Establishing Care Group Criteria

(revised November 12, 2010)

Rationale for this Document:

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

Since 1995, WR, FH, and more than 12 others PVOs in more than 14 countries have "adopted the model," but the degree to which organizations adhere to the original components of the model varies greatly. While there has been increased attention to the model and its effectiveness in lowering child deaths (e.g, mentioned in the UNICEF's 2008 State of the World's Children report), there is a danger that the wide variations in what is called a "Care Group" by various agencies will lead to misunderstandings about the model and the use of less effective strategies that do not fit within the model. These variations, in turn, could lead to fewer opportunities to advocate for the Care Group model and its role in child survival since the term "Care Groups" may come to mean many different things to different people, and will probably develop a very mixed track record. There are already situations in which individuals and organizations are defining Care Groups as "any group where you are teaching mothers" or "any group where you are teaching people to teach other people." Given the excellent and low-cost results seen in the USAID Child Survival and Health Grants Program and Title II food security projects in terms of decreased child mortality and morbidity using Care Groups, we feel that it is important to define official criteria for the Care Group model.

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

Of course there is no way to enforce the use of these criteria – people will use the term how they wish – but by having two organizations that are recognized as having a history of using and promoting Care Groups extensively (one organization being the original developer), defining formal criteria should provide a stronger basis for recognition of the model and lead to better adherence to the most effective components of the model. We also hope that by informing donors and others about these criteria, they will use the criteria to decide to what degree a proposed implementation strategy is really based on the Care Group model. The **CORE Social & Behavioral Change Working Group** (SBCWG) has helped with the dissemination of this document, and we expect this will further legitimize the list, and will lead to better compliance with the recommended criteria. The table below gives the required and suggested criteria along with a rationale for each.

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

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

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

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

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

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Volunteers (e.g., data collection, observation of skills) occurs at least monthly.	supervision of Care Group volunteers, the usual pattern is for the Promoter to supervise through direct observation at least one volunteer following the CG meeting.
12. All of a CG volunteer's beneficiaries should live within a distance that facilitates frequent home visitation and all CG volunteers should live < 1 hour walk from the Promoter meeting place.	It is preferable that the CG volunteer not have to walk more than 45 minutes to get to the furthest house that she visits so that regular visitation is not hindered. (In many CG projects, the average travel time is much less than this.) This also makes it more likely that she will have a prior relationship with the people that she is serving. Before starting up CGs, the population density of an area should be assessed. A low CG volunteer: Mother Beneficiaries (MBs) and low Promoter:CG ratio should be used when setting up CG in rural, low population density areas. If an area is so sparsely populated that a CG volunteer needs to travel more than 45 minutes to meet with the majority of her beneficiary mothers then the Care Group strategy may not be the most appropriate one to use.
13. The implementing agency needs to successfully create a project/program culture that conveys respect for the population and volunteers, especially women.	During Operations Research conducted near the end of the FH Sofala CG project, CG volunteers ("Leader Mothers") were asked who respected them now that did not respect them before. 86% mentioned other mothers/women, 64% mentioned Community Leaders, 61% mentioned their husbands, 45% mentioned their parents or in-laws, 41% mentioned extended family members, and 25% mentioned health facility staff. We believe that an important part of this model is fostering respect for women, and implementers need to make this an explicit part of the project, encourage these values among project staff, and ideally measure whether CG volunteers are sensing this respect.
Suggested:	
1. Formative research should be conducted, especially on key behaviors promoted.	A review of the most effective projects in terms of behavior change for both exclusive breastfeeding and hand washing with soap (by the CORE Group Social & Behavioral Change Working Group) found that they included formative research (e.g., Barrier Analysis, Doer/NonDoer Analysis) on the behaviors. We believe that more systematic use of formative research on behaviors will lead to the best adoption rates. Formative research also helps assure that the behaviors promoted by project staff are more feasible by community members.
2. The Promoter: Care Group ratio should be no more than 1:9.	For Promoters to know and have the trust of those with which they work, it is best to limit the number of volunteers with which they work to about 150, or nine groups (assuming a CG size of between 6 and 16 members). Some social science research confirms that our maximum "social channel capacity" – the maximum number of people with whom we can have a genuinely social relationship – is about 150 people (and 9 groups x 16 people/group = 144).
3. Measurement of many of the results-level indicators should be conducted annually at a minimum.	We have found that regular measurement of at least some key results-level indicators on an annual (or better) basis is helpful in knowing what is changing and what is not in time to do something about it.
4. Social/educational differences between the Promoter and CG volunteer should not be too extreme (e.g., having bachelor-degree level staff working with CG volunteers).	We believe that keeping the educational difference between the Promoter and CG volunteers to a modicum is useful in that it makes it more likely that the Promoters will use language/concepts that the CG volunteers can understand. It also helps to keep costs of the model low.

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