ZIMBABWE CARE GROUPS TRAINING MANUAL 2021

Care Groups: A Training Manual for Program Design and Implementation was first 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 Behavioural Change Task Force (SBCTF) and by World Relief (WR). The Government of Zimbabwe through the Ministry of Health and Child Care further adapted and adopted the Care Group model as the model of choice for health and nutrition social and behavioural communication change.

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List Of Abbreviations

AEW	Agricultural Extension Worker
AGRITEX	Agriculture Technical and Extension Services
ANC	Antenatal Care
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
CCW	Community Case Care Worker
CDC	Community Development Coordinator
CGLs	Care Group Leaders
CGM	Care Group Model
CTDO	Community Technical Development Organisation
DAEO	District Agriculture and Extension Officer
DCP	Dialogue Counselling Process
DDC	District Development Coordinator
DDO	District Development Officer
DEHO	District Environmental Health Officer
DFNSC	District Food and Nutrition Security Committee
DHPO	District Health Promotion Officer
DNO	District Nursing Officer
DRT	District Remedial Tutor
DSWO	District Social Welfare Officer
ECD	Early Childhood Development
EHT	Environmental Health Technician
EMTCT	Elimination of Mother To Child Transmission
EPI	Expanded Program for Immunisation
FAO	Food and Agriculture Organisation
FH	Food for the Hungry
FNSCs	Food and Nutrition Security Committees
FSN	Food Security and Nutrition Network
GBV	Gender Based Violence
HCC	Health Centre Committee
HDDS	Household Dietary Diversity Score
HH	Household Handbook
HIV	Human Immuno-deficiency Virus
HPV	Information Education Communication
IMAM	Integrated Management for Acute Malnutrition
IMC	International Medical Corps
IMNCI	Integrated Management of Neonatal and Childhood Illness
ISAL	Internal Savings and Lending groups
IYCF	Infant and Young Child Feeding
LFSP	Livelihoods and Food Security Programme
LIST	Lives Saved Tools
LLINs	Long Lasting Insecticidal Nets
LM	Lead Mother
LMICs	Low Medium Income Countries
MANA	Multi-sectoral Approach towards Nutrition Adaptation
MDD	Minimum Dietary Diversity

MICS	Multiple Indicator Cluster Survey
MIYCN	Maternal Infant and Young Child Nutrition
MNCAHN	Maternal New-born Child Adolescent Health and Nutrition
MNCH	Maternal Neonatal Child Health
MOHCC	Ministry of Health and Child Care
MUAC	Mid Upper Arm Circumference
NGO	Non-Governmental Organisation
NSBCC	Nutrition Social and Behaviour Change Communication
OVC	Orphans and Vulnerable Children
PDC	Provincial Development Coordinator
PFNSC	Provincial Food and Nutrition Security Committee
PHE	Provincial Health Executive
PNC	Postnatal Care
POTRAZ	Postal and Telecommunications Regulatory Authority of Zimbabwe
PPPs	Private Public Partnerships
PS	Permanent Secretary
QIVC	Quality Improvement Verification Checklist
SBCC	Social and Behaviour Change Communication
SMS	Short Message Services
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VFNSC	Village Food and Nutrition Security Committee
VIDCO	Village Development Committee
WADCO	Ward Development Committee
WASH	Water and Sanitation Hygiene
WFNSC	Ward Food and Nutrition Security Committee
WFP	World Food Program
WHO	World Health Organisation
WHH	Welthungerhilfer
WNC	Ward Nutrition Coordinator
WR	World Relief
YDO	Youth and Development Officer
YO	Youth Officer
ZDHS	Zimbabwe Demographic Health Survey
ZIMVAC	Zimbabwe Vulnerability Assessment Committee
ZMNS	Zimbabwe Micronutrient Survey
ZNNS	Zimbabwe National Nutrition Survey

Introduction

The Care Group approach (CG) is a community-based strategy for promoting behaviour change. Dr. Pieter Ernst and World Relief/Mozambique developed the Care Group approach in 1995. Since then, WR and Food for the Hungry (FH) have pioneered and championed the approach. A CG is a group of 10–15 community-based volunteers that regularly meet together with project staff for training and supportive supervision. CGs creates a multiplying effect and equitably reaches every beneficiary household through neighbour-to-neighbour peer support using interpersonal behaviour change activities. Behaviour change is enhanced through peer support, resulting in the creation of new community norms. Care Group Volunteers 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 provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits.

Overview of the Care Group Model

According to Perry et al (2015), the Care Group approach is a delivery strategy for expanding coverage of maternal and child health intervention. The main goal of this community-based strategy was to improve behaviour change in a large population while maintaining low cost and sustainability. (Peace Corps Benin, 2010). As was noted by George et al, (2014), during a study on evaluation of the effectiveness of Care Groups in expanding population coverage of key child survival interventions and reducing under-5 mortality, it found out that Care Group projects had significantly greater increases in coverage for all key interventions, where data was available. As such, Care Groups have since been implemented and adapted in 27 countries by various international development organizations. (USAID, 2015).

The original Care Group training manual was developed in the context of normalcy, without factoring in the emergency setups such as Covid-19 and natural disasters. However, due to high prevalence of such emergencies, particularly the Covid-19 pandemic, the current implementation of the model in Zimbabwe shall factor in the World Health Organisation (WHO) and Ministry of Health and Child Care (MOHCC) Covid-19 regulations such as social distancing, masking up all the time, hand washing and limited groupings. The lead mothers and Promoters shall use the information and communication technology (ICT) under such emergencies to reach out to the Care Group participants. Examples of such technologies will involve the use of WhatsApp application, nutrition application, audio podcasts, video and sms/messages to share the promoted health and nutrition behaviours to the Care Group participants. Home visits shall be conducted with strict following of the prevailing Covid-19 regulations. All Care Group participants shall be encouraged to be vaccinated and Covid-19 education mainstreamed throughout all activities in the Care Groups. Lead mothers and Promoters shall always be watchful of any signs and symptoms of Covid-19 amongst their groups and advise accordingly.

Specific objectives of the 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.

In view of the above, it is anticipated that by the end of this training, participants will have:
- Analysed 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

Care Group model Training of Trainers programme: A 4-day training schedule

Day 1
Session 1: Introductions, pre-assessment, group norms, expectations and objectives Morning break **Session 2:** Introduction Care Groups Lunch **Session 3:** Care Group criteria Afternoon break **Session 4:** Using formative research to strengthen Care Groups End of day evaluation
Day 2
Previous day review **Session 5:** Organising communities into Care Groups and the numbering system Morning break **Session 6:** Care Group roles, responsibilities and job description Lunch **Session 7:** Volunteer motivation and incentives Afternoon break **Session 8:** Behaviour change and Care Groups: (what happens in a Care Group meeting, neighbour group meeting and home visits) End of day evaluation
Day 3
Previous day review **Session 9:** Home visits: the audience, timing and context Lunch **Session 10:** Supportive supervision and checklists End of day evaluation
Day 4
Previous day review **Session 11:** Care Group information monitoring system: (coordinator, supervisor, promoter, lead mother reports) Morning break **Session 11:** Care Group information monitoring system: (coordinator, supervisor, promoter, lead mother reports) cont... Lunch End of day evaluation

SESSION 1: INTRODUCTIONS, PRE-ASSESSMENT, GROUP NORMS, EXPECTATIONS AND OBJECTIVES

Objectives of this session

By the end of this session participants will have:
- Discussed training expectations and objectives
- Begun to learn about the background and experience of others in the training
- Completed the pre-assessment

Training methodology
Interactive presentation
Written pre assessment
Duration: 2 hours

Materials Needed
- Attendance sheet
- Name tags for each participant, stick stuff, markers, flip charts and stand
- Pre-/Post-Test
- Course time table

Introductions, group norms, expectations and objectives of the training
In this session the facilitator will welcome the participants and they will introduce themselves to each other. The purpose of the training and their role during the program will be explained.

- The facilitator explains that the success of the project depends on people changing their behaviours and the need to use effective behaviour change activities.
- One of the most effective behaviour change activities is the Care Group (CG) approach.
- The Care Group approach has been adopted by several organizations to promote healthy behaviours, particularly those behaviours associated with reducing morbidity and mortality amongst children due to malnutrition.
- The main objective of the workshop is to learn about the Care Group approach and how it is implemented.
- The Facilitator writes expectations on flipchart.
- The Facilitator asks Participants to brainstorm Group Norms; lists on flipchart and the list should remain posted throughout the training.
- The Facilitator introduces the training objectives including the main objective of each session that has been previously written on a flipchart, and compares them with the expectations of the Participants.
- The Expectations and objectives should remain in view during the course of the training.

Collecting Baseline Information from the Participants
The facilitator: Explain that before the workshop begin, we would like to collect some data using a pre-test to assess the effectiveness of the workshop at the end of the course. The pre-test should be completed individually.

Activity
- Pass out the pre-test.
- Give participants sufficient time to complete the pre-test, and 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.

Lesson 1 handout 1: Care Group approach training objectives

Achievement-Based Objectives

By the end of this training, participants will have:

- Analysed 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

SESSION 2: INTRODUCTION TO CARE GROUP MODEL

Objectives of the session

By the end of the training participants will have discussed the:
- Effectiveness of Care Groups
- Structure of the Care Groups

Duration: 2 hours

Materials
- Flip charts, index cards, markers, projector and laptop to play the Care Group video
- Hand-outs
- Care Group difference manual

Methodology
- Interactive presentation
- Group discussion

Activity 1
The facilitator tells participants that the main objective of this training is to help them understand Care Groups and how to implement the Care Group approach.

The facilitator asks participants the following questions:
- How many of them have already had experience working on a project that used the Care Group approach?
- How many of them have read or heard about the approach before?
- What are Care Groups?
- What have they heard about Care Groups?
- How effective are Care Groups? (This question is relevant if only participants have prior knowledge to Care Groups)
- Why do Care Groups focus on the first 1000days?
- Why do Care Groups focus on the household behaviours?
- 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 behaviour 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.
- To date since 2011, the Care Group model has been implemented at varying degrees in 24 out of 64 districts within 6 of the 10 provinces, in Zimbabwe after realising the successes in Mozambique where there was a decrease in malnutrition cases among 0-23 children in areas where the Care Group was being implemented.
- 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 neighbours, sharing what she has learned and facilitating behaviour change at the household level.
- CGs creates a multiplying effect and equitably reaches every beneficiary household through neighbour-to-neighbour peer support using interpersonal behaviour change activities. Behaviour 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 provides the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits.

The Care Group Approach and Structure

- The facilitator refers participants to Care Group key terms that will be used throughout the training.
- Using index cards of different colours, sizes and shapes, create a diagram of a typical CG structure on the wall in the front of the room that follows the Care Group diagram structure.
- As you place the cards, say the name of each staff member/volunteer and his/her main role. Engage participants who have prior experience/knowledge of the approach. Emphasize that CGs are a behaviour change activity. Be sure to point out which people are typically paid staffs and which are volunteers.
- After explaining the staffing structure of the CG approach, briefly explain the main responsibilities of each person, including training, supervision, behaviour change meetings with Promoters, lead mothers, Neighbour Women, men, elderly women and adolescents.
- 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 session, defer discussion of those points until later.

Activity 2: Care Group calculation game

- Divide participants into pairs. Ask each pair to calculate how many mothers they would reach given the different scenarios listed in hand-out 2.

Activity 3: Alternative Care Group Diagram

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

How effective are Care Groups (Optional)

Share success stories of other areas where Care Group model has been implemented in Zimbabwe and other Countries as shown in Session 2: Hand-out 3: Care Group efficacy

Activity 4: Why do some Care Groups focus on the first 1,000 days?

The facilitator tells participants that some Care Groups focus on the first 1000days that is pregnant women and mothers of children under 2. In some areas Care Groups extend to care givers of children under the age of five and women of child bearing age 15-49years.

The facilitator asks participants: Why they think it would be important to focus on the first 1000days?
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.

- 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 over 2, the consequences of under nutrition are particularly severe and often irreversible.
- During pregnancy, under nutrition 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, under nutrition 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, diarrhoea and malaria.

Show and explain to participants the graph on under nutrition found indicating that under nutrition happens early. Note to participants that this graph dramatically illustrates the importance of early childhood nutrition.

Activity 5: Why do Care Groups focus on household behaviours?
In their small groups give participants copies of Session 2: Hand out 5: Causes of deaths in under 5s , ask participants to spend 10 minutes looking at the diagram and discussing what it means. After 10 minutes, request a volunteer to share ONE group's interpretation.

Highlight 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 behaviour change, including behaviours
- related to breastfeeding;
- using insecticide-treated material;
- complementary feeding;
- clean delivery;
- water, sanitation and hygiene (WASH);
- new-born temperature management;
- consuming zinc, vitamin A and oral rehydration solution (ORS).

Ask participants to share questions they have about why Care Groups focus on the first 1,000 days and household behaviour change.

Wrap Up and thank the group for their comments. 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.

Session 2: Hand out 1: Care Group 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 Neighbour Women (NW)
Promoter	A community member, identified and volunteers 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
Neighbour group	A group of 10–15 women that meets with the selected CGV The CGV shares new health session s with them every 2 weeks as a group or individually (through home visits)
Neighbour women	Women in the NG who meet with the CGV once every 2 weeks to hear a new health session
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 verification check-list (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"

Session 2: Care Group calculation 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

Solution to the Care Group calculation 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

Session 2: Hand-out 3: Care Group efficacy

Table 1: Programmes and organisation that have implemented the CG model in Zimbabwe since 2011

Programme/ Organisation	Period of implementation
Amalima	2011
Ensure	2014
CARE	2018
LFSP-ENTERPRIZE	2014
LFSP-INSPIRE	2018
LFSP-EXTRA	2018
NAZ	2018
CARITAS	2019

Table 2: LFSP APN Nutrition rapid assessment survey

Child survival indicator coverage changes	District averages	National averages
Minimum Dietary Diversity	45,3	15,2
Household Dietary Diversity	44,1	23,8

MAD was 53, 4% for Care Group participants compared to 35, 8% for non-Care Group participants.
NB: data from 12 districts where the LFSP APN programme was being implemented since 2018

Table 3: An evaluation of the effectiveness of the Care Group Approach in addressing key drivers of stunting within the first 1000days

Child survival indicator coverage changes	District averages	National averages
Minimum Acceptable Diet	26,4	6,9
Minimum Dietary Diversity	33,3	15,2
Minimum Meal Frequency	70,3	52,8

(NAZ, 2020)

Table 4: AMALIMA care-group experience

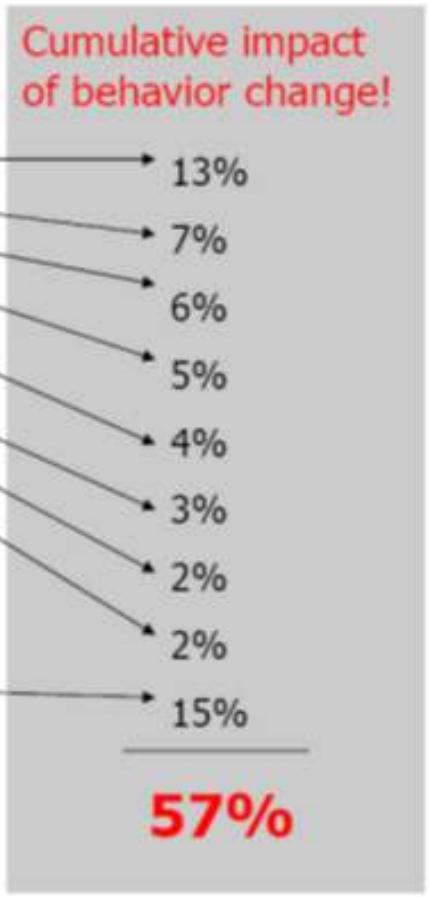
Indicator	Baseline (2014)	End line (2020)
Stunting	31,7%	24,5%
Exclusive Breastfeeding	44,9%	75,3%
Underweight	14,6%	6,5%

The Amalima programme showed improvements in consumption of the three non-staple groups in the “four-star diets” promoted by the Care Groups namely vegetables and fruits (33%), legumes (29%) and animal source foods (59%).

Session 2: Hand out 5: Causes of deaths in under 5s

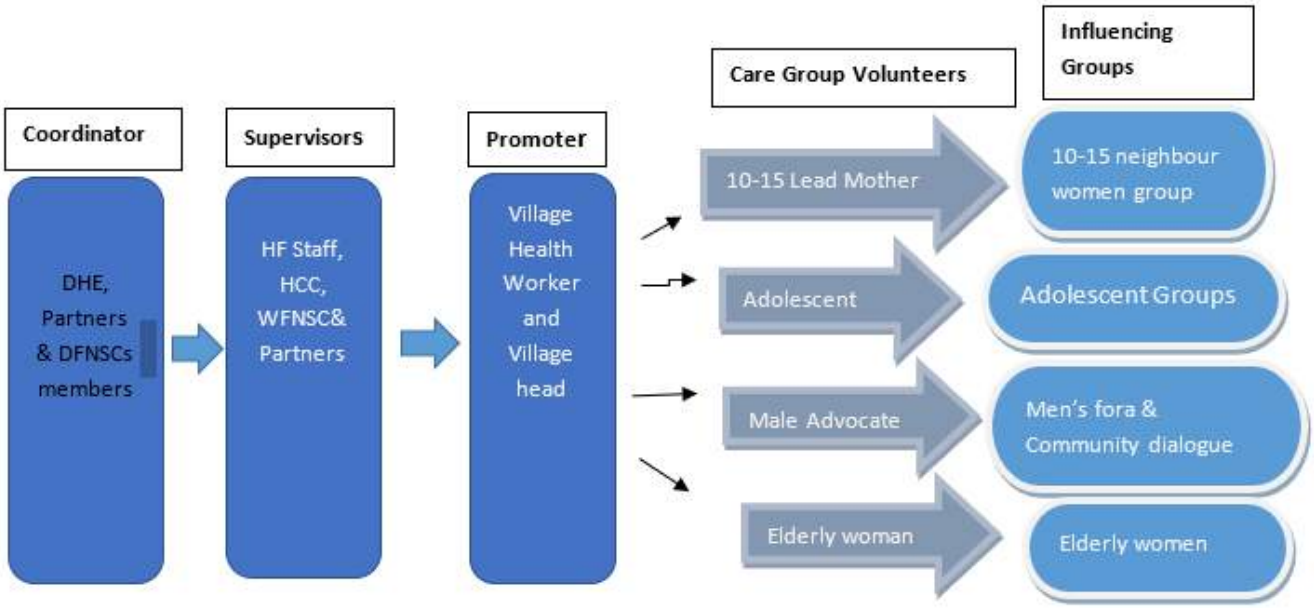
Table 2: **Under-5 deaths that could be prevented in the 42 countries with 90% of worldwide child deaths in 2000 through**

	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%



- The diagram shows the proportion of all deaths of children below the age of 5 that could be prevented with a specific intervention.
- 57% of under-5 deaths could have been prevented with interventions that rely on household behaviour change, including breastfeeding; insecticide-treated material; complementary feeding; zinc supplementation; clean delivery; water, sanitation and hygiene (WASH); new-born 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.

Session 2: Hand out 6: Care Group structure adopted in Zimbabwe



SESSION 3: CARE GROUP CRITERIA

Objectives of the session

By the end of the training 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

Methodology:
- Interactive presentation
- Group work

Introduction
Tell participants: Now that they have learned the structure of the Care Group approach and become familiar with the terms associated with the Care Group model, they need to look more carefully at what distinguishes the Care Group approach from other behaviour change models that might, at first glance, seem to be the same.
Ask participants: Which other models have they encountered 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.
Explain to participants that though the 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 session we are going to identify those critical Criteria and their importance.

Activity:
- Give each participant Session 3 hand out 1 with criteria for establishing the Care Groups – Blank
- Place participants into small groups of 5. Assign each group 3-5 characteristics to review
- Each group should complete 'Why is this important?' for their assigned criteria.
- In groups the participants should spend time discussing how their characteristic makes their CG program more effective and other reasons the characteristic might be important.
- They should note their response in Column 'why is this important?'.
- Give each group 10 minutes per characteristic to complete this.
- Once everyone has completed their group work, discuss each characteristic one by one as a full group.
- Have each group report on their group's findings.
- As the facilitator, offer some ideas from the 'Facilitator Notes: CG Characteristics' if the group doesn't mention these ideas on their own.

Session 3: Hand out 1 on criteria for establishing Care Groups

Criteria	Why is it important?
The intended group ideally should be all women of reproductive age (WRA), or at least pregnant women and mothers of young children.	
The plan is to reach 100% of households in the intended group (and attain at least 80% monthly attendance).	
Each CG should not exceed 15 volunteers.	
Care Group Volunteers (CGVs) should have responsibility for no more than 15 households (with Neighbour Women [NW]).	
When possible, CGVs should be chosen by the mothers in their groups.	
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.	
Each Promoter should be responsible for no more than nine CGs.	
Promoters will supervise at least one CGV from each CG per month (preferably one CGV from each CG every 2 weeks).	
The amount of CGV contact with their assigned beneficiary mothers and CG meeting frequency should be at least once per month, preferably twice monthly.	
CGVs use visual teaching tools such as flip charts to promote health and nutrition in each household.	
CGVs use participatory learning methods in a non-formal educational setting to conduct health promotion at each household.	
CGVs will collect information on pregnancies, births and deaths at each household and report it to the Promoters.	
Formative research should be used to help intended behaviour change communication activities.	
The workload of a CGV is limited to No more than 15 households per volunteer.	

Establishing Care Group criteria: Facilitators notes

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 mortality and morbidity, 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 behaviour, 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. According to the World Relief (WR) CG manual, "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. Behaviour change becomes more than an individual decision—it becomes a social movement involving the entire community."

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 not exceed 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, 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 Neighbour Women [NW])**

Why is this important?
CGVs are volunteers and must be able to sustain the activities required by the program. Many practitioners find it works better with an even lower maximum number of households; 10–12 households seem to be the right size for many CGVs. CGVs should 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, CGVs need to invest in the people that they meet and have time and energy to get involved in the lives of those they visit. Based on previous research, 16 households are too many for CGVs to handle hence it is suggestive to have 10–15 households per CGV. If this number is exceeded, the quality of CGVs to interact is greatly reduces and, the more households are added, 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. CGVs should not be overburdened 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?
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 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 neighbour to discuss sensitive topics is more effective than using an outsider. Chosen CGVs probably do not already practice the behaviours we want them to. It is the Promoter's responsibility to help CGVs change their own behaviour.

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 behaviour.

If the CGVs have made changes in their own lives that their neighbours witness, they will be much more effective at supporting behaviour change than those who do not "practice what they preach".

It is very important that project staff and volunteers try out the behaviours first and believe in their value so they can be good role models for NW. Once CGVs are convinced that the changed behaviour 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 behaviour the more likely they will change their own behaviour.

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 18-45, or three CGs (assuming a CG size of 6–15 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 three 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 being a volunteer who has three CGs that meet every 2 weeks. That is 3 group meetings × 2 contacts every 2 weeks = 6 sessions per month. Suppose that each CG session takes about a ½ day, including travel time. This equals 3 total work days and leaves the promoter with time to do their own household chores and some days for report writing, biweekly meetings with Supervisors, supportive supervision visits with CGVs, and any meetings with local leaders, health centre staff and village health committees.

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 Care Group volunteers (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.**

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 neighbours. The better the relationship between CGVs and NW, the greater the behaviour 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 sessions and facilitates greater encouragement and monitoring of activities.

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 behaviour 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. In practice, some NW always meet in groups, with the CGV only provides home visits to those who miss the group meeting. Some projects only provide home visits. But we recommend both, though we realize it may be necessary to adapt to local situations and sensitivities. Regular meetings help to build community ownership of the groups after the program funding has ended.

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

Why is this important?
Counselling cards and 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 behaviours. CGVs help household members interact with the learning through discussion, drawing, writing, and 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 behaviours 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.

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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 ecessary
- Help CGVs link health practices or environmental factors to effects on health and disease•
- Identify actions CGVs can take in the future, based on session s learned from the discussion

13. Formative research should be used to help intended behaviour 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 behaviours of interest. More systematic use of formative research on behaviours will lead to the best adoption rates. Formative research also helps assure that the behaviours 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 6-12 households' works better, in the experience of many practitioners. Care should be taken not to overload a CGV. She has other personal work to do, and if her CG responsibilities are overwhelming, she may have to resign.

SESSION 4: USING FORMATIVE RESEARCH TO STRENGTHEN CARE GROUPS

By the end of this session participants will have:
- Defined “formative research”
- Heard/read a description of Barrier Analysis (BA), including a list of the 12 determinants of behaviour change
- Identified ways that formative research could be used in a Care Group (CG) approach to improve behaviour change

Duration 1 hour 30 minutes

Methodology
- Interactive presentation
- Group discussion

Introduction
- Inform participants that the main objective of this session is to help them understand how to use the results of formative research to improve the chances that Neighbour Women (NW) will adopt new behaviours.

Ask participants the following question:
- How many 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 approaches?
- What type of formative research they used?
- Ask participants what they know about formative research?
- 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 behaviour change.

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.

Formative Research using a Barrier Analysis
- Explain that this session and the CG approach primarily will use a research method called Barrier Analysis, or BA. Ask how many participants are familiar with this method
- Inform participants: To “even the playing field” for people who are not familiar with Barrier Analysis, we will reference a short description of the approach.
- Distribute Session 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.
- Distribute Session 4 Handout 2: The Twelve Determinants of Behaviour Change. Explain that the BA survey identifies which of the 12 determinants is more critical to changing the behaviour. Since many of the determinants are barriers, they are considered obstacles to behaviour change.
- 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.
- 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 behaviour.

Activity: Using Barrier Analysis Results in the Care Group Model

- 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 behaviour change.
- 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.

Activity: Practice Using Formative Research

- Divide participants into pairs. Give each pair an index card with a behaviour statement on it along with a determinant (or explanation of a formative research result).
- Examples of behaviour statements and related determinants can be found Session 4 Hand-out 3: Example Behaviour Statements and Determinants.
- Each pair of participants should discuss the meaning of the research and propose how they would address the findings listed on the card.
- Pairs will then share their ideas with other pairs at their table. Ask a few pairs to share their suggestions with the entire group.
- Wrap Up
- 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.

Session 4 Hand-out 1: Barrier Analysis Description

Purpose

- Barrier Analysis12 (BA) is a rapid assessment tool that can help organizations identify why a promoted behaviour 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 behaviour change in food security, child survival and other community development programs. It can also be used in an on-going program to determine how to improve the promotion of specific behaviours that continue to show low adoption rates.

Details of Use Overview

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

Lesson 4 Handout 2: The Twelve Determinants of Behaviour 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 behaviours.

1. Perceived positive consequences: what positive things a person thinks will happen, as a result of doing behaviour. Responses to questions related to positive consequences may reveal advantages (benefits) of the behaviour, attitudes about the behaviour and perceived positive attributes of the behaviour.
2. Perceived negative consequences: what negative things a person thinks will happen as a result of doing the behaviour. Responses to questions related to negative consequences may reveal disadvantages of the behaviour, attitudes about the behaviour and perceived negative attributes of the behaviour.
3. Perceived social norms: the individual's perceptions that people important to him/her think that he/she should do the behaviour. 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 behaviour, given his/her current knowledge and skills, or the set of knowledge, skills or abilities necessary to perform a particular behaviour.
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5. Access: the degree of availability (to a particular audience) of the needed products (e.g., fertilizer, insecticide-treated bed nets [ITNs], condoms) or services (e.g., veterinary services, immunization posts) required to adopt a given behaviour. 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 behaviour and an individual's perception that he/she can remember how to do the behaviour. This also includes key powerful events that triggered a behaviour 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 behaviour 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 behaviour one will avoid the problem or that the behaviour 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 much behaviour (particularly for health and nutrition behaviours).
11. Policy: laws and regulations that affect behaviours 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

Session 4 Hand-out 3

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.

There are seven steps in developing a BA:

1. Define the goal, behaviour and intended group
2. Develop the behaviour question
3. Develop questions about determinants and pre-test questionnaire
4. Organize the data collection
5. Collect field data for BA
6. Organize and analyse 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.

Level of skill needed. The tool is meant for use by project management staff and community-level implementers. Past experience with social and behaviour 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 downloaded13). 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 Behaviour Change training. If you have a team of 10 people available to carry out BA, the data collection for each behaviour 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 analyse more behaviours in the same amount of time.

Common constraints/difficulties

The BA cannot be used on behaviours 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 behaviour 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 behaviour. There are many different determinants of behaviours that should be explored when putting together a behaviour change plan.

- “Powerful to Change Analysis14” was conducted by the CORE Group Social &Behaviour Change Working Group (SBCWG) in order to compare those projects that successfully boosted behaviour 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 behaviour 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 Behaviour Change manual (available on the Food Security and Nutrition Network website) includes these modifications. BA should be useful to better understand all types of behaviour at the community level, including behaviours related to value chains. It has been applied in both developing and industrialized countries.

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SESSION 5: ORGANIZING COMMUNITIES INTO CARE GROUPS AND THE NUMBERING SYSTEM

Objectives

- Identified three different ways to identify the intended participants for Care Groups (CGs) and Neighbour 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

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

Introduction

- 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 Neighbour 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.
- Ask participants: Who is the priority group for your project?
- 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 less than 2 years of age.
- Priorities When Organizing Care Groups and Neighbour Groups
- The facilitator informs 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 Neighbour Women (NW) live close together.
- Ask participants: Why is this important? Why do we need Care Group Volunteers and Neighbour 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 behaviour 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.
- 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.
- 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.

- 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 behaviour change, it is important that many mothers adopt the new practices being promoted.
- Behaviour 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.

Three Approaches to Forming Care Groups

- 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
- Briefly explain to participants each method as follows. More information can be found in Session 5Hand-out 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
- To decide which approach is best for their program there are some key questions participants need to consider. Display Session 5Hand-out 2: Key Questions for Forming Care Groups and have a participant fill in the answers as you discuss the key questions.
- Note that in many settings where pregnancy is concealed until it is obvious, it may be difficult to enrol pregnant women through this CG approach. This is one reason why some organizations, including World Relief (WR), prefer to simply enrol all women of childbearing age.
- Ask participants: What if a locality doesn't have enough (neighbour) women that are eligible to participate in the CG program to form a group with 6–15 women?
- Inform participants: If there are not enough women to form a Neighbour 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 Neighbour Women could be shifted around to make groups closer to the idea group size.
- 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.

Activity: Practicing Forming Neighbour Groups and Care Groups

- Refer the participants to Session 5Hand-out 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.
- Working in pairs, have participants formed the WRA or PLW into NGs of 6–15 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.
- When all the pairs have finished go around the room and ask how many NGs were formed and how many CGs.

Monitoring Care Group Volunteers, Neighbour Women, Care Groups and Promoters

- Inform participants: Now that we have formed women of reproductive age or pregnant and lactating women into Neighbour Groups and Care Groups, we need to create a way to monitor the program activities.
- 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.
- Show participants Session 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 neighbour 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 has 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 one to two CGs, but no more than three. Therefore, the second digit should range from 1 to 3, depending on the project design.
- For example, if Promoter 2 has three CGs, his/her CGs would be numbered 2.1, 2.2, 2.3.
- 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 6–15 CGVs. Therefore, the third digit should range from A through O, depending on the project design.
  - For example, in CG 1, supported by Promoter 3, there are 12 CGVs.
  - They would be numbered 3.1.A, 3.1.B, 3.1.C, 3.1.D, 3.1.E, 3.1.F, 3.1.G, 3.1.H, 3.1.I and 3.1.J.
- The final, fourth digit is a number and stands for the Neighbour 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 2, supported by Promoter 1, meets with eight NW.
- They would be numbered 1.2.F.1, 1.2.F.2, 1.2.F.3, 1.2.F.4, 1.2.F.5, 1.2.F.6, 1.2.F.7 and 1.2.F.8.

Activity: Numbering: Check for Understanding

- Display Session 5 Flip Chart 2: Number System Practice Codes and ask participants to work in pairs to state what each code indicates.
- Once finished, ask pairs to share their answers with the larger group. Check answers against the Answer Key to Session 5 Flip Chart 2: Number System Practice Codes
- 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.

Activity: Fun with Numbers

- Using Session 5 Hand-out 4: Numbers for the Numbering Game, make index cards by writing one number per index card and colour-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.
- Start by asking Promoter 3 (i.e., whoever received the Promoter paper) to come to the front of the room.
- 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).
- 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).
- 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.

Wrap Up

- Wrap up this session 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.
- What are two things that need to be considered when forming your Care Groups and Neighbour Groups? They should answer proximity of CGVs to NW and making sure that at least 80% of the intended population is reached.
- For which groups/people do we create a numbering code? They should answer Promoters, CGs, CGVs and NW.
- Why do we need to create number codes for these people/groups? They should answer to more easily track the activities of each group.

Session 5 Hand-outs 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 neighbourhoods 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 neighbourhoods well and can create a map of their neighbourhoods
3. After the map is created, we then need to add details and identify houses, neighbourhood 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 Neighbour 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 session.
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.

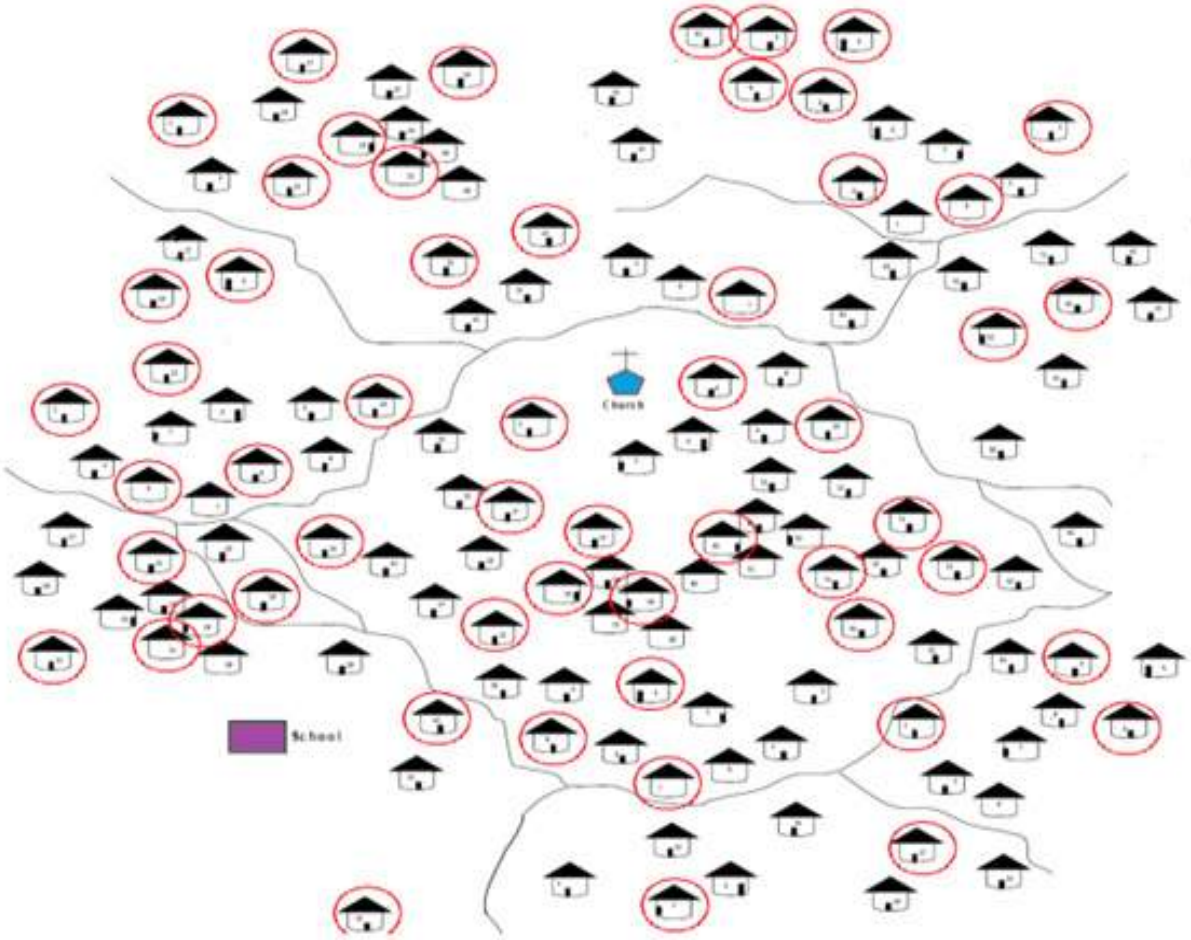
Approach 3: Community Gatherings to Create Care Groups

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 neighbourhoods, then into smaller groups

Hand-out 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?
- Are there any vulnerable groups/ or disabled people who may be interested in joining the Care Group?

Handout 3: Community map



Flip Chart 1: Care Group Numbering System

7. 1. A. 1
7 = Promoter number
1 = Care Group number
A = Care Group Volunteer number
1 = Neighbour woman number

Flip Chart 2: Numbering System Practice Codes

37. 2. C. 3
5. 1. D. 6
17.3. A. 10
20. 1. J. 4
9. 1.H.7

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

37. 2. C. 3 = 37th Promoter, 2nd CG, CGV “C”, 3rd NW
5. 1. D. 6 = 5th Promoter, 1st CG, CGV “D”, 6th NW
17. 3. A. = 17th Promoter, 3rd CG, CGV “A”, 10th NW
20. 1. J. 4 = 20th Promoter, 1st CG, CGV “J”, 4th NW
9. 1. H. 7 = 9th Promoter, 1st CG, CGV “H”, 7th NW

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

Hand-out 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.

NB: In case of Zimbabwe, each promoter should have only 1 or 2 Care Groups and not more than 3 (to minimise workload as promoters are volunteers and not paid staff).

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

Promoter # 7	Care Group	
Care Group #7.6	7.6.A	CG Volunteer
	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

CGV 7.6.F	Neighbor Group	
	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**

SESSION 6: CARE GROUP ROLES, RESPONSIBILITIES AND JOB DESCRIPTIONS

Objectives

By the end of this session 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 required
Flip chart paper
Markers
Handouts

Facilitator's notes
Review and adapt as necessary the essential responsibilities for each position so they match those of participants' Care Group (CG) programs. 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.

Introduction
- 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. Care Groups: A Training Manual for Program Design and Implementation 69

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

1. Activity: Care Group Team Member Major Activities

Ask participants:
- What do you think are the major activities the Care Group Volunteer will do?
- Ask the participants to discuss this question within their small groups. Give participants 5 minutes for the discussion.
- Repeat this activity for Promoters, Supervisors and Coordinators.

2. Activity: Who's responsible?

- 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.
- Distribute Session 6Hand-out 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.
- Refer participants to Answer Key to Session 6Hand-out 1: The "Who's responsible?" Game and have them correct their own work.
- Refer participants to Session 6Hand-out 2: Care Group Team Essential Responsibilities. Give them a few minutes to review the hand out and compare it with their game results.

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.

3. Activity: Care Group Volunteer Selection Guidelines

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 behaviour change strategy.

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. Session 6: Care Group Roles, Responsibilities and Job Descriptions 70
- Explain to participants that 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.
- Provide each table with a copy of Session 6 Flip Chart 1: Importance of Care Group Volunteer Qualities/ Selection uidelines. Refer participants to Session 6 Hand-out 3: Possible Care Group Volunteer Qualities/ Selection Guidelines.
- Ask participants to discuss the guidelines in Session 6Hand-out 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.
- Once finished, ask participants to do a gallery walk to see how the other groups categorized the guidelines.
- Discuss with the larger group which items most tables agreed on and which had significant differences of opinion.
- 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 Session 3, the authors of this manual highly recommend that another name besides Care Group be used, such as cascade group

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				

Handout 2: Care Group Team Essential Responsibilities

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

The Lead Mother

- Meets with her neighbour women at least once per month to promote behaviour change
- Visits each neighbour woman at home at least once per month (according to the need and the relevance of the behaviour) to negotiate behaviour change
- Monitors and reports vital events that have occurred within the group, such as births, deaths, and severe illness
- Mobilizes neighbour women to participate in community activities that will benefit their families, such as integrated health campaigns, income generation initiatives, food production initiatives, food distribution, or WASH interventions e.tc.
- Attends Care Group meetings facilitated by the Village Health Workers and share reports.

- Reports problems that cannot be solved at the household level to local leadership, and requests support and collaboration from the VHW
- Models behaviours being promoted

Male Advocate/ Elderly Woman/ Adolescent Volunteer
- Registers Participants into their influencer groups
- Meets with group members at least once a month to promote behaviour change
- Mobilize group members to participate in community activities that will benefit their families, such as integrated health campaigns, income generation initiatives, food production initiatives, food distribution, or WASH interventions etc.
- Attends Care Group meetings facilitated by the Village Health Workers and share reports.
- Reports problems that cannot be solved at the household level to local leadership, and requests support and collaboration from the VHW
- Models behaviours that are being promoted

Community/Faith Leaders
- Mobilizes the community to join and participate in Care Group activities
- Updates household village register quarterly
- Monitors participation of community members in the Care Group
- Provides support that enables village health workers and Care Group volunteers (male advocate, lead mother and elderly woman) to continue conducting Care Group activities e.g., during community gatherings including funerals
- Models behaviours that are being promoted

The VHW/Promoter:
- Facilitates Care Group meetings with his/her Care Group volunteers (lead mothers, male advocate, elderly woman) at least once a month following the session plans in the educational materials provided
- Supervises each Care Group Volunteer at least quarterly by accompanying them on home visits and/or observing them leading group meetings
- Completes monthly reports based on the Care Group Volunteer's registers
- Coordinates and streamline Care Group activities into other community initiatives and maintains cooperation with other community-level institutions, such as the village assemble, churches, and schools
- Models behaviours being promoted
- Ensure that all Care Groups have adequate tools to conduct Care Group activities

Neighbour Women
- Attend meetings facilitated by the LMs
- Participate in group activities
- Engage their family members in adopting behaviours being promoted
- Mobilize each other to attend group meetings

Health Centre Committee
- Provides support that enables village health workers and Care Group volunteers (male advocate, lead mother and elderly woman) to continue conducting Care Group activities within the health facility catchment area.
- Models behaviours that are being promoted
- Mobilizes the community to join and participate in Care Group activities

Health Facility Staff - EHTs/Nurses/ NWCs
- Organizing and facilitating VHW training on Care Group model
- Support the VHWs in assigned tasks and mentor them to ensure achievement of desired outputs and outcomes

- Establishing, coordinating, and supervising Care Groups
- Collating information gathered by the VHWs to display summaries at strategic sites to provide relevant feedback as well as material for dialogue at household and community levels
- Compiling reports from VHWs and sharing with WFNSC and DHE
- Receiving feedback from the DHE and passing it to the Care Groups and VHWs through dialogue and planning that leads to actions to improve identified issues
- Organize monthly and quarterly review meetings for VHWs
- Advocate for Care Group community awareness at community level
- Provide refresher trainings and updates to VHWs

WFNSC
- Coordinate Care Group activities in the ward e.g., community dialogues
- Convene food and nutrition stakeholders at ward level and get feedback on the Care Group activities
- Participate in the training of Care Groups
- Monitor and evaluate Care Group activities
- Provides support that enables village health workers and Care Group volunteers (male advocate, lead mother and elderly woman) to continue conducting Care Group activities within their ward.

District Health Executive/ DFNSC:
- Mobilizes resources and liaise with other partners for support
- Facilitating ward level cadre trainings on Care Group model
- Provide technical support to ward level staff on Care Group Implementation modalities
- Coordinate Care Group activities at district level
- Plan, coordinate and facilitate inter-ward exchange visit
- Write monthly district Care Group report
- Conduct mentorship and supportive visits to ward level cadres
- Advocacy and social mobilization at district level

Developing and Implementing Partners
- Provide technical and financial support for the implementation of the Care Group

Handout 3: Selection of lead mothers

At minimum, a Lead Mother must possess the following qualities:
- Be willing to work as a volunteer.
- Respected in the community
- At least 18 years of age
- Be supported by their household members
- Positive attitude and have a desire to serve her neighbour s.
- Be willing to adopt and models behaviours being promoted
- Able to read and write.

At a minimum an influencer should possess the following attributes:
- Be willing to work as a volunteer.
- Respected in the community
- At least 50 years of age for elderly women
- Be 12 to 17 years of age for adolescents
- Be supported by their household members
- Positive attitude and have a desire to serve her neighbour s.
- Be willing to adopt and models behaviours being promoted
- Able to read and write.

SESSION 7: VOLUNTEER MOTIVATION AND INCENTIVES

Objectives

By the end of this session participants will have:
- Explained why it is important to keep promoter and Care Group Volunteers (CGVs) motive
- Identified ways that the Care Group (CG) approach typically helps to keep CGVs and promoters motivated
- Listed practical, creative ideas to make CGVs and promoters feel motivated

Duration: 1 hour

Materials required: Flip charts and markers

Introduction

Explain that in this session we are going to talk about how to keep promoters, CGVs happy and motivated to work.

1. Why promoters and Care Group Volunteers are Good for the Program
Ask participants: Why are Promoters and 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 services that do not require new grants or other sources of income.
- They already have close relationships with their neighbours. They will always be part of the 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 neighbours
- They are learners along with their neighbours.
- What they learn can be easily shared with and observed by their neighbours.

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 Neighbour Women, malnutrition might increase!
- Volunteers should be supervised and helped to gain skills and adopt the new behaviours themselves, making sure they are meeting regularly for training and are equipped with correct information

Activity: Keeping Care Group Volunteers Motivated

Ask participants: Why is it important to keep volunteers happy and motivated? List their answers on a flip chart.
- Pass out Session 7 Handout 1: Programmatic Reasons to Keep Care Group Volunteers Motivated and explain each reason.

Ask participants
- to compare the reasons that they gave on the first flip chart to each topic on Session 7 Handout 1.
- 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.
- to share with each other what motivated them to work without pay.
- After a few minutes to return to the larger group and to share some reasons that kept them motivated to work voluntarily.

Show Session 7 Handout 2 and Flip Chart 1: Three Volunteer Motivators and explain that 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

Response: 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 Session 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 Session 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 Session 7 Handout 2 and Flip Chart 1, and compare them with participants' responses.

Activity: From Theory to Practice

- 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.
- 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.
- 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.
- Review the most creative and feasible ideas with the entire group.
- Refer participants to Session 7 Handout 3: Ideas for Ways to Help Volunteers Feel Connected, Valued and Effective for more ideas.

Wrap Up

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.

Handout 1: Programmatic Reasons to Keep Care Group Volunteers and promoters Motivated

1. Intellectual Capital

You have spent time, money and effort training promoters and Care Group Volunteers (CGVs). When a volunteer leaves or stops working for the program, the organization loses all of volunteer'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. Neighbour Women Satisfaction

If Neighbour Women know their promoter or 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 promoters or CGVs lack the same trust, time and relationship with the Neighbour 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 behaviour change to reduce malnutrition.

Handout 2 and Flip Chart 1: Three Volunteer Motivators

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 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
- Behaviour changes tracking tools
- Baseline and follow-up surveys

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 promoters CGVs with tools of tread (such as hats, wraps/zambias, bibs 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 promoters, 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 promoters, CGVs can support each other through these life events. Arrange site visits to other programs so promoters, 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 e.g. (lead mother day).
- 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 promoters and 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 to know about successes to keep us motivated.

SESSION 8: BEHAVIOUR CHANGE AND CARE GROUPS: WHAT HAPPENS IN A CARE GROUP MEETING, NEIGHBOR GROUP MEETING AND HOME VISIT?

Objectives

By the end of this session participants will have:
- Name the two most critical behaviour 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 session
- 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

Now we are going to look at the main behaviour change activities of the Promoters and Care Group Volunteers.

Key questions:
What are the most critical responsibilities that Promoters and Care Group Volunteers have that result in changed behaviours?

- Healthy behaviours are introduced first by the Supervisors to the Promoters, then by the Promoters to the CGVs.
- This usually happens at monthly meetings, with only one session being taught at each meeting.
- CGVs then introduce the new behaviours to their Neighbour Women (NW) during Neighbour Group (NG) meetings and home visits.
- Since these are critical behaviour change activities, projects need to make sure that those meetings are as effective as possible.

Care Group Module and Learning Process
- Typically, there are 16 modules to be used to train CGVs to promote health and nutrition behaviours among NW, each of which is related to a specific theme, such as healthy pregnancy and delivery, new-born care and nutrition, or infant nutrition.
- Each module is then divided into different sessions.
- One session is taught each meeting. Refer to Session 8hand-out 1: Example Modules and Sessions outline which shows one program's set of modules and session plans.

Handout 1: Example Modules and Sessions Outline

Module 1: Care Group Orientation and Essential Nutrition Actions (ENA) (7 Sessions)
This module introduces the Care Group (CG) model and discusses nutrition for pregnant and lactating mothers, anaemia prevention and breastfeeding.

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

Module 2: Essential Nutrition Actions (ENA): Complementary Foods and Micronutrients (6 Sessions)
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 New-borns: Pregnancy and Postpartum (6 Sessions)
This module covers antenatal care, postpartum care for mothers and new-borns, and a brief introduction to family planning.

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

- This module includes diarrhoea prevention, hand washing, creating a Tippy-Tap (hand washing station), disposing of faeces, deworming, water purification, proper feeding of sick children and proper food
- Non-governmental organizations (NGOs) can choose to take the modules and session 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 session s. 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 session.
- For example: -If you have five modules with a total of 22 session s and a new session is introduced every 2 weeks, how long would it take to cover all of the session s? Answer 44 weeks, or approximately 11 months
- 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 session s.

Care Group and Neighbour Group Session Structure

- To help Promoters and Care Group Volunteers remember steps followed in conducting a session, 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.
- Pictures are used as reminders for these steps. But, before we look at the facilitation cues, let’s break down the steps in a typical session and the approximate amount of time spent on each step.
- Refer to Hand-out 2: Care Group and Neighbour Group Session Steps so they can follow along and see how much time should be allocated to each step.

Handout 2: Care Group and Neighbour Group Session Steps

Step	Step name	Time allocated
1	Session objectives	5 mins
2	Game or song	5 mins
3	Attendance, Troubleshooting and vital events	5 mins
4	Behaviour change promotion through pictures	30 mins
5	Activity (demonstrate the behaviour)	15-30 mins
6	Discuss potential barriers and solutions	15 mins
7	Practice and coach	20 mins
8	Request a commitment to try out the new behaviour	10 mins

Total time: 2hours or less

Steps in the session

Step 1. Session objectives
- Each session begins with the behaviour, knowledge and belief objectives that will be covered. Most objectives are behavioural objectives, written as action statements. These are the behaviours 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 session 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 session starts with a game or a song.
- Why do you think this approach was chosen to start each session?
- 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 session 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.
- Why is this step important? This is done to monitor who is attending the session 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 behaviours or taking the actions they committed to last time. This provides an opportunity to troubleshoot any barriers that come up in practicing the new behaviour.

Step 4. Behaviour 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 session is followed by discussion questions. Discussion questions are used to discuss the problems faced by the two main characters in the session. 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 behaviour 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 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 behaviour)
Do people usually change their behaviours if you just tell them to?
- No, behaviour change is a process. Behaviour change will be much more likely if you arrange for Care Group Volunteers and Neighbour Women to try out the new behaviour in a safe environment.
- That is the purpose of this part of the session.
- Talking alone will not be as effective as demonstrating and practicing.

- Therefore, each session includes an activity. The Promoter is responsible for organizing materials for each session'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 behaviour cannot be demonstrated during the meeting.

Step 6. Discuss potential barriers and solutions
Why do you think discussing potential barriers to practicing the new behaviour is so important?

- It gives the CGVs and NW an opportunity to seriously consider what it will take to try the new behaviour.
- When CGVs and NW discuss barriers during each session, they have to really imagine doing the behaviour within their household context.
- This takes the women beyond just hearing about the behaviour. 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 session 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 session s they have learned.

Step 8. Request a commitment to try out the new behaviour
- Why do you think we ask Care Group Volunteers and Neighbour Women to commit to trying the new behaviour, or to at least take a step towards trying the behaviour? Why is this important?
- 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.

Facilitation Cues
- Now that we've discussed the steps of sessions given in meetings between Promoters and Care Group Volunteers, let's look at the pictures that help Promoters remember the steps. These pictures are called facilitation cues.

Facilitator notes:
- Before the training, make 5–6 sets of the pictures found in Handout 3 but without the session step names.
- Give a set of pictures to 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 Handout 2.
- Ask the participants to check their work by referring to Handout 3.

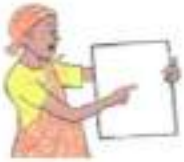
Handout 3: Facilitation cues

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

Handout 4: Bi-Monthly Training Meeting Structure

What are the objectives?

- To encourage and improve Promoters' work
- To review this month's health session
- 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 the 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 session and session plans
- A schedule of upcoming program information
- His/her work plan for the next month Care Groups: A Training Manual for Program Design and

Implementation
- 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 session and session 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

Handout 3: Facilitation cues

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.

SESSION 9: HOME VISITS: THE AUDIENCE, TIMING AND CONTENT

Objectives:

- Review the Care Group Volunteer (CGV) roles and responsibilities.
- State the purpose and list expectations for home visits.
- State Intended audiences and duration for a home visit.
- List the important qualities of an effective home visit.
- Practiced conducting a home visit using previously learned communication skills and the steps in negotiated behaviour change.

Duration: 2 hours 30 minutes

Materials required: Flip chart paper and markers, Handout 1, 2 and 3

Role Play: Steps in a Home Visit using the Negotiated Behaviour Change Process.

Facilitator's Notes
Step 4 is a role play using the script in Session 9 Handout 2: Role Play Dialogue: Showing Steps in a Home Visit using the Negotiated Behaviour 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.

Session 9: Home Visit: The Audience, Timing and Content

Introduction

Step 1
Ask participants: If we only hold monthly Neighbour Group meetings with mothers, how many mothers do you think will adopt the new behaviour?

Responses: Not very many.

Step 2
Ask participants: Why do you think not many mothers will change their behaviours after participating in a just a monthly Neighbour Group meeting?

Responses: Because they will encounter difficulties when they try the behaviour at home, maybe they will forget or maybe they are not really convinced.

Step 3
Explain to participants that: In many programs as part of their responsibilities, CGVs conduct home visits to their Neighbour Women (NW) after the Neighbour Group (NG) meeting. Home visits are the second part of the Care Group (CG) behaviour change strategy. They allow CGVs to see if the NW are practicing the behaviour(s) talked about in the NG meeting and to provide support if NW are encountering problems.

Step 4
Refer participants back to the section on CGVs in Handout 2: Care Group Team Essential Responsibilities and ask them to recall the frequency of home visits. Each CGV should visit each neighbour woman at home at least once per month, after the NG meeting.

Purpose of a Home Visit

Step 5
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 Neighbour Group meeting.

Step 6
Brainstorming session with the participants on the purpose of a Home Visit (duration:5 minutes).

Step 7
Refer participants to Handout 1: Purpose of a Home Visit and compare and contrast the information on the handout with what participants listed on Session 9 Flip Chart 1.

Step 8
Explain to the 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 behaviours. This is what makes the CG approach more effective than other approaches.

Inform the participants that: 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.

Qualities of an Effective Home Visit

Step 9
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 do the visit act? (Skip these questions if no participant has experienced a home visit.)

Step 10
Ask participants to: Brainstorm and list the qualities of a good home visit. Qualities of an Effective Home Visit. Responses should include 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.

Step 11
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 behaviours.

Role Play: Steps in an Effective Home Visit

Step 1
Explain to participants that: you will now practise 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 session. The role play will include the steps in negotiated behaviour change participants learned about in Session 8: Behaviour Change and Care Groups: What Happens in a Care Group Meeting, Neighbour Group Meeting and Home Visit. The participants will observe and identify the different elements.

Step 2
Use Session 9 Handout 2: Role Play: Steps in a Home Visit using the Negotiated Behaviour Change Process to conduct the role play.

Ask participants to: write down the negotiated behaviour change steps they observe.

Step 3
After the role play, ask participants to name the negotiated behaviour change steps they observed. List these on a flip chart.

Step 4
Ask 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 behaviour change through negotiated behaviour change.

Step 5
Refer participants to 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 behaviour change they learned about in Session 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? Wrap Up

Step 6
Wrap up with a discussion of the session s learned through the home visit role play, Handout 1: Purpose of a Home Visit

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

Role Play: Steps in a Home Visit using the Negotiated Behaviour Change Process
Conduct the role play in the order the steps are listed. Read

Characters

- Care Group Volunteer: Rosemary
- Neighbour Woman: Mary
- Mother-in-law: Fancy

Step 1
Greet the neighbour woman in a friendly manner and, if they are present, introduce yourself to/greet the head of household.

- Rosemary: Good morning, Mary. How are you doing? Did you remember that I was going to visit you today?
- Mary: HI, Rosemary. Yes, I remembered. Welcome. Come in.
- Rosemary: How is your husband? Is he here now?
- Mary: OH, he's fine. But he's at work now.
- Rosemary: Please tell him I said hello. OK, I will. Thanks.

Step 2
Ask if other members of the family are present who might need to participate in the discussion (influencing groups).

- **Rosemary:** Is your mother-in-law at home now? I would like her to join us if she can.
- **Mary:** Yes, she's here. Let me get her.
- **Rosemary:** (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 neighbourhood these past few months to talk about this. I think your input will be important in this discussion.
- Mother narwhale my daughter, I'm glad to finally meet you. Mary has told me a bit about the meetings that she has been attending. I really want to hear about what you have to say about keeping the family healthy.

Step 3
Talk with the neighbour woman about changes in the health of the children, such as childhood cases of diarrhoea. If a child is sick, advise the mother to take the child to the nearest health centre for care.

- Rosemary: How are Paul and Timothy doing?
- Mary: Both the kids are doing well now, thanks, but, last week Paul had a bout of diarrhoea.
- Rosemary: Mm, I'm sorry to hear that. Tell me about what happened.
- Mary: Well, it started on Monday. He had several loose stools for 2 days.
- Rosemary: Hmm. That sounds serious, so what did you do after noticing this?
- Mary: Well, the first day I didn't do anything since all children get diarrhoea from time to time. But then he got very weak and I got scared.
- Rosemary: What did you do then?
- Mary: I talked with my husband and we decided to wait another day to see what would happen.
- Rosemary: I see, during this time, what were you giving Paul to eat and drink.
- Mary: I remembered the session from a few weeks ago where we were taught how to prepare the oral rehydration solution, so I prepared it and gave that to him. I also encouraged him to eat, but he refused.
- Rosemary: I am so pleased you prepared the oral rehydration solution. It's important that children with diarrhoea continue to eat. Please go on, tell me what happened next?
- Mary: Even though I continued to give him the oral rehydration solution he got very weak because he wasn't eating and the diarrhoea continued. On the third day we finally decided to take him to the clinic where they gave him some medicine and he got better quickly.
- Rosemary: I am so glad that you decided to take him to the clinic. How do you feel about that decision, Fancy?
- Mother-in-Law: I wish we had taken Paul to the clinic sooner, like after the first day when I noticed that he was getting weaker. The clinic is fairly close, but my son didn't agree.

Step 4
Review the key points of the last (prior) Neighbour Group meeting.

- Rosemary: Mary, can you tell me what you remember about the session about seeking help at the clinic when a child has diarrhoea?
- Mary: Hmm. We talked about how dangerous diarrhoea in children can be and that it's important to go to the clinic. And that's what we did.
- Rosemary: That's true. Do you remember what we said about when you should take a sick child to the clinic, as in how quickly?
- Mother-in-Law: I think Mary told me that it's important to go right away, like during the first day within the 24 hours.
- Rosemary: That's right mother you have a very 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 diarrhoea is bad enough.

Step 5
Ask the mother about her experience trying to practice the new behaviour.

- Rosemary: What prevented you from going to the clinic more quickly?
- Mary: My husband really didn't think it was that serious and thought we should wait thinking that he would soon recover.

Step 6
Listen and reflect on what the mother says.

- Rosemary: Reflecting on Mary's response: Hmm, I see.

Step 7
Identify difficulties/ obstacles to behaviour adoption, if any, along with the causes of the difficulty.

- Mary: If he doesn't agree, then we can't go.
- Mother-in-Law: Yes, he needs to give Mary the money to buy the medicines.

Step 8
Neighbour woman suggests different feasible ways to overcome the obstacles.

- Neighbour woman: I see. So, in the future it would be important to make sure your husband understands how serious diarrhoea in children can be. How do you think we could help him understand this? What can you do?
- Mary: I could perhaps arrange for you to talk to him and explain to him so that he understands how important it is to get the child to the health centre in time.

Step 9
Solicit doable actions: Present several options and support the mother to select one that she can try.

- Neighbour woman: Is there anything you can do to help your daughter in-law? How can we solve this challenge?
- Mother-in-Law: 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.

Step 10
The neighbour woman agrees to try one or more of the solutions and repeats the agreed-upon action.

- Rosemary: Those are all great ideas! Which of these solutions do you want to try?
- Neighbour woman: I will talk to him about the importance of going to the clinic quickly when one of the kids has diarrhoea and what can happen if we wait too long. mother, can you help me?
- Mother-in-Law: Yes, I can help you, for sure.

Step 11
Set a date for the follow-up visit.

- Rosemary: That sounds like a fine plan. I can also lend you the handouts from the session. When do you think Neighbour woman: The picture will help to convince him. I'll try to do it this week. OK?
- Rosemary: That is wonderful, would it be ok if I passed by your place say 2 weeks from today, to see how things have gone with you on this issue?
- Mary: Yes, that would be fine. Yes, no problem.

Step 12
Congratulate the neighbour woman on her good work and thank her for making time to talk with her and remind her when you will be coming back for a follow up visit.

Rosemary: Mary, I want you to know that it was great that you remembered to give oral rehydration solution to Paul when he had diarrhoea. That really helped him a lot. Keep up the good work. And I'll see you 2 weeks from today.

Mary: Thanks for the visit, Rosemary.

Mother-in-Law: Yes, thanks for including me in the discussion. We look forward to seeing you again.

Handout 3: Steps in conducting a home visit

Step 1
Greet the neighbour 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.

Step 2
Ask if other members of the family are present who might need to participate in the discussion (influencing groups).

Step 3
Talk with the neighbour woman about changes in the health of the children, such as any cases of diarrhoea. If a child is sick, observe the mother and refer the child to the health centre for care, if necessary.

Step 4
Review the key points of the last (prior) Neighbour Group meeting.

Step 5
Ask the mother about her experience trying to practice the new behaviour.

Step 6
Listen and reflect on what the mother says.

Step 7
Identify difficulties/obstacles to behaviour adoption, if any, along with the causes of the difficulty.

Step 8
Discusses with the neighbour woman different feasible ways to overcome the obstacles.

Step 9
Recommend/solicit doable actions: Present options and negotiate with the mother to help her select one that she can try.

Step 10
The neighbour woman agrees to try one or more of the solutions and repeats the agreed upon action.

Step 11
Set a date for the follow-up visit.

Step 12
Congratulate the neighbour woman on her good work and thank the neighbour woman for making time to talk with her and remind her when you will be coming back for a follow up visit.

Handout 4: Home Visit Role Play Scenarios

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

Lesson 10: The meeting schedule

Objective:
Participants will learn to answer 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 Required: Flip Charts 1 Table (also serves as the Key for the game) Handouts on:

- Behaviour Change Meeting Facilitation Responsibilities:
- Behaviour Change Meeting (Learning Event)
- Table for the Training Puzzle Game (one copy for each team printed on a flip chart)
- Sets of answers written on post-it 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 centre of the room to give more room. Display Lesson 10 Flip Chart 1: Behaviour Change Meeting (Training Event) Table. Leave this flip chart on the wall for the duration of this lesson.

- 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 behaviour change meetings. In these meetings the participants learn about the behaviours to be promoted.

Step 1. Introduction

Tell participants: We have discussed what the Promoters and Care Group Volunteers do to promote new and healthier behaviours among Neighbour Women and reviewed the contents of meetings between Promoters, Care Group Volunteers and Neighbour 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

- Who is the facilitator?
- 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

Using Handout 10 on the Behaviour 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.

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

Step 4: Answer any questions from participants.

Step 3: Activity: Training Puzzle

- Divide the participants into three or four teams of equal numbers.
- Post/tape copies of Lesson 10:
- Behaviour 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 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.
- 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.
- 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.
- Once all the teams have finished, note the order they finished and assign points accordingly. Compare each team's responses to Lesson 10 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.
- The team with the most points (points for order of completion + points for number of correct responses) wins the game.

Step 4. Wrap Up

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

Lesson 10 Flip Chart 1: Behaviour 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

Handout 10: Behaviour Change Meeting (Learning Event) Facilitation Responsibilities
When the Coordinator Facilitates

- The Coordinator conducts a 5–7-day meeting for the Supervisors to learn each new module before it is introduced to the Care Group Volunteers (CGVs) and Neighbour Women (NW).
- Depending on the level of expertise the Coordinator 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 be available to answer questions that may arise.
- This meeting includes the technical training on the use of the lesson plan and takes several days of coaching of and practicing by each Supervisor
- Normally this meeting happens about months, assuming each module is about six lessons, or before the distribution of each module.
- In larger CG programs, the distances required for staff to travel to bring all the, Supervisors 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

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.

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
- 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.

When the Care Group Volunteer Facilitates

- CGVs teach a new lesson to their Neighbour 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 behaviour 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 behaviour during each meeting.

SESSION 10: SUPPORTIVE SUPERVISION: CHECKLISTS

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

Introduction
Tell participants: Now that we have discussed the Care Group structure, the content of the behaviour 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.

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 flip chart key words from each definition shared, and 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.

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.

3b.A supportive supervision checklist makes it clear what a Supervisor is expected to do when they visit program staff.

3c. There is 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 behaviours 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

.

3d. Supportive supervision checklists help us identify and troubleshoot smaller problems before they become larger issues.

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

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

4. Supportive supervision responsibilities

4a. First, explain the Provincial/National's supportive supervision responsibilities.

- Supervises the maternal and child health and nutrition Coordinator once or twice each quarter (about once every 6 weeks). Visits the Coordinator in the office while he/she is carrying out all of his/her regular activities.
- Once per year, the Province/National visits one Coordinator without scheduling the visit. This is called a surprise visit. Observes the bi-monthly meetings led by the Supervisor.
- May visit the Promoters' homes and talks with them about the program.
- May observe the Neighbour Group (NG) and CG meetings.
- Uses the appropriate supportive supervision checklist.

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

- The Coordinator supervises each Supervisor once per quarter. Every time he/she supervises the Supervisor, he/she will use the appropriate supportive supervision checklist.
- 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.
- The Coordinator visits the Promoters' homes and talks with them about the program.
- The Coordinator also observes the NG and CG meetings.

4c. 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.
- The Supervisor supervises at least one promoter per month: one scheduled supervisory visit or one surprise visit.
- Nb: For effectiveness, the supervisor should strategise to visit at least all promoters by the second quarter, giving first priority to those furthest to the clinic
- The Supervisor supervises his/her Promoters in their homes for that section of the supportive supervision checklist.
- The Supervisor sometimes observes NG and CG meetings.
- 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.

4d. 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 behaviours. It is not a requirement to be a Promoter, but Promoters need to really help their CGVs to try the new behaviours and practice what they teach. After the observation, the Promoter and CGV return to the CGV's home to give feedback. 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 three CGs (the maximum) and if each CG has 15 CGVs (the maximum), this would be 45 total supervisory visits per quarter, or 15 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

Wrap Up

5. Wrap up by telling participants:

Supervision is usually the weak link in most programs and the reason why staff does 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.

SESSION 11: 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

Care Group Check Lists

Name of Province ……

Name of District\Clinic visited: ……

Date visited: ……

Number of staff trained in Care Group model: ……

Number of Promoters trained in Care Group model……

Number of Lead mothers trained in Care Group model……

Total Number of Neighbour Women ……

Province/National Officers' supportive visits form to Coordinators

Availability of the following Necessities	**Tick**	**Recommendations**
Presence of Care Group File (Hard/Soft)		
Care Group information- (number of Supervisors, Promoters, Lead mothers, Care Groups and neighbour women), Number of clinics, Targets and reach		
Evidence of knowledge of the behaviour of the month		
Evidence of training Supervisors on Care Group model		
Evidence of clinic supportive visits		
Evidence of spot checks and community monitoring visits		
Evidence of receiving reports from Supervisors		

Name of Province ……

Name of District\Clinic visited: ……

Date visited: ……

Number of staff trained in Care Group model: ……

Number of Promoters trained in Care Group model……

Number of Lead mothers trained in Care Group model……

Total Number of Neighbour Women ……

Coordinators' supportive visit form to Supervisors

Availability of the following Necessities	**Tick**	**Recommendations**
Presence of Care Group File		
Care Group information- (number of Promoters, Lead mothers, Care Groups and neighbour women) and list of Neighbourhood members compiled by a Lead Mother/Promoter by name in file		
Evidence of teaching behaviour of the month during morning OPD sessions- attendance list/capturing attendance figures		
Evidence of knowledge of the behaviour of the month by all core staff		
Evidence of the distribution list of Care Group training files/ manual to Lead mothers and Promoters		
Evidence of training Promoters on Care Group model		
Evidence of monitoring promoters (check Supervisors' notes)		
Evidence of community monitoring\spot checks		
Evidence of receiving reports from Promoters		

Name of Province ……

Name of District\Clinic visited: ……

Date visited: ……

Number of staff trained in Care Group model: ……

Number of Promoters trained in Care Group model……

Number of Lead mothers trained in Care Group model……

Total Number of Neighbour Women ……

Supervisors' supportive visit form to Promoters

Availability of the following Necessities	**Tick**	**Recommendations**
Care Group training file/manual		
Care Group note book/ exercise book		
Lead mothers/Care Group information- (number of Lead mothers and their names and IDs/ Contact details)		
Knowledgeability about the behaviour of the month		
Evidence of sharing the behaviour of the month with lead mothers - attendance list		
Evidence of knowledge about Care Groups		
Evidence of the distribution list of Care Group training files/manual to Lead mothers		
Evidence of training Lead mothers on Care Group model: attendance register		
Evidence of monitoring the Lead Mothers-attendances		
Evidence of receiving monthly reports from Lead mothers		

Name of Province ……

Name of District\Clinic visited: ……

Date visited: ……

Number of staff trained in Care Group model: ……

Number of Promoters trained in Care Group model……

Number of Lead mothers trained in Care Group model……

Total Number of Neighbour Women ……

Promoters' supportive visit for at a village/Care Group level

Availability of the following Requirements	Tick	Recommendations
Availability of Counselling Cards/Training manual		
Care Group register book		
Neighbourhood mothers information- (number of mothers and their names and IDs/ Contact details) in the Lead Mother's note book		
Knowledgeability of the behaviour of the current and previous month		
Evidence of sharing the behaviour of the month with neighbourhood women – (to check the attendance list)		
Evidence of home-visits: check note books		
Evidence of reaching men and other family members) during home visits (check attendance by gender)		
Evidence of general knowledge about Care Group objectives		
Evidence of submission of reports to Promoters (consolidated monthly reports)		

Care Group roll-out challenges at district level
Care Group roll-out challenges at clinic level
Care Group roll-out challenges at ward/ level
Impacts

Immediate

Anticipated impact

General recommendations/Remarks

Names of the Monitoring Persons/Teams:

1. Name……Designation……

2. Name…… Designation……

3. Name ……Designation……

4. Name…… Designation……

Lead Mother Report

Name of Health Facility …….…….. WARD ……..…. VILLAGE ……..…… MONTH ……..……..

Name of NW Group ……..…….. Name of Lead Mother……..…….. Contact ……..……

Name of Promoter……..……..

Behaviour of the month ……..……...

#	Name of Member	Name of child	Age of child	No of under-fives in household	Joining Date	Monthly Meeting	MUAC (colour code) R-Red Y-Yellow G-Green	Neighbor Woman MEMBER received Counselling/ Home Visit	WASH Section (record number)										Cooking demonstration attended (Yes/ No)
						Absent X Present √	(Children 6-59 months)	Yes/No	Hand washing facilities		Pot Rack		Rubbish pit		Toilet		Nutrition gardens-micro-gardens, keyhole		
									Existing	NEW	Existing	NEW	Existing	NEW	Existing	NEW	Existing	NEW	
1																			
2																			
3																			
4																			
5																			
6																			

7																			
8																			
9																			
10																			
Total																			

	Neighbour women Group Summary Statistics			
		Enrolled	**Reached for the month**	**Coverage**
	Total number of Neighbour women			
Vital Events……				
	Tracking Access			
		Existing	**Newly Constructed/achieved**	**Total**
	Tippy taps			
	Potracks			
	Nutrition gardens-micro-gardens, keyhole			
	Blair toilets			
	Claypot Fridge			
	Improved Granaries			
	Metal Silos			
	Fuel Efficient Stoves eg tsotso stoves			
	Cooking demos			
	Number of members producing bio-fortified crops			

Promoter Report

Name of Health Facility…….....……Ward ……..…… Village ……..……Month……..……YEAR……..……

Name of Promoter……..Contact……..

Behaviour of the month ……..

#	Name of Lead Mother/ Father/ Adolescent/ Elderly	Enter Codes 1-LM 2-LF 3-LA 4-LE	Date of Joining	Total number of Children aged 0-59 months enrolled	LM/LF/ Adolescent /Elderly Meeting attended (Yes /No)	number of home visit / counselling sessions done	Summary attendance of NW/NM/NA/NE meeting		IMAM	MUAC (active screening)- record number			No. Weighed	No of oedema cases	No of children given Vitamin A		Number of cooking demonstrations done
							Total enrolled	Total attendance	No of Defaulters followed up	GREEN	YELLOW	RED			6 to 11 months	12 to 59 months	
1																	
2																	
3																	
4																	
5																	
6																	
7																	
8																	
9																	
10																	
Totals																	

Health Facility Monthly Report

Name of Health Facility…………………………………………………… Wards……………………………………………… Month ……………………………………………Year ……………………

Compiled by……………………………………………………………Contact ……………………………………………………………………

Behaviour of the month ………………………………………………………… Date of meeting …………………………………………………

#	Name of Promoters	Date of Joining	Total number of LM	Total LMs who attended Promoters Meeting	Number of support visits by Promoters	Summary attendance of NW meeting		IMAM	MUAC (active screening)			No. of children Weighed	No. oedema cases	No of Children given Vit A	
						Total NW enrolled	Total attendance for the month	Defaulters followed up	Green	Yellow	Red			6 to 11 mo.	12 to 59 mo.
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
Totals															

	Village Care Group Summary Statistics			
				Total
	Total Number of Care Groups			
		Enrolled	Reporting for the month	Coverage
	Total Number of Lead Mothers			
	Total Number of Lead Fathers			
	Total number of Adolescents			
	Total Number of Elderly Women			
		Enrolled	Reached	Coverage
	Total number of Neighbour women			
	Total number of Neighbour men			
	Total number of Neighbour adolescent			
	Total number of Neighbour Elderly women			
Vital Events……				
Tracking Access				
		Existing	Newly Constructed/achieved	Total
	Tippy taps			
	Potracks			
	Nutrition gardens-micro-gardens, keyhole			
	Blair toilets			
	Claypot Fridge			
	Improved Granaries			
	Metal Silos			
	Fuel Efficient Stoves eg tsotso stoves			
	Cooking demos			
	Number of members producing bio-fortified crops			

District Report

Name of Health Facility……..... Wards……..... Month ……..…….....Year .....

Compiled by……..…….Contact ……..…….....

Behaviour of the month ……..…… Date of meeting ……..…….....

#	Name of Health Facility	No of Promoters	Promoters Monthly Meeting (Not Done X Done √)	Number of support visits (health facility and community level)	Summary attendance of Promoters meeting	Summary attendance of LMs	Summary attendance of lead fathers	Summary attendance of Lead Adolescents	Summary attendance of Lead Elderly Women	IMAM (Defaulters followed up)	MUAC (active screening)			No. Weighed	No. oedema cases	No of children given Vitamin A	
											GREEN	YELLOW	RED			6 to 11 months	12 to 59 months
1																	
2																	
3																	
4																	
5																	
6																	

7																	
8																	
9																	
10																	
Totals																	

	Village Care Group Summary Statistics			
				Total
	Total Number of Care Groups			
		Enrolled	Reporting for the month	Coverage
	Total Number of Health Facilities			
	Total Number of Promoters			
	Total Number of Lead Mothers			
	Total Number of Lead Fathers			
	Total number of Adolescents			
	Total Number of Elderly Women			
		Enrolled	Reached	Coverage
	Total number of Neighbour women			
	Total number of Neighbour men			
	Total number of Neighbour adolescent			
	Total number of Neighbour Elderly women			
Vital Even.....				
Tracking Access				
		Existing	Newly Constructed/ achieved	Total
	Tippy taps			
	Potracks			
	Nutrition gardens-micro-gardens, keyhole			
	Blair toilets			
	Claypot Fridge			
	Improved Granaries			
	Metal Silos			
	Fuel Efficient Stoves eg tsotso stoves			
	Cooking demos			
	Number of members producing bio-fortified crops			

Lead Father/Adolescent/Elderly Woman Monthly Report
Name of Health Facility ……Ward ……Village……Month ……Year……
Name of Group ……Name of group leader…… Contact ……
Name of Promoter……
Behaviour of the month ……

#	Name of Member	Joining Date	Monthly Meeting Attendance Absent X Present √	Member received Counselling/ Home Visit (Yes/No)	Cooking demonstration attended (Yes/No)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
Total					

Neighbour Men/Elderly women/adolescent Group Summary Statistics			
	Enrolled	Reached for the month	Coverage
Total number of Neighbour Men			
Total number of neighbour elderly women			
Total number of neighbour adolescents			

References

Amalima Recipe book http://drive.google.com/open?id=0B7h6Pz RJrAQak5Hx1U1cXRRSGs. Zimbabwe

Brazier A (2015) Healthy Harvest: a training manual for community workers in growing, preparation and processing nutritious food. Second edition FAO, Zimbabwe. ISBN 978-0-7974-6229-8

Brazier A & Khanye T (2017). LANN+ Community Training Manual. ZRBF-MELANA. Zimbabwe.

Children, S. t. (n.d.). Infant and young child feeding recipe book. Save the Children.Zimbabwe

CTDT & RRU (2003) Consumption of Indigenous foods in Zimbabwe. Harare.

CTDO (2019). Post-Harvest Handling and Storage reference guide. LFSP-EXTRA, ZRBF-MELANA.CTDO. Harare Zimbabwe

Development Initiatives (2020), Global Nutrition Report: Action on equity to end malnutrition. Bristol, UK:
FAO (2002). Recipes for Healthy Eating (Promoting Utilization of Zimbabwe's Indigenous Foods. FAO. Zimbabwe

FAO, IFAD, UNICEF, WFP and WHO (2018). The State of Food Security and Nutrition in the World 2018.Building climate resilience for food security and nutrition. Rome, FAO.

Food Security and Nutrition Network Social and Behaviour Change Task Force (2014). Care Group: A training manual for program design and implementation. Washington. DC. Technical and Operational performance support program.

Harvest Plus, Ministry of Agriculture and Livestock (2014). Vitamin A Post Harvest Handling and Storage, Zambia.

Henry Perry, Melanie Morrow,b Sarah Borger,c Jennifer Weiss,d Mary DeCoster,c Thomas Davis,e Pieter Ernst, Care Groups (2015): An Innovative Community-Based Strategy for Improving Maternal, Neonatal, and Child Health in Resource-Constrained Settings, Global Health: Science and Practice 2015 | Volume 3 | Number 3).

International Federation of Red Cross and Red Crescent Societies, Geneva, (2013): Maternal, newborn and child health framework

IFAD (2020). Smallholder Irrigation Revitalisation Project recipe book. Zimbabwe.
Khanye, T., Tapera, R (2017). Biofortified, Neglected and underutilised Foods (NUFs). LFSP-EXTRA, CTDO. Harare.Zimbabwe

Kutyauripo, F., Takawira, D., Khanye, T., Chenge, E., Nyabanga, V., Reinberg,C., Michaulx,K., Kudita,S., and Katsi,M., Changwena,D (2020). IYCF Recipe book (English, Ndebele, Shona). LFSP-Zim. HarvestPlus. Harare. Zimbabwe

LFSP-APN (2020) Livelihoods and Food Security Programme (LFSP): Rapid Nutrition and Biofortification Study. LFSP. https://lfspzim.com/ Accessed 14/10/2020 17.06
LFSP-Zim (2019). LFSP-APN Care Group Counselling Cards. FAO LFSP-Zim. Zimbabwe.

LFSP- INSPIRE Recipe booklet (2019). A training guide for food processing trainings. LFSP.Zimbabwe

LFSP-ENTERPRISE Recipe booklet (2019) Mutakunanzva. Zimbabwe

Montano et al (2015). Chapter 10: Application of the Theory of Reasoned Action/Theory of Planned Behavior and Integrative Behavioral Modhttps://www.healthypeople.gov/2010/hp2020/advisory/phasei/summary.html

NAZ (2020). Evaluation of the effectiveness of the Care Group Strategy in addressing key drivers of stunting during the first 1000 days of life. NAZ

Ncube,P., Murakwani, C Nyathi, M Dzimba, S B Dube and S A Moyo (2020). Is participation in Care Groups associated with enhanced diet quality amongst women and children? Experiences from Zimbabwe. World Nutrition. Volume 11

Takawira, D., Nyabanga, V., Khanye, T et al (2019) Care Group Counselling Cards
(English, Ndebele, Shona version). LFSP. FAO. Harare Zimbabwe.

Requejo J, Bryce J, Victora C. Countdown to 2015. Fulfilling the health agenda for women and children: the 2014 report. Geneva: World Health Organization; 2014. Available from: http://www.countdown2015mnch.org/documents/ 2014Report/Countdown_to_2015-Fulfilling%20the% 20Health_Agenda_for_Women_and_Children-The_2014_Report-Conference_Draft.pdf).

USAID (2014). Care Groups – An effective community-based delivery strategy for improving reproductive maternal neonatal and child health in high mortality resource constrained settings: A guide for policy makers and donors. USAID.

United Nations Children's' Fund (2013). Improving Child Nutrition: The Achievable Imperative for Global Progress. United Nations Children's Fund. New York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