
NW under 2 child deaths	1	0	0	0	0	0	1	0	0	0	0	0			2
NW births	0	0	0	0	0	1	0	0	0	0	0	1			2

Care Group #:	8.2														
CGV letter	A	B	C	D	E	F	G	H	I	J	K	L			Total
NW attended 1st meeting/home visit	11	10	11	12	13	12	13	10	12	12	14	10			140
NW registered 1st meeting/home visit	12	12	12	15	13	12	15	10	14	12	15	15			157
NW attended 2nd meeting/home visit	10	12	10	11	11	13	12	12	11	14	13	14			143
NW registered 2nd meeting/home visit	11	12	14	11	12	14	16	12	12	15	15	15			159
NW maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0			0
NW under 2 child deaths	1	0	0	0	0	0	1	0	0	0	0	0			2
NW births	0	0	0	0	1	0	0	0	0	0	0	1			2

Promoter Name:	Rachel White

Page #: 3

Summary of Neighbor Group Registers (Neighbor Women [NW])

Care Group #:	8.3														
CGV letter	A	B	C	D	E	F	G	H	I	J	K	L			Total
NW attended 1st meeting/home visit	11	10	11	12	13	12	13	10	12	12	14	10			140
NW registered 1st meeting/home visit	12	12	12	15	13	12	15	10	14	12	15	15			157
NW attended 2nd meeting/home visit	10	12	10	11	11	13	12	12	11	14	13	14			143
NW registered 2nd meeting/home visit	11	12	14	11	12	14	16	12	12	15	15	15			159
NW maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0			0
NW under 2 child deaths	1	0	0	0	0	0	1	0	0	0	0	0			2
NW births	0	0	0	0	1	0	0	0	0	0	0	1			2

Care Group #:	8.4														
CGV letter	A	B	C	D	E	F	G	H	I	J	K	L			Total
NW attended 1st meeting/home visit	14	13	10	13	10	12	15	10	13	12	14	12			148
NW registered 1st meeting/home visit	15	13	12	14	12	12	14	10	13	12	15	12			154
NW attended 2nd meeting/home visit	10	12	12	9	9	12	12	12	12	14	14	13			141
NW registered 2nd meeting/home visit	14	14	14	11	12	13	14	12	12	14	15	15			160
NW maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0			0
NW under 2 child deaths	0	2	0	0	0	0	0	0	1	0	0	0			3
NW births	0	0	0	0	0	0	0	0	0	1	0	0			1

Promoter Name:	Rachel White

Page #: 4

Summary of Neighbor Group Registers (Neighbor Women [NW])

Care Group #:	8.5														
CGV letter	A	B	C	D	E	F	G	H	I	J	K	L			Total
NW attended 1st meeting/home visit	11	12	13	10	11	12	13	12	12	13	14	12			145
NW registered 1st meeting/home visit	11	12	14	12	12	14	16	12	12	15	15	15			160
NW attended 2nd meeting/home visit	10	12	10	11	11	13	12	12	11	14	13	14			143
NW registered 2nd meeting/home visit	11	12	14	11	12	14	16	12	12	15	15	15			159
NW maternal deaths	0	0	0	1	0	0	0	0	0	0	0	0			1
NW under 2 child deaths	1	0	0	0	0	0	1	0	0	0	0	0			2
NW births	0	0	0	0	0	1	0	0	0	0	0	1			2

Care Group #:	8.6														
CGV letter	A	B	C	D	E	F	G	H	I	J	K	L			Total
NW attended 1st meeting/home visit	11	10	11	12	13	12	13	10	12	12	14	10			140
NW registered 1st meeting/home visit	12	12	12	15	13	12	15	10	14	12	15	15			157
NW attended 2nd meeting/home visit	10	12	10	11	11	13	12	12	11	14	13	14			143
NW registered 2nd meeting/home visit	11	12	14	11	12	14	16	12	12	15	15	15			159
NW maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0			0
NW under 2 child deaths	1	0	0	0	0	0	1	0	0	0	0	0			2
NW births	0	0	0	0	1	0	0	0	0	0	0	1			2

Promoter Name:	Rachel White

Page #: 5

Summary of Neighbor Group Registers (Neighbor Women [NW])

Care Group #:	8.7														
CGV letter	A	B	C	D	E	F	G	H	I	J	K	L			Total
NW attended 1st meeting/home visit	11	10	11	12	13	12	13	12	12	12	14	12			144
NW registered 1st meeting/home visit	12	12	12	15	13	12	16	12	12	12	15	12			155
NW attended 2nd meeting/home visit	10	12	10	11	11	13	12	12	11	14	14	13			143
NW registered 2nd meeting/home visit	11	12	14	11	12	14	16	12	12	14	15	15			158
NW maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0			0
NW under 2 child deaths	1	0	0	0	0	0	1	0	0	0	0	0			2
NW births	0	0	0	0	1	0	0	0	0	1	0	0			2

Care Group #:	8.8														
CGV letter	A	B	C	D	E	F	G	H	I	J	K	L			Total
NW attended 1st meeting/home visit	12	13	12	12	12	14	12	12	13	12	10	11			145
NW registered 1st meeting/home visit	12	16	12	12	12	15	12	15	13	12	12	12			155
NW attended 2nd meeting/home visit	13	12	12	11	14	14	13	11	11	13	12	10			146
NW registered 2nd meeting/home visit	14	16	12	12	14	15	15	11	12	14	12	14			161
NW maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0			0
NW under 2 child deaths	0	1	0	0	0	0	0	0	0	0	0	0			1
NW births	0	0	0	0	1	0	0	0	1	0	0	0			2

Lesson 15 Handout 5: Example Completed Supervisor Report

Supervisor Report

Note: *This template is modeled after a program with 5 Promoters per Supervisor and 8 Care Groups per Promoter. Additional copies of the second page will be needed for each supervisor report, based on the size of your program*

Page #: 1

MCHN Supervisor name:	Kelly Hughes	Reporting period:	May-11
Promoter #s Supervisor is responsible for:	5 through 8	State/Province/District:	California, Los Angeles
Communities:			

Summary of Care Group Volunteers (CGVs) per Promoter

Promoter number	5	6	7	8		Total		
# of supervision visits to this Promoter	2	3	4	3		12		
QIVC score: Group education (%)	83	85	62	80		Average score:	77	
Care Group #s (1 through 8)	1–7	1–5	1–7	1–8		% attendance		
CGVs attended 1st meeting/home visit	72	50	76	87	A	285	(A ÷ B) × 100 = 94%	
CGVs registered 1st meeting/home visit	78	52	80	93	B	303		
CGVs attended 2nd meeting/home visit	70	48	79	86	C	283	(C ÷ D) × 100 = 93%	
CGVs registered 2nd meeting/home visit	78	50	82	93	D	303		
CGV maternal deaths	0	0	0	1		1		
CGV under2 child deaths	2	1	0	2		5		
CGV births	0	0	2	2		4		
# of CGVs observed with QIVC	6	5	4	13		24		

Comments: Goal # of CGVs to be registered by this Supervisor: Promoter 5: 7 CGs × 12 CGVs; Promoter 6: 5CGs × 12 CGVs; Promoter 7: 7CGs × 12 CGVs; Promoter 8: 8 CGs × 12 CGVs	% of Promoters who completed all 16 QIVCs this month		50
	Average CGV attendance this month: (A + C) ÷ 2	E	284
	Goal # of CGVs to be registered by this Supervisor	F	288
	% of attendance goal reached this month: (E ÷ F) × 100		99

MCHN Supervisor name:	Kelly Hughes

Page #: 2

Summary of Neighbor Women (NW) by Promoter and Care Group

Promoter number	5											
Care Groups #s responsible for	5.1	5.2	5.3	5.4	5.5	5.6	5.7				Total	% attendance
NW attended 1st meeting/home visit	145	140	155	125	150	161	170				A 1046	(A ÷ B) × 100 = 91%
NW registered 1st meeting/home visit	150	162	172	160	162	164	182				B 1152	
NW attended 2nd meeting/home visit	149	160	162	145	145	162	175				C 1098	(C ÷ D) × 100 = 94%
NW registered 2nd meeting/home visit	150	164	180	162	165	168	182				D 1171	
NW maternal deaths	0	0	1	0	0	0	0				1	
NW under 2 child deaths	1	2	1	2	1	2	2				11	
NW births	1	2	1	3	1	1	1				10	

Comments: Attendance goal set during program design phase. This example: 12 NW per CGV. Important to note it's fine to exceed this number, so % of attendance goal can be > 100%. Promoter 5: 7 CGs × 12 CGVs ×12 NW = 1008.

Average NW attendance this month: (A + C) ÷ 2	E	1072
Goal # of NW to be registered by this Promoter	F	1008
% of attendance goal reached this month: (E ÷ F) × 100		> 100

Promoter number	6											
Care Groups #s responsible for	6.1	6.2	6.3	6.4	6.5						Total	% attendance
NW attended 1st meeting/home visit	152	149	160	150	165						A 776	(A ÷ B) × 100 = 90%
NW registered 1st meeting/home visit	162	155	172	190	182						B 861	
NW attended 2nd meeting/home visit	155	161	171	172	181						C 840	(C ÷ D) × 100 = 96%
NW registered 2nd meeting/home visit	163	165	175	189	185						D 877	
NW maternal deaths	0	1	0	0	0						1	
NW under 2 child deaths	2	0	2	1	1						6	
NW births	2	1	2	1	1						7	

Comments: Goal # of NW to be registered by Promoter #6: 5 CGs × 12 CGVs ×12 NW =720

Average NW attendance this month: (A + C) ÷ 2	E	808
Goal # of NW to be registered by this Promoter	F	720
% of attendance goal reached this month: (E ÷ F) × 100		> 100

MCHN Supervisor name:	Kelly Hughes

Page #: 3

Summary of Neighbor Women (NW) by Promoter and Care Group

Promoter number	7												
Care Groups #s responsible for	7.1	7.2	7.3	7.4	7.5	7.6	7.7				Total		% attendance
NW attended 1st meeting/home visit	170	164	154	134	149	134	181				A	1086	(A ÷ B) × 100 = 91%
NW registered 1st meeting/home visit	182	180	172	160	152	155	191				B	1192	
NW attended 2nd meeting/home visit	152	163	162	135	132	120	171				C	1035	(C ÷ D) × 100 = 86%
NW registered 2nd meeting/home visit	183	179	172	170	150	160	190				D	1204	
NW maternal deaths	0	0	0	0	0	0	0				0		
NW under 2 child deaths	2	0	1	2	1	0	1				7		
NW births	1	2	0	2	1	2	0				8		

Comments: Goal # of NW to be registered by Promoter #7: 7 CGs × 12 CGVs × 12 NW = 1260

Average NW attendance this month: (A + C) ÷ 2	E	1061
Target # of NW to be registered by this Promoter	F	1008
% of attendance target reached this month: (E ÷ F) × 100		› 100

Promoter number	8												
Care Groups #s responsible for	8.1	8.2	8.3	8.4	8.5	8.6	8.7	8.8			Total		% attendance
NW attended 1st meeting/home visit	145	140	142	148	145	140	144	145			A	1149	(A ÷ B) × 100 = 91%
NW registered 1st meeting/home visit	160	157	160	154	160	157	155	155			B	1258	
NW attended 2nd meeting/home visit	143	143	143	141	143	143	143	146			C	1145	(C ÷ D) × 100 = 90%
NW registered 2nd meeting/home visit	159	159	159	160	159	159	158	161			D	1274	
NW maternal deaths	1	0	0	0	1	0	0	0			2		
NW under 2 child deaths	2	2	2	3	2	2	2	1			16		
NW births	2	2	2	1	2	2	2	2			15		

Comments: Goal # for NW to be registered by Promoter #8: 8 CG × 12 CGVs × 12 NW = 1152

Average NW attendance this month: (A + C) ÷ 2	E	1147
Goal # of NW to be registered by this Promoter	F	1152
% of attendance goal reached this month: (E ÷ F) × 100		100

Lesson 15 Handout 6: Example Completed Coordinator Report

Coordinator Report

Note: *This report template is modeled after a program with 4 Supervisors reporting to the Coordinator and 4 Promoters per Supervisor. Additional copies of the second page will be needed for each coordinator report, based on the size of your program.*

Page #: 1

MCHN Coordinator name:	Sara Smith	Reporting period:	May-11
Name of Supervisors the Coordinator is responsible for:	Carolyn, Kelly, Jen, and Emily	State/Province/District:	West, California, Los Angeles
Communities:			

Summary of Care Group Volunteers (CGVs) per Supervisor

Supervisor name	Carolyn	Kelly	Jen	Emily		Total		
# of supervision visits to this Supervisor	4	3	2	3		12		
QIVC score: Group education (%)	75	81	62	91		Average score:	77	
Promoter and Care Group #s responsible for	1.1–4.8	5.1–8.8	9.1–12.8	13.1–16.8		% attendance		
CGVs attended 1st meeting/home visit	352	285	321	332		A	1290	(A ÷ B) × 100 = 89.1%
CGVs registered 1st meeting/home visit	392	303	352	401		B	1448	
CGVs attended 2nd meeting/home visit	372	283	352	342		C	1349	(C ÷ D) × 100 = 91.8%
CGVs registered 2nd meeting/home visit	405	303	360	402		D	1470	
CGV maternal deaths	1	1	0	0		2		
CGV under2 child deaths	3	5	2	1		11		
CGV births	5	3	3	4		15		
# of CGVs observes with QIVC	31	24	32	28		115		
# of Promoters who completed all 16 QIVCs	70	50	92	65		69		
Comments: Goal # of CGVs to be registered by this Coordinator: 4 Supervisors × 4 Promoters per Supervisor × 8 CGs per Promoter × 12 CGVs per CG = 1536		Average CGV attendance this month: (A + C) ÷ 2				E	1320	
		Goal # of CGVs to be registered by this Coordinator				F	1536	
		% of attendance goal reached this month: (E ÷ F) × 100				86		

MCHN Coordinator name:	Sarah Smith

Summary of Neighbor Women (NW) by Supervisor and Promoter

Supervisor name	Carolyn Wilson							
Promoter #	1	2	3	4		Total		% attendance
NW attended 1st meeting/home visit	921	872	801	941		A	3535	(A ÷ B) × 100 = 99%
NW registered 1st meeting/home visit	1001	902	821	851		B	3575	
NW attended 2nd meeting/home visit	923	840	821	856		C	3440	(C ÷ D) × 100 = 95%
NW registered 2nd meeting/home visit	1005	924	850	860		D	3640	
NW maternal deaths	0	1	0	1		2		
NW under 2 child deaths	3	5	4	11		23		
NW births	9	6	9	10		34		
Comments: Goal # of NW to be registered by this Supervisor: 4 Promoters × 8 CGs 12 CGVs × 12 NW = 4608				Average NW attendance this month: (A + C) ÷ 2		E	3487.5	
				Goal # of NW to be registered by this Supervisor		F	4608	
				% of attendance goal reached this month: (E ÷ F) × 100		76		

Supervisor name	Kelly Hughes							
Promoter #	5	6	7	8		Total		% attendance
NW attended 1st meeting/home visit	1046	776	1086	1149		A	4057	(A ÷ B) × 100 = 91%
NW registered 1st meeting/home visit	1152	861	1192	1258		B	4463	
NW attended 2nd meeting/home visit	1098	840	1035	1145		C	4118	(C ÷ D) × 100 = 91%
NW registered 2nd meeting/home visit	1171	877	1204	1274		D	4526	
NW maternal deaths	1	1	0	2		4		
NW under 2 child deaths	11	6	7	16		40		
NW births	10	7	8	15		40		
Comments: Goal # of NW to be registered by this Supervisor: 4 Promoters × 8 CGs × 12 CGVs × 12 NW = 4608				Average NW attendance this month: (A + C) ÷ 2		E	4088	
				Goal # of NW to be registered by this Supervisor		F	4608	
				% of attendance goal reached this month: (E ÷ F) × 100		89		

MCHN Coordinator name:	Sarah Smith

Page #: 3

Summary of Neighbor Women (NW) by Supervisor and Promoter

Supervisor name	Jen Milner							
Promoter #	9	10	11	12		Total		% attendance
NW attended 1st meeting/home visit	800	901	954	776		A	3431	(A ÷ B) × 100 = 96%
NW registered 1st meeting/home visit	820	950	998	802		B	3570	
NW attended 2nd meeting/home visit	802	897	951	790		C	3440	(C ÷ D) × 100 = 95%
NW registered 2nd meeting/home visit	865	925	1001	823		D	3614	
NW maternal deaths	0	1	0	0		1		
NW under 2 child deaths	1	7	2	9		19		
NW births	7	9	5	8		29		
Comments: Goal # of NW to be registered by this Supervisor: 4 Promoters × 8 CGs × 12 CGVs × 12 NW = 4608			Average NW attendance this month: (A + C) ÷ 2			E	3436	
			Goal # of NW to be registered by this Supervisor			F	4608	
			% of attendance goal reached this month: (E ÷ F) × 100			75		

Supervisor name	Emily Hayes							
Promoter #	13	14	15	16		Total		% attendance
NW attended 1st meeting/home visit	962	852	951	801		A	3566	(A ÷ B) × 100 = 95%
NW registered 1st meeting/home visit	982	872	1021	898		B	3773	
NW attended 2nd meeting/home visit	941	825	976	856		C	3598	(C ÷ D) × 100 = 94%
NW registered 2nd meeting/home visit	1001	880	1025	912		D	3818	
NW maternal deaths	1	0	0	0		1		
NW under 2 child deaths	2	6	1	5		14		
NW births	6	5	7	5		23		
Comments: Goal # of NW to be registered by this Supervisor: 4 Promoters × 8 CGs × 12 CGVs × 12 NW = 4608			Average NW attendance this month: (A + C) ÷ 2			E	3582	
			Goal # of NW to be registered by this Supervisor			F	4608	
			% of attendance goal reached this month: (E ÷ F) × 100			78		

Lesson 15 Handout 7: Report Quiz

1. Look at Promoter Rachel White's report in Lesson 15 Handout 4.

   A. How many Care Group Volunteers (CGVs) were observed with a quality improvement and verification checklist (QIVC)?

   B. How many Care Groups (CGs) does Rachel White train and supervise?

   C. How many of Rachel's CGVs had babies during the month of May?

   D. In Care Group 8.4, how many Neighbor Women (NW) attended the first meeting/home visit?

2. Look at Supervisor Kelly Hughes' report in Lesson 15 Handout 5.

   A. What percent of CGVs under this Supervisor attended the second meeting?

   B. For all NW under Promoter 8, how many children under 2 years of age died?

3. Look at Coordinator Sarah Smith's report in Lesson 15 Handout 6.

   A. What percentage of Sarah's Promoters completed all six QIVCs this month?

   B. What percentage of Sarah's target number of CGVs were reached in May?

   C. Find the summary information of NW under Supervisor Emily Hayes. How many NW in total were registered during the second half of the month?

Answer Key to Lesson 15 Handout 7: Report Quiz

1. Look at Promoter Rachel White's report in Lesson 15 Handout 4.

   A. How many Care Group Volunteers (CGVs) were observed with a quality improvement and verification checklist (QIVC)?

   13

   B. How many Care Groups (CGs) does Rachel White train and supervise?

   8

   C. How many of Rachel's CGVs had babies during the month of May?

   2

   D. In Care Group 8.4, how many Neighbor Women (NW) attended the first meeting/home visit?

   148

2. Look at Supervisor Kelly Hughes' report in Lesson 15 Handout 5.

   A. What percent of CGVs under this Supervisor attended the second meeting?

   93%

   B. For all NW under Promoter 8, how many children under 2 years of age died?

   16

3. Look at Coordinator Sarah Smith's report in Lesson 15 Handout 6.

   A. What percentage of Sarah's Promoters completed all six QIVCs this month?

   69%

   B. What percentage of Sarah's target number of CGVs were reached in May?

   86%

   C. Find the summary information of NW under Supervisor Emily Hayes. How many NW in total were registered during the second half of the month?

   3,818

Lesson 16: Planning for Sustainability[27]

Achievement-Based Objectives

By the end of this lesson participants will have:

- Shared definitions of sustainability
- Identified aspects of the Care Group (CG) approach that realistically can be sustained
- Identified opportunities in their context to improve the likelihood of sustainability
- Identify design modifications and early steps to take to improve the likelihood of sustainability

Duration

1 hour 30 minutes

Materials Needed

- Flip chart paper and markers
- Lesson 16 Flip Chart 1: A Definition of Sustainability
- Lesson 16 Flip Chart 2: Categories of Sustainability
- Lesson 16 Flip Chart 3: Aspects of Care Groups that Might be Sustained
- Lesson 16 Handout 1: Examples of Improving Care Group Sustainability

Facilitator's Notes

Ask participants to sit with others who are working on the same project or are in the same geographical area.

Steps

1. Introduction

   1a. Tell participants: Now that we have discussed the details of how the Care Group approach is implemented, we should take some time to discuss the important topic of sustainability.

   1b. Ask participants to read **Lesson 16 Flip Chart 1: A Definition of Sustainability** and go over the definition with them.

   1b. Ask participants: Why do you suppose the designers of this training decided to include a lesson about sustainability? Answers should include: because planning for

[27] This lesson has been oriented towards Care Groups specifically. For additional guidance on sustainability in community health programming in general, please see: Eric Sarriot, Jim Ricca, Jennifer Yourkavitch, Leo Ryan and the Sustained Health Outcomes (SHOUT) Group. 2008. *Taking the Long View: A Practical Guide to Sustainability Planning and Measurement in Community-Oriented Health Programming*. Calverton, MD: Macro International, Inc. This manual can be downloaded from http://mchipngo.net/lib/components/documents/susManualnoAnoC.pdf, and annexes can be downloaded from http://mchipngo.net/lib/components/documents/susAnnex.pdf.

sustainability should not be left until the end of the project, and there are many decisions made at the beginning of a project that will have a positive or negative impact on sustainability.

1c. Ask participants: Can anyone mention a decision that was made at the beginning of a project (any project) that ended up having a negative impact on sustainability?

1d. Tell participants: Since we would like the Care Group approach to continue after the official project ends, we have to start thinking about sustainability from the very beginning of the project, or as soon as possible.

2. Sustainability of Care Group Activities

2a. Tell participants: We know that not everything that a project can accomplish with paid staff and additional resources can continue in perpetual motion. However, it is helpful to identify from the beginning any activities or outcomes we do expect to continue or otherwise be sustained and how we realistically think that could be possible.

2b. Break participants into small groups of people working in the same or similar contexts. Ask participants to list the things they would realistically like to see sustained, identify who will be responsible for sustaining that activity or outcome, and order the list from most likely to be sustained to least sustainable in their context.

2c. Show participants **Lesson 16 Flip Chart 2: Categories of Sustainability** and **Lesson 16 Flip Chart 3: Aspects of Care Groups that Might be Sustained**. Ask participants to compare their lists with the lists provided in the manual.

2d. Now that participants have prioritized list of CG aspects they think can be sustained, have each small group:

- Select the top two elements they would like to see sustained
- Discuss within the small group what specific actions should be taken from the beginning of the project to make sure those two elements are likely to continue without external support
- t

2f. Have one member of each small group present each group's top aspect (or a different one from those already presented) to the rest of participants. Allow time for other participants to pose questions and make other suggestions.

2g. Refer participants to **Lesson 16 Handout 1: Examples of Improving Care Group Sustainability** for ideas about sustainability from other projects implementing the CG approach.

3. Wrap Up

3a. Explain that sustainability is not something that happens on its own. It is something that requires reflection and planning at the beginning of the project or as soon as possible.

3b. Ask participants to write in their notebooks the names of the people they will have to talk with about sustainability when the training is finished.

Lesson 16 Flip Chart 1: A Definition of Sustainability[28]

Sustainability is a process that improves conditions that enable individuals, communities and local organizations to improve their functionality, develop mutual relationships of support and accountability, and decrease dependency on insecure (institutional, technical and financial) resources. Sustainability enables these local stakeholders to play their respective roles effectively, thus maintaining gains in health and development beyond the project period. The individuals, communities, health services and local organizations constitute a local system interacting with and embedded in a larger environment. The efforts and interactions of these actors in the local system are what lead to lasting health impact. Their efforts will be based on their own understanding of their community's health and development.

[28] From: Eric Sarriot, Jim Ricca, Jennifer Yourkavitch, Leo Ryan and the Sustained Health Outcomes (SHOUT) Group. 2008. *Taking the Long View: A Practical Guide to Sustainability Planning and Measurement in Community-Oriented Health Programming*. Calverton, MD: Macro International, Inc. Available at http://mchipngo.net/lib/components/documents/susManualnoAnoC.pdf.

Lesson 16 Flip Chart 1: Categories of Sustainability

1. Sustained improvement in household health behaviors and outcomes

For example:

- Breastfeeding
- Hand washing
- Care seeking

2. Enduring changes in social norms, capacity and social capital

For example:

- It is no longer socially acceptable to delay care seeking for suspect malaria.
- Couples have improved communication and relationships from the experiences of jointly discussing sensitive topics, like family planning, for the first time.
- Caregivers have the knowledge, confidence and support of their families to seek timely medical care for children when needed
- Mothers know they can check with their volunteer when they have a question about child feeding.
- Care Group Volunteers (CGVs) and village health committees can collectively solve problems.

3. Continuation of specific program activities and services

For example:

- Home visits by CGVs
- Collecting and reporting community health information

Lesson 16 Flip Chart 3: Aspects of Care Groups that Might be Sustained

- Care Group Volunteers (CGVs) continue to visit households
- Care Groups (CGs) continue to meet bi-weekly
- CGs receive new lessons
- Continued supervision of CGs
- CGVs continue to collect and report vital events
- CGVs continue to meet with NGs
- New Neighbor Women (NW) are being included in the NG
- Behaviors continue to be practiced

Lesson 16 Handout 1: Examples of Improving Care Group Sustainability

Facilitation of Care Groups (Burundi Example)

In Burundi, Concern Worldwide was able to take advantage of the government's community health workers (CHWs) to experiment with having Ministry of Health (MOH) staff and CHWs implement CGs in place of nongovernmental organization (NGO) staff. Operations research is on-going, but thus far has found similar achievements in areas where the CGs were facilitated directly by NGO staff versus the experimental area, where facilitation was done by CHWs. The latter has clear implications for sustainability that could include continuation of CG training and supervision. However, it should be noted that Concern Worldwide invested significantly in building the capacity of district and local MOH staff in order for this to be possible. The deeper the MOH system reaches into communities, the greater the opportunity for linking CGs to permanent MOH structures.

Community Performance-Based Financing

Community performance-based financing has created special opportunities for support and sustainability of CG activities in settings where MOH staff and/or CHWs receive compensation based on the achievement of community health indicators. Where these indicators align well with CG objectives, there is particular incentive for ongoing support of CGs, particularly once the CGs have demonstrated their effectiveness.

Savings and Income Generation

In response to Care Group Volunteers' (CGVs') request to do income generating activities, World Relief (WR)'s Umucyo Child Survival Project in Rwanda (2001–2006) turned its CGs into 202 formal associations recognized by the government. The groups were trained to save members' individual contributions and income generated by group activities, including the subsidized sale of insecticide-treated bednets (ITNs), a water purification product and other group-initiated activities. Unfortunately, the original CGs and CGV roles were hindered post-project by new MOH policy on CHWs that prevented NGOs from creating and working with any volunteers who were not part of the new CHW system. Despite this, 6 years after project end, 11% (23/202) of the CGs were still active, presumably because of the shared economic incentive they still had in coming together.

Done carefully, there is potential for savings activities to act as an ongoing incentive for groups to meet during and after a project has formally ended. Because savings groups should be self-selected and voluntary, WR Burundi has found success with giving well-established CGs the opportunity to participate in separate savings groups, to which they can invite additional members. Since the majority of savings group members are also members of the CG, they meet just before or just after the CG meeting, which creates additional incentive for CG meeting attendance and sustainability.

Community Health Information System

WR/Mozambique designed its Community Health Information System with sustainability in mind, using parallel data flow during the life of the project. This means that in addition to having

data flow from household to CG to project staff and upwards via NGO personnel, the CGs also shared their data with village health committees and upwards to health facilities. During the life of the project, one method of quality control included comparing the community data that arrived at district level via the project staff with the independent, parallel channel. Post project, WR found that volunteer data collection and aggregation continued in the catchment areas of health facilities where the data manager had been trained by the NGO. Over time, as MOH staff changed post-project, the system weakened. For greater sustainability, the community vital events data ideally would be incorporated into the national system, formalizing its inclusion and the expectation for reporting, a challenge for future advocacy.

Preparing Communities to take on responsibly

What are additional ways that communities could be prepared to take ongoing responsibility for aspects of community health and nutrition fostered by CGs? Answering this question requires thinking a bit more specifically about preparing for handover, including anticipating the project end and planting seeds that can grow into the future. Answers could include the following.

- Tell the communities at the beginning when you expect the project will end. Explain that many people will be trained so they are able to continue the CGs after the project finishes.
- In the second half of the project, when interventions are typically reviewed, rather than having paid Promoters conduct CG training, build the capacity of the CGVs to train their peers.
- Hold public graduation-type ceremonies honoring what CGs have learned.
- Ask CGVs, mothers, village health committee members and others to give public testimony about how they are stronger now. This will validate the growth and change that has taken place in the community.
- Acknowledge to staff the uncertainty that comes with project closeout. Discuss with them how community members may be experiencing related uncertainty and that staff should talk through opportunities communities have to continue the parts of the CG program they value.

Lesson 17: Planning for Care Groups

Achievement Based Objectives

By the end this lesson participants will have completed the Care Group (CG) reference table.

Duration

1 hour

Materials Needed

- Flip chart paper and markers
- Lesson 17 Handout 1: Blank Care Group Planning Table
- Lesson 17 Handout 2: Example Completed Care Group Planning Table

Facilitator's Notes

This lesson is most useful for people who are involved in writing a project proposal that includes the CG approach. This lesson will help them create staffing plans and make budgeting decisions. If your trainees are not involved with this step or the project has already been planned and budgeted for, you can skip this lesson.

Steps

1. Introduction

    1a. Tell participants: If you decide that the Care Group approach is the most appropriate behavior change activity for your project, you will want to plan carefully for its implementation. This means knowing what types of staff are needed, how long the implementation process takes, and how much to budget for staff, materials, supplies, transportation and other necessary aspects. We will discuss these issues in this session.

2. Planning Questions

    2a. Ask the participants: Has anyone ever planned a behavior change activity like Care Groups before? If yes, move participants around so that all tables have at least one experienced person.

    2b. Ask the small groups to brainstorm a list of questions that they would need to answer in order to implement the CG approach, develop a budget and write about it in a proposal. Give groups 15 minutes to write all their questions in a notebook. Write the following categories on a flip chart to guide their question development:

        - Key Management Staff and Level of Effort
        - Supervision Tasks at All Levels
        - Transportation

- Staff Training
- Formative Research
- Care Group Materials Development
- Monitoring and Evaluation (Tools and Implementation)

2c. Give participants **Lesson 17 Handout 1: Blank Care Group Planning Table**, and ask the small groups to check the questions they listed against the information required in the table.

2d. If participants are not currently implementing the CG approach, give them some parameters of a hypothetical situation (population of 100,000 and 12% of the population is women of reproductive age [WRA], for example). Give each small group 30 minutes to try to complete the blank table.

2e. With the larger group, ask volunteers to share responses for different questions and key lessons learned, for example, the appropriate ratios of Coordinators to Supervisors and Supervisors to Promoters.

2f. Give participants **Lesson 17 Handout 2: Example Completed Care Group Planning Table** and explain that this is how a completed Care Group Planning Table might look. Give participants 5 minutes to review and compare their Planning Tables. Answer any questions.

2g. Tell participants that there are two tools that have been developed to help project planners and budget developers to accurately plan to implement CGs. These tools can be found (along with many other CG resources) on the www.caregroupinfo.org website.

- This Care Group budget template has been used by Food for the Hungry (FH) as a starting point for budget development for CG projects. The template can help you remember important costs that should be included in most CG projects. The template can be found at http://www.caregroupinfo.org/docs/CG_Budget_Template.xls.

- The Care Group planning tool allows you to enter demographic data and estimate the number of CGs, Promoters and Care Group Volunteers (CGVs) needed and the beneficiary population that you will serve. This tool can be found at http://www.caregroupinfo.org/docs/Care_Group_Planning_Tool.xls.

3. Wrap Up

3a. Remind participants that the CG approach must be well planned from the start in order for it to work effectively. Using the Planning Table and the other tools is a good way to make sure that they will have all the necessary resources to make the CG approach function optimally.

Lesson 17 Handout 1: Blank Care Group Planning Table

Instructions: Compare your list of questions to the items listed in the left-hand column. Then insert potential responses in the right-hand column.

Name of the Project:	
Questions	**Responses**
1. Program Essentials	
List of key management staff and level of effort (%):	
# of Coordinators:	
# of Supervisor:	
# of Promoters:	
# of CGs per Promoter:	
# of CGVs per CG:	
# of NW per NG:	
CGVs (gender, age and child status required):	
NW (gender, age and child status required):	
2a. Coordinator Supportive Supervision	
Who do Coordinators report to?	
Who, where and how often does the Coordinator supervise?	
How often do Coordinators fill out the Supervisor supportive supervision checklist?	
2b. Supervisor Supportive Supervision	
Who does the Supervisor report to?	
Who, where and how often does the Supervisor supervise?	
How often do Supervisors fill out the Promoter supportive supervision checklist?	

Name of the Project:	
Questions	**Responses**
2c. Promoter Supportive Supervision	
Who do Promoters report to?	
Who, where and how often does the Promoter supervise?	
How often do Promoters fill out a QIVC for educational session facilitation?	
3. Training	
Who trains the Supervisor in the CG curriculum and how often?	
Who provides the Supervisor with refresher training about the CG curriculum and how often?	
Who trains Promoters in the CG curriculum and how often?	
Who trains CGVs in the CG curriculum and how often?	
Who trains NW in the CG curriculum and how often?	
4. Care Group Curriculum	
Which modules and lessons are most pertinent for your CG project?	
How many months will it take to teach the CG curriculum?	
Who will or has developed the CG curriculum?	
What, if any, formative research is being used to adapt the CG curriculum to the local context?	

Name of the Project:	
Questions	**Responses**
5. Monitoring & Evaluation	
What information will be tracked by the CGs themselves?	
Which surveys will you conduct as part of your CG program? How often will you conduct them?	
6. Other	
Additional questions:	
Additional questions:	
Additional questions:	
Additional questions:	
Additional questions:	

Lesson 17 Handout 2: Example Completed Care Group Planning Table

Name of the Project: Lamika Project	
Questions	**Responses**
1. Program Essentials	
List of key management staff and level of effort (%):	1 manager (50%) 1 BCC Coordinator (100%) 1 M&E Coordinator (50%) 1 M&E officer (100%)
# of Coordinators:	3
# of Supervisor:	15
# of Promoters:	90
# of CGs per Promoter:	6
# of CGV per CG:	12
# of NW per NG:	10
CGVs (gender, age and child status required):	Must have been a mother at one time, any age, child can be any age or deceased, must be elected by NW
NW (gender, age and child status required):	WRA, PLW or other group of intended beneficiaries, such as pregnant women and mothers of children under 5
2a. Coordinator Supportive Supervision	
Who do Coordinators report to?	Manager
Who, where and how often does the Coordinator supervise?	Supervisor At least once per month in the community
How often do Coordinators fill out the Supervisor supportive supervision checklist?	Once per Supervisor per quarter
2b. Supervisor Supportive Supervision	
Who does the Supervisor report to?	Coordinator
Who, where and how often does the Supervisor supervise?	Promoter At least twice per month in the community
How often do Supervisors fill out the CG Promoter Supportive Supervision Checklist?	Once per Promoter per quarter

Name of the Project: Lamika Project	
Questions	**Responses**
2c. Promoter Supportive Supervision	
Who do Promoters report to?	Supervisor
Who, where and how often does the Promoter supervise?	CGVs Once per quarter in the community teaching NW
How often do CG Promoters fill out a QIVC for educational session facilitation?	Six times per month
3. Training	
Who trains the Supervisor in the CG curriculum and how often?	Manager and BCC Coordinator train Coordinators and Supervisor on new curriculum every 3–6 months at the start of a new module[29]
Who provides the Supervisor with refresher training on the CG curriculum and how often?	Coordinators, once per month (2 lessons covered in each refresher training)
Who trains CG Promoters in CG curriculum and how often?	Supervisor, twice per month (1 lesson covered in each refresher training)
Who trains CGVs in the CG curriculum and how often?	CG Promoters twice per month
Who trains NW in the CG curriculum and how often?	CGVs, twice per month
4. Care Group Curriculum	
Which modules and lessons are most pertinent for your CG project?	See **Appendix 6**
How many months will it take to teach the CG curriculum?	Modules 1, 2, 4: 3 months each Module 3: 4 months Module 5: 3 ½ months Total: 16 ½ months, up to as much as 24 months to allow for holidays, vacation and bad weather
Who will or has developed the CG curriculum?	Headquarters curricula specialist and BCC Coordinator
What, if any, formative research is being used to adapt the CG curriculum to the local context?	Local Determinants of Malnutrition Study and Barrier Analysis

[29] If you have the luxury of having the full curriculum available, it may work as well to train Coordinators and MCHN Supervisors on all the material at the beginning of the program.

Name of the Project: Lamika Project	
Questions	**Responses**
5. Monitoring & Evaluation	
What information will be tracked by CGs?	CGV attendance at CGs, number of NW visited, deaths, births, child deaths
Which surveys will you conduct as part of your CG program? How often will you conduct them?	Baseline evaluation, midterm evaluation, final evaluation, mini-KPC every 4–6 months (and not more often than a module has been completed)
6. Other	
Additional questions:	
Additional questions:	
Additional questions:	
Additional questions:	
Additional questions:	

Lesson 18: Introducing the Care Group Approach to Others

Achievement-Based Objectives

By the end of this lesson participants will have:

- Listed the key aspects of the Care Group (CG) approach
- Composed a short laser talk about the CG approach
- Practiced delivering the short talk about the CG approach

Duration

1 hour 30 minutes

Materials Needed

- Flip chart paper and markers
- Lesson 18 Handout 1: Example Talking Points about the Care Group Approach
- Lesson 17 Handout 1: Blank Care Group Planning Table (filled out by participants with details about their projects)
- Lesson 18 Handout 2: Delivering a Laser Talk

Steps

1. Introduction

    1a. Tell participants: Now that you have a much clearer understanding of what the Care Group approach is about, you will need to plan to explain it to your collaborating partners and to the community.

    1b. Ask participants: Who needs to be informed about the Care Group approach even before you go to the community? Answers should include the Ministry of Health (MOH), local partners, community leaders and others, depending on location.

    1c. Explain to participants that if they intend for these groups to play important roles in the establishment and implementation of the CG approach, they need to be prepared to explain it to these partners. Once projects have secured partner buy-in, they also will need to explain the CG approach to the community.

2. Activity: Brainstorming Important Information to Share with Collaborating Partners and Community Members

    2a. Instruct participants, in small groups, to brainstorm what collaborating partners and communities need to know to understand the CG approach and to write their ideas in their notebooks.

    2b. After about 15 minutes, have each table to contribute something that should be included in the explanation of the CG approach and list these on flip chart. Go around the room until all the new ideas are listed.

2c. Refer participants to **Lesson 18 Handout 1: Example Talking Points about the Care Group Approach** and compare the group's master list to the handout. Ask participants: Is anything missing from our list?

3. Providing Monetary Incentives or Goods as Part of a Care Group Program

3a. Tell participants that the CG approach is a behavior change program. It is best that community participants focus on long-lasting changes, such as reducing child deaths, rather than on short-term, material gains. It is best not to tell communities what material goods the program plans to provide, even if you are confident the project will provide the inputs.

3b. Tell participants that mentioning incentives during your talk can cause the following problems to arise.

- People may become volunteers or participate in program activities to receive the incentives. After they receive the incentives they may stop participating because they were only motivated to receive material goods.
- Once a promise is made to a community to provide something the community will consider the organization obligated to provide it. If, for various reasons, the material benefit does not arrive, the community will lose trust in the organization.

4. Activity: Presentation Practice

4a. Refer participants to **Lesson 18 Handout 2: Delivering a Laser Talk** and review it together. Give some examples of using talks related to CGs. Explain to participants that the purpose of their talk is to get buy-in for the CG approach.

4b. Divide participants into pairs. Ask them to write up some notes to follow when making a 2–4 minute presentation about the CG approach. Participants can refer to Lesson 18 Handout 1 for this information, if they need to.

4c. Ask the pairs to practice explaining to each other key elements of the CG approach, including program goals, methodology and the essential program details. Make sure that each participant gets a chance to practice his/her talk.

4d. Instruct participants that after they listen to their partner's Laser talk they should give one positive comment and one suggestion for improving the talk. Suggestions should use "How about…" or "What if…" phrases. Because of time constraints, do not encourage a dialogue between the pairs. Instruct the participant receiving the feedback to just say "thank you".

4e. If time permits, ask for volunteers or randomly choose a couple participants to give their Laser talks to the whole group.

5. Wrap Up

5a. Wrap up this session by explaining that everyone associated with the Project implementing Care Groups should be able to talk about it in the same way. This will avoid confusion.

Lessons Learned in Orienting Communities about the CG Approach

In South Sudan, the Food for the Hungry (FH) CG project manager oriented communities to the project by coordinating with community leaders to have 30 men, 30 women and 30 youth present about the CG approach. The manager led a discussion and encouraged community groups to discuss local challenges they faced. This was followed by a discussion about community resources (what they had to solve these problems) and time to brainstorm solutions to local challenges. Then the CG project manager shared about FH's work and how the CG project intersected with some of their health challenges. It was a great way to position CGs as a solution to the felt needs and challenges the community already acknowledged.

Lesson 18 Handout 1: Example Talking Points about the Care Group Approach

Make sure to adapt these talking points to your local context.

1. The Care Group program's goal is to prevent malnutrition in children under 2 years of age.

2. The Care Group program will focus on the following areas: *[List the topics here that your Care Group program will cover, such as Essential Nutrition Actions (ENA) and Essential Hygiene Actions (EHA).]*

3. Half of child deaths can be prevented if families do very simple things to care for their children. These things include behaviors relating to hygiene, sanitation, child feeding and caring for children when they are sick. If families learn to do these things and make these changes, the program can make a lasting difference in the community.

4. Right now nearly X% of all children in this community suffer from chronic malnutrition. In order to change this situation, families have to change household practices.

5. To change these behaviors, the Care Group program will train community volunteers so they can train all the families in the community. To do this we need your help.

6. The Care Group program will provide the training and educational material, but we need the community to provide volunteers who are committed to improving the health of the children in this community. These volunteers will not receive a salary or subsidy. They will receive free education and an opportunity to improve and save the lives of the children in this community.

7. These volunteers will not be staff of this organization. They will be members of your community.

8. If volunteers attend the trainings, they share what they learn with the families in this community and the families adopt the new behaviors, malnutrition will be reduced. If the volunteers are not willing to learn and if families will not listen to the volunteers or adopt the behaviors, malnutrition will not decrease during the life of the program.

9. The Care Group program is a development program, not an emergency and relief program. Many programs are meant to provide short-term relief to a problem like a famine or during times of civil unrest. Relief programs normally give away a lot of food or goods, like soap and tools, and these things help for a short period of time. However, the goal of this Care Group program is more long term: to change behavior and improve the community's ability to prevent their children from dying of malnutrition.

Lesson 18 Handout 2: Delivering an Introductory Talk

Learning how to speak powerfully about our issues and our work is one of the most important tools in our toolkit. This format was created by RESULTS (www.results.org), an organization working to eliminating world hunger, to enable its volunteers to create powerful "laser talks", short and compelling talks that are the backbone of their work. Laser talks can be used during meetings or chance encounters with policy-makers at any level, community leaders, reporters or anyone you want to persuade about something you really care about.

The examples below are from a talk given to a journalist from a local newspaper.

- **Engage your audience:** Get your listener's attention with a dramatic fact or short statement. Keep this opening statement to one or two sentences, if possible.

  For example: “In the past 30 years, the world has cut in half the number of children under 5 that die of preventable causes every year. In other words, we’ve cut the number to 7 million children. We’ve achieved this by increasing access to healthcare and education and by developing new health technologies, like vaccines that fight pneumonia and diarrhea.”

- **State the problem or what is possible:** Present causes of the problem you introduced in the first section. Make sure to mention how widespread or serious is the problem.

  For example: “But, it isn’t enough to cut child deaths in half when 20,000 children still die every day from completely treatable and preventable diseases.”

- **Informing about solutions:** Inform the listener about a solution to the problem you just presented.

  For example: “On June 14 and 15, Ethiopia, India, the United States and UNICEF are cohosting a call to action on child survival. At this meeting, world leaders will create a roadmap for ending preventable child deaths within a generation, a goal global health experts now think is possible.”

- **Call to action (the ask):** Once you have engaged your listener, presented the problem and told them about a solution, be specific about what you want them to do. This enables you to follow up to learn if they have taken this action. Present this action in the form of a yes or no question.

  For example: “Will you write an editorial highlighting our child survival successes and our nation’s leadership opportunity to create a world where no child dies unnecessarily before their fifth birthday?

Tips on Delivering Your Talk

- Be sure to rehearse your talk. With practice you will discover where you need more practice or where you may want to change a part of your talk.
- Speak rather than read your talk. However, you can refer to notes when you are first learning to give your laser talk.
- Keep the talk short, at no more than 2 minutes.
- Update your talk as new information becomes available.

Lesson 19: Training Closing

Achievement-Based Objectives

By the end of this lesson participants will have:

- Completed the post-test
- Received certificates
- Given feedback to the facilitator for adaptation of future workshops

Duration

1 hour

Materials:

- Appendix 1: Pre-/Post-Test (including answer key)
- End of Training Feedback Form found in Appendix 3: Training Feedback Forms
- Training Certificates

Steps

1. Introduction

    1a. Tell participants: We have come to the end of the training. We need to do several things. We need to administer the post-test, evaluate the training as a whole and give out the training certificate.

2. Activity: Post-Test

    2a. Tell participants to put away all class notes. (Also remove flip chart pages from the walls if they have any answers to the post-test).

    2b. Give out the post-test, found in **Appendix 1: Pre-/Post-Test (consider re-ordereding the questions on the post-test)**. Remind participants how to fill it out.

        - Enter their names at the top of page one.
        - Circle “Post-“.
        - Choose and circle only one answer.

    2c. Collect papers when all participants have finished.

3. Activity: Workshop Evaluatoin

    3a. Hand out the End of Training Feedback Form found in **Appendix 3: Training Feedback Forms**. Ask participants to fill out the form and add any suggestions they have for improving future trainings.

4. Activity: Training Certificates

    4a. Give closing remarks encouraging the participants in their work. Hand out the certificates and call each participant by name.

5. Optional Activity: Closing Circle

    5a. You might not choose to do this activity, but this can be a very memorable and affirming way for participants to end the time together.

    5b. Form a circle and give participants the opportunity to share good wishes, thoughts and reflections about what the week has meant to them and their hopes, desires, commitments and thoughts on how they will use what they have learned.

Appendix 1: Pre-/Post-Test

Name _____ Date _____

Is this the pre-test or post-test? Circle one.

1. When designing a Care Group project, what percentage of the intended population should you plan to enroll in the project?
   A. 70% coverage with at least 50% monthly attendance
   B. 80% coverage with at least 60% monthly attendance
   C. 90% coverage with at least 70% monthly attendance
   D. 100% coverage with at least 80% monthly attendance

2. In Care Group projects, mothers (also known as Neighbor Women) should choose/elect their group's Care Group Volunteer. Why is this important?
   A. People will choose someone that they respect, someone that they are willing to listen to. If an outsider chooses someone, it is more likely that person will not be accepted by the community.
   B. It would take a lot of time for project staff to choose Care Group Volunteers. Therefore it is more efficient for the mothers (i.e., Neighbor Women) to elect their own Care Group Volunteer.
   C. This is a trick question. Mothers should not elect their own Care Group Volunteers. This is something that the Community Development Committee should do in partnership with the Ministry of Health.

3. What are the four main types of information that registers in Care Group programs collect?
   A. Immunization coverage, vital events, registration and curriculum
   B. Attendance, registration, vital events and curriculum
   C. Births, deaths, membership and household size

4. What information does a Promoter use to fill out his/her monthly report?
   A. Care Group registers
   B. Neighbor group registers
   C. A and B
   D. None of the above

5. Which of the following is NOT one of the steps in a meeting with Care Group Volunteers?
   A. Justifying the need for the lesson
   B. Coaching
   C. The activity
   D. Taking attendance

6. When giving feedback using the quality improvement and verification checklists for educational session facilitation, which of the following should NOT be done?
   A. Ask the worker to discuss how they think they performed before you begin giving feedback.
   B. Provide more positive feedback than negative feedback to encourage the worker.
   C. Ask the worker how they think they could overcome some of the difficulties that they had during the training.
   D. Ask the worker to commit to sharing their scores with the community leaders.

7. If the Promoter scored 70% on the QIVC for educational session facilitation, what should the Supervisor do?
   A. Use the QIVC less frequently because the worker scored above the target.
   B. Stop visiting this worker because they have scored above the target.
   C. Continue using the QIVC each time he/she visit the Promoter until the Promoter's score is 80% or above.
   D. Continue using the QIVC each time he/she visits until the Promoter's score reaches 100%.

8. What is the recommended maximum number of Care Groups a Promoter should have?
   A. 15
   B. 12
   C. 9
   D. 5
9. What is the recommended maximum number of hours per week a Care Group Volunteer should be asked to work?
   A. 6
   B. 8
   C. 12
   D. 20

10. Which of the following is the primary purpose of the Care Group approach?
    A. To provide health education to mothers
    B. To create support groups among mothers whose children are malnourished
    C. To help mothers adopt healthy behaviors
    D. To create leaders in the community

Answers to Pre-/Post-Test

1. D
2. A
3. B
4. C
5. A
6. D
7. C
8. C
9. A
10. C

Appendix 2: Learning Resource and Needs Assessment

1. Please describe your previous experience working with Care Groups (a cascade behavior change module that reaches all households through community volunteers).

2. Please describe training you have already received about Care Groups. List the name of the training and the organization that led the training.

3. Please describe your work experience supervising others. Also list tools you have used during supportive supervision.

4. Please describe your work experience organizing or working with community volunteers.

5. With your current training and experience, how comfortable do you feel training others about the set-up and management of Care Groups? (1 = not comfortable; 10 = extremely comfortable)

6. What do you hope to get out of this training?

7. If you have previous experience with Care Groups, would you be interested in participating in an evening of sharing? If yes, please plan to tell some stories and show any sample materials, such as a flip chart, photos or videos of your previous Care Group projects.

Appendix 3: Training Feedback Forms

Daily Feedback Form: Evaluation for Day _____

Please indicate below your overall satisfaction with each of the sessions that you attended today, and offer any ideas you have on how to improve these sessions.

A. Lesson number: _____ Lesson name: _____

Very Dissatisfied	Somewhat Dissatisfied	Neutral	Somewhat Satisfied	Very Satisfied
1	2	3	4	5

B. Lesson number: _____ Lesson name: _____

Very Dissatisfied	Somewhat Dissatisfied	Neutral	Somewhat Satisfied	Very Satisfied
1	2	3	4	5

C. Lesson number: _____ Lesson name: _____

Very Dissatisfied	Somewhat Dissatisfied	Neutral	Somewhat Satisfied	Very Satisfied
1	2	3	4	5

D. Lesson number: _____ Lesson name: _____

Very Dissatisfied	Somewhat Dissatisfied	Neutral	Somewhat Satisfied	Very Satisfied
1	2	3	4	5

E. The most useful thing about today:

F. The thing I'm still confused about:

APPENDIX 4: End of Training Feedback Form

Please provide your comments and offer suggestions for anything related to the workshop content, format or logistics.

1. **What suggestions do you have for any future trainings?**

2. **How would you rate your satisfaction with the training content?**

Very Dissatisfied	Somewhat Dissatisfied	Neutral	Somewhat Satisfied	Very Satisfied
1	2	3	4	5

3. **How would you rate your satisfaction with the facilitators?**

Very Dissatisfied	Somewhat Dissatisfied	Neutral	Somewhat Satisfied	Very Satisfied
1	2	3	4	5

4. **What recommendations do you have to help the facilitators improve their training methods?**

Appendix 4: Care Groups Definition and Criteria[30]

History

Staff from World Relief (WR) developed the Care Group (CG) model in Mozambique in 1995. Food for the Hungry (FH) adopted the model in Mozambique in 1997 after discussions with WR project staff, and both organizations have pioneered use of the model since then. Since that time, the CORE Group has helped document and disseminate the model and it has been used by 20 (and counting) other nongovernmental organizations (NGOs) in more than 20 countries, largely through the support of the U.S. Agency for International Development (USAID). In particular, the USAID Child Survival and Health Grants Program (CSHGP) and the USAID Food for Peace (Title II Food Security) Program (FFP) have helped to fund programs using the CG model.

Definition

A CG is a group of 10–15 volunteers, community-based health educators, who regularly meet with project staff for training and supervision. They are different from typical mother's groups in that each volunteer is responsible for regularly visiting 10–15 of her neighbors, sharing what she has learned and facilitating behavior change at the household level. CGs create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication. They also provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits.

Why criteria?

Since 1995, WR, FH, and more than 24 other private voluntary organizations (PVOs) in more than 21 countries have "adopted the model," but the degree to which organizations adhere to the original components of the model varies greatly. While there has been increased attention to the model and its effectiveness in lowering child deaths (e.g., mentioned in the UNICEF's 2008 State of the World's Children report), there is a danger that the wide variations in what is called a "Care Group" by various agencies will lead to misunderstandings about the model and the use of less effective strategies that do not fit within the model. These variations, in turn, could lead to fewer opportunities to advocate for the CG model and its role in child survival since the term "Care Groups" may come to mean many different things to different people and will probably develop a very mixed track record. There are already situations in which individuals and organizations are defining CGs as "any group where you are teaching mothers" or "any group where you are teaching people to teach other people." Given the excellent and low-cost results seen in the CSHGP and Title II food security projects in terms of decreased child mortality and morbidity using CGs, it is important to define official criteria for the CG model.

During meetings between WR and FH staff on April 23, 2009, the CG criteria in the checklist below were agreed upon as a draft list. The list is divided into those that should be required to be present when using the term Care Group and other criteria that we feel have been helpful when included in the model, but that should not be considered required. Edits to this list were then made by the two founders of the model, Dr. Pieter Ernst and Dr. Muriel Elmer. During the CORE Group

[30] For a detailed explanation of the criteria, please also visit http://www.caregroupinfo.org/blog/criteria.

Spring Meeting in April 2010, this list was presented to other community health practitioners and revisions were made based on their input.

Of course there is no way to enforce the use of these criteria; people will use the term how they wish. But, by having two organizations that are recognized as having a history of using and promoting CGs extensively (one organization being the original developer), defining formal criteria should provide a stronger basis for recognition of the model and lead to better adherence to the most effective components of the model. By informing donors and others about these criteria, it is hoped that they will use the criteria to decide to what degree a proposed implementation strategy is really based on the CG model. The Food Security and Nutrition Network Social and Behavioral Change Task Force (SBCTF) and the CORE Social & Behavioral Change Working Group (SBCWG) helped to disseminate this document, which will further legitimize the checklist and will lead to better compliance with the recommended 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 maternal and child health and nutrition [MCHN] behaviors.) Care Group Volunteers (CGVs; e.g., "Leader Mothers," "Mother Leaders") should be chosen by the mothers within the group of households that they will serve or by the leadership in the village.	CGs 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 CGVs) can be more effective[31] in promoting adoption of behaviors among their neighbors than others who do not know them as well. CGVs should be mothers of young children or other respected women from the community. CGVs 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,[32] and we believe they will be more effective in their communication, trusted by the people they serve, and most willing to serve others with little compensation.
2. The workload of CGVs is limited: No more than 15 households per CGV.	Having one volunteer trained to serve 30+ households is more in line with the traditional community health worker (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 CGV 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.[33]

[31] S.M. Burn. 1991. Social psychology and the stimulation of recycling behaviors: The block leader approach. *Journal of Applied Social Psychology*, 21, 611–629.

[32] Operations Research on CGs in Sofala, Mozambique, showed that CGVs chosen by the mothers that they serve were 2.7 times more likely to serve for the life of the project (p=0.009).

[33] See M. Gladwell. 2002. *The tipping point*, Little, Brown, & Co publishers, pp. 175–181.

Criteria for Care Groups	Rationale
3. The CG size is limited to 16 members and attendance is monitored.	To allow for participatory learning, the number of CGVs in the CG should be between six 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 (less than 70%) at CG 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. CGV contact with her assigned beneficiary mothers—and CG meeting frequency–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 CGV works, we feel it is necessary to have at least monthly contact with them. CGs should meet at least once monthly, as well. We also believe that overall contact time between the CGV and the mother (and other family members) correlates with behavior change. We recommend twice a month contact between CGVs and beneficiary mothers, as well as twice a month CG meetings, 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 at least a monthly basis, and the project attains at least 80% monthly coverage of households within the target group. Coverage is monitored.	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 likely to happen when there is regular, direct contact with all 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). There is sometimes a combination of group meetings and individual household contacts with beneficiary mothers, but at least some household visits should be included. For group meetings with beneficiary mothers, any mothers that miss meetings should receive a household visit. Household visits are helpful in seeing the home situation and in reaching people other than the mother, such as the grandmother, daughter or mother-in-law.
6. CGVs collect vital events data on pregnancies, births and death.	Regular collection of vital events data helps CGVs 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 CG 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 CGs creates behavior change directed towards reduction of mortality and malnutrition (e.g., Essential Nutrition	This requirement was included mainly for advocacy purposes. We want to establish that the CG 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 Millennium Development Goals. While the cascading or multiplier approach used in CGs may be suitable for other purposes (e.g., agriculture education),

Criteria for Care Groups	Rationale
Actions [ENA], Essential Hygiene Actions [EHA]).	we suggest that a different term be used for those models (e.g., "Cascade Groups based on the CG model").
8. The CGVs 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 CGVs 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 behavior change communi-cation (BCC) are used in the CG with the CGVs and by the volunteers when doing health promotion at the household or small-group level.	Principles of adult education should be applied in CGs and by CGVs since they have been proven to be more effective than lecture and more formal methods when teaching adults.
10. The CG instructional time (when a Promoter teaches CGVs) is no more than 2 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 CGVs (e.g., data collection, observation of skills) occurs at least monthly.	For Promoters (who teach CGVs) and CGVs to be effective we believe that regular, supportive supervision and feedback is necessary on a regular basis (monthly or more). For supervision of CGVs, the usual pattern is for the Promoter to supervise through direct observation at least one volunteer following the CG meeting.
12. All of a CGV's beneficiaries should live within a distance that facilitates frequent home visitation and all CGVs should live less than a 1-hour walk from the Promoter meeting place.	It is preferable that the CGV not have to walk more than 45 minutes to get to the furthest house that she visits so that regular visitation is not hindered. (In many CG projects, the average travel time is much less than this.) This also makes it more likely that she will have a prior relationship with the people that she is serving. Before starting up CGs, the population density of an area should be assessed. A low CGV: Mother Beneficiaries and low Promoter:CG ratio should be used when setting up CG in rural, low population density areas. If an area is so sparsely populated that a CG volunteer needs to travel more than 45 minutes to meet with the majority of her beneficiary mothers then the CG strategy may not be the most appropriate one to use.

Criteria for Care Groups	Rationale
13. The implementing agency needs to successfully create a project/program culture that conveys respect for the population and volunteers, especially women.	During operations research conducted near the end of the FH Sofala CG project, CGVs ("Leader Mothers") were asked who respected them now that did not respect them before. 86% mentioned other mothers/women, 64% mentioned community Leaders, 61% mentioned their husbands, 45% mentioned their parents or in-laws, 41% mentioned extended family members and 25% mentioned health facility staff. We believe that an important part of this model is fostering respect for women, and implementers need to make this an explicit part of the project, encourage these values among project staff, and ideally measure whether CGVs are sensing this respect.
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 SBCWG) found that they included formative research (e.g., Barrier Analysis, Doer/Non-Doer 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:CG 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 six 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. Social/educational differences between the Promoter and CGV should not be too extreme (e.g., having bachelor-degree level staff working with CGVs).	We believe that keeping the educational difference between the Promoter and CGVs to a modicum is useful in that it makes it more likely that the Promoters will use language/concepts that the CGVs can understand. It also helps to keep costs of the model low.

Care Group Minimum Criteria Reviewer Checklist[34]

The checklist below is based on the criteria solidified at the CORE Group Spring Meeting in April 2010 and can serve as an aide to USAID reviewers and others who want to see to what degree a proposed "Care Group" project meets these criteria.

	Yes	No
1. The project has a strong peer-to-peer health promotion component……	❑	❑
2. Care Group Volunteers will be chosen by the mothers within the group of households that they will serve or by the leadership in the village…….	❑	❑
3. Care Group Volunteers will visit no more than 15 households each……	❑	❑
4. The Care Groups will have between 6 and 16 members……..	❑	❑
5. There are plans to monitor Care Group meeting attendance……	❑	❑
6. Care Group Volunteers will contact each of their beneficiary mothers at least once a month…… ……	❑	❑
7. Care Group meeting frequency is planned to be at least once a month……	❑	❑
8. It is planned that 100% of intended group households will be reached at least once a month.	❑	❑
9. There is a plan in place to monitor coverage of households (by Care Group Volunteers)……	❑	❑
10. The plan mentions that vital events data on pregnancies, births, and death will be collected via Care Group Volunteers…… ……..	❑	❑
11. The majority of what is promoted through the Care Groups will create behavior change directed towards reduction of mortality and malnutrition[35]……..	❑	❑
12. The plan mentions that Care Group Volunteers will use some sort of visual teaching tool (e.g., flipcharts) to do health promotion at the household level…….	❑	❑
13. The plan mentions that participatory teaching methods will be used in the Care Groups…..	❑	❑

[34] Revised November 30, 2012

[35] If it does not meet this criterion, but meets all others, an alternate term should be used (e.g., "Cascade Groups") rather than Care Group.

14. The staff plan to have Care Group Volunteers use participatory methods at the household/small-group level…… ❑ ❑
15. The Care Group instructional time (when a Promoter teaches Care Group Volunteers) will be no more than two hours per meeting…… ❑ ❑
16. Supervision of Promoters and at least one of the Care Group Volunteers (e.g., data collection, observation of skills) will occur at least monthly…… ❑ ❑
17. All of a Care Group Volunteer's beneficiaries will live within a distance that facilitates frequent home visitation…… ❑ ❑
18. The Promoter meeting place will be within 1 hour walk from the Care Group Volunteers' homes…… ❑ ❑
19. The implementing agency has plans to create a project/program culture that conveys respect for the population and volunteers, especially women…… ❑ ❑

Score: _____% (Yes/19)

Projects scoring less than 90% should not be considered Care Group projects and should be encouraged to follow more of the criteria. Projects that meet many, but not most, of these criteria should be considered Cascade Groups.

Appendix 5: Example Review Activities

Sing it!

Divide the participants into teams. Ask each team to reflect on things they have learned thus far in the training, to compose some lyrics to a song on one topic, and to prepare to perform their song for the rest of the participants. Give participants 10 minutes for preparation and 2 minutes each for performance.

Rock, Paper, Scissors

Ask each participant to reflect on things they have learned recently and to write a review question and put it in their pocket. Have participants form two lines facing each other. Show them the rock, paper, and scissor hand signals. Going down the line each pair of participants plays rock, paper, scissors. The one who wins gets to ask the other one his/her review question. All participants listen in case a help-line is needed. Continue down the line until each pair has asked/answered a question.

Unravel the Ball

Make a ball from used flip chart paper and tape. Form a circle of the participants and instruct them to toss the ball from participant to participant in such a way that it is not easy to catch the ball. When someone drops the ball, the thrower gets to ask that person a review question. Questions can be written by participants before the game starts or the facilitator can develop review questions.

Musical Chairs

Connect speakers to the computer or sound system and select a fun dance song to play. Place the chairs back-to-back in two rows. Remove two chairs so there are two chairs fewer than the number of participants. Tell participants that they need to march/dance to the music around the rows of chairs. When the music stops, each person needs to sit in a chair. There will be two people with no chairs; these people will answer review questions and sit out the remainder of the game. After this happens, remove two or more chairs and repeat the process until no one is left to march/dance around the chairs. The people who are sitting out ask the next review question.

Appendix 6: Curriculum Development and Overview

This appendix is broken into three parts.

1. **Part 1: Designing New Curriculum for Your Program** provides basic guidance to help you develop your own Care Group (CG) materials.
2. **Part 2: Care Group Lesson Lists** provides sample lesson lists.
3. **Part 3: Considerations for using Another Organization's Materials for Your Program** provides basic guidance to help you if you are considering using another organization's materials.

Part 1: Designing New Curriculum for Your Program

This section describes the principles of designing quality, new curriculum for your program. The core principles are:

1. Know your audience
2. Study your intended audience through formative research
3. Plan for sustained teaching
4. Develop materials that align with the principles of adult learning
5. Pretest the materials
6. Make your materials durable
7. Make your materials the appropriate size

1. Know Your Intended Audience

Make sure that you narrowly define your intended audience before you begin developing materials. Consider their age, social status, language, education level, current behaviors and practices, and the things that have prevented them from doing the "key practices" in the past. The more you understand the needs of your audience the easier it will be to develop materials for them.

Consider reading ability. Choose the grade level that best represents the majority (95%) of the intended audience. It is better to choose a lower level than assume a higher level of reading. Once you begin to develop materials, you should test the reading level of the materials to assess how well you wrote to the audience level.[36]

2. Study Your Audience through Formative Research

Once you have narrowly defined the people who will be receiving the messages (your intended audience), it is best to study them to test your

The Importance of Formative Research

International Medical Corps found that its CG approach was more efficient if it started the program by using formative research, such as a Barrier Analysis. In Samburu, Kenya, Barrier Analysis highlighted the influencing power of men on complementary feeding. You need to understand the community you are working with right from the start if you really want to have an impact. You can use the training modules that are available online (www.caregroupinfo.org),

[36] One option for testing reading level of completed materials is the SMOG test
Family Health International. 2002. *Developing Materials on HIV/AIDS/STIs for L*

assumptions. A baseline survey (e.g., standard Knowledge, Practice, and Coverage [KPC] surveys) is a great way to gather information about current practices.[37] Barrier Analysis, a rapid assessment tool for community health and development projects, can be conducted to identify behavioral determinants associated with a particular behavior.[38] You also may consider in-depth focus groups, positive deviant inquiries (such as the Local Determinants of Malnutrition Study[39]) and other formative research methods to gather more information about your intended audience and behaviors. Use this research to develop key practices for your audience.

For more information about defining intended audience and key practices (including guidelines for Barrier Analysis), please see the Designing for Behavior Change curriculum.[40]

3. Plan for Sustained Teaching (Number of Modules)

Determine how many lessons will be taught each month (usually about two lessons per month) and how long your program will last. Once you know how many lessons will be taught over the life of your program, you will be able to better budget for developing and producing materials.

For example, imagine you are managing a 3-year project and the CGs will meet every 2 weeks for 2 of those years (the remaining year is for start-up workshops, hiring of staff and closeout activities). In this example, you could design approximately 50 lessons (26 lessons per year) to sustain 2 years of teaching. Alternatively, you could choose a smaller number of lessons that are repeated throughout the project. For example you may want to focus on just 25 lessons that are repeated twice during the project.

A sample CG materials list can be found in **Part 3: Considerations for using Another Organization's Materials for Your Program**.

4. Develop Materials that Align with the Principles of Adult Learning

Don't assume that facilitators know how to teach in a participatory way. Include guidance and instructions in the text to enable facilitators to teach in a participatory way, with discussion questions, small group activities, demonstrations and time to discuss challenges to the new behaviors. For more information about adult learning theory, refer to the Adult Learning Theory trainings conducted by Freedom from Hunger (see website below).

The Community-Integrated Management of Childhood Illness (C-IMCI) Facilitators Guide has excellent lessons on facilitations skills as well, and can be found at http://www.medicalteams.org/docs/learning-zone/C_IMCI_Facilitators_Guide.pdf?sfvrsn=0.

---

[37] For more information about how to conduct and analyze a KPC survey, a series of tools and resources are available on Maternal and Child Health Integrated Program (MCHIP)'s website at http://mchipngo.net/, then click on "TOOLS", then select "Project Monitoring & Evaluation (M&E)".

[38] For more information about Barrier Analysis, please see the Barrier Analysis Facilitator's Guide by Food for the Hungry (2004) available at http://www.caregroupinfo.org/docs/Barrier_Analysis_Facilitator_Guide.pdf.

[39] The Local Determinants of Malnutrition Study is an expanded Positive Deviance inquiry, developed by Food for the Hungry (FH), to identify local associations between behaviors and malnutrition. A manual is currently being developed.

[40] The 2013 version of *Designing for Behavior Change: For Agriculture, Natural Resource Management, Health and Nutrition* is available on the Food Security and Nutrition Network website, at http://www.fsnnetwork.org/sites/default/files/combineddbc_curriculum_final.pdf.

Food for the Hungry (FH) uses a standard format for each lesson, including games, discussion about current practices, stories, activities, discussion of barriers and time for making commitments. For more about FH's materials, see the main CG website, www.caregroupinfo.org.

5. Pretesting Materials

Once the first draft of materials is developed, test them with small groups or individual interviews (the latter work best for low-literacy reviews) for understanding, acceptance and amount they inspire action. The materials should promote particular behaviors or actions; make sure the audience receives the same message that you intended.

6. Make Durable Materials

CG materials should be built to last so that teaching can continue in the community after a project closes. Ideally, teaching aids/tools (e.g., flip charts) should printed be on laminated cardstock bound at either the side or the top. This keeps the pages together and helps them resist mildew and deterioration.

7. Size of Materials

Because Neighbor Women and Care Group Volunteers (CGVs) will be meeting in small groups of approximately 12 women, the materials need to be large enough so that each woman in the group can see the pictures (or other visuals) at a distance. We recommend A3 picture pages that are bound into a flip chart or flip book. This way, images will be large enough for the women to see, but lightweight enough for the CGVs to carry when walking in the community.

For more information on developing new materials, see: PATH. 2002. *Developing Health and Family Planning Materials for Low-Literate Audiences: A Guide*. Seattle, WA: PATH. Available at http://www.path.org/publications/files/DC_Low_Literacy_Guide.pdf.

Part 2: Care Group Lesson Lists

Sample Care Group Lessons Grouped by Topic

Food for the Hungry prints its teaching aids/flip charts as a series of modules, as listed below. Each module contains six to 12 lessons and addresses a specific health topic. Samples flip charts can be found at http://www.caregroupinfo.org/blog/narrated-presentations-on-care-groups-and-care-group-tools/care-group-curricula. Please note that the recommendations for Essential Nutrition Actions have been updated, refer to the World Health Organization's site for the latest information. http://www.who.int/nutrition/publications/infantfeeding/essential_nutrition_actions/en/

- Module 1: Essential Nutrition Actions (ENA): Prenatal Nutrition and Breastfeeding
  - Lesson 1: Nutrition for Pregnant and Lactating Mothers: Supplements, Use of Iodized Salt and Anemia Prevention
  - Lesson 2: Antenatal Care, Advantages of Delivery at the Health Center and Maternal Danger Signs

  - Lesson 3: Preparing for Delivery and Birth
  - Lesson 4: Early Initiation of Breastfeeding
  - Lesson 5: Newborn Care
  - Lesson 6: Maternal Postpartum Care
  - Lesson 7: Exclusive Breastfeeding

- Module 2: Essential Nutrition Actions (ENA): Complementary Foods and Micronutrients
  - Lesson 1: Complementary Feeding of Children 6–8 Months
  - Lesson 2: Complementary Feeding of Children 9–12 Months
  - Lesson 3: Complementary Feeding and Continued Breastfeeding of Children 13–23 Months
  - Lesson 4: Positive Deviance Foods and Practices, Use of Snacks, and Men's Responsibilities for Child Nutrition
  - Lesson 5: Sanitary Meal Preparation for Young Children and Hygiene
  - Lesson 6: Importance of Vitamin A-Rich Foods and Vitamin A Supplementation
  - Lesson 7: Micronutrients: Importance of Iron-Rich and Other Nutrient-Rich Foods
  - Lesson 8: Growth Monitoring and Promotion, Nutrition Counseling, and Referral for Growth Faltering

- Module 3: Essential Hygiene Actions (EHA)
  - Lesson 1: Diarrhea Definition, Transmission, and Signs and Symptom, Including Danger Signs
  - Lesson 2: Hand Washing with Soap or Ash
  - Lesson 3: Creation of Household Hand Washing Stations, Including Tippy Tap and Dish Drying Racks
  - Lesson 4: Disposal of Feces, Latrines and De-Worming of Children and Pregnant Women
  - Lesson 5: Point-of-Use Water Purification and Proper Water Storage
  - Lesson 6: Proper Feeding of Sick Children: Oral Rehydration Solution (ORS)/Recommended Home Fluids (RHFs), Increased Breastfeeding and Complementary Feeding During and After Illness

- Module 4: Malaria and Parasites
  - Lesson 1: Malaria Transmission and Effects for Children, Pregnant Women and Food Security
  - Lesson 2: Prevention using Insecticide-Treated Bednets (ITNs), Household Spraying and Intermittent Preventive Treatment (IPT) for Pregnant Women
  - Lesson 3: Early Recognition of Malaria, Care Seeking and Artemisinin-Based Combination Therapy (ACT)
  - Lesson 4: Parasites (Intestinal and Liver) Defined and Their Effects on Food Security
  - Lesson 5: Parasite Transmission and Prevention using Essential Hygiene Actions (EHA)

  - Lesson 6: Promotion of Regular Treatment of Parasites (Intestinal and Liver)

- Module 5: Acute Respiratory Infections (ARIs)
  - Lesson 1: ARI Definition, Transmission, Signs and Symptoms
  - Lesson 2: ARI Prevention
  - Lesson 3: Prompt Treatment of ARI and Early Recognition of the Danger Signs of Pneumonia
  - Lesson 4: Recognizing Tuberculosis and Promoting Prompt and Complete Treatment
  - Lesson 5: Proper Feeding of Sick Children and General Danger Signs
  - Lesson 6: Preparing for Graduation and How to Maintain Your Care Group and Your Results

- Module 6: HIV/AIDS and Preventing Mother-to-Child Transmission
  - Lesson 1: HIV and AIDS Symptoms and Transmission
  - Lesson 2: HIV Prevention
  - Lesson 3: HIV Stigma Effects on Food Security and Decreasing that Stigma
  - Lesson 4: Promotion of HIV Testing and Treatment
  - Lesson 5: Prevention of Mother-to-Child Transmission of HIV
  - Lesson 6: Proper Nutrition for HIV-Positive Children and Adults

- Module 7: Family Planning
  - Lesson 1: Family Planning Introduction (Including Benefits)
  - Lesson 2: The Lactational Amenorrhea Method
  - Lesson 3: The Two Day Method
  - Lesson 4: Cycle Beads
  - Lesson 5: Health Facility Options
  - Lesson 6: Talking with You Partner about Family Planning (Including Negotiation Skills)

Sample Care Group Lessons Grouped by Stage in Pregnancy

- Module 1: Essential Nutrition Actions (ENA), Essential Hygiene Actions (EHA) and Other Important Care during Pregnancy (Part 1)
  - Lesson 1: Introduction to Care Groups
  - Lesson 2: Teaching Techniques
  - Lesson 3: Care Group Volunteer Responsibilities
  - Lesson 4: Watching for Change and Monitoring Groups

- Module 2: Essential Nutrition Actions (ENA), Essential Hygiene Actions (EHA) and Other Important Care during Pregnancy (Part 2)
  - Lesson 1: Antenatal Care and Health Center Births

  - Lesson 2: Maternal Nutrition and Anemia Prevention
  - Lesson 3: Iodized Salt and Iron-Rich Foods
  - Lesson 4: Hand Washing with Soap or Ash
  - Lesson 5: Creation of Household Hand Washing Stations
  - Lesson 6: Preventing Malaria in Pregnant Women
  - Lesson 7: Preparing for Birth and Delivery
  - Lesson 8: Immediate Breastfeeding
  - Lesson 9: Newborn Care Practices

- Module 3: Essential Nutrition Actions (ENA) and Essential Hygiene Actions (EHA) during Early Infancy
  - Lesson 1: Importance of Postpartum Care
  - Lesson 2: Exclusive Breastfeeding: Benefits, Breastfeeding on Demand and Breastfeeding while HIV-Positive
  - Lesson 3: Exclusive Breastfeeding: Overcoming barriers)
  - Lesson 4: General Danger Signs during Childhood Illness
  - Lesson 5: Breastfeeding Problems and Care of the Breasts
  - Lesson 6: Importance of Clinical Services
  - Lesson 7: Men's Involvement in Breastfeeding and Child Care
  - Lesson 8: Child Spacing
  - Lesson 9: Point-of-Use Water Purification
  - Lesson 10: Proper Disposal of Feces
  - Lesson 11: Malaria Transmission and Prevention
  - Lesson 12: When a Child has Malaria: First Response and Home Care

- Module 4: ENAs and EHAs during Late Infancy and Childhood
  - Lesson 1: Good Complementary Feeding of Children 6–8 Months
  - Lesson 2: Good Complementary Feeding of Children 9–11 Months
  - Lesson 3: Complementary Feeding of Children 13–23 Months
  - Lesson 4: Recipes: Proper Use of Rations
  - Lesson 5: Vitamin A-Rich Foods and Vitamin A Supplementation (for Children and Postpartum Women)
  - Lesson 6: Worms and Deworming
  - Lesson 7: Proper Food Storage and Sanitary Food Preparation
- Module 5: Management of Common Childhood Infections
  - Lesson 1: Signs of Dehydration and Why Dehydration is Deadly
  - Lesson 2: Prevention of Dehydration with Oral Rehydration Solution (ORS)
  - Lesson 3: Proper Feeding of Sick Children
  - Lesson 4: Deadliest Types of Diarrhea: Dysentery and Persistent Diarrhea
  - Lesson 5: Prevention of Pneumonia and Care Seeking
  - Lesson 6: Home Vegetable Gardening

Part 3: Considerations for using Another Organization's Materials for Your Program

Ask other non-profit organizations (e.g., Food for the Hungry, Tear Fund, Freedom from Hunger [FH], World Relief [WR], CARE, Save the Children, Compassion International) if they will share their materials.

The following are a few online resources where CG curriculum is publically posted.

- Care Group Info http://www.caregroupinfo.org (view the curriculum page)
- Infant and Young Child Nutrition Project http://www.iycn.org/2011/07/strengthening-community-nutrition-programming-2/
- Media Materials Clearinghouse http://www.m-mc.org/: Search by topic and media type. Materials will have to be adapted to fit the Care Group setting.
- Knowledge for Health (K4Health) http://www.k4health.org/

Use the guidance below to guide you through deciding whether to use existing materials/resources.

1. Find out if the materials can be reprinted and used with no cost for non-profit proposes. Some organizations require that you request permission. Contact the author of the materials if the copyright information is not clear in the manual.

2. Read the main objectives of the curriculum. Look at the objectives for each lesson. Compare this list with the objectives your program (those outlined in the proposal). Identify the proposal objectives that are not covered and write them down. Write down a few ideas of how you could overcome this discrepancy if you were to adapt the materials.

3. Consider the design (or theory) of the materials. Write down the differences that you see in the following areas.

   – How is the subject matter taught? Do they use non-formal or formal teaching techniques? For example, if the proposal says the nongovernmental organization (NGO) will use non-formal education techniques to teach beneficiaries, but the manual uses lectures and large group presentations (formal education techniques), this is a difference in theory that you should document.

   – How are the beneficiaries changed by the materials? If the proposal says that the NGO will use behavior change theory (behavioral determinants) to prevent HIV, but the manual uses information and facts to persuade beneficiaries, then this is a difference that needs to be documented.

4. Identify for whom the curriculum was developed (the intended audience). Compare this with the intended group as written in the proposal. If they are not the same, make a note of the differences between the two groups. For example, if the manual is designed for orphans and vulnerable children when our program targets pregnant and lactating women (PLW), this is a difference that should be noted. Write down a few ideas of how you could overcome this discrepancy if you were to adapt the materials.

5. Identify the time needed for each lesson and the entire training. Compare this with the time allotted for these activities as described in the program proposal. For example, are the sessions 2 hours in length when the NGO planned for 30-minute sessions? Is the entire training 3 weeks when the NGO planned for 6 months of training? Write down the differences that you see. Write down a few ideas of how you could overcome this discrepancy if you were to adapt the materials.

6. Review the reading level of the materials by asking the following.

   – Is this written for a small child (easy to understand) or a college professor (with many large words and complicated sentences)? If the reading level is not the same as the reading level of the beneficiaries in the program, write down an explanation of what needs to be changed so that the reading level can be adapted to the level of the beneficiaries.

   – Is the format of the manual easy to follow? Based on the literacy level of the teachers in your program, will they be able to follow the formatting in the manual with ease? Write down any problems that you see. Write down a few ideas of how you could overcome the formatting difficulties if you were to adapt the materials.

7. Review the cultural references in the materials. Write down the stories, activities or discussions that are not appropriate to the beneficiary culture. Write down a few ideas of how you could adapt the materials to overcome these problems.

   – Do the people in the pictures look like our beneficiaries? For example, if all of the illustrations are of Nigerians, and your organization is using the materials created for Burundi, it would not be appropriate for the local culture.

  - Are the people, discussions and situations in the manual similar to the people, discussions and situations of beneficiaries in your community? For example, if examples in the manuals include references to upper-class citizens who struggle purchasing a new car, this example would not be relevant to a Burundian woman who does not have money to send her child to school.

Now review the notes that you took on the above questions.

- Questions 2, 3 and 4 are the most important questions. If for these questions you listed large differences between the materials and your program goals, you should look for other materials. If the differences are small, you may consider deleting a few activities or adding supplemental lessons and activities so that the materials will match your program needs. However, if the worldview and theory are not the same (or very similar), you will have a very difficult time meeting your program objectives and justifying the differences between your proposal intent and the materials you chose. Make sure that you seek outside approval (and assistance) before making a decision when questions 2, 3 and 4 have large differences.

- Differences listed for questions 5, 6, 7 and 8 can be resolved with some work on your part. This requires someone who is willing and able (has the time) to work on adapting the materials so they match the intent of your program.
  - List the main things that need to be changed in order to make these materials appropriate for the program.
  - List the names of people on staff who are capable (and available) to do this.
  - Confirm that you are you able (check copyright information) to adapt the materials for your program. Contact the author or publisher if you are not sure. Some authors require that they approve the materials first, which may delay your efforts. Consider making a supplemental booklet to go along with the materials.
  - Consider the time it will take to make these changes.
  - Decide if you are able to adapt the materials or simply add supplemental text or if you need to find new materials.

  Remember the objectives of your program! Do not choose new materials because they seem “fine”. Choose the materials that are proven to work and that match the intent of your program. Do not attempt to change the proposal to match your materials; your materials need to match the proposal.

Appendix 7: How to Hire Care Group Promoters

The best Care Group (CG) Promoters already live in the communities where they will work and only have a secondary school education (or less in some countries), and they are the most likely to be willing to spend their days visiting groups of mothers and/or visiting women in their homes. They speak the local dialect of the women they are working with and are held accountable for their actions and behavior as they go about their daily activities since they are surrounded by their friends and extended family members. The disadvantage to working with such locally based staff is that they may have to go through a process of change in themselves before they are convinced of the new information and practices they are being paid to promote. However, experience has proven that locally hired CG Promoters do try out the new practices they are taught, and as they experience the benefits they become powerful agents of change.

Many rural CG projects make the mistake of announcing CG Promoter positions through local newspapers and in city centers. This can lead to a pool of professional candidates who have high expectations regarding salary and the benefits of working for a nongovernmental organization (NGO). Often these people expect to work in an office and they desire to spend the majority of their time in the city, where they may have a house and their children may attend school. Such candidates may have more knowledge about the maternal and child health and nutrition (MCHN) behaviors the CG project will promote, but typically they do not make the best CG Promoters.

The basic CG Promoter qualifications are:

1. Able to read and write
2. Good reading comprehension in the language the flip charts are produced in
3. Basic math skills: addition, subtraction and able to calculate percentages
4. Nominated by the community he/she will serve for the position
5. Fluent in the local dialect and the professional language of the country
6. Able and willing to be in the community 5 days per week (normally, in a rural community this requires living in the community)
7. Physically able to use the transport provided by the project (bicycle or motorcycle) to move around the project area
8. Able to travel to the provincial capital for 1–2 week periods for training
9. Willing to model practices taught in the CG curricula (e.g., using a latrine, hand washing station or mosquito net)
10. Able to speak confidently in front of groups of 12 people and facilitate discussion
11. Respectful and considerate of others

For a complete list of qualifications and the CG Promoter job description see **Lesson 6**, particularly **Lesson 6 Handout 2: Care Group Team Essential Responsibilities**.

Adapting to Administrative Challenges: GOAL's Experience in Ethiopia

GOAL implemented CGs as part of its Child Survival Programme in Awassa, Ethiopia. It was a very useful intervention and GOAL plans to expand it to other country programs. Involving the Ministry of Health (MOH) in the design and planning phase from the outset and ensuring that MOH and Woreda (district) staff understood the intervention were important steps.

At the same time, the Government of Ethiopia was promoting a community health army approach, which was a strategy to try to get community health activities disseminated across the community. The Woreda Health Staff saw the CG approach as part of this approach and felt that GOAL was assisting them in the implementation of the set-up of the health army approach.

A few months after each CG was established, GOAL involved health extension workers (HEWs) at Kebele/Health Post, asking them to take on facilitating the care groups, with GOAL staff mantling some support and supportive supervision, but not directly implementing the CGs. HEWs had a responsibility to work in the community, so the CG approach also supported their work.

Again, GOAL found that by working with the MOH at district and facility levels from the outset and explaining how this intervention could be used to attain its program objectives, the CG approach had good support and buy-in throughout.

Should Promoters be male or female?

Some CG projects only hire female Promoters. Food for the Hungry has found that although Promoters work with groups of women, both men and women can make excellent CG Promoters.

Advantages to having a male Promoter include that they tend to stay longer with the program, can easily leave their families to attend trainings, handle bicycles and motorcycles well, and when conflicts arise in households because of new practices taught by the CG program, male Promoters can advocate with other men on behalf of the women.

There is also an advantage to hiring female CG Promoters, and some of the best Promoters in Food for the Hungry projects have been women. Female Promoters can model new behaviors specific to women, more easily speak about sensitive subjects that normally only are discussed among peers of the same gender and encourage Care Group Volunteers (CGVs) to be leaders by modeling how to be a strong female community leader.

What if no one at the community level has the basic CG Promoter qualifications?

Occasionally, no one at the community level will be qualified to work as a CG Promoter. If this is the case, grown children or extended family members of community members who have moved to larger cities for education or work can be nominated by the community. This way, the Promoter will still have ties to the community. If hired, such candidates would be expected to move back to the community for their period of employment.

Recommended Steps for Hiring CG Promoters

1. Hire your manager, coordinator(s), supervisor(s) and any other management staff specific to your project.

2. Train them about CGs and how to start up a CG project using the lessons in this manual.

3. The manager, coordinator(s), supervisor(s) and any other management staff specific to the project then orient communities about the program. Once communities understand what CGs are and how the project will operate, ask them to nominate two or three men and women from their community who they think will make good Promoters . Make it very clear to community leaders that the NGO will select the best candidates through interviews and the results of reading and math tests.

4. A team of CG project personnel and human resources staff should interview candidates.

5. It is very important that candidates' reading comprehension and math skills be tested. A sample test is available later in this appendix. (Note that this reading comprehension test was designed for students who have completed grade 6 in the United States. You can find tests online for lower grade levels if you think this test is too challenging for the majority of people in your country who have completed 6 grades of schooling.)

6. Occasionally none of the candidates nominated by the community will meet the qualifications. In this case, return the community and ask for additional nominations.

7. After you have selected all your CG Promoters, train them about CGs and project start-up.

Another Administrative Challenge: Lessons Learned about Labor Laws

ADRA's JENGA II project in South Kivu, Democratic Republic of Congo, had part-time Promoters who were going to work with the CGs. ADRA discovered that this plan had to be changed due to the country's labor laws for part-time staff: the Promoters would most likely have been working more hours than allowed. It is important for international organizations to know the labor laws in their country programs.

If possible, projects should have 20 or more CG Promoters and hire one or two Promoter "floaters". These extra Promoters will not be assigned to a specific community, but fill in for a set period of time when Promoters with permanent placements go on maternity leave or fall sick.

Sample Math and Reading Comprehension Test for Care Group Promoters (with Answers)

Directions: Answer the following mathematical problems. You may use a calculator, if you like.

1. You are working with five (5) groups of women. Each group has ten (10) women in it. How many women in total are you working with?

Answer: 5 × 10 = 50

2. What is the sum of the following ten numbers? 10, 15, 8, 12, 40, 43, 9, 11, 12, 45

Answer: 205

3. 12 × 12 = ___?

Answer: 144

4. 120 ÷ 30 = ___?

Answer: 4

5. If 25 out of 75 children are malnourished, what percentage of children are malnourished?

Answer: 25 ÷ 75 = 1/3 = about 33%

6. If two (2) out of four (4) households have a latrine, what percent of households have a latrine?

Answer: 2/4 = 1/2 = 50%

7. Your goal is that at least 80% of women would exclusively breastfeed their 0–6 month old children. You do a survey and find that 60 women out of 80 women sampled do exclusively breastfeed their children. Have you met your goal?

Answer: No, only 75% of women are exclusively breastfeeding

8. You have four (4) Care Groups. Each Care Group has twelve (12) Care Group Volunteers in it. Each Care Group Volunteer reaches out to ten (10) Neighbor Women. How many Neighbor Women are being reached by your four Care Groups?

Answer: 4 × 12 × 10 = 480 women

9. You are told to visit each of your Care Group Volunteers once every three (3) months. You have a total of ninety (90) Care Group Volunteers. Each month you have fifteen (15) days available to visit your Care Group Volunteers. To reach your goal, how many volunteers must you visit each day you have available to do visits?

Answer: 90 ÷ (3 × 15) = 2 visits per day

Directions: Read the following passage then answer the questions afterward about what you read.

Passage: Spotted Cats

Several members of the cat family have spotted fur. Do you know the difference between a leopard, a jaguar and a cheetah? From a distance they may appear somewhat similar. However, examined at closer range, they are clearly different cats. They differ in various ways, including where they live, how big they are, how they move and hunt, and how their fur is marked.

Of all the big cats in the wild, the true leopard is found across the largest area. Leopards live in much of Asia and Africa. A leopard grows to be 3 to 6 feet long, with an added 3 feet of tail. Leopards are skilled climbers that can hunt monkeys in trees. They can also lie in wait and pounce on passing prey. When food sources are scarce, they might eat fruit, field mice and large insects. Leopard spots are not actually solid spots; they are broken circles.

The jaguar is native to the Americas. Its natural range is from the southern United States to northern Argentina, with the largest concentration of jaguars being in Brazil and Central America. The beauty and power of the jaguar inspired worship among ancient peoples. It measures from 3 and 6 feet long without the tail, which adds another 1 ½ to 2 ½ feet. Possessing a large head and body, the jaguar has legs that are shorter and thicker than a leopard's. Jaguars are excellent climbers and can swim well. They dine on a variety of land, tree and water creatures. Their fur can be a vivid yellow color or a rusty shade. Their "spots" are called rosettes. Each rosette is large and black, consisting of a middle spot with a circle of spots around it.

Most cheetahs live in the wilds of Africa. There are also some in Iran and northwestern Afghanistan. The cheetah's head is smaller than the leopard's, and its body is longer. This cat is built for speed. Its legs are much longer than the leopard's, allowing it to run at speeds of up to 120 kilometers per hour! This incredible ability helps the cheetahs catch their dinner, which is usually an unfortunate antelope. A cheetah's spots are simply black spots, not rosettes or circles.

Other spotted cats include the smaller ocelot, mainly of Central and South America, and the lynx or bobcat, mainly of North America. What all of these cats have in common is that they are wild, powerful animals of tremendous grace and beauty.

1. All of these are ways to tell the difference between spotted cats *except*:

   A. How big they are

   B. What their spots look like

   C. Where they live

   D. How beautiful they are

   Answer: D

2. Which words from the passage are used as persuasion, in that they express an attitude of sympathy for animals that are prey to big cats?

   A. "how they move and hunt"

   B. "might eat fruit, field mice and large insects"

   C. "dinner, which is usually an unfortunate antelope"

   D. "that they are wild, powerful animals"

   Answer: C

3. Which of these statements best summarizes this passage?

   A. All spotted cats are powerful, beautiful and graceful.

   B. Spotted cats may look similar, but they are different in many ways.

   C. There are many different spotted cats in the world.

   D. Spotted cats in the wild hunt many different kinds of animals.

   Answer: B

Appendix 8: Care Groups and the Preventing Malnutrition in Children Under 2 Approach (PM2A)

PM2A is a methodology used to reduce the prevalence of child malnutrition by targeting a package of health and nutrition interventions, including food distribution, to all pregnant and lactating women (PLW) and children under 2 years of age in food-insecure program areas, regardless of nutritional status. PM2A requires that behavior change communication (BCC) programming accompany the food ration distribution, but does not specify a specific methodology for the BCC. Due to the successes of Care Groups (CGs) in creating behavior change, some programs have sought to integrate the two models by modifying the CG model to include only PLW and children under 2 years of age. Outlined below are some recommendations on how to use both approaches in the same project, while protecting and maintaining the elements of the CG approach that make it particularly effective.

A Note on Food Distribution

Food for the Hungry (FH) recommends that when a project provides direct food assistance and protective household rations to pregnant women and children, the food distribution be conducted separate and independent from the CG activities.

1. **Participation in CG activities should not be limited only to those receiving the PM2A ration, but should be provided to all women of reproductive age (WRA) and mothers of children under 5 years of age.**

   It is important to note that CG programs originally targeted all WRA and women with children 0–59 months of age. Keeping the target population broader is still highly recommended. This ensures that the majority of women in a community that are currently (or soon to be) caring for a child under 2 years of age receive key maternal and child health and nutrition (MCHN) messages prior to actually needing the information.

With PM2A, the maximum amount of time a woman and child pair can receive rations is 30 months (6 months of pregnancy + 6 months of exclusive breastfeeding [EBF] + 18 months for the child). But, most PM2A programs limit initial registration to pregnant women in their second or third trimester only or to pregnant women in their second or third trimester plus women with children under 6 months of age. This excludes women with children 6–23 months of age from being reached initially by CGs unless they become pregnant during the period of time when the project is enrolling new mothers. It also can have the unfortunate effect of limiting the pool of Care Group Volunteers (CGVs) or limiting the time they can serve.

Recommendation: Register all WRA and mothers of children 0–59 months for inclusion in the CGs activity. Create a separate registration for those eligible for to receive the food ration. As women move into the area or otherwise become eligible for inclusion (e.g., 15 years old, pregnant), register them in a Neighbor Group (NG).

Point to consider: For this approach to be successful and to avoid conflict within groups where some women receive rations and some do not, projects must work with community opinion leaders to continuously sensitize project participants about the reasons for targeting rations at PLW and mothers of children under 2, as well as the benefits of participation in the CGs regardless of ration status.

2. PM2A programs may require CG Promoters and/or CGVs to assist with food distribution activities, shifting their focus away from behavior change.

If Promoters and/or CGVs serve as the gateway for NW to receive food rations, it places them in a position of power over their neighbors. This can change the nature of the peer-to-peer relationship and expose Promoters and CGVs to possible intimidation. These additional responsibilities also can decrease the time a Promoter or CGV has to dedicate to behavior change activities and the development of relationships that promote behavior change. When the PM2A and CGs are combined, CGs will inevitably take the back seat and not be done well because the focus will be on the food distribution. Promoters, in particular, may find a significant portion of their work day spent filling out distribution lists, preparing distribution sites and assisting with the actual distribution. Having a lower Promoter-to-CGV ratio and CGV-to-NW ratio can help remove some of these disadvantages, but not all of them (especially the power differential created).

Recommendations: Projects should have separate staff and separate, but linked, data management systems to monitor participation in CG activities and ration distribution. Promoters should have a significant portion[41] (ideally 100%) of their time protected for CG activities.

Point to consider: It is best to link data from the commodities database with CG attendance in order to track how many NW receive both rations and behavior change messages through CG activities. This is particularly important given that biological rations should be given without conditionality (which means there is no explicit data link between the two). Linking commodity and CG data will help programs ensure that PLW and mothers of children under 2 years of age who come into the program through CGs have the opportunity to receive rations and those that only may be participating in the ration component also have the opportunity to join CGs.

Social Motivators for CGVs

ACDI/VOCA has found that the same social benefits that encouraged CGVs to continue in their roles beyond the end of a Child Survival project also hold true in a PM2A project. Women have indicated and demonstrated their willingness to continue to act as volunteers after they no longer receive food rations because of, for example, their increased social standing and community respect; seeing proven results in their communities and feeling it is their duty to ensure that women continue to gain improved health outcomes; and feeling that CG meetings build social cohesion and provide a foundation for other types of community groups, such Village Savings and Loan Associations.

3. PM2A links group behavior change participation and attendance (e.g., participation in the CG or NGs) with an extrinsic benefit.

When the food ration benefit ends, CG participation may stop as well. Since attendance at CG meetings is perceived as (or is actually) a condition to receive food rations, it is feared that as soon as the CGVs or NW are no longer eligible to receive food rations they may stop attending CG sessions (research on motivation confirms this tendency). The CG curriculum includes four to eight modules that take 24–48 months to fully teach. To be consistent with adult learning principles

[41] Note: if Promoters are not 100% dedicated to CG activities the total number of CGs they supervise should be adjusted proportionally.

and to facilitate high-quality teaching by women with limited education, we believe that this length of training is essential. Therefore, for CGVs and NW to receive all the key MCHN messages, they need to participate in CGs or NGs for the time it takes for all modules to be taught. For this reason, it is important to encourage CGVs and NW and allow them to participate in group meetings, even if their child passes out of the age range.

Recommendation: Avoid linking CG attendance or behavior uptake with receipt of food rations.

Point to consider: Despite a project's decision to de-link rations and CG participation, PLW and children under 2 may perceive the two to be linked, so the project must continually reinforce the separate but complementary benefits of each activity.

Appendix 9: Monitoring the Impact of Care Group Projects[42]

What are mini-KPCs?

Mini-Knowledge, Practice and Coverage surveys (mini-KPCs) are short surveys of 12–20 questions that are conducted every 4–6 months. The survey easily can be analyzed by field offices and the results quickly obtained to inform program decisions. Performance by district can be determined with a small sample (e.g., 19 interviews per district) using Lot Quality Assurance Sampling (LQAS) survey methodology.

Why use mini-KPCs?

Development projects typically measure their impact and result-level indicators at baseline and midterm, when only 40% of the project is left to be completed, allowing little time to adjust strategy and focus on hard-to-change behaviors. Food for the Hungry (FH) has used mini-KPCs in Title II, U.S. Presidents Emergency Plan for AIDS Relief (PEPFAR) and Child Survival programs to improve program effectiveness by targeting indicators that are not improving as expected within individual supportive supervision areas.

Table 1 explains the differences between using Mini-KPCs and traditional/full KPCs.

Table 1: Traditional/Full KPCs versus Mini-KPCs

	Traditional/Full KPC	Mini KPC
Number of questions	About 60 questions	12–20 questions
Timing	Conducted at baseline, midterm and final	Conducted frequently, every 4–6 months
Sample size required	Normally about 300–500 caregivers of children under 5 years of age	Normally about 100 caregivers of children under 6 months and about 100 caregivers of children 6–24 months
Who is surveyed	Population-based sample	Beneficiary-based sample
Staff time required	Requires a large amount of staff time for training, implementation and analysis	Once staff are trained in the methodology, only short refresher and new questionnaire trainings are needed
Staff expertise required	Advanced statistical analysis skills required	Staff with little statistical training can do the analysis and quickly use the results
Type of information provided	Attempts to provide information that allows for a program (or program area) to be completely assessed or evaluated	Attempts to provide frequent feedback about specific aspects of a program
Staffing requirements	Requires large team of staff operating full time for multiple weeks	After a one day training about a new questionnaire, staff can conduct the surveys as part of their normal community work

[42] Access the blank Microsoft Excel file used to prepare this plan at http://www.caregroupinfo.org/blog/narrated-presentations-on-care-groups-and-care-group-tools/planning-m-e-tools.

Benefits of Mini-KPCs

- LQAS survey methodology is used to determine progress at the supportive supervision area level, allowing each supportive supervision area to focus on its problem indicators.
- Regular monitoring using LQAS and a simple-to-use Microsoft Excel spreadsheet for data analysis allows for field-based monitoring and evaluation (M&E). This allows staff, with only a little training necessary, to quickly analyze data and provide survey results to program management.
- Because results are quickly obtained at the project level, they can be immediately used to inform programming decisions.
- Frequent and regular monitoring by supportive supervision area allows program managers to identify slow moving indicators and tailor programming to focus on problem areas, both technically and geographically.

Implementing Mini-KPCs

- Mini-KPCs should be scheduled every 4–6 months, considering the timing of the baseline, midterm and final evaluations. If a larger evaluation is planned, there is no need to do a Mini-KPC. **Table 2** provides a breakdown of when Mini-KPCs and other important surveys could be scheduled throughout the course of the program, and which indicators to collect during each survey.
- The Mini-KPC should track the indicators listed in the project proposal. If during the length of activity you decide you want to track additional indicators, you will not have baseline data with which to compare your results.
- Survey questionnaires should be designed to measure only those indicators listed in the project proposal (the specific indicators the program is targeting and hopes to improve).
- Keep in mind that Mini-KPCs are beneficiary-based surveys, not population-based surveys. The results of one type of survey cannot be compared to the other. For example, if your baseline survey was population-based and you found that 35% of mothers were exclusively breastfeeding their under 6-month-old children, you could not say that exclusive breastfeeding (EBF) had improved if you found that 65% of your beneficiaries were exclusively breastfeeding during your first Mini-KPC. The Mini-KPC results indicate that your beneficiaries are practicing EBF more than the general population of the area, but you have not yet measured program results.

Table 2: Mini-KPC Schedule (Example)

Program Year:	Year 1				Year 2				Year 3				Year 4				Year 5			
Quarter:	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Survey Type: Indicator No.:	Baseline KPC		Mini KPC 1			Mini KPC 2			Midterm KPC			Mini KPC 3			Mini KPC 4			Final KPC		
Indicator 1	X		X						X									X		
Indicator 2	X		X						X			X			X			X		
Indicator 3	X		X						X									X		
Indicator 4	X		X						X						X			X		
Indicator 5	X		X						X						X			X		
Indicator 6	X		X						X			X						X		
Indicator 7	X		X						X									X		
Indicator 8	X		X						X									X		
Indicator 9	X					X			X									X		
Indicator 10	X					X			X						X			X		
Indicator 11	X					X			X			X			X			X		
Indicator 12	X					X			X									X		
Indicator 13	X					X			X									X		
Indicator 14	X					X			X						X			X		
Indicator 15	X					X			X						X			X		
Indicator 16	X					X			X						X			X		
Indicator 17	X								X			X						X		
Indicator 18	X								X			X						X		
Indicator 19	X								X			X						X		
Indicator 20	X								X			X						X		

Using LQAS in the Care Group (CG) Setting to Select Survey Respondents

Note: This section is not intended to be a primer on LQAS, but how to use LQAS in an area where the population you desire to sample is already organized into CG. For training manuals on LQAS please go to www.coregroup.org/our-technical-work/working-groups/monitoring-and-evaluation.

LQAS is the sampling method used for Mini-KPCs for three reasons.

1. **LQAS allows for small sample sizes.**

CG projects try to keep the cost per beneficiary low, so as many people as possible can be reached with life-saving information. It is important to invest time and resources into M&E, but the majority of staff time and resources should be focused on creating behavior change. LQAS methodology uses a randomly chosen sample that is spread throughout each supportive supervision area, thus it has a design effect of one. This allows a small sample to provide reasonably specific results with a low investment in time and money.

2. **LQAS provides management with information to inform program decisions.**

LQAS divides the population to be sampled into supportive supervision areas. A sample of at least 19 respondents is taken from each supportive supervision area, and survey results indicate if a region of the project is performing below the acceptable program average, allowing program management to know where resources and efforts need to be focused in order to reach program goals.

3. **LQAS allows for a point estimate to be calculated for the total project area (not each supportive supervision area) to measure project progress toward an indicator.**

This allows program management to track indicator progress at the project level.

Consider the following criteria to determine whether you should use LQAS in your CG project.

1. The sample population demographic of interest must be contained within the CG participants. For example, if you wish to sample pregnant women, you could use CG participants since this demographic is contained within the CG participants. If you wish to sample all women with children 6–23 months of age, you also could use CG participants. However, if you wish to sample men 18–55 years of age, you cannot use CGs.
2. Existing CGs must include all women in a geographic area that fit the criteria for inclusion in CGs.
3. A list of all CG participants is required so that beneficiaries may be randomly chosen properly for inclusion in LQAS. These lists should be made according to the numbering system described in **Lesson 5: Organizing Communities into Care Groups and Numbering**.

You must answer the following two questions before setting up your sampling frame.

1. What is the total sample size you want to collect? Normally, aim to collect a total sample of 96. To allow room for error, try to collect about 10% more samples than needed. Therefore, a total sample size of 106 will likely result in at least 96 good samples being collected.
2. How many supportive supervision areas will you divide your project into? A sample between 19 and 50 should be collected in each supportive supervision area. Therefore, if your total desired sample is 96, you should consider a minimum of three to a maximum of five supportive supervision areas.

Take the following steps to use LQAS in a CG project.

1. Divide your project area into supportive supervision areas.
2. List all the CGs in each district.
3. Divide the total number of CGs in a district by the number of interviews scheduled to be done in each district to obtain the sampling interval.
4. Select a random number between 1 and the sampling interval. The first CG with the corresponding number will be the first CG selected for random sampling. Add the sampling interval to this random number to select the second CG to be randomly sampled. From this point on, simply add the sampling interval to the previous CG number to choose each CG to be randomly sampled until all the CGs where interviews should occur have been identified.
5. To determine the number of interviews needed in each area, divide the total number of desired samples by the number of supportive supervision areas in the project.
6. **Table 3** provides examples for how to sample in a CG project. Area A has 50 CGs. It is determined that 36 interviews need to be conducted in this area. For Area A, the sampling interval was calculated by dividing the number of CGs (50) by the sample size needed for this supportive supervision area (36). The random number chosen in this example was 1, as can be seen by the fact that the sampling interval is 1.38. Notice that for Area C, more than one interview is done in the first, fifth, tenth, etc. CG because the number of interviews needed from this supportive supervision area is greater than the number of CGs in this supportive supervision area.

Table 3: Selecting Care Groups in Each Area for Interviews

Area A				Area B				Area C			
Care groups		50		Care groups		40		Care groups		30	
Interviews per area		36		Interviews per area		36		Interviews per area		36	
Sampling interval		1.38		Sampling interval		1.10		Sampling interval		0.83	
Random #		1		Random #		1		Random #		1	
Samples needed	Selected groups (always round down)	Care group number	Groups selected for sampling	Samples needed	Selected groups (always round down)	Care group number	Groups selected for sampling	Samples needed	Selected groups (always round down)	Care group number	Groups selected for sampling
1	1.00	1	X	1	1.00	1	X	1	1.00	1	X,X
2	2.38	2	X	2	2.10	2	X	2	1.83	2	X
3	3.75	3	X	3	3.20	3	X	3	2.65	3	X
4	5.13	4		4	4.30	4	X	4	3.48	4	X
5	6.50	5	X	5	5.40	5	X	5	4.30	5	X,X
6	7.88	6	X	6	6.50	6	X	6	5.13	6	X
7	9.26	7	X	7	7.61	7	X	7	5.95	7	X
8	10.63	8		8	8.71	8	X	8	6.78	8	X
9	12.01	9	X	9	9.81	9	X	9	7.61	9	X

Area A				Area B				Area C			
10	13.39	10	X	10	10.91	10	X	10	8.43	10	X,X
11	14.76	11		11	12.01	11		11	9.26	11	X
12	16.14	12	X	12	13.11	12	X	12	10.08	12	X
13	17.51	13	X	13	14.21	13	X	13	10.91	13	X
14	18.89	14	X	14	15.31	14	X	14	11.73	14	X
15	20.27	15		15	16.41	15	X	15	12.56	15	X,X
16	21.64	16	X	16	17.51	16	X	16	13.39	16	X
17	23.02	17	X	17	18.61	17	X	17	14.21	17	X
18	24.39	18	X	18	19.72	18	X	18	15.04	18	X
19	25.77	19		19	20.82	19	X	19	15.86	19	X,X
20	27.15	20	X	20	21.92	20	X	20	16.69	20	X
21	28.52	21	X	21	23.02	21	X	21	17.51	21	X
22	29.90	22		22	24.12	22		22	18.34	22	X
23	31.28	23	X	23	25.22	23	X	23	19.17	23	X
24	32.65	24	X	24	26.32	24	X	24	19.99	24	X,X
25	34.03	25	X	25	27.42	25	X	25	20.82	25	X
26	35.40	26		26	28.52	26	X	26	21.64	26	X
27	36.78	27	X	27	29.62	27	X	27	22.47	27	X
28	38.16	28	X	28	30.72	28	X	28	23.29	28	X
29	39.53	29	X	29	31.83	29	X	29	24.12	29	X
30	40.91	30		30	32.93	30	X	30	24.94	30	X
31	42.28	31	X	31	34.03	31	X	31	25.77		
32	43.66	32	X	32	35.13	32	X	32	26.60		
33	45.04	33		33	36.23	33		33	27.42		
34	46.41	34	X	34	37.33	34	X	34	28.25		
35	47.79	35	X	35	38.43	35	X	35	29.07		
36	49.17	36	X	36	39.53	36	X	36	29.90		
		37				37	X				
		38	X			38	X				
		39	X			39	X				
		40	X			40					
		41									
		42	X								
		43	X								
		44									
		45	X								
		46	X								
		47	X								
		48									
		49	X								
		50									

6. In each randomly chosen CG that was selected for one or more interviews, a random number is used to determine which Care Group Volunteers (CGVs) to interview. A list of the selected CGVs and all their Neighbor Women (NW) is then produced, and a random number is used to determine which NW to interview. If the first woman selected had a child under 6 months of age, then another random number is drawn until a mother with a child 6–23 months of age is selected. Table 4 illustrates a process for selecting women to be interviewed.

Table 4: Selecting Women to be Interviewed in the Randomly Selected CGs

CG number	Groups selected for sampling
1	X

Care Group 1	
CGVs	Random number
1	
2	
3	X
4	
5	
6	
7	
8	
9	
10	
11	
12	

CG 1 is selected for an interview. All the CGVs are listed. Because there are 12 CGVs, a random number between 1 and 12 is selected. In this example, CGV 3 is selected.

Care Group 3	
CGV and NW	Random number
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	X

CGV 3 is listed with all her NW. Because there are 13 NW, a random number between 1 and 13 is chosen. In this example, NW 13 is selected, and the CGV is chosen for the interview.

Conducting Interviews in the Field

1. Before the survey, set a protocol for the number of times you will return to find CGVs who are not at the meeting or NW who are not in their homes. Only after returning this set number of times unsuccessfully to interview this CGV or neighbor woman may you choose another CGV or neighbor woman. Also, a selection bias may be introduced if you only interview women from CGVs who come to the central meeting place or NW who are home from, for example, 12 to 5 pm.

2. Determine which CGs and CGVs are selected for interviews in each area. Then, call the selected CGVs and use their registers to choose the NW to interview by selecting another random number, which will determine the NW to interview. (Remember to assign the CGV a random number, as well, so she has as an equal a chance of being selected as her NW.) Then, have the CGV lead you to the randomly selected NW.

3. Interviews should be conducted by project personnel who do not directly supervise the work of the CG promoter, CGV or NW, but who fluently speak the language of the respondents. Enumerators may be hired, but, for example, FH usually switches CG project personnel from one project area to another.

4. It is important that the supervisor reviews the surveys before the team leaves the village where the interviews were conducted. Many errors can be caught and corrected if a review is done in the field.

For more on conducting LQAS surveys, including LQAS using parallel sampling please visit http://www.coregroup.org/our-technical-work/working-groups/monitoring-and-evaluation.

Appendix 10: Care Groups and Low Social Capital Settings: The Example of Curamericas in Guatemala[43]

Social capital has been conceptualized in diverse ways. Leading contemporary social epidemiologist Ichiro Kawachi defines social capital as "access to network-based resources such as trust, norms, and reciprocity exchanges"[44] and includes those features of social relationships—such as levels of interpersonal dependence and norms of mutual aid—that promote collective action for shared benefit.[45] An expanding literature base indicates that social capital plays an important role in community engagement across a variety of domains, ranging from individual health (e.g., social capital has been found to be associated with child nutritional status across four countries[46]) to community health status variables through mechanisms such as promoting healthful practices, providing health education and increasing responsibility for the well-being of others.[47] Although individual and community wellbeing must be contextualized within the broader political, historical, social and cultural milieu, the bonds and connectedness of people within a community facilitate the achievement of community health goals through mechanisms of trust, cooperation, connectedness and reciprocity. Social scientists know that communities that possess deep reserves of social capital can enhance the success of projects designed to empower vulnerable populations.

Field experience with Care Groups (CGs) suggests that high social capital is favorable for the success of the CG approach. Experience in post-conflict settings also has demonstrated that this can also be an advantageous outcome of the approach as CGs enhance the rebuilding of social capital in areas of social destruction and make communities more resilient against future challenges.

For example, the indigenous Mayan population in Guatemala is one such group with a history of social capital destroyed (and, in CGs project areas, rebuilt). The past century in Guatemala has been characterized by authoritarianism, violence and instability. Most recently, a 36-year long civil war, including unimaginable human rights violations, brought widespread physical and human destruction and resulted in lasting social fragmentation and a culture of deep mistrust. Four hundred and forty villages were completely annihilated, and close to 200,000 Mayan men, women and children were either massacred outright or thrown from helicopters into the Pacific Ocean. Many families lived for decades as refugees in northern Mexico, displaced from their traditional lands and homes. In the midst of violent raids, Mayan communities dispersed, social networks were fractured and trust was abolished. Community members were so traumatized by over 30 years of violence and displacement and as returning refugees that they did not trust

---

[43] This appendix was authored by Erin Pfeiffer (Food for the Hungry [FH], formerly Curamericas Global; epfeiffer@fh.org), Sarah Bauler (FH, formerly Samaritans Purse; sbauler@fh.org) and Mary DeCoster (FH, formerly Curamericas Global; mdecoster@fh.org).

[44] I. Kawachi, S.V. Subramanian and D. Kim. 2007. *Social Capital and Health*. Springer.

[45] I. Kawachi. 1999. Social Capital and Community Effects on Population and Individual Health. *Annals of the New York Academy of Science*, 896: 120–130.

[46] M.J. DeSilva and T. Harpham. 2007. Maternal social capital and child nutritional status in four developing countries. *Health and Place* 13: 341–355.

[47] S. Folland. 2007. Does "community social capital" contribute to population health? *Social Science Medicine* 64: 2342–2354.

their own neighbors and deeply feared outsiders. The experience of Curamericas Global and its implementing partner Curamericas/Guatemala in implementing CGs in this context of low social capital is shared to encourage and assist other implementers dealing with similar challenges.

Curamericas/Guatemala's first experience with CGs (2002–2007) was in a project area in three isolated municipalities of the highlands of Huehuetenango as part of a U.S. Agency for International Development (USAID)-funded child survival (CS) project. The area was so difficult to work in that several other nongovernmental organizations (NGOs) attempted to work in the project area but gave up and left the area after persistent rejection from the communities. Even attempts to deliver food and basic medical aid were refused out of distrust.

Curamericas/Guatemala aimed to use the CG approach to empower women and rebuild the social connectedness that had disintegrated. The lack of trust made it extremely difficult to recruit Care Group Volunteers (CGVs). Field staff noted that men frequently prohibited their wives from participating under the assumption that no good thing could come from meeting with outsiders. Projections were to recruit 400 CGVs, but there was continued resistance even when the women themselves began to express interest. The project director took care to hire staff who spoke the local Mayan languages and, when possible, to hire from within the project area, which helped tremendously in gaining trust. By the end of the project, there were over 300 active groups, each lead by a CGV.

As time went by, trust increased through meetings and community mobilization. The CGVs held meetings with the Neighbor Women (NW) in their group and made home visits. Many of the groups are still active and still meet the needs of new mothers for information and support. Mothers interviewed in focus group discussions stated, "This is great help for us. It is hard to get to the health post. They [CGVs] come to visit us and now we know them and trust them." Two years later, by the project's midterm evaluation, there was a "growing trust and confidence" among the communities. Project staff stated, "Currently the Care Groups are formed. One of the strengths that we have with them is that in the community there are now women leaders." As the project came to an end, there was a visible sense of enthusiasm and an impressive mobilization of women, even in the most unapproachable communities. Much of this interest and involvement can be directly linked to the use of the CG networks.

The breakthrough in community trust through CGs was tremendous, but the process was slow and arduous. Curamericas/Guatemala is currently starting up another CS project including the CG approach and now knows to expect that building social capital can take time and patience. Some communities responded more quickly than others. The different degree of trust and experience with community-based activities in the three project municipalities in the past showed that it takes time to earn trust and reach the point where most community members accept services and participate.

The Guatemala experience using CGs led to several lessons learned. General conditions that favor CG implementation include:

- A socially cohesive community: that is, a community that is reasonably stable, has established mechanisms for social support and problem resolution, and has a commonly shared culture and language

- A population that is relatively stable, with minimum and/or predictable migration patterns

Conditions that make CG implementation more difficult to introduce are when:

- A community is unstable due to severe social, political or economic disruption
- Social cohesiveness has been destroyed, social capital is low and a culture of reciprocal trust is lacking

To overcome challenging conditions of low social capital, Curamericas/Guatemala used the following steps for building social trust and cohesiveness.

1. Develop a relationship between the health program and the potential intended area population through a series of meetings, discussions and visits between project staff and traditional and formal community leaders (CLs). Mutual trust and confidence are prerequisites for progress, and this is best gained through patient, respectful dialog at the pace of the CLs.

2. During the early, exploratory meetings, guard against raising false expectations, which may lead to long-term negative consequences between the program and communities. An ongoing, candid self-appraisal of what CGs can offer the communities, together with a clearly positive response to this question from key community representatives, will be essential for further program development.

3. One means to develop good working relationships, particularly if the implementing entity is external to the communities in which it intends to work, is to identify a high community perceived priority health need that can be addressed using CGs and to agree to carry out this work mutually until measurable success is achieved. This activity should further develop the relationship of trust between health program staff and community members.

4. Be sure staff members are prepared to give clear and consistent messages about the purpose and design of the CG project (see **Lesson 18: Introducing the Care Group Approach to Others**).

The post-conflict context of Guatemala was a major effort, particularly in light of the isolation and difficult terrain of the project area and the initial distrust and suspicion encountered in the communities. However the CG model demonstrated itself as an effective approach to building social cohesiveness. Now people know and trust their neighbors and project staff more, and there are active village health committees. Although it is a more difficult outcome to measure, this is a clearly valuable result—not just reductions in child malnutrition and death, but the fact that CGs appeared to be very successful in rebuilding the social capital lost in this area.

Finally, the impact of increased social capital appeared to improve the community's resilience in coming together to deal with a variety of challenges and natural disasters, as communities continue to mobilize themselves to form local committees and advocate for local government resources and the groups continue to meet and support new mothers long after the CS project ended.

Building resilience by strengthening social capital as a mechanism to improve post-disaster recovery also is strongly supported by recent research findings. Daniel Aldrich[48], a researcher from Purdue University, studied four disasters in developed and developing countries over the last 100 years and found that social capital is the greatest predictor of resilient disaster recovery. These findings contradict commonly believed theories that increasing levels of aid and rebuilding physical infrastructure are the most critical factors in the recovery process. In other words, Aldrich's research found that rebuilding social infrastructure was much more important than rebuilding the physical infrastructure in post-disaster and population recovery.

The CGV mobilization strategy rebuilds social infrastructure by strengthening social capital bonds between family and friends and across different religious and ethnic groups and by linking marginalized mothers with people in power by giving them a stronger voice with local decision-makers. The CG structure also mobilizes "collective action" to overcome barriers and obstacles to good maternal and child health services and behaviors. Collective action also was found to be strongly associated with higher levels of trust and deeper social networks. The effect of the CG approach on rebuilding social capital has tremendous potential and should be measured and studied in the future, not only as a mechanism to improve post-disaster recovery but also as a protective measure to mitigate against disasters in the future.

[48] D. Aldrich. 2012. *Building resilience: Social capital in post-disaster recovery.*