THREE ROOTS INTERNATIONAL

Three Roots International [TRI]

Care group Manual:

For Program Design and Implementation

Reference Manual

First Edition

Addis Ababa, Ethiopia

November 2022

Contents

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
CG	Care Group
CGV	Care Group Volunteer
EBF	Exclusive Breastfeeding
EHA	Essential Hygiene Actions
ENA	Essential Nutrition Actions
HIV	Human Immunodeficiency Virus
HWWS	hand washing with soap
LNRA	Learning Needs Resources Assessment
LQAS	Lot Quality Assurance Sampling
M&E	monitoring and evaluation
MB	mother beneficiaries
NG	Neighbor Group
NW	Neighbor Women
ORS	Oral Rehydration Solution
PLW	Pregnant and Lactating Women
QIVC	Quality Improvement and Verification Checklist
RHF	Recommended Home Fluid
TRI	Three Roots International
WASH	Water, Sanitation and Hygiene
WRA	Women of Reproductive Age

ACKNOWLEDGEMENTS

TRI would like to acknowledge its staff who contributed to the development of this manual. Special thanks go to Barkot Tamiru for his active and generous participation in reviewing the document.

TRI sincerely thanks everyone who contributed to this important tool for improving social and behavior change programming in the target area.

CHAPTER ONE: INTRODUCTION

1.1. Background

Three Roots International, a non-government charitable organization started operations in Ethiopia in January 2017 TRI is committed to address the underlying conditions that create extreme poverty within the most vulnerable communities through integrated, participatory and community-led approaches, working to support local and national institutional structures. TRI has grown to serve its target beneficiaries through participatory development programs focusing on three thematic areas of education, health and economic empowerment.

TRI will draw on several key strategies in order to achieve the program results, outcomes and impact. Care Groups Model is among the key strategies that TRI will respond to the health needs in communities. The Care Group Model is a proven and powerful model for vast community-based behavior change. Care Groups create a multiplying effect to equitably reach every beneficiary household through neighbor-to-neighbor peer support using behavior change activities. Peer support not only increases the adoption of new behaviors, but also helps in the maintenance of those behaviors, resulting in the creation of new community norms.

Care Group Volunteers also provide peer support to one another, develop stronger commitments to implement health activities, and find more creative solutions to challenges through group collaborative effort. All of these benefits of the Care Group methodology are made possible through the Care Group structure, which efficiently and effectively cascades health promotion messages from the Promoter, to the Care Group Volunteer, and finally to the neighborhood individuals through peer education.

1.2. Objectives of the Care Group manual

This manual was developed as a guiding resource for designing, implementing and monitoring Care Group (CG) programs. It seeks to help Three Roots International (TRI) 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.

This is a draft manual. It was prepared for the first use of TRI's Care Group approach in Ethiopia, which focuses on health, nutrition, WASH, MIYCN behaviors, and early child development including some child Protection behaviors. There may be errors that will be amended and get revised in the future versions of this manual.

1.3. Goals, Outcomes and Expected impact

The goal of Care Groups program implementation is to promote improved infant nutrition, improve hygiene and increase the number of children who are fully vaccinated and exclusively breastfed for the first 6 months. The behavioral changes promoted by Care Groups (such as safe infant feeding, frequent hand washing, consistent mosquito net usage, providing suitable complementary foods from 6 months old) have the potential of averting preventable deaths particularly among children under five.

1.4. What Is the Care Group difference?: Brief Overview

A care group is a group of 10 to 15 volunteer community-based health educators who regularly meet together with promoter for training and with project staff for supervision and support. Care groups are distinguished by the on-going relationships within the care group as well as each volunteer's responsibility to teach individual households outside of the meeting, thus multiplying training.

Volunteers belonging to care groups provide greater peer support, develop stronger commitment to health activities and find more creative solutions to challenges by working as a group compared to individual volunteers expected to work independently.

Multiplied effort: Care groups enable a relatively small number of paid project staff to reach a large beneficiary population without overburdening staff or individual volunteers. Care groups create a "multiplier effect" — one staff supervisor trains and supervises 10 promoters and one promoter trains and supervises as many as of 10-15 volunteers each.

Complete coverage: Care groups achieve complete and consistent coverage of the project area. The "saturation coverage" design ensures that every household with a child under age 5 or a woman of child-bearing age receives a volunteer visit at least once a month. Each care group volunteer is responsible for visiting and teaching health lessons to mothers and other important health decision-makers in the 10-15 households closest to her. These 10 households can meet as a group or the volunteer goes to each household individually. This relatively low ratio of households per volunteer makes it possible for the volunteer to interact with each household more frequently and develop deeper personal relationships for promoting behavior change compared to models using a higher ratio of households to volunteers.

Peer support: Care group volunteers work toward goals set for the entire group, not just for individual volunteers. Promoters set goals that care group volunteers can only reach through a corporate effort. Shared goals create a sense of identity and solidarity in the care group, encouraging volunteers to assist each other when they encounter problems. The high proportion of volunteers in a community means they have many resources — each other — to turn to for help, rather than relying solely on project staff. At care group meetings, volunteers benefit from the small group training environment and the opportunity to share and learn from one another. The combined strength of the group also makes it easier to include illiterate volunteers – the care group model requires only a minimal number of volunteers with basic literacy skills.

Peer motivation: A group of volunteers striving towards shared goals work together with greater commitment and support than separate volunteers who are left to work as individuals in their communities. As the care group members review the program statistics together and see the wide scale impact on the community, each sees that she is part of something bigger than herself. Group solidarity and shared sense of community service grow very strong in care groups, sustaining the spirit of volunteerism and preventing volunteer burn-out.

Changed communities: The number of care group volunteers in every community creates a critical mass for changing health practices. In a participating community, there is at least one care group volunteer for every 10-15 households who is leading the way to better health practices. Behavior change becomes more than an individual decision — it becomes a social movement involving the entire community. Furthermore, the care group model effectively mobilizes community and religious leaders, local village health committees and Ministry of Health (MOH) staff. These

community leaders support care groups' work, reinforce their health messages and work with care groups to take wider action on community health issues.

Sustainable systems: Care groups outlast funding cycles because they promote truly changed communities who value care group volunteers' contributions to their health and wellbeing. Over time, communities identify the care groups as belonging to the community rather than the project. The obvious impact and community support motivate volunteers to continue their work.

1.5. Project area

Gandagorba Kebele is located in Bishoftu Administration, in the East Shewa Zone in Oromia Regional State. Gandegorba Kebele has one Health Post located in Gandegorba village with a total population of 1160 households. Health Post is the smallest unit next to the Health Center in the district Health Office structure. The Gandegorba Health Post has three health extension workers.

1.6. Project duration

A project's duration – the length of time project activities will take place – also influences the effectiveness of care groups. Care groups work best in projects that last for years, not months. The care group model requires intensive work at the start of a project to recruit volunteers and form care groups. This start-up phase may last between six or seven months before the care groups are ready to begin outreach to beneficiary households. Because of the lengthy start-up, care groups are well suited to projects of four to five years. If a project has a shorter time frame of less than two or three years, the care group model may not be feasible or effective for communicating behavior change messages.

Considering this TRI allows adequate time (2 years) to set up care groups and effectively deliver health messages to households.

CHAPTER 2: THE CARE GROUP APPROACH AND STRUCTURE

Establishing appropriate ratios of paid project staff to targeted beneficiaries guides decisions whether the care group model is feasible with a project's number of staff. Care groups create a cascade effect, multiplying the training of supervisors and promoters.

The following graphic illustrates Three Roots International's organization of staff and care groups.

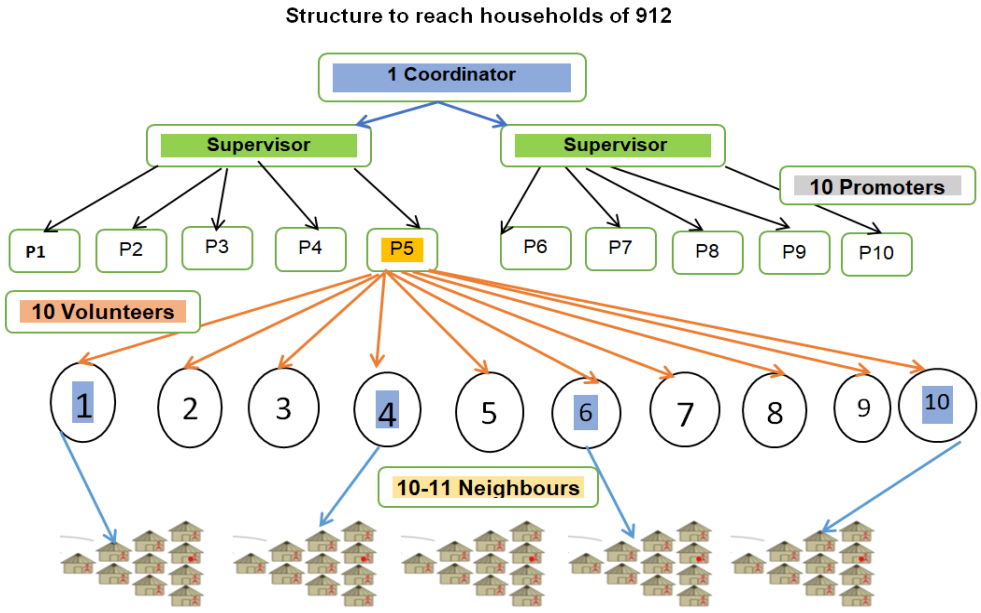

Figure 1 Care group structure

Supervisors per promoters: The supervisor to promoter ratio is 1:5. This is an efficient use of resources while still providing enough oversight and support to promoters to ensure quality training and sound technical content

Supervisor to promoter of 1:5

Promoters per care groups: One promoter will be responsible for one care group. Assuming two-week work cycles, the 1:1 ratio allows the promoter to spend one day training with care group while leaving one day per week for training with a supervisor and other program events and meetings. This creates a manageable workload for promoters and still achieves the desired population coverage.

Promoter to Care group ratio of 1:1

Volunteers per care group and households: One care group will be made up of approximately 10-15 volunteers. Each of these volunteers should be responsible for regularly visiting and teaching 10-15 beneficiary households (including her own household).

Ratio between a volunteer and her assigned households between 1:10 to 1:15.

Promoters per households: Through care groups' multiplier effect, one promoter is responsible for a large number of households. The ratio of promoters to households will be 1:100 to 1:150.

2.1. Project Partnerships

Partnering with local Health care providers: As Care groups work on preventative health issues partnering with local health care providers, such as the Regional and City administration health offices, Health Center and health posts is essential to foster sustainability by creating relationships between health service provider and care groups. The health service provider benefits from care groups' ability to mobilize grassroots level response as well as collect and report community-level data. Care group benefit by having a resource for directing families to seek clinical care, and they also may benefit from being linked to an established structure.

2.2. Care group criteria

Table 1 Care group criteria

Criteria
1. Essential Information
The model is based on mother-to-mother health promotion. Care Group Volunteers (CGVs; e.g., "Leader Mothers," "Mother Leaders") should be chosen by the mothers within the group of households that they will serve or by the leadership in the village.
The intended group ideally is all women of reproductive age (WRA; or at least all pregnant women and mothers of young children).
Respect for women: The implementing agency needs to successfully create a project/program culture that conveys respect for the population and volunteers, especially women.
Coverage of intended group: CG behavior change activities should aim to reach 100% of households in the intended group at least once per month.
CGs will have between 10 and 15 CGVs.
Each CGV will be responsible for no more than 15 households (of Neighbor Women [NW]).
CGVs should be chosen by the mothers within the group of households that they will serve or by the leadership in the village.
The weekly workload of CGVs is limited to no more than 15 households per CGV.
2. Supportive Supervision
A Promoter should not supervise more than one CGs (i.e., the Promoter to CG ratio should be no more than 1:1).
A Promoter should supervise at least one CGV from each CG per week (preferably one CGV from each CG every week) using supportive supervision.
Supervisors provide regular supportive supervision and feedback to Promoters on a monthly (or more) basis.
3. Behavior Change Meetings
CGVs meet with their assigned NW twice per month (recommended), or at least monthly.
Meetings between Promoters and CGVs should last no more than 2 hours per meeting.
The CGVs use visual teaching/educational tools (e.g., flipcharts).
Participatory education methods are used with the CGVs and when doing health promotion at the household or small-group level.
4. Monitoring & Evaluation and Formative Research
Formative research should be conducted, especially on key behaviors promoted
CGVs collect "vital events data" on pregnancies, births and deaths.

Care Group Volunteer selection criteria

1. Willing to work as a volunteer

2. Desires to serve his/her neighbors
3. Positive attitude (hopeful and optimistic)
4. Is a mother or grandmother
5. Knows how to read and write
6. Female
7. Is between 18 and 40 years of age
8. Is a mother or grandmother
9. Models good hygiene, sanitation and nutrition practices
10. Respected by the community
11. Capable of leading a discussion with 8–12 women
12. Has good relationships with existing community health workers
13. Has permission from her husband to be a volunteer
14. Has good relationships with existing community health worker

CHAPTER 3: CARE GROUP ROLLES AND RESPONSIBILITIES

3.1. Care Group Volunteer (CGV)

- Meets with 10-15 Neighbor Women (NW) at least once per month to promote behavior change using an educational flip chart/booklet
- Visits each neighbor woman at home once per month (according to the need and the relevance of the behavior) to negotiate behavior change
- Reports to the Promoter on a bi-weekly basis the number of NW she visited and who attended the behavior change meeting
- Monitors and reports vital events that have occurred in the community, such as births, deaths and severe illness
- Mobilizes NW to participate in community activities that will benefit their families, such as immunization campaigns, food distribution or latrine construction
- Attends Care Group (CG) meetings provided by the Promoter
- Report problems that cannot be solved at the household level to local leadership, and request support and collaboration from the Promoter
- Models the health, nutrition and sanitation behaviors she teaches NW

3.2. Promoter

- Coordinates local-level activities and maintain cooperation with other community-level institutions, such as the kebele, Health posts, churches and schools
- Meets with the local leadership committee (Community Development Committees) in the community to coordinate, monitor and evaluate
- Facilitates CG meetings with his/her Care Group Volunteers (CGVs) every two weeks following the lesson plans in the educational materials provided
- Attends training and reporting meetings provided by the Supervisor and the module training sessions to accurately replicate trainings given by the CGVs, sharing correct information and demonstrating skills learned
- Models the health, nutrition and sanitation behaviors he/she teaches CGVs in his/her own homes
- Supervises each CGV at monthly by accompanying them on home visits and observing them leading group meetings
- Assists with other program activities, such as national vaccination days, distribution of vitamin A and deworming medicine, and weighing children under 5

- Completes monthly reports based on the CGV registers and NW registers

3.3. Supervisor

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

3.4. Coordinator

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

CHAPTER 4: BEHAVIOR CHANGE AND CARE GROUPS

4.1. What happens in care group meeting, Neighbor group meeting and Home visit

4.1.1. Care Group and Neighbor Group Lesson Steps

Step 1. Lesson objectives

- Each lesson begins with the behavior, knowledge and belief objectives that will be covered. Most objectives are behavioral objectives, written as action statements. These are the behaviors that we expect the CGVs and NW to practice based on the key messages in the flip chart.

Step 2. Game or song

- Each new lesson starts with a game or a song.

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).

Step 4. Behavior change promotion through pictures

- The Promoter or CGV reads the story printed on the flip chart/booklet, using the images to share the story. The story in each lesson is followed by discussion questions. Discussion questions are used to discuss the problems faced by the two main characters in the lesson. Use the story and discussion questions to find out the current practices of the women in the group.

Step 5. Activity (demonstrate the behavior)

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

Step 6. Discuss potential barriers and solutions

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

Step 7. Practice and coach

- For CG meetings between Promoters and CGVs: This is the opportunity for each CGV to practice teaching a lesson to someone else and for the Promoter to give advice about the CGV's facilitation skills. This helps the CGVs become familiar and comfortable with the flip charts and the messages
- For meetings between CGVs and NW: This opportunity allows NW to practice telling each other the key messages they learned, and provides a chance to practice how they might tell other family members about the lessons they have learned.

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

- Ask participants: Why do you think we ask Care Group Volunteers and Neighbor Women to commit to trying the new behavior, or to at least take a step towards trying the behavior? Why is this important?
- Tell participants: Studies have shown that when someone promises to do something they are much more likely to do it. The facilitation cue for commitment should reflect how people make a promise in the local culture.

4.1.2. Bi-Monthly Meeting between Supervisors and Promoters

What are the objectives?

- To encourage and improve Promoters' work

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

Where is it held?

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

How often does this meeting happen?

- Twice per month ideally (once in a month can be considered based on the feasibility)

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)

What is the cost?

- A day-long meeting might include lunch
- Transportation cost for the promoters

What should the Supervisor bring?

- Flip chart for this month's health lesson and lesson plans
- A schedule of upcoming program information
- Monthly report form (to be filled out during the meeting by getting information from the Promoters)

What should the Promoter bring?

- 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

Table 2 Care Group and Neighbor Group lesson steps

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

Total time: 2 hours or less

CHAPTER FIVE: HOME VISITS: THE AUDIENCE, TIMING AND CONTENT

5.1. Purpose of a Home Visit

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

5.2. Qualities of an Effective Home Visit

- 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.

5.3. Steps in Conducting a Home Visit

1. Greet the neighbor woman in a friendly manner and, if they are present, introduce yourself to/greet the head of household. Show a sincere interest in the situation of each family member to create confidence and reassure the family.

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

CHAPTER 6: SUPPORTIVE SUPERVISION; CHECKLISTS AND SUPERVISORY WORK PLANS

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

6.1. Supervisor's supportive supervision responsibilities

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

6.2. Promoter's supportive supervision responsibilities

- The Promoter visits CGVs in their homes. This is the "model" mother in the community, so the Promoter should be able to see by her home and her practices that she is following the things she is teaching. If not, the Promoters need to help her overcome the barriers that she is facing that prevent her from practicing the new behaviors. It is not a requirement to be a Promoter, but Promoters need to really help their CGVs to try the new behaviors and practice what they teach
- The Promoter supervises CGVs, only using the QIVC for meeting facilitation, as they teach NGs. After the observation, the Promoter and CGV return to the CGV's home to give feedback using the QIVC. It is during this home visit that the Promoter also can ask about her nutrition, health and hygiene practices and observe her home

6.3. Categories in the Supervisor's Checklist for Supervising Promoters

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

CHAPTER SEVEN: WORK PLANS

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

7.1. Activities to plan for the Promoter

- Teach one Care Groups every month
- Spend at least a ½ day writing reports before meeting with the Supervisor
- Attend two bi-monthly meetings with the Supervisor (about a ½ day per meeting)
- Supervise Care Group Volunteers (CGVs) every month
- Receive a supportive supervision visit once a month during his normal activities
- Attend the community development committee meeting once per month (½ day)

7.2. Activities to plan for the care group volunteer

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

7.3. Activities to plan for the supervisor

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

CHAPTER EIGHT: QUALITY IMPROVEMENT AND VERIFICATION CHECKLISTS Quality (QIVC)

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

Quality Improvement and Verification Checklist (QIVC) for Meeting educational session facilitation has three main purposes:

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

The QIVC is the ONLY tool used to supervise CGVs and promoters. The Promoter does not use a supportive supervision checklist at this level since CGVs are not employees. The QIVC rapidly increases facilitation performance

That most questions have a yes or no answer. After reading the question, they should decide if the answer is "yes" or "no" and mark the corresponding box. If the question is not relevant for a particular training, then draw a line through the YES or NO boxes.

8.2. Calculating scores and using data from the quality improvement and verification checklist (QIVC)

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

There are two types of calculations that programs need to make.

1. program performance score: Number of scores that are 80% or higher divided by total number of individual
2. Average score: All the scores added together divided by total number of individual

1. **Frequency of Supervising with the QIVC**

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

0. **Individual and Program Performance Goals**

Individual Performance Goal

Each person scores 80% or higher on the quality improvement and verification checklist (QIVC).

Program Performance Goal

Of all of the QIVCs done in a quarter, 80% of them to have a score of 80% or higher

Program Performance Score

Definition: The percentage of total QIVCs conducted that quarter that were scored 80% or higher

How to calculate:

1. Count the number of individual QIVC scores for that quarter.
2. Count the number of scores that are 80% or above during that quarter
3. Divide the number of scores that are 80% or above by the total number of QIVC scores for that quarter

4. Remember, do not add scores, and just count them.

CHAPTER NINE: CARE GROUP MONITORING INFORMATION SYSTEM

9.1. Introduction to registers

The Care Group Management Information System (CGMIS) is based on two basic information sources:

1. Neighbor group (NG) register
2. Care Group (CG) register

These registers are very similar to one another and collect four types of information from either the NGs or CGs:

1. Date when the members joined (registration information)
2. Attendance at group meetings or home visits
3. Vital events of group members (maternal deaths, deaths of children under 2 and child births)
4. Lessons in the CG curriculum that have been covered
5. Information (such as immunization coverage, antenatal care attendance and childhood illness).

Flow of Information in the Care Group Monitoring Information System

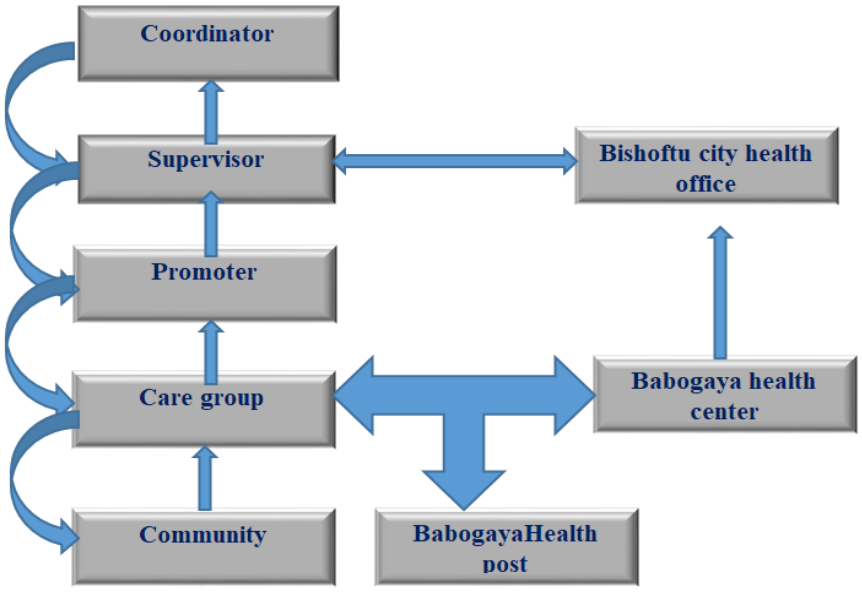

Figure 2 Flow of Information in the Care Group Monitoring Information System

Promoter, Supervisor and Coordinator Reports

Information comes directly from the registers of the Care Groups (CGs) and Neighbor Groups (NGs) under that Promoter

Planning for sustainability

Sustainability is a process that improves conditions that enable individuals, communities and local organizations to improve their functionality, develop mutual relationships of support and accountability, and decrease dependency on insecure (institutional, technical and financial) resources. Sustainability enables these local stakeholders to play their respective roles effectively, thus maintaining gains in health and development beyond the project period.

The individuals, communities, health services and local organizations constitute a local system interacting with and embedded in a larger environment. The efforts and interactions of these actors in the local system are what lead to lasting health impact. Their efforts will be based on their own understanding of their community's health and development.

The care group model empowers a group of trained volunteers to be a powerful community resource and problem-solving team — a team that can keep on working even after the project ends and promoters provide no more direct support. The care group is the main source of incentives and support, rather than project staff.

Care groups generate their own incentives through relationships with each other, households and communities. As the promoter once did, the group sets new community goals that are easily measured, so volunteers and their communities can see the results of their efforts. Measurable impact, community recognition and the on-going support and friendship of the care group motivate volunteers to continue their work.

10.1. Categories of Sustainability

1. Sustained improvement in household health behaviors and outcomes

For example:

- Breastfeeding
- Hand washing
- Care seeking

2. Enduring changes in social norms, capacity and social capital

For example:

- It is no longer socially acceptable to delay care seeking for suspect malaria.
- Couples have improved communication and relationships from the experiences of jointly discussing sensitive topics, like family planning, for the first time.
- Caregivers have the knowledge, confidence and support of their families to seek timely medical care for children when needed
- Mothers know they can check with their volunteer when they have a question about child feeding.
- Care Group Volunteers (CGVs) and village health committees can collectively solve problems.

3. Continuation of specific program activities and services

For example:

- Home visits by CGVs
- Collecting and reporting community health information

10.2. Aspects of Care Groups that Might be Sustained

- Care Group Volunteers (CGVs) continue to visit households
- Care Groups (CGs) continue to meet bi-weekly
- CGs receive new lessons
- Continued supervision of CGs
- CGVs continue to collect and report vital events\
- CGVs continue to meet with NGs
- New Neighbor Women (NW) are being included in the NG
- Behaviors continue to be practiced

REFERENCES

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

2. The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators. Prepared by the World Relief Health Team Author: Megan Laughlin Editors: Katie Bradbury; Pieter Ernst, MBChB; Rebecca Heidkamp; William M. Long, DrPH; Melanie Morrow, MPH; Linda Nghatsane, RN; and Olga Wollinka, MSHE.

ANNEXES

Annex-I: Supervisor's Checklist for Supervising a Promoter

Name of Promoter being supervised: _____ Name of Supervisor completing the form: _____ Quarter: _____ Year: _____ Every Visit: Take time to find out how the Promoter is doing, how you can support him/her, and what challenges or success he/she has encountered since your last visit. Instructions: Place a "Y" for Yes (the task was done) or an "N" for No (the task was not done). Write "n/a"(not assessed) if the item could not be (or was not) assessed for some reason. The gray cells are further instructions and do not require a written check mark.

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

2a. Is the Promoter keeping the CGV and NW registers in a safe, dry place? 2b. Has the Promoter always marked attendance for the CGVs over the last 3 months?			
2c. Did the Promoter (or CGV or someone else) always mark attendance for the NW over the last 3 months?			
3. Review the Promoter's Monthly Reports			
3a. Has the Promoter completed the monthly reports correctly (e.g., there are few errors)?			
4. Observation of the Promoter's Equipment (transport, scale, storage area, other materials)			
4a. Is the Promoter maintaining his/her motorbike/bicycle in a fully functioning condition?			
4b. Is the weighing scale working properly?			
4c. Were all other materials (e.g., flip charts, MUAC strip, lesson plans, blank reporting forms) stored in a safe and dry place?			
4d. Does the Promoter have sufficient amounts of all materials needed?			
5. Review of Visits and Interviews with Care Group Volunteers			
5a. Randomly select 3–5 CGVs to visit and interview them. Were those selected all found, and did they confirm that they were attending teaching lessons and generally understood what they were learning?			
6. Review of Visits and Interviews with Neighbor Women			
6a. Randomly select 3–5 NW to visit and interview them. Did the selected NW confirm that they attend meetings and generally understand what they are learning?			
6b. Ask selected NW about their children. Did the NW verify that their children were being weighed regularly?			
6c. Ask selected NW about danger signs. Were all NW able to mention most of the danger signs during child illness?			
7. Review of Visit to Community Leaders or Participate in a Community Leadership Meeting and Interview the Leaders			
7a. Ask community leaders about the Promoters' activities and their coordination. Were they aware of the Promoter's activities in the community?			
7b. Did the community leaders say that they have been coordinating with the Promoters?			
7c. Ask community leaders if they are actively resolving problems that arise related to the program?			
8. Review of Visit to the Health Worker at the Nearest Health Facility			
8a. Visit local health workers at the nearest facility. Are the health workers aware of the work of the Promoter?			
8b. Has the Promoter been referring patients to the health center for care?			
9. Review of Visit to the Promoter's Home			
9a. Observe: Does the Promoter have a latrine with a lid and a roof?			
9b. Observe: Does the Promoter have a hand washing station?			
9c. Observe: If there is a hand washing station, is there water?			
9d. Observe: If there is a hand washing station, is there soap/ash available			
9e. Observe: Does the Promoter have a system for purifying drinking water?			
9f. Observe: Does the Promoter have a system for keeping animals (including chickens) away from the child's play area?			
9g. Observe: Does the Promoter have a mosquito net for every bed or sleeping mat?			
9h.Observe vaccination card: Are the Promoter's youngest child's vaccinations up to date?			
TOTAL YES:			
PERCENT YES:			

Annex-II Quality Improvement and Verification Checklist (QIVC) for Meeting Facilitation

Name of facilitator: _____

Date: _____

Evaluator: _____

Community: _____

Methods Yes /No

1. Did the facilitator seat people so that all could see each other's faces? .....

2. Did the facilitator sit at the same level as the other participants? …… ..

3. Did the facilitator introduce the topic well (who he/she is, topic, time)? ……

4. Did the facilitator speak loud enough so that everyone could hear? …….. …

5. Did the facilitator use proper eye contact with everyone? …….

6. Did the facilitator changes his/her voice intonation (not monotone)? ……

7. Did the facilitator speak slowly and clearly? ……

8. Did the facilitator ask about the current practices of the participants? …….

9. Did the facilitator read each caption aloud to the participants? ……

10. Did the facilitator explain the meaning of each picture? ..…….

11. Did the facilitator demonstrate any skills that he/she was promoting? …….

12. Did the facilitator verify that people understood the main points using open-ended questions? …….

Discussion **Yes No**

13. Did the facilitator ask the participants open-ended questions? ……

14. Did the facilitator give participants adequate time to answer questions? ……

15. Did the facilitator ask participants if there were barriers that might prevent them from trying the new practices? ……

16. Did the facilitator encourage discussion among participants to solve the barriers mentioned? ……

17. Did the facilitator encourage comments by paraphrasing what people said (repeating statements in his/her own words)? ……

18. Did the facilitator ask participants if they agree with other participants' responses? ……

19. Did the facilitator encourage comments by nodding, smiling or other actions to show he/she was listening? ……..

20. Did the facilitator always reply to participants in a courteous and diplomatic way?.....

21. Did the participants make lots of comments? …….

22. Did the facilitator prevent domination of the discussion by one or two people? …… …..

23. Did the facilitator encourage timid participants to speak/participate? ……

24. Did the facilitator summarize the discussion? ……

25. Did the facilitator reinforce statements by sharing relevant personal experience or by asking others to share personal experience? ……

26. Did the facilitator ask each person to make a commitment? ……..

27. Did the facilitator ask each person about previous commitments? ……..

Content **Yes/No**

28. Was the content of the educational messages correct? ……

29. Was the content of the educational messages relevant? …….

30. Was the content of the educational messages complete? ……

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

Score: _____

Comments:

Annex-III Care Group Register

Care Group register: CGs are led by promoters; the members are Care Group Volunteers (CGVs).

Key	• Attended group meetings	X Absent	• Received home visit
	CB Under 2 child birth	CD Under 2 child death	MD Maternal death

CGV letter	Promoter name: / CG Volunteer name:	Date of registry in CGs	Month: / Date: / Lesson:	Births or deaths?	Date: / Lesson:	Births or Deaths?

Total attended/visited (add all • and)						
Total registered (add all CGVs still in the CG						
Maternal Deaths (add all MDs)						
Deaths in Children Under 2 Years Old (add all CDs)						
Child Births (add all CBs)						

- In the lines beneath this date the Promoter should indicate if the Volunteer attended the teaching session by placing a "↔" for attended, an "X" for absent, and a "·" if the CGV was visited at home. Next to this line, the Promoter should fill record any births or deaths that occurred this month. Use the codes from the key: "CB" for child born, "CD" for child death and "MD" for maternal death

Annex-IV Neighbor Group Register

Neighbor Group (NG) register: NGs are led by Care Group Volunteers (CGVs)

Key	• **Attended group meetings**	**X Absent**	• **Received home visit**
	CB Under 2 child birth	**CD Under 2 child death**	**MD Maternal death**

CGV letter	**CGV (group leader) name:** **Neighbor Woman (NW) name:**	**Date of Registry in Neighbor Group**	**Month:** **Date:** **Lesson:**	**Births or deaths?**	**Date:** **Lesson:**	**Births or Deaths?**

Total attended/visited (add all • and)						
Total registered (add all CGVs still in the CG						
Maternal Deaths (add all MDs)						
Deaths in Children Under 2 Years Old (add all CDs)						
Child Births (add all CBs)						

Annex-V Promoter Monthly Report

Note: This report template is modeled after a program with 1 Care Group per Promoter and 10 Care Group Volunteers per Care Group.

Promoter Name:		**Reporting period:**	
Promoter #		**Province/District:**	

Summary of Care Group Registers (Care Group Volunteers [CGVs]

Care Group Number	
CGVs attended 1st and 2nd meeting/home visit	
CGVs missed one of the two meetings/home visit	
CGV maternal deaths	
CGV under 2 child deaths	
CGV births	
# CGVs observed with a QIVC*	
Average QIVC score (%)	

Comments	

Summary of Neighbor Group Registers (Neighbor Women [NW])

CG letter													Total
NW attended monthly meeting/home visit													
New NW registered during monthly meeting/home visit													
NW Biths													
NW maternal death													
NW under 2 child deaths													

Annex-VI Supervisor Report

Note: This template is modeled after a program with 10 Promoters per Supervisor and 1 Care Groups per Promoter. Additional copies of the second page will be needed for each supervisor report, based on the size of your program

Supervisor name:		Reporting period:	
Promoter #s		Province/District:	

Summary of Care Group Volunteers (CGVs) per Promoter

Promoter number													Total
# of supervision visits to this Promoter													
QIVC score: Group education (%)													
CGVs attended 1st meeting/home visit												A	
CGVs attended 2nd meeting/home visit												B	
CGVs registered this month												C	
CGV maternal deaths													
CGV under2 child deaths													
CGV births													
# of CGVs observed with QIVC													
Comments													
		% of Promoters who completed QIVCs this month											
		Average CGV attendance this month: (A + C) ÷ 2											