A Guide to Mobilizing Community-Based Volunteer Health Educators

THE CARE GROUP DIFFERENCE

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The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators

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Reference websites: www.coregroup.org and www.caregroupinfo.org

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And the Vurhonga team…

Dr. Pieter Ernst is the designer of World Relief’s care group model and the project director of Vurhonga. He leads a team of dedicated staff in implementing Vurhonga – together they make a life-changing impact on the health of women and children in Gaza Province, Mozambique.

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Acronyms and Definitions

BCC	Behavior change communication
BL	Baseline
CG	Care group
CSP	Child survival project
DIP	Detailed implementation plan
DPT	Diphtheria, pertussis and tetanus (immunization)
EOP	End of project
EBF	Exclusive breastfeeding
EPI	Expanded program for immunization
FBO	Faith-based organization
HH	Household
HIV	Human immuno-deficiency virus
KPC	Knowledge, practice and coverage
LRA	Local rapid assessment
MT	Midterm
MOH	Ministry of Health
ORT	Oral rehydration therapy
Socorrista	Lowest cadre of Mozambican Ministry of Health workers, equipped to give first aid, dispense anti-malarials and make referrals
STI	Sexually transmitted infection
TBA	Traditional birth attendant
TT	Tetanus toxoid (immunization)
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHC	Village health committee
WR	World Relief

Introduction

When World Relief (WR) first submitted its child survival proposal for Cambodia, it was turned down. Among the concerns cited by the review panel was that it was too dependent upon volunteers and that projects based on volunteers do not work in Cambodia. In many ways, the review panel had the weight of evidence and experience on its side. Projects based upon volunteer commitment have often failed to achieve lasting change.

For almost a decade now, the care group model, in several countries (including Cambodia) has provided a counter-balance to the negative outcomes of many volunteer-based programs. Care groups are the core element in an emerging model for organizing, training, supervising and motivating volunteers in a cost-effective, sustainable manner. Care groups achieve broad, deep and lasting community change.

Building upon the case studies of the model pioneered by WR in its Vurhonga child survival projects in Mozambique, this manual answers three questions:

- Do care groups actually work? We present evidence of impact of two USAID-funded child survival projects (CSPs) in Gaza Province, Mozambique – Vurhonga I from 1995-1999 and Vurhonga II from 1999-2003.

- Would care groups work in your project? We will suggest criteria to assist health project leaders and technical advisors who want to examine the feasibility of the care group model for their programs.

- How do you begin? Drawing lessons from World Relief's CSPs, we present a "how-to" guide for starting and sustaining care groups.

Even proven models can fail in implementation. Evaluators of the Vurhonga projects often mentioned the "spirit of Vurhonga" as key element in their success. Care groups rest on more than an implementation plan. Care groups thrive on nuturing relationships with project staff, beneficiaries and the community at large.

A Gabayan proverb says, "The drop of water that stands alone goes crooked." This proverb captures an important truth about thought and practice not only in Africa but in many Asian and Latin American cultures as well. In the care group model, no volunteer stands alone. Each woman is supported by networks of relationships that teach, support, encourage and motivate her. These relationships foster effective training and behavior change – first in care groups, then between volunteers and mothers and finally in community at large – catalyzing change throughout entire communities who see their children living, not dying.

CHAPTER 1

Introduction to Care Groups

SECTION 1

Why Care Groups Were Created: Background

The WR care group model grew out of "Vurhonga," WR's first child survival project (CSP) in Gaza Province, Mozambique. The project name means "dawn" in the local language and reflects the CSP's role in awakening healthier communities following 17 years of civil war. Dr. Pieter Ernst, a physician and the CSP director, designed the care group structure in 1995 in order to reach a large population while maintaining cost-efficiency, sustainability and intensive support to volunteers and beneficiaries.

The need for a volunteer model: While in the design phase for Vurhonga, Dr. Ernst recognized that the project's 19 health promoters alone could not adequately reach a population of 107,000. Nor could staff provide the intensive training and consistent support necessary for behavior change messages to truly take root in communities. Creating a network of volunteers to reach many beneficiary households seemed an ideal solution from a financial and logistical point of view.

However, attrition and volunteer burnout were potential threats to projects using volunteers. This indicated the need for a more comprehensive approach to engaging community members in volunteer service. Dr. Ernst and the senior Vurhonga staff resolved to design a system that would provide support for volunteers without making their responsibilities too burdensome. Volunteers would not work alone, but with the support and encouragement of one another.

Project leadership drew on their years of experience and lessons learned from working and living among communities targeted by health and development initiatives. Dr. Ernst in particular built upon his experience with a community health outreach through Kilm, Tshilidzini and Elim hospitals in Limpopo Province, South Africa – the work there also used community-based volunteers.

Responding through care groups: The result of their efforts, the care group model, creates a vast network of community volunteers. Each staff health promoter trains and supports as many as eight care groups. About 10-15 volunteers comprise each group, which meets twice a month. Then, every volunteer is responsible for re-teaching lessons learned in the care group to 10-15 households. Her primary source of support and encouragement is her fellow volunteers in the care group rather than project staff or material incentives.

Care groups dramatically influenced health practices of households in Vurhonga's area, successfully surpassing nearly all of its end of project (EOP) objectives as soon as the midterm (two years after the project began). It also created a network of committed, motivated and effective volunteer health educators. The model's success – first in Vurhonga I from 1995-1999, as well as in Vurhonga II from 1999-2003 – led WR to apply it to subsequent CSPs.

Replicating care groups: The care group model is adaptable to a wide range of cultures and countries. WR has since used the model in Cambodia, Malawi and Rwanda (see Appendix A for project profiles). In 1997 skeptics doubted whether a volunteer-intensive strategy could be successful in Cambodia, where communities were fragmented by genocide and lacked the high degree of community identity so often found in African villages. A careful assessment of the communities enabled senior project staff to make adjustments and adapt the model to cultural and situational needs. The Cambodia program has been highly successful.

Other organizations, including Food for the Hungry International and Curamericas have since applied the care group model in a Title II Food Security project in Mozambique and a CSP in Guatemala, respectively (see Appendix B for project information).

WR is also exploring ways to use the care model in other health and development contexts. For example, WR is using care groups to train peer educators in HIV/AIDS prevention and care. While the interventions differ, the core elements of the care group model – multiplication of volunteer effort, peer support and community mobilization – remain the same.

SECTION 2

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 project staff for training, 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 promoter trains and supervises as many as eight care groups of 10-15 volunteers each. The large number of volunteers mobilized ensures breadth of outreach – WR's second CSP in Mozambique used 2,315 volunteers to reach more than 50,000 direct beneficiaries every two weeks.

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 twice 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 do not meet as a group – 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. In a follow-up survey to Vurhonga I conducted 20 months after the project stopped working in the area, care groups' net retention rate of volunteers was 94%. In addition, sustainablity is enhanced as community leadership act on feedback from care groups, using the volunteers to mobilize community responses to changing health needs.

SECTION 3

Measuring the Impact of Care Groups: Evidence of Effectiveness

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

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

Before the work of care groups, the grannies in this village in Mozambique had been captive to an understanding of disease that to them felt like slavery. They attributed many diseases and deaths of women and children to the work of spirits and curses. Four years later, far fewer of their grandchildren were dying. The young children were thriving not because the spirits had become more kindly but because their parents and caregivers were taking positive, effective action to prevent or to rapidly treat their diseases.

However compelling the grannies' story, is it true? Is it possible to substantiate that the behavior of their children and grandchildren had changed? Did underlying beliefs about health and disease shift? If so, what differences had care groups made in bringing about change?

3.1 Change in Health Behavior: Quantitative Evidence

Data indicates marked changes in health practices in Vurhonga's project areas. The changes WR observed in Mozambique are reflected in villages in other countries where care groups promote change. The table on the following page describes results in WR CSPs that used care groups, as measured by Knowledge, Practice and Coverage (KPC) surveys. Each project was four years long. Though not all of WR's CSPs shared the same objectives, each used the care group model to achieve success.

Care groups guide households through the process of behavior change. Behavior change communication (BCC) is a process for promoting and sustaining healthy changes in behavior through participatory, appropriate health messages conveyed in a variety of ways ("Developing Materials on HIV/AIDS for Low-Literate Audiences," PATH and FHI, 2002). With the support of project staff, care group volunteers in a CSP teach houeholds health lessons related to each major intervention, providing on-going encouragement to households. The project first implements interventions focused on behaviors often regarded as easier to change – such as treatment of diarrhea and treatment-seeking. As trust builds between promoters, care groups, and the households, they cover behaviors that tend to be more sensitive to address – such as feeding practices or family planning.

	Vurhonga I			Vurhonga II			Malawi			Cambodia		
	Target	Baseline	**Final**	Target	Baseline	**Final**	Target	Baseline	**Final**	Target	Baseline	**Final**
Children 12-23 mos. Up-to-date on immunizations*	80%	37%	**93%**	90%	74%	**91%**	NA	NA	**NA**	NA	5%	**68% (81)**
Children who have had diarrhea in last two weeks receive ORT	60%	47%	**82%**	80%	53%	**94%**	NA	NA	**NA**	75%	18%	**80%**
Children under 6 months breastfed exclusively**	30%	16%	**55%**	NA	NA	**NA**	50%	36%	**95%**	21%	8%	**37%**
Seek treatment within 24 hours if children have fever (malaria)***	35%	11%	**85%**	75%	28%	**90%**	90%	35%	**74%**	NA	NA	**NA**
Seek treatment within 24 hours for rapid breathing (ARI)****	NA	NA	**NA**	50%	2%	**87%**	50%	28%	**64%**	NA	NA	**NA**
Children 0-35 months weighed in last 3 mo.	70%	59%	**91%**	85%	75%	**90%**	90%	65%	**97%**	NA	NA	**NA**
Mothers of growth-faltering children receive nutrition counseling	NA	20%	**87%**	80%	22%	**92%**	NA	NA	**NA**	NA	NA	**NA**
Use of modern family planning methods	10%	3%	**23%**	20%	7%	**29%**	40%	23%	**61%**	30%	21%	**56%**

* Vurhonga II did not have this as an official indicator but nevertheless promoted and tracked immunizations. Cambodia measured end of project immunization rates in a special survey following the final KPC to capture intensified immunization efforts in the final months of the project.

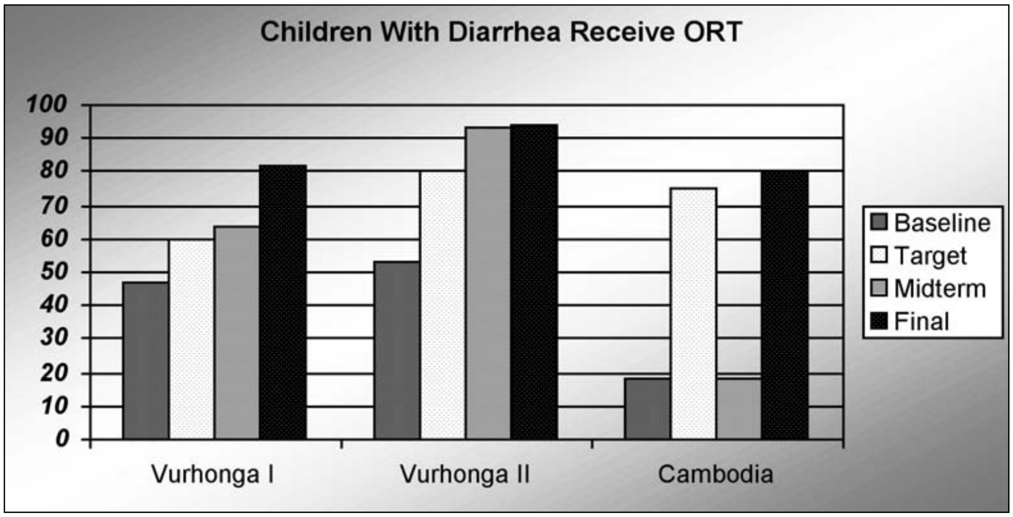
** Cambodia measured exclusive breastfeeding to 4 months.

*** Treatment-seeking within 24 hrs. measured as "same day" in Vurhonga II.

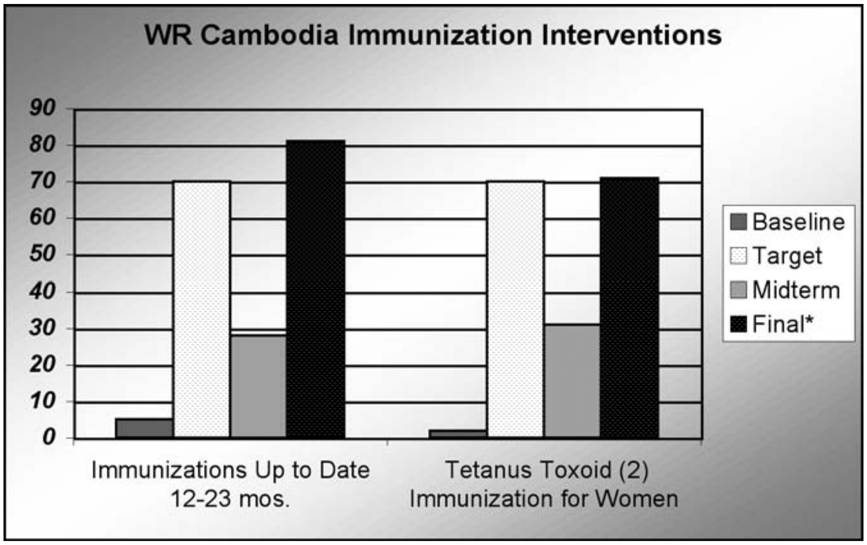
**** Vurhonga II coding of survey responses first defined treatment seeking as "same day" and had a result of 60%. When recoded to include "within 24 hours," the result was 87%.

For a full report of objectives and evaluation results for Vurhonga I, Vurhonga II, Malawi, and Cambodia, please see Appendix C.

The projects in Mozambique and Cambodia included promotion of ORT (Oral Rehydration Therapy) among their first interventions. The graphs below illustrate baseline indicators, end of project (EOP) targets and final KPC results, as well as data from the midterm KPC (usually done two years into the project). As shown below, Vurhonga acheived most of its EOP targets by the midterm point.

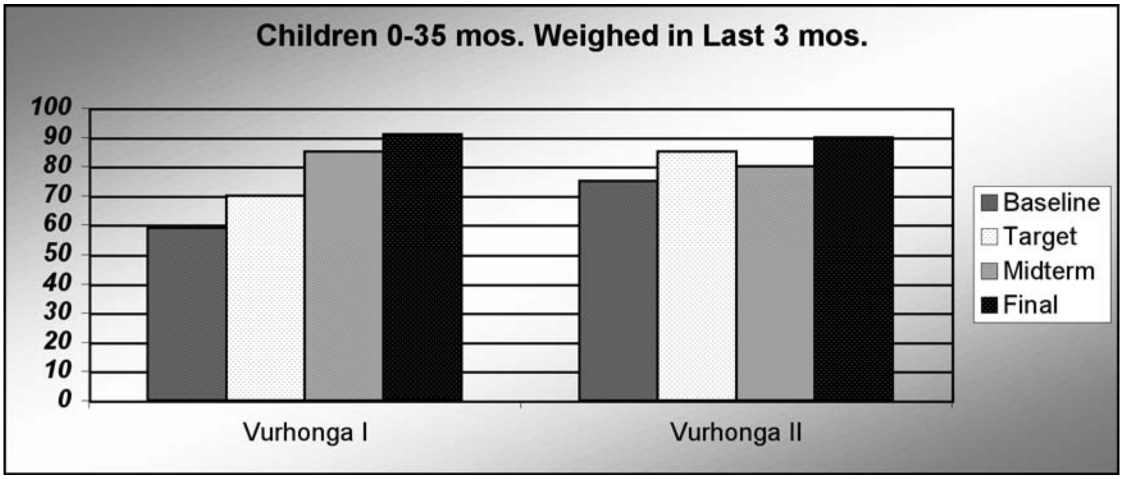


Immunization coverage was another early intervention of WR's CSP in Cambodia – and a very positive example of care groups' impact in an Asian context. Mothers in the project area had a strong cultural resistiance to immunizations, fearing injections and the slight fever that sometimes followed the shots. Care group volunteers' consistent interactions with households helped convince mothers to bring their children to immunization sessions.

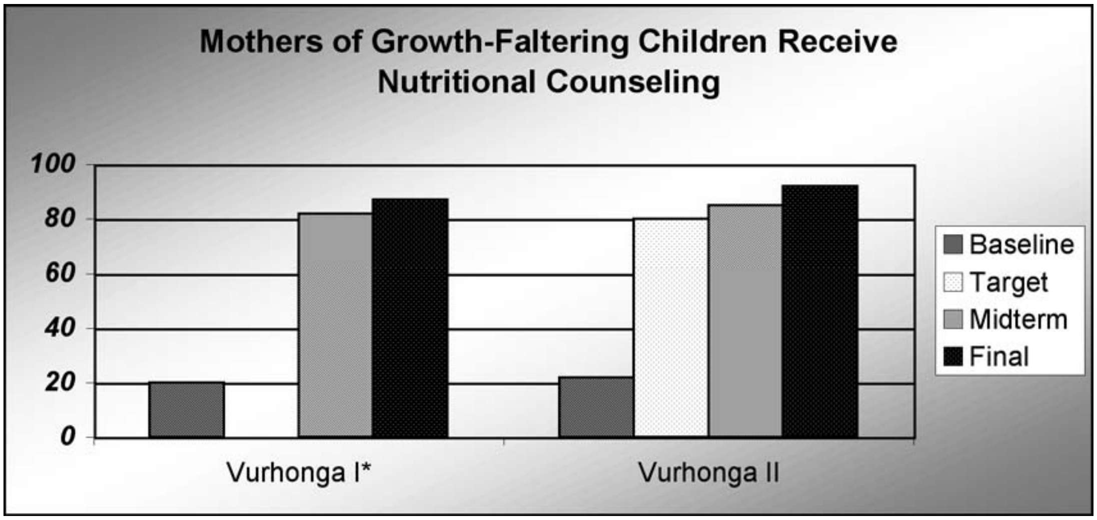


* Cambodia measured end of project immunization rates in a special survey following the final KPC to capture intensified immunization efforts in the final months of the project.

Interventions related to nutrition were implemented later in by Vurhonga I and Vurhonga II. For example, care groups successfully encouraged mothers to have their children weighed.

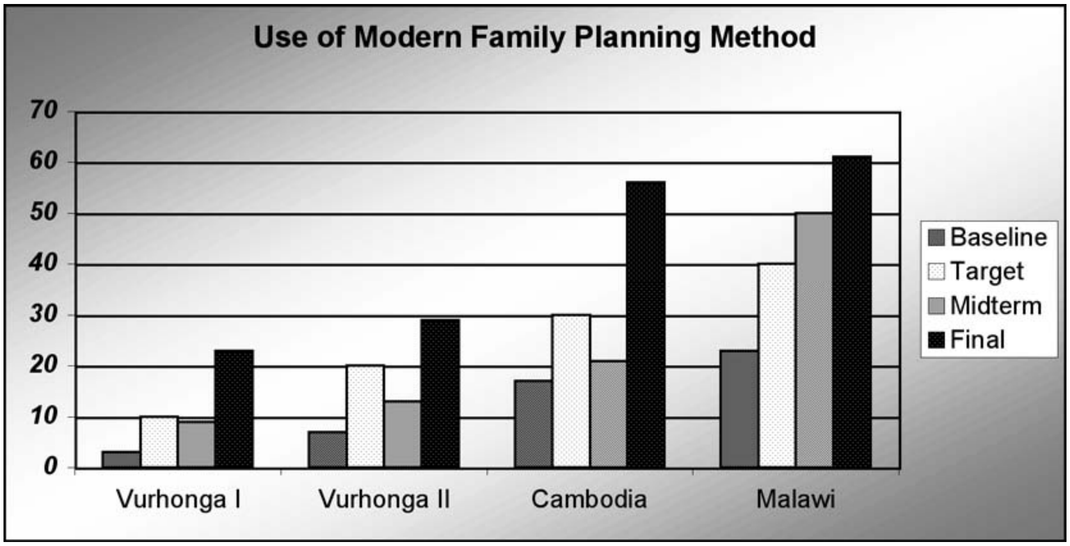


The care groups followed up by providing nutritional counseling to households whose children were not gaining weight appropriately. The low ratio of households per volunteer made it easier to give individual attention to mothers whose children were below normal weight.



* Vurhonga I did not initially set a goal for nutritional counseling.

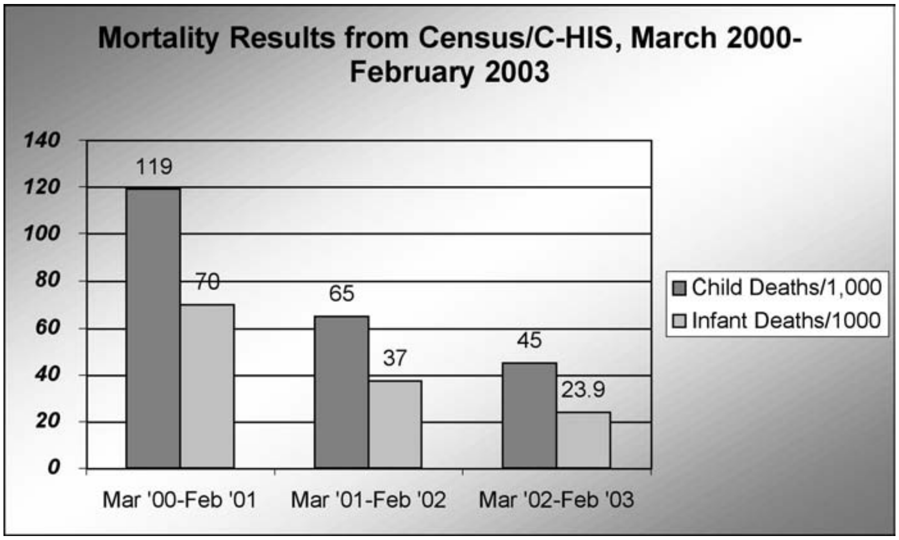
One of the last interventions in each of WR's four CSPs was birth spacing through use of a modern family planning method. Care group volunteers contributed to the positive results through the trusting relationships they developed with households over time, making it easier to address behaviors related to sexuality.



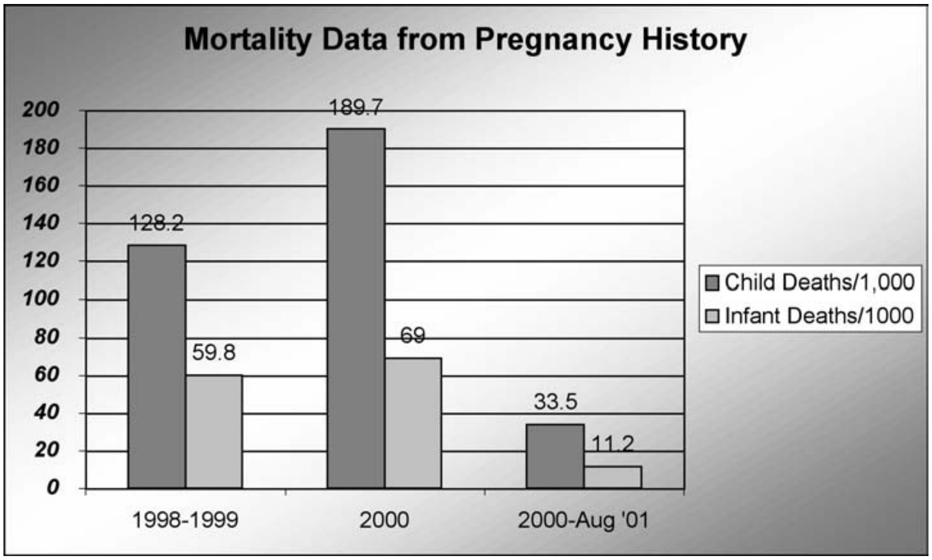
3.2 Trends in Infant and Child Deaths: Examining Mortality Data

Fewer children were dying in the project area, according to data from the community-based health information system based on Vurhonga care groups. The quality and comprehensiveness of Vurhonga II's Community Health Information System (C-HIS) made it possible to collect reliable mortality data. During a three-year period, the C-HIS indicated that under-5 mortality decreased by 62%, (119/1000 in 2000, 65/1000 in 2001, 45/1000 in 2002). Vurhonga II collected mortality data for about the last three years of the project, starting after an unusual flood disaster in February 2000 (deaths linked to the flood were not included in the mortality results).

Project staff used two methodologies to arrive at these totals. Vurhonga staff conducted a retrospective census-based survey asking mothers about births and deaths that took place in one-year intervals, from March 2000-February 2001 and March 2001-February 2002. Data for March 2002-February 2003 were gathered through the project's C-HIS. In addition, promoters followed up C-HIS results in each village to verify births and deaths. The following table illustrates the compiled findings.



As part of the final evaluation, external evaluator Dr. Carl Taylor of the Johns Hopkins Bloomberg School of Public Health led a pregnancy history study to follow up on Vurhonga II's findings. The CSP staff interviewed 250 women about their pregnancy histories, using a convenience sample from 10 randomly selected villages. Five randomly selected clusters of 5 interviews were conducted per village. The study included results from 1998 in order to compare with the situation before Vurhonga II activities began. Overall, the child mortality results based on pregnancy histories corroborated data already collected by the project.



**2000 includes deaths resulting from an unusual flood disaster in February.*

WR, with support from CORE, is doing additional research on impact on mortality rates in Vurhonga II's project area. The results were pending at the time of this manual's publication – the final study will be released by the end of 2004.

3.3 Shifts in Health-Related Beliefs: Anecdotal Evidence

Compelling anecdotal evidence shows changes in underlying beliefs that influence health behaviors. At both the individual and community level, impact on belief is widely reflected in almost all in the villages covered by the Vurhonga projects. The evaluations of all WR's CSPs using care groups have recorded these changes in each location, at various times, and from many different people from mothers and grannies to chiefs to government workers.

The implementation of the Hearth nutrition rehabilitation model by care groups in Vurhonga illustrates how households change their beliefs about the causes of good or poor health. The effectiveness of Hearth greatly improved the health of participating children. (For example, more than 80% of children attending Vurhonga I's second cycle of Hearth gained adequate weight.) This impacted beliefs–households previously thought that evil spirits caused poor child growth, but Hearth, through the implementation and follow-up by care group volunteers, demonstrated that improved nutrition and feeding practices influenced growth.

The dramatic improvement of children participating in Hearth impacted entire households – grannies, mothers and fathers all came to appreciate good nutrition. Regarding the shift in mothers' beliefs, Vurhonga I final evaluator Dr. Franklin Baer wrote, *"They also demonstrate knowledge that the causes of malnutrition are under their control, and due to feeding practices, rather than previously held beliefs such as "'being sat upon by spirits.'"*

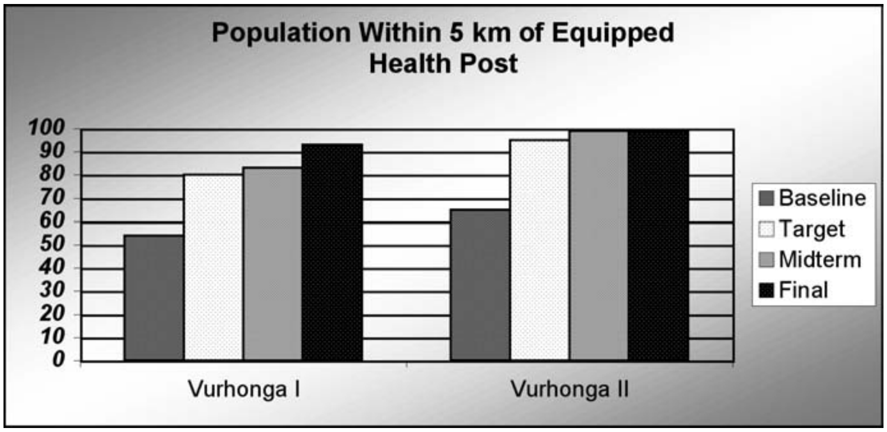
During Vurhonga II's final evaluation, one socorrista (a part-time MOH health worker), said, *"I was impressed by what Vurhonga taught us about malaria and diarrhea. We didn't used to know what caused them, and so blamed other people. But now we know. If the child had malnutrition we thought it was an evil spirit–now we know it's just a simple lack of food."*

Many health workers at local health posts also note that mothers' attitudes towards health improved–and that they take action on their new beliefs. During Vurhonga II's final evaluation, health post workers said, *"They (mothers) have a better understanding of the importance of care. For instance, mothers tended not to go to health clinic for convulsions, but things are changing now that people are more aware of possible treatment. They used to treat them with inhaled smoke or by hitting a spoon on a pan near the ears of the convulsing child, but now they take their child to the health post."*

3.4 Building the Capacity of Clinical Care Providers

Changes in the community tell only part of the story. Improved health depends not only on the behaviors of the community; essential preventative and curative services must also be available. Care groups play important roles in linking households and clinical care, such as MOH health posts and clinics in the project area.

Increasing access to MOH services: Vurhonga staff and the MOH, with participation from care groups, increased the number of trained MOH health workers working in the project areas. By the end of Vurhonga I, the percentage of the population living within 5 km of a trained health provider rose from 58% to 98%. In Vurhonga II, the change was from 65% to 99%. The results are illustrated below.



The initial increase in access was largely due to Vurhonga staff training low-level MOH workers, called socorristas, in collaboration with the MOH. Socorristas work locally on a part-time basis, provide basic services (first aid and referrals) and dispense medicines, including chloroquine. Vurhonga staff helped train and establish socorristas at a very low cost to the project –communities contributed by building the socorristas' simple health posts using locally available materials.

Care groups help make sure that access to clinical providers, such as socorristas, is mainained and utilized. Care groups teach households to seek appropriate treatment from local clinical care. The increased demand motivates MOH workers to keep up their work and be available to the communities.

Care groups become valuable resources to clincial providers. Care group leaders regularly pass on care group reports on vital statistics to MOH workers. Often in Vurhonga's project area, this information is more comprehensive than what the MOH otherwise has. The data gives clincial workers a better understanding of the general health of women and children in the surrounding communities. This strengthens on-going relationships and information exchange between care groups. In addition, the MOH can rely on care groups to help with their community mobilization efforts. For example, MOH staff call on volunteers to rally households in a village for immunization campaigns or weighing sessions. After the MOH communicates to the care group leaders, all volunteers spread the news to their assigned households, generating a greater turnout for the event.

Increasing demand: Communities learned to expect and indeed demand more from the MOH through the work of care groups. Health center staff reported that demand for services skyrocketed over the course of Vurhonga II. This delighted health center staff – MOH workers also said that they feel much more motivated in their work. Previously, people who did go to the health center went as a last resort – when treatment was often too late to be effective.

The MOH statistics from the time of Vurhonga II show that the average number of consultations rose. The average number of consultations at health posts increased from 1,511 in 6 health posts in 2000 to reach 5,533 in the 28 health posts functioning in 2001 (many of these consultations took place at the socorristas local health posts, which are very basic, cost-efficient structures). This corresponds to a 30% increase in the total number of consultations in health posts and health centers in one year.

3.5 Fostering Sustainability: Care Groups, Communities and Clinical Providers

Sustained behavior change after a project's end suggests that new health practices have become rooted in changed beliefs and not only pressure from the project. Care group volunteers' continued activity, such as attending meetings and visiting households, are a key element to sustainability. Also, community buy-in, including the support of local leaders, adds to sustainability even after the project is no longer officially active.

Care group commitment: Care groups experience a low attrition rate. In Vurhonga I, the volunteer turnover among 1,520 volunteers was only 6% over the life of the project. Attrition was defined as leaving the post of volunteer for reasons other than death, disability or moving from the project area. In Vurhonga II, the attrition rate was even lower–3% among the project's 2,315 volunteers. In the final evaluation of Vurhonga II, 92% of households reported receiving a visit from a care group volunteer within the last two weeks.

Care groups build the foundation for sustainable improvements to the health of people in their communities. Not only did care groups experience low volunteer attrition during the project–care group volunteers also faithfully continued meeting together and visiting households after direct CSP involvement ended. Staff did site visits to Guija and Mabalane Districts and conducted a survey 20 months after Vurhonga operations moved to Chokwe District. The results revealed on-going care group activity and commitment without further input from the Vurhonga staff or another outside agency: the volunteer attrition rate remained below 10% and half the households surveyed reported visits from a volunteer within the past two weeks.

Volunteer Retention at Vurhonga I Project Area
20 Months After End of Project

Volunteers active at End of Project	1,457
Volunteers who: Left post or moved	 −92
Died	−44
Were selected as replacements	+40
Volunteers functional 20 months after EOP	1,361
Net attrition 20 months after EOP	6.59%
Households reporting a visit from volunteer within last two weeks	50%

The care group structure enables care group volunteers to easily recruit and train new volunteers to replace those who drop out. Communities and care groups post-Vurhonga I arranged for replacement volunteers to assume responsibility for about half the vacant volunteer positions, facilitated their training and integrated them into the existing care groups.

Application: WR CAMBODIA
The CSP in Cambodia also used the care group model and had strong volunteer retention during the 1998-2002 project. The attrition rate was 13% over the life of the project–the CSP's target at the outset was that attrition not surpass 35%. The project achieved low attrition in spite of the special obstacles to care groups in Cambodia. Volunteering was not part of the culture, volunteers often demanded payment, violence at local and national levels made people less trusting of strangers, and many women had jobs in addition to their farming tasks. Despite this, the project used more than 940 volunteers organized into 126 care groups. The project continues to use the care group model now that it has expanded.

Application: WR RWANDA
The CSP in Rwanda, currently at the midpoint of its five-year project at the time of this manual's publication, has experienced high volunteer retention. The volunteer attrition rate over the life of the project is about 3%, which includes volunteers who moved out of the project area or died.

Village Health Committees: There is also evidence that the care group model succeeds at equipping communities to proactively address local health needs. By working with local community development groups, care groups move the discussion about health priorities from the predominanty female care groups to include local leaders of both genders. This gains a cross-section of community support for care groups and their work.

Project staff, with the involvement of care groups, can help facilitate the creation of village health and development committees (VHCs) if none already exist in the project area. Promoters sensitize the local leaders in their village to health needs and the possible responses, encouraging the formation of a VHC. Once the VHC is establsihed, the care group leader usually becomes a member, and she provides the VHC reports on vital statistics and health information gathered by her care group. This data equips VHCs to make well-informed decisions regarding issues affecting community members' health.

VHCs help institutionalize new health practices and beliefs into the on-going life of the community. Community leadership works with care groups, promoting and even enforcing improved health behaviors. During Vurhonga I, one village chief said, *"People who will not change their behaviors can poison the entire village. If a man continually refuses to permit the volunteer to visit, the entire care group will go and visit him. If he still does not let them in, the head of the village health committee will go and counsel him. If he still refuses, I will call a village meeting and bring him before all of the elders."* Vurhonga promoters confirmed that they and the care groups had decided to approach the chiefs concerning those who would not change. Together, they decided that the procedure described by the chief would be followed in all of the villages.

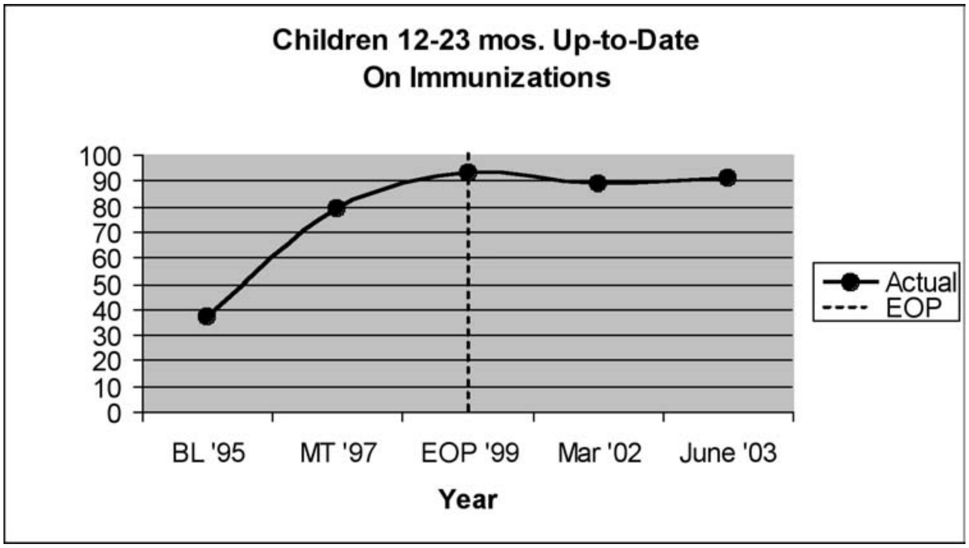
Very few VHCs existed or were active in either the Vurhonga I or II project areas. Vurhonga I facilitated the development of 41 VHCs, all of which were active at the end of the project. Vurhonga II staff helped organize VHCs by the midterm. All 48 villages in the project area had an active VHC by the end of project. (Vurhonga measures a VHC as "active" if 60 percent of its members are present for at least 60 percent of meetings.) Vurhonga II's goal was that 70% of VHCs meet at least once in the last two months. At the end of the project, 91% of VHCs had met that frequently.

In addition, Vurhonga staff and care groups facilitated relationships between the MOH and VHCs. During Vurhonga II, an MOH representative attended 95% of VHC meetings, surpassing the goal of 80%.

Sustaining services: Finally, continued access to and action by clinical providers is needed to help households maintain improvements to their health. Follow-up surveys indicate sustained changes to health practices in Guija and Mabalane Districts, where Vurhonga I finished working in 1999. These results reflect not only sustained behavior change at the household level, but also continued service provision by the MOH.

For example, children ages 12-24 months who were completely vaccinated increased from 37% to 93% by the project end of Vurhonga 1 in 1999. The immunization rate has been maintained since then by the MOH, without further project inputs. In the four years following the project's conclusion, immunization rates have varied between 89-91%.

These results reflect not only sustained behavior change at the household level but also continued service provision by the MOH, since immunization rates depend on the MOH to conduct regular vaccination sessions.



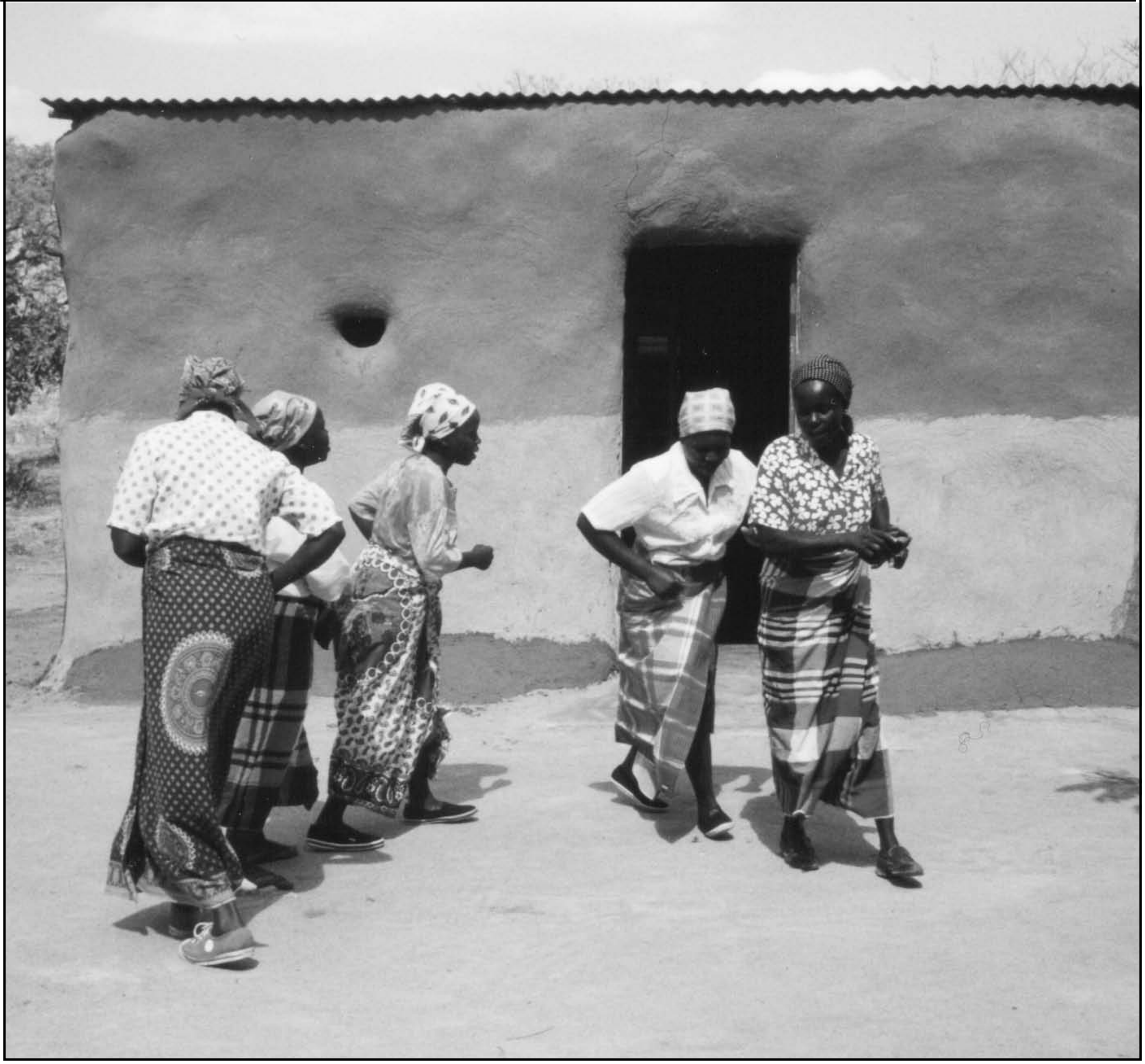
Other indicators show continued maintenance of behaviors, possible through support from sustained MOH activity. Treatment seeking within 24 hours for suspected malaria increased from 11% to 85% over the life of Vurhonga I. In the four years afterwards, it has varied between 80-93% in subsequent measurements. ORT use during diarrhea increased from 46% to 82%, and since the end of the project ORT use has ranged from 84-100%. Family planning use increased from 3% at baseline to 23% at end of project, and subsequently has ranged from 22% to 27%.

Conclusion

The story of the grannies' sense of liberation is not an isolated event. Evidence supports the effectiveness of the care group model in a variety of ways. Care groups saturate all households in the project area with lessons on new health practices, resulting in widespread behavior change. There are shifts in beliefs related to health, creating a solid foundation on which to sustain the health practices. Finally, care groups involve VHCs and clinical care providers in the process of change. The transformational effect of care groups reaches far, creating a lasting difference in communities.

CHAPTER 2

Deciding When to Use Care Groups



SECTION 1

Evaluating When To Use Care Groups: Criteria

During a project's design phase, certain criteria need to be examined to determine whether or not the care group model is appropriate for a particular health project's context and needs.

1.1 Project Area

The project area – the geographic region served by a particular program – is very influential to care groups' success or failure. In WR's CSPs, often the project area has been been one or two health districts or political districts, with total populations between 78,000 and 184,000 people.

Population density: The population density of a project area affects the size of the volunteer pool and the distance volunteers and staff must travel. Population density may also affect variables that are more difficult to measure, such as the sense of community cohesion or the availability of paid employment that competes for the time of volunteers.

In WR's experience, care groups function best in moderate to highly populated rural areas, where households are within reasonable walking distance of one another.

The Care Group Difference:
The care group model depends on volunteers living within reasonable walking distance of care group meetings and their assigned households.

➡ **Consider three main factors when deciding whether care groups would work well within a particular project area.**

- ***Volunteer pool:*** Is there a large enough population from which to draw sufficient volunteers – are there 10 groups (of 10 households each) within walking distance?
- ***Reasonable travel:*** Are households and villages spaced to make it easy for volunteers to visit their assigned households and to walk to the care group meetings? Can the project staff travel between care group meeting sites and conduct field supervision using available and cost efficient means of transportation?
- ***Volunteer availability:*** Do women in the program site have time in their daily lives to attend biweekly care group meetings and carry out their volunteer responsibilities? Can they commit to spending roughly 5 hours per week on volunteer activities?

The Care Group Difference:
A moderate population density best facilitates volunteer communication and support, while keeping project costs low.

The care group model is not well-suited to sparsely populated or remote locations (such as regions with homestead farms). These environments strain volunteers' time and financial resources, increasing the likelihood of dropouts. They also greatly increase the cost of the project since staff must spend time and resources traveling to distant care group meeting sites. Traveling long distances in remote areas may also be more dangerous for volunteers and staff.

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

Urban challenges to volunteer retention include:

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

The Care Group Difference:
A lack of community stability or identity in urban areas can undermine care groups' solidarity and commitment to community service.

Questions to consider:

- What is the population density of the project area?
- What is the population size the project will target?
- How far must volunteers travel to care group meetings? Is this reasonable, given their time and resources?
- How far must promoters travel to care group meetings? Is this reasonable, given the project's budget and promoters' workload?
- Is it safe for volunteers and promoters to travel to care group meetings?
- Are there densely populated urban sites within the project area? Will the project include these?

1.2 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 in best in projects that last for years, not months.

Project timeline: The care group model requires intensive work at the start of a project to recruit volunteers and form care groups (see Chapter 3, Section 1 "Timeline"). 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 – i.e. the typical CSP timeline. If a project has a shorter time frame of less than two or three years, the care group model may not be feasiable or effective for communicating behavior change messages.

The Care Group Difference:
Care groups function well in projects lasting between three to five years.

➡ **Consider if the project's duration allows adequate time to set up care groups and effectively deliver health messages to households.**

Once the care group structure is in place and volunteers are regularly meeting and doing household visits, a health project can easily add interventions – (for CSPs, each intervention is a major health topic divided into lessons, such as an intervention on control of diarrheal diseases covered over five lessons). Adding interventions does not require significut inputs from the project once care groups are functioning (see Chapter 2, section 2 "Budget Implications"). A four to five year project allows enough time to phase in all major interventions by the midterm (usually about 4-6 interventions for a CSP). Then, the project can repeat interventions during its final half, reinforcing behavior change and promoting sustainability.

➡ **Consider if the project timeline is long enough to add on or repeat interventions at a minimal cost.**

Questions to Consider:

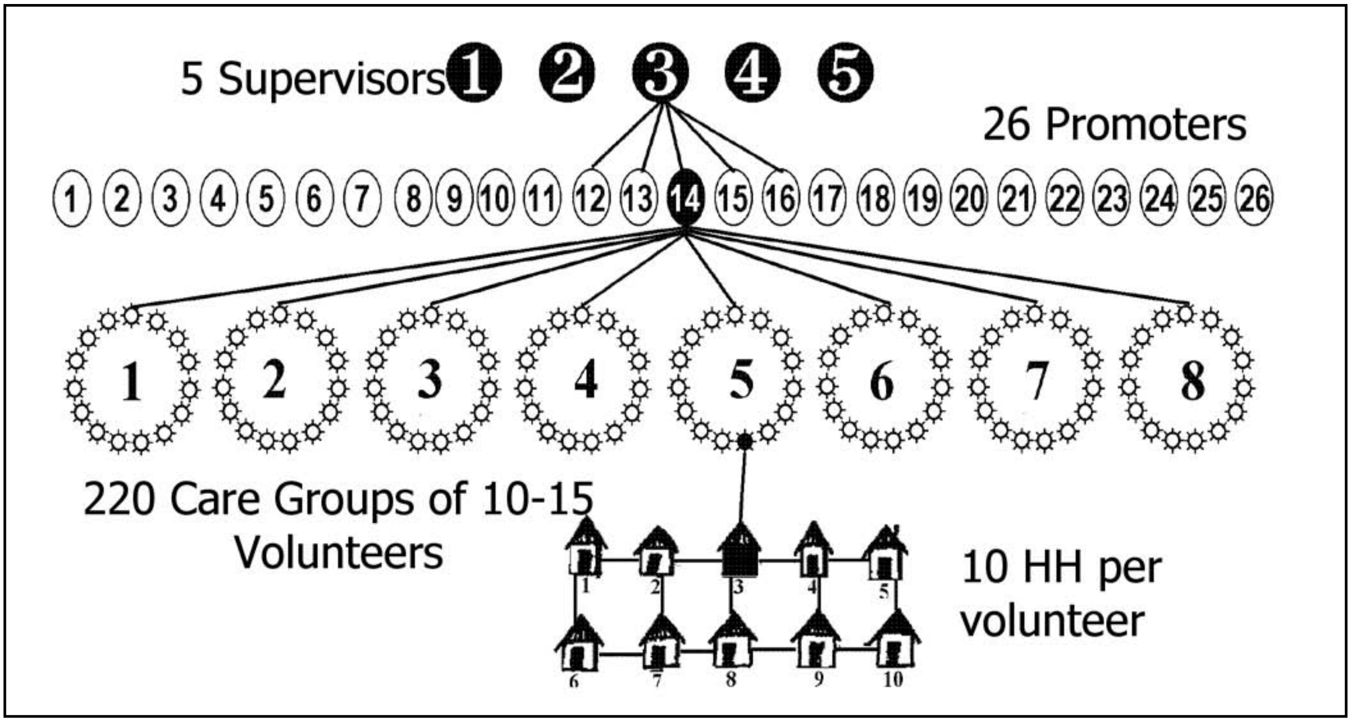
- What is the total time allotted for the project?
- How many major interventions does it plan to cover?
- Does the project have the time, staff commitment and financial resources to recruit and organize care groups?
- What are the expectations of donors and other CSP stakeholders surrounding the timeline and start of household-level activities?

1.3 Ratios for Staff and Population

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. However, no staff member's workload should grow too great, or effectiveness decreases.

The following graphic illustrates Vurhonga II's organization of staff and care groups.

Structure To Reach Population of 130,000


5 Supervisors
1 2 3 4 5
26 Promoters
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26
1 2 3 4 5 6 7 8
220 Care Groups of 10-15 Volunteers
1 2 3 4 5 6 7 8 9 10
10 HH per volunteer

Graphic by Dr. Franklin Baer

Supervisors per promoters: The supervisor to promoter ratio functions well at approximately 1:5. Vurhonga found that this is an efficient use of resources while still providing enough oversight and support to promoters to ensure quality training and sound technical content.

➡ **Plan on a supervisor to promoter ratio of 1:5.**

Promoters per care groups: One promoter should be responsible for no more than eight care groups. Assuming two-week work cycles, the 1:8 ratio allows the promoter to spend one day training each care group while leaving one day per week for other program events and meetings. This creates a manageable workload for promoters and still achieves the desired population coverage.

➡ **Plan on a promoter to care group ratio of 1:8.**

Volunteers per care group and households: One care group should 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).

➡ **Plan on a 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 an extremely large number of households. However, this is an indirect relationship – the promoter focuses on her eight care groups, not the individual beneficiaries at the household level. In Vurhonga II, the ratio of promoters to households was 1:942.

The Care Group Difference:
Projects with limited numbers of paid staff can reach a large beneficiary population through care groups.

In Vurhonga I reached a total population of 107,000 using three supervisors and 19 promoters. This created a supervisor to promoter ratio of 1:6.6. There were 173 care groups, so the promoter to care group ratio was 1:7.4. The total number of volunteers was 1,520, so there was roughly one care group per 8.8 volunteers. These volunteers reached 15,200 households; this made the volunteers to households ratio 1:10. The promoter to household ratio was 1:800.

Vurhonga II served a total population of 130,000. The supervisor to promoter ratio was 1:5.2, with 5 supervisors overseeing 26 promoters. There were 220 care groups, and the promoters to care groups ratio was 1:6.6. With 2,315 volunteers, the ratio of care groups to volunteers was 1:10.6. The volunteers visited 24,500 households. The care group volunteer to household ratio was 1:10.6.

Questions to consider:

- What is the population size the health project aims to reach?
- Given the number of beneficiary households, how many volunteers will the project need? How many care groups must be formed? How many staff are needed to train and supervise the care groups?
- Does the project have enough staff and the financial resources to maintain appropriate ratios of supervisors to promoters, and promoters to care groups?

Scaling up: Different ratios of staff to beneficiaries should be expected when scaling up a health project, particularly a CSP. The need to reach a larger population may not be matched by a proportionate budget increase for hiring more supervisors and promoters. But, project staff can draw on skilled care group volunteers from past projects when scaling up and expanding the program.

The Care Group Difference:
Care groups create a very large pool of skilled volunteers, from which staff can draw additional support when scaling up a project.

Vurhonga III plans to reach five new districts, reaching 102,357 direct beneficiaries. It will use approximately 350 care groups. To cope with larger numbers and a less dense population, the number of promoters will rise to about 100. However, the majority of these will be part-time (half-time or even quarter-time staff), depending on the population of the local area. The overall ratio of promoters to care groups will range from 1:4 to 1:8. In addition, the project area of Vurhonga II, where care groups continue to operate, will serve as a training center for the expanded impact project.

> **Application: WR CAMBODIA**
> WR followed its first CSP with a cost-extension project that doubled the total population reach, tripled the number of volunteers and expanded into more remote areas. The project achieved large scale-up at a minimal cost by identifying about 50 excellent volunteers from the first CSP to help train and support newly-formed care groups in the expansion area. These "volunteer supervisors" work approximately 5 days a month training new care groups. Each woman is responsible for four care groups and is paid part-time. As a result, the project achieved scale-up while only adding two new promoters to the existing 16 promoters. Today, the ratio between regular staff promoters and care groups is 1:16 in the project's expansion area.

Questions to consider:

- If scaling up, does the project have the budget to add a proportionate amount of staff?
- Are there creative ways to meet expansion challenges – altering staff to care group ratios without overburdening staff?

1.4 Project Partnerships

Partnering with local clinical providers: Preventative health projects may choose to partner with local clinical care providers, such as the MOH or other hospitals or clinics. These partnerships foster sustainability by creating relationships between clinic staff and care groups. The clinical 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, if the health clinic is viewed positively by the community.

Questions to consider:

- Is local MOH, hospital or health clinic staff interested in and supportive of grassroots-level work? How do they view community-based volunteers?
- What sort of community outreach activities are already being carried out by a potential partner? Do they focus on the poorest of the poor?
- Do they have a health information system that tracks community health data, or do they only use clinical admission records to gather data?
- Do the local people trust and respect the services of the local health facilities?

Partnering with local faith-based organizations: Health projects implemented by faith-based organizations (FBOs) may also want to consider partnering with indigenous faith communities. If staff are of the same religion as the local FBO, the links are often natural. These partnerships can include working with health centers or hospitals operated by churches or mosques, or projects might use faith communities' meeting places as venues for meeting with communities about health. Building relationships with local faith communities also promotes community acceptance of care groups.

Links between Vurhonga, care groups and local churches contribute to community support of health behavior change. Religious leaders in Vurhonga's project area participate in special "pastoral care groups," where they receive preventative health training. The pastors then pass health messages to their congregations and the community at large. In addition to raising awareness of health, local churches in Vurhonga's area more broadly promote other aspects of positive behavior change, such as transformation in people's sense of efficacy, empowerment and hope.

Questions to consider:

- If there is a faith-based health center, does it have a good relationship with local religious leaders?
- Are local FBOs interested in serving physical needs, such as poverty or health?
- Does the FBO running a hospital or health center share the community-service values of the care groups and seek to encourage their activities?
- Would local religious leaders come to village health committee meetings? Would they attend pastoral care group meetings?

Application: WR MALAWI

WR Malawi's CSP partnered with three hospitals operated by the Synod of Livingstonia of the Central Church of Africa Presbytery, as well as the local MOH, to build their capacity for community-based child survival activities. Focusing on the hospitals' catchment areas enabled the CSP to reach a total population of more than 170,000. The CSP benefited from partnership with an established, sustainable institution with a strong commitment to community health. The care groups were linked with the referral systems and staff structure in the hospitals. However, working with three hospitals was challenging for CSP leadership, as project staff coordinated with the multiple management levels of the Synod and each hospital. Project decisions became much more time-consuming.

SECTION 2

Care Groups' Cost: Budget Implications

The multiplier effect of the care group model keeps costs low. The large number of volunteers drives up certain costs, but volunteers multiply the work of paid project staff by reaching every household in a project area. Although the health project invests much time and effort during start up, the cost of using care groups decreases over time, as the initial investment is offset by the eventual operating efficiency.

2.1 Budget Considerations

The care group model is "person-intensive." The project invests far less in physical structures or consumable supplies than in the human resources required to develop highly capable care group volunteers. Promoters pour their time into training, monitoring and encouraging care groups.

The care group model especially influences budget line items related to transportation requirements and the large number of volunteers.

Budgeting for transportation: Population size, density, security and topography are all major factors in determining a project's transportation costs.

➡ **Budget for the amount and schedule of travel needed for each promoter to support her various care groups.**

- Do promoters need cars, or will motorcycles, public transportation, or other less expensive transport suffice?
- What distances must be covered, over what terrain, and how often? If the promoters are able to travel to an area on Monday and stay there until they return on Thursday, the cost is obviously less than if they "commute" daily. How may this differ from one season to the next?
- For purposes of security, do promoters have to travel to some places together? Does the project need to provide a radio or some other means of communication to the promoters while they are in the field?

Budgeting for size: Providing any item to 2,000 or more volunteers rapidly increases total costs. Incentives are a particularly signficant cost, though WR's care group model annually budgets only $4 to $5 per volunteer in material incentives.

- **BCC Materials:** Every volunteer must have a copy of simple education materials used in home visits. Therefore, the care group model requires purchasing several thousand copies of visual aids. When purchasing materials, carefully consider the balance between initial cost and durability.
- **Incentives**: The large number of volunteers in the care group model makes monetary payment or large material incentives cost-prohibitive. Even a relatively inexpensive annual incentive totals $8,000 to $10,000 each year.

Continuing operating costs and sustainability: The person-intensive approach of care groups does not set up a level of service that is dependent upon continuing subsidies of outside funding. Vurhonga commits to not establish structures or services that are beyond the capacity of local partners to sustain. As long as volunteers or staff are not involved in the regular distribution of any commodity, none of the major operating costs or systems must be continued at the end of the project in order to assure sustainability. Transportation is not required for the volunteers to do their work. The care groups themselves and community structures take the role of the promoters. Community respect and gratitude, the social bond of the care group and the joy of changing a community become continuing incentives. Only the services provided by the MOH or other clinical providers require an on-going commitment of funds.

2.2 Efficiency

Cost-efficiency: The multiplier effect of the care group model results in a low project cost per beneficiary. In Vurhonga II, the average cost per direct beneficiary was $6.65 per year (total budget/direct beneficiaries/years of programming). This includes USAID funding and the match from WR, including indirect cost recovery ($1,420,883/53,418 direct beneficiaries/4 years).

➡ **Reap a low cost per beneficiary by reaching a large population through care groups.**

Applications: WR Cambodia, Malawi and Rwanda
The annual cost per direct beneficiary in WR's first CSP in Cambodia was $10.10. In the current cost-extension project, the cost is $5.40. In Malawi, the yearly cost per beneficiary was $4.84. In Rwanda's five-year project, the annual cost per beneficiary is $6.37.

Time costs: The paid staff time a project invests is greatly multiplied by the care group volunteers. In Vurhonga II, the average annual investment of paid promoter time per direct beneficiary was 0.9 hours (26 promoters x 48 wks x 40 hours/53,418 beneficiaries).

The Care Group Difference:
A low project cost per beneficiary is achieved as extensive volunteer inputs reach a large number of beneficiaries.

Including all Vurhonga II staff – the project director, supervisors, and support staff such as the bookkeeper and guards – the average annual investment of paid staff time was 1.5 hours per beneficiary (42 staff members).

By contrast, volunteers spend much more time per beneficiary engaging in volunteer activities. In Vurhonga II, the average per beneficiary benefit per year was 10.5 volunteer hours. This is based upon the total number of volunteers working an estimated average of five hours a week (2,315 volunteers x 48 weeks x 5 hours/53,418 beneficiaries).

Therefore, the ratio of Vurhonga II promoter hours to volunteer hours was nearly 1:11. The ratio for all CSP staff was nearly 1:10.

➡ **Maximize paid staff hours through volunteers' activities in the community.**

Intervention costs: The care group model has a high cost in preparation time, since it takes about six to seven months to organize care groups. But once care groups are in place, the costs of maintaining them are relatively small. Therefore, once the initial investment has been made in establishing the care group network, adding on subsequent interventions is done at moderate cost. Delivering more interventions becomes increasingly cost-efficient over time.

CHAPTER 3

Getting Ready

SECTION 1

Setting Up the Structure: Timeline for Care Groups

Care groups require extensive preparations during the start-up phase of a health project. A project using the care group model will need to invest significantly in staff and care groups' recruitment and training before home visits actually begin.

1.1 Key Events Timeline

The following table and sample workplan highlight key events in program start-up. The details of the steps will be discussed in the following chapters.

Months	Key Event	Notes
1-2	Begin community mobilization Hire CSP staff	• Introduce project to village leaders, gain their support • Collaborate with MOH, other relevant stakeholders • Staff orientation and initial training
2-3	Conduct count of households in project area to determine beneficiary population size	• Time needed varies with context
3-6	Recruit and select volunteers Develop curriculum for first intervention Train CSP staff in interventions	• Begin recruitment during community mobilization activities • Number of volunteers determined by beneficiary household count • Curriculum development needs and schedule varies by project
6-7	Begin training volunteers in first intervention.	• Care groups meet every two weeks
6-10	Volunteers begin household visits and teach first intervention Start recording C-HIS data collected by care groups after first month of visits	• Length of interventions vary, but assume 1 lesson every 2 weeks (i.e. intervention with 6 health lessons would take 3 months) • Volunteers report vital statistics at care group meetings
8-11	Organize VHCs and other special care groups (i.e. care groups of religious leaders) Conduct first Local Rapid Assessment (LRA), or use other monitoring and evaluation method.	• If village development groups already present, cooperate with existing groups. • Conduct LRAs every 3-4 months, or following each intervention

Sample Workplan of Key Activities Assuming a Four Year CSP

	Year 1												Year 2				Year 3				Year 4			
	1	2	3	4	5	6	7	8	9	10	11	12	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Secure formal agreements with MOH	▨																							
Negotiate, sign cooperative agreement	▨																							
Contact collaborating communities	▨	▨																						
Hire supervisors		▨																						
Hire promoters		▨	▨																					
Conduct baseline KPC		▨	▨																					
Train staff (including initial training camp)			▨	▨	▨																			
Count all beneficiary households*				▨	▨												▨							▨
Promoters begin recruiting volunteers				▨	▨																			
Select volunteers					▨	▨	▨																	
First promoter refresher rraining (1 week)							▨					▨		▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
Train care groups (2x a month)							▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
Intervention A								▨	▨	▨	▨							▨						
CGs report statistics (1x a month)								▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
C-HIS tracks progress								▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
Form religious leader care groups								▨	▨															
Form VHCs								▨	▨	▨														
Train religious leader CGs									▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
VHCs Meet (1x every 2 months)									▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
Conduct LRAs (5 days)											▨		▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
Promoter refresher trainings (1 week)												▨		▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
Intervention B												▨	▨						▨					
Intervention C														▨						▨				
Intervention D															▨	▨					▨	▨		
Intervention E																	▨						▨	▨
Give annual volunteer incentives												▨				▨			▨					▨
On-going staff development													▨				▨			▨				
Train CG leaders to re-teach lessons																		▨	▨	▨	▨	▨	▨	▨

*Assumes 1 month for midterm re-count of beneficiaries.

**Assumes interventions lasting 3-4 months. Interventions vary according to number of health lessons.

The timelines in this chapter are not meant to be restrictions but approximate guidelines – a project's actual schedule will depend on the local situation. More challenging environments, such as politically unstable situations, may require longer community sensitization and volunteer recruitment periods to ensure community buy-in and capable volunteers. The start-up period may be shorter for experienced projects that are scaling up or projects working in communities already familiar with volunteer-driven initiatives.

> **Application: WR CAMBODIA**
> The CSP in Cambodia (following a year delay due to political instability and funding) got underway in 1998. After promoters were hired in September 1998, it took another nine months to select volunteers, form care groups and start the actual care group training. But, when the project expanded through a second CSP grant, the experienced staff had organized and started training new care groups four months after the expansion started.

Please see Appendix D for Vurhonga II's complete work plan.

SECTION 2

Creating Models for Care Groups: Preparing Project Staff

The project staff set a standard for care group volunteers to follow. The senior project leadership treat their staff (supervisors and promoters) as a "care group." In turn, the supervisors will do the same for the promoters they oversee, and promoters will nurture the volunteers in care groups. Preparing project staff sets a pattern of relationships that runs down through the entire project, all the way to the household level.

2.1 Key Positions – Senior Leadership

Project director: The project director bears responsibility for guiding the overall direction of the project. Candidates for the position should have extensive experience in management of large scale community-based programs.

The project director role requires:

- Overall project management, including supervising staff, ensuring technical quality, overseeing KPCs and other surveys and fulfilling donor reporting requirements.
- Managing relationships with donors, technical advisors, the MOH, evaluators and other project partners or potential partners.
- Frequent visits to the field, taking time to visit care group meetings and local MOH staff. The director can also visit for special times of care group celebration and affirmation, such as handing out incentives or attending a community appreciation banquet in a village.
- Ability to speak local language of promoters and volunteers.

Health educator: The health educator works directly with the supervisors and promoters, training and supervising them as her own care group. She leads the curriculum development process and oversees all training activities.

The health educator role requires:

- Extensive experience in participatory education methods; she models how to train volunteers through her training of supervisors and promoters.
- Strong interpersonal skills, including fluency in local language.
- Ability to spend most of her time in the field supporting the staff.

The Care Group Difference:

The project director and health educator model fundamentals of care groups as they relate to staff.

2.2 Key Positions – Supervisors and Promoters

The supervisor and promoter positions have the most direct contact with volunteers and communicate core project values directly to care groups. Supervisors and promoters need excellent interpersonal and conflict resolution skills, a solid command of participatory teaching and learning and a thorough understanding of project goals and interventions.

Education: Education level will vary by context. Supervisors and promoters should have at least the same education level as those they are overseeing (a supervisor should equal or exceed the general education level of the promoters; promoters should be at least as educated as volunteers). Literacy and basic math skills are essential, and the project will likely be able to spend less time training staff if they are more highly educated. But, it can be challenging to recruit highly educated staff if a project is working in a remote or impoverished region. More important than formal credentials is that promoters are bright, willing to learn and quick to grasp new ideas and teaching methods. Since Vurhonga works and recruits most staff in an area with very low education rates, few promoters have completed secondary school, and none have university degrees. However, they are all very capable and responsive to training provided by the project.

Gender and age: Hiring female promoters is preferable when most care group volunteers are women. If a project decides to hire only female promoters, they should preferably be mothers (even if the woman no longer has living children). Promoters should also be old enough to command the respect of those with whom they are working. This will vary by cultural context. Having female promoters:

- Establishes credibility with care group volunteers.
- Enhances relationships between promoters and volunteers.
- Facilitates the communication of shared concerns as women and mothers.
- Facilitates discussion of reproductive health topics.

Since supervisors usually do not work directly with care groups, it is less important that they are women. However, it is helpful – all Vurhonga supervisors are women.

Application: WR CAMBODIA

The CSP has only female promoters but also has a Behavior Change Communication team that is mostly comprised of male staff. The BCC team does puppetry and drama for children ages 5-12 on health topics. In that culture, it is more appropriate for men to be involved in community dramas than holding care group meetings with female volunteers. The male BCC team members also engage men in the project area and build relationships, strengthening the CSP's outreach to all members of the community.

Health experience: Some supervisors may have a clinical background, such as nursing. A solid clinical background means the individual knows the fundamentals of health, has greater technical knowledge and possibly has links to the clinical care providers. However, the person might need to overcome didactic tendencies that result from how she was educated in nursing school or how MOH supervisors treated her. Often teachers and other candidates with community development experience are equally qualified to serve in the supervisor role as those with clinical experience.

Field-based: Supervisor and promoter positions are field-based and focused on grassroots work. It may be difficult to recruit qualified staff from remote regions, so promoters hired elsewhere should be willing to relocate permanently or stay in their assigned communities during the work week. For example, nearly all Vurhonga promoters are from a major district town, but Monday through Thursday they live in the villages. Making this commitment means that staff must be very dedicated to the project's goals and activities.

The Care Group Difference:

Promoters living in local villages strengthen the relationships built through the care group model.

Living in the villages contributes to care groups' success by:

- Modeling commitment to helping communities.
- Setting a daily example of exemplary health practices in their own lives to the villagers.
- Helping promoters identify with the communities, and vice versa.
- Building credibility with care group volunteers and households.
- Fostering relationships with volunteers outside of care group meetings.
- Gaining intimate knowledge of the local culture, community needs and traditional beliefs and practices.

Application: WR Malawi and Rwanda

In Rwanda and Malawi, WR CSP promoters were recruited from the same communities where they now work training care groups. They travel to a central location only for regular project-wide meetings.

2.3 Training Staff

Staff, especially promoters, are the machinery that set care groups in motion – thoroughly preparing staff ultimately helps care groups run smoothly and effectively.

Good training:

- Creates a learning environment based on trust and respect.
- Finds creative solutions for overcoming obstacles to behavior change.
- Models respect, participatory techniques and good communication skills.

Time requirements: Senior staff will need to spend significant time training promoters over the first two to three months of the project. The level at which promoters begin (such as their education level and knowledge of health) influences the time needed for training.

Training approach: In Mozambique, WR successfully uses a "training camp" approach to staff training, which brings together all staff. During that time, the staff live together in tents, share meals and have extended time to practice the techniques they are learning. Vurhonga holds an initial two to three week intensive training camp at the beginning of the project for staff orientation. Staff attend one week "refresher" training camps before the introduction of each major health intervention (roughly every three to four months).

The training camp also helps create a sense of project identity and unity among staff. This models ways that promoters go on to foster unity and solidarity in care groups. Vurhonga promoters and supervisors build team spirit by living together in tents and sharing meals during the training camp.

In addition, Vurhonga invites female leadership of other groups in the community (such as the Women's Organization of Mozambique and members of the MOH) to participate in the "refresher" training camp sessions. This forges relationships with stakeholders and helps ensure sustainability. Programs with male and female promoters should also consider inviting male community leaders to stay with them for training camps.

For more detailed information about Vurhonga's training camps, including sample schedules, see Appendix E.

Interpersonal skills: It is often a challenge for project leadership to develop promoters into community role models. When they are hired, promoters may have low levels of health understanding. Some may even be skeptical of new behaviors advocated by the health project or participate in the same harmful traditional practices as the target population. Senior staff should be patient as they correct promoters' misconceptions and ensure that they master the technical content of each intervention.

Promoters need training in interpersonal skills and group facilitation as they prepare to train and support care groups. Some promoters may at first be prejudiced against volunteers – who are often poor and uneducated women. Promoters must learn how to engage volunteers with respect, accept individuals for who they are and approach them as peers. Then, they can empower volunteers with communication skills, build their self-esteem and entrust them with responsibility.

The Care Group Difference:
Promoters need training on group dynamics and conflict resolution to prepare them to work with care groups.

Conflict resolution skills are also needed to cope with diverse dynamics and relationships in care group meetings. Promoters must also prepare to meet the needs of individual volunteers in the midst of the group context.

➡ **Equip promoters with conflict resolution skills. Guide promoters on how they can meet individual volunteers' needs.**

Promoters:

- As the schedule allows, spend one-on-one time with each volunteer – spread your time evenly.
- Do not correct harshly in front of other volunteers.

SECTION 3

Setting Up Care Groups: Selecting Volunteers

Selecting volunteers is a time-consuming process for project staff. However, the eventual success of each care group rests on committed volunteers who are truly interested in improving health and helping their communities. The decisions are a mix of individual initiative and community consensus, with guidance from project staff.

3.1 Who Makes a Good Volunteer?

It is important for the project to establish criteria for volunteer selection and communicate these criteria to the community at large. This makes the process as transparent as possible.

Vurhonga uses the following key criteria for evaluating potential volunteers:

- Female
- Mothers (even if the child is grown or is no longer living)
- Age – old enough to be respected by beneficiary households
- Interested in health issues
- Positive attitude and desire to serve neighbors
- Respected in the community
- Not addicted to alcohol

Having female volunteers helps establish a basis of common concern – the health of children – for home visits. Another advantage of female volunteers is that husbands of beneficiaries are more likely to be suspicious or jealous of male volunteers making home visits. Vurhonga finds that very young women often lack confidence during home visits, and they are not respected by older community members. Early in its experience, Vurhonga also encountered several problems with volunteers who were addicted to alcohol, which negatively affected their attendance at care group meetings and the regularity of their home visits.

Application: WR MALAWI

Roughly a third of care group volunteers in Malawi were male. The benefit of including men was that they more easily built relationships with male heads of households, and they were often more effective in discussing family planning interventions and STIs with men in beneficiary households. Project staff and volunteers also felt that male participation gave care groups greater credibility in the views of community members. However, the Malawi project experienced that male volunteers were more likely to stop volunteering and to expect pay. And, as the external evaluator noted in the project's final evaluation, "Women are more enthusiastic, effective [Behavior Change Communication] agents than are men... [and] attend meetings more regularly."

Application: WR CAMBODIA
The CSP in Cambodia specifies an age range for volunteers. The project sets guidelines that volunteers be no younger than 25 years old nor older than 49. This ensures that the volunteers are old enough to be respected in that culture, but they are still young enough to be considered beneficiaries themselves (women of child-bearing age).

Literacy: It is not at all necessary that volunteers be literate, since most communication – both in care groups and in the community – is verbal. The lessons to care groups and in home visits are oral and taught in the local language. Regular reporting by volunteers during care group meetings is also verbal. Requiring literacy can exclude older, respected women, who are often effective teachers and established community leaders. It is only necessary that one volunteer per care group be literate to record vital statistics about volunteers' assigned households (see Chapter 5, Section 1).

The Care Group Difference:
Care group volunteers do not need to be literate to be effective. Verbal reporting, and the pooled skills of all care group members, compensate.

As a general guideline, volunteers should not be less educated than the typical education level for women in the project area. Having a typical education helps ensure that volunteers are respected. In Vurhonga's project area, about 70% of women are illiterate, and so the majority of care group volunteers are also illiterate.

Application: WR RWANDA
There is a high level of literacy in Rwanda, including most of the project area. Therefore, literacy is an important criterion for selecting care group volunteers.

3.2 Working With Communities To Select Volunteers

Raising interest: Staff have the first opportunity to raise the issue of volunteers during the community sensitization phase, which happens in the first one or two months of the project. Various staff members – from promoters to the project director – might participate in this phase.

The Care Group Difference:
Recruit one volunteer for every 10-15 households.

➡ **During community sensitization, explain the care group model to communities.**
Project staff:
- Give an overview of the project.
- Explain that the project is looking for volunteers from every community.
- Highlight that volunteers will play an important role in improving the health of young children and women in the community, but be sure to note the volunteers will not be paid.

Determining project needs: The care group model works best when there is one volunteer selected for every 10-15 households. The household count will determine the total number of beneficiary households and the number of volunteers needed (see Chapter 5, Section 1).

The Care Group Difference:
Encourage many people to attend the informational meetings, since every beneficiary household will be impacted.

Giving more information: Staff invite interested women, local leaders and other community members to meetings focused on volunteer recruitment.

➡ **Hold meetings in each community, encouraging interested women to attend.**
Project staff:
- Explain purpose of volunteers.
- Present criteria for volunteer selection.
- Explain responsibilities and staff expectations – such as attending meetings twice a month and visiting other households.
- Explain time commitments – usually four to five hours per week.
- Communicate clearly that there is no pay.
- Describe the benefits – such as improving the health of children in the community, the fun of being part of a group, etc.
- Answer questions.

Explaining the criteria and responsibilities of volunteers helps more people in the community understand the purpose of the project and care groups. It also increases transparency, since potential volunteers learn about expectations and incentives (including no remuneration). Women can then opt out of volunteering if they wish.

Facilitating community decisions: The community – especially beneficiary households and local leaders – should influence the decision about who will be volunteers.

➡ **Encourage each group of 10 to 15 households to give input on who will be its volunteer.**
Project staff:
- Identify the smallest existing grouping of households within a village and try to respect those groups when organizing households into groups of 10-15 to fit with the care group model.
- Explain volunteer responsibilities and criteria to each group of households.
- Encourage households to discuss who would be the best volunteer from among their group.
- When a decision is reached, meet the volunteer. Confirm that she meets the criteria, and record her name.

The Care Group Difference:
Care group volunteers represent the smallest grouping of households in a village.

This process can vary depending on the context. In some places, village chiefs may influence the process by providing recommendations or approving selections. However, promoters should still try to include the beneficiary households in the process in some way. Input from households and promoters prevents village chiefs from selecting volunteers for personal reasons (such as choosing relatives), but who may have no interest in health or community service. Only one volunteer should be picked per group. If no woman in the group initially wants to volunteer, it may take a process of negotiation and persuasion among the households, local leaders and project staff. Having more than one volunteer per 10 households is not recommended, since that makes the care group size too large. Promoters arrange an initial meeting of a care group once the volunteers for that group are selected.

The Care Group Difference:
Staff must devote a significant amount of time to making sure that there is in fact one volunteer for every 10 to 15 households.

The selection process may be faster if households are already organized into smaller groups by the government or tribal authorities. In Mozambique, the smallest administrative unit recognized by the government is a block of 10 households. If households are not already in groups, project staff will need to make designations to select volunteers and ensure coverage of all beneficiary households.

Application: WR RWANDA
In Rwanda, there are pre-existing groups of 10 households called "nyumba kumi." CSP staff helped organize elections at the nyumba kumi level to vote for the group's volunteer – in Rwanda it was the locally acceptable way to choose the volunteers. The election turnout was even higher than staff anticipated.

Application: WR CAMBODIA
Villages are organized into communes in Cambodia. Communes are usually much larger than 10 households, and so the CSP staff helped the community designate groups of 10 within each commune.

3.3 Selecting Care Group Leaders

Once volunteers are selected and assigned to a care group, the care group should meet and select one of the volunteers to be the "care group leader," sometimes called a chief volunteer. The care group leader has a special role – ultimately, she helps lay the foundation for the group to be self-sustaining after the project ends.

The Care Group Difference:
A capable care group leader promotes sustainability, since this volunteer will eventually take over the supervision of the care group (with the help of other community groups).

The care group leader:

- Helps organize meetings by communicating time and place to rest of the group.
- Mediates internal conflicts if the group designates her to settle disagreements.
- Takes the lead among volunteers in interacting with village health committees, clinical providers and other community leaders.
- Helps promoters re-train the care group in repeated health lessons.
- May record monthly statistics as other volunteers in her care group verbally report on vital events in their assigned households.
  - Literacy is helpful but not essential.
  - If the leader is illiterate, the care group can designate a literate volunteer as secretary.

Care groups choose their own leaders, and promoters should help facilitate the process. Often, care groups in Mozambique choose a leader who is older and well-respected in the community.

➡ **Encourage every care group to choose a care group leader.**
Promoters:

- Discuss the responsibilities of a care group leader with the entire group.
- Ask volunteers to suggest members who could be the leader.
- Encourage the care group to discuss the different options.
- Affirm the group's mutual decision.

SECTION 4

Meeting Times: Logistics and Schedules

The timing and frequency of care group meetings and home visits helps determine the training schedule for both volunteers and households.

4.1 Time Requirements for Care Group Meetings

Frequency: It is preferable that care groups meet twice a month. This provides regular contact with volunteers and repetition of the health lessons without demanding too much of volunteers' time.

Though two meetings a month is preferable, the project will need to conform to the economic realities and time constraints of volunteers. Most volunteers must balance their participation with working in the fields, doing household chores and caring for their families. There are also issues of travel and security, which may vary with the time of year. Results can be achieved with as little as one meeting a month.

Application: WR CAMBODIA
Care groups in Cambodia meet once a month. CSP staff found that meeting every other week was not possible for volunteers. Unlike in Vurhonga's project area, many women had other income-earning activities besides agriculture that added to the demands on their time. The Cambodia care group volunteers visit assigned households a minimum of once a month, corresponding to the care group meetings. At first, staff were concerned this would be insufficient to result in behavior change, However, the project achieved nearly all of its objectives. One drawback was that meeting less often meant it took longer for promoters to build relationships and establish trust with volunteers.

Scheduling meetings: The promoter will decide which days of the month the group will meet while the group will decide the time of day for the meetings. The promoter will be visiting a different care group each day of the week, supporting volunteers as well as attending special events or meetings (such as immunization sessions, VHC meetings, meetings with MOH staff, etc.). These may vary for each care group she is overseeing. The promoter's schedule can quickly become quite complicated if she also has to travel a long time to each care group site.

➡ **Consider all demands on promoters' time when scheduling care group meetings.**

The preferred time of day for the meeting should be decided by the care group. It is important to allow time for the promoter and all members to reach the location.

➡ **Hold care group meetings at a mutually agreed-upon time.**

- The promoter asks volunteers to identify free periods in their day.
- The volunteers discuss when they can meet for a care group meeting.
- All agree to meet at a particular time.

Often volunteers choose to meet in the afternoon. This usually fits the local rhythm of work in agricultural communities.

Duration: Care group meetings last up to two hours. This is about the time needed to interact with health lessons, discuss community health issues, record statistics for assigned households and address other issues.

Location: The site of care group meetings should be fairly central to volunteers' homes, so no one volunteer must spend a great deal of time getting to the meeting. Meeting at community gathering spots has the benefits of increasing openness with the community. However, this also increases distractions and chances of interruption. Another common spot for a care group meeting is the home of a volunteer. This helps reduce interruptions from others and is often a place where the women feel comfortable.

The Care Group Difference:
Identify a time and place for meeting that is easily acessible to every member of the care group.

➡ **Meet at a mutually agreed-upon location.**
  - Volunteers and the promoter discuss the pros and cons of various places and make a group decision.

4.2 Timing Home Visits

Frequency: To be most effective, care group volunteers should visit assigned households at least twice a month. This allows volunteers to communicate health lessons to households following each care group meeting.

Duration: Home visits may range from less than one-half hour to much more. Cultural practices may influence the visit's duration – time is required for greetings, inquiring after family members, etc. This is not wasted time, since it builds relationships between the volunteer and the beneficiary. Visits take longer when care group volunteers use visual aids or do a demonstration, such as how to mix ORT.

A volunteer may also follow up in shorter conversations throughout the week, simply chatting about the topic as they go about their daily lives in the village.

CHAPTER 4

Working With Care Groups

SECTION 1

Strength in Numbers: Training and Care Groups

Project staff do not train volunteers in groups simply because it is efficient and saves on cost. The care group approach to training and supervision allows volunteers to work together towards shared goals, learn from one another and take action together.

1.1 Training Through Shared Goals

Care groups create opportunities for volunteers to work together, using the combined strength of the group to support every individual volunteer. Training methods increase volunteers' ability for joint problem-solving, so care group volunteers can turn to each other for assistance rather than relying solely on promoters (see section Chapter 4, Section 3, "Volunteer Incentives").

Goals for building knowledge: Staff foster group identity and thorough comprehension of health messages by setting learning goals for the group to achieve together, instead of measuring performance individually.

➡ **Set a shared goal to measure how well volunteers learn each intervention.**
Promoters:
- At the end of a series of lessons, give an oral quiz on the content of the intervention to the care group.
- Ask each individual volunteer a different question, but have the answer contribute to a group score for passing the quiz.

In Vurhonga, care groups "pass" an intervention when 60% of volunteers successfully answer questions about it. Each volunteer's answer contributes to the group benchmark of 60%. Volunteers' performance usually far exceeds this minimum. The group goal encourages volunteers who are quick to understand a lesson to teach it to others, ensuring that everyone learns it well.

The Care Group Difference:
Set goals for the care group to achieve together, rather than setting separate goals for individual volunteers.

Goals for changing health practices: The care group can also set goals for behavior change among group volunteers. An example is that all volunteers have a latrine, a dish rack or a refuse pit at their house. Volunteers who first adopt new health practices encourage those in their group who are more reluctant to change. They report on their progress each month.

➡ **Encourage volunteers to share the outcomes of their own behavior change with one another, including any challenges they faced.**

Care group volunteers themselves represent about 10% of all targeted households. When an entire care group adopts a new healthy behavior, this makes a visible difference in the community.

Goals for household visits: Volunteers are each responsible for visiting their assigned households, but goals relating to reaching those households should be for the care group, not for the individual volunteer.

➡ Set goals for behavior change among assigned households for the care group to work towards together.
Promoters:
- Set the same goal for the entire care group to work on at the same time.
- Choose goals that are easy to measure, so volunteers can observe their progress and impact.
- Make the process participatory by inviting volunteers to suggest goals and give input.

The Care Group Difference:
By encouraging behavior change within volunteers' own households, care groups create a significant number of households in a community who are early adopters of healthy behaviors.

For example, a promoter could give the following group goals: "Let's make sure every child in the village is up-to-date on immunizations," or "Let's weigh every child at the next weighing session." It is manageable for an individual volunteer to rally each of her assigned households to have its child weighed. It is manageable for her to check 10 immunization cards to be sure they are up to date – and if she's illiterate, she can go to a literate volunteer to help her. When the care group works together, achieving such goals does not overwhelm any one group member.

Confronting harmful traditional practices: The care group's strength in numbers is particularly helpful when encouraging households to stop harmful traditional practices and adopt healthier behaviors. Care group volunteers are able to present a more convincing case because the entire group is advocating behavior change. The volunteers point out another woman in the community whose changed behavior is clearly resulting in improvements to her child's health. They also give personal examples of the benefits of the healthier practices for their families.

The Care Group Difference:
Care group volunteers have many resources – in each other – when they confront harmful traditional practices. Volunteers visit resistant households together.

Generating excitement: All groups will need some extra support and encouragement from the promoter as they work to achieve their goals. It is not easy during the earlier days when group identity and unity have not been fully established.

➡ **Help care group volunteers get excited about working together to meet goals.**
Promoters:
- Give regular feedback on progress.
- Accompany individual or teams of volunteers during home visits.
- Do not make empty promises; be honest and realistic about what is achievable and how the group will celebrate its successes.
- Be patient and positive even when work is progressing slowly. Offer extra assistance to groups and individuals who need it.

1.2 Teaching Each Other

Teaming up: Encourage care group volunteers to work together to be more effective in home visits. If one volunteer is unsure about a question or encounters a difficulty during a household visit, she can call on another volunteer for help. The other volunteer can return to the household with her, and together they can answer a question or re-teach a lesson, urging the family to change its health practices. In this manner, a care group volunteer does not feel that she is the sole person in her neighborhood advocating new health practices, since the other group members are teaching the same messages throughout the community.

The Care Group Difference:
If one volunteer has a problem in a home visit, she calls on a fellow volunteer for help. Together, they look for a solution, bringing in other volunteers or the promoter if needed.

Improving weak volunteers: Promoters should also encourage volunteers to mentor each other. After several months of activity, promoters should informally rate the individual volunteers in a care group as being "strong" or "weak." This classification is for the promoter's use only; it should not be shared with the individual or made public in any other way.

Weak volunteers are characterized by:
- Shyness
- Inability to use participatory teaching methods – impose their views on households
- Poor understanding of technical content
- Unsatisfactory progress from baseline indicators among assigned households

Strong volunteers are characterized by:
- Self-confidence
- Engaging use of participatory teaching methods
- Personal and friendly approach during household visits
- Good understanding of technical content
- Satisfactory progress from baseline indicators among the volunteer's assigned households

The promoter can pair strong and weak volunteers and have them visit their assigned households together. Ten volunteers per care group means there are sufficient numbers for matching up volunteers. The mentoring happens naturally, as the weaker volunteer absorbs the teaching methods and knowledge of the stronger volunteer. Once the promoter deems the volunteer sufficiently improved and self-confident, she resumes home visits by herself.

The Care Group Difference:
Volunteers strengthen one another by doing home visits together, pairing weak volunteers with stronger volunteers in the care group.

➡ **Match a weak volunteer with a strong volunteer in order for the less-skilled volunteer to improve her teaching.**
Promoters:
- Assess volunteers and pair them accordingly.
    - Do not tell the pair why they are being put together.
- Avoid laying off weak volunteers.
    - They are mothers and members of the community who need to be reached with health messages.
    - Removing a volunteer can cause serious damage to volunteers' trust and to the care group's identity.

The promoter should also spend one-on-one time with individual volunteers who need extra help, and may join home visits with a weak volunteer.

Training a weak care group: It is unlikely to find an entire care group of weak volunteers, but if that does happen, the promoter has several options.

➡ **If there is more than one care group in a village, draw on the stronger care group.**
Promoters:

- Pair volunteers from a weak group with volunteers from a strong group.
- Re-assign the work area to cover all 20 to 30 households between each pair.
- Continue doing home visits in pairs until the weak care group becomes skilled.

➡ **If there is only one care group in a village, draw on other community members for help.**
Promoters:

- Choose new care group volunteers from the community.
- Train these new volunteers, with the help of project supervisors and the project health educator.
- Involving extra project staff speeds up the training process so the group does not lag too far behind.
- Pair the newly chosen volunteers with the old weak ones and send them on home visits together.
- Give the care group extra support.

1.3 Participatory Training

Using participatory training methods is not unique to the care group model, but it is a crucial element in effectively teaching and equipping volunteers to promote health. Care groups function best when the training and curriculum follow principles of adult learning. This manual's purpose is not to give guidance about developing materials or messages – those are other areas of expertise that need to be incorporated into the approaches suggested here. Project leadership may want to review other manuals and texts on non-formal adult education before undertaking the care group model.

Please see Appendix H for a list of resources.

Participatory teaching methods: There are many participatory activities useful in teaching care groups. However, project staff need to make sure that the activities are not too complicated for the care group volunteers to replicate when teaching their assigned households.

➡ **Model training methods in care group meetings that volunteers can use themselves during home visits.**

Pictures are helpful tools for engaging the audience, helping them remember information and communicating to low literacy households.
Promoters:

- Use pictures identical to what care group volunteers will use to train households.
- Train with tools that volunteers are comfortable using themselves.
- Equip each care group volunteer with visual aids.

Song and dance are wonderful training tools, particularly in low literacy settings. The songs in care groups should focus on the interventions.
Promoters:

- Set health messages to traditional or popular melodies.
- Encourage care group volunteers to make up their own creative songs.
- Suggest corrections or changes as needed to make sure lyrics are technically accurate.
- Encourage volunteers to create dances or hand motions to go with the songs.

Demonstrations and role plays help volunteers get hands-on experience in health activities, such as mixing ORT or conducting a home visit.
Promoters:

- Engage volunteers by having them participate in the demonstration.
- In role plays, rotate roles of "beneficiary" and "visiting volunteer" between different care group volunteers.
- Help volunteers create skits acting out good health practices, and encourage them to present their dramas during household visits or at community functions.

The Care Group Difference:
Health messages are quickly spread in informal ways since 10% of the population, the volunteers, know the same songs dances, etc.

Curriculum: Vurhonga developed its curriculum to fit the special structure and needs of care groups. The curriculum has several attributes tailored to the care group model:

- Easily used in a small group (10-15 people) as well as in a one-on-one teaching at the household level.
- Informal approach encourages dialogue to take place in a non-threatening manner and creates a safe environment for learning.
- Incorporates special tools for promoters, such as checklists to monitor consistency and accuracy of teaching at the care group and household levels.
- Timed so that the entire community is receiving same messages at the same time.

Please see Appendix F for an example of Vurhonga's curriculum. Also, please refer to Appendix G for an explanation of how Vurhonga uses care groups to implement the Hearth nutrition rehabilitation model.

Conducting household visits: Volunteers model their teaching methods after the way they were trained in the care group. There are three key elements in presenting health interventions during home visits that follow accepted principles of effective health education.

1) **Technical content:** Care group volunteers must have a thorough grasp of each lesson in order re-teach it completely and accurately.
2) **Participatory teaching methods:** Mothers, like the volunteers themselves, often have a very low rates of literacy and learn best through non-formal education approaches.
    - Volunteers teach health lessons using the participatory methods through which they learned best (pictures, songs, role plays, etc.).
3) **Encouraging behavior change:** Care group volunteers help households link the health lessons to practices within each household's ability to change.

Volunteers:

- Model behavior change through their own good health practices.
- Link outcomes to changed practices.
- Call on a fellow volunteer for assistance if encountering a problem.

Modeling positive behaviors: Care group volunteers lead by example, and behavior change often happens first among volunteers. As volunteers change their actions, they add credibility and first-hand experience when they promote behavior change to their assigned households. People are more likely to adopt a new behavior when their role model is very similar to them. Also, they take action when it benefits them and not only the project's objectives. Project staff should take volunteers' and the community's interests to heart and deal with barriers that keep them from action.

The Care Group Difference:
The numerous care group volunteers create many positive examples of women who are of similar status and situation as beneficiaries.

The concept of modeling is not unique to care groups, but care groups do help jump-start the process through their sheer numbers. The number of care group volunteers trying the new practice also enhances the counseling stage of health education, as households actually try a new behavior and begin changing their attributions of health.

In the WR Rwanda CSP, a care group volunteer explained how the first intervention impacted her personally. *"Before the training care group, I never washed my hands before feeding my child, but now it is starting to be a habit. I did not know that a child with diarrhea needs to be breastfed, but now when my child has diarrhea I breastfeed more than usual."*

➡ **Help volunteers adopt and maintain new health practices as well as understand the relationship between the practice and improvements in health.**
Promoters:
- Explain practical steps of how volunteers themselves can adopt a healthier practice.
- Help volunteers identify obstacles in their lives to adopting the new practice.
- Talk through any obstacles with volunteers, problem-solving with them.
- Encourage and support them as they try the new behavior.
- Discuss the outcomes together.
- Link the new behavior with the outcome.
- Volunteers change how they attribute the causes of poor health and the reasons for good health.

In Vurhonga, promoters live in the villages in the project area to help set good examples. They become "exemplary mothers" in the villages. They demonstrate healthy practices in their everyday lives. Promoters' examples becomes an important factor in volunteers' decisions to change their behavior. Living in the villages also demonstrates their extraordinary commitment to the work.

SECTION 2

Reaching Deep Through Care Groups: Relationships

Building strong relationships in the care group and with households is the foundation for effective community outreach. Promoters reflect core project values in the way that they interact with the care group and the individual volunteers. Volunteers internalize this as they build relationships with each other. Care group volunteers truly do care for one another, relying on the group for help and encouragement as they teach their community.

2.1 Building Relationships Within Care Groups

The Care Group Difference:
Volunteering is more fun and enjoyable when working with a group of peers, rather than being a solitary volunteer in a community.

Promoting friendship: Volunteers must enjoy coming to a care group meeting for the care group model to be effective and retain volunteers. Women in the project area often have many responsibilities in their own households and face difficult challenges in their daily lives. Care group meetings are a special opportunity for women to have fun together. This builds unity and motivates volunteer attendance.

➡ **Encourage friendships and make learning fun in care group meetings.**
Promoters:

- Make the meeting as informal as possible without losing focus of the objective.
- Lead group games and activities to build trust and understanding between volunteers.
- Take an active interest in volunteers' lives, asking them questions.
- Give volunteers the opportunity to casually talk and enjoy each other's company at the beginning and end of the meetings.

➡ **Set group norms to minimize conflict in the care group.**
Promoters:

- Discourage negative behaviors that inhibit participation (i.e. if someone gives a wrong answer, the other volunteers should not laugh at her).
- Agree together on conflict resolution mechanisms to address disputes among volunteers or between volunteers and the promoter.
  - ▪ Choose a respected member of the care group or community to help resolve problems.
  - ▪ Or, if more appropriate, engage the existing leadership structure of the care group's community.

Creating safe environments: The care group must be a safe environment for participants characterized by respect and trust between volunteers and the promoter.

Respect: Respect is fundamental to effective adult education. As promoters and volunteers show respect to one another through their words and actions, respect grows in the group as a whole.

Trust: Building respect and friendship between volunteers and the promoters builds trust. In addition, relying on each other for support also strengthens trust between volunteers. Trust is especially important if a health lesson conflicts with a harmful traditional practice.

Volunteers trust promoters to:

- Act in volunteers' best interests
- Provide accurate health information
- Teach valuable information–the lessons are worth learning and acting upon.

➡ **Take the lead in facilitating a safe learning environment in care group meetings.**
Promoters:

- Listen carefully to each volunteer.
- Answer questions – admit when you don't have answer and commit to finding out the correct information.
- Praise participation.
- Praise volunteers publicly for the care group's accomplishments.
- Correct a volunteer in private – do not correct her in front of the whole group.
- At all costs, avoid comparing volunteers to each other.

Peer support and accountability: Volunteers must rely on one another to achieve group goals. (See also Chapter 4, Section 1, "Training and Care Groups"). Strong relationships foster peer support and accountability.

The Care Group Difference:
Strong relationships and shared goals lead to peer accountability – volunteers use friendly pressure to encourage each other to attend meetings and do home visits.

➡ **Encourage care group volunteers to support each other in a variety of ways.**
Volunteers:

- Praise one another as a regular part of care group meetings.
- Celebrate together as the group meets goals.
  - Take extra time for congratulatory songs and dances.
  - Bring food and prepare a meal to share together during meeting time.
- Help meet each other's material needs if it is within volunteers' abilities.
- Provide emotional support during stressful situations or times of loss.
- Rotate care group meeting locations (example: meeting in different volunteers' homes).
- Visit other care groups in the same village or nearby villages to encourage each other and learn from one another.

➡ **Encourage care group volunteers to be accountable to the other members of the group.**

- The enthusiasm of the care group can encourage a reluctant volunteer to continue participating.
- Allow care group volunteers to talk through their fears and concerns as a group.
- If one volunteer misses a meeting, another care group volunteer can visit her and teach her the lesson.
  - If a particular problem prevents a volunteer from attending a meeting or visiting households, she should share the problem with other volunteers. They can then do what they can to help her.

2.2 Building Relationships With the Community

Care group volunteers pattern their interactions with households after their relationship with their promoters. The project values and culture – a deep respect and sense of worth for every beneficiary – are integral to effective home visits.

The Care Group Difference:
Home visits are grounded on existing relationships between care group volunteers and households located closest to them.

With beneficiaries: Care group volunteers are not bringing health lessons to strangers – they are visiting their neighbors, friends and relatives. Care groups leverage the cultural importance of community, often found in rural areas of developing nations, to make training households easier and more effective.

Volunteers naturally visit their immediate neighbors, since one care group volunteer is selected per group of 10 households (see Chapter 3, Section 3 "Selecting Volunteers" to review how communities choose volunteers).

The close proximity of volunteers makes it easy for volunteers and their assigned households to teach and apply health lessons during everyday life. The low ratio of households per volunteer increases the frequency of interactions compared to programs that have only one or two volunteers per village. Likewise, it is easier for households to access their volunteer when they have problems.

As a Vurhonga I volunteer from Guija town said, *"We have starting times, but no finishing times."*

Application: WR RWANDA
Home visits help foster a healthy sense of community concern in areas where relationships might be poor. In Rwanda, CSP staff encountered distant relationships among community members and a lack of trust, partly owing to the country's long history of conflict. Many households were surprised and even suspicious that care group volunteers wanted to visit and help them. One care group volunteer said, *"In the beginning, the mothers didn't really trust us, asking us, 'What can you do for me, why are you here? You are just another housewife.' It has been exciting to see that over time, most of the mothers and their husbands are no longer skeptical and have embraced the program with enthusiasm."*

Mother-to-mother: Shared concerns are another important basis for home visits. Home visits are essentially lessons shared from mother to mother. While not unique to care groups, the greater depth of relationship possible with care groups enhances these relationships.

➡ **Maximize the common concern of mothers for their children's well-being.**
Volunteers:
- Approach beneficiaries on the common ground of being mothers.
- Take an active interest in what beneficiaries are doing at the time of the visit.
- Be on the look out for positive behaviors and compliment them.
- Demonstrate commitment to households by visiting regularly.

With the entire household: It is usually very difficult for a mother to change her behavior without the support of the household. Other family members – husbands, grandmothers and elders – often have decision-making power about how a young child is raised. Care group volunteers should find ways to influence these other key decision makers.

➡ **Gain the support of all involved in making decisions and caring for a child in order to change household health practices.**
Volunteers:

- Invite the household members to participate in the household visit, lesson and activities, such as joining in the lesson, demonstration, songs, etc.
- Talk with the beneficiary mother to determine if another household decision-maker (husband, grandmother, etc.) is preventing positive behavior change.
- Seek out the resistant decision-maker and explain the health lesson.
- Return with another care group volunteer to help convince the person, if necessary.
- Engage the help of community leadership if the problem persists.

The Care Group Difference:
Over time, care groups impact many household decision-makers since they regularly visit every beneficiary household in the project area.

For example, Mozambican grandmothers often decide when a mother should stop breastfeeding her baby – volunteers made a special effort to involve them in discussions with mothers about breastfeeding. Vurhonga finds that husbands may initially be suspicious of why care group volunteers visit often and urge their wives to change the way they care for the children. By involving husbands in home visits, volunteers dispel doubts and gain their support.

Application: WR CAMBODIA
Rural Cambodian women often leave a young child in the care of an older sibling while they work in the rice fields. Teaching only mothers would not reach the siblings who care for infants most of the day. To respond, the CSP includes puppet and drama teams that focus on children ages 5 to 12. The puppet team teaches older children the same health lessons that mothers learn.

With the community: The consistent, one-on-one interactions with each household quickly spread new knowledge throughout a community. Simulataneously introducing a health lesson to all beneficiary households means that households are not alone in trying the new behavior. Besides the support of the care group volunteers, other households are engaged in the same process of behavior change. This encourages households to more quickly try out and adopt new health practices.

Application: WR RWANDA
The WR Rwanda CSP met many of its EOP targets by the midterm of the five-year project. Midterm evaluator Dr. Henry Perry of Future Generations wrote, *"The rapid uptake of interventions once they are developed and once the project infrastructure is in place is truly impressive."*

Perseverance: Perseverance is needed to convince households – and volunteers – to stop harmful traditional practices. It may take time for volunteers to be willing to change a behavior rooted in their culture.

➡ **Be patient, gently but persistently working for positive behavior change.**
Promoters:

- Start with practices that are less likely to be controversial and would not be met with resistance. As mutual trust and confidence peaks, then introduce more difficult interventions.
- Continually demonstrate respect – do not express anger or rejection, nor expect volunteers to change harmful practices immediately.
- Enlist the help of supportive community leaders to introduce difficult interventions.
- Give examples of success of communities already practicing the proposed interventions.

Volunteers must also patiently guide households through the learning process that leads to behavior change.

➡ **Persistently teach households, drawing on the model of promoters.**
Volunteers:

- Be as informal as possible – negotiate rather than imposing ideas on the household.
- Look at everything from the household's viewpoint – maximize benefits and minimize barriers that matter to the family.

A grandmother from Matidze village described the perseverance of Vurhonga I care group volunteers, saying, *"Sometimes we had differences with the volunteers. When they saw a child who was sick and that what we were doing made him worse, they were still patient. They would beg us and love us. When we chased them away, they came back three, four times. Finally, they would carry us to the place where we could get help and stay there with us, so that we could see it worked."*

SECTION 3

“Helping Our Community Together”: Volunteer Incentives

Care group volunteers give freely of their time and energy–they receive no monetary pay or allowances. The care group model relies primarily on intangible incentives to motivate participants, prevent volunteer burnout and ensure sustainability of the interventions. Vurhonga evaluators commented that they did not hear volunteers sound the common phrase of *“Doing the project’s work without pay.”* Instead, the refrain is *“Helping our community together.”*

3.1 Intangible Incentives

Three key intangible incentives drive the care group approach.

1) ***Care group support:*** The volunteers enjoy the simple fun and friendship of care group meetings. They support each other in learning, makinghome visits and modeling positive behaviors for their neighbors and communities (see also Chapter 4, Section 2 “Relationships”).
2) ***Group goals:*** The care group volunteers set shared goals and support one another in achieving those goals. By reaching goals and celebrating achievements, volunteers feel a renewed sense of purpose that strengthens the group identity.
3) ***Community recognition and empowerment:*** Praise from the community raises volunteers self-esteem and helps convinece them that their work is important. Being catalysts for community-wide action makes them feel connected to a movement larger than themselves.

The Care Group Difference:
The primary incentives are not material benefits; instead, care groups depend on relationships, shared sense of purpose, achievement and community recognition.

3.2 Solidarity Through Group Goals

The success of the care group depends on the strength of the group identity. Setting goals for the group to achieve together is an important tool for building the solidarity of the group. Progress towards building health knowledge, engagement with the community and impact of the interventions can all be easily measured by the care group itself through a participatory goal setting and monitoring process (see also Chapter 4, Section 1 “Training and Care Groups”).

Celebrating accomplishments: It is important for a care group to celebrate together when it reaches a goal, such as passing an oral quiz on an intervention. This affirms all volunteers for contributing to the success of the group.

➡ **Celebrate group successes.**
Promoters:
- Praise and affirm the group during care group meetings and when possible, in public forums.
- Celebrate with extra time for singing and dancing.

- Prepare a meal with volunteers and eat together during the meeting time (volunteers take the lead in contributing food).
- Organize exchange visits – bring together different care groups so they can share experiences and encourage one another.

Personal development: Volunteers take advantage of the opportunity to develop their skills and talents as they participate in care groups. Each uses gifts that otherwise might have remained buried. For example, a volunteer can discover and improve her gift for teaching other people. The talents of each volunteer contribute towards group success, increasing volunteers' appreciation of each other and cooperation.

The Care Group Difference:
Volunteers stay motivated through each others' support, as they practice and teach new health behaviors.

Entrusted with responsibility: Promoters entrust volunteers with responsibility – volunteers are the ones teaching households health lessons, not project staff. This communicates respect and value to volunteers. But, the small number of households per volunter helps prevent volunteers from becoming overwhelmed and burning out.

The Care Group Difference:
Sharing responsibility among the care group increases group solidarity and a common spirit of helping change the community together.

Application: WR RWANDA
Care group volunteers complained that community members sometimes referred to them as *"Abakorerabusa"* or *"those who work for nothing."* CSP staff and care groups decided to make the title of volunteers *"Abakorera abandi" – "those who serve others."*

3.3 Community Recognition and Empowerment

Power of many: The high proportion of volunteers to beneficiaries is a motivating force. Volunteers form a critical mass of caring volunteers whose presence in each community builds momentum for their work.

The Care Group Difference:
"Care groups transform behavior change from an individual decision to a social movement." Dr. Franklin Baer, final evaluator for Vurhonga I and WR Malawi's CSP.

Care groups empower more than individual volunteers. Care group volunteers feel they are connected to something much bigger than themselves. Volunteers see that they are a driving force behind broader improvements as many households begin changing their behavior. In addition, local leaders also work with care groups to understand and respond to issues affecting the health of people in the community (see Chapter 6, Section 1 "Local Leaders").

Elevated status: Many care group volunteers benefit from an elevated social status in their village, as the community grows to appreciate the importance of preventative health and the impact of care groups.

The Care Group Difference:
The caring network of care group volunteers has greater visibility because of their large numbers – it is easy for communities to notice their presence.

Community affirmation and recognition: Affirmation is used in many volunteer models, and congratulatory words are likewise important in motivating care groups.

- Households thank care groups as their children become healthier.
- Promoters affirm their care groups at meetings and explain project statistics to help them understand their positive impact.
- Senior project staff and promoters praise volunteers' work at VHC meetings and at other public events.
- VHCs praise volunteers at meetings and affirm them by reinforcing health messages.
- Village leaders ask care groups to perform their songs and dances at public events.

The Care Group Difference:
Broader change in the community motivates volunteers as realize that they are catalysts.

Exposure to outside world: Care group volunteers come into contact with people from beyond their community, such as technical advisors, donors and evaluators, and these interactions help motivate volunteers. Visitors often praise volunteers at public events. Volunteers feel affirmed and important when outside visitors ask the care groups questions and discuss how they are changing their community.

3.4 Material Incentives

Gifts: Giving a small gift on an annual basis is common with volunteer models. Though the care group model does not depend on gifts, a tangible "thank-you" is still important in making volunteers feel appreciated.

➡ **Give presents that either assist volunteers' role in doing their job or reinforce their identity as care group members.**

The Care Group Difference:
Payment or large gifts as incentives would be very expensive because of the large number of volunteers and would not promote care group sustainability.

An example of a gift that assists a volunteer's work is an umbrella, which makes it easier for the volunteer to visit households during the rainy season. Gifts that identify volunteers as part of the care group, such as T-shirts with a matching design, contribute to a sense of group solidarity.

One of the most popular volunteer gifts Vurhonga gave was a "kapalana," or length of fabric worn as a skirt or used to carry children. The least popular gift was a pin, because it was more decorative than functional. In order to discourage women from joining a care group for the gifts alone, Vurhonga does not give tangible incentives more than once a year.

Whenever possible, these material incentives should be presented to volunteers in a community forum or other event that leads to community recognition of the volunteers' service and achievements.

CHAPTER 5

Monitoring and Evaluation

SECTION 1

Data Collection and Reporting: Involving Care Groups

A project's monitoring and evaluation (M&E) system should do more than collect data-it should enable timely actions that improve the health of beneficiaries at the grassroots level. Numerous stakeholders – in the communities, in the project and in the MOH – need to be part of the information chain in order to respond to issues affecting community health. M&E methods based on the unique strengths of care groups – their large numbers and thorough coverage of beneficiaries – empower communities. Care groups and communities can sustain their ability to measure and respond to health needs even after the project ends. Care groups do more than collect information and share it with stakeholders – care volunteers also participate in the response and take local leaders' decisions back to the grassroots level, following up with their assigned households to ensure behavior change.

1.1 Stakeholders' Needs

The multiple community stakeholders that are part of a Community Health Information System (C-HIS) each have various needs for information. To truly enable action at all levels, a C-HIS must address the needs of each stakeholder.

All stakeholders need to understand changing health needs and trends, including mortality rates. However, they tend to focus on different levels of aggregation. A care groups is primarily concerned about individual households as well as its community. A VHC is also primarily concerned with the community and household levels. The promoters and project leadership primarily need information on health needs and trends in both specific communities and the overall project area, as do clinical providers.

Care group volunteers need to:

- Respond to problems individual households are experiencing.
- Find answers to questions raised during household visits.
- Understand their impact among their assigned households.
- Understand health needs as well as the care group's impact among all households served by the group.
- Get feedback on the effectiveness of their teaching methods.

VHCs need to:

- Understand care groups' impact on the health of women and children in the community.
- Identify particular households resisting improved health practices advocated by care groups.
- Identify changing needs and problems affecting community health

Promoters need to:

- Identify health needs and trends (including mortality rates) particular to a community.
- Understand the collective impact of a care group on beneficiary households.
- Assess the effectiveness of each volunteer's teaching in home visits.
- Identify less cohesive care groups, such as those characterized by low attendance or high turnover.

Project leadership needs to:

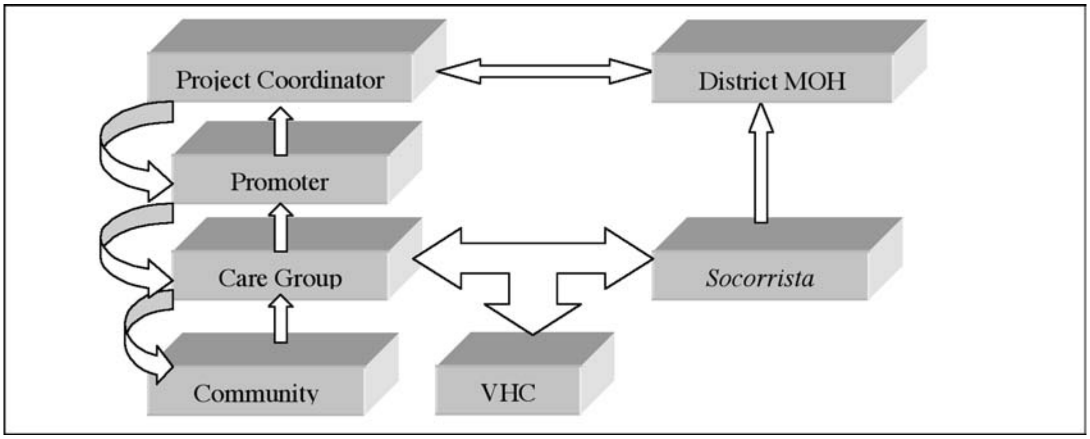
- Measure the effectiveness of each intervention after it is implemented, as indicated by household behavior change.
- Measure progress towards meeting project objectives.
- Understand health needs and trends (including mortality) in the project area.
- Identify obstacles to a project's success.
- Identify weak promoters.
- Identify areas underserved by the MOH or other clinical providers.

Clinical providers (i.e. the MOH) need to:

- Get a more complete picture of the state of community health outside the clinic walls.
- Identify communities that need greater access to clinical services.
- Understand care groups' impact in regards to changing health trends in the area.
- Anticipate outbreaks of diseases.

The following graphic illustrates the information chain in Vurhonga II's C-HIS.

Flow of Information in Vurhonga



A care group passes the information it gathers from the community to its promoter. The care group leader also reports the results to the local MOH worker (the socorrista in Mozambique) and sometimes she also reports to the local VHC. In some communities, the MOH worker may report to the VHC instead of the care group leader. Promoters in turn compile results from the care groups they supervise, and share the information with the project leadership. Project leadership and promoters get project-wide information as they aggregate information from all the promoters (and thus all the care groups). The local MOH worker passes location specific information (provided to her by the care group leader) on to the district MOH. The district MOH also receives data for entire project area from the project leadership. Responses to the data flows back down to the grassroots level through the same channels.

1.2 Care Groups and the C-HIS

The care group model involves volunteers in an on-going C-HIS that captures vital statistics, analyzes trends and feeds the results back to key stakeholders and the community at large. The C-HIS works well with care groups, because the care group model adds a distinctive population-based monitoring tool to typical project M&E tools – care groups' monthly reports on vital statistics. Monthly care group statistics are a population-based tool that collects data on every beneficiary household visited by volunteers. The monthly statistics are the heart of the C-HIS. They meet the needs of all levels of project stakeholders – from volunteers to the project to the MOH.

The Care Group Difference:
The sheer numbers of volunteers and their saturation coverage of beneficiary households create a comprehensive system of data collection.

Gathering monthly care group statistics: Care groups' complete, consistent coverage of beneficiary households is the foundation for collecting reliable monthly statistics on vital events. As part of their household visits, volunteers take note of births, pregnancies, and deaths of young children and women of child-bearing age. At one care group meeting a month, they verbally report on these vital events among their assigned households. The system is designed to be easy to use and non-threatening for both literate and illiterate volunteers. There is no sampling – every volunteer reports on all of her households. The method is simple – volunteers ask their friends "How are you all?"

The Care Group Difference:
Illiterate volunteers are able to collect, remember and report verbally on vital statistics for their small number of assigned households.

➡ **Report vital statistics for beneficiary households, including births, pregnancies and deaths of young children and women of child-bearing age.**

Volunteers:
- During a home visit, ask about family members' health.
- Take note of births, deaths or pregnancies of beneficiaries.
- Ask about circumstances surrounding the event, such as symptoms, the family's response, etc.
- At one care group meeting a month, verbally report vital events.
- Illiterate volunteers can easily recall all vital statistics because these events are generally infrequent among their 10 to 15 assigned households.
- A literate volunteer (often the care group leader) records the information.
- The care group leader turns in the form to the promoter.

Promoters:
- Aggregate and hand-tabulate results from all care groups.

Promoters, supervisors and senior staff:
- Analyze results and trends.

The Care Group Difference:
Collecting data on vital statistics is a minimal burden for project staff, because they work through care group volunteers.

Besides gathering vital statistics, care group volunteers can ask their households other specific questions and collect data on any number of subjects. It is important that care group volunteers see the data as information they act on for the good of the community – this keeps them motivated to collect data.

The Care Group Difference:
The high proportion of volunteers to households means data collection is not very time-consuming for volunteers.

Understanding monthly care group statistics: Not only do care groups form a comprehensive, efficient network for data collection; more importantly, the care group helps volunteers understand and act on the information they collect. Understanding begins in the care group meeting as volunteers discuss information regarding individual households as well as the care group's overall work area.

In care group meetings, the volunteers always discuss information in its context. As one volunteer shares her understanding of what happened in a household, the other care group members begin to add what they know. The process is usually self-corrective, as volunteers detect any false information and learn from one another's insights. The volunteers improve their understanding of what causes poor or good health in the community. Promoters also learn more about health determinants, as they guide care groups in discussion and ask volunteers questions.

➡ **Create the opportunity for two-way learning and analysis.**
Promoters:
- Immediately discuss the household vital statistics with volunteers as they report the information.
- Ask the reporting volunteer to give a possible reason for the event.
- Invite the other volunteers to share their understanding of the event.
- Discuss with volunteers, learning from their insight and correct any false information, if necessary.
  - Help volunteers link health practices or environmental factors to effects on health and disease.
- Identify actions volunteers can take in the future, based on lessons learned from the discussion.

Discussing care group statistics teaches the care group how to problem-solve together and draw on past experiences. Together, the volunteers can compare a current problem to past events and lessons learned. Or, they can identify if they are all encountering similar a problem in their assigned households that points to a larger health issue affecting the community. The process involves all the volunteers in applying a health lesson they learned to a current situation. "You remember that she had a lot of bleeding in her last pregnancy. We will have to watch her." "We had two children die and another 22 are sick. What's happening here?"

Each volunteer has on-going relationships with her households and frequent contact both through home visits and everyday life. Therefore, a care group is not discussing a cold statistic. They are talking about a child that one volunteer – if not all of them – knows and cares about. Working together, the care group identifies what the volunteer can do to respond to a situation. The personal connections motivate the volunteer to action. After discussing the situation in the care group meeting, the volunteer is able to quickly follow up with the household.

The Care Group Difference:
Information is acted upon at the level at which it is collected. A volunteer gets feedback from the entire group and the promoter as soon as she reports a situation.

If a child or women dies, conducting a verbal autopsy (discussing circumstances around the event and signs of illness) helps volunteers and promoters determine the probable cause of death. This helps volunteers better understand the behavioral and environmental factors that cause sickness and death. Promoters can also follow up with individual households to get more information and ascertain the cause of death. Before they even become volunteers, most care group members know their 10 assigned households and often have a relationship of trust or respect – a criterion the community considers for their selection. The volunteer, therefore, may be an intermediary for project staff to the community, enabling community members to more openly discuss their beliefs and concerns than they would with a stranger. This helps the volunteers and the promoter learn as much as they can from the verbal autopsy.

The Care Group Difference:
The focus on 10-15 households fosters personal relationships and concern that motivate volunteers to respond to families' needs as quickly as possible.

1.3 Project-Based M&E

Other M&E activities are carried out by the project with promoters and supervisors collecting data instead of the care groups.

Local rapid assessments: An LRA is a project-based M&E tool that meets many information needs of promoters and project leadership. This is a powerful program management tool because project – wide results can be disaggregated for analysis. LRAs work with the tiers of groupings created by care group model's structure: the individual household, the 10 households per volunteer, the 100 households per care group, and the 800+ households under the supervision of an individual promoter.

LRAs are effective tools because they:

- Yield information specific to a micro-geographic area within the project
- Yield data that correspond to the project management structure.
- Enable project managers to assess the performance of a particular promoter and the care groups she supervises.
- Identify emerging problems with MOH coverage or other issues without localized problems getting lost in project-wide aggregation of data.
- Show project-wide trends when aggregated.

LRAs base the survey sample on the beneficiary households covered by selected care groups rather than the entire population. The survey results demonstrate changes in the knowledge and behavior of households reached by one care group of a particular promoter. A health project can conduct LRAs every three to four months (roughly at the end of each intervention) to capture how it is progressing towards its objectives.

If the LRA questions focus on a recently completed intervention, project leadership and promoters can measure how well they implemented the intervention. For CSPs, it is usually helpful to use questions from the baseline KPC survey to compare progress. In Vurhonga's experience, LRAs usually correlate well to the larger KPC surveys.

➡ **Regularly conduct LRAs to track progress.**
Project leadership:

- Randomly select one care group from each promoter.
    - For a smaller sample, first randomly select several promoters, and then randomly choose from among their care groups.
- Identify all the households reached by the volunteers in the selected care group.

    - ▪ For a smaller sample, randomly select a certain number of households reached by the care group.
- Preserve objectivity by having promoters trade areas, so they do not interview households visited by their volunteers.

Promoters:

- Survey all the selected households using selected KPC questions.
    - ▪ To measure the impact of a recent intervention, select questions relevant to that intervention.
    - ▪ Interview one woman of child-bearing age from each household.

Promoters and project leadership:

- Tabulate and analyze the data.
    - ▪ Analyze in aggregate and by promoter.
- Share results with care groups and various stakeholders.
    - ▪ Explore implications to future actions.

Understanding LRAs and other evaluations: Promoters can report also the results of wider project evaluations to volunteers during care group meetings. While care groups do not carry out LRAs or KPCs themselves, the volunteers can give insight into trends shown by the data. It also helps a care group see that its work contributes to the efforts of care groups throughout the project.

The Care Group Difference:
Discussing health trends and project results with care groups gives staff more input from the local level, especially if care groups ask households follow up questions.

➡ **Encourage volunteers to understand and give input on evaluations.**
Promoters:

- Periodically share trends over time (for care groups' local area and the entire project area) and LRA survey results.
    - ▪ Use simple illustrations or explanations when presenting statistics and trends.
- Invite volunteers to share their understanding of the data's meaning.
- Discuss possible reasons for a good or bad outcome with volunteers.
- Carry back care groups' analysis to discuss with other promoters and project leadership.

Promoters may ask care group volunteers to carry the discussion back to their neighbors or ask their households a follow-up question. Promoters may also conduct focus groups with relevant groups from the community to better understand a trend.

Qualitative performance measures: Gathering qualitative information on care groups is another necessary component of the health project's overall M&E system. This gives first-hand insight into the accuracy of the teaching as well as how participatory and engaging the teaching is.

➡ **Visit the field regularly to collect qualitative data and feedback**
Promoters:

- Go on home visits with volunteers on a regular basis, assessing how well they communicate the health lessons.
    - ▪ Assist individual volunteers, providing guidance and support.
- Either before or after a care group meeting, spend time with at least one volunteer per meeting. Over time, all volunteers will receive individual attention (support from their care group is much more frequent).
- Spend extra time with struggling volunteers.

Supervisors:

- Ideally accompany each promoter to the field at least once every two weeks. This can include attending care group meetings and home visits.

Project director and health educator:

- Visit supervisors, promoters and care group volunteers regularly in the field.

In Vurhonga, the project director travels to the field at least once a week and also resides in the project area.

Household counts: Another project-based M&E tool is the household count. Household counts track the number of direct beneficiaries in each household, total number of beneficiary households, and can also be used to collect mortality data on births and deaths. They are primarily useful at the beginning of the project. From the initial household count, project managers determine the total number and distribution of care groups and promoters. Conducting a thorough household count of the project area is crucial to establishing the network of care groups.

The Care Group Difference:
Care group's monthly reports on vital statistics and LRAs are location-specific, enabling each VHC to address needs in its community.

In Vurhonga, a household count differs from a true census in that the project does not count everyone in living in the project area. It only counts beneficiaries and does not keep a record of non-beneficiaries (such as males). The project also does not keep a roster of beneficiaries' names. This is because the care groups reach such a large number of beneficiaries that recording all names would quickly become time consuming. Furthermore, the time investment that a roster would require would not yield information as helpful for making decisions as other M&E activities.

If a project chooses to, staff can include questions about births and deaths of children in each household at the same time they are doing the count. This gives the project a retrospective overview of mortality rates in the project area.

The table below gives a summary of M&E components utilized by Vurhonga II.

Components of Vurhonga II M&E System

Methodology	**Who Collects Data**	**What the Data Measures**	**How Data is Used**	**Frequency and Time Commitment**
Household Count				
Count of beneficiary households and direct beneficiaries (number = 24,671 households)	CSP staff (and sometimes volunteers)	Number of beneficiaries. Can include retrospective infant and child mortality data	Number of volunteers needed; impact on mortality; results shared with VHCs by promoters and care groups	Beginning and middle of project. Time commitment varies
KPC Survey				
30 Cluster Survey with 50 questions (n=300)	CSP staff	Project indicators	Project staff establish baselines & targets; and results shared w/ care groups, VHCs, MOH	Beginning/midterm/end of project; 5 days for data collection, tabulation
Monthly Care Group Statistics (C-HIS)				
Volunteers orally report vital events for their households to care group leader; care group leader reports to local MOH worker	Care group volunteers and MOH socorristas	Vital statistics such as births, deaths, pregnancies and probable cause	Discuss in care group meetings; volunteers share results shared with VHCs and MOH; summary data compiled project-wide for project use and MOH	Monthly; reporting and tabulation = 30 min. during Care Group meetings; project-wide compilation = 30 min. at district hospital
Local Rapid Assessments				
Abbreviated KPC survey of all households in one randomly selected Care Group per promoter (n=2,800)	CSP staff and volunteers	Selected project indicators (usually related to current intervention)	CSP staff track progress; re-focus curriculum strategies as indicated; care groups and CSP staff share results with VHCs and MOH	About every 3-4 months; 5 days for data collection and tabulation

The chronological order for establishing M&E components in Vurhonga is generally as follows:

1. Baseline KPC survey and household count.
2. Care groups organized and functioning.
3. Care groups report monthly vital statistics.
4. LRAs begin (usually about 3 to 4 months after care group training starts, or around the end of the first intervention).
5. Midterm/final KPCs and external evaluations.

1.4 Stakeholders Taking Action

Care group monthly statistics are the heart of the C-HIS, but the results of all M&E – including project-based activities – can be fed back through the information chain. The C-HIS establishes a reporting process that makes it easily to pass on information, relying primarily on relationships and verbal reporting. This gives all stakeholders access to timely information. As each group analyzes and understands the data, stakeholders make and execute decisions that respond to the changing health needs and trends at various levels throughout the project area.

Care groups: Care groups are the first line of action in the C-HIS. As discussed in the preceding sections, volunteers reflect on individual situations with their care group and promoter and leave the meeting to follow up with the household. Care groups are usually the first to discern changes in the health of their communities. Care groups do more than send information up the reporting ladder –

they translate community and project decisions into action. Each volunteer works with her assigned household to respond to needs highlighted by the C-HIS and project-based M&E.

Project managers: Because of the information provided through care groups, project leadership identifies obstacles as quickly as possible. Rapid, personalized feedback helps keep the project flexible and responsive to community needs.

➡ **Identify obstacles to progress.**
Project managers:
- Discuss and implement responses, drawing on staff, care groups and other stakeholders as appropriate.

An example is when Vurhonga II tracked a decline in mosquito net use during the months of August through October. Staff investigated and learned that community members perceived nets unnecessary since mosquitoes were less bothersome during the dry season, but malaria was still endemic. The staff refocused malaria messages, emphasizing the importance of nets year-round. Usage soon increased.

Vurhonga also benefits from personalized feedback loops among staff (enhanced by all staff speaking the local language). In Vurhonga, project leadership, supervisors and all promoters meet together every Monday morning and Friday afternoon. Regular meetings of all staff create frequent opportunities for group problem-solving and taking action.

➡ **Look for ways to shorten feedback loops and keep the project flexible.**
Project staff:
- Meet together frequently.
- Interact often in the field, including the project director.

Sharing with Village Health Committees: Care groups take the lead in sharing monthly vital statistics to VHCs, involving the broader community in the C-HIS. Care groups also pass on results from project-led M&E to community leaders during VHC meetings. The promoter may also periodically attend to present LRA results and trends. The VHC then discusses the results, causes and implications for their community.

➡ **Share data on a regular basis with VHCs, raising awareness, highlighting progress, and increasing transparency.**
Care group leaders:
- Regularly report information to VHCs or to other key community-based involved with health.
    - Share the report verbally to the entire VHC.
    - Give the VHC leader a written report of monthly statistics (or provide a copy to another VHC member, if the leader is not literate).

➡ **Encourage VHCs to understand information specific to their community.**
Care group leaders (and other volunteers):
- Share from experience and use participatory methods to help VHCs link health practices to outcomes in community health.

Promoters:
- Use appropriate methods to help VHC members, who may be illiterate, understand general concepts and trends in C-HIS and other M&E data (such as pictures or other visual presentations).

After being briefed on C-HIS findings, VHCs can discuss implications for their communities. Sometimes they are able to compare the results for their village to another village, using location-specific LRA results or monthly care group statistics. They can also compare particular households within the same village, since monthly care group statistics are tied to each volunteer's assigned households.

VHC Action: As VHCs and care groups jointly recognize changing health needs in their community, they respond appropriately.

➡ **Encourage VHCs to make and carry out decisions regarding community health.**
Care group leaders and/or project staff:
  - Point out changing health needs, as shown in the C-HIS.
  - Highlight care groups ability to respond to health needs and reach all beneficiary households.

The Care Group Difference:
Communities turn to the network of care group volunteers to carry out specific responses to needs revealed by the C-HIS.

Communities take action in a variety of ways. If a particular household is very resistant to a volunteer's teaching, the VHC may bring its community influence to bear and encourage the household to comply with the volunteer's health teaching. While communities encouraging compliance may seem like a harsh practice from a Western perspective, in many non-Western cultures it is acceptable and expected that village leaders exert such authority.

VHCs can also take action on broader health issues highlighted by the C-HIS, involving care groups to ensure behavior change takes place among individual households.

- Care groups leaders trained by Vurhonga II notified VHCs when malnutrition started increasing in the former project area. Since care groups were previously trained in the Hearth intervention, VHCs decided that volunteers should reinstitute Hearth (Hearth was not a current CSP intervention at the time). Despite drought and heightening food shortages, the prevalence of underweight children decreased during 2002 from 13% in March to 7.2% in July.

- In Mapapa village during Vurhonga II, C-HIS feedback alerted the VHC that 19 of its households did not have latrines, leading to a community-set goal of all households having latrines within three months.

Application: WR CAMBODIA
Mothers in the communities feared immunizations, particularly the mild fevers their children sometime had after being vaccinated. The CSP initially depended upon extrinsic incentives to change behavior. The project took free photographs of children who were completely immunized, drama teams provided entertainment (and health education) at immunization sessions, and the volunteers had to rally the mothers to get them to attend the sessions. However, acceptance and momentum for immunizations only began to grow when the C-HIS demonstrated to village leaders that fewer children were dying from tetanus and other vaccine-preventable diseases. Motivation then became intrinsic-the C-HIS, operating through the care groups, convinced village leaders that the death of so many babies was avoidable, and it convinced mothers that they could get their children immunized and do something about their health. The immunization rate quickly grew.

Sharing with clinical providers: C-HIS information, as well as KPC and LRA results, also equip the MOH and other clinical providers for action. Aggregated information helps them understand health trends in the entire project area. Providing disaggregated information, such as LRAs, can highlight specific needs (i.e. gaps in immunization coverage, etc.)

➡ **Share information with the clinical care providers/MOH at both the local and district level.**

Care group leaders:

- Report monthly care group vital statistics to accessible, appropriate clinical workers (likely a local, more junior clinical worker).

Promoters:

- Follow up with local clinical/MOH staff, as appropriate.

Project director:

- Share KPC, LRA results and aggregated vital statistics, and also share disaggregated information as needed.

Highlighting health needs and urging the MOH to action can motivate timely responses. When Vurhonga care group volunteers tracked an increased incidence of diarrhea, they notified VHCs and the MOH. This enabled the MOH to prepare for a possible cholera outbreak. The district was ready to respond when cholera struck, while other districts to the north were caught unaware.

CHAPTER 6

Links to Communities and Health Services

SECTION 1

Community Buy-In for Care Groups: Local Leaders

Care groups function best when they are linked to groups in the community that publicly support and take part in their work. To this end, project staff and care groups facilitate the establishment of village health committees. VHCs help ensure that care groups do not stand alone as the creation of a project; instead, VHCs integrate care groups into ongoing community life.

1.1 Building Relationships

Broader support: VHCs provide care groups a broader cross-section of support from many segments of the community. VHCs are made up of both men and women and often include representation from village chiefs, other traditional authorities, religious leaders, women's associations and other prominent groups within a community. These groups of local leaders become important links among care groups, the community at large and clinical care. Support from multiple community leaders is very important in gaining community acceptance for care groups.

VHCs are a crucial element to community action since members have the ability to either support or undermine the efforts of care groups. Fostering relationships between care groups and VHCs encourages community leaders to publicly support volunteers, reinforce health messages and join them in taking action to improve health within their community. This prepares VHCs to take on the responsibility of supervising care groups' on-going work once the project itself ends. VHCs' support also helps sustain care groups.

➡ **Focus on developing relationships at the community level through consistent interaction beyond formal meetings.**

Project staff:

- Inform a broad cross-section of the community, including male leaders, about care groups and the project.
- Demonstrate respect in frequent visits.
- Greet leaders whenever visiting the village.
- Praise VHCs and care groups for working together to bring positive change to their community.
- Be transparent – speak openly about goals, challenges and the project's timeline. (For example, clearly state if the project is only guaranteed funding for four years of work, etc).
- Answer questions and concerns honestly and realistically.
- If unable to answer a question, commit to finding the answer.

Project staff should begin the process of starting VHCs about two to six months after care groups start operating. If similar committees focused on health or development already exist in a community, project staff should cooperate with them rather than developing a new group.

➡ **Form VHCs to support care groups and community health if no similar committees already exist.**

Promoters and senior staff:

- Hold several meetings with key community leaders to introduce the VHC concept.
- Facilitate formation of VHCs soon after establishing care groups.
- Explain the advantages of VHCs in relation to the growth and sustainability of positive health practices.
- Involve leaders early in addressing community problems.

Vurhonga I learned that forming VHCs early on in the project is crucial to fostering the groups' sustainability. Staff helped organize VHCs after the project midterm – more than two years after starting work. However, this did not allow enough time for VHCs to become established and take root before Vurhonga I ended a year or two later. As a result, most VHCs stopped meeting roughly within a year after the project ended. In response to this problem, Vurhonga II formed nearly all VHCs in its first year-and-a-half of work.

➡ **Communicate frequently with VHCs to inform them of the work of care groups and health needs in the community.**

Care group leaders:

- Regularly provide verbal and written reports on care group monthly statistics, health trends and project-based evaluations giving information on their community.
- Inform VHCs of the start of new interventions.

Project staff:

- Attend VHC meetings when possible, particularly early in the project.
- Help volunteers share results of evaluations, surveys, KPCs and other relevant information. (See also Chapter 5, Section 1).

VHC action: Building strong relationships between VHCs and care groups prepares them to take tangible steps that support care groups. Effective VHCs take initiative in the community through their words and actions.

Involved and effective VHCs:

- Publicly affirm care groups.
- Invite care groups to perform their songs and dances at local events.
- Reinforce care group health messages.
- Encourage resistant households to adopt healthier practices advocated by volunteers, bringing community authority to bear when necessary.
- Discuss health issues and identify solutions.
- Set community goals for health.
- Pass local laws related to health.
- Enforce community compliance in reaching goals (or obeying rules) related to community health.

Vurhonga experienced numerous examples of VHCs taking practical steps to respond to information gathered by care groups.

- The VHC for Muzumuia village learned from monthly care group statistics that pregnant women were continuing to deliver their babies at home rather than at hygienic delivery huts assisted by a trained traditional birth attendant (TBA). Further investigation revealed that the TBA was demanding unauthorized payment. The VHC raised this issue to the district MOH, who resolved the problem.

- In Mapapa village, the VHC established a community-set goal of all households having latrines within three months after C-HIS feedback alerted the VHC that 19 of its households did not have latrines. The 25 de Septembro village VHC passed a law requiring any household without a latrine to pay for the labor of community members sent to build it for them.
- The VHCs of 25 de Septembro and other villages took note of an increase in malnourished children detected by growth monitoring data reported by care groups. They decided that care groups, already experienced in Hearth, should start new Hearth sessions. Despite drought and food shortages, the prevalence of underweight children decreased during 2002.

The Care Group Difference:
Care groups equip VHCs with information to make decisions, and they also serve as vehicles for carrying out these decisions.

In Mozambique, VHCs also oversee part-time, local MOH workers (see Chapter 6, Section 2 “Integrating with Local Health Providers”).

Village health representative: The official village health representative (this is a community member, not a MOH worker) often serves as the VHC leader. The link between the care group and the village health representative should be particularly strong. In Vurhonga, this person is called the “Chef de Saude” (Chief of Health) – often, the village chief appoints someone to this position. The health representative is the local “cheerleader and coach” for the care groups. He/she should take over the liaison functions of the project promoter, i.e., linking care groups to community leaders, the VHC and to the health post.

The Care Group Difference:
Local leaders maintain direct contact with the care groups since the care group leaders are members of the VHC.

➡ **Build close relationships between care groups and their community’s village health representative.**
Promoters:
- Provide the same training in health interventions that volunteers receive.
- Include the health representative in a local care group.
- Encourage the health representative to take a leading role in publicly supporting care groups and reinforcing their health messages.
- Encourage the health representative to rally the entire VHC to support the volunteers.

The Care Group Difference:
Training the village health representative along with a care group fosters a shared sense of teamwork.

➡ **Equip the village health representative to be a liaison between care groups, the VHC and the MOH.**
Promoters:
- Train in leadership skills, such as conflict resolution and meeting facilitation.
- Encourage the health representative to rally the entire VHC to support the volunteers.

Membership: The members of a VHC are decided locally, and in Vurhonga they usually include the following:
- Village chief
- Official village health representative
- MOH representative from the health post (in Vurhonga, this is the socorrista)

- Care group representative/leader from each care group in the village
- Neighborhood leaders (2-3, maximum of 5)
- Women's leader (in Mozambique, this is often the leader of the local chapter of a national women's organization)
- Representative from local care group of religious leaders

Vurhonga promoters are not officially members of the VHC, but they frequently attend the committee meetings.

Vurhonga sets the standard that a minimum of 60% of VHC members must attend meetings for the VHC to qualify as active. Meetings are held every one to two months. At the time of Vurhonga II's final evaluation, 91% of VHCs had met within the last two months, surpassing the initial target of 70%.

Application: WR CAMBODIA
At the outset of the project in Cambodia, CSP staff planned to work in collaboration with another agency that had committed to starting VHCs. However, the other agency was unable to follow through, and so VHCs were not formed in the project area. The lesson learned was that organizing VHCs should not be delayed and should be directly incorporated into the project's efforts. CSP staff responded to the problem by building good relationships with village chiefs and encouraging them to support the care groups. Care group leaders began to regularly report to them and raise community concerns about health. The relationships with village chiefs helped fill the absence of VHCs.

1.2 Care Groups of Religious Leaders

Working with religious leaders: Forming special care groups of local religious leaders creates another link between care groups and community leaders. It also generates understanding and appreciation of health among religious leaders.

Project staff invite local religious leaders in an area to attend special care group meetings about once a month. Vurhonga finds it works well if the religious leaders' care group involves leaders from the same religion while still including all denominations of that religion. The leaders receive the same health training as care groups.

An important difference from the regular volunteer care groups is that the religious leaders do not visit assigned households. But, they do have the responsibility of sharing health messages with community members during the normal course of their religous work. They are also expected to publicly support the activities of care groups.

Vurhonga, since it works with local churches, calls the groups "pastoral care groups." Vurhonga II's final KPC found that the attendance rate among pastoral care groups was 70% – the target was 60%. In addition, 72% of mothers who attended church during the past month reported that they heard a health message, exceeding the target of 50%. Neither of these objectives were included in the project's baseline KPC, but they reflect that religious leaders cooperated with the project and reinforced health messages in their communities.

Regular care groups and communities benefit in several ways when a project trains care groups of religious leaders.

The religious leaders:

- Grow to understand and appreciate health and the efforts of care groups.
- Publicly praise care group volunteers.
- Promote healthy practices and behavior change in public meetings (such as during sermons to their congregations).
- Recognize symptoms of illnesses and urge families to seek appropriate treatment – this is particularly useful when the family of a sick child calls a religious leader to pray with them or offer spiritual comfort.
- Stop unhealthy practices or giving ineffective treatment for sickness (religious leaders may also be involved in harmful traditional healing practices).

Vurhonga saw a number of examples of pastors stopping unhealthy traditional practices. At the start of the project, Vurhonga staff found that many pastors of the Zionist denomination would admit sick children to their homes and delay treatment with drugs. These pastors were among leaders trained in pastoral care groups. They learned to refer patients with suspected malaria and pneumonia for appropriate treatment–though as one Zionist pastor acknowledged during a final evaluation, he did not really need to make referrals because households were already choosing the health post over admission to a pastor's house. The pastor interviewed was not bitter about the decrease in business. Instead, he remarked how effective the treatment at the health post was for such ailments – and that it was helping to save the lives of children in the village. In addition, many pastors reported pride in being able to refer people to effective treatment, knowing that it increased their own credibility within the community.

Building the capacity of religious leader care groups enables them to take initiative on their own. Pastoral care groups in Vurhonga II demonstrated an ability to plan health interventions and mobilize community support. Initial training in HIV/AIDS catalyzed Chokwe churches to address AIDS more broadly. Without any outside funding and little outside direction, pastors formed an inter-denominational task force to educate their communities about HIV/AIDS.

Application: WR RWANDA

The CSP in Rwanda has had great success using pastoral care groups. At the end of the project's second year, 31 pastoral care groups were meeting regularly. These groups train about 330 church participants, including both key lay leaders as well as 82 trained pastors. Volunteers sometimes invite a church leader to attend a regular care group meeting, further building relationships between religious leaders and volunteers.

SECTION 2

Integrating with Local Health Providers: Accessing Services

Care groups do not and cannot function in a vacuum. Project interventions that include referral to clinical care–such as seeking treatment for malaria or pneumonia, or getting immunizations–are only effective when those services are available. Care groups can enhance communities' ability to integrate their efforts with local health providers, as they advocate for and strengthen services.

2.1 Identifying and Strengthening Local Services

Assessment: Health project staff should assess what health services community members need in order to act on the health messages promoted by care group volunteers. Then, the project needs to look for ways to help increase the community's access to both clinical services and essential drugs for treatment.

➡ **Evaluate beneficiaries' access to drug and care services.**
Project staff:

- What services are currently available locally?
- What is MOH policy (i.e. what is legal)?
- Where do people currently seek care?
- What is the order in which people choose to access to different care sources?
- What are the current boundaries to accessing care and services?

Identifying access points: In Vurhonga's project areas, the most basic and accessible health services are the lowest cadre of MOH workers. These workers are called "socorristas." Socorristas are part-time health workers who work on a fee-for-service basis, providing first aid treatment, anti-malarial drugs and referrals to larger health centers. Vurhonga identified socorristas as a key contact for interventions involving treatment-seeking. However, upon investigation, the project found that many socorristas existed only within MOH records–they were not actually active.

Increasing availability: A project may need to take steps to increase the availability of health services. Vurhonga and care groups used their network of relationships to revitalize socorristas. Promoters and care group leaders began regularly to meet regularly with the socorrista in their local area. In cooperation with the district MOH, Vurhonga staff held training sessions for socorristas. Training socorristas was a minimal cost to the CSP, since promoters used curriculum already developed for training care groups. In addition, socorristas' health posts were very basic – staff and care groups encouraged the communities to contribute to the construction of new socorristas' health posts. Community members pitched in and built simple facilities using local materials.

➡ **Look for innovative, cost-effective solutions to increase communities' access to clinical care.**
Project staff:
- Identify potential sources for clinical services, drawing on care groups' ideas.
- If necessary, provide training to local providers.
- Use care group curriculum to train local providers, as appropriate.
- Lobby the MOH to stock local providers with essential drugs and supplies (anti-malarials, bed nets, etc.).

Promoters:
- During care group meetings, raise awareness among volunteers about the local clinical services available.
- Encourage care groups to interact with local health providers.

The Care Group Difference:
Care groups' saturation coverage creates widespread community awareness of and demand for clinical services.

Care group leaders in Vurhonga started sharing monthly care group reports on vital statistics with socorristas. Care group leaders and volunteers also began encouraging them to become more active in the community. And when they worked with beneficiaries, all care groups encouraged households to go to socorristas when their children had signs of malaria or pneumonia. People began seeking socorristas out for treatment, and this made them feel important – it motivated them to be more available and involved.

The Care Group Difference:
Regularly reporting local health data and discussing health needs with local health providers builds relationships between them and care groups.

➡ **Build links between the community and local providers.**
Care groups leaders:
- Meet regularly with local health providers, including on an informal basis.
- Share monthly care group vital statistics and LRA results.

Care group volunteers:
- Teach households about where they can seek care and encourage them to use services.
- Encourage local providers by emphasizing the importance of their work, and building their sense of self-worth.

Increased access: The end result was that Vurhonga significantly increased the population's access to health services. This primarily resulted from the low-cost efforts of establishing and training new socorristas, rather than an increase in new durable (concrete) health centers, though this happened as well.

The Care Group Difference:
Care groups' data collection provides a level of surveillance that becomes a useful tool for the MOH.

In both Vurhonga I and II, more than 90% of the total population were within 5 kilometer access to a health post by the final evaluations. The following tables indicate the change in health services available in Vurhonga project areas.

Health Infrastructure of Mabalane and Guija Districts (Vurhonga I, 1995-1999)

Health Facilities *(construction + type of staff)*	**Mabalane**		**Guija**		**Total**	
	1995	1999	1995	1999	1995	1999
Health Center *(durable + nurses + midwife)*	1	1	1	1	2	2
Health Post *(durable + nurse and/or midwife)*	1	2	5	5	6	7
Health Post *(durable + Soccorista)*	0	4	0	2	0	6
Health Post *(local materials + Soccorista)*	1	5	3	12	4	17
Total	**3**	**12**	**9**	**20**	**12**	**32**
Population within 5kms of a Health Post	37,692	68,076	15,234	21,552	52,926	89,628
Total Population in the Project Area	68,640	68,640	22,896	22,896	91,536	91,536
% of population with access to Health Post	**55%**	**99%**	**67%**	**94%**	**58%**	**98%**

Note: One Mabalane health post and several small villages situated west of the Limpopo River (outside the project area) were not included in the above calculation.

The health infrastructure for the districts of Mabalane and Guija increased by 266% between 1995-1999. This included the addition of seven durable health posts (six built with the assistance of Doctors Without Borders and Lutheran World Federation). As the external evaluator noted, however, even more impressive was the addition of 13 local material health posts. These were constructed by the communities and staffed by a soccorista selected by the community and trained by the MOH with assistance from Vurhonga I. The project assisted the MOH in curriculum development for the training of both soccoristas and nurses.

Health Infrastructure of Chokwe District (Vurhonga II, 1999-2001)

Health Facilities	**Chokwe District**	
(construction materials + type of staff)	**1999**	**2001**
Health Center *(durable + nurses + midwife)*	3	3
Health Post *(durable + nurse and/or midwife)*	10	10
Health Post *(durable + Socorrista)*	2	3
Health Post *(local materials + Socorrista)*	2	28
Total	**17**	**44**
Population within 5 kms of a Health Post	84,630	132,084
Total Population in the Project Area	130,492	132,480
% of population within 5 km of a health post	**64.8%**	**99.7%**

At the beginning of Vurhonga II, MOH infrastructure included the hospital of Chokwe, three health centers with nurses and 14 health posts with either a nurse or socorrista. There were 34 villages without health posts. Population access to health services within 5 km of the village was 65%. Four years later, 99% lived within 5 km of a trained health provider, either a socorrista or a health post staffed by nurses and/or midwives. The number of active socorristas greatly increased.

Application: WR RWANDA
Care groups in Rwanda found access to malaria drugs to be a large obstacle in their area. Only government-approved pharmacies could dispense the drugs – and these pharmacies were few and far between. Volunteers and the CSP proposed an innovative solution to the government – authorize care group leaders to sell anti-malarials to the communities they serve. Now, WR's CSP and several other projects are starting a government-sanctioned pilot project, where care group leaders dispense drugs to mothers seeking treatment for children with malaria.

Application: WR CAMBODIA
In Cambodia, the project identified both formal and informal sources of care. Mothers' most basic access points for malaria drugs are local drug sellers – informal "pharmacies" are much easier to access than the MOH in more remote areas. Because of that, staff are training local drug sellers to correctly identify malaria symptoms and provide appropriate treatment. Likewise, care groups teach mothers that they can go to trained drug sellers when their children are sick. To build links between care groups and the MOH, CSP staff give MOH staff scheduled opportunities to assist in training the care group volunteers. Through this, the MOH workers meet all the volunteers in their coverage area. The volunteers are given the chance to advocate community needs tothe MOH. The result fostered understanding and mutual accountability. More villages responded in a recent MOH immunization campaign, and the MOH included villages that were previously ignored.

Care group support: Relationships between care groups and local health providers create two-way relationships – local providers can also utilize care groups to assist with MOH activities.

The Care Group Difference:
Care groups benefit the MOH by publicizing announcements and helping the MOH at health events in their villages.

If the MOH decides to hold an immunization session, the socorrista contacts the care group leader. Volunteers publicize the upcoming event during home visits and rally mothers to bring their children. They are present at the actual session and help organize people by lining them up, helping to ensure things run as smoothly as possible for the MOH. Volunteers also take advantage of the time to present health messages to the crowd waiting for immunizations. In this way, care groups help the MOH have a successful immunization session by mobilizing a high turnout.

At Majangue Health Center in Chokwe district, Sister Dalva Trinadade, a Brazilian nurse who was working at the center, recognized the work of care group volunteers. During Vurhonga II's final evaluation, she explained that the volunteers often bring mothers and children to the health center. On Fridays, when the government is distributing milk and conducting supplementary feedings for children from at-risk families, care group volunteers come to give nutritional instruction to the women and also assist with food preparation. The volunteers use that opportunity to teach about the importance of breastfeeding and the use of enriched porridge during weaning. The care group volunteers also regularly help to clean the health center and the grounds – something never envisioned by WR as part of the volunteers' responsibilities. Over the course of the program, rather than volunteer interest waning, it actually increased as volunteers took increasing pride in their work and the results they could see in the community.

> **Application: WR CAMBODIA**
> Care groups helped the MOH increase immunization rates, as volunteers worked with households to overcome their strong resistance to vaccinations. During the final evaluation of WR's first CSP in Cambodia, a member of the MOH immunization team said, *"Before, we used to come to a village and only immunize 1-2 children. It was not worth going all that distance. Now that the volunteers motivate the community, we immunize between 15-30 each time. We can give them a list of children and women to come to the next session, and they will show up the next time."*

Changed attitudes: There is a symbiotic relationship between demand for services and motivation of health care workers. At Mapapa, the nurse explained that prior to Vurhonga, he saw perhaps 400 patients a month – four years later he was seeing more than 1,000. To his satisfaction, people are coming in early enough for treatment to be effective. He stated that the increased demand made him feel like he had an important job, and his increased ability to provide effective treatment made him feel good about his abilities as a nurse. Furthermore, he said it was a lot more gratifying to work with people who have a basic understanding of hygiene and health – and with volunteers whom he can rely on to mobilize the community as needed.

The competency of care groups and their impact on community health can transform the attitudes of MOH staff. They become more willing to work at the community level and offer more services. During the final evaluation of Vurhonga I, the district director of Guija summarized the improvements in health services provided at health posts. He said, *"In the health posts, we now have good relationships with the villagers. Before our staff would be short-tempered, speak harshly, and want things to be done quickly. But now we know that if the villagers are treated with love and respect they can change. We want to continue to do what we saw the Vurhonga staff do."*

The Care Group Difference:
Care groups help transform the attitudes and sense of efficacy among clinical workers, as proactive, informed beneficiaries seek assistance from them.

2.2 Integrating VHCs and Clinical Services

Managing socorristas: In Mozambique, VHCs manage socorristas along with the MOH–VHCs have influence over the schedule of fees, hours services are offered, and resolution of any grievances against the socorrista. Socorristas report to both VHCs and the MOH.

Likewise, VHCs also provide support to socorristas. For example, they publicly praise socorristas and help resolve any disputes with the community. As one socorrista said in Vurhonga II's midterm evaluation, *"If I have a problem, I can take it the committee, so I don't struggle alone."*

Vurhonga staff helped facilitate relationships between socorristas and VHCs by encouraging socorristas to regularly attend VHC meetings. At the end of Vurhonga II, 91% of VHC meetings included an MOH representative, usually a socorrista. The baseline was 0% and the target was 70%.

Lobbying for services: VHCs can push for greater access to care from the MOH. Through socorristas, VHCs can ask for greater access to MOH health services, such as asking for more frequent immunization sessions. VHCs work with socorristas to voice concerns to the upper levels of the MOH. Though the socorrista does not have the authority to call a session, he/she can carry the VHC's request to the appropriate MOH representatives.

Care groups and VHCs are more effective at lobbying the MOH for change when they work together. A VHC gains greater credibility and has a better grasp of what services the community needs when it is backed by the data and support of care groups. When needed, VHCs can also work with project staff to lobby the MOH for more services. Project staff likewise argue more convincingly and with greater credibility when they have community support from the VHCs.

CHAPTER 7

Sustainability

SECTION 1

Maintaining Care Group Momentum: Sustainability

The name "Vurhonga" means "dawn" in the local Shangan language – it was first chosen to signify the new beginning and new knowledge for communities awakening from the darkness of Mozambique's long civil war. Vurhonga was and is led by the care groups, who view and nurture the project as their own. Vurhonga I health educator Linda Nghatsane said that volunteers use the name "Vurhonga" as if it were the name of the baby, and they refer to themselves as mothers of Vurhonga. *"Volunteers were saying to each other, 'Wake up, Vurhonga's mother, let us work while it is dawn.'"*

Care groups' work transforms behavior and attitudes–of volunteers, of beneficiaries and of entire communities. They serve as on-going support to empowered communities long after a health project departs. Through care groups, the night is gone – daybreak is shining.

1.1 Resources in the Care Group

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.

Continuing care group activities: After several years of working with the project, volunteers have internalized health messages. In Vurhonga, care groups "graduate" when the care successfully passes an oral quiz on all interventions. This graduation signifies that the group has mastered the knowledge and is well able to continue teaching their communiites. At the end of Vurhonga II's four years, 100% of care groups graduated.

At the end of a project, volunteers have not only the knowledge but the skills they need to continue delivering health lessons to households. Volunteers grow quite skilled in simple but effective participatory teaching methods, and making household visits has become a routine part of their lives. Beneficiary households also grow to expect continued visits and engaging teaching. As they visit households, volunters call on each other for support when they encounter questions or difficult households, pairing two care group volunteers together if one has a problem. Neither their established participatory teaching skills nor volunteers ability to problem-solve together depends on the continued presence of project staff.

The Care Group Difference:
Care groups institutionalize the delivery of health messages and health beliefs in a community.

Volunteer Retention at Vurhonga I Project Area

Volunteers active at End of Project	**1,457**
Volunteers who:	
Left post or moved	–92
Died	–44
Were selected as replacements	+40
Volunteers functional 20 months after EOP	**1,361**
Net attrition 20 months after EOP	**6.59%**
Households reporting a visit from volunteer within last two weeks	50%

With a strong, active care group, care groups are able to reach new beneficiaries as more children are born in the area and new households need teaching. Nearly two years after Vurhonga I ended, about half of households surveyed reported receiving a visit from a care group volunteer in the last two weeks.

Maintaining the care group: Volunteers recognize the strength of the group and maintain it. In Vurhonga I, care groups continue to function long after the project ended. One survey 20 months after Vurhonga I's conclusion showed that the net attrition among volunteers was only 6%.

Selecting replacement volunteers offsets the losses of volunteers who died or moved away. The care groups take the lead in selecting new volunteers and integrating them into the group. Volunteers, particularly the care group leaders, are accustomed to teaching health lessons to each other. When Vurhonga repeats an intervention in its last two years, a promoter first retrains the care group leader, who then retrains the entire care group. As the care group leader gains confidence and skills, she is ready to keep re-teaching and leading the care group after the promoter is gone at the end of the project. This enhances the care group's ability to train a replacement volunteer.

The Care Group Difference:
The group shares in the work and responsibility of training a replacement volunteer.

In addition, care groups do not need promoters to continue the practice of "mentoring" each other – a new or "weak" volunteer goes on home visits with a skilled volunteer until she is ready to teach her assigned households by herself (see Chapter 4, Section 1.2).

The Care Group Difference:
Care groups make group action and problem-solving possible after the end of a project – this would be more difficult for an individual volunteer.

➡ **Replace departing volunteers by selecting and training new volunteers.**
Care groups:
- Select replacements by following the established volunteer criteria and working with households and community leaders to select the volunteers.
- Train new volunteers in the health interventions.
- Pair a new volunteer with an experienced care group member during household visits.

In addition, selecting replacement volunteers maintains the ratio of volunteers to households, so home visits do not become too much of a burden on any one volunteer.

Incentives: None of the above would happen unless volunteers remain motivated to continue their activities. The care group model creates intangible incentives that remain after the project ends and no longer provides any material incentives.

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.

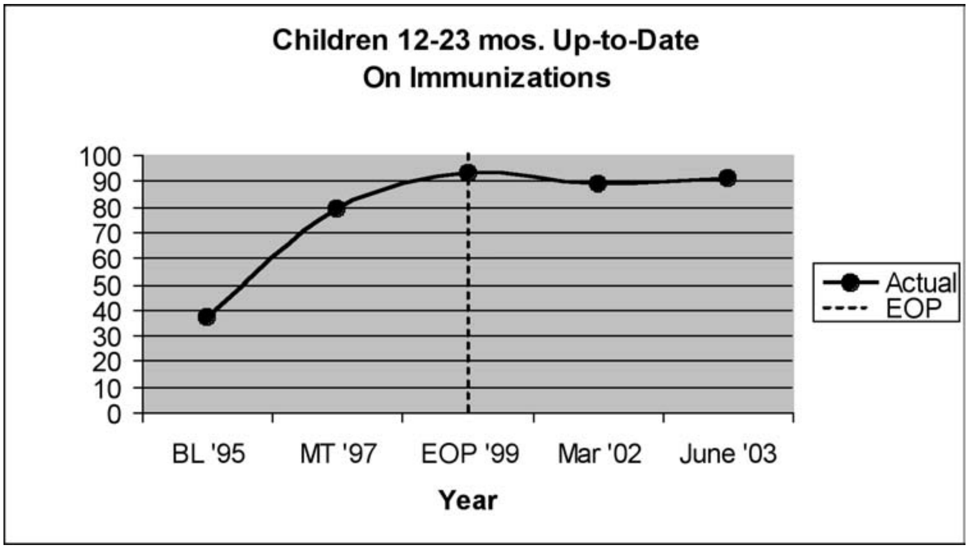
1.2 Sustaining Behavior Change

Care groups help households sustain the health practices first introduced by the project. Continued visits by care group volunteers – as well as communities' own recognition of the effectiveness of the behaviors – contribute to the maintenance of healthy practices. In addition, widespread behavior change among households makes it easier for households to maintain these changes, since they do not feel as if they are alone in keeping up the practices. Behavior change is also linked to sustained availability of clinical services, since several of the behaviors depend on the MOH or other clinical providers.

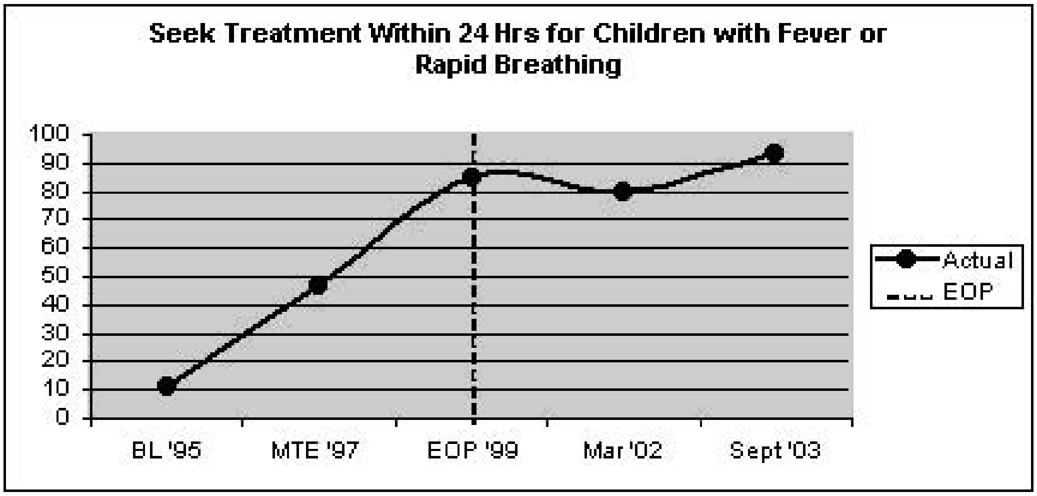
Evidence of sustained change: Vurhonga staff conducted regular follow up surveys in Guija and Mabalane Districts in the four years after Vurhonga I ended. These surveys found that nearly all tracked behaviors had been maintained and some had even improved, even though the CSP was no longer active in the districts.

The Care Group Difference:
The widespread behavior change care groups make possible empowers communities to maintain changed behavior after the project ends.

During the four years of Vurhonga I's activity, the immunization rate of young children rose from 37% to 93%. Follow up surveys over the next four years showed that the immunization rate stayed high, varying between 89% to 91%. The sustained immunization rate also indicates sustained services by the MOH – the local and district MOH remains one of the few sources for clinical services in Guija and Mabalane. Maintaining the immunization rate, as illustrated in the graph below, would not be possible without the MOH also keeping up its services.

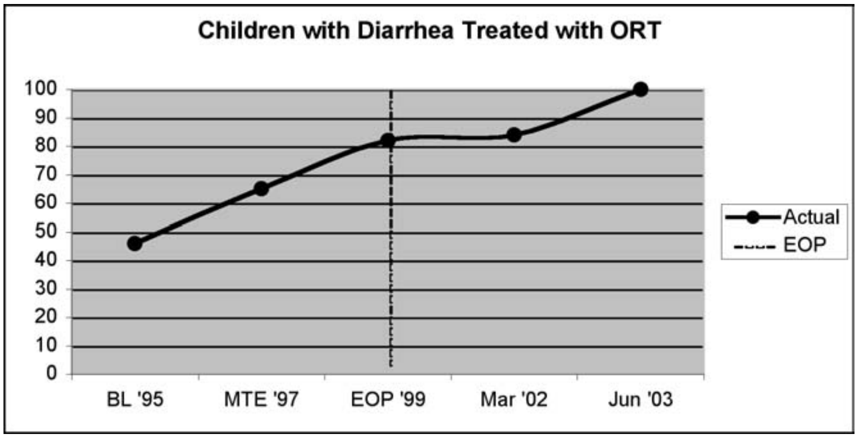


Another behavior maintained by households was rapidly seeking treatment when children showed signs of malaria or pneumonia. After reaching 87% by Vurhonga I's EOP, the rate subsequently ranged between 80% and 93% in the four years.

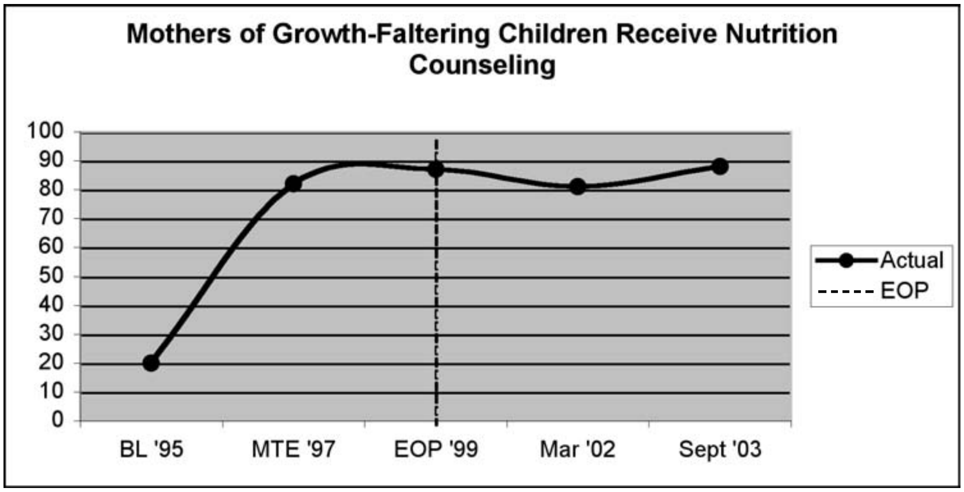


The continuation of widespread treatment-seeking behavior reflects the sustained availability of clinical services – it is less likely that households would continue seeking care if none were available or if treatment were not timely or effective. Surveys showed that the large majority of the lowest cadre of MOH workers – the socorristas trained by Vurhonga staff, the MOH and care groups – remained active after Vurhonga I. Two years after the end of the project, 87% continued their work at local health posts. The socorristas' relationship to on-going demand from the community is symbiotic. High demand means sufficient clientele and profitability which encourages them to stay active. Widespread demand also helps socorristas feel relevant and that they are doing an important job.

Households not only sustained but even improved the rate of children receiving ORT.



Mothers of growth-faltering children continued receiving nutrition counseling post-Vurhonga I. Keeping up this indicator most likely reflects continued activity of care groups and MOH workers. First of all, the percentage of children weighed in three months was also maintained. Though the weighing rate peaked at the EOP and declined over the next four years, it remained around 80% (well above the project's original target of 70%). As weighing sessions identified growth-faltering children, volunteers provided the needed nutrtional counseling. The rate at Vurhonga I's EOP was 87% and afterwards varied between 81% to 87%.



1.3 Sustaining Community Action

Maintaining data collection: The C-HIS and monthly care group vital statistics are designed to be sustained after the end of the project. The vital data itself is simple and usually easy to verify. The events are sufficiently infrequent and easy to determine (births, deaths and pregnancies), so that illiterate volunteers are easily able to remember and report on vital events among their assigned households.

Data collection at the household level requires no technology or even literacy. During the monthly care group meetings, the only requirements are pen and paper and one literate volunteer per care group to record the vital data reported by each volunteer. Likewise, the end of the project does not remove on technology needed to pass information on to other stakeholders. The design is intended to maximize the relationships between care groups, VHCs and clinical workers by making it easy for care groups to verbally pass on data through the information chain.

The C-HIS helps care groups assess, understand and respond to changing health needs in the community. Care groups are experienced at pooling their experiences during care group meetings and advising fellow volunteers how to respond to difficult situations. In this way, the care group is able to discuss and take action regarding a particular household. They also identify and respond to wider trends in the community.

Sustaining relationships with VHCs: Furthermore, the data collected by care groups is easily understood and acted upon at the village level through. The care groups can continue reporting vital monthly statistics and current health trends to VHCs. If VHCs themselves stop meeting, care groups can report information to village leaders and other key community groups.

Over the life of the project, VHCs learn to value volunteers and their dramatic impact on the health of community members. VHS' appreciation – and expectations – help with sustainability. VHCs encourage care groups to continue their work, and they act as a source of community accountability to care groups. They can help supervise their activities and be an outside moderator for settling any disputes involve care groups and community members.

Special responses: The network of care groups network can be mobilized for responding to needs other than their typical preventative health and teaching activities. For example, care groups helped respond in a time of crisis early in Vurhonga II. Devastating floods hit the project area, displacing most of the population in Chokwe District. In the relief camps, the displaced promoters and care group volunteers connected with each other and began helping in WR's disaster relief efforts. Though not all care groups had been formed since the project was in its early stages, promoters and some volunteers delivered crucial health and hygiene messages in the camps. In another situation later in Vurhonga, care groups participated with UNICEF by selling mosquito net retreatment kits in the project area. Though these activities took place during the course of Vurhonga II, it is possible that care groups could respond in similar ways after a project ends. As long as care groups continue to function, they remain a resource that the community and others can utilize in addressing a range of needs.

1.4 Conclusion

Empowerment: More difficult to measure – but just as important to sustained care group activity and behavior change – is community empowerment and transformation of attitudes. Vurhonga I's external evaluator noted, *"A more important reality is that no numbers can quantify the sense of enthusiasm and joy that now permeates village life. A palpable sense of self-reliant social competence has reached a tipping point in reflecting high level community empowerment. People, and this includes fathers as well as mothers, say they don't need data to know that babies are no longer dying as they used to. All those participating in the project do, however, enjoy getting good information in order to find out what can still be improved. There is no question that it is the communities who have produced and therefore own the process of empowerment under the guidance of World Relief staff."*

Ultimately, widespread community empowerment is at the heart of care groups' many accomplishments. Care group volunteers, empowered not only by new knowledge but by a new sense of efficacy and self-worth, make the difference. A health project may form the care groups, train the volunteers and introduce the interventions, but it is the care groups who teach their communities, one household at a time. Poor, illiterate women join together and unite as agents of change in their communities. Care groups share their empowerment with mothers, with households, with local leaders, with clinical workers, until the entire community is gathered together in the process of change. This remains even after an NGO project reaches its conclusion. Like a stone thrown into a pond, the ripple effects of care groups keep going, even though the stone can no longer be seen. Transformed communities are the lasting difference.

Appendices

Appendix A: Profile of World Relief Child Survival Projects

Mozambique

Project Name: Vurhonga I, "Dawn"
Project Director: Dr. Pieter Ernst
Dates: September 1995-September 1999
Location: Guija and Mabalane Districts, Gaza Province
Local Partners: MOH

Direct Beneficiaries:	57,277
Children Under 5:	31,764
Women:	25,513
Total Population:	107,000

Care Groups: 177
Care Group Volunteers: 1,520

Major Areas of Focus: Malaria, Hygiene and Diarrheal Disease, Immunization, Nutrition, Maternal and Newborn Care.

Project Name: Vurhonga II
Project Director: Dr. Pieter Ernst
Dates: September 1999-September 2003
Location: Chokwe District, Gaza Province
Local Partners: MOH

Direct Beneficiaries:	53,418
Children Under 5:	22,080
Women:	31,338
Total Population:	130,000

Care Groups: 220
Care Group Volunteers: 2,315

Major Areas of Focus: Malaria, Hygiene and Diarrheal Disease, Pneumonia, Immunization, Nutrition, Birth Spacing, Maternal and Newborn Care, HIV/STIs Prevention and Treatment.

Project Name: Vurhonga III
Project Director: Dr. Pieter Ernst
Dates: October 2004-September 2009
Location: Chibuto, Chicualacuala, Chigubo, Massangena and Massingir Districts, Gaza Province
Local Partners: MOH

Direct Beneficiaries:	101,757
Children Under 5:	38,635
Women:	63,122
Total Population:	227,260

Care Groups: 350
Care Group Volunteers: 3,500

Major Areas of Focus: Diarrheal Disease, Malaria, Pneumonia, Immunization, Nutrition, Breast Feeding and HIV/AIDS.

Cambodia

Project Name: "Light For Life"
Director: Kay Hansen, with Sivan Oun, Deputy Director
Project Dates: September 1998- September 2002
Location: Pohnea Kriek District, Kampong Cham Province
Local Partners: MOH

Direct Beneficiaries:	33,300
Children Under 5:	7,479
Women:	18,866
Villages:	84
Total Population:	77,804

Care Groups: 126
Care Group Volunteers: 940

Major Areas of Focus: Hygiene and Diarrheal Disease, Immunization, Nutrition, Maternal Care.

Project Name: "Light For Life II"
Project Director: Sivan Oun, with Geoffrey Bowman, Project Advisor
Dates: September 2002-September 2007
Location: Ponhea Kriek and Dombe Districts, Kampong Cham Province
Local Partners: MOH

Direct Beneficiaries:	66,482
Children Under 5:	20,354
Women:	46, 128
Villages:	215
Total Population:	184,642

(Note: the CSP is a cost-extension project, and serves the original project area as well as the expansion area. The numbers above are for the total population served.)

Care Groups: 444
Care Group Volunteers: 3,497

Major Areas of Focus: Hygiene and Diarrheal Disease, Pneumonia, Immunization, and Nutrition.

Malawi

Project Name: Tiweko Tose, “All Of Us Together”
Director: Victor Kabadghe, with Deputy Director Paul Mkandawire
Dates: September 2000-September 2004
Location: Mzimba and Rumphi Districts, Northern Malawi
Local Partners: 3 district hospitals operated by the Central Church of Africa Presbytery, the Synod of Livingstonia, and the MOH

Project Beneficiaries:	68,917
Children Under 5:	36,732
Women:	32,185
Total Population:	170,000

Care Groups: 230
Care Group Volunteers: 2,300

Major Areas of Focus: Malaria, Pneumonia, Nutrition, Maternal and Newborn Care, HIV/STIs Prevention and Treatment

Rwanda

Project Name: Umucyo, “To Illuminate”
Project Director: Melene Kabadge
Dates: September 2001-September 2006
Location: Kibogora Health District, Cyangugu Prefecture
Local Partners: Kibogora Hospital (operated by the Free Methodist Church of Rwanda), MOH, and World Relief Rwanda’s AIDS and Microenterprise Development programs.

Direct Beneficiaries:	54, 451
Children Under 5:	22,517
Women:	31,934
Total Population:	136,470
Number of villages:	181

Care Groups: 288
Care Group Volunteers: 2,864

Major Areas of Focus: Malaria, Hygiene and Diarrheal Disease, Immunization, Nutrition, Maternal and Newborn Care, HIV/STIs Prevention and Treatment.

Appendix B: Other Examples of Care Groups

Food for the Hungry International

Background: Food for the Hungry International (FHI) began relief operations in Sofala Province, Mozambique, in 1989 in response to famine and chronic food shortage caused by civil war, intermittent drought and a breakdown in rural infrastructure and marketing networks. In 1997, FHI started a Title II food security Development Activity Program (DAP). FHI's health/nutrition project also began in 1997 as part of the food security program in Nhamatanda and Marromeu districts in Sofala province, with assistance from USAID. Later in 2000, Gorongosa district was also included. The first phase of the Title II food security program ended in 2001, successfully achieving its intended targets.

Current project: USAID continued its support to FHI for a second phase of the food security project. The Title II project currently includes nutrition programs in 4 districts of Sofala Province: Nhamtanda, Gorongosa, Marromeu and Caia. The program began in 2002 and will finish in 2006.

Staff and volunteers: In each district, there are currently 10 health promoters each responsible for training 80 to 100 mother volunteers (care group volunteers). Currently, there are 3,200 mother volunteers regularly reaching 28,100 households with children under 5 years of age.

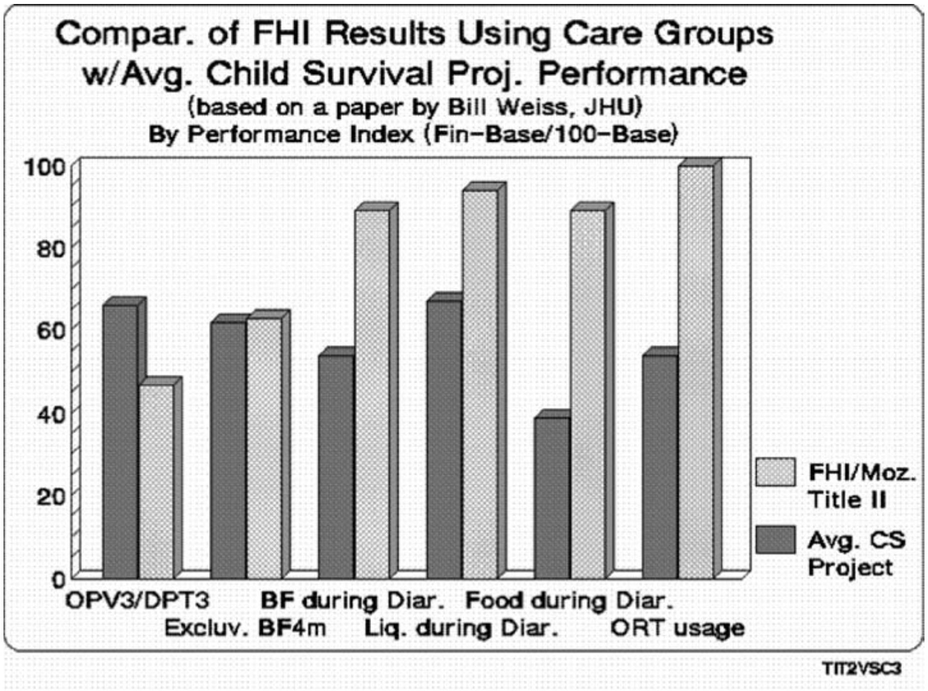
Goals: The project aims at reducing chronic malnutrition by 20% during the five-year project. The major strategies are nutrition and health education through care groups, as well as growth monitoring, rehabilitation of malnourished children, and promoting positive health care practices in the community. The nutrition component will rehabilitate malnourished children less than five years using the Positive Deviance/Hearth nutrition rehabilitation strategy.

The project is designed to be synergistic, with the agriculture component assisting the nutrition component in the diffusion of vitamin A-rich sweet potato varieties, quality protein maize varieties, and increasing the variety of vegetables grown.

Results: FHI has reached more than 42,000 households every two weeks in their Title II project using care groups.

During the 1997-2001 project, significant gains were made in impact-level and results-level indicators using care groups. For example, moderate malnutrition (MN) dropped by 25%, severe malnutrition dropped by 48% ($p<0.05$), exclusive breastfeeding (EBF) to four months increased by 80% and immunization with the third dose of diptheria, pertussis and tetanus (DPT) increased from 49% to 73%.

The graph below illustrates FHI's results compared to other child survival projects, including interventions such as an immunization, breastfeeding, and ORT use.



In addition, FHI's Title II project has shown impressive results in terms of increased agricultural and nutritional knowledge and adoption of practices, and increased ability of farmers to market produce.

Curamericas

Background: Curamericas is using the care group model in its CSP in Guatemala. Specifically, the project works in the rural area department of Huehuetenango, including the rural communities and town centers of the San Rafael de la Independencia, San Miguel Acatán, and San Sebastian Coatán municipalities. The project began in 2002 and will continue through 2007.

Staff and volunteers: Care groups meet twice a month. Twenty-seven community facilitators, who receive a small stipend, lead the care group meetings. Initially, the project hoped to have one care group volunteer for every 12-15 beneficiary women. However, the CSP decided to have one volunteer for every 8-12 women because of the distances in this remote, rural area.

Project goals: The overall project goal is to significantly improve the health and nutrition of preschool children and women of reproductive age, with a focus on decreasing perinatal, infant, and maternal mortality through improvements in health care and health promotion access, quality and coverage. The project interventions are 30% nutrition, 25% maternal and newborn care, 10% child spacing, 15% pneumonia, 10% control of diarrheal disease, and 10% immunizations. The Curamericas CSP is partnering with the district health offices of the MOH as well as Curamericas Guatemala, an independent Guatemalan NGO.

Results: The CSP reaches 26,553 direct beneficiaries (12,281 children under age 5 and 14,272 women of reproductive age. The project was at the end of its second year of work at the time of this manual's publication – at that point, care groups had been established in 104 out of 127 total communities targeted for services by the project.

Appendix C: World Relief's Child Survival Project Results

The following tables show results for baseline, midterm and final KPC surveys for WR's four completed CSPs that used the care group model.

Vurhonga I–1995-1999

Objectives and Target	Baseline	Midterm	Final
1. Increase the number of children completely immunized by 12 months from 37.4% to 80%	37	79	93
2. To increase the number of children with diarrhea in the last two weeks who have received ORT from 46.8% to 60%	47	64	82
3. Increase the number of mothers who give more food than usual to a child during recovery (at least one week) from diarrhea.	8	56	86
4. Increase the number of children 0-35 months weighed in the last 3 months from 58.6% to 70%.	59	85	91
5. Increase the number of mothers who receive rehabilitative nutritional counseling for children 0-35 months who have not gained weight since last being weighed from 20% to 80%	20	82	87
6. Increase the number of children 0-4 months exclusively breastfed from 15.8% to 30% (figures in parentheses indicate those who received a small supplement)	16	46 (77)	55 (91)
7. Increase the number of children 0-59 months treated within 24 hrs. for malaria from 11.4% to 35%.	11	47	85
8. Increase the number of mothers who received at least one prenatal care check during the last pregnancy from 30% to 55%.	30	83	90
9. Increase the number of women who have received at least 2 doses of TT from 37.3% to 60%.	37	65	82
10. Increase the number of women using family planning from 3% to 10%	3	9	23
11. At least 80% of Care groups have met 4 times in last six months.	–	100	100
12. At least 80% of World Relief installed borehole pumps function at least 11 months per year.	–	95	96
13. At least 80% of communities (village and Care group leaders) have met one time during the last 3 months with a MOH rep.	–	53	98
14. Increase the number of mothers who ate the same or more food during last pregnancy from 40% to 60%	38	66	86
15. Increase population access to health post within 5 km from 54% to 80%	54	83	93
16. Mothers who know at least 2 ways of HIV transmission from 13% to 40%	–	–	71

Vurhonga II–1999-2003

Objectives and Target	**Baseline**	**Final**
Nutrition:		
1a. Increase from 75% to 85% the number of children 0-35 months weighed at least once during last 3 months.	75%	90%
1b. Increase from 22% to 80% the number of malnourished children's mothers who received nutrition counseling	22%	92%
1c. Increase from 50% to 70% the number of malnourished children who received nutritious foods/enriched porridge	50%	97%
2. At least 70% of children who completed the HEARTH program achieve and sustain adequate or catch-up growth per month during at least 2 months after HEARTH.	NA	73%
Maternal Care:		
3. Increase from 45% to 70% the number of mothers who eat the same amount or more food during pregnancy.	45%	82%
Malaria and Pneumonia:		
4a. Increase from 28% to 75% the number of children treated within 24h for fever (suspected malaria) at any health facility.	28%	90%
4b. Increase from 0.3% tot 70% the proportion of children under 5 who use insecticide treated nets year round.	0%	85%
4c. Increase from 2% to 50% the number of children treated within 24h for rapid, difficult breathing at appropriate health facility	2%	60%
4d. Increase to 100% the health facility-based providers who have received continuing education in malaria and pneumonia protocols during the project. (MOH Capacity Building)	0%	100%
Diarrhea Case Management		
5a. Increase from 53% to 80% the proportion of children with diarrhea treated with ORT by mothers/volunteers.	53%	94%
5b. Increase from 19% to 65% the proportion of mothers who give extra food to children for 2 weeks following diarrhea.	19%	87%
Reproductive Health:		
6a. Increase from 0.3% to 50% the number of mothers who know 3 ways to prevent transmission of STI including HIV/AIDS.	0%	53%
6b. Increase from 1.6% to 50% the number of women and partners who recognize at least 3 common symptoms of STI.	2%	59%
6c. Increase from 0.3% to 50% the number of women and partners who recognize that STI increases risk of HIV/infertility.	0%	52%
7. Increase from 65% to 70% the number of mothers who deliver child by trained provider.	65%	88%
8. Increase from 7% to 20% the number of women who are using a modern method of birth spacing.	7%	29%

Immunization Immunization was not a project objective but was promoted and tracked.	74%	91%
SUSTAINABILITY & CAPACITY BUILDING: **1. MOH / District Level**		
1.a At least 95% of beneficiaries in the project area will live within 5 km of a health facility staffed with trained personnel and equipped with essential supplies.	65%	99%
1b. Chloroquine will not be out of stock for more than three days per month in at least 90% of health posts.	80%	98%
1c. 75% of Socorristas will have received a supervisory visit from Chokwe District staff or Vurhonga project director within the previous quarter.	0%	85%
1d. 70% of VHCs will have met at once during the last two months.	0%	91%
1e. Health Post staff will attend at least 80% of the meetings of VHCs	0%	95%
1f. 50% of beneficiaries will report that they are satisfied with their last visit to an MOH facility as measured by a satisfaction index	NA	99%
2. Community–Level		
2a. 95% of villages will have established VHCs by EOP.	NA	100%
2b. 70% of VHCs will meet at least once in the last two months.	NA	91%
2c. 100% of Care Groups will "graduate" during the fourth year of project.	NA	100%
2d. The monthly attendance rate at church leaders Care Group meetings will be at least 60%.	NA	70%
2e. 50% of mothers who attended church during the past month report that they heard a health message.	NA	72%
Volunteer and Family Level		
3a. At least 60% of families have been visited by their volunteer during the past two weeks.	NA	92%
3b. The attrition rate of volunteers for reasons other than death, disability, or movement out of the project area will be less than 10%.	NA	3%
3c. Use indicators for specific CS interventions, e.g., participation in growth monitoring, EPI coverage, etc.	74% 78%	EPI=91% GM=90%

WR Cambodia I–1998-2002

Objectives	Baseline	Target	Midterm	Final
Children 12-23 mos. who are up to date on immunizations	5	70	28	81*
Women who have received two or more TT immunizations	2	70	31	71*
Mothers who use ORT for sick children	18	75	18	80
Women know 2 danger signs of diarrhea disease	4	30	7	56
Mothers who give extra food during recovery from diarrhea	4	20	14	50
Women who wash hands before cooking	22	50	34	78
Women who wash hands after defecating	6	90	6	78
Households have hand washing station	NA	NA	57	99
Children 6-23 mos. who have received dose of Vitamin A	0	60	10	67*
Women who take iron supplements for 60+ days during pregnancy	0	20	10	38
Use of modern birth spacing method	17	30	21	56
Children 0-4 mos. who are exclusively breastfed	8	16	7	37
Households use iodized salt	0	NA	7	55

* Cambodia measured end of project immunization rates in a special survey following the final KPC to capture intensified immunization efforts in the final months of the project.

WR Malawi—2000-2004

Objectives and Target		Baseline	Midterm	Final
1. Increase from 35.4% to 90% the percentage of children <5 yrs treated the same or next day for fever at an appropriate health facility		35.4	52.1	73.8
2. Increase from 27.6% to 50% the percentage of children < 5 yrs who are treated the same or next day for rapid difficult breathing at an appropriate health facility		27.6	55.0	63.6
3. Increase from 8.5% to 50% the number of children < 5 years and pregnant women sleeping under bed net	***Under Fives***	8.5	23.1	60.3
	Pregnant Women		20.1	60.1
4. Increase from 62% to 75% the percentage of bed nets that will be retreated within the last 12 months		62	62.2	96.9
5. Increase from 65% to 90% the number of children 0-35 months weighed regularly in GMC sessions		65	65.2	97.2
6. Increase from 3% to 30% the proportion of pregnant or lactating women who receive daily IFA supplements		3	5.1	75.9
7. Increase from 36% to 50% the proportion of mothers exclusively breastfeeding 0-6 months infants		36	82.1**	95.4
8. Increase from 23% to 40% the percent of married women who use a modern method of contraception		23	50.1	61.0
9. Increase from 17.5% to 30% the percent of sexually active married women who state using a condom during their most recent sexual act		27.5	22.0	38.2
10. Increase from 9.5% to 90% the percent of families who have an emergency transport plan in place before delivery		9.5	86.3**	84
11. Increase from 30% to 60% the percent of pregnant women who receive at least 2 doses of SP during pregnancy		30.6	63.0	61.3

** The CSP used a different methodology for measuring breastfeeding at the midterm. But for the final evaluation, the project used the same methodology used to collect baseline data.

Appendix D: Work Plan

Below is the work plan of Vurhonga II, as presented in the project's Detailed Implementation Plan (DIP). Please note that in February 2000, the worst flood in decades hit Gaza province. The flooding displaced the general population of the project area – including Vurhonga promoters and supervisors – into relief camps. This interrupted the project, which was selecting organizing care groups and conducting the household count at the time. Vurhonga staff, and the nascent care groups, responded by participating in relief activities led by World Relief. They led trainings in the camps about hygiene and the prevention and treatment of diarrhea. The project resumed its normal activities after roughly one month.

Vurhonga II Project Work Plan – Years One to Four

Vurhonga II Project Work Plan	**‘99**		**2000**				**2001**				**2002**				**2003**		
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3
Project Design and Planning:																	
Revise project design to reflect technical and budget review	X																
Negotiate and sign cooperative agreement.	X																
Secure formal agreements with MOH	X																
Contact collaborating communities (village leaders)	X	X															
Contact/consult with USAID mission	X																
DIP preparation (Feb ‘00 and Jan ‘01)			X				X										
Development of six month work plan	X	X															
Emergency Flood Relief (following Feb 2000 flood):																	
Hygiene Training at Xiaquelane (disaster camp)			X														
Distribution of food, seeds and tools				X													
Management of Project Personnel:																	
Phaseover staff from Vurhonga I		X															
Promotion of three animators to become supervisors	X	X															
Selection and training of Animators		X															
Supervision of Animators by Supervisors			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Weekly Monitoring, Discussion Mtgs with Animators			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Quarterly Planning with Supervisors/Animators)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Animators begin recruiting volunteers and meeting leaders		X	X														
Selection of Volunteers for Mother & Pastoral Care Groups			X														
Complete Census of all mothers and children < 5			X	X													
Formation of the Care Groups (interrupted by floods)			X	X													
Formation of Village Health Committees (VHCs)																	
Training of Care Groups					X	X	X	X	X	X	X	X	X	X	X	X	X
“Granny” Training (once each two months)					X	X	X	X	X	X	X	X	X	X	X	X	X
Annual Incentives provided to Volunteers						X				X				X			
Care Groups and VHC “Graduations”														X	X	X	X
Formation of Village Health Committees						X											
Purchase supplies and equipment for office		X		X		X		X		X		X		X		X	

Vurhonga II Project Work Plan – Years One to Four

Vurhonga II Project Work Plan	'99		2000				2001				2002				2003		
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3
Curriculum and Teaching Materials Development:																	
Revise curricula and teaching materials (old interventions)		X						X									
Review/Revise curricula/AV for Reproductive Health								X	X								
Develop curricula/teaching materials for Pneumonia									X	X							
Prepare and Print teaching materials in South Africa		X							X		X						
Review and update of curricula and teaching materials												X	X	X	X		
Training Sessions:																	
Supervision Seminar for project supervisors							X		X		X		X		X		
Training new animators		X															
Malaria Training Camp (one week)					X												
CDD Training Camp (one week)						X											
Nutrition Training Camp (one week)							X										
HEARTH Training Camp (one week)							X										
HIV/AIDS Training Camp (one week)								X									
Maternal Health & Child Spacing Training Camp (1 week)										X							
Pneumonia Training Camp (one week)											X						
Participatory Methods Training (one week)							X										
Conflict resolution methods (1-2 days in 3 parts)						X	X		X								
AIDS home care methods									X								
Chef de Saude Training Camp												X					
Socorrista Training (Mal., Pneu., HIV/AIDS, TB, CDD)						X							X				
Training of TBAs in collaboration with MOH							X										
Introduction of CS Interventions:																	
Malaria					X	X	X	X	X	X	X	X	X	X	X	X	X
Distribution of Insecticide Treated Mosquito Nets					X	X											
Retreatment of Mosquito Nets							X		X		X		X		X		X
CDD						X	X	X	X	X	X	X	X	X	X	X	X
Nutrition and HEARTH							X	X	X	X	X	X	X	X	X	X	X
HIV/AIDS									X	X	X	X	X	X	X	X	X
STI/HIV/AIDs prevention for men returning home										X	X			X	X		
Maternal Health and Child Spacing										X	X	X	X	X	X	X	X
Pneumonia											X	X	X	X	X	X	X
Retraining of Trainers based on curricula updates												X	X	X	X		

Vurhonga II Project Work Plan – Years One to Four

Vurhonga II Project Work Plan	‘99		2000				2001				2002				2003		
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3
Baseline Surveys / Monitoring & Evaluation / Reporting																	
Review/Planning Mtgs with MOH (at least 1 per quarter)		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Bi-Annual Review by MOH (with project participation)		X		X		X		X		X		X		X		X	
Health Information System (Data Collection and Analysis)						X	X		X	X	X	X		X	X	X	
Post Flood Retreat/Annual Retreat (Internal Evaluation)						X				X				X			
KPC Surveys		X							X								X
Quarterly and Annual Reporting		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Midterm and Final Evaluations									X								X
Implement Mid-Term Evaluation recommendations										X	X	X					
Technical Assistance and Trips:																	
Malaria (Bednets Distribution & Dipping)/Oxfam TA				X	X												
Participatory Methods Trainer							X										
Conflict resolution methods Trainer							X										
Nutrition intern for HEARTH Operations Research								X	X								
AIDS home care methods Trainer									X								
Visits by World Relief/US staff			X				X		X			X			X		X
Visits by World Relief/Mozambique Maputo staff																	
Annual Visit to Vurhonga I project site					X				X				X			X	
Global Health Conference and CCIH								X				X					
Continual Education Workshop (Kenya two weeks)												X					

Appendix E: Staff Training

Vurhonga holds a 2 to 3 week "kickoff" training camp for promoters early in the project. Topics covered include participatory training methods, group dynamics, conflict resolution, and all of the health interventions. In the case of Vurhonga II, this was possible since project leadership had already developed the entire curriculum.

Vurhonga holds 5 day "refresher" training camps for promoters before phasing in each intervention in the care groups.

Below is a schedule for a refresher training before implementing a nutrition intervention.

Nutrition Training Program: Day One

TIME	ACTIVITIES	ACTIVIDADES	Person Responsible
Jan 22		**DIA 22/01**	
6.00 h.	Departure from Chokwe	Partida de Chokwe	Supervisors/Supervisoras
8.00 h.	Arrival at camp	Chegada e Descarregamento	Entire team/Toda a equipa
8.30 h	Setting up Tents	Esticar a tenda de estudos	All the team/Toda a equipa
9.00 h.	Preparation of small lunch	Preparacao do pequeno almoco	Cooks/Cozinheiras
11.00 h.	**Opening and welcome**	Abertura e boas-vindas	2 Supervisors/Celina e Cristina
12.00 h.	**Review Plan for the week for Training Groups 1-4**	Apresentacao do plano de trabalho e Formacao de grupos I – IV	2 Supervisors/Clara e Guida
12.30 h	Small Lunch	Pequeno almoco	Cooks/Cozinheiras
13.15 h.	Orientation on accommodations	Orientacao sobre os quartos	2 Supervisors/Celina e Cristina
13.30 h	**Lesson 1 and Practice**	Licao 1 e Practica	1 Supervisor/Clara Javana
16.00 h.	Relaxation	Divertimento/Desporto	Staff/Agostinho e Muiambo
16.30 h	Bathing time	Banho	
18.30 h	Supper	Jantar	Cooks/Cozinheiras
19.30 h	Group 1	Grupo 1	Relevant group/Proprio
21.00 h.	End of Day One	Fim do trabalho do dia e	grupo

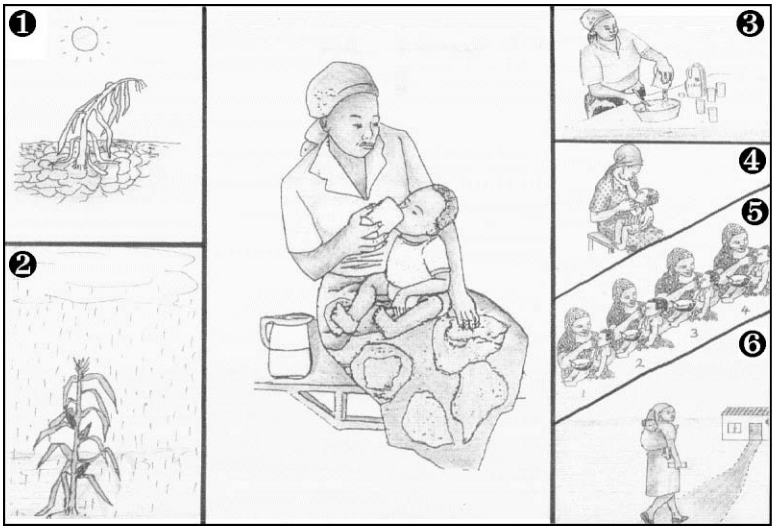
Each training camp includes an evaluation session. All participants are asked to anonymously write down any positive or negative observations concerning the activities and management of the training camp. These observations are then read to the entire group and discussed until a general consensus and recommendation is adopted. The project supervisors, who are in charge of planning the next refresher training camp, take note of any changes that need to be made.

Appendix F: Vurhonga Curriculum

As Vurhonga I staff initially developed curriculum, they realized that care group volunteers found flip charts too confusing to use as they taught their assigned households. Instead, Vurhonga I and II trained care group volunteers by using one main picture on a single sheet of paper for each health lesson, with smaller pictures grouped around the main image. This made it easier for volunteers to remember the lesson and accurately replicate health messages. Promoters equip every care group volunteer with a durable copy of each picture for volunteers to use during household visits.

The image below is an example of Vurhonga II curriculum on ORT.

The Treatment of Diarrhea



DISCUSSION OPENING:
Q. What do you see in the picture in the center?
A. A child drinking. A mother giving ORT to her child.

Key Health Messages:

1) Diarrhea for a child is like a maize plant that has not received rain – they both wilt.

2) The plant recovers after receiving rain. In the same way the child is weak without water, but will improve as soon as he receives fluids.

3) Give a child who has diarrhea ORS or home available fluids.

4) Continue breastfeeding a child who has diarrhea.

5) Give the child more food than usual, e.g., four times a day, after recovery from diarrhea for at least two weeks.

6) If the child still doesn't improve on home treatment, or has a fever or blood in the stools, take the child promptly to the nearest health post.

Appendix G: Hearth and Care Groups

Health projects can utilize the care group model to effectively implement the Positive Deviance/Hearth nutrition rehabilitation strategy. (Please refer to CORE's Positive Deviance/Hearth manual for a complete guide.) Volunteers in Vurhonga benefit from the participation and support of their care group as they hold Hearth in their community.

Hosting Hearth: Care group volunteers rotate the location of Hearth sessions among the group. Each day, mothers and children participating in Hearth gather at the home of a different volunteer. All volunteers get first-hand exposure to Hearth as they take turns holding sessions at their homes.

➡ **Share the responsibility of providing daily locations for Hearth sessions.**

- The entire care group learns about Hearth in the care group meeting.
- A care group volunteer hosts a Hearth session at her home, with the help of her promoter.
- Several other volunteers should also be present to assist (it is not necessary that the whole care group attends).
- The next day, another volunteer takes her turn holding Hearth at her house.
- The location is rotated between volunteers until the entire 12-day Hearth cycle is completed.
- Over the next two weeks, volunteers provide intensive follow up and support to their assigned households who participated in the Hearth session.

Leading Hearth: When Vurhonga repeats the nutrition intervention in the second half of the project, promoters build the capacity of care groups to assume implementation of Hearth.

The Care Group Difference:
Share the burden of hosting and leading Hearth by rotating responsibilities among all care group volunteers.

➡ **Share the responsibility for leading a Hearth session.**

- At first, the promoter leads each Hearth session, with the volunteer who is hosting assisting her.
- As volunteers become more skilled at Hearth, the promoter gradually phases out her involvement.
- The care group leader leads a Hearth session at her home, with the promoter providing support.
- Each volunteers takes her turn leading Hearth when the session is held at her house.
- The promoter provides on-going supervision and support.

All care group volunteers grow skilled in Hearth, both in leading sessions and holding them at their homes. Through the group participation, the intervention ultimately becomes more sustainable in the community.

Appendix H: Resources

Background Materials for Nonformal Adult Education

Freire, Paulo. History and background: The Pedagogy of the Oppressed; Education for Critical Consciousness. Continum Publishing Co., NY.

Knowles, Malcolm. Androgogy in Action: Applying Modern Principles of Adult Learning. Jossey-Bass Publishers.

Merriam, Sharan B. and Rosemary S. Caffarella. Theory: Learning in Adulthood: A comprehensive guide. Jossey-Bass Publishers.

Mezirow, J. Fostering Critical Reflection in Adulthood: A Guide to Transformative and Emancipatory Learning. Jossey-Bass Publishers.

Vella, Jane. Principles and Practice: Learning to Listen, Learning to Teach: the power of dialogue in educating adults. Jossey-Bass Publishers.

Vella, Jane. Taking Learning to Task. Jossey-Bass Publishers.

Participatory Education Materials

Pretty, Jules. Participatory Learning and Action: a trainer's guide. International Institute for Environment and Development (IIED) London.

Silberman, Mel. 101 Ways to Make Training Active. Jossey-Bass Publishers.

Training Trainers for Development: a workshop on participatory training techniques. CEDPA, Washington, DC.

Other Reference Materials

BEHAVE Framework for Behavior Change Programming. See Technical Reference Materials: Behavior Change Interventions. Child Survival Technical Support+ Project, 2004.

Bhattacharyya, Karabi; Winch, Peter; LeBan, Karen and Marie Tien. Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention and Sustainability. Basics Support for Institutionalizing Child Survival Project (Basics II) for the United States Agency for International Development. Arlington, Virginia.

Improving the Performance of Facility- and Community-Based Health Workers. Child Survival Technical Support Project, Calverton, MD.